

Tennessee’s Collaborative Maternal, Infant and Early Childhood Home Visiting Program
Tennessee Department of Health
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Tennessee’s Collaborative Maternal, Infant and Early Childhood Home Visiting Program Narrative

Section 1: Identification of the State’s Targeted At-risk Community(ies)

Assessment of Needs and Existing Resources

In September 2010, Tennessee submitted the Statewide Needs Assessment as part of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. The Needs Assessment ranked all 95 Tennessee counties based on indicators outlined in the Phase 2 federal guidance. When guidance became available for the Updated State Plan (February 2011), the MIECHV Steering Committee decided to distribute the federal funding to at-risk communities through a request for application (RFA) process. Applicants were allowed to apply for funding to implement one of the seven federally-identified evidence-based models for implementation in one or more of the fifteen counties ranked as being at highest risk in the Needs Assessment. Counties in which programs will be implemented include: Campbell, Davidson, Hamilton, Maury, Montgomery, and Shelby. While Montgomery County was not one of the fifteen highest-risk counties, it is the home of Fort Campbell Army base; a desire to provide support for military families (given their designation as a priority population in the federal guidance) led the steering committee to include Montgomery County in the selected counties.

Community Strengths and Risk Factors

Many of the communities selected for implementation already have a strong record of collaboration around early childhood issues. Existing infrastructure such as the Early Success Coalition (Shelby County), Family Resource Center network (Davidson County), Mule Town Family Network (Maury County), and the Sheppard’s Home faith-based collaboration (Campbell County) will serve as a nucleus for expanded collaboration for the MIECHV-funded sites. In each of these areas, collaborative partners have worked on understanding the needs of children and families, identifying existing community resources, and linking those in need with appropriate referral agencies. Additionally, a statewide home visitation collaborative (whose membership includes all the funded sites) has provided strong state-level leadership for issues surrounding home visitation and will continue to offer support for the MIECHV-funded expansions.

Despite these community strengths, social comorbidities include high rates of unemployment (range of 9.0-15.3%), high crime rates (96.3 to 149.9 per 1,000 population), and high school dropout rates (5.5% to 16.8%). These social factors certainly place children and families at risk of adverse future outcomes. Table 1 provides county-level data for risk factors outlined in the Needs Assessment.

Table 1--Community Risk Factors

County	Overall Poverty (%)	Reported Crimes (per 1,000)	Youth Arrests (per 100,000)	Domestic Violence (per 100,000)	Dropouts (Cohort, %)	Unemployment (%)	Child Abuse (per 1,000)
Campbell	22.8	121.8	404	1,228	10.5	12.7	13.8
Davidson	13.0	136.1	1,427	2,143	16.8	9.0	8.0
Hamilton	12.1	106.2	1,682	1,023	16.8	9.0	2.5
Maury	14.1	109.2	2,504	2,068	15.1	15.3	5.1

County	Overall Poverty (%)	Reported Crimes (per 1,000)	Youth Arrests (per 100,000)	Domestic Violence (per 100,000)	Dropouts (Cohort, %)	Unemployment (%)	Child Abuse (per 1,000)
Montgomery	10.0	96.3	1,630	1,506	5.5	8.5	8.8
Shelby	16.0	149.9	2,915	2,442	14.4	10.3	8.6

Characteristics and Needs of Participants

The community risk factors outlined in Table 1 correlate with the individual characteristics and needs of home visiting participants. Mothers in the selected communities have high rates of smoking (ranging from 6.0% to 31.1%) and are likely to become pregnant as teenagers (range of 29.8 to 52.3 per 1,000). Infants born to mothers in these communities also face significant challenges. Many are born prematurely (range of 10.2% to 13.2%) and at low birth weights (range of 9.3% to 11.3%). In some communities, as many as 12.6 out of every 1,000 infants will not live to see their first birthday. Table 2 provides county-level data for risk factors outlined in the Needs Assessment.

Table 2--Individual Risk Factors

County	Preterm Birth (%)	Low Birth Weight (%)	Infant Mortality (per 1,000)	Maternal Smoking (%)	Teen Pregnancies (per 1,000)
Campbell	13.7	9.4	6.6	31.1	29.9
Davidson	11.5	9.3	7.7	9.3	52.1
Hamilton	14.8	11.1	9.5	12.9	36.5
Maury	11.6	9.8	7.3	18.4	29.4
Montgomery	10.2	8.4	8.0	15.6	29.8
Shelby	13.2	11.3	12.6	6.0	52.3

Existing Home Visiting Services

A number of community home visiting services currently exist in Tennessee. Those that are currently operating or have been discontinued since March 23, 2010 are listed in Table 3.

Table 3--Existing Home Visiting Services

County	Existing Programs/Models
Campbell	Child Health and Development (CHAD): Home visiting program administered by the Tennessee Department of Health targeting pregnant women and children ages birth to six. Uses the Partners for Healthy Babies (Florida State University) curriculum.
Campbell	Help Us Grow Successfully (HUGS): Home visiting program administered by the Tennessee Department of Health targeting pregnant women, postpartum women for up to two years, and infants and children up to age 5. Uses the Partners for Healthy Babies (Florida State University) curriculum.
Campbell	Maternal Infant Health Outreach Worker (MIHOW): Home visitation program offered by the Mountain Community Parent Resource Center. Uses local home visitors to visit pregnant women and families with young children up to three years of age.

County	Existing Programs/Models
Campbell	Tennessee Early Intervention System (TEIS): Home-based case management program related to IDEA Part C. Voluntary for families with children ages birth through 2 years with qualifying disabilities or developmental delays.
Davidson	Creating Hope by Assisting Parents (CHAP): Administered by Catholic Charities. Offers education, crisis intervention, and case management.
Davidson	Healthy Families Tennessee: Administered by Prevent Child Abuse Tennessee. Uses the Healthy Families America model.
Davidson	Healthy Start: Administered by the Metropolitan Nashville/Davidson County Health Department. Modeled after Healthy Start Hawaii model.
Davidson	Help Us Grow Successfully (HUGS): See above description.
Davidson	In-Home Counseling: Administered by the Exchange Club Family Center. In-home parenting program, consisting of 3-6 months of in-home services focused on strengthening families with children of any age. This program is temporarily closed.
Davidson	Maternal Infant Health Outreach Worker (MIHOW): Administered by Vanderbilt University. See above description.
Davidson	Maternal Infant Health Outreach Worker (MIHOW): Administered by United Neighborhood Health Services. Discontinued February 2011.
Davidson	Nurses for Newborns: Provides home-based services to babies who are born with medical problems, born to teen moms, or born to mothers with disabilities/mental health concerns.
Davidson	Tennessee Early Intervention Services (TEIS): See above description.
Hamilton	Help Us Grow Successfully (HUGS): See above description.
Hamilton	La Paz Promotores de Salud: Administered by La Paz Chattanooga. Focuses on serving Hamilton County's growing population of Latino families with a focus on health.
Hamilton	Nurses for Newborns: Provides home-based services to babies who are born with medical problems, born to teen moms, or born to mothers with disabilities/mental health concerns.
Hamilton	Parents Are First Teachers (PAFT): Operates county-wide as a universal model. Uses the Parents as Teachers model.
Hamilton	Partnership for Families, Children, and Adults: Provided home visiting services using the Healthy Families America model. Operation discontinued in January 2011.
Hamilton	Tennessee Early Intervention Services (TEIS): See above description.
Maury	Centerstone Mental Health Case Management: Behavioral/parenting interventions and case management for families of children age 17 or younger with a serious emotional disturbance (SED) diagnosis. Uses a case management model.
Maury	Help Us Grow Successfully (HUGS): See above description.

<i>County</i>	<i>Existing Programs/Models</i>
Maury	Mule Town Family Network: High-fidelity wraparound services provided to families of children and youth (age birth-21) with diagnoses of serious emotional disturbances.
Maury	Tennessee Early Intervention Services (TEIS): See above description.
Montgomery	Help Us Grow Successfully (HUGS): See above description
Montgomery	Healthy Start: Modeled after the Healthy Start Hawaii model. Administered by the Shelbyville Center for Family Development.
Montgomery	Tennessee Early Intervention Services (TEIS): See above description
Shelby	Early Head Start: Two early Head Start programs are offered by Porter-Leath and Shelby County. Home- and center-based services promote parent education and child development for pregnant women and children birth to three.
Shelby	First STEPS Program: Administered by the Exchange Club. Offers child abuse prevention support, parent education, and skills development to teen mothers (age 12-19). Uses the Nurturing Parenting Program curriculum.
Shelby	Healthy Families America: Administered by LeBonheur Community Health and Well-Being. Provides parenting education and skill building, assessment of risks, and child development monitoring to first time mothers. Uses the evidence-based Healthy Families America model.
Shelby	Healthy Start Initiative: Administered by the Shelby County Department of Health. Provides services to high-risk pre- and post-natal teens and women with infant children. Uses Partners for a Healthy Baby Curriculum.
Shelby	Help Us Grow Successfully (HUGS): See above description.
Shelby	Nurse Family Partnership: Administered by LeBonheur Community Health and Well-Being. Provides prenatal care, parenting skills and education, and periodic medical and developmental screenings to first-time mothers. Uses the evidence-based Nurse-Family Partnership model.
Shelby	One By One: Administered by One By One Ministries, a faith-based organization. Mentors work with pregnant women and continue with them after the baby's birth, providing parenting education, skills development, and encouraging regular well-child checkups.
Shelby	Parent Aide Program: Administered by the Exchange Club. Helps families identify resources to meet basic needs, access benefits and/or community resources, and addresses child abuse and neglect concerns. Services parent or guardians with children under age 12. Uses the Nurturing Parenting Program curriculum.

<i>County</i>	<i>Existing Programs/Models</i>
Shelby	Parent Outreach Program: Administered by LeBonheur Community Health and Well-Being. Short-term program that provides parent education to prevent child abuse and neglect. Serves pregnant and new mothers during baby’s first year. Uses Healthy Families San Angelo curriculum and Florida State curriculum.
Shelby	Parents as Teachers: Administered by Porter-Leath. Provides parenting skills and education to support school readiness and reduce child abuse and neglect for expectant mothers and women with children up to age 5. Uses Born to Learn model.
Shelby	Tennessee Early Intervention Services (TEIS): See above description.

Existing Screening, Identification, and Referral Mechanisms

Each of the communities selected for MIECHV-funded projects have existing mechanisms for screening, identification, and referral of families to home visiting services. Referrals come from a variety of sources, including faith-based programs, community service agencies, early intervention services, child protective services, housing services, and self-referrals. All programs have established relationships with other community partners so that cross-referrals can be made or families can be referred to other home visiting services when programs are at capacity.

Davidson County is currently the only community with a centralized referral system; this system has been in place since 1997 and grew out of a recommendation from the Child Death Review Team. The centralized referral system is housed within the Metro Public Health Department and screens all referrals for home visiting services in Davidson County in an effort to avoid duplication of service and offer the most appropriate home visiting program to the family.

Shelby County has an Early Success Provider Network consisting of 12 home visiting or site-based programs for families with children. Network providers are connected through referral and information-sharing agreements and protocols to deliver an integrated, coordinated experience of services for expectant mothers and families with young children. Referrals are generated from a number of community agencies (utilizing a “no wrong door” approach) and families are provided with information about the variety of network programs so that they can select one that best meets their needs. The Early Success Provider Network has developed a referral “Tool Kit” that consists of user-friendly program descriptions, contact information, and a one-page client information form. Training is underway to implement the toolkit among community partners.

Community Referral Resources

The programs selected to receive MIECHV funding for expanded community home visiting services have established partnerships with other community entities that provide support services for children and families. Because each funding recipient is already established within the community, new participants will readily benefit from a variety of community services that complement those received through the home visiting program. Such services include:

- Public assistance programs (Families First, Supplemental Nutrition Assistance Program)

- Early Intervention
- Early childhood services (Head Start, pre-K)
- Physical and mental health services
- Substance abuse services
- Women, Infants, and Children (WIC) program
- Housing authority
- Domestic violence resources
- Child Abuse prevention programming
- Parenting resources
- Faith-based communities
- Pregnancy and Adoption Services
- Legal Aid
- Sources of material resources (food, clothing)

Plan for Coordination Among Home Visiting Programs and Community Resources

Funded programs are expected to continue existing partnerships with other community agencies and expand those partnerships as needed to best serve their children and families. Where possible, programs will be encouraged to develop or expand memoranda of understanding with community agencies to facilitate inter-agency referral. Programs are expected to continue their participation in existing community collaborations (such as the Davidson County Community Advisory Board, Shelby County Early Success Provider Network, and Maury County Early Childhood Network).

Additional existing infrastructure will further support coordination among home visiting programs and community resources. Tennessee has a well-established statewide home visiting collaborative that has existed since 2005, led by Prevent Child Abuse Tennessee (one of the entities receiving MIECHV funding). Within the Department of Health, there is a robust statewide network of local, Community Health Councils that has a 20-year history of participatory planning and partnership with multiple stakeholders targeting improved health in their communities.

As the lead agency, the Department of Health will also continue to convene the MIECHV Steering Panel and Advisory Council to identify and implement opportunities for enhanced coordination across the MIECHV-funded services as well as by other participating agencies. Appendix C contains a list of the membership of these two groups.

The Department of Health also administers the HRSA-funded Early Childhood Comprehensive Systems (ECCS) program. A current initiative of ECCS is to catalog existing community resources for children and families in a manner that is readily accessible to community members, including resource agencies and home visiting programs. The acting ECCS Program Director is also a member of the MIECHV Advisory Council and will continue to seek input from home visiting programs during the design and implementation of this project.

Capacity to Implement Home Visiting Programs into Integrated Childhood System

At the state level, the Department of Health constantly strives to enhance the integration of services for children and families. Through the ECCS program, a variety of stakeholders meet

regularly to identify and implement strategies for strengthening the network of services available for children and families. Other agencies involved in these efforts include the Department of Children's Services, Department of Mental Health and Developmental Disabilities, Department of Education, Governor's Office of Children's Care Coordination, Tennessee Commission on Children and Youth, Family Voices, and child advocacy organizations.

Community-level infrastructure for integrated childhood systems already exists in three of the funded sites. The Early Success Coalition in Shelby County already includes 12 home visiting or site-based programs for children and families and has a well-established network for referral and information sharing. In Davidson County, the Community Advisory Board (led by the Resource Linkage program of the Department of Children's Services) provides opportunities for the Department, families, and available community resource providers to assist with the development of community-based resources that may be needed by families. Additionally, the Central Referral System in Davidson County links numerous community home visiting programs through a single referral entity. The Early Childhood Network in Maury County is another example of a community-wide, collaborative infrastructure; its goal is to build and expand capacity and initiate system improvements for families with young children. The partnership includes representation from health, mental health, early childhood development, child welfare, child maltreatment prevention, domestic violence prevention, education, families, and respite providers. Network members engage in continual system assessment that includes knowledge of services provided, number and scope of cross-referrals, and identification of service gaps.

Communities Not Selected for Program Implementation

Available funding has limited implementation plans to the six counties outlined above. Of the remaining fifteen counties identified as being at highest risk in the Needs Assessment, those not selected for program implementation at this time include: Lauderdale, Haywood, Rhea, Hardeman, Hardin, Henderson, Madison, Sequatchie, Coffee, and Dyer counties.

Section 2: State Home Visiting Program Goals and Objectives

State Home Visiting Program Goals and Objectives

The following goals and objectives for the State Home Visiting Program have been identified:

- **Goal 1:** Improve the quality of home visiting services for children and families in Tennessee
 - **Objective A:** During FY 2012, implement three evidence-based models (HFA, NFP, PAT) in five communities.
 - **Objective B:** During FY 2012, implement a program for continuous quality improvement among agencies receiving MIECHV funding for program implementation.
 - **Objective C:** During Q1 and Q2 of FY 2012, hire state-level coordinating staff (Program Administrator, Program Director, Senior and Junior Epidemiologists, Statistical Analyst, and Administrative Assistant) to provide support for community home visiting agencies.
 - **Objective D:** By Q1 of FY 2013, obtain national model-developer accreditation (or renewal of accreditation) for all MIECHV-funded sites.

- **Goal 2:** Improve outcomes for young children and families in Tennessee
 - **Objective A:** During Q1 of FY 2012, identify outcome measures that can be assessed to measure compliance with legislated MIECHV benchmarks.
 - **Objective B:** During Q1 and Q2 of FY 2012, design and implement a data collection and monitoring system to track benchmark-associated process and outcome measures.
 - **Objective C:** During Q1 and Q2 of FY 2012, establish a reporting system for communicating data back to community home visiting programs.
- **Goal 3:** Strengthen the early childhood home visiting workforce in Tennessee
 - **Objective A:** During FY 2012, work with national model developers to obtain model-specific training for the five selected community sites.
 - **Objective B:** On an ongoing basis, include home visitors in the educational videoconferences coordinated through TDOH and Vanderbilt's HRSA-funded LEND (Leadership Education in Neurodevelopmental and Related Disabilities) program.
 - **Objective C:** By Q1 of FY 2013, develop and implement a core training series for home visitors in Tennessee.
- **Goal 4:** Promote a comprehensive, high-quality early childhood system in Tennessee that includes home visiting programs.
 - **Objective A:** On an ongoing basis, participate in the statewide Home Visiting Collaborative to promote information sharing, collaboration around common goals, and alignment of opportunities.
 - **Objective B:** On an ongoing basis, include the MIECHV Program Administrator and Program Director as well as representatives from each of the community programs in the state's Early Childhood Comprehensive Systems (ECCS) meetings.

Strategies for Integrating Home Visiting with Other State Programs and Systems

The designation of the Department of Health as the lead agency for the MIECHV program and the subsequent placement of the MIECHV program within the Department's Maternal and Child Health Section will maximize the opportunities for integrating the program into other existing state programs and systems. Once hired, the MIECHV staff will work alongside staff who administer a number of other programs serving the maternal/child population, including: other home visiting services, Children's Special Services (the state's Title V CSHCN program), Early Childhood Comprehensive Systems (ECCS), lead poisoning prevention, injury prevention, infant and child fatality review, newborn metabolic and hearing screening, family planning, and breast and cervical cancer screening. Regular staff meetings will present the opportunity for MIECHV staff to share their work with other members of the Maternal and Child Health team, allowing for cross-pollination of ideas and development of natural linkages between programs.

Additionally, the Maternal and Child Health section has a strong history of collaboration with the state's Early Intervention program, Medicaid, Child Abuse Prevention and Child Protective Services, and Head Start. We fully anticipate that MIECHV staff will meet with staff from these programs to share information that may inform the enhancement of a comprehensive, integrated system for children and families in Tennessee. We will request that MIECHV staff be able to

attend meetings of these other agencies as appropriate and will encourage regular dialogue between MIECHV staff and program-level staff at the other agencies.

Program Logic Model

The logic model for Tennessee’s MIECHV Program is attached in Appendix D.

Section 3: Proposed State Home Visiting Program and Explanation of How the Program Meets the Needs of Identified Communities

Evidence-Based Models Selected for Implementation

Our MIECHV Steering Committee opted to utilize a request for application (RFA) process to select home visiting programs for the at-risk communities identified in the Needs Assessment. Eleven applications were submitted. A review panel scored each application and the highest-scoring applications were selected for implementation. The list of selected applicants and communities are listed in Table 4, along with the proposed model. Included in Appendix E are letters of approval from the designated model developers indicating their approval for our implementation of the models as described in this plan.

In addition to the models selected through the competitive application process, the Tennessee Department of Health (TDOH) has opted to implement a Healthy Families America program in Montgomery County. The Department currently administers the Help Us Grow Successfully, (HUGS) program in all 95 Tennessee counties. Montgomery County is home to the Fort Campbell Army Base, an installation which has seen multiple large deployments in the recent past. Based on input from community members familiar with the needs of families in Montgomery County and given the federal guidance’s designation of military families as a priority population, TDOH will convert the existing HUGS program in Montgomery County to a Healthy Families America program. This MIECHV funding will be used to expand service to Fort Campbell military families.

Table 4--Evidence-Based Models To Be Implemented in Tennessee

<i>Organization</i>	<i>At-Risk Community</i>	<i>Model</i>
Centerstone	Maury County	Healthy Families America
Child and Family Tennessee	Campbell County	Nurse Family Partnership
Hamilton County Government	Hamilton County	Parents As Teachers
LeBonheur Center for Children and Families	Shelby County	Healthy Families America Nurse Family Partnership Parents as Teachers
Prevent Child Abuse Tennessee	Davidson County	Healthy Families America
Tennessee Department of Health	Montgomery County	Healthy Families America

Description of How Selected Models Meet Community Needs

The three models that will be implemented in Tennessee—Healthy Families America (HFA), Nurse Family Partnership (NFP), and Parents as Teachers (PAT)—were all designated as “evidence-based” in the Home Visiting Evidence of Effectiveness (HOMEVEE) project conducted by the United States Department of Health and Human Services . As shown in Table 5, these models have been documented in the literature to improve outcomes in domains related to the health and well-being of children and families.

Table 5--Evidence for Model Effectiveness Among Child and Family Domains

<i>Domain</i>	<i>HFA</i>	<i>NFP</i>	<i>PAT</i>
Child Development and School Readiness	X	X	X
Child Health	X	X	
Family Economic Self Sufficiency	X	X	
Linkages and Referrals	X		
Maternal Health		X	
Positive Parenting Practices	X	X	X
Reductions in Child Maltreatment	X	X	
Reductions in Juvenile Delinquency, Family Violence, and Crime	X	X	

The Healthy Families America expansion sites will be located in Davidson, Maury, Montgomery and Shelby Counties. In these counties, there are high rates of: poverty, child abuse, and infant mortality. As the HFA model has been documented to improve outcomes associated with family economic self-sufficiency, child maltreatment, and child health, the model represents a good match of community need with model strengths.

The Nurse Family Partnership expansion sites will be located in Campbell and Shelby Counties. Both counties have high rates of poverty, preterm birth, low birth weight, maternal smoking, and child abuse. The NFP model has support in the literature for improvements in maternal and child health, family economic self sufficiency, and child maltreatment. Given the risk factors for mothers and children in these counties, the positive outcomes associated with the NFP model make this model a good fit with the particular needs of these communities.

The Parents as Teachers expansion sites will be located in Hamilton and Shelby Counties. This model has been shown to improve child development and school readiness and to promote positive parenting practices. Given the high rates of poverty and school dropouts in these counties, the PAT model represents a good fit with the needs of these communities.

State’s Current and Prior Experience with Selected Models and Capacity for Implementation

For each of the selected models, the identified implementing organizations all possess substantial experience with the selected programs or with similar evidence-based programming.

- **Healthy Families America:** HFA will be implemented in Davidson County by Prevent Child Abuse Tennessee (PCAT), in Shelby County by LeBonheur Community Health and Well-Being (LeBonheur), in Maury County by Centerstone, and in Montgomery County by the Tennessee Department of Health (TDOH). PCAT started the Parent Pathway program (using the HFA model) in 1994. PCAT has been affiliated with HFA since 2007 and accredited since January 2011 to serve Davidson and Anderson Counties.

LeBonheur initiated Healthy Families in 1995 and received credentialing in 2006 to provide services in Shelby County. Centerstone has provided prevention, intervention, educational, substance abuse, and mental health treatment services throughout Middle Tennessee for 56 years and has an extensive, well-documented history of planning, implementing, and evaluating State and federally-funded, evidence-based programs and services. Centerstone has substantial administrative, technological, and direct service expertise to support implementation of HFA in Maury County. TDOH currently administers a number of home visiting programs, including the Help Us Grow Successfully (HUGS) program, Healthy Start (based on the Healthy Families America Model), and Child Health and Development (CHAD). TDOH Central office staff provides technical support to home visitors and regional supervisory staff. Additionally, TDOH has an extensive data collection system in place (using the Department's patient billing management information system) as well as established mechanisms for continuous quality improvement and is well-positioned to support implementation of HFA in Montgomery County.

- **Nurse Family Partnership:** The NFP model will be implemented in Shelby County by LeBonheur and in Campbell County by Child and Family Tennessee. LeBonheur was approved as an implementing agency of NFP by the NFP National Service Office in 2009 and began enrolling Shelby County families in February 2010. Child and Family Tennessee received an ACF Evidence-Based Home Visitation grant in 2008 to begin implementation of the NFP model in Knox and surrounding counties through Project Babies.
- **Parents as Teachers:** Parents as Teachers will be implemented in Hamilton County by Hamilton County Government and in Shelby County by Porter Leath. Hamilton County Government has operated a Parents as Teachers program since 1994 and serves as the Tennessee State Office for Parents as Teachers. Porter Leath began providing home visitation services in 1996 to clients (prenatal to age five) and implemented the Parents as Teachers Born to Learn model in November 2009.

Plan for Ensuring Fidelity to Selected Models

At the program level, all but two of the communities are currently providing home visiting services using the selected models. These sites currently have certification by the model developers indicating their ability to implement the model with fidelity. Each site will be required to maintain ongoing certification by the respective model developer, ensuring independently-verified fidelity to the models. Each site will be required to submit documentation to TDOH on an annual basis to verify their program's current certification status with the model developer.

For the sites in Montgomery and Maury counties (both HFA sites), TDOH will work with HFA staff to ensure that home visitors receive appropriate training for model implementation and that affiliation and certification with the HFA national office is obtained, allowing for third-party, independent verification of adherence to the HFA model.

On an ongoing basis, the TDOH Home Visiting Administrator (name TBD) will work with each community site to ensure that appropriate supervision of home visitors is occurring and that program staff are following established protocols to ensure adherence to model requirements.

Anticipated Challenges and Risks to Implementing Selected Models

An immediate challenge to implementing these models in Tennessee is the availability of state-level staff to provide central administration of these programs. Without dedicated staff for the MIECHV staff, existing staff in the Maternal and Child Health section would likely have difficulty providing the necessary oversight and technical assistance to the expansion sites across the state. Though the TDOH only recently received authorization to release the positions for hire, position announcements have already been posted, and applications are currently being received and reviewed. We anticipate resolution of this challenge by hiring the state-level staff in the summer of 2011.

An additional challenge is the massive requirement for benchmark data collection. Each of the three models being implemented in Tennessee has a different data collection system, and within a given model, implementing program sites utilize a variety of data collection tools. To facilitate the legislatively-mandated reporting for the MIECHV sites, the TDOH is designing a data collection tool that will standardize data collection across sites. This tool will document the process and outcome measures required for the annual federal report. We recognize that the standard data collection tool may present an additional burden to home visitors who are already completing program-specific forms. We plan to seek technical assistance from both the model developers and the federal MIECHV program staff regarding best practices for standardizing data collection across various program models in ways that support legislative reporting requirements.

Section 4: Implementation Plan for Proposed State Home Visiting Program

Process for Engaging At-Risk Community(ies) Around State Plan

Throughout all phases of the MIECHV application process, the TDOH has sought input from stakeholders representing communities across the state. The following groups have been a part of the process, including development of the initial state plan (July 2010), the statewide Needs Assessment (September 2010), and this updated State Plan.

- Bureau of TennCare
- Centerstone
- Child and Family Services
- Department of Children's Services
- Department of Education
- Department of Health
- Department of Health—TENNderCare
- Department of Human Services
- Department of Mental Health
- Domestic Violence Coalition
- Fight Crime, Invest in Kids
- Governor's Office of Children's Care Coordination
- Hamilton County Parents as Teachers
- Head Start State Collaboration Office

- Le Bonheur Community Health and Well-Being
- Metro-Nashville Public Health Department
- MIHOW
- Nurses for Newborns
- Porter-Leath
- Prevent Child Abuse Tennessee
- Select Committee on Children and Youth
- Tennessee Children’s Trust Fund
- TN Commission on Children and Youth
- Vanderbilt School of Nursing

Additionally, the State Plan was presented to the Home Visiting Steering Committee for review and comment. This group consists of the entities designated in the original federal guidelines, including: Title V, Child Abuse Prevention and Treatment (CAPTA), Substance Abuse, and Head Start.

Approach to Development of Policies and Standards

The TDOH has utilized a collaborative approach to the planning process associated with the MIECHV program and will continue this approach during program implementation. The expertise of the Home Visiting Steering Panel and Advisory Council helped direct the Needs Assessment and development of the initial state plan. The Steering Panel worked closely with TDOH leadership to develop the Request for Applications process by which the community home visiting funds were distributed. Administratively, the home visiting programs will be housed within the Maternal and Child Health Section (MCH) of the TDOH. The MCH Director will work with the MIECHV Administrator and members of the Steering Panel to develop and implement policies and standards related to the program. This group will also seek input from the five funded community sites so that their practical considerations can be incorporated into the development of home visiting policies and standards. Additionally, standards will be designed in such a way that the programs meet the model requirements set by the national model developers.

Plan for Working with National Model Developers

Three evidence-based models will be implemented in Tennessee: Healthy Families America, Nurse Family Partnership, and Parents as Teachers. The TDOH anticipates seeking technical assistance from each model developer during the implementation and ongoing administration of the home visiting programs.

- **Healthy Families America:** We will work with the model developer to obtain model-specific training for the home visitors in Shelby, Davidson, Maury, and Montgomery counties. At a minimum, we anticipate seeking specific technical assistance on collecting and reporting benchmark data, providing clinical supervision for home visitors, developing a multi-site training system, incorporating the HFA home visiting model into a comprehensive early childhood system, and implementing the HFA model in new areas (Montgomery County).
- **Nurse Family Partnership:** We will work with the model developer to obtain model-specific training for the home visitors in Campbell and Shelby counties. In addition to program training, we anticipate requesting technical assistance on implementation of

NFP program protocols, benchmark data collection, provision of clinical supervision for home visitors, and incorporation of the NFP home visiting programs into a comprehensive early childhood system.

- **Parents as Teachers:** We will work with the model developer to obtain model-specific training for the home visitors in Hamilton and Shelby counties. In addition to program training, we will seek technical assistance from the model developer regarding: planning and conducting CQI activities, collecting and reporting benchmark data, assuring ongoing professional development for parent educators, and implementation of perinatal depression and domestic violence screening and referrals.

Timeline for Obtaining Curriculum and Materials

Because the models identified for implementation in Tennessee are already in place in all but two communities, we anticipate minimal delay in obtaining program-specific curriculum and materials. Once the community contracts are in place (anticipated start date of 7/1/2011), the implementing agencies will be able to purchase any additional curricular materials, screening tools, or program materials necessary for their program expansion. The TDOH MIECHV Administrator will work with the sites in Maury and Montgomery counties (the two new sites) to obtain program-specific materials from Healthy Families America. The TDOH has already purchased the Florida State University “Partners for a Healthy Baby” curriculum which can be used in the Healthy Families America site in Montgomery County.

Description of Training and Professional Development Activities

The TDOH will work with the funded community sites to provide basic training on continuous quality improvement and benchmark data reporting. The TDOH will also encourage all the community sites to participate in the videoconference series co-sponsored by the Department’s MCH section and the HRSA-funded Vanderbilt University LEND (Leadership Education in Neurodevelopmental and Related Disabilities) program; this series provides training on a variety of topics of interest to those serving families and young children. We expect that each implementing local agency will conduct ongoing training for agency-specific protocols and that program-specific training around model implementation will be provided through agreements with the national model developers.

Plan for Recruiting, Hiring, and Retaining Appropriate Staff

The TDOH plans to employ six positions for management and oversight of the MIECHV program: a Public Health Program Administrator, Senior Epidemiologist, Junior Epidemiologist, Statistical Analyst, Program Director, and Administrative Services Assistant. These positions were posted on a variety of recruitment websites and email listings and applications are currently being reviewed for an anticipated hire date of Summer 2011. Staff will receive mentoring from the TDOH MCH Director as well as the Director of Quality Improvement and Public Health Accreditation. The staff will be encouraged to participate in ongoing leadership development offered to program management in the MCH section.

Plans for Subcontractor Organizations

With guidance from the MIECHV Steering Panel, the TDOH issued a Request for Applications for community-based organizations wishing to implement evidence-based home visiting programs. Eleven applications were submitted and five community programs were awarded

funding after review and selection by a three-member committee. Each subcontracting organization will be required to recruit, hire, and retain their staff. Each program has submitted to TDOH a plan for recruiting and hiring the necessary staff for program implementation. Agencies have reported plans to post job listings on internal agency hiring bulletins and various community websites and to seek applicants through partner organizations (such as Schools of Nursing). The Hamilton County site (Parents as Teachers) already has staff in place. In their application, each agency described strategies for retaining staff; these strategies included: quality supervision, support, training, professional development, evaluation and merit performance rewards where available.

Plan to Ensure High Quality Clinical Supervision and Reflective Practice

Each of the agencies selected for funding for expansion of evidence-based home visiting services has already demonstrated the capacity to provide high-quality clinical supervision and reflective practice for home visitors. With the exception of two sites (Centerstone and the Tennessee Department of Health), all sites currently meet model-specific requirements for supervision of home visitors. The MIECHV Program Administrator will work with Centerstone (Maury County) and the Department of Health (Montgomery County) as well as the model developer for the program being implemented in these counties (Healthy Families America) to ensure that all supervisory staff are appropriately trained and that high-quality supervision is provided on an ongoing basis. Ongoing accreditation by model developers will serve as an additional mechanism of assurance that all program sites are performing appropriate supervision of home visitors.

Estimated Number of Families Served

The TDOH anticipates that 460 families will be served through MIECHV-funded programs. In their applications for funding, each community agency proposed an estimate of families they could serve during the initial 15-month funding period (see below). Additionally, we estimate that 25 families will be served in Montgomery County (based on previous enrollment in the TDOH Help Us Grow Successfully (HUGS) program and HFA model caseload requirements). Community-specific estimates for the number of families to be served are as follows:

- Campbell County (Nurse Family Partnership): 50 families
- Davidson County (Healthy Families America): 75 families
- Hamilton County (Parents as Teachers): 75 families
- Maury County (Healthy Families America): 50 families
- Shelby County (Healthy Families America): 40 families
- Shelby County (Nurse Family Partnership): 25 families
- Shelby County (Parents as Teachers): 120 families

Plan for Identifying and Recruiting Participants

Each community site will be responsible for engaging community partners to increase awareness of program services and availability. Such community partners include (but are not limited to): housing authorities, schools, early childhood education providers (e.g. Head Start and child care centers), family resource centers, birthing centers, hospitals and clinics, and substance abuse treatment programs. Additionally, MIECHV-funded sites will be expected to perform outreach within their target communities to increase program awareness among those who serve their target population(s). Given the well-established partnership networks of each of the funded

community sites, we anticipate robust sharing of information between the funded sites and their partner agencies that will facilitate referrals to the MIECHV programs. In Davidson County, recruitment will be enhanced by referral through the Central Referral System, and in Shelby County, some participants will be identified through the Early Success Provider Network.

Plan for Minimizing Participant Attrition Rates

Given the high-risk nature of the families who will be served in these programs, attrition is a very real concern. In their request for funding, each community site addressed various strategies for minimizing participant attrition. Such strategies (across all sites) included:

- Identifying families with high risk scores at time of enrollment with specific plans for offering additional community resources
- Acquiring as many phone contacts for families and friends at time of enrollment that family is willing to provide to minimize program's loss of contact with family
- Encouraging home visitors to talk to families specifically about the possibility of the family moving and the importance of maintaining contact with their home visitor when that happens
- Participating in training about engaging families and building trust
- Including discussions about retention in supervisory sessions and developing specific plans for individual families who appear to be at risk for dropping-out
- Development of an individualized family service plan (IFSP) which includes an individualized family needs assessment, based on family strengths and designed to serve the family in the natural environment
- Hiring of home visitors with cultural diversity and capacity for empathy to facilitate strong relationships with families
- Ongoing data collection and analysis (through continuous quality improvement) to identify and address reasons for program attrition
- Provision of low-cost but meaningful incentives for participating families

Recognizing that participant attrition is a common challenge across home visiting programs, the TDOH MIECHV Program Administrator and Program Director will work with the national model developers to identify best practices for reducing attrition and support community sites in implementation of such practices.

Timeline for Reaching Maximum Caseload

In their applications for funding, each community agency provided an estimated timeline for reaching maximum caseloads in their communities. The timelines vary from 1-15 months (see below):

- Campbell County (Nurse Family Partnership): 6-8 months
- Davidson County (Healthy Families America): 15 months
- Hamilton County (Parents as Teachers): 4 months
- Maury County (Healthy Families America): 10 months
- Shelby County (Healthy Families America): 3 months
- Shelby County (Nurse Family Partnership): 3 months
- Shelby County (Parents as Teachers): 1 month

For the Montgomery County site (a new Healthy Families America site), TDOH plans to convert the existing theory-based model to the HFA model over the course of 12 months.

Operational Plan for Coordination Between Home Visiting Programs and Community Resources

In several of the communities selected for funding, coordinated early childhood systems already exist. The Shelby County Early Success Coalition and Maury County's Early Childhood Network will serve as models for the other funded communities. These sites will be asked to share their experiences with creating these coordinated systems with the other sites and provide guidance for the other sites as they engage community partners to develop such systems. Despite the presence of formal systems in the other communities, each site's application documented longstanding relationships between the existing home visiting program and other community programs and resources, including those that provide services related to: health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services. All sites will be encouraged to strengthen existing systems and where none currently exist, to create partnerships to ensure that a comprehensive, coordinated system of care exists for at-risk children and families.

At the state-level, the MIECHV Program Administrator and representatives from each funded site will be asked to join the Early Childhood Comprehensive Systems (ECCS) Advisory Council, which meets quarterly. In this capacity, the MIECHV representatives will interact with representatives from other child- and family-serving organizations throughout the state. The MIECHV Program Administrator will also share information with the funded community sites through regular communication and standing meetings/calls, further enhancing the community sites' ability to strengthen local systems.

Plan for Obtaining or Modifying Data Systems for Ongoing CQI

The TDOH has a robust patient billing management information system (PTBMIS) that is used for tracking process and outcome measures with TDOH-administered home visiting programs. Additionally, many of the community agencies selected for funding have existing data collection protocols and systems. The TDOH MCH Director has worked with the Department's Director of Quality Improvement and the community agencies to identify existing data collection tools across programs, compare to required benchmarks, and identify strategies for streamlining data collection while assuring that all required benchmark measurements are obtained. Recognizing that we are implementing three models throughout the state and that each model has its own data collection recommendations, tools and systems, TDOH staff are designing a standard form to be submitted by community programs to the MIECHV Administrator for statewide data aggregation, analysis, and reporting. We anticipate working closely with each of the community sites throughout the funding period to refine the data collection and reporting system.

Approach to Model Fidelity and Quality Assurance

The TDOH is committed to implementation of the chosen models with fidelity. Through ongoing submission of process measures by community sites and regular monitoring with feedback by the MIECHV Administrator and Program Director, adherence to model fidelity will be assured. The MIECHV Administrator will also work with each of the national model developers to identify tools for state-level monitoring of community programs to ensure high-

quality program implementation. We will encourage each community site to take advantage of any technical assistance offered by the national model developers related to model fidelity and quality assurance.

Anticipated Challenges to Maintaining Quality and Fidelity

We feel confident that the selected community sites will be successful at implementing high-quality home visiting services with fidelity to their chosen models. The sites in Davidson County (Healthy Families America), Hamilton County (Parents as Teachers), and Shelby County (Healthy Families America, Nurse Family Partnership, and Parents as Teachers) are already accredited by their national model developers, indicating independent verification of their ability to implement high-quality programming with fidelity. Additionally, the agency chosen to implement services in Campbell County (Child and Family Tennessee) has received accreditation from the national Nurse Family Partnership organization, indicating their ability to successfully meet the developer's criteria for model fidelity and quality assurance. Given the strong track record of evidence-based model implementation by the remaining sites (Centerstone in Maury County and the Department of Health in Montgomery County), we do not foresee any major challenges to maintaining high-quality services and implementation with fidelity to the national models.

While we do not anticipate major challenges to maintaining quality and fidelity, we have considered the following challenges and how we would plan to respond:

- **Limitation of program services to families meeting enrollment criteria:** Given their visibility in the community and their history of reaching out to serve some of the most vulnerable children and families, the selected community agencies may occasionally receive referrals for children or families that do not meet the enrollment criteria. Inclusion of such participants threatens model fidelity. Each community agency will work with partner organizations that have different or less stringent enrollment criteria to connect referred families with services when such services would not be appropriately provided through their agency.
- **Funding for continued engagement with national model developers:** Accreditation and support from the national model developers is vital for continued provision of high-quality home visiting services with fidelity to the selected models. Such support, however, is often at great cost that otherwise have been devoted to the provision of direct services. The TDOH MIECHV Administrator and Program Director will work with the national model developers and community agencies to streamline resources where appropriate and allowable and to minimize non-direct service costs.
- **Limitation of services when programs are at capacity:** The community agencies may receive referrals for services after reaching maximum caseloads. To accept such referrals into the program would threaten model fidelity. Each community agency will work with partner organizations to identify those who would have the capacity to accept new referrals when their own caseloads are at capacity.

List of Collaborative Public and Private Partners

Tennessee has benefitted in the past from strong collaborative efforts around early childhood home visiting. An extensive statewide collaborative (led by Prevent Child Abuse Tennessee) provides valuable stakeholder input on home visiting priorities and state-level initiatives.

Additionally, each of the funded sites has a strong record of established community partnerships with both public and private partners. A list of partners is included in Appendix F.

Assurances Required in Supplemental Information Request

- The TDOH assures that the State’s home visiting program is designed to result in participant outcomes noted in the legislation. Adoption of evidence-based models with documented improvements in the required benchmarks will facilitate the achievement of the desired outcomes.
- The TDOH assures that the funded community agencies will conduct individualized assessments for participating families and subsequently provide services in accordance with those individual assessments and national model guidelines.
- The TDOH assures that all MIECHV services will be provided on a voluntary basis.
- The TDOH assures that the State will comply with the Maintenance of Effort requirement outlined in the original funding announcement.
- The TDOH assures that priority will be given to community members who meet one or more of the following criteria: have low incomes; are pregnant women who have not attained age 21; have a history of child abuse or neglect or have had interactions with child welfare services; have a history of substance abuse or need substance abuse treatment; are users of tobacco products in the home; have, or have children with, low student achievement; have children with developmental delays or disabilities; are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

Section 5: Plan for Meeting Legislatively Mandated Benchmarks and Outcomes

Proposed Measures, Proposed Definitions of Improvements

Measures for each construct within each benchmark are included in Appendix G. For collection of measures which are best obtained through interview or self-report (e.g. demographics, socioeconomic data, etc...), the evaluation system will utilize (where available and applicable) standardized questions from currently administered statewide surveys (i.e. Pregnancy Risk Assessment and Monitoring System - PRAMS and Behavioral Risk Surveillance System – BRFSS, both from the Centers for Disease Control and Prevention). For collection of measures which require normalized scales, the evaluation system will utilize scales/scores which have undergone reliability/validity reviews. References for scales/score chosen are included in Appendix G.

Tennessee will have three or more evidence-based home visiting models participating in the statewide evaluation plan. All models will be required to collect and submit the measures included in Appendix G. Standardization of measures across models is sought to build a robust system of continuous quality improvement (CQI) across the program models and allow the models to compare themselves among different programs within the state.

Plan for Sampling

No sampling plan is being proposed. Data for each element will be collected on all enrollees and for all programs.

Proposed Data Collection Schedule and Analysis Plan

Frequency of data collection and specified population studied are summarized in Appendix G. Data analysis will initially occur frequently (every week to every month) to assess data quality (i.e. completeness and accuracy). Once data quality is assured, analysis of the initial and longitudinal surveys will occur every month to every six months. Process measures, such as screening rates and referral rates, will be tracked monthly and shared with the programs during a monthly conference call. Process measures that indicate lower than expected screening rates and referral rates will be utilized as tracking measures in continuous quality improvement (CQI) projects by the programs. Program outcome measures will be analyzed/reviewed internally every six (6) months, while reporting on outcome measures will occur annually. The plan to incorporate CQI into the program evaluation is covered in *Section 7*.

Proposed Plan for Ensuring Quality of Data Collection and Analysis

Training for data collection and use of selected measures will occur prior to the implementation of the evaluation system. All field staff, supervisors, State Health Department agency staff, and epidemiologists participating in the program evaluation system will undergo centralized training on use of the measures (scales and survey tools) and on the data collection system.

After initiation of the evaluation system, the data will be reviewed frequently to assess missed data fields or illogical data entries. Monthly telephone conferences will periodically address data quality issues with the field staff (i.e. staff surveying and collecting the data) and the supervisory staff.

Data quality, if determined to be a significant issue, will be an initial continuous quality improvement (CQI) project for the home visiting programs participating in the evaluation system.

The personnel responsible for the maintenance of the evaluation system, data management, and data analysis are two doctorate/masters level epidemiologists. The epidemiologists are led by a senior researcher/physician who has significant experience in program evaluation and quality improvement methods and has been trained in epidemiology and health services research at the doctorate and masters level. During the initial design, implementation, and analysis of the evaluation system and data, the epidemiologists are estimated to spend 100% of their time on this effort. Field staff that will collect the data via surveys and evaluation tools will spend about 1-3 hours in data collection every four to six months.

Plan for Further Identification of Useful Metrics for Evaluation

Review of data on a continuous basis will determine the direction and whether or not there is a need for additional metrics to be added to the program evaluation system.

Plan for Analyzing Data at the State and Local Level

The Division of Quality Improvement within the Tennessee Department of Health, a group that collaborates closely with the Maternal and Child Section at the State Agency, has developed the

evaluation system and the process to review data quality and subsequently analyze the collected data periodically. The evaluation system will allow for data to be collected electronically for evaluation at the State Agency. Results from the analysis will be shared with the individual programs and with the local and regional communities on a periodic basis.

As noted above, data quality (i.e. data field completeness and accuracy) will be assessed periodically; initially the data quality reviews will occur frequently (weekly/monthly) as the system is implemented and move to less frequent reviews (monthly). Data analysis will initially occur frequently (every week to every month) to assess data quality (i.e. completeness and accuracy). Once data quality is assured, analysis of the initial and longitudinal surveys will occur every month to every six months. Process measures, such as screening rates and referral rates, will be tracked monthly and shared with the programs during a monthly conference call. Process measures that indicate lower than expected screening rates and referral rates will be utilized as tracking measures in continuous quality improvement (CQI) projects by the programs. Program outcome measures are analyzed every six (6) months.

Both process measures and outcome measures will be analyzed by program. Additional stratification by groups of participants whose characteristics are similar (e.g. clients who entered the program in the prenatal stage as compared to clients who entered in the postpartum stage) will also be analyzed. Since the evaluation system at the state level will be standard across all programs participating (regardless of evidence-based model being used), the analysis can also be aggregated at the state level.

The plan to incorporate CQI into the program evaluation is covered in *Section 7*.

Plan for Gathering and Analyzing Demographic and Service Utilization Data on Families Served
Demographic data, including identifying data to allow for matching to existing data maintained either by the Tennessee Department of Health or the Tennessee Department of Children's Services, will be collected on all enrolled participants and significant family members (e.g. mother and child). For data maintained by an agency outside of the Tennessee Department of Health, a Memorandum of Understanding (MOU) has been obtained and included in Appendix H. Currently, the only dataset not maintained by the Tennessee Department of Health is the child abuse and neglect data maintained by the Tennessee Department of Children's Services (DCS) (see Appendix H).

Demographic data to be collected includes the following: (a) identifying data (i.e. full name); (b) maternal date of birth; (c) maternal race; (d) maternal educational status; (e) maternal ethnicity; (f) maternal employment status; (g) maternal marital status; (h) language spoken in the home; (i) characteristics of family members living in the home; and, (j) military status of mother/father.

Service utilization will be tracked on an annual basis. Data collected to track service utilization includes the following: (a) number of incoming referrals into each home visiting program; (b) number of enrolled clients in each program; (c) length of service for each client enrolled; (d) number of enrolled clients per home visitor (cross-sectional sample every six (6) months); and (e) number of enrolled clients who meet the national program model's definition of appropriate frequency of visit.

Plan for Using Benchmark Data for CQI at the Local, Community, and State Level
Please see *Section 7*.

Proposed Plan for Data Safety and Monitoring

Client consent forms will be obtained. The Tennessee Department of Health Institution Review Board (IRB) has been consulted and is reviewing current data collection plans. Data collected and transferred to the State Agency will be done according to regulations by the State of Tennessee and the federal government for transmission of private health information. All staff will undergo appropriate training regarding applicable regulations related to IRB and human subjects protection, HIPAA, and FERPA.

Anticipated Barriers or Challenges

Three or more evidence-based home visiting models are included in this home visiting evaluation plan. In addition to the State of Tennessee mandated evaluation system, each program has an evaluation program that must be completed for the national model. This will lead to some duplication in measurement and will be a noted challenge for the state evaluation system. For example, one agency may currently be working with the Family Stress Checklist to meet the current national model requirements for program evaluation; yet, the state evaluation system has chosen to assess the construct of “Parent emotional well-being or parenting stress” with the Protective Factors Survey.

To address the challenge of duplication in measurement, the state evaluation system, where possible, has tried to coordinate and use measures that are common to all home visiting programs (i.e. Ages and Stages – 2nd Ed.). The state evaluation system also collects data on a periodicity schedule (every six months) that attempts to minimize the burden of measurement collection yet still maintain timely data review to allow for CQI. In addition, the state evaluation system will incorporate information technology to reduce the burden of data collection by paper.

Another challenge is the very short time frame to design and build an evaluation system and then subsequently train all staff to use the system. Also, an added challenge is the need to train staff on use of new tools for evaluation. The State Agency has experience with establishing new evaluation systems and use of new tools to track outcomes in programs. The State Agency will carefully monitor the data collected and assess through monthly feedback sessions with all staff which components of the evaluation system are not clearly understood.

Section 6: Plan for Administration of State Home Visiting Program

Lead Agency

The Tennessee Department of Health was designated in 2010 by the Governor’s Office as the lead agency for this program.

Collaborative Public and Private Partners

Successful implementation of this program will require ongoing collaboration between a number of public and private sector partners; a list of currently-identified partners is included in Appendix F.

Overall Management Plan for Home Visiting Program

Tennessee's MIECHV efforts will be led by Dr. Cathy Taylor, Assistant Commissioner for Health Services. Dr. Taylor has a background in public health nursing, research, and home visiting. Programmatically, the MIECHV program will be housed in the Maternal and Child Health Section of the TDOH. Home visiting programs currently administered by TDOH are housed within this section. The section is headed by Dr. Michael D. Warren, a pediatrician who has experience in both primary care pediatrics and in state government efforts to coordinate child health policy. Dr. Warren will supervise the MIECHV Program Administrator 1 (name TBD), who will oversee the day-to-day state-level operation of the program. The Program Administrator 1 will work with each community site to ensure compliance with individual model requirements, identify technical assistance and training needs and work with site leaders to address such needs, and coordinate all federal MIECHV reporting. Dr. Warren and the Program Administrator 1 will work closely with Dr. Bridget McCabe, the TDOH Director of Quality Improvement. Dr. McCabe and her team will assist state and local site staff in establishing benchmarks, implementing program measures, monitoring ongoing data collection, and performing analysis of program data. At the local level, each site will have a designated project manager responsible for coordinating local-level program operation and reporting back to the state program.

Plan for Coordination of Referrals, Assessment, and Intake Processes Across Models

At present, only one community in the state (Davidson County) has a central intake and referral process. There is great interest in replicating the Davidson County model statewide. As this project proceeds, TDOH staff will work with the Home Visiting Advisory Committee to identify opportunities to expand this intake and referral process to the local communities with MIECHV-funded projects and eventually throughout the state.

Identification of Other Related State or Local Evaluation Efforts

TDOH conducts ongoing evaluation of other (non-MIECHV-funded) home visiting initiatives; this evaluation includes both process and outcome measures and are reported on an annual basis to the Tennessee General Assembly to fulfill requirements established in state statute.

Job Descriptions for Key Positions

Job descriptions for the key state-level positions are attached in Appendix I. For positions where staff have already been identified, resumes or curriculum vitae are attached.

Organizational Charts

Organizational charts for both the state-level MIECHV program management and local project sites are included in Appendix J.

Plan for Meeting Legislative Requirements

Through the request for application process, the state MIECHV program identified the community agencies most likely to be able to implement new or expanded evidence-based home visiting services: Centerstone, Child and Family Tennessee, Hamilton County Government, LeBonheur Community Health and Well-Being, and Prevent Child Abuse Tennessee. The selected agencies all have a strong history of recruiting and retaining

well-trained, competent staff; providing high quality supervision; possessing strong organizational capacity to implement activities involved; collaborating with or establishing referral and service networks available to support their programs and the families they serve in at-risk communities; and monitoring of fidelity of program implementation to ensure that services are delivered pursuant to the specified model. Selection of these particular agencies will facilitate TDOH's assurance of meeting these legislative requirements for evidence-based home visiting programs.

Compliance with Model-Specific Prerequisites for Implementation

Tennessee fully expects to be able to comply with model-specific prerequisites in the identified at-risk communities. In four of the communities, the programs already exist and have current certification from the model developers indicating compliance with prerequisites required by their respective models. In the two communities where new programs will be initiated (HFA in Montgomery and Maury Counties), the state will consult with the HFA National Office to ensure that all HFA prerequisites are met. We anticipate no problems meeting these requirements, as there are numerous other HFA sites throughout Tennessee (including MIECHV-funded sites) from which we can receive technical assistance during the project startup period.

Coordination with State Advisory Council Plan and Early Childhood Comprehensive Systems

The Tennessee State Plan will be presented in early FY2012 at meetings of the Early Childhood Comprehensive Systems (ECCS) program as well as the State's Early Childhood Advisory Council. Members of the MIECHV Advisory Committee are active participants in both groups and can serve as liaisons between these initiatives.

To further integrate the MIECHV-funded home visiting programs into a comprehensive, integrated early childhood system, the state ECCS program will invite representatives from each of the community sites to join the ECCS Advisory Committee; this will allow for at least quarterly updating of numerous state and community stakeholders on home visiting initiatives, sharing of successes and challenges, and provision of peer-to-peer technical assistance on identified challenges.

Collaborations with other State Early Childhood Initiatives

At this time, there are no formal established collaborations between Tennessee and other State early childhood initiatives. However, the TDOH has a strong relationship with the Maternal and Child Health section in the Kentucky Department of Health and there have been numerous discussions about community home visiting between staff in the two states. Additionally, Tennessee has been an active participant in all HRSA-sponsored MIECHV conference calls and webinars, providing numerous opportunities to learn from the experiences of other states.

Section 7: Plan for Continuous Quality Improvement

The State Agency has a history of incorporating CQI in its endeavors. Through the Division of Quality Improvement, the Home Visiting Programs will be participating in a Quality

Improvement (QI) curriculum that was originally established for the local health departments in Tennessee during a tobacco cessation initiative¹.

The curriculum combines a standardized, formal introduction to terminology, methodology, tools and techniques used in QI^{2,3,4} as well as hands-on experiences (Appendix K; Continuous Quality Improvement Plan). Participants implement QI techniques in relation to the on-going QI projects to improve the home visiting program processes. The curriculum is a series of short PowerPoint slides and worksheets that follow the *Embracing Quality in Local Public Health*⁵. The curriculum is designed primarily to be web-based and is to occur once a month for one hour over twelve to fifteen months. The first 15 minutes is didactic, while the remaining 45 minutes is designated for practical use of the methods, techniques, and tools on a current QI issue as well as exchanging lessons learned.

The first continuous quality improvement (CQI) topics will revolve around the evaluation system, the evaluation tools, and data quality. Appropriate use of the system and data quality are required for accurate interpretation of the data analysis.

To encourage and incorporate CQI into the everyday work of the home visiting programs, the State Agency will use the curriculum in conjunction with the Institute for Healthcare Improvement's (IHI) Collaborative Model for Achieving Breakthrough Improvement (Figure

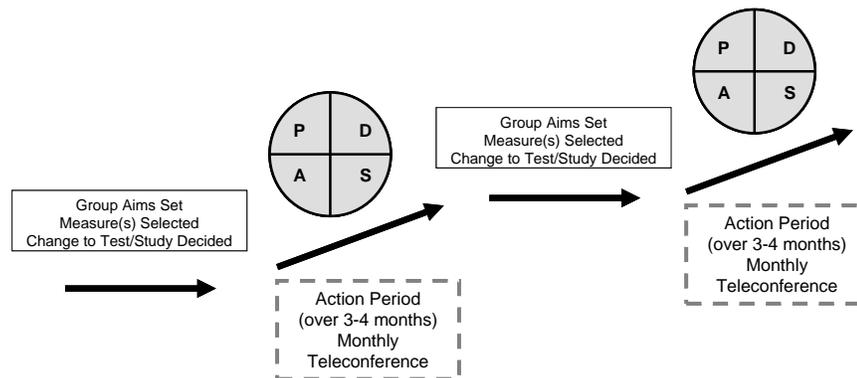


Figure 1. Continuous Rapid Cycle Improvement from the Model of Improvement.^{vi, vii}

¹ McCabe BK, Taylor CR, Cooper SR. Translating Clinical QI Success To Public Health. *Public Health Quality Improvement Handbook*. Bialek R, Moran JW and Duffy GL (editors). Public Health Foundation. 2008.

² Nancy R. Tague (2004) *The Quality Toolbox*, Second Edition, ASQ Quality Press, 2004.

³ *Quality Tools: Tools and Templates*. Retrieved February 25, 2009 from the American Society for Quality Web site: <http://www.asq.org/learn-about-quality/data-collection-analysis-tools/overview/overview.html>

⁴ *Plan-Do-Study-Act (PDSA) Worksheet for Testing Change*. Retrieved February 25, 2009 from the Institute for Healthcare Improvement Web site: <http://www.ihl.org/NR/rdonlyres/8C03F6DC-8EEC-4297-AF91-BD4E7436F043/5599/PDSASheetforTestingChange.doc>

⁵ Tews DS, Sherry MK, Butler JA, Martin A. (2008) *Embracing Quality in Local Public Health: Michigan's Quality Improvement Guidebook*.

1)^{6,7}. This IHI model provides a framework for experiential learning of CQI under the direction and technical assistance of the State Agency.

Section 8: Technical Assistance Needs

Description of Anticipated Technical Assistance Needs

We anticipate needing technical assistance in the following areas: 1) strengthening a statewide early childhood system; 2) centralized program monitoring to ensure model fidelity; 3) measurement of benchmarks and incorporation of benchmark data into ongoing quality improvement; 4) organization of data from multiple program models into a statewide assessment; 5) facilitation of data sharing between diverse organizations.

Plan for Obtaining Technical Assistance

We plan to seek technical assistance from the model developers regarding: 1) implementation of model with fidelity; 2) collection of relevant data on an ongoing basis; 3) implementation of initial and ongoing provider training; and 4) provision of high-quality supervision for home visitors.

Section 9: Reporting Requirements

TDOH assures that the State will comply with the federal legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the program. TDOH will oversee the compilation and submission of the report. Contents of the report will include updates on the following components outlined in the SIR:

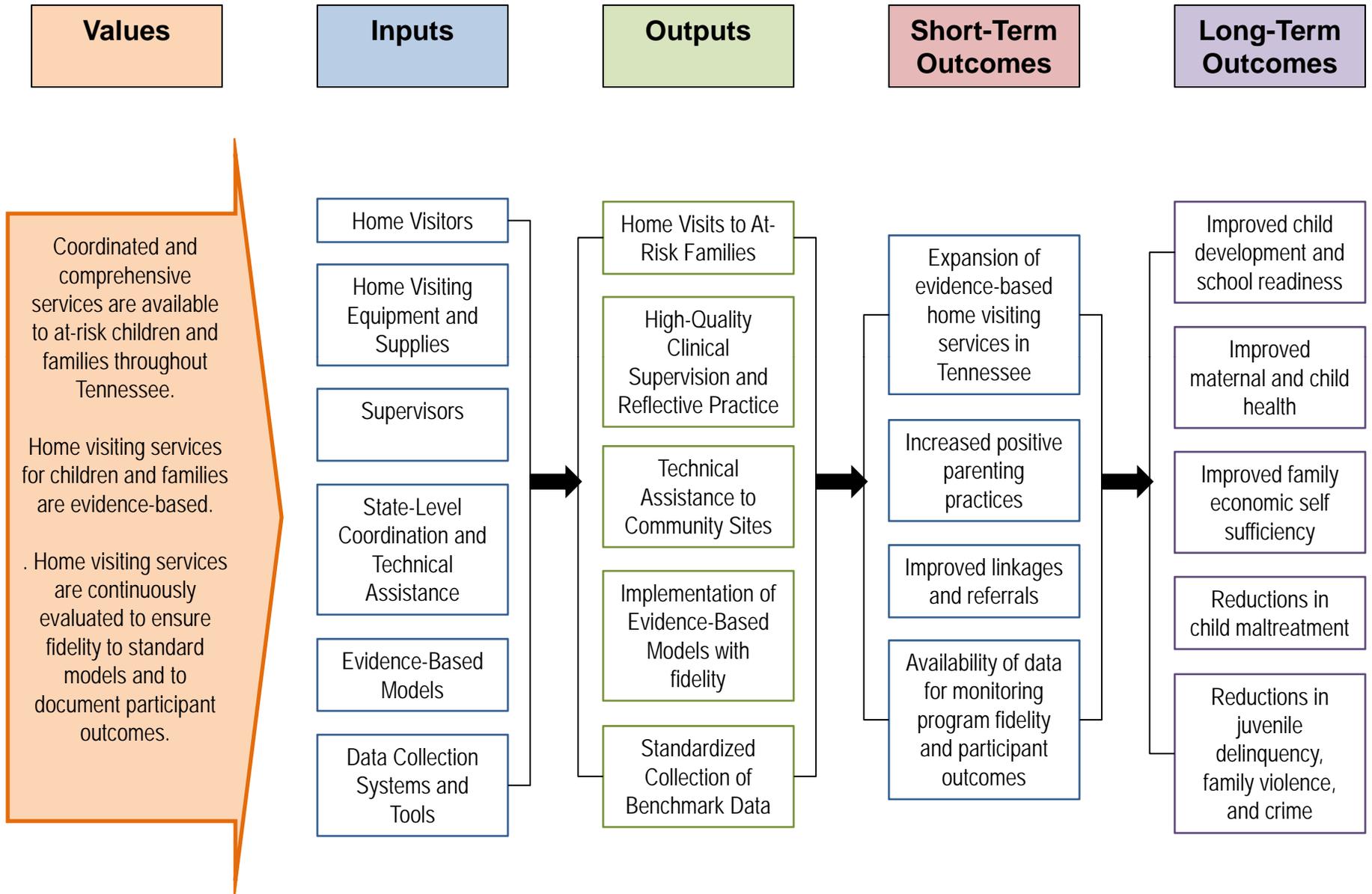
- State Home Visiting Program Goals and Objectives
- Implementation of Home Visiting Program in Targeted At-risk Communities
- Progress Toward Meeting Legislatively Mandated Benchmarks
- Home Visiting Program's CQI Efforts
- Administration of State Home Visiting Program
- Technical Assistance Needs

⁶ *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. (2003).* IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement.

⁷ Langley GJ, Nolan KM, Nolan TW, Norman CL, Provost LP. (1996) *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance.* Jossey-Bass:San Francisco. pp. 10, 60.

Logic Model

Tennessee Maternal, Infant, and Early Childhood Home Visiting Program



MIECHV Benchmarks and Constructs

Benchmark 1: Improved Maternal and Newborn Health

(Note: Psychometric properties of measurement tools, where available, are noted in the footnotes).

Construct	Indicator	Operational Definition / Calculation	Definition for Improvement	Population	Source / Measurement Tool	Data Collection Plan		
						Mechanism for Data Collection	Frequency	Link to CQI
Prenatal Care	Percent of pregnant women receiving prenatal care stratified by trimester	Number of pregnant women receiving care by trimester (first/second/third) divided by total number pregnant women enrolled	Improved percentage of women receiving prenatal care over time	Pregnant women	PRAMS ⁱ standardized question (How many weeks pregnant were you when you had your first visit for prenatal care?)	The home visitor will ask women a standard question.	Intake and every 6 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Prenatal use of alcohol, tobacco, or illicit drugs	Percent of pregnant women who report prenatal use of alcohol, tobacco, or illicit drugs	Number of pregnant women who report prenatal use of alcohol, tobacco, or illicit drugs divided by total number of pregnant women enrolled	Reduced percentage of women reporting prenatal use of alcohol, tobacco, or illicit drugs	Pregnant women	Life Skills Progression (Mental Health/Substance Abuse and Other Risk Scales) ⁱⁱ	The home visitor will ask women a standard series of questions.	Intake and every 6 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Preconception care	Percentage of women who report routine use of family planning method	Number of enrolled mothers who report routine use of family planning method divided by total number of enrolled mothers	Improved percentage of women reporting routine use of family planning method	Non-pregnant women	PRAMS standardized question (What are you or your partner/husband doing to keep from getting pregnant?)	The home visitor will ask mothers a standard question.	Intake and every 6 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Inter-birth intervals	Percentage of enrolled mothers with subsequent births spaced greater than 18 months	Number of enrolled mothers with subsequent births spaced greater than 18 months from previous birth divided by total number of enrolled mothers with subsequent births	Improved percentage of women with birth spacing greater than 18 months over time	Mothers	Interview/Self Report (will need list of all pregnancies and live births since enrollment— infant name, DOB)	The home visitor will ask mothers a standard question	Intake and every 12 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Screening for maternal depressive symptoms	Percentage of mothers screened with standardized depression screen	Number of mothers screened with standardized depression screen divided by total number of enrolled mothers	Improved percentage of mothers screened with standardized depression screen	Mothers	Edinburgh Postnatal Depression Scale ⁱⁱⁱ	The home visitor will ask mothers a standard series of questions.	One time; as needed	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Breastfeeding	Percentage of pregnant women who intend to breastfeed their babies	Number of pregnant women who intend to breastfeed their babies divided by total number of pregnant women	Improved percentage of mothers who intend to breastfeed	Pregnant women	PRAMS standardized question (During your pregnancy, did you plan on breastfeeding your baby?)	The home visitor will ask mothers a standard question.	Intake; every 6 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator

Construct	Indicator	Operational Definition / Calculation	Definition for Improvement	Population	Source / Measurement Tool	Data Collection Plan		
						Mechanism for Data Collection	Frequency	Link to CQI
Well child visits	Percentage of children who have a regular source of well-child care	Number of children whose caregivers report having a regular source of well-child care divided by total number of children enrolled	Improved percentage of children who have a regular source of well-child care	Children	Life Skills Progression (Health and Medical Care Scales, 17-23)	The home visitor will ask caregivers a standard series of questions.	Intake; every 6 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Maternal and child health insurance status	Percentage of children who have health insurance Percentage of enrolled women who have health insurance	Number of children whose caregivers report having health insurance divided by total number of children enrolled Number of women who report having health insurance divided by total number of women enrolled	Improved percentages of children and women who have health insurance	Children Women	PRAMS standardized question (Do you have health insurance?)	The home visitor will ask caregivers and women a standard question.	Intake; every 6 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report current rate for indicator

Benchmark 2: Child injuries, child abuse, neglect, or maltreatment and reduction of emergency department visits

Construct	Indicator	Operational Definition / Calculation	Definition for Improvement	Population	Source / Measurement Tool	Data Collection Plan		
						Mechanism for Data Collection	Frequency	Link to CQI
Visits for children to the emergency department from all causes	Rate of children with emergency room visits for any reason (per 10,000)	# of ED visits for any reason among enrolled children divided by total number of children enrolled x10,000 (per year)	Decrease in the rate of children enrolled in the program who have emergency room visits for any reason	Children (*Stratified by age)	Interview/Self Report	The home visitor will ask caregiver a standard question.	At each home visit (incident report)	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Visits of mothers to the emergency department from all causes	Rate of mothers with emergency room visits for any reason (per 10,000)	# of ED visits for any reason among enrolled mothers divided by total number of children enrolled x10,000 (per year)	Decrease in the rate of mothers enrolled in the program who have emergency room visits for any reason	Mothers	Interview/Self Report	The home visitor will ask mothers a standard question.	At each home visit (incident report)	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Information provided or training of participants on prevention of child injuries	Percent of participants who received age-appropriate injury prevention information/ training	# enrolled families who receive injury prevention information/training divided by total # enrolled families	Increase in the percentage of families enrolled in the program who receive injury prevention information/ training	Family (*Stratified by age of child)	AAP Safety Checklist (age appropriate)	The home visitor will document in the encounter record when information or training is provided.	Ongoing	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Incidences of child injuries requiring medical treatment	Rate of child injuries requiring medical attention (per 10,000)	# of child injuries requiring medical attention among enrolled children divided by total number of children enrolled x10,000 (per year)	Decrease in the rate of child injuries requiring medical attention	Children (*Stratified by infant or child)	Interview/Self Report	The home visitor will ask mothers a standard question.	At each home visit (incident report)	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Reported suspected maltreatment for children in the program	Percent of children with suspected maltreatment reported	# enrolled children with suspected maltreatment reported divided by total # enrolled children	Decrease in the percentage of children enrolled in the program who have suspected maltreatment reported	Children	Administrative data linked to demographic data collected by home visitor (first/last name, SSN, DOB)	Administrative data obtained via report from Department of Children's Services (DCS) (information-sharing agreement)	Annually	Annually report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • current rate for indicator
Reported substantiated maltreatment for children in the program	Percent of children with substantiated maltreatment reported	# enrolled children with substantiated maltreatment reported divided by total # enrolled children	Decrease in the percentage of children enrolled in the program who have substantiated maltreatment	Children	Administrative data linked to demographic data collected by home visitor (first/last name, SSN, DOB)	Administrative data obtained via report from DCS (information-sharing agreement)	Annually	Annually report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • current rate for indicator
First-time victims of maltreatment for children in the program	Percent of children who are first-time victims of maltreatment	# enrolled children who are first-time victims of maltreatment divided by total # enrolled children	Decrease in the percentage of children enrolled in the program who are first-time victims of maltreatment	Children	Administrative data linked to demographic data collected by home visitor (first/last name, SSN, DOB)	Administrative data obtained via report from DCS (information-sharing agreement)	Annually	Annually report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • current rate for indicator

Benchmark 3: Improved Maternal and Newborn Health

Construct	Indicator	Operational Definition / Calculation	Definition for Improvement	Population	Source / Measurement Tool	Data Collection Plan		
						Mechanism for Data Collection	Frequency	Link to CQI
Parent support for children’s learning and development	Percentage of families with increased HOME scale and subscale scores after one year of enrollment	Percentage of families with increased HOME scale and subscale scores after one year of enrollment divided by total number of enrolled families	Increases in parent support for child’s learning and development between entry and at one year after enrollment	Caregivers	HOME Inventory ^{iv}	The home visitor will ask caregivers a standard series of questions.	Annual	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Parent knowledge of child’s development and their child’s developmental progress	Percentage of families with increased HOME scale and subscale scores after one year of enrollment	Percentage of families with increased HOME scale and subscale scores after one year of enrollment divided by total number of enrolled families	Increases in parent support for child’s learning and development between entry and at one year after enrollment	Caregivers	HOME Inventory (Infant/Toddler and Early Childhood)	The home visitor will ask caregivers a standard series of questions.	Annual	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Parenting behaviors and parent-child relationships	Percentage of families with increased HOME scale and subscale scores after one year of enrollment	Percentage of families with increased HOME scale and subscale scores after one year of enrollment divided by total number of enrolled families	Increases in parent support for child’s learning and development between entry and at one year after enrollment	Caregivers	HOME Inventory (Infant/Toddler and Early Childhood)	The home visitor will ask caregivers a standard series of questions.	Annual	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Parent emotional well-being or parenting stress	Percentage of families with increased Protective Factors Scale scores after one year of enrollment	Percentage of families with increased Protective Factors Scale scores after one year of enrollment divided by total number of enrolled families	Increases in parent support for child’s learning and development between entry and at one year after enrollment	Caregivers	Protective Factors Survey ^v	The home visitor will ask caregivers a standard series of questions.	Annual	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Child’s communication, language, and emergent literacy	Percentage of enrolled children identified as at-risk	Number of children identified as at risk (indicating further assessment) divided by total number of children enrolled	Increases in developmental progress of children between entry and at one year after enrollment	Caregivers	Ages and Stages Questionnaire, 2 nd edition ^{vi}	The home visitor will ask caregivers a standard series of questions.	Intake; every 6 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Child’s general cognitive skills	Percentage of children identified as at-risk	Number of children identified as at risk (indicating further assessment) divided by total number of children enrolled	Increases in developmental progress of children between entry and at one year after enrollment	Caregivers	Ages and Stages Questionnaire, 2 nd edition (subscales)	The home visitor will ask caregivers a standard series of questions.	Intake; every 6 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator

Construct	Indicator	Operational Definition / Calculation	Definition for Improvement	Population	Source / Measurement Tool	Data Collection Plan		
						Mechanism for Data Collection	Frequency	Link to CQI
Child's positive approaches to learning including attention	Percentage of children identified as at-risk	Number of children identified as at risk (indicating further assessment) divided by total number of children enrolled	Increases in developmental progress of children between entry and at one year after enrollment	Caregivers	Ages and Stages Questionnaire—Social Emotional, subscales ^{vii}	The home visitor will ask caregivers a standard series of questions.	Intake; every 6 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Child's social behavior, emotion regulation, and emotional well-being	Percentage of children identified as at-risk	Number of children identified as at risk (indicating further assessment) divided by total number of children enrolled	Increases in developmental progress of children between entry and at one year after enrollment	Caregivers	Ages and Stages Questionnaire—Social Emotional, subscales	The home visitor will ask caregivers a standard series of questions.	Intake; every 6 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Child's physical health and development	Percentage of enrolled children identified as at-risk	Number of children identified as at risk (indicating further assessment) divided by total number of children enrolled	Increases in developmental progress of children between entry and at one year after enrollment	Caregivers	Ages and Stages Questionnaire, 2 nd edition	The home visitor will ask caregivers a standard series of questions.	Intake; every 6 months	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator

Benchmark 4: Crime or Domestic Violence

Construct	Indicator	Operational Definition / Calculation	Definition for Improvement	Population	Source / Measurement Tool	Data Collection Plan		
						Mechanism for Data Collection	Frequency	Link to CQI
Screening for Domestic Violence	Percentage of mothers screened for domestic violence	Number of women screened for domestic violence divided by total number of women enrolled	Increased percentage of women screened for domestic violence over time	Women	PRAMS standardized question (In the last 12 months, did your partner (or ex-partner) push, hit, slap, kick, choke, or physically hurt you in any way?)	The home visitor will ask women a standard question.	Annual	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Of families identified for the presence of domestic violence, the number of referrals made to relevant domestic violence services	Percentage of mothers with a positive domestic violence screen that receive a referral for a local domestic violence service	Number of women with positive domestic violence screens referred for local domestic violence service divided by total number of women with positive domestic violence screen	Increased percentage of women with positive domestic violence screen referred for local domestic violence services over time	Women	Encounter record	The home visitor will document in the encounter record when a referral is provided.	Ongoing	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Of families identified for the presence of domestic violence, the number of families for which a safety plan was completed	Percentage of mothers with a positive domestic violence screen for which a safety plan is completed (includes verbal)	Number of women with positive domestic violence screens for which a safety plan is completed divided by total number of women with positive domestic violence screen	Increased percentage of women with positive domestic violence screen for which a safety plan is completed over time	Women	Encounter record	The home visitor will document in the encounter record when a referral is provided.	Ongoing	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator

Benchmark 5: Family Economic Self-Sufficiency

Construct	Indicator	Operational Definition / Calculation	Definition for Improvement	Population	Source / Measurement Tool	Data Collection Plan		
						Mechanism for Data Collection	Frequency	Link to CQI
Household income	Average amount (in dollars, rounded to hundreds) of household income and benefits	Total amount (in dollars, rounded to hundreds) of household income and benefits for all enrolled families divided by number of enrolled families	Increase in total household income and benefits over time	Household	Interview/Self Report (What is each source of income and benefits and what is the amount gathered from each source?)	The home visitor will ask caregivers a set of standard questions.	Intake; then annually	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Employment or education of adult members of the household	<p>Average percent of adult household members employed during the month</p> <p>Average number of hours per month worked by each adult household member</p> <p>Educational benchmarks achieved by each adult household member since previous survey</p> <p>Average hours per month spent by each adult household member in educational programs</p>	<p>Total percent of adult household members employed during the month divided by the total number of adult household members in enrolled families</p> <p>Total number of hours worked by adult household members during the month divided by the total number of adult household members in enrolled families</p> <p>Total number of educational benchmarks achieved since previous survey among enrolled families</p> <p>Total number of hours spent in educational programs by adult household members divided by total number of adult household members in enrolled families</p>	<p>Increase in the number of paid hours plus unpaid hours devoted to care of an infant by all adults in participating households over time</p> <p>Increase in the educational attainment of adults in participating households over time</p>	Household	Interview/Self Report (What is the number of adult household members employed during the month; how many hours per month does each adult household member work; how many hours per month does each adult household member spend in educational programs; were any educational benchmarks (program completion, degree attainment) achieved since the last interview)	The home visitor will ask caregivers a set of standard questions.	Intake; then annually	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Health insurance status	Percentage of household members with health insurance benefits	Across all enrolled families, average percentage of household members with health insurance benefits (number of household members with insurance benefits divided by total number of household members)	Increase in the number of household members who have health insurance over time	Household	PRAMS standardized question (Do you have health insurance?)	The home visitor will ask caregivers a set of standard questions.	Intake; then annually	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator

Benchmark 6: Coordination and Referrals for Other Community Resources and Supports

Construct	Indicator	Operational Definition / Calculation	Definition for Improvement	Population	Source / Measurement Tool	Data Collection Plan		
						Mechanism for Data Collection	Frequency	Link to CQI
Number of families identified for necessary services	Percentage of families screened for needed services	Number of families screened for referral services divided by the total number of participating families	Increase in the proportion of families screened for needs, particularly those relevant for affecting participant outcomes	Household	Administrative Data	The home visitor will document in the encounter record when screening is completed.	Ongoing	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Number of families that required services and received a referral to available community resources	Percentage of families with positive screen receive referral to community resource	Number of families with positive screen referred to community resource divided by the total number of families with positive screens	Increase in the proportion of families identified with a need who receive an appropriate referral, when there are services available in the communities	Household	Administrative Data	The home visitor will document in the encounter record when screening and referral is made.	Ongoing	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator
Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community	Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community	Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community (by program and total across all programs)	Increase in the number of formal agreements with other social service agencies	Home Visiting Program	Home Visiting Agency Self Report (using state-prepared quarterly report form)	Each home visiting agency will complete the quarterly report and submit to the Department of Health.	Quarterly	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report
Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies	Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies	Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies (by program and total across all programs)	Increase in the number of social service agencies that engage in regular communication with the home visiting provider	Home Visiting Program	Home Visiting Agency Self Report (using state-prepared quarterly report form)	Each home visiting agency will complete the quarterly report and submit to the Department of Health.	Quarterly	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report
Number of completed referrals	Percentage of families referred to community resource who complete referral	Number of families with completed referrals divided by the total number of families with referrals made	Increase in the percentage of families with referrals for which receipt of services can be confirmed	Household	Administrative Data	The home visitor will document in the encounter record when referral is completed.	Quarterly	Periodic report to programs (community, program-specific, and by program worker) documenting: <ul style="list-style-type: none"> • completeness report • current rate for indicator

- ⁱ **Pregnancy Risks Assessment Monitoring System:** Centers for Disease Control and Prevention (CDC), *Pregnancy Risks Assessment Monitoring System*, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention: Atlanta, GA.
- ⁱⁱ **Life Skills Progression Instrument:** Wollensen L & Peifer K. *Life Skills Progression (LIFE SKILLS PROGRESSION): An Outcome and Intervention Planning Instrument for Use with Families at Risk*. Baltimore, MD: Paul H. Brookes Publishing Company, Inc. p. 39. For Health and Medical Care Scales: Construct Validity: Alpha score=0.94; Test-Retest Reliability: average interitem correlation=0.90. For Mental Health and Substance Abuse Scales: Construct Validity: Alpha score=0.99; Reliability: average interitem correlation=0.90. For Child Development Scales: Construct Validity: Alpha score=0.94; Test-Retest Reliability: average interitem correlation=0.90. For Basic Essentials: Construct Validity: Alpha score=0.94; Test-Retest Reliability: average interitem correlation=0.90. For Relationship Scales: Construct Validity: Alpha score=0.94; Test-Retest Reliability: average interitem correlation=0.90.
- ⁱⁱⁱ **Edinburgh Postnatal Depression Scale:** Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150, 782-786. Reliability: None reported. Validity - Concurrent Validity: a validation study on British mothers found that a 12.5 cutoff score identified over 80 percent of the mothers with major depression and about 50 percent of the mothers with minor depression, and had a sensitivity value of 67.7 percent. Another study found a score of 9.5 or higher to be more appropriate for identifying depression among Chinese mothers.
- ^{iv} **Home Observation for Measurement of the Environment (HOME) – Infant/Toddler Inventory, 3rd Ed.** : Caldwell, B.M., and Bradley, R.H. (2001). *Home Inventory Administration Manual, Third Edition, 2001*. Little Rock, AR: University of Arkansas at Little Rock. Caldwell, B.M., and Bradley, R.H. (unpublished manuscript). *Psychometric Characteristics*. Validity: The HOME Inventory is intended to be a more valid measure of a child's developmental environment than family socioeconomic status only. Nevertheless, the two measures should be related to some extent. The HOME subscales for both versions correlate moderately (.3-.5) with such socioeconomic status measures as parents' education and occupation, father's presence, and home crowding. The HOME Inventory, particularly the Birth to Three version, has been extensively used in studies of the cognitive development of children. Reliability: The reliability for the Birth to Three HOME came from a sample of 174 ethnically and socio-economically diverse families residing in Little Rock, AK. Internal consistency (KR-20 coefficient) was .89 for the total HOME and averaged .70 for the six subscales. HOME data were available for children in 91 families when the children were 6, 12, and 24 months of age. Intra-class correlations, computed as a measure of stability for total HOME scores, were .57 for 6 versus 12 months and .76 for 12 versus 24 months. Reliability results for the Preschool HOME, using a previous 80-item version completed with 238 families, are similar to those summarized for the Birth to Three HOME.
- ^v **Protective Factors Survey:** Counts, J. M., Buffington, E. S., Chang-Rios, K., Rasmussen, H. N., & Preacher, K. J. (2010). The development and validation of the protective factors survey: A self-report measure of protective factors against child maltreatment. *Child Abuse & Neglect*, 34(10), 762-772. Validity: In the validity analyses, all 4 subscales of the PFS were significantly negatively correlated with child abuse potential and stress. In the confirmatory factor analysis (CFA), factor loadings using both maximum likelihood and weighted least square means and variance (WLSMV) solutions supported those of the initial EFA sample. Factor correlations in the CFA also remained consistent with those from the original sample. Results demonstrate that the factor structure generalized well to a new sample. Reliability: The exploratory factor analysis (EFA) included 45 items theoretically serving as indicators of 4 factors: Family Functioning (FF), Emotional Support (ES), Concrete Support (CS), and Nurturing and Attachment (NA). The most interpretable factor structure emerging from the EFA retained 27 items. Based on a combination of standard factor retention criteria, model fit, and interpretability, a 4-factor EFA solution was chosen as the most appropriate model for the retained items. Additional items were removed due to low loadings, nontrivial cross-loadings, and parsimony, yielding a final scale with 20 items. Coefficient alphas for three subscales were acceptable for FF = 0.94, ES = 0.86, and NA = 0.83. The coefficient alpha for CS (0.63) was below the acceptable range of 0.80.
- ^{vi} **Ages and Stages Questionnaires: A Parent-Completed, Child Monitoring System, 2nd Edition (ASQ):** Bricker, D., Squires, J. and Twombly, E. (1999). *Ages and Stages Questionnaires: A Parent-Completed, Child Monitoring System, Second Edition*. Baltimore, MD: Paul Brookes. Validity: Overall agreement across questionnaires is 83 percent, with a range of 76-91 percent. Sensitivity (i.e., children for whom the Ages & Stages Questionnaires (ASQ) system indicated a delay and who were categorized by the standardized assessment as having a delay) ranged from 38 percent to 91 percent, and specificity (i.e., children for whom the ASQ system did not indicate a delay and who were characterized by a standard assessment as developing typically) ranged from 81 percent to 91 percent. Positive predictive value (i.e., a measure of the probability that a child with a questionnaire that indicated delay would have a poor outcome on the standardized assessment) ranged from 32 percent to 64 percent. Reliability: Test-retest information was collected by asking a group of 175 parents to complete two questionnaires for their children at 2- to 3-week intervals. Classification of each child based on the parents' responses on the two questionnaires was compared and found to exceed 90 percent agreement. Interrater reliability was assessed by having a trained examiner complete a questionnaire for a child shortly after a parent had completed a questionnaire. Agreement on classification between 112 parents and 3 trained examiners was more than 90 percent.
- ^{vii} **Ages and Stages Questionnaires: Social-Emotional - A Parent-Completed, Child Monitoring System for Social-Emotional Behaviors.** Squires, J., Bricker, D., and Twombly, E. (2003) *The ASQ:SE User's Guide for the Ages and Stages Questionnaires: Social-Emotional*. Baltimore, MD: Paul Brookes. Validity: (1) Concurrent validity: percent agreement of ASQ:SE with similar established tools ranged from 81 to 95 percent and was 93 percent overall. (2) Predictive validity: no information available. Reliability: (1) Internal consistency reliability (Cronbach's alpha): the alphas for the questionnaires were .82 overall, .69 (6-month), .67 (12-month), 18-month (.81); 24-month (.80); 30-month (.88); 36-month (.89); 48-month (.91); 60-month (.91). (2) Test-retest reliability, with one to three weeks between tests: percent agreement between scores by the same rater on two occasions is 94 percent. (3) Inter-rater reliability: no information available.