The Mother and Infant Home Visiting Program Evaluation

Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program

A Report to Congress

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The Mother and Infant Home Visiting Program Evaluation: Early Findings on the Maternal, Infant, and Early Childhood Home Visiting Program
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MDRC and subcontractors James Bell Associates, Johns Hopkins University, Mathematica Policy Research, the University of Georgia, and Columbia University are conducting the Mother and Infant Home Visiting Program Evaluation (MIHOPE) for the Department of Health and Human Services (HHS) under a contract with the Administration for Children and Families (ACF), funded by HHS under a competitive award, Contract No. HHS-HHSP23320095644WC. The project officer is Nancy Geyelin Margie.

Overview

Children from low-income families often have poor social, emotional, cognitive, behavioral, and health outcomes. One approach that has helped parents and their young children is home visiting, which provides information, resources, and support to expectant parents and families with young children. The Patient Protection and Affordable Care Act greatly expanded the availability of home visiting when it amended Title V of the Social Security Act to create the federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV or the Home Visiting Program). In doing so, it allocated $1.5 billion from fiscal year 2010 to fiscal year 2014 to states, territories, and tribal entities to fund home visiting programs. The Protecting Access to Medicare Act of 2014 provided an additional $400 million through the middle of fiscal year 2015. MIECHV required states to make a priority of services for at-risk families in order to improve a broad range of outcomes related to parental and child health and well-being, parenting, economic self-sufficiency, and intimate partner violence. It also required states to spend most funds on national models that met rigorous criteria for evidence of effectiveness defined by the Department of Health and Human Services (HHS).

This report presents the first findings from the Mother and Infant Home Visiting Program Evaluation (MIHOPE), the legislatively mandated national evaluation of MIECHV. Sponsored by the Administration for Children and Families and the Health Resources and Services Administration within HHS, MIHOPE is studying MIECHV in its early years. The study is being conducted for HHS by MDRC in partnership with James Bell Associates, Johns Hopkins University, Mathematica Policy Research, the University of Georgia, and Columbia University. Key findings in this report include:

- **States used initial MIECHV funds primarily to expand the use of four evidence-based home visiting models in at-risk communities.** The national home visiting models most frequently chosen by states for MIECHV funding were Early Head Start - Home Based Program Option, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. As intended, states targeted counties with high rates of poverty, child maltreatment, and premature birth, among other indicators of risk.

- **As intended, MIECHV-funded programs serve a group of mothers with many needs.** When they entered the study, more than 30 percent of women had symptoms of depression, almost 20 percent had health problems that limited their activities, 92 percent were receiving some form of public assistance, more than three-quarters had no more than a high school diploma, and a tenth reported being the victim of intimate partner violence.

- **MIECHV-funded programs are designed to help parents support the healthy development of infants and toddlers and overcome the problems low-income families face.** MIECHV encouraged some local programs to broaden the outcomes they focused on, and home visitors reported that they were generally well trained and supported in working with families to address a wide range of outcomes. Local programs also reported having the management information systems and infrastructure they needed to implement programs effectively.

This report provides a foundation for understanding the implementation and impacts of MIECHV-funded home visiting programs. Later reports will explore the local and national implementation of those programs, and their effects on families with young children.

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Acknowledgments

The Mother and Infant Home Visiting Program Evaluation (MIHOPE) is a large and complex project that resulted from the collaboration of many people and organizations. From the project's inception, it has benefited greatly from the advice of a number of people at the Department of Health and Human Services. At the Office of Planning, Research and Evaluation, Lauren Supplee and Nancy Geyelin Margie have provided regular feedback to the study team, and Naomi Goldstein has provided invaluable guidance on difficult issues the team has faced. At the Health Resources and Services Administration (HRSA), Carlos Cano, Romuladus Azuine, Benyamin Margolis, Kathleen Kilbane, and Julie Ross have also weighed in on various project issues.

MIHOPE's ability to investigate the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) comes from the states and local programs that are participating in the study, and we are grateful for their participation. We also thank the project's site recruitment team, which was led by Sharon Rowser and Dina Israel at MDRC, and had team members at MDRC (Marie Cole, Rebecca Hughes, Magdalena Mello, Alexander Vazquez, Ashley Weech, and Evan Weissman), James Bell Associates (Nicole Miller, Kerry Ryan, Lance Till, Susan Zaid, and Alexandra Joraanstad), and Mathematica Policy Research (Luke Heinkel, Jacob Hartog, and Cheri Vogel). In addition, this effort would not have been possible without the assistance of the HRSA project officers and MIECHV administrators the team consulted in the various states, and particularly in the 12 states that were eventually chosen to participate in this study.

The discussion of the national home visiting models was greatly informed by available program documentation and through surveys and discussions with the national model developers, including David Jones and Angie Godfrey for Early Head Start; Cydney Wessel, Kathleen Strader, and Kathryn Harding at Healthy Families America; Molly O'Fallon and Ely Yost at Nurse-Family Partnership; and Karen Guskin and Kerry Cavelry of Parents as Teachers.

In addition to information collected from the national model developers, this report contains a great deal of information on the local home visiting programs and families that have enrolled in the study. For that, we owe our gratitude to the local programs and families for providing the information, and to the MIHOPE data team for processing it. Desiree Alderson oversaw all aspects of the data work for MIHOPE. Electra Small developed the web surveys used with home visiting program staff members, with assistance from Melinda

Jackson and Alexandra Parma, who also assisted in analyzing the data. Kristen Faucetta led MDRC's efforts to analyze information on participating families, and directed the work of Patricia Chou and Jessica Kopsic in doing so. Martha Kovac led a large Mathematica team that included field interviewers at the 88 MIHOPE sites (who obtained consent from families in the study) and phone interviewers at the survey operations center. Ms. Kovac was assisted in her work by a number of people, including Annalee Kelly, Sara Skidmore, and Ananth Koppikar. Finally, Melane Estarziau, Kerry Ryan, and Alexandra Joraanstad from James Bell Associates helped compile information on the national home visiting models.

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The Authors

Executive Summary

Children from low-income families often suffer from poor social, emotional, cognitive, health, and behavioral outcomes.[1] Children develop fastest in their earliest years, and developing early skills and abilities lays the foundation for future success in school and life.[2] For that reason, the most cost-effective time to intervene may be early in a child's life.[3] One important approach that has helped parents and their young children is home visiting, which provides individually tailored information, resources, and support to expectant parents and families with young children.

Home visiting aims to support the healthy development of infants and toddlers and help low-income families overcome the problems they face. In general, it consists of three types of activities: assessment of family needs, parent education and support, and referral to and coordination with needed services. Home visitors use a variety of strategies to provide support and education to families, including setting goals with caregivers and creating plans for meeting those goals, helping caregivers resolve problems, helping parents and children build better relationships, intervening during crises, providing information on children's developmental stages and feedback on parenting, working to strengthen families' support networks, supporting and coordinating referrals to additional community resources, and providing emotional support, written information, or other materials.

The Patient Protection and Affordable Care Act greatly expanded the availability of home visiting in the United States when it amended Title V of the Social Security Act to create the federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV or the Home Visiting Program). In doing so, it allocated $1.5 billion to states, territories, and tribal entities (which include tribes, tribal organizations, and urban Indian organizations) to fund home visiting from federal fiscal year (FY) 2010 through the middle of FY 2015.[4] The legislation also required an evaluation of MIECHV in its early years along with a report to Congress due by March 31, 2015. To fulfill these requirements, this

[1]Brooks-Gunn, Jeanne, and Greg J. Duncan, "The Effects of Poverty on Children," *The Future of Children* 7, 2 (1997): 55-71.

[2]National Research Council and Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington, DC: National Academy Press, 2000).

[3]Doyle, Orla, Colm P. Harmon, James J. Heckman, and Richard E. Tremblay, "Investing in Early Human Development: Timing and Economic Efficiency," *Economics and Human Biology* 7, 1 (2009): 1-6.

[4]The Protecting Access to Medicare Act of 2014 provided an additional $400 million investment through FY 2015.

report presents the first findings from the Mother and Infant Home Visiting Program Evaluation (MIHOPE). MIHOPE was launched in 2011 by the Administration for Children and Families and the Health Resources and Services Administration within the Department of Health and Human Services (HHS). The study is being conducted for HHS by MDRC in partnership with James Bell Associates, Johns Hopkins University, Mathematica Policy Research, the University of Georgia, and Columbia University.

The legislation required the evaluation to include four components:

- **Analysis of needs assessments.** The legislation required states and territories to assess the needs of local communities in order to determine where home visiting resources should be spent. The legislation required the evaluation to provide an analysis, on a state-by-state basis, of the results of the needs assessments, including indicators of maternal and prenatal health and infant health and mortality, and state actions in response to the assessments.

- **Effectiveness study.** The evaluation will assess the effect of early-childhood home visiting programs on child and parent outcomes, including health, child development, parenting skills, school readiness and academic achievement, crime or domestic violence, and family economic self-sufficiency.[5]

- **Subgroup analysis.** The evaluation will assess the effectiveness of the programs on different populations, including the extent to which the ability of the programs to improve participant outcomes varies across programs and populations.

- **Analysis of effects on the health care system.** The evaluation will assess whether the activities conducted by such programs, if expanded to a broad scale, have the potential to improve health care practices, eliminate health disparities, improve health care quality and efficiency, and reduce costs.

[5]The legislation required grantees (states, territories, and tribal entities) to show improvement in six specified benchmark areas. In addition, the legislation required that MIECHV-funded programs be designed to improve individual outcomes for participating families in seven areas. Because there is considerable overlap between the benchmark areas and the individual participant outcomes, this report uses the term "outcomes" to refer to both lists. MIHOPE is designed to assess impacts relevant to all of these outcomes.

The current report presents MIHOPE's findings to date. These include information on the needs identified by states and their plans for using MIECHV funds to meet those needs, a description of where the study is being conducted, some information on the families in the study, and a discussion of whether plans for local home visiting programs reflect the requirements of MIECHV.

Home Visiting Models Studied in MIHOPE

MIHOPE is studying four national evidence-based models that, at the start of the study, were supported with MIECHV funds in 10 or more states.[6] These are Early Head Start - Home Based Program Option, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers.

In general, home visiting programs work with expectant mothers and families with young children to do three things: (1) assess family needs, (2) educate and support parents, and (3) help families gain access to services, all with the goal of improving outcomes for families throughout their children's early years and beyond. Although the four national models follow this basic framework, they differ in some important ways.

- **Goals.** All of the models try to improve child health and development, but some have historically focused more on preventing child maltreatment, others on improving maternal and child health, and others on positive parenting or school readiness.

- **Target population and age at enrollment.** The models aim to serve at-risk families, such as those with low incomes. However, each focuses on different types of risk. Nurse-Family Partnership targets first-time mothers, Healthy Families America focuses on families at risk of child maltreatment or with behavioral health issues, Early Head Start seeks to serve a broad group of low-income families, and Parents as Teachers has no specific eligibility requirements at the national level. All four models can enroll women when they are pregnant or when they have newborns,

[6]To determine which national models were considered evidence-based, HHS commissioned the Home Visiting Evidence of Effectiveness (HomVEE) review. Models met the HHS criteria for evidence of effectiveness if they had at least one study of at least moderate quality with statistically significant impacts in two or more of eight outcome domains, or at least two such studies with statistically significant impacts in the same domain.

although Early Head Start and Parents as Teachers also enroll families with toddlers.

- **Home visitor qualifications.** The four national models require different qualifications of their home visitors. Nurse-Family Partnership home visitors must be registered nurses, Early Head Start requires home visitors to have knowledge and experience in child development, Parents as Teachers requires home visitors to have at least a high school credential, and Healthy Families America does not require home visitors to have a specific educational background.

MIHOPE Study Design

MIHOPE plans to enroll more than 4,000 families through 88 local home visiting programs that are operating one of the four national evidence-based models in 12 states. The study is large enough to provide reliable information about MIECHV-funded programs' effects on the range of outcomes identified in the legislation and to provide information on the characteristics of more effective local programs. To generate the most credible estimates of those effects, families are being assigned at random to either a MIECHV-funded home visiting program or to a control group that will be referred to other appropriate services in the community.

Analysis of State Needs Assessments

To receive MIECHV funding, states were required to identify the quality and capacity of existing home visiting programs and to collect information on community characteristics to determine where MIECHV funds would be best spent. With that information in hand, they developed plans for spending those funds that covered where funds would be used, for which evidence-based models, and to target which families. The legislation required MIHOPE to analyze those needs assessments and state plans. Among the findings of that analysis are:

- **States chose high-needs communities for MIECHV funds.** As intended by the legislation, states generally proposed using MIECHV funds in counties with high rates of risk indicators. For example, most states targeted communities with high poverty and unemployment rates and high rates of premature births.

- **Home visiting services were extensive prior to MIECHV.** States identified more than 5,000 local home visiting programs operating prior to MIECHV. The most widely disseminated models were the four being studied in MIHOPE, but almost half of local home visiting programs used models that were not evidence-based according to HHS's criteria.

- **MIECHV encouraged states to expand the use of evidence-based home visiting models.** In their initial plans for using MIECHV funds, states proposed to support primarily the four national models being studied in MIHOPE. In interviews for MIHOPE, state administrators confirmed that MIECHV encouraged them to expand the reach of evidence-based home visiting. As of their FY 2011 plans, 40 states planned to use MIECHV to support Nurse-Family Partnership programs, 39 for Healthy Families America programs, 29 for Parents as Teachers programs, and 17 for Early Head Start programs.

States and Local Programs Chosen for MIHOPE

As noted earlier, MIHOPE includes 88 MIECHV-funded local home visiting programs in 12 states. Since initial state plans indicated that MIECHV would support more than 500 such programs, the study had to choose which states and local programs to include.

MIHOPE selected states using several criteria:

- **They were using MIECHV funds to expand at least two of the four evidence-based models.** This would help the study distinguish between the influence of a particular state and the influence of a particular program model.

- **They were planning to support five or more eligible local programs.** Such states were considered a higher priority because they would help achieve the study's goal of choosing about 85 local programs from 12 states.

- **Collectively, they represented four geographic clusters.** These clusters corresponded to the Northeast, South, Midwest, and Mountain and West.

These criteria resulted in 12 states being selected for the study: California, Georgia, Illinois, Iowa, Kansas, Michigan, Nevada, New Jersey, Pennsylvania, South Carolina, Washington, and Wisconsin.

Within these states, MIHOPE selected local home visiting programs if they met the following criteria:

- They operated one of the four national evidence-based models.
- They had been in operation for two or more years and were thus past initial start-up challenges.
- They had enough demand for services that they could enroll at least 40 families for the study while allowing for the ethical creation of a control group.
- They helped provide an approximately equal distribution of local programs across the four national models. The local programs participating in MIHOPE include 19 operating Early Head Start, 26 operating Healthy Families America, 22 operating Nurse-Family Partnership, and 21 operating Parents as Teachers.

Family Characteristics

This section presents information on MIHOPE families using surveys of women conducted as they entered the study. Because sample recruitment continues, the findings are based on about a third of the families who will eventually be enrolled in the study. The characteristics of these families were shaped by the requirements of both the national models and of MIECHV. In particular, the legislation required states to give priority to families headed by parents who had served in the Armed Forces and to high-risk groups, including low-income, pregnant women under age 21; families with a history of child abuse or substance abuse; tobacco users; families with children who have low academic achievement; and children with developmental delays. In general, the national models aim to serve families with similar risk factors, although Nurse-Family Partnership is limited to women early in their first pregnancies, while Healthy Families America targets families at risk for child maltreatment or other negative childhood experiences.

The MIHOPE sample is young, with an average maternal age of 23 at the time of enrollment. Nearly 70 percent were pregnant, with about 43 percent in the legislation's pri-

ority population of pregnant women under age 21. The sample is also racially and ethnically diverse, with most mothers being Hispanic (34 percent), non-Hispanic white (25 percent), or non-Hispanic black (31 percent).

The information on families also provides insights into the risks and challenges faced by mothers and children in the outcome areas identified for improvement in the legislation.

- **Maternal health and well-being.** In some respects, women in MIHOPE exhibited healthy behavior and were in good health: 80 percent initiated prenatal care in the first trimester, and nearly 90 percent said they were in good or excellent health. At the same time, more than a third reported using tobacco and a third reported binge drinking in the three months before pregnancy or using illegal drugs in the month before pregnancy. Forty percent exhibited symptoms of depression or anxiety when they entered the study, and a tenth had been the victim of physical intimate partner violence in the past year.

- **Parenting.** To meet the goal of improving child health and development, all four national models emphasize positive parenting skills. Surveys of parents indicate some positive parenting practices before women entered the study, but also indicate some room for improvement. For example, nearly 80 percent of mothers had initiated breastfeeding and a similar number of pregnant women planned to breastfeed. However, only about half had at least 10 books in the home, which has been found to be an important predictor of children's ability to understand and use language and to think and understand.[7]

- **Family economic self-sufficiency.** Home visiting programs often target low-income families, and nearly all families in the study were receiving some government benefits intended for low-income families. In addition, 44 percent of mothers had not finished high school.

- **Child health and development.** Because children were very young or their mothers were pregnant when they entered the study, only a little is

[7]Linver, Miriam R., Anne Martin, and Jeanne Brooks-Gunn, "Measuring Infants' Home Environment: the IT-HOME for Infants Between Birth and 12 Months in Four National Data Sets," *Parenting* 4, 2-3 (2004): 115-137.

known about children's health and development at that time. Among the young children, about 10 percent were born prematurely and about 10 percent were born with low birth weights. Both rates are similar to national averages. Nearly every child had a usual source of health care, although about a tenth of children were not covered by health insurance.

- **Characteristics by national model.** As noted earlier, the four national models target somewhat different groups of families. In general, there were few differences in the types of families enrolled by the four models, although Nurse-Family Partnership programs enrolled only pregnant women while about half of the women enrolled by other MIHOPE programs were pregnant.

Characteristics of Home Visiting Programs

The familial risks described above underscore the challenges that home visiting programs face. This report describes how the four national models and the local home visiting programs participating in MIHOPE are planning and supporting the implementation of home visiting services. The information comes from interviews and surveys with the four national model developers, web-based surveys of 77 program managers around the time their programs entered the study, and web-based surveys with 377 home visitors around the same time.

Characteristics of Home Visiting Planned Services

This section describes whom programs intend to serve, what outcomes they intend to improve, what services they plan to deliver to achieve those improvements, and how they intend to staff programs to deliver services.

Intended Recipients

All four national models serve families at risk of poor child outcomes. All indicated to the MIHOPE team that they assume major responsibility for improving the outcomes of the child and all indicated that they assume at least some responsibility for the mother's outcomes. In general, local programs are consistent with their national models in this respect.

Intended Goals and Outcomes

When presented with a list of outcomes ranked as high priorities in the legislation that created MIECHV, all four national model developers assigned high priorities to five outcomes: promoting positive parenting behavior, preventing child abuse and neglect, fostering economic self-sufficiency, encouraging child preventive care, and promoting child development. However, the national model developers differed for other outcomes. Nurse-Family Partnership, for example, gave the highest priority to all of the outcomes, while Parents as Teachers placed a high priority on some but low priority on others. Despite differences among the national models, a majority of local program managers ranked each outcome highly. This may reflect the influence of MIECHV: some local programs claimed that MIECHV encouraged them to make a higher priority of outcomes mentioned in the authorizing legislation.

Intended Service Delivery

Home visits generally consist of information gathering, education and support, and referrals for needed services. Nearly all local programs reported that they required formal screening to identify maternal mental health issues and infant developmental delays, and about three-quarters required formal assessment of participants for maternal substance abuse, intimate partner violence, and parenting behavior. This is consistent with the requirements of the national models, which all required local programs to conduct developmental screenings but varied in their requirements for screening in other areas. Despite the widespread use of screening, many local programs lacked protocols for education and support in cases where screens detected problems. For example, when they entered MIHOPE, only about half of the local programs had protocols for responding to developmental delays and fewer than half had written protocols for the other problems that screens might detect, such as maternal substance use, intimate partner violence, or poor parenting behavior. Turning to referral policies, many local programs reported that home visitors were expected to help families gain access to necessary resources, which is consistent with national model requirements that home visitors monitor families' success in using referrals.

Regarding the approaches that home visitors use in their daily work with families, all four national models encouraged observation of parent-child interaction accompanied by both positive and constructive feedback, and all of the national models encouraged home visitors to use at least one supportive strategy such as goal setting, problem solving, or emotional support. However, only Early Head Start and Nurse-Family Partnership encouraged home visitors to demonstrate positive parenting practices, and Early Head Start, Healthy

Families America, and Nurse-Family Partnership encouraged home visitors to direct parent-child activities. In contrast to their national models, most local programs across all national models reported that they encouraged the use of all of these techniques.

Implementation System

The implementation system is the link between intended and actual service delivery. The components of the implementation system discussed in this report include staff development, clinical support, administrative support, and system support.

Staff Development

In web-based surveys, most home visitors indicated that they were expected to help mothers across the range of outcomes described earlier. The vast majority of home visitors also reported they were adequately trained to help mothers in these areas, and that local programs provided useful strategies and tools to assist them in helping mothers.

Clinical Support

Because of the complex challenges seen in disadvantaged families, local programs may provide home visitors with access to expert advice from clinical consultants. Overall, about three-quarters of local programs reported that they did provide access to expert consultants, and the availability of expert consultants was relatively uniform across outcome domains.

Links to Community Resources

Home visiting programs must work with other organizations to identify eligible families and to connect them with needed services. Overall, two-thirds of local programs had formal referral agreements with organizations in their communities, although fewer than a quarter had formal referral agreements with health-related organizations.

Administrative Support

Nearly all local home visiting programs used management information systems for internal program monitoring. Most monitored the number of referrals into their programs and their retention rates, and most home visitors could use these systems to document what happened during home visits. As required under MIECHV, the majority of local programs

had undertaken continuous quality improvement activities in the year prior to entering MIHOPE.[8]

Discussion

This report provides an early indication that MIECHV is being implemented in ways that support its intended goals. First, states developed plans to use MIECHV funds to expand evidence-based home visiting in at-risk communities. Reflecting those plans, local programs are serving a high-needs group of mothers, including some of the high-priority groups specified in the Affordable Care Act. Finally, MIECHV-funded programs appear to be designed to help families overcome the multiple and severe problems they face, and where there are gaps between families' needs and the services they provide, they appear to be paying attention to MIECHV goals and adjusting their priorities accordingly.

This report also sets the stage for future reports on the services delivered under MIECHV and the effects of the home visiting programs on family and child outcomes. It suggests that MIHOPE is well positioned to learn about the effects of home visiting for many of the high-priority groups identified in the authorizing legislation. It also suggests that MIHOPE can provide valuable information on several aspects of program implementation, including how local program implementation varies across the national models and how the quality of home visiting services varies with the priority that local programs and national models give to different outcomes.

[8] "Continuous quality improvement" is a process to ensure programs are systematically improving services and increasing positive outcomes for the families they serve. See FRIENDS National Resource Center for Community-Based Child Abuse Prevention, "Continuous Quality Improvement," website: http://friendsnrc.org/continuous-quality-improvement, accessed August 12, 2014.

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Chapter 1

Introduction

Children from low-income families often suffer from poor social, emotional, cognitive, behavioral, and health outcomes.[1] Children develop fastest in their earliest years, and the skills and abilities they develop in those years help lay the foundation for future success in school and life.[2] For that reason, the most cost-effective time to intervene may be early in a child's life.[3] Since parents play a critical role in shaping children's early development, early interventions with parents have great potential to produce long-term benefits.[4]

One approach that has helped parents and their young children is home visiting, which provides individually tailored information, resources, and support to expectant parents and families with young children. Home visiting programs in the United States have their origins in the late nineteenth century, when charitable organizations used home visiting to try to reduce poverty by changing the behavior of the urban poor.[5] Home visiting later expanded to include such approaches as visits by public health nurses to promote infant and child health, Head Start home visiting to promote child development, and home-based family support to promote positive parenting and prevent child maltreatment.[6] The Patient Protection and Affordable Care Act greatly expanded the availability of home visiting in the United States when it amended Title V of the Social Security Act to create the federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV or the Home Visiting Program) and allocated $1.5 billion to states, territories, and tribal entities (which include tribes, tribal organizations, and urban Indian organizations) to fund home visiting from federal fiscal year 2010 through the middle of fiscal year 2015.[7]

The legislation also required an evaluation of MIECHV in its early years, the Mother and Infant Home Visiting Program Evaluation (MIHOPE). MIHOPE was launched in 2011 by the Administration for Children and Families and the Health Resources and Services Administration within the Department of Health and Human Services (HHS). The

[1]Brooks-Gunn and Duncan (1997).
[2]National Research Council and Institute of Medicine (2000).
[3]Doyle, Harmon, Heckman, and Tremblay (2009).
[4]Brooks-Gunn and Markman (2005).
[5]Weiss (1993).
[6]Combs-Orme, Reis, and Ward (1985); Harding et al. (2007); Love et al. (2005).
[7]The Protecting Access to Medicare Act of 2014 provided an additional $400 million investment through the middle of fiscal year 2015.

evaluation is being conducted for HHS by MDRC in partnership with James Bell Associates, Johns Hopkins University, Mathematica Policy Research, the University of Georgia, and Columbia University.

The overarching goals of MIHOPE are to learn whether families and children benefit from home visiting, and to investigate how states and local agencies implemented home visiting under MIECHV to improve family outcomes. In addressing these two issues, MIHOPE is also collecting a wealth of information to analyze which features of local home visiting programs increase their effectiveness. It is therefore designed to provide an unprecedented resource to help national, state, and local home visiting administrators develop and put into place effective home visiting programs.

This report presents the first findings from the study. The report's findings include:

- **States targeted at-risk communities for MIECHV funds.** The legislation required states and territories (hereafter referred to as states) to assess the needs of local communities in order to determine where home visiting resources should be spent. An analysis of those needs assessments reveals that home visiting programs were an important resource throughout the country prior to MIECHV, but that many communities did not use evidence-based models or had unmet home visiting needs. States proposed to spend MIECHV funds in communities that, compared with states' overall averages, had higher poverty rates, higher rates of poor birth outcomes, higher rates of child maltreatment, and worse rates for other indicators of disadvantage.

- **MIHOPE chose a diverse set of local home visiting programs.** As of May 2014, 12 states and 88 local home visiting programs had joined the study, including 19 Early Head Start - Home Based Program Option (also referred to as Early Head Start in this report), 26 Healthy Families America, 22 Nurse-Family Partnership, and 21 Parents as Teachers programs. Because larger programs were more likely to meet the study's sample requirements and rural programs tended to be smaller, over three-quarters of local programs included in MIHOPE operate in metropolitan counties.

- **Women enrolled in MIHOPE programs face many risks.** Because home visiting focuses on women with risk factors such as poverty or an environment conducive to child maltreatment, women in the MIHOPE sample are at risk of adverse outcomes. They are generally quite young

and poor, with limited education or work experience. They also face high levels of depression and high rates of intimate partner violence.

- **National home visiting models and local programs implementing those models vary in the outcomes they are trying to influence and in how they intend to provide services.** Although all national models studied in MIHOPE make a high priority of improving parenting, child health and development, and economic self-sufficiency, some place less emphasis on improving maternal health and health behaviors. Perhaps because MIECHV has asked states and local programs to improve these outcomes as well, when they entered the study most local home visiting programs said they emphasized the full range of outcomes, even outcomes that were not emphasized by their national models. In addition, most home visitors perceived that they were expected to help mothers across a wide range of outcomes and believed they were trained to do so.

MIECHV and MIHOPE

According to the authorizing legislation, MIECHV is intended to improve outcomes for families in at-risk communities, which includes those with concentrations of the following: poverty, crime, domestic violence, adverse birth outcomes such as premature birth and infant mortality, high school dropouts, substance abuse, unemployment, and child maltreatment. States are to give priority to individuals who are in the Armed Forces or who previously served, and to specific high-risk subgroups including low-income, pregnant women under age 21; families with a history of child abuse or substance abuse; tobacco users; families with children who have low academic achievement; and children with developmental delays.

The legislation that created MIECHV requires each state to use a majority of funds to support home visiting models with "evidence of effectiveness." To determine which national models fit into this category, HHS commissioned the Home Visiting Evidence of Effectiveness (HomVEE) review, which is being conducted by Mathematica Policy Research.[8] As of May 2014, HomVEE had found 14 models that met HHS's criteria for evidence of effectiveness, which means at least one study of at least moderate quality found

[8]For more information on HomVEE, visit http://homvee.acf.hhs.gov.

statistically significant impacts in two or more of eight outcome domains, or at least two such studies found statistically significant impacts in the same domain.[9]

The legislation required the evaluation to include four components:

- **Analysis of needs assessments.** An analysis, on a state-by-state basis, of the results of the needs assessments, including indicators of maternal and prenatal health and infant health and mortality, and state actions in response to the assessments.
- **Effectiveness study.** An assessment of the effect of early childhood home visiting programs on child and parent outcomes.
- **Subgroup analysis.** An assessment of the effectiveness of the programs on different populations, including the extent to which the ability of the programs to improve participant outcomes varies across programs and populations.
- **Analysis of effects on the health care system.** An assessment of whether the activities conducted by such programs, if expanded to a broad scale, have the potential to improve health care practices, eliminate health disparities, improve health care quality and efficiency, and reduce costs.

MIHOPE is also collecting extensive information on how local programs are implemented, which will allow the evaluation to describe the home visiting services that are delivered under MIECHV, how those vary from place to place, and how variation in program implementation is linked to variation in program effects.

Research on Home Visiting Programs

Although there have been a number of previous studies of home visiting, syntheses of those studies have generally found modest benefits for families on average. But they have also

[9]The 14 programs were Child FIRST, Early Head Start - Home Based Program Option, Early Intervention Program for Adolescent Mothers, Early Start (New Zealand), Family Check-Up, Healthy Families America, Healthy Steps, Home Instruction for Parents of Preschool Youngsters, Maternal Early Childhood Sustained Home Visiting Program, Nurse-Family Partnership, Oklahoma's Community-Based Family Resource and Support Program, Parents as Teachers, Play and Learning Strategies Infant, and SafeCare Augmented.

found that effects have varied across studies.[10] This raises several issues that MIHOPE seeks to address.

- **Inconsistent effects.** Across program models and even within a given evidence-based model, effects have often varied for different groups of families. In addition, findings of effects for certain outcomes and subgroups have often not been replicated in later studies. MIHOPE is large enough to detect modest effects so that the field has clear evidence on the effects of evidence-based home visiting programs on the outcomes of interest.

- **Different outcomes tested in different studies.** One difficulty in interpreting home visiting research is that different studies have measured different outcomes. In part, this is because different program models target different domains, and studies of those models may have only focused on the targeted outcomes. In addition, different evaluators have looked at different measures within a given outcome domain. MIHOPE is designed to add to the existing body of knowledge about home visiting programs by collecting consistent information across all relevant outcome domains for all four models being studied.

- **Insufficient evidence of effectiveness in subgroups.** HomVEE found that many studies of home visiting programs did not include enough families to allow a precise analysis of subgroup effects, and those studies that have examined how effects varied by subgroup have often focused on different subgroups. This has led to thin evidence on some subgroups. MIHOPE is filling this gap by including enough families of sufficient diversity to help identify what works for different types of families.

- **Lack of information on program implementation.** Prior studies of human service programs have found that their implementation is associated with a number of factors such as program maturity and the detail and specificity of the intervention.[11] However, evaluations of home visiting programs have rarely collected detailed information on the services delivered. This makes it difficult to know whether weak impacts are due to problems of implementation or problems with the program model itself.

[10]Filene, Kaminkski, Valle, and Cachat (2013).
[11]Carroll et al. (2007); Fixsen, Blase, Naoom, and Wallace (2009).

MIHOPE is filling this gap by systematically examining how program features and implementation systems are associated with service delivery and impacts.

- **Program models that have changed over time.** Some of the evidence reviewed in HomVEE is as much as 40 years old, and most of the evidence-based models have changed over time to reflect growing knowledge about best practices. Thus, results from HomVEE might not reflect the effectiveness of those models as they are currently delivered.

The gap in knowledge on program implementation has recently been filled to some extent by the Administration for Children and Families through the Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment Initiative. That study of 17 agencies implementing home visiting across 15 states found substantial variation in fidelity among programs running the same national model.[12] The study found that among the important factors in delivering high-quality services were the strength of the home visitor-parent relationship, the clarity of a program's goals and measures of success, and the presence of an appropriate infrastructure for achieving desired goals. MIHOPE is designed to go the next step to investigate whether these and other features of home visiting programs lead to larger or broader effects for families and children.

MIHOPE Study Design

To provide reliable estimates of the effects of home visiting programs, families recruited into the study are being randomly assigned either to a MIECHV program or to a control group that will be referred to other appropriate services in the community.[13] In total, MIHOPE expects to include more than 4,000 families spread across 88 local programs that are operating one of four evidence-based models in 12 states. MIHOPE will thus provide precise estimates of the effects of home visiting on families, both for the full sample and for key subgroups of families. The large number of local programs will also provide the study with an opportunity to learn about the relationship between local program features and the impacts of home visiting on family and child outcomes.

Since it can be difficult to compare many outcomes across a broad range of children's ages, and because the majority of MIECHV-funded programs target women during

[12]Boller et al. (2014).

[13]The evaluation design is described in detail in Michalopoulos et al. (2013), and briefly summarized here.

pregnancy or shortly after childbirth, MIHOPE includes only families in which the mother is pregnant or the child is less than 6 months old when the family enrolls in the study.

The National Home Visiting Models Studied in MIHOPE

As will be discussed in Chapter 2, states' initial plans indicated they would use MIECHV primarily to support four national evidence-based models: Early Head Start, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. Because they were the only four national models chosen by 10 or more states in their initial plans, MIHOPE is studying only those four models. This section provides an overview of the four models.

In general, home visiting consists of three types of activities: assessment of family needs, parent education and support, and referral to and coordination with needed services. Home visitors use a variety of strategies to provide education and support to families, including setting goals with caregivers and creating plans for meeting those goals, helping caregivers resolve problems, helping parents and children build better relationships, intervening during crises, providing information on children's developmental stages and feedback on parenting, working to strengthen families' support networks, and providing emotional support, pamphlets, or other materials. Home visitors also use methods such as positive reinforcement, direct feedback, and motivational interviewing and reflection to encourage parents to change particular attitudes and behaviors. Finally, home visitors provide referrals to community health and human service resources based on each family's identified needs.

Although the four national models share these major components as well as the overall goal of improving outcomes for at-risk families and their young children, they differ in a number of important ways. Table 1.1 summarizes some important features of the four national models.

- **Program goals.** While all of the models try to improve child health and development in the broad sense, their specific goals differ. For example, Early Head Start provides comprehensive services that focus on the development of infants and toddlers, supporting parents in their roles as caregivers and teachers of their children and promoting school readiness. In addition to the goals of strengthening nurturing parent-child relationships, promoting healthy childhood growth and development, and enhancing family functioning, Healthy Families America has a particular emphasis on preventing child maltreatment. Nurse-Family Partner-

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Table 1.1

Key Components of the Planned Services of the Evidence-Based Home Visiting Programs in the Evaluation

Home Visiting Model	Program Goals	Target Population/ Age at Enrollment	Program Intensity/Duration	Home Visitor Qualifications
Early Head Start - Home Based Program Option	Enhance the development of very young children Promote healthy family functioning	The program targets low-income pregnant women and families with children birth to age 3, families at or below the federal poverty level, and children with disabilities who are eligible for Part C services under the Individuals with Disabilities Education Act in their state. Services can begin prenatally.	Weekly home visits for a minimum of 90 minutes Minimum of 48 home visits and 22 group socialization activities per year Services offered until the child is 3 years old (and older in some circumstances)	Home visitors must have knowledge and experience in child development and early childhood education; principles of child health, safety, and nutrition; adult learning principles; and family dynamics. Home visitors must effectively communicate with children and families with no or limited English proficiency directly or through an interpreter, and be familiar with the ethnic backgrounds of these families.

(continued)

Table 1.1 (continued)

Home Visiting Model	Program Goals	Target Population/ Age at Enrollment	Program Intensity/Duration	Home Visitor Qualifications
Healthy Families America	Systematically reach out to parents to offer resources and support Cultivate the growth of nurturing, responsive parent-child relationships Promote healthy childhood growth and development Build the foundations for strong family functioning	The program targets parents facing challenges such as single parenthood, low income, childhood history of abuse or adverse experiences, current or prior behavioral health issues, or domestic violence. Individual programs select the specific characteristics of the target populations they plan to serve. Families are enrolled prenatally or within the first 3 months after a child's birth.	Home visits typically a minimum of 60 minutes Minimum of weekly home visits for the first 6 months after a child's birth; frequency of the visits after 6 months determined by local programs based on family risk factors Services beginning prenatally or at birth and continuing through the first 3 to 5 years of life	There are no specific educational requirements for home visitors. Home visitors should be selected based on personal characteristics and experience in working with families with multiple needs, experience working with or providing services to children and families, ability to establish trusting relationships, acceptance of individual differences, experience in working with culturally diverse communities, knowledge of infant and child development, and ability to maintain boundaries between personal and professional lives.

(continued)

Table 1.1 (continued)

Home Visiting Model	Program Goals	Target Population/ Age at Enrollment	Program Intensity/Duration	Home Visitor Qualifications
Nurse-Family Partnership	Improve prenatal health and outcomes Improve child health and development Improve families' economic self-sufficiency and maternal life-course development	The program targets first-time, low-income mothers and their children. The first home visit must occur no later than the end of week 28 of pregnancy. Programs are recommended to begin conducting visits in the 2nd trimester (14 to 16 weeks of gestation).	Home visits typically 60 to 75 minutes Weekly home visits for the 1st month after enrollment, then every other week until baby is born Weekly home visits for the first 6 weeks after the baby is born and then every other week until the baby is 20 months; last 4 visits monthly until the child is 2 years old Visit schedule potentially adjusted to meet client needs	Home visitors must be registered professional nurses with a minimum of a bachelor's degree in nursing.

(continued)

Table 1.1 (continued)

Home Visiting Model	Program Goals	Target Population/ Age at Enrollment	Program Intensity/Duration	Home Visitor Qualifications
Parents as Teachers	Provide parents with child development knowledge and parenting support Provide early detection of developmental delays and health issues Prevent child abuse and neglect Increase school readiness	The program has no eligibility requirements for participants. Local programs select the specific characteristics of their target populations, such as children with special needs, families at risk for child abuse, families with low incomes, teen parents, first-time parents, immigrant families, families with little literacy, or parents with mental health or substance abuse issues. Programs target enrollment prenatally or soon after birth.	Home visits recommended to last between 50 and 60 minutes Minimum of 10-12 annual visits and 20-24 annual visits for higher-need families on a monthly, biweekly, or weekly basis Monthly group connections (meetings) offered Length and intensity of services determined by local programs, potentially lasting from pregnancy through kindergarten entry	Parent educators must have high school diplomas or General Educational Development (GED) certificates and a minimum of 2 years' previous supervised work experience with young children or parents. It is preferable for parent educators to have at least a 4-year degree in early childhood education or a related field or at least a 2-year degree or 60 college hours in early childhood education or a related field. Parent educators should have experience working with young children or parents.

SOURCES: Program model websites and the U.S. Department of Health and Human Services HomVEE website: http://homvee.acf.hhs.gov/programs.aspx.

ship has a strong emphasis on prevention and on the social determinants of health, particularly on improving birth outcomes through preventive health practices and improving child health and development. It also aims to improve mothers' economic self-sufficiency and development. Parents as Teachers' focus is on supporting families to enhance parents' knowledge of early childhood development, improve parenting practices, help detect early signs of developmental delays and health issues, and promote children's school readiness and success.

- **Target population and age at enrollment.** Most of these models serve families they identify as being at risk of poor child outcomes, based on one or more family characteristics. Although the indicators used to identify families at risk differ among the models, most models target low-income families. Nurse-Family Partnership specifically targets women early in their first pregnancies, while Healthy Families America targets parents during any pregnancy or shortly after birth who face a variety of risk factors for child maltreatment or other negative childhood experiences (risk factors such as histories of trauma or intimate partner violence, behavioral health issues, and single parenthood). Parents as Teachers has historically served a broad array of families with children in its target age range. All of the models can enroll women when they are pregnant or when they have newborns, although Early Head Start and Parents as Teachers accept families whose youngest child is up to 3 years old and through kindergarten entry, respectively. This means that Early Head Start and Parents as Teachers enroll a much broader range of families than are being studied in MIHOPE, which includes only families with children under 6 months old.

- **Program intensity and duration.** The national models also vary somewhat in the frequency of home visits and the age at which they stop. Early Head Start has weekly home visits, while Healthy Families America and Nurse-Family Partnership offer weekly visits during critical periods (for example, shortly after birth) and Parents as Teachers specifies monthly or biweekly visits depending on families' needs. While Nurse-Family Partnership provides services through a child's second year, Early Head Start generally continues home visits through a child's third year, Healthy Families America can continue until a child is 5 years old,

and Parents as Teachers varies by local program but can last until a child enters kindergarten.

- **Home visitor qualifications.** The national models have a wide range of standards for home visitor qualifications. For example, Nurse-Family Partnership requires that home visitors be registered nurses with a minimum of a bachelor's degree in nursing, but Healthy Families America recommends selecting home visitors based on a combination of personal characteristics (such as being nonjudgmental and compassionate), willingness to work in culturally diverse communities, experience working with families with multiple needs, and educational background. Early Head Start requires home visitors to have experience in child development, early childhood education, and other areas,[14] while Parents as Teachers requires home visitors to have at least a high school credential (with a bachelor's degree recommended), plus two years of experience working with young children or parents.

- **Local variation.** Although not noted in the table, the national models vary in how much flexibility they allow local programs. For example, Nurse-Family Partnership has specific requirements regarding whom its programs can serve, the curricula that can be used, and the qualifications home visitors must have. In contrast, Early Head Start allows local programs flexibility in choosing curricula and setting the educational requirements of home visitors;[15] Healthy Families America allows considerable flexibility for local programs to decide target populations, curricula, and the educational backgrounds of home visitors (as long as they meet the other criteria described above); and Parents as Teachers provides local programs with a specific parenting curriculum but allows them flexibility in selecting target populations and eligibility criteria.

[14]The other areas include principles of child health, safety, and nutrition; adult learning principles; and family dynamics.

[15]U.S. Department of Health and Human Services (2009b).

Questions Addressed by this Report

This report presents early evidence from MIHOPE to address the following questions:

- **Did states target the types of communities specified in the legislation that created MIECHV?** Chapter 2 answers this question, presenting an analysis of the needs assessments that states, territories, and the District of Columbia completed to obtain MIECHV funds and summarizing the types of communities that states identified as in need of home visiting.
- **Will the states and local home visiting programs chosen for MIHOPE provide reliable information on MIECHV nationally?** Chapter 3 explains the process for choosing states and local programs for the study, and describes those that were chosen.
- **Do MIECHV programs target the high-priority and high-needs families mentioned in the legislation?** Chapter 4 addresses this question, describing the families enrolled in MIHOPE through January 15, 2014 using data from surveys completed by study participants and observations of their home environments made by research team field interviewers.
- **Do national models and the local programs that implement those models report goals and infrastructure consistent with the expectations of MIECHV?** Will variation in their approaches allow the study to determine which program features lead to larger benefits for families? Chapter 5 addresses these questions.

The final chapter summarizes the findings and discusses their implications for future MIHOPE reports.

Chapter 2

Analysis of the State Needs Assessments and State Plans

The legislation that created the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) required states and territories (referred to as "states" in the remainder of this chapter) to assess which of their communities might need home visiting services because they had concentrations of premature birth, school dropouts, substance abuse, or other indicators.[1] States were also required to report on the quality and capacity of existing home visiting programs, including home visiting models already in use and the number of families they served, and to discuss any gaps or duplications in the services available in the identified communities. To receive MIECHV funds, states were also required to create plans that indicated in which communities the funds would be used and the home visiting models that would be supported with them.

This chapter summarizes information from the needs assessments and state plans, including (1) the extent to which home visiting services were available prior to MIECHV, (2) the communities identified by states as in need of home visiting, and (3) the evidence-based models and promising approaches states planned to support through MIECHV. The chapter also summarizes information, gathered from interviews with MIECHV administrators in the states participating in the Mother and Infant Home Visiting Program Evaluation (MIHOPE), about how the needs assessments were developed and used in determining where and how to spend MIECHV funds.

Main Findings

- **All states had home visiting services prior to MIECHV.** The typical state identified eight home visiting program models in operation. States reported using many different approaches to home visiting, and nearly half of the local home visiting programs identified by states were not using "evidence-based" models, defined as ones that met criteria for effec-

[1]The legislation also included a 3 percent set-aside for grants to tribal entities (which includes tribes, tribal organizations, and urban Indian organizations). Tribal MIECHV grantees were not included in MIHOPE. For more information on Tribal MIECHV see Early Childhood Development (2014).

tiveness designed by the Department of Health and Human Services (HHS).[2]

- **States also found many areas with unmet needs and focused MIECHV funds on those areas.** Within a state, communities targeted for MIECHV funding generally had higher rates of premature birth, poverty, unemployment, and child maltreatment than the state overall. Home visiting services were already available in the vast majority of these communities, but they were not serving all families in need and were not necessarily operating in the specific neighborhoods where the newly expanded evidence-based services would be provided.

- **MIECHV encouraged states to support evidence-based home visiting.** The legislation required states to spend a majority of MIECHV funds on "evidence-based" models. Although many preexisting home visiting programs implemented models that did not meet those criteria, states planned to use MIECHV funds primarily to support evidence-based models. The most frequently proposed models in the states' initial plans were the four models included in MIHOPE: Nurse-Family Partnership, Healthy Families America, Parents as Teachers, and Early Head Start - Home Based Program Option. Most states used MIECHV funds to expand evidence-based models already in operation in the state rather than to fund new models.

- **MIECHV administrators used a complex process to choose where to spend funds.** Interviews with state MIECHV administrators indicated that the needs assessment process helped them identify high-risk communities, but was not the only source of information used in making decisions. For example, some states balanced need with the ability of local areas to adequately implement home visiting services, based on state assessments of local infrastructure and capabilities.

[2]To determine which home visiting models would be defined as evidence-based, HHS commissioned the Home Visiting Evidence of Effectiveness (HomVEE) review. See http://homvee.acf.hhs.gov.

Home Visiting Services Available Prior to MIECHV

To help states determine which areas were most in need of home visiting services, the legislation required each state to describe the home visiting programs that existed there prior to MIECHV and the numbers and types of individuals and families served by these programs. Each state was also asked to describe the gaps in home visiting services there and the extent to which existing programs were meeting the needs of eligible families. Appendix A provides information about the home visiting services described by states in their needs assessments.

With one month to complete their needs assessments, states varied in how comprehensively they were able to respond to the requests for information. States also varied in the information they provided about existing home visiting services and in what they considered to be home visiting programs. Because the Health Resources and Services Administration (HRSA) and the Administration for Children and Families did not specify what should be considered a "program," some states named home visiting models while others named the organizations implementing the programs. Given the variation in what states identified as "programs," this report refers to "state-identified programs" when discussing the programs that states reported in their needs assessments. The average state reported eight such programs operating prior to MIECHV.

State-identified programs varied widely in their geographic coverage, with some serving large portions of a state and others serving a portion of a county. Many states did not provide the requested information for all their state-identified programs; in particular, only a minority of states provided detailed information on the demographic characteristics of the families served by the programs they identified. One reason for this was that information was often limited to what was shared by the organizations operating these programs. Finally, it is important to remember that because home visiting services can operate across a range of state, county, and private agencies, the administrators charged with gathering information may not have been aware of every home visiting program operating in their states.

Information on home visiting models identified by two or more states is summarized in Table 2.1, while other programs are shown in Appendix B. Table 2.1 also divides home visiting models into those that were found to be evidence-based by the HomVEE review as of 2010 and those that were not. In total, 19 models were reported as being implemented by two or more states, although the use of some models may be underreported to

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Table 2.1

Home Visiting Models Used by State-Identified Programs Operating Prior to MIECHV

Model	Number of States	Number of Counties[a]
Evidence-based as of 2010		
Early Head Start - Home Based Program Option	50	933
Family Check-Up	0	0
Healthy Families America	33	592
Healthy Steps	1	3
Home Instruction for Parents of Preschool Youngsters	17	137
Nurse-Family Partnership	36	367
Parents as Teachers	48	785
Non-evidence-based as of 2010		
Early Steps to School Success	5	85
Even Start: Home Visiting	7	66
Family Connections	2	16
Head Start: Home-Based	22	329
Healthy Start: Home Visiting	17	176
Homebuilders Program	4	11
Maternal Infant Health Outreach Worker	3	13
Nurturing Parenting Programs	7	15
Parent-Child Home Program	11	64
Positive Parenting Program	2	3
Resource Mothers Program	3	72
SafeCare[b]	4	107
Other[c]	50	1,789

SOURCE: 2010 MIECHV state needs assessments. For a few states, information on state-identified programs was supplemented with information from the state plans or first round of competitive grant applications.

NOTES: This table includes all models that had been designated as evidence-based by the HomVEE project as of 2010, in time for states to include them in their FY 2010 and FY 2011 state plans, and models that were reported in use by more than one state.

In this table, "state" is used as shorthand for states, territories, and the District of Columbia.

[a]The number of counties offering each model is an estimate. For models that were reported to be implemented by multiple programs in a state, this table assumes that the number of counties offering the model in a state is equal to the largest number of counties served by the model by one program. This table also assumes that for organizations offering multiple models, every county served by the organization has at least one family receiving each of the models the organization offers.

[b]SafeCare Augmented, an adaptation of SafeCare, has been designated as evidence-based since 2010. It is unclear how many states and counties in this table used this adaptation.

[c]"Other" refers to programs that either used a model reported by only one state or did not specify a model in the needs assessments. A full list of these is in Table B.1.

the extent that states missed some programs in their needs assessments or neglected to specify the model used by some programs.

Table 2.1 shows that the most frequently implemented models prior to MIECHV were Early Head Start, operating in 50 states and 933 counties; Parents as Teachers, in 48 states and 785 counties; Nurse-Family Partnership, in 36 states and 367 counties; and Healthy Families America, in 33 states and 592 counties. Other models reported to be operating in a large number of states and counties included Head Start: Home-Based (in 22 states and 329 counties), Home Instruction for Parents of Preschool Youngsters (in 17 states and 137 counties), and Healthy Start: Home Visiting (in 17 states and 176 counties).

In addition to reporting evidence-based home visiting models, most states reported some home visiting programs that were not implementing these models. In particular, 50 states reported programs that either did not specify a home visiting approach or reported implementing home visiting approaches that were not reported by any other states (see Appendix Table B.1 for a list). Some of these programs appeared to be using homegrown models, although some borrowed practices and curricula from nationally recognized home visiting models. Such programs were common; they were reported as operating in nearly 1,800 counties.

Identifying At-Risk Communities

Although home visiting services already existed in all states, MIECHV was created to fill a perceived gap in those services. In their needs assessments, states were asked to identify and provide data for at-risk communities, defined in the authorizing legislation as communities with concentrations of the following: premature birth, low birth weight, infant mortality, poverty, crime, domestic violence, high school dropouts, substance abuse, unemployment, or child maltreatment. In practice, most states identified counties or groups of counties as their at-risk communities and provided information at the county level.

The full set of indicators states reported for each of these communities is presented in Appendix C. It should be noted that most states provided information on most indicators, but states often could not provide all of the indicators exactly as they were requested. When states were unable to provide data on the requested indicator, they sometimes included information on a close substitute. For example, many states reported the nonmedical use of pain relievers in the past year rather than the nonmedical use of prescription drugs in the past month. In addition, while HRSA requested that states report the rate of "substantiated" child maltreatment, states responded using metrics such as the rate of "child abuse and ne-

glect confirmations" and the "child victim rate." For this reason, rates for child maltreatment should not be compared across states. Appendix C contains the language of HRSA's request and the metric each state used in its assessment.

Table 2.2 summarizes information on four indicators — rates of premature birth, poverty, unemployment, and child maltreatment — that were selected to represent different categories of risk. For each indicator, the table compares the state average with the average for the communities chosen to receive MIECHV funds. In examining these indicators, it is important to remember that many states intended to support MIECHV-funded programs in the highest-need areas *within* the target communities. Thus, community averages may understate the level of risk in targeted areas.

Indicator values varied regionally.[3] A comparison of the indicators in Table 2.2 shows that states in the South (HRSA Regions 4 and 6) tended to have higher average indicator values than states in other parts of the country, and states in the Northeast (HRSA Regions 1-3) tended to have lower levels of poverty and unemployment.[4] Target community average values also tended to be higher in the South, indicating that states in the South identified target communities that were more disadvantaged than target communities in the rest of the country, which is not surprising given the higher values for these indicators in the southern states overall. While target communities in the Northeast were less disadvantaged than target communities in the South, states in the Northeast tended to have larger disparities between their target community averages and their state averages.

Table 2.3 summarizes the information presented in Table 2.2 by showing how many states had target communities with greater levels of disadvantage than their overall averages, and how much difference there was between the average target community and the state averages overall. As shown in Table 2.3, states generally selected communities that had relatively high rates of poverty: In 50 of the 53 states that provided this information, the average target community had a poverty rate that was higher than the state average. Often, the gap was considerable: In 34 states, the poverty rate in the average target community was greater than the state average rate by 25 percent or more.

[3]The analysis that follows includes only states, not territories. Because states used different metrics to measure child maltreatment, child maltreatment indicators are excluded from this cross-state comparison.

[4]HRSA Region 1 includes the six New England states. HRSA Region 2 includes New Jersey and New York. HRSA Region 3 includes Delaware, the District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia. HRSA Region 4 includes Alabama, Georgia, Florida, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. HRSA Region 6 includes Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.

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Table 2.2

Selected Community Risk Indicators in Communities Chosen for MIECHV Funding, by State

Area	Premature Births[a] (%)		Residents Living in Poverty (%)		Residents Unemployed (%)		Child Maltreatment[b]	
	Target Community Average[c]	State Average	Target Community Average[c]	State Average	Target Community Average[c]	State Average	Target Community Average[c]	State Average
HRSA Region 1								
Connecticut[d]	11	11	24	12	8	6	28	1
Maine	9	9	14	13	10	9	13	13
Massachusetts	9	9	18	9	8	9	39	20
New Hampshire	10	10	11	8	6	6	545	315
Rhode Island	12	12	20	12	13	11	19	12
Vermont	11	9	11	9	8	7	6	5
HRSA Region 2								
New Jersey	11	10	17	6	7	4	-	-
New York	12	12	14	15	5	5	156	169
Puerto Rico	15	20	62	45	26	19	30	41
U.S. Virgin Islands	-	1	-	29	-	8	-	14
HRSA Region 3								
Delaware[d]	15	14	12	10	4	8	1	1
Maryland[d]	17	11	42	10	10	7	7	2
Pennsylvania	11	10	14	12	11	9	2	1
Virginia	12	11	19	10	6	4	5	3
West Virginia	15	12	22	17	9	10	-	14
District of Columbia	15	12	27	13	19	10	410	-
HRSA Region 4								
Alabama	-	17	27	16	16	10	8	9
Florida[d]	14	14	25	22	6	7	51	40
Georgia	14	13	19	14	9	10	8	13
Kentucky	19	14	31	20	14	13	32	17
Mississippi	22	18	31	21	10	7	-	-
North Carolina	14	13	18	15	12	11	38	30
South Carolina	12	12	22	16	14	13	7	6
Tennessee	13	12	15	14	11	11	8	8

(continued)

Table 2.2 (continued)

Area	Premature Births[a] (%)		Residents Living in Poverty (%)		Residents Unemployed (%)		Child Maltreatment[b]	
	Target Community Average[c]	State Average	Target Community Average[c]	State Average	Target Community Average[c]	State Average	Target Community Average[c]	State Average
HRSA Region 5								
Illinois[e]	-	-	-	-	-	-	-	-
Indiana	12	11	24	17	22	19	-	11
Michigan	11	11	18	14	13	14	16	12
Minnesota	10	10	13	10	6	5	6	4
Ohio	14	13	17	13	11	10	11	9
Wisconsin	12	11	12	11	10	9	4	4
HRSA Region 6								
Arkansas	18	14	27	17	8	8	8	9
Louisiana[f]	15	14	23	18	10	7	-	-
New Mexico	12	11	25	17	11	8	27	16
Oklahoma	11	11	17	16	7	7	16	15
Texas	15	14	21	16	8	8	14	11
HRSA Region 7								
Iowa	10	9	16	11	8	7	33	18
Kansas	10	9	16	11	11	7	6	3
Missouri	17	13	24	14	7	6	6	5
Nebraska	8	10	14	10	4	3	10	7
HRSA Region 8								
Colorado	11	10	22	11	10	8	11	9
Montana[d]	8	8	22	19	7	7	51	38
North Dakota	-	10	-	14	-	4	-	1
South Dakota	16	12	40	13	8	5	-	1
Utah	12	10	10	10	-	7	31	15
Wyoming	11	11	11	10	6	6	5	4
HRSA Region 9								
Arizona	10	10	19	15	10	10	32	10
California	11	11	15	13	13	12	11	9
Hawaii	11	11	33	11	6	6	7	1
Nevada	11	11	12	11	14	14	13	10
American Samoa	-	-	61	61	30	30	-	-
Guam	3	5	60	20	25	-	-	2
Northern Mariana Islands	7	8	56	40	-	8	72	223

(continued)

Table 2.2 (continued)

Area	Premature Births[a] (%)		Residents Living in Poverty (%)		Residents Unemployed (%)		Child Maltreatment[b]	
	Target Community Average[c]	State Average	Target Community Average[c]	State Average	Target Community Average[c]	State Average	Target Community Average[c]	State Average
HRSA Region 10								
Alaska	11	11	7	9	7	8	67	61
Idaho	11	10	14	13	9	9	7	4
Oregon	11	10	17	14	11	11	18	13
Washington	12	11	15	11	12	9	73	44

SOURCE: 2010 MIECHV state needs assessments.

NOTES: In this table, "state" is used as shorthand for states, territories, and the District of Columbia.

HRSA = Health Resources and Services Administration.

Most states identified target communities as counties or groups of counties, so target community average data typically reflect county data; however, some states identified and reported data for smaller regions. Some states reported indicator data of a larger region to which a target community belonged when information was not available at the community level.

Unless otherwise noted, hyphens indicate instances when the state did not provide target community or state average data for the indicator.

[a]Defined as number of live births before 37 weeks of gestation/total number of live births.

[b]In their needs assessments, states reported indicators for child maltreatment that varied widely in both what they measured and how they were measured. Examples of child maltreatment indicators reported by states include substantiated child abuse cases, confirmed victims of child abuse and neglect, and overall child maltreatment. While most states reported the indicator by rates per 1,000, others reported percentages, total numbers, or other rates. Because states reported this indicator so differently, values should not be compared between states. For more information on what HRSA requested and what states reported, see Appendix C.

[c]Some states did not report data on the indicators for all of their target communities. In those cases, the target community average only reflects the average of the target communities for which information was provided.

[d]This state reported a slight variation on the indicator for residents living in poverty. See the state's table in Appendix C for more information.

[e]Illinois reported data for its target communities as ranges of values and did not report data for the state, so averages were unavailable.

[f]For its child maltreatment indicator, Louisiana reported the percentage of child maltreatment cases that were substantiated. Since this measure was very different from the other measures states used for this indicator, it has been excluded from this table. See Appendix Table C.19 for more information.

Table 2.3

Number of States for Which Target Community Averages Are Less Than, Greater Than, or Much Greater Than State Averages, for Selected Community Risk Indicators

Target Community Average Is…	Premature Births[a]	Residents Living in Poverty	Residents Unemployed	Child Maltreatment[b]
Less than or equal to state average	10	3	13	7
Greater than state average	41	50	37	37
Greater by 0% - 25%	36	16	24	10
Greater by 25% or more	5	34	13	27
Total states with available information[c]	51	53	50	44

SOURCE: 2010 MIECHV state needs assessments.

NOTES: In this table, "state" is used as shorthand for states, territories, and the District of Columbia.

[a]Defined as number of live births before 37 weeks of gestation/total number of live births.

[b]In their needs assessments, states reported indicators for child maltreatment that varied widely in both what they measured and how they were measured. However, they typically did measure consistently for both their target communities and the state as a whole, allowing comparisons between the state and target community averages. For more information on what HRSA requested and what states reported, see Appendix C.

[c]Some states did not report data on these indicators for their target communities or did not include overall state averages. Some states also reported data in such a way that those data could not be included in this table. For example, the Illinois needs assessment reported ranges of values for its indicators in each of its target communities, so it was not possible to calculate an average.

States also tended to select target communities with higher rates of premature birth, unemployment, and child maltreatment than their overall averages. In 27 of 44 states, the target community average rate of child maltreatment was higher than that of the state overall by 25 percent or more; conversely, however, in seven states these average rates in target communities were actually lower than the state averages.

States' Proposed Plans for MIECHV Funding

Two types of MIECHV funding were made available from fiscal year (FY) 2010 through FY 2015: formula funding, which all states were eligible to receive, and competitive funding, which a limited number of states received following a competitive application process.

For each fiscal year, states developed and submitted plans for how they intended to use the funds, and these plans were expected to draw upon information from their needs assessments. This report summarizes the earliest plans that were submitted, which are the FY 2010 and 2011 formula funding applications and FY 2011 competitive grant applications for states that received competitive grants. Although states continued to have opportunities to revise their plans for MIECHV funds with each round of funding, these earliest versions provide valuable insight into how state plans were related to their needs assessments, which had been completed shortly before. They are summarized in Table 2.4. More detailed information on states' plans is presented in Appendix D. It should be noted that neither Table 2.4 nor Appendix D reflects any changes in plans states have made in more recent years.

Table 2.4 shows that the average state proposed using MIECHV funds in eight communities, although some states proposed funds for only one community while one state proposed funding for 42. Communities often included more than one local program, and the average state proposed using MIECHV funds to support 10 local programs. In the average state, about 56 percent of the local programs for which states proposed to use MIECHV funding were metropolitan.[5]

The average state proposed to use MIECHV funds in 30 percent of its counties. Although the target communities were the ones states had previously identified as being most in need of home visiting, states also reported that 96 percent of the counties corresponding to these target communities did have home visiting services prior to MIECHV. This suggests that existing programs in the neediest communities were not meeting all of those areas' needs.

As noted earlier, the legislation that created MIECHV required states to spend a majority of those funds on evidence-based home visiting models. Table 2.5, which summarizes the models identified by states for MIECHV support, confirms that most states planned to use all of their MIECHV funds to support evidence-based models. In their early plans only eight states reported that they planned to use MIECHV funds for promising, non-evidence-based approaches. Most states (33) planned to expand the use of evidence-based home visiting models that were already in operation, but eight states proposed supporting evidence-based models that were not already operating within their borders, and 14 states proposed to do both.

[5]To designate counties as metropolitan or nonmetropolitan, this report follows the Department of Agriculture Economic Research Service's Rural-Urban Continuum Codes classification scheme. See Economic Research Service (2013a).

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Table 2.4

Summary of Communities, Local Programs, Counties, and Models Proposed for FY 2010 and FY 2011 MIECHV Funding, Across States

	Average Value for States	Minimum Value for States	Maximum Value for States
Target communities proposed for funding	8	1	42
Local programs proposed for funding[a]			
Number	10	1	56
Percentage in metropolitan communities[b]	56	0	100
Percentage in nonmetropolitan communities[b]	43	0	100
Target counties proposed for funding			
Percentage of total counties targeted	30	2	100
Percentage with home visiting services reported prior to MIECHV[c]	96	50	100
Evidence-based models proposed for funding	2	1	4

SOURCES: FY 2010 and FY 2011 state plans, the first round of competitive grant applications, and 2010 MIEHCV state needs assessments.

NOTES: In this table, "state" is used as shorthand for states, territories, and the District of Columbia. North Dakota is excluded from this table because it did not submit state plans for MIECHV funding. The information in this table is limited to what was proposed in the FY 2010 and FY 2011 state plans and the first round of competitive grant applications. State plans for MIECHV funding continued to evolve after these documents were submitted. Target communities are the communities that states selected to receive MIECHV funding. They can cover areas in one or more target counties. Proposed local programs are the programs that have been selected to implement evidence-based home visiting programs with MIECHV funding. In some cases, a target community will have more than one local program.

[a]Local organizations are counted once for each model they are funded to operate; for example, if a local organization is funded to operate two models, it is counted as two local programs.

[b]To designate counties as metropolitan or nonmetropolitan, this report follows the Department of Agriculture Economic Research Service's Rural-Urban Continuum Codes classification scheme. See Economic Research Service (2013a). American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands were not designated under this scheme. The local programs in those territories were assumed to be nonmetropolitan, based on definitions from the Office of Management and Budget. See Economic Research Service (2013b).

[c]Montana did not provide information on which counties were served by pre-MIECHV home visiting programs. Therefore Montana was excluded from this row.

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Table 2.5

Summary of FY 2010 and FY 2011 State Plans for MIECHV Funding

	States	Counties[a]
Proposed use of funds		
Expand existing evidence-based models only	33	158
Fund new evidence-based models only	8	176
Expand existing evidence-based models and fund new evidence-based models	14	53
Fund promising approaches[b]	8	-
Evidence-based model use[c]		
Early Head Start - Home Based Program Option	17	49
Family Check-Up	0	0
Healthy Families America	39	177
Healthy Steps	2	6
Home Instruction for Parents of Preschool Youngsters	7	30
Nurse-Family Partnership	40	169
Parents as Teachers	29	123

SOURCES: FY 2010 and FY 2011 state plans, the first round of competitive grant applications, and 2010 MIECHV state needs assessments.

NOTES: In this table, "state" is used as shorthand for states, territories, and the District of Columbia. North Dakota is excluded from this table because the state did not submit plans for MIECHV funding.

The information in this table is limited to what was proposed in the FY 2010 and FY 2011 state plans and the first round of competitive grant applications. State plans for MIECHV funding continued to evolve after these documents were submitted.

[a]While some states identified target communities that were not counties, this table summarizes information at the county level to be consistent across states. One state and some additional target communities in other states were not included in the county-level analyses in this table because information was not provided on either which models were operating before MIECHV or which models were proposed to be implemented for all of the target communities.

[b]States were allowed to commit up to 25 percent of their funding to support promising approaches that did not qualify as evidence-based models at the time they were creating their state plans. In this table, a state was counted as planning to use a promising approach if it mentioned an intention to use a promising approach in its FY 2011 state plan or first-round competitive grant application, even if it had not yet decided on a particular model to use. Information on the number of counties in which states proposed to operate promising approaches is unavailable because many states had not yet reached that stage of planning.

[c]This table only includes information for the first seven models that were designated as evidence-based. Additional models have since been designated as evidence-based, but they were not able to be included in the FY 2010 and FY 2011 state plans.

Although the HomVEE review had found seven evidence-based home visiting models by the time the first state plans were developed, Table 2.5 indicates that states planned to use MIECHV primarily for only four of them: Nurse-Family Partnership (40 states), Healthy Families America (39 states), Parents as Teachers (29 states), and Early Head Start (17 states). On average, states proposed funding two evidence-based models, and 10 states planned to fund four evidence-based models (not shown in Table 2.5). Among the three other evidence-based models from which states were able to select, seven states proposed to fund Home Instruction for Parents of Preschool Youngsters, two states proposed to fund Healthy Steps, and no states proposed to fund Family Check-Up.

Findings from Interviews with 12 MIECHV State Administrators

To provide context for the states' needs assessments and planning processes, this section summarizes interviews with MIECHV state administrators from the 12 states that are participating in MIHOPE (see Chapter 3 for a description of how those 12 states were selected). These interviews provide insights into how state-level agencies and leaders responded to MIECHV and planned for its implementation, including the types of factors that were considered outside the documents that states submitted. The information summarized below centers on the following questions:

- How did states compile and use the needs assessments to make decisions about allocating funds and expanding home visiting services in local communities?
- What factors did the 12 states consider when using the needs assessments to select communities for MIECHV funding?
- What factors did they consider in identifying and selecting evidence-based models?
- How did states use the needs assessments to target priority populations?

Developing the State Needs Assessments

Several state administrators noted that it was difficult to complete needs assessments in the time allowed by HRSA. Nonetheless, all 12 states were able to form cross-agency collaborations, as encouraged by HRSA, to support the development and integration of a broad network of early childhood systems and programs. These collaborations were formed most often among departments of public health, human services, and education.

Many states also included nonprofit and educational organizations with investments in early child development or maternal and child health in these collaborative groups, and some included representatives from national evidence-based models that were already operating in the state. A few states noted particular underserved or vulnerable communities that were of concern to the leaders of their collaborative groups, including Native American or refugee populations. In those few states, the agency that had been designated to receive the state's MIECHV funds added representatives from tribal affairs offices or migrant and refugee services to the group completing the needs assessment.

These collaborations were formed largely to discuss how to gather, pool, and analyze data for the states' needs assessments. States had slightly different processes for selecting and deciding on the data and constructs to use to measure risk indicators for their needs assessments. Two state administrators noted that they considered whether recent data were available, underscoring their concern that numbers from five years earlier, for example, might be misleading given recent demographic shifts in some areas (caused by, for example, new immigrant populations) and the effects of the recession that began in 2007. One of these administrators further recounted that for metropolitan areas the data were recent and relatively easy to assemble but that for other areas the data were older.

After collecting information on the indicators required by HRSA, one state identified where counties ranked across indicators. That state also developed a survey of county-level health directors to inquire about other possible factors or measures. The results of this first round of data were used to develop the initial needs assessment. A request for information put out by HRSA following states' initial needs assessments provided an opportunity for this state to gather information below the county level.[6]

Another state administrator noted that some of the information requested as part of the needs assessments (in particular, information related to the prevalence of substance abuse) was not available at the local level. In this case, the state did not include any information at the local or state level for this indicator.

Making Decisions About Targeting Communities

All state administrators said they could not fund services in all of their high-risk communities. They therefore had to be thoughtful about how they could allocate funds. Most states used the indicators summarized earlier in this chapter to identify the counties or

[6]Health Resources and Services Administration (2011).

groups of counties that had the greatest needs. The state plans and needs assessments were always used in identifying these communities, as most of the administrators conveyed a desire to make transparent decisions based on evidence. The majority of states used the needs assessments to create overall risk scores, typically cumulative summaries of all the indicators that were considered, and targeted those communities that scored the worst.

In determining risk scores, several states used both quantitative indicators and qualitative information. At least two of the 12 states, for example, interviewed local stakeholders to learn about nuances not captured by the needs-assessment indicators. One state conducted focus groups with community residents to understand their concerns about maternal, infant, and child health and well-being. The state used this information to understand the different types of need present in the community, although this information was essentially supplemental to the quantitative risk-scoring process.

Although all states used an evidence-driven process, several administrators from states with very large metropolitan areas noted that discussions about how to identify and define geographic areas of risk were at times contentious. One state administrator noted, "There is a lot of political strain going on based on [geographic] areas of focus." That debate, however, was not about differing poverty levels per se, but rather was driven by variations in density: The poor are more sparsely distributed in the state's less urban areas than in its major city and the adjacent communities. Indeed, a few states strove to direct MIECHV funding to both urban and rural areas. In other states, however, other considerations made it difficult to achieve such even representation. As one state administrator revealed, "Some counties are fairly high-risk but they have no infrastructure or individuals in some areas to run a program." Another similarly noted that some counties whose indicators showed that they had high levels of risk were not chosen for funding because they did not appear to have strong infrastructure. Thus, states had to balance two goals — reaching the highest-risk communities and ensuring that home visiting programs could be adequately implemented — and varied in how they did so.

For states that received both formula and competitive funding, the competitive funds allowed them to serve additional high-risk communities. As one administrator noted, "When the competitive funds came, we just continued down the list." A few states also chose to further expand programs in areas that had received formula funding. One state used MIECHV competitive funds to focus more acutely on a particular health concern (infant mortality) and to target communities that had the highest racial disparities in that area.

Selecting Evidence-Based Models

As recounted by many of the 12 state administrators, using the HomVEE review as an aid to model selection illustrated a shift toward "evidence-based" decisions in the field of home visiting. Several administrators noted that MIECHV did not lead their states to expand local, "homegrown" home visiting programs, but moved them toward the broader use of models that had demonstrated rigorous evidence of affecting specific domains.

All states looked for evidence-based models that matched the needs of their populations. States weighed several considerations in choosing which models to implement. Many state administrators used the HomVEE findings to determine which models were likely to meet the needs of targeted communities. One state, in fact, brought in Nurse-Family Partnership, which previously did not have a presence there, based on evidence that the model improved maternal and infant health (including birth outcomes), areas of particular concern for that state. Two states noted they emphasized serving teenage and young mothers, which supported their decisions to fund Nurse-Family Partnership programs in addition to other evidence-based programs. The timing of client enrollment proved important as well because several states were particularly focused on improving prenatal maternal health and infant health at birth. This focus led them to make a higher priority of Nurse-Family Partnership or Healthy Families America programs, which have both shown positive effects on birth outcomes. Conversely, another state noted that Nurse-Family Partnership could be "limiting" because it only enrolls first-time mothers. This state allocated MIECHV funding to Nurse-Family Partnership programs, but also chose to fund other programs that enroll women who are not first-time mothers.

As discussed in Chapter 3, all of the states participating in MIHOPE implemented two or more of the evidence-based models. According to the MIECHV administrator interviews with the 12 MIHOPE states, as of 2013 only one state had made any change to the original models selected in its FY 2011 plan, adding a model to its original list. As described earlier, FY 2010 and 2011 data show that as of then only eight states had funded more than three models. One state administrator explained that because of concerns regarding gathering comparable data across the different models (which use different data-collection and monitoring systems), working with more than two or three models seemed like it would make timely data collection and reporting too burdensome.

States usually funded national models that were operating within their borders prior to MIECHV. In order to "hit the ground running," state administrators often thought it was best to either fund agencies that were already functioning or expand existing models to new

communities or agencies. A few states allowed local communities or programs to decide which evidence-based models to implement based on the populations they were serving.

Identifying Target Populations

State administrators reported that MIECHV funds would target populations with at least one risk-related characteristic of compromised health and well-being, including populations explicitly identified in the authorizing legislation such as low-income families, teenage mothers, and families with mental health and substance-use concerns. A few state administrators also mentioned their attempts to target areas with military families, which are also a priority population. However, one administrator noted that this proved challenging because military families in the state tended to be located in training bases and to be transient, residing in one location for only a few months at a time. This made it difficult to provide services designed to last months or years in a stable manner.

Perhaps because the populations and communities highlighted by the authorizing legislation are broad and at times overlapping, a few states identified their own concerns and priorities as they interpreted the definition of high-risk populations. One state administrator, for example, noted that concerns about racial and ethnic disparities prompted the state to collect information during the needs assessment process on the racial and ethnic composition of communities. Another state wanted local programs to focus on transient and homeless populations, in addition to populations with other risk factors. A different state was particularly concerned about children born with inheritable diseases and conditions. This was admittedly a very small number of families, but those families were to be approached by local programs and given a high priority for services if they desired them.

For the most part, however, state administrators typically conveyed that choosing high-risk communities and working with evidence-based models that target disadvantaged families would result in outreach to and enrollment of high-risk families. As one state administrator recounted, "Model selection was based on the risk factors present in that community and the model's ability to or what research said they could best handle as risk factors. And then we let the models say what they target. We didn't say to them, 'Go beyond this.'" States appeared to be cautious about not appearing overly officious in managing local programs' enrollment processes, and to recognize that community-based agencies understood the needs of the families in their areas the best.

Nevertheless, a few states asked local programs (including those implementing Early Head Start, Healthy Families America, and Parents as Teachers) to focus more heavily

on enrolling women during pregnancy than they had in the past. Conversely, at least one state told local programs that they should not enroll pregnant women because their national model had not exhibited evidence of improving pregnancy-related outcomes, according to the HomVEE review.

Conclusion

States were able to identify at-risk communities in need of home visiting services, and MIECHV encouraged states to spend resources developing and newly implementing evidence-based home visiting models, especially the four models being studied in MIHOPE. The next chapter describes how the MIHOPE team used state plans to decide which states might be the most appropriate for the study, and how that led to a process that resulted in 12 states being asked to participate.

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Chapter 3

Selection of MIHOPE States and Local Programs

As reported in Chapter 2, funds for the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) were used throughout the country primarily to support local home visiting programs running one of four national evidence-based models. Because those models were chosen by at least 10 states, they are being studied in the Mother, Infant, and Home Visiting Program Evaluation (MIHOPE). Although states and local programs were required to participate in MIHOPE if asked, the study did not have enough resources to include a nationally representative set of local home visiting programs, but planned to choose a set of local programs that were representative of the diversity of MIECHV sites. It therefore sought to include a total of about 85 local programs from 12 states, which would provide enough local programs to allow the study to explore variation in services and impacts across different locations but few enough states to make the costs of enrolling families and collecting data manageable. This chapter describes the process of selecting states and local programs for the study and summarizes selected characteristics of the local programs and their staff.

Main Findings

- **As of May 2014, 12 states and 88 local home visiting programs were participating in MIHOPE.** States were chosen to represent all regions of the country. Local programs were chosen to provide a roughly equal number of programs operating each national evidence-based home visiting model, to provide as many programs operating in nonmetropolitan areas as feasible, and to provide enough families overall to provide reliable estimates of the effects of home visiting on outcomes for families and children.

- **Most local programs operate in large urban areas.** Over three-quarters of local programs included in MIHOPE operate in metropolitan counties. This is greater than the percentage of MIECHV-funded programs in metropolitan counties nationally as reported in the state plans (56 percent, as discussed in Chapter 2). This is because many rural programs considered for MIHOPE were not large enough to contribute at least 40 families to the study while still allowing for the ethical creation of a control group.

- **The study includes fewer local programs operating Early Head Start - Home Based Program Option than the other evidence-based models.** As noted in Chapter 2, of the four evidence-based models being studied in MIHOPE, initial MIECHV funds were used least frequently to support the expansion of Early Head Start programs. As a result, only 19 of the study's 88 programs are operating Early Head Start, compared with 26 local programs for Healthy Families America, 22 for Nurse-Family Partnership, and 21 for Parents as Teachers.

Selecting States

Initial Identification of High-Priority States

As one of its first activities, the study team reviewed the 2010 and 2011 state plans for MIECHV funds in order to determine which states were most likely to contribute the right mix and number of local programs to the study. This resulted in 31 states being considered a high priority for study participation because they met the following criteria:

- **They were planning to implement more than one of the four evidence-based models being studied by MIHOPE.** This would help analyses distinguish between the influence of a particular state and the influence of a particular national model.
- **They were planning to support five or more eligible local programs.** Such states were considered a higher priority because they would help the study achieve its goal of choosing about 85 local programs from 12 states.
- **They mentioned an intention to serve military families.** Since the legislation that created MIECHV includes military families in its list of target populations, the study sought to include states whose local programs served such families.

Final Selection of States

Since the study did not have the resources to conduct research in all 31 high-priority states, the study team chose a subset for further outreach based on the following criteria:

- **They would represent each of four geographic regions of the United States** using combinations of regions defined by the Administration for

Children and Families and the Health Resources and Services Administration. These corresponded to the Northeast,[1] South,[2] Midwest and Plains,[3] and Mountain and West.[4]

- **They would allow the study to include a similar number of local programs for each of the four evidence-based national models.**
- **They would allow the study to include some local programs operating in nonmetropolitan areas.**

Based on these criteria, the study team began discussions with 10 states early in 2012. The team made contact with each state to assess its progress in implementing MIECHV, including whether other research on home visiting was taking place in the state and the status of decisions regarding MIECHV funding. After these discussions, the study team began discussions with seven additional high-priority states to ensure more equal model distribution and geographic diversity.

These discussions also revealed that the targeted states could not provide as many Early Head Start programs as programs for the other three national evidence-based models. This was consistent with the state plans (discussed in Chapter 2), which showed that fewer states chose to use MIECHV funds for Early Head Start than for the other three models. An examination of other high-priority states identified a cluster of newly eligible Early Head Start programs in several states, which were added to the list of actively recruited states.

The following 12 states are participating in MIHOPE: California, Georgia, Illinois, Iowa, Kansas, Michigan, Nevada, New Jersey, Pennsylvania, South Carolina, Washington, and Wisconsin. In Figure 3.1, these states are highlighted in gray.

[1]The Northeast included New England, New York, Pennsylvania, New Jersey, Delaware, and Maryland.

[2]The South included Virginia, West Virginia, North and South Carolina, Georgia, Florida, Alabama, Mississippi, Louisiana, Tennessee, Kentucky, Arkansas, Texas, and Oklahoma.

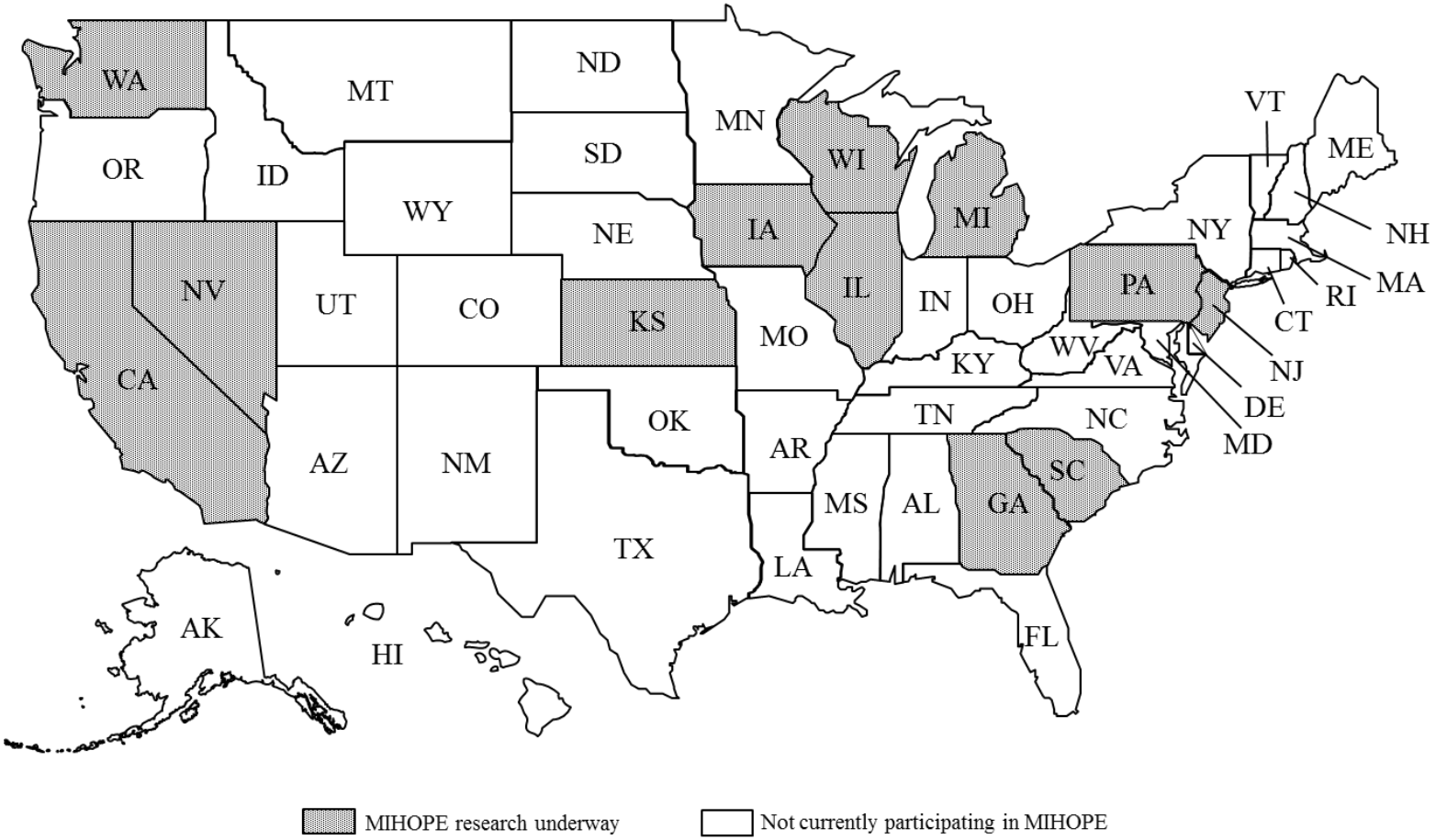
[3]The Midwest and Plains region included Ohio, Michigan, Indiana, Illinois, Missouri, Wisconsin, Minnesota, Iowa, North and South Dakota, Nebraska, and Kansas.

[4]The Mountain and West region included California, Oregon, Washington, Hawaii, Alaska, Arizona, Nevada, New Mexico, Colorado, Utah, Idaho, Wyoming, and Montana.

Mother and Infant Home Visiting Program Evaluation

Figure 3.1

Map of MIHOPE States



Selecting Local Programs

MIHOPE's initial goal was to select approximately 85 local programs across the four national evidence-based models. Although Chapter 2 indicated that states planned to use MIECHV funds to support several hundred such local home visiting programs, local programs had to meet several criteria to be included in MIHOPE.

- They had to have been in operation for at least two years when they entered the study.
- They had to be able to recruit enough families to fill program slots and to allow for a randomly chosen control group.
- They had to be located where control group members would be unlikely to have access to alternative evidence-based home visiting services.
- They had to have more than one MIECHV-funded home visitor so that evaluation activities would be spread across program staff members.
- They had to contribute to the goal of roughly equal representation of the four evidence-based national models.
- They could not be operating in "frontier locations," which included both counties with fewer than 2,500 people and urban areas with fewer than 20,000 people that were not adjacent to a metropolitan area. These areas were excluded to reduce the costs of recruiting families and collecting information.

In states with more eligible programs than were needed for the study, the study team randomly chose programs to participate, with some weighting toward programs in rural counties where possible.

To identify and choose local programs for the study, study team members visited most local programs that were receiving MIECHV funds and had been in operation for at least two years. The team presented an overview of MIHOPE and facilitated a discussion about the feasibility of participation in the study given the programs' administrative structures, implementation schedules, and sizes. Follow-up phone calls with local programs being considered for MIHOPE were used to learn more about issues such as whether a program received enough referrals to provide at least 40 families to the study while still providing a control group. In a few cases, local programs were not considered because the national model developer expressed concerns about how services were being implemented there.

This process resulted in the selection of 87 local programs, which entered MIHOPE between October 2012 and February 2014. An eighty-eighth local program was added in December 2014. Table 3.1 shows the breakdown of local programs by state and geographical region, and by national model. As Figure 3.1 and Table 3.1 illustrate, there are MIHOPE states in the Northeast, Midwest, South, and Mountain and West, although there are more states in the Midwest than elsewhere. As described earlier, MIECHV funding is in part based on a formula, which resulted in more populous states receiving more funding. Therefore, there was considerable variation in the number of local programs that received MIECHV funding in each state. This is true for the number of local programs selected for MIHOPE in each state as well; it ranges from 3 (Nevada and South Carolina) to 14 (Illinois). The average number of local programs per state is 7⅓.

Although the study sought to include a similar number of local programs for each of the four national models, there are more Healthy Families America programs than the other three models, and there are fewer Early Head Start programs than the other models, which reflects the number of eligible local programs operating each national model in the selected states.

By design, each state has local programs representing at least two national models. Slightly more than half of the participating states have local programs representing three or more national models. This may in part be due to the expansion of more home visiting programs with competitive funding; MIHOPE states all received competitive MIECHV funds in addition to formula-based funds.

Characteristics of Local Programs and Home Visitors

Table 3.2 shows some characteristics of local programs when they entered the study, including the type of agency implementing each program, the years the program had been in operation, its enrollment capacity, the type of county it served, and the proportion of its funding that came from MIECHV. Some of these characteristics could be associated with how programs are implemented at the local level, and, in turn, how they affect families. For example, studies of human-service programs have produced some evidence that program effects are associated with factors such as program maturity.[5] Also, the type of implementing agency can shape the types of resources local programs have access to and the degree to which they focus on linking families to particular types of services.

[5]Fixsen et al. (2005); Rubin et al. (2011).

Table 3.1

MIHOPE States and Programs

State	Region	Total Programs	EHS	HFA	NFP	PAT
California	Mountain and West	6	0	1	5	0
Georgia	South	6	1	3	0	2
Illinois	Midwest and Plains	14	1	5	1	7
Iowa	Midwest and Plains	11	4	7	0	0
Kansas	Midwest and Plains	8	2	2	0	4
Michigan	Midwest and Plains	7	3	2	2	0
Nevada	Mountain and West	3	2	0	1	0
New Jersey	Northeast	12	0	4	5	3
Pennsylvania	Northeast	8	4	0	2	2
South Carolina	South	3	0	1	2	0
Washington	Mountain and West	6	0	0	4	2
Wisconsin	Midwest and Plains	4	2	1	0	1
Sample size		88	19	26	22	21

SOURCE: MIHOPE site-selection team.

NOTE: EHS = Early Head Start - Home Based Program Option, HFA = Healthy Families America, NFP = Nurse-Family Partnership, PAT = Parents as Teachers.

Information on local program characteristics was provided by program managers around the time programs started participating in MIHOPE. The majority of local programs (60 percent) are run by community-based nonprofit agencies; others are implemented by local health departments, school districts, health care organizations, or other types of organizations.

Over three-quarters of local programs serve families in metropolitan counties. Although the design of MIHOPE called for the study to select programs to represent both urban and rural counties, it proved to be difficult to include states that both funded multiple home visiting models and funded programs in rural counties. As a result, MIHOPE

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Table 3.2

Basic Characteristics of Local Programs at Entry into Study

Characteristic (%)	Local Programs
Type of local implementing agency	
Community-based nonprofit	60
Local health department	18
School district	10
Health care organization	5
Other [a]	8
County served[b]	
Metropolitan	78
Nonmetropolitan	14
Both	9
Years program had been in operation[c]	
2 to 3	1
4 to 5	12
6 or more	87
Enrollment capacity[d]	
≤ 50 families	11
51-100 families	28
> 100 families	61
Proportion of funding from MIECHV	
Less than 20%	46
20% - 49%	29
50% - 74%	13
75% or more	12
Sample size	80

SOURCES: Calculations based on data from the MIHOPE program manager baseline survey and the MIHOPE site-selection team.

NOTES: Rounding may cause slight discrepancies in sums.

[a]Other types of organizations include: state-funded institution of higher education, local government and cooperative extension university, and social-service nonprofit.

[b]To designate counties as metropolitan or nonmetropolitan, this report follows the Department of Agriculture Economic Research Service's Rural-Urban Continuum Codes classification scheme. See Economic Research Service (2013a).

[c]Years using the specific national model in use at study entry.

[d]The number of families served at any one time.

included many of the most populous states in the country, which limited the number of counties that were deemed to be rural. Lastly, even within the populous MIHOPE states, there were some local programs in rural counties that were excluded due to other factors. For example, in one state, five programs in rural counties were deemed to be poor candidates for MIHOPE due to the small sizes of their communities, the proximity of other home visiting programs, or a demand for services insufficient to provide a control group for the study.

The vast majority of local programs had been operating for six or more years when they began participating in the study. This reflects both the fact that states used MIECHV funds primarily to expand existing programs (as described in Chapter 2) and MIHOPE's selection of local programs that had been in operation for at least two years.

As might be expected given that most of them existed for some time prior to MIECHV, programs reported considerable funding from other sources. In fact, MIECHV provides less than 20 percent of the funding of nearly half of the local programs participating in MIHOPE. For about 12 percent of local programs, however, MIECHV provides 75 percent or more of the program's financial resources.

The majority of local programs reported enrollment capacity of more than 100 families, which is considered relatively large for a local home visiting program. This may also reflect the fact that the study was limited to programs that had more than one home visitor and that could contribute at least 40 families to the study.

Table 3.3 shows some variation in staff characteristics such as age, race and ethnicity, educational background, and prior experience providing home visiting services. Some of these characteristics, such as educational background and experience in home visiting, may indicate differences in skills in working with families, which in turn might be associated with how effectively staff members deliver services. Other attributes of home visitors, such as their psychological well-being, can also influence the services they deliver.[6]

About a quarter of home visitors employed at local programs were less than 30 years old and slightly more than half were less than 40 years old. This is consistent with other studies suggesting that most home visitors are less than 40 years old.[7] Supervisors

[6]McFarlane et al. (2010).

[7]Burrell et al. (2009); LeCroy and Whitaker (2005); Whitaker (2014).

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Table 3.3

Characteristics of Home Visitors and Supervisors

Characteristic (%)	Home Visitors	Supervisors
Age		
29 or under	27	8
30-39	29	32
40-49	24	20
50 or older	20	40
Race/ethnicity		
Hispanic	20	8
Non-Hispanic, white	57	74
Non-Hispanic, black	16	12
Asian	2	3
Other/multiracial	5	4
Educational and employment background		
Highest level of education		
High school/General Educational Development (GED) certificate or less	3	0
Vocational/technical training or some college	11	3
Associate's degree or training program degree	12	0
Bachelor's degree	60	62
Master's degree or higher	15	36
Prior experience providing home visiting services		
None	50	38
Less than 1 year	6	3
1-2 years	10	7
3-5 years	10	20
More than 5 years	24	33
Sample size	440	117

SOURCES: Calculations based on data from the MIHOPE baseline home visitor survey and the MIHOPE baseline supervisor survey.

NOTE: Percentages may not sum to 100 because of rounding.

tended to be older: 40 percent were more than 50 years old. Home visitors and supervisors were also more likely to identify themselves as non-Hispanic white than any other race or ethnicity.

About three-quarters of home visitors and nearly all supervisors had at least a bachelor's degree. It is notable that such a high proportion of home visitors had bachelors'

degrees since Nurse-Family Partnership is the only one of the four national models to require this level of education for home visitors. This is consistent with a recent cross-model study of evidence-based home visiting that found that 79 percent of home visitors had a bachelor's degree or higher; earlier studies have reported rates of bachelor's degrees among home visitors ranging from 32 percent to 72 percent.[8]

In general, the national models have qualifications for home visitor employment that are focused on personal characteristics and experience working with families. In MIHOPE, half the home visitors had no experience providing home visiting services prior to their current positions but a quarter had more than five years of prior experience. This pattern holds true for supervisors as well.

Conclusion

MIHOPE used a systematic approach to determine which of the dozens of states and hundreds of local home visiting programs were the best candidates for meeting the study's goals of recruiting the desired number of families across about 85 local home visiting programs in 12 states. The process resulted in a selection of states that represented every region of the country and local programs that provided substantial representation for each of the four evidence-based home visiting models being studied. The next chapter describes the characteristics of families recruited into the study through January 15, 2014.

[8]Boller et al. (2014); Burrell et al. (2009), Whitaker (2014).

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Chapter 4

Characteristics of Families Enrolled in MIHOPE

This chapter provides the first glimpse of the women who have enrolled in the Mother and Infant Home Visiting Program Evaluation (MIHOPE) using information from surveys conducted with the women when they entered the study and observations of their home environments at that time. As noted in earlier chapters, women were eligible for MIHOPE if they were pregnant or had children under 6 months old. Information on participating families provides some insights into the challenges faced by women who receive home visiting, which should be reflected in the types of services that the programs aim to provide. The information can also shed light on which subgroups are likely to be large enough to analyze in later MIHOPE reports, filling a gap in the literature noted by the Home Visiting Evidence of Effectiveness (HomVEE) review (as discussed in Chapter 1). Finally, it provides information on the extent to which states successfully targeted the types of families identified in their plans and emphasized as a high priority by the Patient Protection and Affordable Care Act.[1]

Because recruitment into the study continues, this chapter reports characteristics of families who entered the study by January 15, 2014. This includes 1,652 families, or slightly more than a third of the families who will eventually enroll in the study. The overall characteristics of study families may change when enrollment has been completed, but such changes are expected to be small.

Main Findings

- **Enrollees face a number of risks for poor outcomes for them and their children.** They were fairly young when they joined the study, with 37 percent of the sample between the ages of 15 and 20. The vast majority of women did not have schooling beyond high school. Over a third had smoked within the previous two years and a third reported using illegal drugs or heavy drinking before becoming pregnant. Finally, about a third reported depressive symptoms.

[1]It is important to note that MIHOPE families are not necessarily representative of families served by the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) because MIHOPE did not include a random sample of local home visiting programs, as discussed in Chapter 3.

- **MIECHV programs participating in MIHOPE have targeted most of the high-priority populations mentioned in the Affordable Care Act.** These include pregnant women under age 21, families who have a history of substance abuse or who are in need of substance-abuse treatment, and families with tobacco users in the home.

- **There are few differences among the four evidence-based home visiting models in the families they have enrolled.** Levels of intimate partner violence, substance abuse, mental health concerns, and maternal education are similar in the families served by each of the four national models. The main differences in families across models is that Nurse-Family Partnership programs enrolled younger women than programs running the other evidence-based models, and all women who enrolled in Nurse-Family Partnership were pregnant (because of the model's eligibility requirements) compared with about half of the women enrolled in the other three national models.

Social and Demographic Characteristics

Table 4.1 shows some of the social and demographic characteristics of MIHOPE families when they entered the study. Some groups, such as military families and pregnant women under 21 years of age, are shown because the authorizing legislation identified them as priorities. Other characteristics shown are relevant to understanding the risk profiles of families served by local programs in MIHOPE, including maternal age, maternal race and ethnicity, pregnancy status, maternal linguistic acculturation, household composition, and housing mobility. Since women who enroll in home visiting when they are pregnant face different challenges and have different needs than those who enroll after giving birth, Table 4.1 compares characteristics of pregnant women with those of postpartum women (as do several other tables in this chapter).

As shown in Table 4.1, women in the MIHOPE sample were young at the time they enrolled, with an average age of 23 (slightly younger for pregnant women). Almost 40 percent of the women were between 15 and 20 years old. Being younger (particularly being younger than 20) is associated with greater risk of poor birth outcomes and delays in child

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Table 4.1

Selected Maternal and Household Characteristics, by Pregnancy Status at Enrollment

Characteristic	Total	Women Who Enrolled During Pregnancy	Women Who Enrolled After Giving Birth	
Maternal				
Average age (years)	23.4	22.7	24.9	***
Age 15-20 (%)	36.9	43.3	23.5	***
Pregnancy status (%)				
Pregnant				
Less than 28 weeks	51.6	76.2	NA	
More than 28 weeks	16.1	23.8	NA	
Given birth	32.3	NA	100.0	
Pregnant when enrolled and under 21 years old (%)	29.3	43.3	NA	
Race/ethnicity (%)				
Hispanic	33.6	36.3	27.7	***
Non-Hispanic, white	25.3	22.2	31.9	***
Non-Hispanic, black	31.0	30.6	31.9	
Asian	1.5	1.3	1.7	
Other/multiracial	8.6	9.5	6.6	*
Language other than English spoken in the home (%)	34.6	36.5	30.5	**
Ability to speak English self-rated as "not very well" or "not at all" (%)	7.9	6.7	10.3	**
Household and family (%)				
Child's father lives in the home[a]	42.4	39.0	49.6	***
Other adult relative lives in the home[b]	49.7	56.5	35.6	***
A nonadult sibling of the child lives in the home[c]	34.2	25.7	51.9	***
Moved more than once in the past year	22.0	24.0	17.8	***
Family member is serving in the military[d]	1.0	0.7	1.6	
Sample size	1,652	1,119	533	

(continued)

Table 4.1 (continued)

SOURCE: Calculations based on data from the MIHOPE family baseline survey.

NOTES: NA = not applicable.
A chi-squared test was applied to differences between the characteristics of women who enrolled prenatally and women who enrolled postnatally, for categorical variables. A t-test was applied to differences in age between the women who enrolled prenatally and women who enrolled postnatally. Statistical significance levels are indicated as follows: *** = 1 percent, ** = 5 percent, * = 10 percent.
[a]Includes the child's biological father as well as the child's adoptive father or stepfather.
[b]Includes any relative who is age 18 or older, other than the child's biological mother, biological father, adoptive father, or stepfather.
[c]Includes stepsiblings.
[d]Includes the child's mother and her partner or spouse.

development,[2] although these relationships may be driven by differences in socioeconomic factors such as income, marital status, and education.[3]

As expected (since women eligible for MIHOPE had to be pregnant or have recently given birth) the majority of women were pregnant at the time they enrolled in the study, and over 40 percent who enrolled prenatally were under the age of 21. More than half the women enrolled when less than 28 weeks pregnant — one of the Nurse-Family Partnership eligibility criteria — which in part reflects the fact that 28 percent of the sample was enrolled through Nurse-Family Partnership programs (with 13 percent coming from Early Head Start - Home Based Program Option programs, 32 percent from Healthy Families America, and 28 percent from Parents as Teachers).

The sample is racially and ethnically diverse, and almost evenly distributed across the three largest racial/ethnic groups in the country: 34 percent are Hispanic, 25 percent are non-Hispanic white, and 31 percent are non-Hispanic black. Those who enrolled after giving birth are significantly more likely to be non-Hispanic white. Corresponding to the number that are Hispanic, about a third of the sample spoke a language other than English in the home. Only 8 percent of women reported poor English-speaking ability. Although a small subgroup, enrollees who do not speak English may be more challenging to serve if home visitors or other community service providers do not speak the mother's native language. Research has also shown that the acculturative process among first-generation immigrants — which often includes the loss of one's native language and the adoption of negative

[2]Chandra et al. (2002); DuPlessis, Bell, and Richards (1997); Sommer et al. (2000).
[3]Chittleborough, Lawlor, and Lynch (2011); Reichman and Pagnini (1997).

health behaviors and movement away from ethnic support networks — creates risk for chronic health conditions and mental health problems.[4]

Overall, it was uncommon for MIHOPE enrollees to live alone. Half of the women reported living with other relatives, perhaps reflecting how young many of them were. Among the participants who were living with relatives, about 42 percent were living with their parents or parents-in-law (not shown). Women who enrolled in home visiting after giving birth were more likely to be living with the child's biological father, adoptive father, or stepfather (50 percent) than women who enrolled during pregnancy (39 percent). Still, half of the women who enrolled after birth were living apart from the child's father or father figure.

About 22 percent of the sample reported moving more than once in the past year. Frequent moves can be a proxy for transience and unstable housing, particularly if there appears to be a consistent pattern of moves over several consecutive years. The prevalence of recent moves among the MIHOPE sample is slightly lower than the rate found in a study of housing mobility across 10 U.S. cities, in which about one in four low-income families had moved in the previous year.[5]

Only a handful (about 1 percent) of women enrolled in MIHOPE had a family member in the military, suggesting that MIHOPE programs and their communities might not have high concentrations of military families or be located near military bases. Again, this sample is not necessarily representative of the communities home visiting programs serve, given the site-selection criteria described in Chapter 3.

Characteristics Related to Outcome Domains

The remainder of the chapter describes baseline characteristics of MIHOPE families related to five outcome domains identified by the authorizing legislation: (1) prenatal, maternal, and newborn health; (2) child health and development; (3) parenting skills; (4) crime and domestic violence; and (5) family economic self-sufficiency. [6] The legislation also identi-

[4]Abraído-Lanza, Ambrister, Florez, and Aguirre (2006).

[5]Kutty (2008).

[6]The legislation required grantees (states, tribes, and tribal organizations) to show improvement in six specified benchmark areas. In addition, the legislation required that MIECHV-funded programs be designed to improve individual outcomes for participating families in seven areas. Because there is considerable overlap between the benchmark areas and the individual participant outcomes, this report uses the term "outcomes" to refer to both lists. MIHOPE is designed to assess impacts relevant to all of these outcomes.

fied two other outcome domains — school readiness and academic achievement, and referrals and coordination — that are not discussed here because they could not be assessed when families entered the study. Specifically, school readiness and academic achievement could not be assessed because children were no more than 6 months old at enrollment. Referrals and coordination were not assessed because families were enrolling in home visiting at the same time they enrolled in MIHOPE, and therefore had not yet received any referrals or experienced coordination between programs.

Prenatal, Maternal, and Newborn Health

Although home visiting programs have historically emphasized the health and development of children, many recognize that a mother's physical and emotional health is intrinsically tied to the well-being of her children. Table 4.2 describes various aspects of the health of women and infants at the time they enrolled in the study, including their health status, health-related behaviors, and access to health care coverage.

One indicator of maternal health is a mother's own account of her health status. Although it is a subjective measure, longitudinal research studies have found that self-rated health status is a surprisingly strong predictor of future health deterioration and mortality, even after adjusting for objective measures of health.[7] Few women in MIHOPE reported they were in fair or poor health at the time they enrolled in the study, although women who had already given birth were more likely to do so. Not surprisingly, more pregnant women in MIHOPE than women who had already given birth faced limitations on engaging in moderate activities such as moving a table, vacuuming, or climbing several flights of stairs.

Improving prenatal health is an important objective of many home visiting programs. This goal could include reducing unhealthy behavior such as tobacco use, poor nutrition, and alcohol consumption, as well as ensuring early access to prenatal health care. The American College of Obstetrics and Gynecology recommends that prenatal care visits begin as soon as a woman knows she is pregnant. The vast majority of women in MIHOPE initiated prenatal care in the first trimester of pregnancy. Some initiated care before they enrolled in home visiting, suggesting that early initiation of prenatal care is already high among women in the MIHOPE sample.

[7] Idleand Benyamini (1997); Miilunpalo et al. (1997).

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Table 4.2

Selected Characteristics of Maternal, Prenatal, and Newborn Health, by Pregnancy Status at Enrollment

Characteristic (%)	Total	Women Who Enrolled During Pregnancy	Women Who Enrolled After Giving Birth	
Maternal health, mental health, and well-being				
Health self-rated "poor" or "fair"	11.4	9.7	14.8	***
Health problems self-rated as limiting activities "a lot"	18.7	20.9	13.9	***
Depression (10-item CES-D) score at or above cutoff[a]	33.8	36.3	28.5	***
Anxiety (GAD-7) score at or above cutoff[b]	25.2	28.4	18.6	***
Prenatal health care				
Initiated prenatal care in the 1st trimester	79.7	79.3	80.6	
Health-related behaviors				
Tobacco use				
Any tobacco use in the past 2 years	35.2	35.4	34.7	
Any current smoking	15.2	12.3	21.3	***
Smoking is permitted in the home	19.2	23.4	10.4	***
Alcohol and substance abuse				
Binge alcohol use[c]	25.6	26.9	23.0	*
Illegal drug use[d]	12.9	14.6	9.3	***
Maternal health insurance and access to care				
Insurance type[e]				
Uninsured	20.9	21.4	19.9	
Public health coverage	70.9	70.9	70.8	
Private insurance	12.1	10.6	15.3	***
Has usual source of care[f]	62.9	58.1	73.0	***
Birth outcomes				
Preterm birth (<37 weeks)	9.6	NA	9.6	
Child had low birth weight, <2,500 grams or 5.5 lbs	10.5	NA	10.5	

(continued)

Table 4.2 (continued)

Characteristic (%)	Total	Women Who Enrolled During Pregnancy	Women Who Enrolled After Giving Birth
Child health care access			
Insurance type[e]			
Uninsured	12.0	NA	12.0
Medicaid/Children's Health Insurance Program (CHIP)	76.8	NA	76.8
Other	10.8	NA	10.8
Has usual source of primary care	93.4	NA	93.4
Sample size	1,652	1,119	533

SOURCE: Calculations based on data from the MIHOPE family baseline survey.

NOTES: NA = not applicable.

A chi-squared test was applied to differences between the characteristics of women who enrolled prenatally and women who enrolled postnatally, for categorical variables. A t-test was applied to differences in age between the women who enrolled prenatally and women who enrolled postnatally. Statistical significance levels are indicated as follows: *** = 1 percent, ** = 5 percent, * = 10 percent.

[a]This was measured using a 10-item Center for Epidemiologic Studies Depression Scale (CES-D). A score of 8 or higher indicates clinically significant depressive symptoms. See Kohout, Berkman, Evans, and Cornoni-Huntley (1993).

[b]A score of 10 or higher on the Generalized Anxiety Disorder seven-item scale (GAD-7) indicates moderate or severe anxiety symptoms. See Spitzer, Kroenke, Williams, and Löwe (2006).

[c]Binge alcohol use is defined as drinking four or more drinks in one sitting, and was reported for the three months before pregnancy.

[d]Illegal drug use was reported for the month prior to pregnancy.

[e]Insurance-type percentages may not add up to 100 percent, as some survey respondents indicated having more than one type of insurance.

[f]Maternal usual source of care includes all care except prenatal care and family planning.

Mothers and children can both benefit from reduced maternal tobacco, alcohol, and drug use. These behaviors are associated both with negative birth outcomes such as fetal growth retardation, and with risks for children after birth, such as respiratory illness, and in the case of alcoholism and illegal drug use, cognitive delays, child abuse and neglect, and intimate partner violence.[8] Home visiting may help families mitigate the prevalence or fre-

[8]U.S. Department of Health and Human Services (2004); National Institute on Drug Abuse (2011); Chomitz, Cheung, and Lieberman (1995); Lemon, Verhoek-Oftedahl, and Donnelly (2002); Magura and udet (1996); Russell et al. (1991); Centers for Disease Control and Prevention (2014a).

quency of these behaviors, and families with histories of substance use and household tobacco use are identified as priority groups for MIECHV in the authorizing legislation.

Table 4.2 shows that about 35 percent of women reported using tobacco in the previous two years. Although this is much higher than the national rate of smoking among all adult women (16 percent) and the rate among pregnant women (12 percent),[9] it is similar to the smoking rate of female Medicaid enrollees prior to becoming pregnant (34 percent).[10] Pregnant women in MIHOPE were almost half as likely to smoke as women who had already given birth, but more than twice as likely to permit smoking in the house. Regarding substance use, few women reported using illegal drugs in the month prior to pregnancy, but a quarter of the sample reported an episode of binge drinking (consuming four or more drinks in a two-hour period) during the three months prior to pregnancy. However, frequent binge drinking was rare: only 4 percent of those who reported binge drinking in the three months prior to pregnancy did so at least every other week. Since respondents tend to underreport the prevalence of these behaviors, the true rates of smoking and substance use are likely to have been higher than shown.[11]

In addition to physical health, home visiting programs are increasingly trying to address maternal mental health problems, as these problems can have serious repercussions for both maternal and child well-being.[12] Poor maternal mental health may also present different risks to pregnant women and their unborn children than it does to women who have already given birth and their infants. For example, maternal anxiety during pregnancy may harm fetal development by altering the uterine hormonal environment, which in turn impairs the central nervous system of the fetus and subsequent infant motor development, while maternal anxiety after giving birth may affect maternal parenting, which may consequently increase children's risk for anxiety disorders.[13]

There are high rates of depressive symptoms in the MIHOPE sample: About a third of women indicated such symptoms. This rate is much higher than the 13 percent of women who have depressive symptoms nationally while pregnant or soon after pregnancy.[14] However, depression may be substantially higher among low-income women with young chil-

[9]Agaku, King, and Dube (2014); Tong et al. (2013).

[10]Tong et al. (2013).

[11]Gorber et al. (2009); Northcote and Livingston (2011).

[12]Chung et al. (2004); Petterson and Albers (2001); Ross and McLean (2006).

[13]Ginsburg, Grover, and Ialongo (2005); Glover (2011); Mulder et al. (2002); Van den Bergh and Marcoen (2004); Davis et al. (2004).

[14]U.S. Department of Health and Human Services (2009a).

dren than among other income groups.[15] Perhaps for that reason, the prevalence rates of depressive symptoms among MIHOPE women are comparable to those found in smaller, community-based studies of low-income pregnant mothers.[16] More pregnant MIHOPE women than postpartum women expressed high levels of anxiety (28 percent compared with 19 percent). It is important to note that these are not clinical assessments of anxiety or depression, although validation studies have found that measures of depressive and anxiety symptoms are moderately to highly correlated with clinical diagnoses.[17]

Beyond health status, maternal access to health care at the time of enrollment is also relevant, as a wide body of research has documented that the uninsured receive fewer preventive and diagnostic services, and tend to be at a more severe stage of illness when they are diagnosed with a medical condition.[18] Lacking insurance coverage is a notable barrier to receiving adequate prenatal care, and may also prevent mothers from seeking health care for themselves after birth.[19] Lacking insurance coverage has also been linked to racial and ethnic differences in whether a person has a regular source of care.[20]

At the time of enrollment, about 71 percent of the women in MIHOPE reported receiving public health coverage, which includes Medicaid, Medicare, Medigap, Children's Health Insurance Programs (CHIP), military insurance, the Indian Health Service, and state-sponsored insurance. The high rate of public health coverage reflects these women's low incomes. However, about one in five pregnant women and one in five new mothers were uninsured. The 15-month follow-up report may find higher rates of health coverage because of the provisions in the Affordable Care Act that expand coverage opportunities.

The majority of women had a usual source of care, although pregnant women were less likely to report this (58 percent compared with 73 percent). This may reflect the fact that pregnant women were asked not to consider prenatal care or family planning as their regular source of care, even though many of them might have been using prenatal care in that way.

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[15]McDaniel and Lowenstein (2013).

[16]Chung et al. (2004).

[17]Eaton, Neufeld, Chen, and Cai (2000); Kroenke, Spitzer, Williams, and Löwe (2010).

[18]Hadley (2003).

[19]Egerter, Braveman, and Marchi (2002).

[20]Lillie-Blanton and Hoffman (2005). Even among low-income, nonelderly adults, minorities, particularly Hispanics, are more likely to be uninsured than other groups. Low-income, nonelderly, non-Hispanic black adults are slightly less likely to be insured than their non-Hispanic white counterparts. See Staveteig and Wigton (2000).

Birth weight and gestational age are well-recognized measures of birth outcomes and infant health tracked and monitored by the Centers for Disease Control and Prevention. These newborn health indicators are also associated with long-term health and development and therefore serve as key characteristics to identify subgroups of children who are at particular risk of poor long-term outcomes. Table 4.2 shows that about 10 percent of the women who had given birth shortly before enrolling in MIHOPE had a preterm birth (an infant born at less than 37 weeks of gestational age), which is actually lower than the national average of 12 percent. Just over 10 percent reported having had a low-birth-weight infant, which is slightly higher than the national average of 8 percent.[21] Finally, 77 percent of children in MIHOPE were covered by Medicaid and CHIP, which is similar to the proportion of MIHOPE mothers with public health coverage. It is notable that 1 in 10 children lacked any type of insurance or health coverage when they enrolled in the study, given the number of federal, state, and local programs that provide low-cost or free health coverage for young, low-income children. Nevertheless, almost all mothers reported that their children had usual sources of care.

Child Health and Development and Parenting

To help parents improve their children's health and development, home visiting programs emphasize positive parenting skills. Table 4.3 describes the quality of the home environment as observed by a research team field interviewer at the time of enrollment into the study, as well as survey reports of characteristics that may foster or indicate positive parenting practices, including breastfeeding. This table also shows measures of father involvement, which is important given the growing literature on father involvement and its relationship to child well-being.[22]

In some respects, most study participants had home environments that appeared to be conducive to fostering healthy child development. Only about 15 percent had cluttered or unclean homes, and evidence of recent alcohol or drug use was found in only a small minority of homes (6 percent). Most women exhibited adequate conversational skills, with only 12 percent observed to have weak skills (which means their speech was not distinct, they did not initiate conversations, or they did not converse in a free and easily audible manner). Weak conversational skills may indicate difficulties in promoting children's cognitive development.

[21]Martin et al. (2013).

[22]Carlson and Magnuson (2011); McLanahan and Carlson (2010); Wilson and Prior (2010).

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Table 4.3

Selected Home Environment and Parenting Characteristics, by Pregnancy Status at Enrollment

Characteristic (%)	Total	Women Who Enrolled During Pregnancy	Women Who Enrolled After Giving Birth	
Environment for learning[a]				
Mother has weak conversational skills[b]	12.0	11.8	12.5	
Home is cluttered or unclean	15.1	14.2	16.9	
Evidence of recent alcohol or drug use in the home	6.1	6.9	4.5	*
Household has at least 10 books	52.0	49.9	56.1	**
Father involvement				
Biological father is present in the home	42.2	38.9	49.1	***
Father provides material support for child[c]	56.8	50.0	70.2	***
Parenting				
Mother has weak empathy skills[d]	24.4	25.6	21.8	*
Mother ever breastfed	77.1	NA	77.1	
Mother intends to breastfeed	82.6	82.6	NA	
Sample size	1,652	1,119	533	

SOURCES: Calculations based on data from the MIHOPE family baseline survey and the research team's baseline home observations.

NOTES: NA = not applicable.

A chi-squared test was applied to differences between the characteristics of women who enrolled prenatally and women who enrolled postnatally, for categorical variables. A t-test was applied to differences in age between the women who enrolled prenatally and women who enrolled postnatally. Statistical significance levels are indicated as follows: *** = 1 percent, ** = 5 percent, * = 10 percent.

[a]Based on observations of the home interior. These data are available for all families.

[b]This means that the mother's speech was not distinct, she did not initiate conversations, or she did not converse in a free and easily audible manner.

[c]Father helped with pregnancy expenses or bought things for the child a few times a month or more.

[d]Parental empathy for children's needs was measured using a subscale of the Adult Adolescent Parenting Inventory-2. See Bavolek and Keene (1999).

However, only about half of all households in MIHOPE had at least 10 books, a measure that is correlated with family literacy practices and child language and cognitive development.[23]

Another way that women can support the healthy development of their children is to breastfeed. The bottom of Table 4.3 shows that most pregnant women intended to breastfeed and most women who had given birth had initiated breastfeeding. This is important because breast milk promotes the immunological health and growth of infants and may have health benefits for mothers.[24] These rates suggest that home visiting programs may not have to spend much time encouraging mothers to initiate breastfeeding. Nevertheless, there is room for home visiting to make a difference in longer-term breastfeeding rates, given that other community-based research studies have found that some low-income women who initiate breastfeeding do not continue past the first week.[25]

Only about 40 percent of women lived with the biological fathers of their children. This rate is similar to the rates of separate parental living arrangements found in the Fragile Families and Child Well-Being Study, a representative sample of births in urban hospitals from 1998 to 2000.[26] A recent review of the literature on family structure and child well-being has found that children of single mothers are at greater risk of poor health, behavioral, and cognitive outcomes. However, those poor child outcomes may be caused by mothers being in unstable relationships rather than mothers living separate from fathers per se.[27] In MIHOPE, more women who had already given birth than pregnant women were receiving material support from the father (70 percent compared with 50 percent). This difference may suggest that fathers become more involved after the births of their children.

Crime and Domestic Violence

Although most economically disadvantaged families are able to avoid violence and involvement with crime, the young children who are exposed to such events experience high levels of stress and are more likely to exhibit externalizing or "acting out" behavior later on.[28] Exposure to intimate partner violence is also associated with child abuse and ne-

[23]Linver, Martin, and Brooks-Gunn (2004).
[24]American Academy of Pediatrics (2012).
[25]Lee, Elo, McCollum, and Culhane (2009).
[26]Reichman, Teitler, Garfinkel, and McLanahan (2001); Waldfogel, Craigie, and Brooks-Gunn (2010).
[27]Waldfogel, Craigie, and Brooks-Gunn (2010).
[28]Sternberg et al. (1993); Wolfe et al. (2003).

glect along with other adverse outcomes for children.[29] Table 4.4 presents several measures of criminal activity and intimate partner violence at the time women enrolled in the study.[30]

About 7 percent of women reported that they had been arrested in the year prior to entering the study; this rate is slightly higher for women who enrolled during pregnancy. About 10 percent of women reported having experienced physical intimate partner violence and 7 percent reported having experienced psychological intimate partner violence in the past year. Roughly 21 percent of women who had already given birth and about 26 percent of pregnant women reported being physically violent to their spouses or partners in the previous year. However, the context in which this violence was experienced and perpetrated by women is unknown. Research has indicated that it is important to consider contextual factors when comparing the rates at which women are perpetrators or victims of violence. For example, women may perpetrate violence in self-defense, or as a coping mechanism for violence or other sources of stress.[31] Prior research has sometimes found that victimization and perpetration are related: For example, one study of women assessed for intimate partner violence in an emergency department setting found that 56 percent of victims had also perpetrated violence over the past year.[32] Two percent to 3 percent of women in MIHOPE reported perpetrating severe physical intimate partner violence (defined as using a knife, gun, or weapon or choking, slamming, kicking, burning, or beating one's partner) at least once in the prior year.

Intimate partner violence is not only a concern for adult victims; it also has consequences for children. Children of abused women are often victims of abuse and neglect themselves, and are apt to witness violent altercations between their parents.[33] Witnessing intimate partner violence has been shown to affect children's behavioral and health outcomes, leading to poor academic performance and higher rates of posttraumatic stress disorder, depression, anxiety, and substance use and abuse.[34] Male children who are exposed to intimate partner violence between their parents are more likely to engage in intimate partner violence as adults, and female children who witness intimate partner violence are more

[29]Tajima (2004).

[30]Note that because these measures are self-reported, the results here may underestimate the prevalence of these behaviors.

[31]Hellmuth, Gordon, Stuart, and Moore (2013); Swan et al. (2008); Stuart et al. (2006); Babcock, Miller, and Siard (2003).

[32]Lipsky, Caetano, Field, and Bazargan (2004).

[33]Dube et al. (2002).

[34]Dube et al. (2002); Summers (2006).

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Table 4.4

Selected Characteristics of Crime and Intimate Partner Violence, by Pregnancy Status at Enrollment

Characteristic (%)	Total	Women Who Enrolled During Pregnancy	Women Who Enrolled After Giving Birth
Crime			
Arrests in the past year	7.3	8.2	5.3 **
Intimate partner violence[a]			
Physical violence toward mother			
Any violence toward mother[b]	10.4	10.5	10.2
Severe violence toward mother[c]	2.3	2.2	2.4
Psychological violence toward mother[d]	7.0	6.7	7.8
Physical violence perpetrated by mother			
Any violence perpetrated by mother[b]	24.6	26.3	20.9 **
Severe violence perpetrated by mother[c]	2.3	2.1	2.7
Sample size	1,652	1,119	533

SOURCE: Calculations based on data from the MIHOPE family baseline survey.

NOTES: A chi-squared test was applied to differences between the characteristics of women who enrolled prenatally and women who enrolled postnatally, for categorical variables. A t-test was applied to differences in age between the women who enrolled prenatally and women who enrolled postnatally. Statistical significance levels are indicated as follows: *** = 1 percent, ** = 5 percent, * = 10 percent.

[a]Only women with a spouse or partner living in the household at the time of enrollment were asked about experiences of intimate partner violence.

[b]Acts included in this measure are throwing something at one's spouse or partner; pushing, shoving, hitting, slapping, or grabbing one's spouse or partner; using a knife, gun, or weapon on one's spouse or partner; and choking, slamming, kicking, burning, or beating one's spouse or partner. Using threats of force to make her have sex is also included in the measure of any intimate partner violence toward the mother and is not included in the measure of any intimate partner violence perpetrated by the mother.

[c]Acts included in this measure are using a knife, gun, or weapon on one's spouse or partner, and choking, slamming, kicking, burning, or beating one's spouse or partner. Using threats of force to make her have sex is also included in the measure of severe intimate partner violence toward the mother and is not included in the measure of any intimate partner violence perpetrated by the mother.

[d]This was measured using a six-item version of the Women's Experience with Battering scale. Smith, Earp, and DeVellis (1995), modified with the permission of Paige Smith.

likely to enter into abusive relationships in adulthood.[35] Because home visitors have unique access into families' lives, they may have opportunities to prevent and address intimate partner violence by identifying its presence and by reaching socially isolated families who are disconnected from other service providers.

Family Economic Self-Sufficiency

Family economic self-sufficiency was identified by the legislation that created MIECHV as a priority outcome for home visiting services. The importance of improving economic self-sufficiency is underscored by research documenting the numerous, negative consequences of poverty, including negative impacts on birth outcomes and child health, cognitive development, academic achievement, and social and emotional development.[36] Family economic characteristics may also be used to identify important subgroups highlighted in the legislation, such as low-income families. Table 4.5 presents a number of indicators of family economic self-sufficiency, including maternal employment history, maternal earned income, household receipt of public benefits, and maternal education.

Although the majority of mothers had been employed at some point during the three years before they enrolled in MIHOPE, about 24 percent of pregnant women and 20 percent of other women had not. More than half of the sample reported no monthly earnings in the most recent month, which is not surprising given the sample's youth and how close its members were to a recent or upcoming birth.

Turning to receipt of public benefits, 75 percent of mothers were enrolled in the Women, Infants, and Children program (WIC) at the time they joined the study. Similarly, the majority were enrolled in the Supplemental Nutrition Assistance Program (SNAP), and about half were enrolled in both WIC and SNAP (not shown). Overall, women who enrolled in MIHOPE after giving birth were more likely to have been receiving public benefits than pregnant women; in particular, the women who enrolled into the study after giving birth reported receiving SNAP, WIC, or earnings from other household members at higher rates than did pregnant women. While about 19 percent of the full sample reported household receipt of disability insurance including Supplemental Security Income or Social Security Disability Insurance, more pregnant women (20 percent) reported household receipt of disability insurance (which may include short-term disability insurance related to pregnancy complications or conditions) than women who enrolled after birth (15 percent).

[35]Brown and Bzostek (2003).

[36]Duncan and Brooks-Gunn (2000); Aber, Bennett, Conley, and Li (1997); Eamon (2001).

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Table 4.5

Selected Economic Self-Sufficiency Characteristics, by Pregnancy Status at Enrollment

Characteristic (%)	Total	Women Who Enrolled During Pregnancy	Women Who Enrolled After Giving Birth	
Maternal employment during the past three years				
None	22.3	23.7	19.5	*
Employed for 1-12 months	38.0	39.9	34.2	**
Employed for 13 months or more	39.6	36.4	46.4	***
Household income in the last month				
Maternal monthly earnings				
$0	64.3	60.6	71.9	***
$1 - $999	20.9	23.9	14.6	***
$1,000 - $1,999	11.0	11.9	9.1	
$2,000 or more	3.9	3.6	4.5	
Sources of household income or benefits				
Temporary Assistance for Needy Families (TANF)	22.1	20.5	25.6	**
Food stamps/SNAP	62.0	59.0	68.1	***
Disability insurance	18.5	20.3	14.9	***
Earnings from other household members	30.1	26.2	37.9	***
WIC	75.3	70.7	85.1	***
Maternal education				
Currently taking education or training classes	25.7	29.1	18.4	***
Currently planning to take education or training classes[a]	62.3	64.2	58.8	*
Highest level of education[b]				
No high school diploma				
Age 20 and younger	22.0	26.3	12.8	***
Age 21 and older	22.3	19.9	27.4	***
High school diploma	33.6	33.7	33.3	
Some college but no degree	16.4	14.8	19.7	**
Bachelor's degree or higher	3.0	2.6	3.9	
Sample size	1,652	1,119	533	

(continued)

Table 4.5 (continued)

SOURCE: Calculations based on data from the MIHOPE family baseline survey.

NOTES: A chi-squared test was applied to differences between the characteristics of women who enrolled prenatally and women who enrolled postnatally, for categorical variables. A t-test was applied to differences in age between the women who enrolled prenatally and women who enrolled postnatally. Statistical significance levels are indicated as follows: *** = 1 percent, ** = 5 percent, * = 10 percent.

[a]Of the women who were not taking educational or training classes when they enrolled, the percentage who were planning to do so before their children's first birthdays.

[b]Does not include 2.7 percent of respondents who reported earning an associate's degree. Percentages may not add up to 100 as a result.

MIHOPE mothers also possessed low levels of education at the time they enrolled, which may reduce their ability to find jobs that pay well enough to make them economically self-sufficient. Only a small number (fewer than 3 percent) had obtained college degrees, for example, and more than 40 percent had no high school diploma. In comparison, most births in the United States occur among women with some college education or more (54 percent), while only 20 percent of births in the United States occur among women with less than a high school education.[37] In part, the low high school graduation rate may reflect the youth of the sample, but among women 21 and older, nearly 20 percent of pregnant women and 27 percent of other women had not graduated from high school. Women who enrolled in MIHOPE after giving birth were more likely than pregnant women to report that they had completed some college courses. At the same time, pregnant women were more likely to report that they were then taking or were planning to take educational or training classes.

Characteristics by National Model

As noted in the beginning of the chapter, each of the four national models defines its eligible population somewhat differently. For example, all programs can enroll pregnant women, but only Nurse-Family Partnership enrolls solely first-time, expectant mothers no later than the twenty-eighth week of pregnancy. Both Healthy Families America and Parents as Teachers allow local programs to select or refine their target populations to a certain extent (they can target, for example, families at risk of child maltreatment, families with low literacy levels, or families with mental health and substance-use issues), which implies that these programs may have a fair degree of variation in the risk profiles of families. Similarly, Early Head Start allows local programs flexibility in defining their target populations, but

[37]Livingston and Cohn (2010).

also specifies that eligible families should be at or below the federal poverty level, and further targets children with disabilities. Therefore, most Early Head Start families are expected to have low incomes and some might have children with special needs.

Table 4.6 presents selected baseline family characteristics across the four national models. This table highlights differences in risk factors and in primary reasons for enrolling in home visiting. Women who enrolled in one program may be demographically different from women who enrolled in another, and as a result may have different motivations and expectations.

Families vary as expected in the demographic characteristics that distinguish models' eligibility criteria. Nurse-Family Partnership programs enrolled only expectant mothers no later than the twenty-eighth week of pregnancy (although a few were at their twenty-eighth week and thus on the cusp of being ineligible), and women enrolled by Nurse-Family Partnership programs were consequently about twice as likely as women enrolled in any of the other programs to be pregnant. Although all models were reaching young pregnant mothers (under age 21), on average Nurse-Family Partnership programs had higher shares of this group, likely because that model only enrolls first-time mothers. In contrast, Early Head Start and Parents as Teachers programs were reaching more families with older children living in the home.

There appear to be few differences across the national models in the risk profiles of families. For example, there are no sizable differences in reports of substance abuse, mental health concerns, or prior maternal arrests across national models. However, rates of living with biological fathers and of maternal education do vary across models: Women enrolled in Parents as Teachers were the least likely to be living with children's biological fathers at the time of enrollment and had the least education.

In recent years, there has been growing interest among members of the public health community in documenting the role of early life experiences in children's development, particularly exposure to stressful events, because these experiences could potentially harm children's long-term health and well-being. The Adverse Childhood Experiences study used retrospective questionnaires of adults enrolled in a large health maintenance organization, collecting information on different categories of adverse childhood experiences including abuse (physical, sexual, or psychological), witnessing domestic violence against one's mother, living with substance abusers, living in households with mentally ill or suicidal

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Table 4.6

Selected Family Characteristics at Enrollment, by Program Model

Characteristic	Total	EHS	HFA	NFP	PAT	
Maternal demographic and household characteristics						
Average age (years)	23.4	25.0	23.2	21.1	25.1	***
Age 15-20 (%)	36.9	21.3	37.0	55.4	25.7	***
Pregnancy status (%)						
Pregnant						
Less than 28 weeks	51.6	35.6	31.9	98.7	35.0	***
More than 28 weeks	16.1	23.1	24.2	1.3	18.3	***
Given birth	32.3	41.2	44.0	0.0	46.7	***
Pregnant when enrolled and under 21 years old (%)	29.3	15.7	23.8	55.4	16.1	***
Nonadult sibling of the child living in the home[a] (%)	34.2	58.6	34.6	1.3	54.8	***
Risk factors (%)						
Maternal experience or perpetration of physical intimate partner violence	26.5	20.8	29.3	27.1	25.4	
Maternal substance abuse[b]	33.0	30.4	32.8	34.6	32.7	
Maternal mental health concerns[c]	40.9	40.5	41.8	42.3	38.9	
Biological father who does not live in the household	57.8	59.1	57.3	62.9	52.8	**
Low level of maternal education[d]	29.2	32.4	30.5	17.6	37.8	***
Mother arrested in the past year	7.3	6.1	7.3	7.5	7.7	
1 risk factor	28.9	33.3	28.3	25.6	30.8	
2 or more risk factors	58.4	55.4	59.7	58.9	57.8	
Primary reasons for enrolling in home visiting services[e] (%)						
Prenatal, maternal, and newborn health	10.4	4.4	8.2	21.5	4.6	***
Child health and development	35.4	53.7	29.7	31.2	37.0	***
Parenting support	28.4	27.8	30.4	25.8	29.0	
Family economic self-sufficiency	5.0	5.4	5.2	2.7	6.8	*
Referrals and service coordination	11.5	15.6	11.1	7.0	14.3	***
General advice and support	38.6	25.4	43.4	45.4	33.1	***
Sample size	1,652	216	521	455	460	

(continued)

Table 4.6 (continued)

SOURCE: Calculations based on data from the MIHOPE family baseline survey.

NOTES: A chi-squared test was applied to differences among characteristics for the home visiting program groups. Statistical significance levels are indicated as follows: *** = 1 percent, ** = 5 percent, * = 10 percent.

EHS = Early Head Start - Home Based Program Option, HFA = Healthy Families America, NFP = Nurse-Family Partnership, PAT = Parents as Teachers.

[a]Includes stepsiblings.

[b]Defined as either binge drinking in the three months prior to becoming pregnant or using illicit drugs in the month before becoming pregnant.

[c]Defined as scoring at or above the cutoff on either a 10-item CES-D measure of depression or the GAD-7 measure of anxiety.

[d]Based on the mother's highest level of education completed and her age.

[e]Mothers were asked to provide up to three reasons for enrolling in home visiting. Percentages may not add up to 100 as a result.

individuals, and living with individuals who had been imprisoned.[38] By linking reports of adverse early life experiences to indicators of current health and well-being, the Adverse Childhood Experiences study demonstrated that as the number of negative experiences in childhood increases, the risk for a number of problems in adulthood (such as alcoholism and alcohol abuse, depression, poor health-related quality of life, illicit drug use, intimate partner violence, smoking, and unintended pregnancies) also increases.

Table 4.6 also presents a child risk index (based on a mother's reports of current adverse experiences in her family) that includes intimate partner violence (experienced or perpetrated), maternal substance abuse, poor maternal mental health, parents living separately, low maternal education, and maternal arrests in the past year.[39] More than half of families across all models reported two or more of these risk factors, which suggests a high level of risk for poor outcomes among their children. These rates of two or more negative risk factors are similar across all four models.

[38]Centers for Disease Control and Prevention (2014b); Felitti et al. (1998).

[39]Since the original Adverse Childhood Experiences study, researchers have used various categories to create a cumulative measure of adverse childhood experiences. For example, the National Survey of Children's Health developed a modified list based on its survey, which included the following: (1) perceived socioeconomic hardship; (2) the divorce or separation of parents; (3) the death of a parent; (4) a parent who served time in jail; (5) witnessing domestic violence; (6) being a victim of neighborhood violence; (7) living with someone who was mentally ill, suicidal, or severely depressed; (8) living with someone with an alcohol or drug problem; and (9) one's perception of being treated or judged unfairly due to race or ethnicity. See Child and Adolescent Health Measurement Initiative (2013).

Conclusion

MIHOPE has enrolled a group of young women with low levels of education; relatively high rates of smoking, drinking, and drug use; and worrying rates of depressive symptoms and intimate partner violence. Each of these indicators is a well-documented, independent risk for compromised infant health and child development.[40] At the same time, many of these risks are arguably alterable with access to appropriate resources and services, and with education and encouragement to change. These risk factors thus suggest important ways for home visiting programs to help families improve their circumstances early in their children's lives. Chapter 5 explores whether home visiting programs participating in MIHOPE are operating programs intended to ameliorate these risk factors.

[40]Campbell (2002); Cummings and Davies (1994); Currie and Moretti (2003); Grote et al. (2010); Noonan, Reichman, Corman, and Dave (2007); Pollack, Lantz, and Frohna (2000); Shankaran et al. (2007); U.S. Department of Health and Human Services (2004); Chandra et al. (2002); DuPlessis, Bell, and Richards (1997); Sommer et al. (2000).

Chapter 5

Characteristics of Local Home Visiting Programs

The diverse nature of the risks faced by families (portrayed in Chapter 4) underscores the challenges facing home visiting programs. These programs must address deep-seated social issues such as poverty while also encouraging individual behavioral change.[1] This chapter presents the first look at how local home visiting programs included in the Mother and Infant Home Visiting Program Evaluation (MIHOPE) plan and support the implementation of this critical work.

This chapter has two overarching goals. One is to provide an initial examination of how local home visiting programs participating in MIHOPE are planning and supporting implementation. In particular, are their infrastructure and planned services consistent with the expectations of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) as well as their respective national models? The other objective is to provide information about the degree to which local programs vary in their approaches, and the extent to which they differ from their national models. Some variation across local programs is to be expected, given the breadth of MIECHV's goals, the number of national models that are being used, the flexibility that some models allow local programs, and the differences in community contexts. However, this will be the first systematic information available about the ways MIECHV local programs vary in their priorities and the types of support they offer for implementation.

The chapter begins by describing components of local programs' planned services, including whom the programs intend to serve, what outcomes they intend to improve, what services they plan to deliver to achieve those improvements, and whom they intend to hire to deliver services. While the study is still collecting data on individual families' experiences in the program, understanding local programs' blueprints for service delivery is a first stage in understanding the outcomes they aim to affect. Because MIECHV promotes change in a large number of domains, a particularly important question concerns which of these domains local programs rank as higher or lower priorities, and whether these rankings vary from program to program. Variation of this kind could ultimately lead to variation in family outcomes.[2] Because variations in local programs are likely to be driven by differ-

[1] Gomby (2000).
[2] Weiss, Bloom, and Brock (2013).

ences in the histories, goals, and approaches of the national models, the chapter often presents and discusses information on local programs by national model.

The second part of the chapter describes aspects of local programs' implementation systems, the infrastructure they have in place to support staff members in carrying out the program's planned family services. Specifically, the chapter summarizes the programs' referral agreements with other community partners and the types of administrative support they use to monitor and facilitate implementation. Finally, the chapter provides reports from home visitors themselves about how well trained and equipped they feel to deliver services related to each outcome domain.

The data presented are drawn from several sources: semistructured interviews and surveys with the four national model developers, web-based surveys of 80 program managers conducted around the time their programs entered the study (between October 2012 and February 2014), and web-based surveys of 422 home visitors conducted around the same time.

Main Findings

- **Most local programs reported that they aimed to improve a broad range of family outcomes.** Most programs aimed to improve all major outcomes named by the MIECHV authorizing legislation, including maternal health and well-being, positive parenting, child health and development, and economic self-sufficiency. To do this some local programs had made a higher priority of some outcomes since MIECHV began, especially outcomes related to prenatal and maternal health.

- **The national model developers differ from one another in their priorities.** This is not surprising given their different histories. This variation is generally reflected in local program priorities, although local programs often made a high priority of outcome areas that their national models do not consider a high priority.

- **Local programs had appropriate infrastructures.** They appeared to possess the types of implementation infrastructure that MIECHV explicitly expects of them, including management information systems, continu-

ous quality improvement procedures,[3] and connections to community services in each domain area.

- **Home visitors generally thought they were adequately trained.** The majority of home visitors reported that they were adequately trained and equipped to help mothers improve the full range of outcomes targeted by MIECHV. However, more of them perceived their training and tools to be adequate for outcomes related to child development and parenting than for outcomes related to maternal health and well-being.

Characteristics of Planned Home Visiting Services

This section describes what the four national models and the local programs involved in MIHOPE said about whom they intend to serve, which outcomes they intend to influence, what approaches they intend to take to delivering services, and how they intend to hire staff. The information is based on interviews with and materials from the national model developers and surveys of local program managers.

Intended Recipients

As discussed in Chapter 1, the four national models vary in the extent to which they target pregnant women. The national models also differ in which individuals within the family they aim to serve. Table 5.1 shows the family members for whom the national model developers and local programs report assuming "major responsibility" for improving outcomes.[4] The scope of perceived responsibility is potentially important because programs that assume major responsibility for affecting a greater number of family members may be more comprehensive, but may also be more challenging to implement because of their greater complexity.

[3]"Continuous quality improvement" is a process to ensure programs are systematically improving services and increasing positive outcomes for the families they serve. See FRIENDS National Resource Center for Community-Based Child Abuse Prevention (2014).

[4]The four national models were also asked for whom they expect programs to assume some responsibility. Early Head Start - Home Based Program Option indicated that programs are expected to assume some responsibility for the mother, biological father, other father figure, and subsequent pregnancies. Healthy Families America indicated that programs are expected to assume some responsibility for other father figures, a child's other familial caregivers, a mother's other children, and subsequent pregnancies. Parents as Teachers indicated that programs are expected to assume some responsibility for a mother's other children.

Table 5.1

Individuals Targeted for Improved Outcomes, According to National Models and Local Programs

Major Responsibility Assumed for Individual	National Model Developer				Percentage of Local Programs				
	EHS	HFA	NFP	PAT	EHS	HFA	NFP	PAT	Overall
Child	Yes	Yes	Yes	Yes	100	96	89	84	93
Mother	-	Yes	Yes	Yes	61	88	100	84	84
Biological father	-	Yes	-	Yes	44	21	6	33	26
Other father figure	-	-	-	Yes	22	21	6	26	19
Other familial caregivers	-	-	-	-	22	4	6	22	13
Older children	-	-	-	Yes	11	0	0	11	5
Children born after the enrolled child	-	-	-	-	33	21	22	53	32
Sample size					18	24	19	19	80

SOURCES: Calculations based on data from the MIHOPE national model developer survey and the MIHOPE program manager baseline survey.

NOTE: EHS = Early Head Start - Home Based Program Option, HFA = Healthy Families America, NFP = Nurse-Family Partnership, PAT = Parents as Teachers.

As Table 5.1 shows, all four national models expect programs to assume major responsibility for the unborn or newborn child. Three of the four models also assume major responsibility for the mother (and the fourth assumes some responsibility for the mother, which is not shown in the table). In addition to the mother and child, Healthy Families America and Parents as Teachers also expect their local programs to assume major responsibility for the biological father. Parents as Teachers further expects local programs to assume major responsibility for other father figures and other children in the household (in addition to the unborn or newborn child).

The extent to which local programs' intended beneficiaries match the target populations described in their national models is a potential indicator of how well the national models' intentions are communicated to the local programs. This alignment between national and local offices' intentions may also influence the adequacy of the support available to help local programs achieve their goals. However, it is important to note that other fac-

tors, such as funders or other local organizations and partners, may influence a local program's intended beneficiaries. In general, the local programs were consistent with their national models. Nearly all local programs assumed major responsibility for the unborn or newborn child, most assumed major responsibility for the mother, and few assumed major responsibility for other family members. These results are consistent with prior research, which has found that typically only mothers and children participate in home visits. For example, one study of Healthy Families America found that fathers took part in only about 18 percent of visits, while a study of Early Head Start - Home Based Program Option found that only 17 percent of fathers participated in monthly home visits.[5]

Local programs also tended to vary in a pattern that is consistent with their national models. For example, the Early Head Start national office indicated that its programs are expected to assume some responsibility — but not major responsibility — for the mother, and Early Head Start local programs were the least likely of all MIHOPE programs to report assuming major responsibility for the mother. However, Early Head Start local programs were also the most likely to report major responsibility for the father, even though this was not a priority reported by the national Early Head Start office. Local program managers might have varied in these responses for reasons that are not related to the national models' priorities, reflecting, for example, the needs of the types of families they enroll in their programs, differing interpretations of what it means to assume major responsibility for an individual, and other influences on their programs such as MIECHV, local stakeholders, or other funders.

Goals and Intended Outcomes

As discussed in Chapter 1, both MIECHV and the national model developers may influence the outcomes that local programs emphasize. MIECHV expects states to change an ambitious range of outcomes, and local programs are expected to collect and report outcome data to the state in a number of different areas. At the same time, each of the national models also guides its local programs concerning specific program goals and outcomes, although some leave more discretion to local programs than others. In addition, local funders and other community-based agencies may exert an influence on the priorities of local programs, which may be especially relevant in MIHOPE since MIECHV funding is a relatively small share of local programs' overall funding streams (as described in Chapter 3).

[5]Duggan et al. (2004); Raikes, Summers, and Roggman (2005).

Table 5.2 describes national model developers' and local program managers' priorities for outcomes in some of the domains specified in the MIECHV legislation. The extent to which the national model developers and local program managers agree on their priorities may indicate how clearly local programs will be able to communicate expectations to home visitors and how consistently they can prepare and support home visitors to fulfill these expectations. Clarity and consistency of support for specific outcomes may also affect how home visitors are trained and supported, the services they provide, and the outcomes they achieve.

As Table 5.2 shows, all four national model developers assign high priority (a ranking between 8 and 10 on a scale of 1 to 10) to five outcomes: promoting positive parenting behavior, preventing child abuse and neglect, fostering economic self-sufficiency, encouraging child preventive care, and promoting child development. However, the national model developers differ in how they rank other outcomes. Nurse-Family Partnership assigns high priority to all of the other eight outcomes, while Healthy Families America assigns high priority to all but four outcomes (prenatal health, maternal physical health, family planning and birth spacing,[6] and tobacco use). In comparison, Early Head Start assigns high priority to only one additional outcome (prenatal health). Parents as Teachers is the only national model developer to rank some outcomes as low priority (ranking between 1 and 3): maternal physical health, family planning and birth spacing, and tobacco use.

Despite these differences among the national model developers, a majority of local program managers ranked each outcome as a high priority. However, as was the case with intended recipients, there is some correspondence between the local and national rankings. For example, for four of the five outcomes that were rated high priorities by all national models, 95 percent or more of local programs also ranked them highly, and 83 percent of local programs rated the fifth such outcome (family economic self-sufficiency) as a high priority.

Likewise, where the national models diverge in their ranking of an outcome, there tend to be greater differences among local programs. For example, all local Nurse-Family Partnership programs rated family planning and birth spacing as a high priority, consistent with the national Nurse-Family Partnership rating. Meanwhile only 39 percent of Early Head Start programs and 42 percent of Parents as Teachers programs rated family planning

[6]The aim related to this outcome is to reduce the frequency with which women have another child within two years.

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Table 5.2

Priority Ratings for Intended Outcomes, by National Models and Local Programs

Outcome	National Model Developer Rating[a]				Percentage of Local Programs That Rated Outcome as a High Priority[b]				
	EHS	HFA	NFP	PAT	EHS	HFA	NFP	PAT	Overall
Maternal health and well-being									
Prenatal health	High	Medium	High	High	78	79	95	84	84
Maternal physical health	Medium	Medium	High	Low	47	63	74	63	62
Family planning and birth spacing	Medium	Medium	High	Low	39	79	100	42	66
Tobacco use	Medium	Medium	High	Low	35	78	84	42	62
Mental health and substance use	Medium	High	High	Medium	71	78	100	59	78
Intimate partner violence	Medium	High	High	Medium	67	92	100	61	81
Parenting									
Breastfeeding	Medium	High	High	Medium	72	78	94	58	76
Positive parenting behavior	High	High	High	High	100	92	100	100	97
Child abuse and neglect	High	High	High	High	100	100	100	89	98
Family economic self-sufficiency	High	High	High	High	78	88	89	74	83
Child health and development									
Birth outcomes	Medium	High	High	High	78	83	100	79	85
Child preventive care	High	High	High	High	100	96	95	89	95
Child development	High	High	High	High	100	96	100	95	98
Sample size					18	24	19	19	80

(continued)

Table 5.2 (continued)

SOURCES: Calculations based on data from the MIHOPE national model developer survey and the MIHOPE program manager baseline survey.

NOTES: EHS = Early Head Start - Home Based Program Option, HFA = Healthy Families America, NFP = Nurse-Family Partnership, PAT = Parents as Teachers.

[a]Low = ratings from 0 to 3, medium = ratings from 4 to 7, high = ratings from 8 to 10.

[b]High priority includes ratings of 8, 9, and 10.

and birth spacing as a high priority, consistent with their national model developers' reports that this outcome is a moderate (Early Head Start) or low priority (Parents as Teachers). Similarly, local programs varied along with their national models in how high a priority they made of intimate partner violence.

For particular maternal health outcomes, there appears to be disagreement between the national models and their respective local programs. For example, 59 percent to 71 percent of local Parents as Teachers and Early Head Start programs ranked maternal health and substance use as a high priority, whereas their national model developers ranked this as a moderate priority. Intimate partner violence was ranked as a moderate priority by the Early Head Start and Parents as Teachers model developers, but over 60 percent of local Early Head Start and Parents as Teachers programs rated this as a high priority.

Differences between national models and local programs could suggest that local programs are being tailored to local needs and concerns. These differences may also reflect the influences of MIECHV. As described earlier, local programs are expected to collect information on a number of benchmark indicators that state MIECHV agencies monitor. State agencies, in turn, are expected to show improvements on these indicators across funded programs in their states. State MIECHV administrators developed benchmark-data-collection plans articulating their planned approaches for collecting, analyzing, and reporting data for all constructs within the benchmark areas. State MIECHV administrators were given discretion to develop plans that reflected their programs' and populations' priorities, while adhering to federal and model developer requirements. Many grantees developed data working groups or advisory committees with representatives from local programs and other community organizations and agencies in various disciplines such as education, maternal and child health, child welfare, and law enforcement. These groups enabled grantees to build on the knowledge and expertise of a larger group of stakeholders to ensure that the benchmarks states chose were contextually and culturally appropriate. The groups also

allowed grantees to link benchmark plans with other early childhood programs and initiatives in their states.[7]

The resulting benchmark indicators may go beyond the stated goals and priorities of the national model developers. In some cases, the addition of new priority areas for these established local programs implies that their planned services will grow more complex, meaning they will need to strengthen the training and support they provide to home visitors.

Table 5.3 shows the percentage of local program managers who reported that MIECHV changed how they rank different outcomes. No local program reported that MIECHV reduced the priority of an outcome. Thus, the table shows only whether program managers indicated that MIECHV increased their programs' focus on the outcome. About a third of Early Head Start programs reported raising the priority of various maternal health and well-being outcomes, as well as birth outcomes. Healthy Families America programs also reported increasing their emphasis on maternal health and well-being outcomes, particularly the outcomes of mental health and substance use and intimate partner violence. A small share of Nurse-Family Partnership programs reported raising the priority of outcomes related to mental health and substance use, intimate partner violence, parenting, and child health and development. It appears that local Parents as Teachers programs shifted the most after MIECHV, placing greater emphasis on a number of maternal health and well-being outcomes in particular. For example, more than half of local Parents as Teachers programs reported placing greater emphasis on family planning and birth spacing, tobacco use, and intimate partner violence.

Even if local programs ranked an outcome as a high priority, home visitors are the ones who must translate that priority into their daily work with families. Theories of behavior suggest that home visitors are more likely to help families in the outcome areas they believe they are expected to work on.[8] Table 5.4 displays the percentage of home visitors who agreed or strongly agreed that they were expected to help mothers achieve particular outcomes. The table shows that most home visitors, regardless of national model, believed that their role was to assist mothers with improving a wide range of outcomes. This is consistent with the local program managers' reports described in Table 5.3. For example, between 81 percent and 97 percent of home visitors (depending on the national model) agreed or strongly agreed that they were expected to help mothers have a healthy lifestyle during the

[7]Strader, Counts, and Filene (2013).
[8]Montaño and Kasprzyk (2008); Durlak and DuPre (2008).

Table 5.3

Programs that Raised the Priority of Intended Outcomes as a Result of MIECHV

Outcome (%)	EHS	HFA	NFP	PAT	Overall
Maternal health and well-being					
Prenatal health	33	25	11	47	29
Maternal physical health	39	29	0	32	25
Family planning and birth spacing	33	29	5	53	30
Tobacco use	44	38	0	53	34
Mental health and substance use	33	42	16	47	35
Intimate partner violence	33	50	17	63	42
Parenting					
Breastfeeding	17	21	16	32	21
Positive parenting behavior	0	8	16	17	10
Child abuse and neglect	22	8	0	37	16
Family economic self-sufficiency	11	22	5	21	15
Child health and development					
Birth outcomes	39	17	11	33	24
Child preventive care	0	13	16	22	13
Child development	0	8	5	26	10
Sample size	18	24	19	19	80

SOURCE: Calculations based on data from the MIHOPE program manager baseline survey.

NOTE: EHS = Early Head Start - Home Based Program Option, HFA = Healthy Families America, NFP = Nurse-Family Partnership, PAT = Parents as Teachers.

prenatal period. Nearly all of the home visitors also reported that they were expected to assist mothers with behaviors to improve child health and development. Many also agreed that they were expected to help mothers become economically self-sufficient and gain access to relevant community resources for themselves, their children, or their families.

Although expectations were high across all outcomes, the home visitor sample agreed on some more universally than others. Between 11 percent and 52 percent of home

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Table 5.4

Home Visitors' Perceptions of Their Role, by National Model

Home Visitors Are Expected to Help Mothers...[a] (%)	EHS	HFA	NFP	PAT	Overall
Maternal health and well-being					
Have a healthy lifestyle prenatally	81	91	97	88	90
Develop a healthy lifestyle outside of pregnancy	79	88	91	81	85
Space their births	48	80	89	60	71
Reduce their tobacco use	55	87	88	68	76
Recognize and deal with problem alcohol/other drug use	67	92	90	74	82
Recognize and deal with mental health issues	81	93	90	83	87
Recognize and address intimate partner violence	80	91	91	81	87
Parenting					
Start and continue breastfeeding	62	80	91	69	77
Use positive child behavior-management techniques	89	95	95	93	93
Babyproof their homes	84	95	88	92	90
Family economic self-sufficiency					
Become economically self-sufficient	72	89	91	68	81
Child health and development					
Make sure children are up-to-date on shots and well-child care	93	97	94	92	94
Support their children's cognitive and language development	92	97	96	95	95
Support their children's social and emotional development	92	97	96	95	95
Access to community resources					
Have health care coverage or access to a free or low-cost clinic for themselves	83	75	80	69	76
Secure high-quality child care	66	83	73	78	76
Have health care coverage or access to a free or low-cost clinic for their children	90	87	89	80	86
Get the public benefits for which they qualify	85	91	90	82	87
Sample size	87	130	118	105	440

(continued)

Table 5.4 (continued)

SOURCE: Calculations based on data from the MIHOPE home visitor baseline survey.

NOTES: EHS = Early Head Start - Home Based Program Option, HFA = Healthy Families America, NFP = Nurse-Family Partnership, PAT = Parents as Teachers.

[a]Percentages reflect respondents who reported that they "agreed" or "strongly agreed."

visitors, depending on the national model, did not agree that they were expected to help mothers improve birth spacing. Similarly, 12 percent to 45 percent of home visitors did not agree that they were expected to help mothers reduce their tobacco use.

Intended Service Delivery

The MIECHV authorizing legislation underscored the importance of adhering to a clear and consistent evidence-based home visiting model.[9] Core components of a local program's plans relate to the types and frequency of services that it delivers to clients. While information on actual service delivery is still being collected, it is important to ascertain first what services local programs intend to deliver to improve the family outcomes targeted by MIECHV, including those services' content, amount, and approach. Intended service delivery should influence actual service delivery and is the standard for measuring local programs' fidelity. This section describes programs' plans for service delivery and their alignment with programs' national models, and identifies early patterns of variation among local programs.

Content

Home visits consist of three types of tasks: information gathering, education and support, and referral to other services. Some programs may have formal policies or protocols concerning how to screen for different risks, and may provide explicit guidance on how to proceed when a problem is detected. Other programs may not have formal policies, or may allow home visitors more discretion to make decisions.

Table 5.5 displays the percentage of local programs with explicit policies for information gathering, education and support, and referral and follow-up for five outcome areas related to maternal health and well-being, parenting, and child development. The behavioral

[9]Patient Protection and Affordable Care Act (2010).

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Table 5.5

Local Programs' Policies for Information Gathering, Education and Support, and Referrals

Program Policy (%)	Maternal Mental Health	Maternal Substance Use	Intimate Partner Violence	Parenting Behavior	Developmental Delays
Information gathering					
Formal screening is required[a]	95	72	71	77	99
At a specified time before or after a child's birth or enrollment[b]	91	70	71	77	99
When home visitor or parent has a concern[b]	42	19	22	15	55
Education and support[c]					
Family education and support when screening detects a problem					
Specified in written protocol[b]	35	23	23	26	54
Determined in consultation with supervisor[b]	53	31	34	32	39
Referral[c]					
Role of home visitor in making referral					
Provide information to families	33	49	42	37	27
Help family gain access to the resource	54	43	50	51	68
No policy	13	8	8	12	6
Role of home visitor in following through on referral					
Home visitor expected to monitor	91	90	90	88	92
Home visitor not expected to monitor	0	0	2	0	3
No policy	9	10	8	12	6
Sample size					74

SOURCE: Calculations based on data from the MIHOPE policies and procedures inventory.

NOTES: [a]Possible screening tools included options for many commonly used tools, state- or model-specific tools, and respondent write-in options.

[b]Response categories are not mutually exclusive, so percentages can total more than 100. Within each domain, some sites might use more than one tool and might have different policies for each tool.

[c]Only for local programs where formal screening is required.

outcome areas described in Table 5.5 are assessed here because they reflect either important child outcomes or influences on child outcomes that all models endorse. In addition, identifying the presence of and need for services in these areas requires sensitivity and skill in gathering information and responding to results (in comparison with a more straightforward task such as screening a family for eligibility for a safety-net program). Finally, in each of these outcome areas valid and reliable screening tools exist that home visitors can readily use to identify needs and risks.

Nearly all local programs required formal screening of maternal mental health and infant developmental delays, but only about three-quarters required formal assessment of maternal substance abuse, intimate partner violence, and parenting behavior. This is consistent with the requirements of the national model developers, which all require local programs to conduct developmental screening but vary in their requirements for screening in other areas. Local programs varied somewhat by national model (see Appendix E). While nearly all Nurse-Family Partnership programs required formal screening for maternal substance use (consistent with a national model requirement), only a little over 60 percent of local Early Head Start and Parents as Teachers programs did. Nurse-Family Partnership programs were also more likely to require formal screening for intimate partner violence than the other local programs.

When a local program required a formal screening tool, it usually specified the timing of the screening rather than leaving it to the home visitor's discretion, although some local programs also allowed screening of maternal mental health and developmental delays whenever a home visitor or parent had concerns. This pattern is generally consistent across national models (see Appendix E).

Regarding education and support, all of the national models have requirements regarding programs' responses to screening results. These policies allow local programs to define specific standards and allow for staff members to make judgments regarding appropriate responses.

At the local level, Table 5.5 shows that many programs lacked protocols for education and support in response to positive screening results. About half had such written protocols for responding to developmental delays when they were found. However, only about 20 percent had written protocols for how to respond when a screen detected maternal substance use, intimate partner violence, or poor parenting behavior.

Local programs varied in whether they also required home visitors to consult with supervisors in deciding what to do in response to a positive screening result, perhaps in ad-

dition to having a written protocol. More than half required consultation with regard to maternal mental health. For the other outcomes, only 30 percent to 40 percent of local programs required home visitors to consult with their supervisors, and these proportions are largely the same across national models (see Appendix E).

Turning to referral policies, between 27 percent and 49 percent of local programs reported that home visitors were to provide information when making referrals to address problems revealed by screening, but that it was the family's responsibility to follow through. A greater percentage of local programs reported that home visitors were expected to help families gain access to necessary resources, for example by calling to arrange appointments or monitoring the outcomes of referrals. This pattern is consistent across the five outcome areas examined, with programs most likely to report that they expect home visitors to help families in response to developmental delays. It is also consistent with national model requirements that home visitors monitor families' success in using referrals. However, in each outcome area a handful of local programs had no policy on home visitors' role in making and following through on referrals.

Dosage

The number of home visits, or "dosage," that families are meant to receive is one aspect of service delivery for which all the national models provide guidance to their local affiliates. The national models vary in how they specify the duration and frequency of home visiting services. Home visits can last a minimum of 60 minutes (Parents as Teachers) to a minimum of 90 minutes (Early Head Start). All models establish either a minimum number of home visits per year or vary visits depending on the time since a family's enrollment or a child's age. Services can begin as early as pregnancy for all models, and depending on the model can be delivered until a child reaches age 2 (for Nurse-Family Partnership) to as much as age 5 (Healthy Families America). Local programs operating Healthy Families America and Parents as Teachers determine the length and intensity of services based on family need, and Nurse-Family Partnership allows for adjustment of visit schedules to meet client needs. Nearly all local programs aligned with their national models in defining intended service initiation, duration, visit length, and visit frequency. For example, 89 percent of local programs reported that they had the same preference for visit length as their national model developers (results not shown).

Approach

It is clear that improving parenting and early child development are primary goals for all four national models. The approaches that home visitors use in their daily work with families are likely to influence their ability to achieve these goals. For example, a recent meta-analysis found that when parent training programs encourage parents to practice newly developed skills or techniques with their own children during program sessions, they produce significantly larger impacts on parenting behavior and child acting-out behaviors.[10] Table 5.6 therefore summarizes national and local approaches to specific parent-training techniques and supportive strategies including problem solving, modeling, and education.

The table shows that all of the national models encourage home visitors to observe and provide parents with both positive and constructive feedback on their interactions with their children, and all of the national models encourage home visitors to use at least one supportive strategy such as goal setting, problem solving, or emotional support. In other respects, however, the national models differ. For example, both Healthy Families America and Parents as Teachers discourage home visitors from modeling (demonstrating) positive parenting practices, while Early Head Start and Nurse-Family Partnership encourage them to.[11] While Early Head Start, Healthy Families America, and Nurse-Family Partnership encourage home visitors to facilitate and guide parent-child activities, Parents as Teachers discourages this practice.

In contrast to their national models, most local programs across all national models reported that they encouraged the use of every technique shown in Table 5.6. The most prominent exception is that only 24 percent of local Nurse-Family Partnership programs encouraged home visitors to direct parent-child activities, even though the national model developer encourages this technique.

Intended Staffing

In order to provide high-quality services to families, programs must be adequately staffed. Two indicators of intended staffing include supervisor caseloads of home visitors and home visitor caseloads of families. Caseloads are important because they have been shown to be related to staff burnout and service quality.[12]

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[10]Kaminski, Valle, Filene, and Boyle (2008).

[11]Healthy Families America discourages this behavior to avoid potentially traumatizing or disempowering a parent who may not yet be able to get the same reaction from an infant as a home visitor.

[12]Gillespie and Cohen (1984).

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Table 5.6

Parent Training Techniques and Supportive Strategies Encouraged by National Models and Local Programs

Technique or Strategy	National Model Developer[a]				Percentage of Local Programs That Encouraged Technique				
	EHS	HFA	NFP	PAT	EHS	HFA	NFP	PAT	Overall
Parent training techniques									
Demonstrating positive parenting practices	E	D	E	D	94	96	89	100	95
Directing parent-child activities	E	E	E	D	61	96	24	89	70
Observing and giving positive feedback on parent-child interaction	E	E	E	E	100	100	100	100	100
Observing and giving constructive feedback on parent-child interaction (noting ways parent could improve his or her behavior)	E	E	E	E	78	96	68	100	86
Playing with child/direct interaction with child	E	N	E	N	67	88	58	67	71
Supportive strategies									
Caregiver goal setting	E	E	E	E	94	100	100	100	99
Caregiver problem solving	E	E	E	E	94	100	100	100	99
Crisis intervention	E	E	E	N	78	83	79	95	84
Emotional support	E	E	E	E	94	100	95	95	96
Sample size					18	24	19	19	80

SOURCES: Calculations based on data from the MIHOPE national model developer survey and the MIHOPE program manager baseline survey.

NOTES: EHS = Early Head Start - Home Based Program Option, HFA = Healthy Families America, NFP = Nurse-Family Partnership, PAT = Parents as Teachers.

[a]E = encouraged, D = discouraged, N = neither encouraged nor discouraged.

The national models vary in whether and how they specify limits for home visitor and family caseloads. Early Head Start does not have a policy specifying the number of home visitors a supervisor is to oversee. The other three models specify caseloads ranging from 6 (Healthy Families America) to 8 (Nurse-Family Partnership) to 12 (Parents as Teachers) home visitors per supervisor. Early Head Start and Nurse-Family Partnership

have set family caseload limits for home visitors: Early Head Start specifies 12 families per home visitor and Nurse-Family Partnership specifies 25 families per home visitor. Healthy Families America and Parents as Teachers have more nuanced caseload limits. For example, Healthy Families America takes the frequency of visits into consideration when determining caseload size and Parents as Teachers sets different goals for numbers of home visits depending on the home visitor's years of experience and on whether or not the home visitor is working full time.

Most local programs have the same policies as their national models for the maximum number of home visitors a supervisor is expected to oversee (see Appendix E). As for number of families per home visitor, about 40 percent of local programs set their caseload limits lower than their national models, and about 60 percent of programs have caseload policies that are the same as the maximums specified by their national model developers.

Characteristics of Implementation Systems

Local programs' implementation systems consist of the infrastructure they have in place to prepare, enable, and reinforce staff members in carrying out their roles. The implementation system is the critical link between the local program's planned and actual service delivery. It includes system support, administrative support, staff recruitment, staff development, and clinical support.

System Support: Links and Referrals to Community Resources

MIECHV emphasizes home visiting's role as part of a larger early childhood system of care, specifically its role in improving coordination with and referrals to other community resources. Home visiting programs must work with other organizations to identify and reach eligible families and to connect enrolled families with services they need. It is possible that local programs with strong ties to other services may be more likely to get referrals from those organizations to help them fill available slots and enroll families likely to benefit from home visiting. Similarly, local programs with strong ties to community resources may be more successful at linking families to these services in order to improve outcomes.

One sign that a home visiting program has strong relationships with other local organizations is if it has formal referral agreements with them (memoranda of understanding, for example). Table 5.7 presents the percentage of local programs that have formal

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Table 5.7

Formal Agreements with Referral Sources for the Recruitment of Families Across Local Programs

	Local Programs with Formal Referral Agreements[a]				
Referral Partner (%)	EHS	HFA	NFP	PAT	Overall
Any organization	72	79	47	63	66
Centralized intake	33	63	16	56	43
Maternal health and well-being					
Hospitals	11	38	11	22	22
Health departments	28	13	5	22	16
Prenatal clinics	22	13	21	17	18
Parenting					
Child welfare agencies	39	17	16	6	19
Family economic self-sufficiency					
WIC programs	28	38	16	22	27
Schools	33	21	5	22	20
Child health and development					
Pediatric clinics	28	8	5	6	11
Other[b]	17	4	16	0	9
Sample size	18	24	19	19	80

SOURCE: Calculations based on data from the MIHOPE program manager baseline survey.

NOTES: EHS = Early Head Start - Home Based Program Option, HFA = Healthy Families America, NFP = Nurse-Family Partnership, PAT = Parents as Teachers.

[a]Response categories are not mutually exclusive so percentages might total more than 100.

[b]Includes children and youth services, early intervention services, homeless services, juvenile delinquent halls, residential drug treatment programs, domestic violence shelters, and nonprofit community partners.

referral agreements with a range of local organizations that commonly refer families to home visiting programs. Overall, two-thirds of local programs have such agreements. Local programs without formal referral agreements may have informal arrangements for referrals or rely on other methods of recruitment such as direct outreach and walk-ins, although MIHOPE does not have systematic data on this. Healthy Families America programs were most likely to have written referral agreements; this may be due in part to the high percentage that reported having formal agreements with centralized intake systems. In many com-

munities, a centralized intake system allows referrals to flow through one agency and then be assigned to the most appropriate service provider. More than half of Parents as Teachers programs also had formal arrangements with a centralized intake system.

Aside from centralized intake systems, local programs had low rates of formal agreements with referral sources, ranging from the 27 percent that had formal agreements with Women, Infants, and Children (WIC) programs to the 11 percent that had formal agreements with pediatric clinics.

Home visiting programs do not assume that they can meet all of their clients' needs, so they depend on strong ties with other community providers for additional services. To assess the availability of services, local programs were asked to identify at least one provider to which they referred families for each of nine services relevant for MIECHV outcomes: prenatal care, family planning and reproductive health, substance use and mental health treatment, shelter from intimate partner violence, intimate partner violence counseling, adult education or employment services, pediatric primary care, child care, and early intervention services for babies and toddlers with developmental delays and disabilities. Nearly all local programs could identify at least one community resource to which they could refer enrolled families for each of the nine services. While this finding is encouraging, the existence of a service is just one indicator of its actual availability to the clients of the home visiting programs; future reports will use additional measures to assess these services' accessibility.

Administrative Support

MIECHV emphasizes that it is important for states to build the administrative support structures programs need to help them deliver intended services — management information systems, for example. It also calls for states to engage in continuous quality improvement — which includes practices to collect information used to monitor and provide feedback on program performance — and stipulates that training and technical assistance for these activities should be provided. Administrative support should promote fidelity in helping local programs carry out activities. For example, a program with a management information system to document and monitor service delivery might be more likely to deliver services successfully.

Table 5.8 describes the availability and use of three types of administrative support: management information systems, program monitoring, and continuous quality improvement activities. Overall, nearly all local programs reported using a management

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Table 5.8

Data Management, Program Monitoring, and Continuous Quality Improvement Across Local Programs

Activity	Percentage of Local Programs
Data management	
Management information system (MIS) in place	99
Use of MIS for program monitoring and quality improvement	93
Staff to assist with service-delivery data entry	72
Program monitoring	
Annual or biannual reporting on local program performance	84
Monitoring of selected aspects of operations[a]	
Referrals into program	
Number of referrals	98
Appropriateness of referrals	75
Family enrollment	
Family retention rates at specific points	84
Reasons families drop out	89
Visits	
Visit frequency	99
Visit length	71
Mother no-show rates	68
Screening	
Maternal depression	76
Maternal substance use	54
Intimate partner violence	59
Child development	95
Continuous Quality Improvement (CQI)	
One or more CQI activities in the past 12 months	84
Staff members with dedicated time for CQI	62
Sample size	80

SOURCE: Calculations based on data from the MIHOPE program manager baseline survey.

NOTE: [a]Response categories are not mutually exclusive so percentages might total more than 100.

information system. In fact, over a quarter used more than one such system (not shown in the table), which might include both national and local systems. Similarly, nearly all local programs used their systems for internal program monitoring and quality improvement. Nearly three-quarters of local programs reported having designated staff members to assist with data entry.

Overall, the majority of local programs reported that they monitored many types of activities, but they varied in the scope of activities they monitored. Nearly all monitored the number of referrals they received, and most monitored the appropriateness of these referrals. Nearly all monitored retention rates, the reasons families dropped out, and visit frequency, while a substantial majority monitored visit length and the frequency with which mothers failed to attend scheduled home visits

Local programs did vary in their monitoring of screening rates — not surprising, given how much variation there was among them in the type of screening they conducted. Nearly all monitored child-development screening rates, while a majority monitored screening rates for maternal depression, domestic violence, and maternal substance use. This pattern seems to be consistent with the priority given to these outcomes by the MIECHV benchmarks, national models, local program managers, and home visitors. Activities to improve the highest-priority outcomes (in this case, child development) were more likely to be monitored and have adequate administrative support.

Turning to continuous quality improvement, over 80 percent of local programs reported that they had undertaken such activities in the previous year. In addition, over 60 percent of local programs reported having a staff person with dedicated time to design and direct these activities, to collect information on them, and to analyze that information.

Clinical Support

Clinical support includes access to expert consultants as well as tools and strategies for providing services effectively. One key question related to clinical support is whether home visitors have access to expert consultants to help them address issues or situations beyond their skills and expertise. Prior work has found that consultative expertise in content areas is associated with stronger program implementation.[13] In a home visiting program, a

[13]Fixsen et al. (2005).

Table 5.9

Availability of Consultants by Service Area Across Local Programs

Consultant Service Area (%)	Local Programs with Available Consultants				
	EHS	HFA	NFP	PAT	Overall
Any	100	63	79	53	73
Maternal health and well-being					
Prenatal health	94	63	74	53	70
Maternal physical health	94	63	74	53	70
Substance use	89	54	74	47	65
Stress and mental health	100	58	79	53	71
Healthy adult relationships	89	63	68	53	68
Family economic self-sufficiency	83	58	74	53	66
Child health and development					
Parenting to support child development	94	63	68	53	69
Parenting to support child health	94	58	74	53	69
Sample size	18	24	19	19	80

SOURCE: Calculations based on data from the MIHOPE program manager baseline survey.

NOTE: EHS = Early Head Start - Home Based Program Option, HFA = Healthy Families America, NFP = Nurse-Family Partnership, PAT = Parents as Teachers.

consultant is typically a trained professional within or outside the local program's implementing agency who advises the home visitor about her work with individual families, although in some cases a consultant may go with a home visitor to a client's home.

Table 5.9 describes the availability of consultants across MIECHV outcome domains for local programs in each national model. Overall, most local programs reported access to expert consultants, and at least two-thirds reported providing access to consultants for each outcome domain. This varies considerably by national model, however. All Early Head Start local programs reported having access to at least one professional consultant and more than 80 percent of Early Head Start programs had access to consultants in each domain. This may be because most Early Head Start programs are based in large Head Start agencies, which typically employ other professionals including nurses and

mental health counselors. In contrast, nearly half of Parents as Teachers programs did not have access to any consultants.

It is important to understand not only whether program managers believe that they have made clinical support available (as shown in Table 5.9), but also to get a sense of how home visitors perceive the value of this support, as well as the value of other strategies and tools provided by the program. Table 5.10 shows the percentages of home visitors who agreed or strongly agreed that their local programs provided useful strategies and tools to assist them in helping mothers achieve intended outcomes.

Among home visitors who reported that they were expected to assist mothers with particular outcomes, most agreed that their programs provided them useful strategies and tools to help mothers in those areas. However, in the areas of recognizing and dealing with problem substance use and mental health, about a quarter of home visitors (27 percent and 23 percent, respectively) did not agree that their programs provided them with useful strategies and tools to help mothers. More home visitors reported that their programs had useful strategies and tools to help them promote child health and development than outcomes in any other area, which is consistent with other results in this chapter relating to programs' attention to this domain.

Staff Development

Each of the national models has specific approaches to initial and continuing training for its home visitors. Healthy Families America home visitors are required to receive orientation training prior to providing any services to families; role-specific core training within 6 months of being hired; continuing training within 3, 6, and 12 months of being hired; and annual training thereafter. All Early Head Start home visitors receive orientation training that focuses on the goals, philosophy, and implementation of the model. All home visitors are required to receive a minimum of 15 hours of continuing training, and are required to receive training in the curriculum and assessments used by the program. Parents as Teachers home visitors are required to attend a three-day foundational training course and a two-day model implementation training course prior to serving families. In addition, Parents as Teachers home visitors are required to complete 20 hours of professional development within one year of completing the model training, 15 hours during their second year, and 10 hours in their third and subsequent years. Nurse-Family Partnership home visitors are required to attend a self-directed training session and four days of in-person training prior to serving families. In addition, they must complete three online lessons within 6 months of the in-person training.

Table 5.10

Home Visitors' Perceptions of the Usefulness of Their Programs' Strategies and Tools and the Adequacy of Their Training

Home Visitor Perception (%)	"Local Program Has Useful Strategies and Tools to Help Mothers…"[a]	"Home Visitors Are Adequately Trained to Help Mothers…"[a]
Maternal health and well-being		
Have a healthy lifestyle prenatally	91	90
Develop a healthy lifestyle outside of pregnancy	89	89
Space their births	82	84
Reduce their tobacco use	82	77
Recognize and deal with problem alcohol or other drug use	73	69
Recognize and deal with mental health issues	77	73
Recognize and address intimate partner violence	79	77
Parenting		
Start and continue breastfeeding	90	89
Use positive child behavior management techniques	91	90
Babyproof their homes	89	91

(continued)

Table 5.10 (continued)

Home Visitor Perception (%)	"Local Program Has Useful Strategies and Tools to Help Mothers…"[a]	"Home Visitors Are Adequately Trained to Help Mothers…"[a]
Family economic self-sufficiency		
Become economically self-sufficient	81	79
Child health and development		
Make sure children are up-to-date on shots and well-child care	92	94
Support their children's cognitive and language development	95	93
Support their children's social and emotional development	95	93
Access to community resources		
Have health care coverage or access to a free or low-cost clinic for themselves	92	73
Secure high-quality child care	82	85
Have health care coverage or access to a free or low-cost clinic for their children	92	72
Get the public benefits for which they qualify	82	79
Sample size	NA[b]	NA[b]

SOURCE: Calculations based on data from the MIHOPE baseline home visitor survey.

NOTES: [a]Home visitors included are only those expected to help mothers with each activity. Percentages reflect respondents who reported that they "agreed" or "strongly agreed."

[b]NA = not applicable. Sample size varies for each variable. The percentage of home visitors expected to help mothers with each activity is shown in Table 5.4.

But requirements related to training do not reveal whether the training is helpful to home visitors, who must apply what they learn to meet both program and family goals. Table 5.10 presents the percentages of home visitors who agreed or strongly agreed that they had received adequate training to carry out their roles in helping mothers achieve particular outcomes. Among the home visitors who reported that they were expected to help mothers improve each outcome, a substantial majority felt they were adequately trained to help mothers in that area. Although the majority felt adequately trained to improve the wide range of outcomes related to maternal health and well-being and to help mothers with their children's health and development, about 30 percent of home visitors did not feel adequately trained to recognize and deal with substance use and mental health problems.

Conclusion

The results presented here suggest that local programs are setting up their MIECHV-funded home visiting programs in ways that are broadly consistent with expectations laid out in the legislation that created MIECHV, and that MIECHV is influencing how local programs set their priorities. Local programs have increased the priority of some outcomes identified as important in the MIECHV legislation, and are conducting the types of activities endorsed by the legislation, monitoring them in the ways it envisioned, and ensuring clinical support and training as it directed.

Each national model developer also exerts substantial influence over local programs: Local programs' reported priorities for family outcomes and approaches to service delivery tend to differ depending on the national model that they are implementing.

Across outcome domains, this chapter finds that the national models, local programs, and local staff members give the highest priority and the most support to activities related to child health and development and promoting positive parenting. There is more variation in the emphasis they place on activities related to maternal health and well-being; some outcome areas (for example, birth spacing, maternal physical health, tobacco use, and maternal mental health) are not uniformly ranked as a high priority by the national models or the local programs. Perhaps reflecting these differing priorities, fewer home visiting staff members report that they are expected to influence these outcomes than the outcomes related to child health and development and parenting, or report that they feel adequately trained or supported to influence them.

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Chapter 6

Discussion

This report to Congress provides an analysis of the states' needs assessments and initial plans for implementing home visiting programs funded under MIECHV. It also presents information available to date on the families, staff members, local programs, and national models participating in the Mother and Infant Home Visiting Program Evaluation (MIHOPE) and lays the foundation for future reports on the impacts and implementation of home visiting programs in MIHOPE. This chapter summarizes the report from these two perspectives.

Summary of Findings

The findings provide an early indication that MIECHV is being implemented in ways that support its intended goals. First, states developed plans to spend MIECHV funds in at-risk communities, as intended. They targeted counties with higher rates of poverty and child maltreatment than their respective averages, and with somewhat higher rates of premature birth. These differences are important because among MIECHV's stated goals are increasing family economic well-being, reducing child maltreatment, and improving birth outcomes.

In their initial plans, states indicated they would use MIECHV funds to support six evidence-based national models: Healthy Steps and Home Instruction for Parents of Preschool Youngsters plus the four studied in MIHOPE: Early Head Start - Home Based Program Option, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. Of the 554 counties identified in initial state plans as recipients of MIECHV funds, 94 percent were implementing or planning to implement one of the four evidence-based models included in MIHOPE. These included 49 counties with Early Head Start programs, 177 local Healthy Families America programs, 169 local Nurse-Family Partnership programs, and 123 local Parents as Teachers programs.

Interviews with MIECHV administrators in the 12 MIHOPE states reveal that they used the needs assessments to decide which communities to target and used research evidence from the Home Visiting Evidence of Effectiveness review to decide which evidence-based models to fund. Once these decisions were made, state administrators often

deferred to local programs and the national models to set priorities among families at the community level.

MIHOPE sought to enroll about 85 local MIECHV-funded home visiting programs. States were required to participate if chosen and were expected to pass this mandate on to MIECHV-funded programs, but not every MIECHV-funded program was considered for the study. First, the study included only programs that had been in operation for two or more years in order to focus on those that had had a chance to mature to full effectiveness. Second, to conserve resources and to allow for the ethical creation of a control group, MIHOPE sought local programs that could contribute 40 or more families to the study over a period of about 18 months. Because programs in small communities often had difficulty meeting these two criteria, most MIHOPE sites are in metropolitan areas. Finally, to allow the study to separate the effects of geography from the effects of program models, MIHOPE sought to include states that used MIECHV funds to expand at least two of the four national models selected by at least 10 states. This criterion excluded most states. Taken together, therefore, the local programs included in MIHOPE are more urban and more mature than the full set of programs listed in the initial state plans. However, the 12 MIHOPE states include some of the largest states in the country and did receive about a third of all MIECHV funds, so they are indicative of a large number of MIECHV-funded programs.

Even if they are not completely representative of MIECHV programs nationally, the local programs included in MIHOPE serve a very disadvantaged group of mothers. When they entered the study, more than 30 percent had symptoms of depression; almost 20 percent had health problems that limited their activities; most were receiving some form of public assistance from sources such as the Supplemental Nutritional Assistance Program, Temporary Assistance for Needy Families, or disability benefits; more than three-quarters had no more than a high school diploma; and about a tenth had been the victim of intimate partner violence. Of babies born to mothers prior to entering the study, about 10 percent were born prematurely and nearly 11 percent had low birth weights. MIHOPE should therefore provide a good test of how these models affect the families the authorizing legislation aimed to reach.

Fortunately, MIECHV-funded programs are designed to be able to help families overcome the multiple and severe problems they face. Home visitors reported that they were expected to help families achieve better outcomes in all the areas specified in the authorizing legislation and to overcome a large number of risk factors. Home visitors also mostly reported that they were well trained and supported in helping families address a wide range of issues. In addition, local programs reported making a high priority of out-

comes in the domains mentioned in the legislation. The final report from the implementation study will provide information on the frequency and content of training and supervision for home visitors, the amounts and types of services provided to individual families in the study, the ways services vary for families with different risk factors, and the implementation factors related to stronger service delivery at the local level.

Implications for Future Reports

In addition to providing the first glimpse of how MIECHV is being implemented by states and local home visiting programs, this report lays the groundwork for future MIHOPE analyses. In the coming years, MIHOPE plans to draw on additional data to issue findings in three areas: (1) local program implementation (including the costs of operating the programs), (2) the estimated effects of home visiting programs in each domain specified in the authorizing legislation, and (3) the features of local programs that are associated with larger or smaller effects for families.

The characteristics of the families in the study shed some light on which subgroups could be reliably examined. Of the high-priority groups listed in the legislation that created MIECHV, MIHOPE is well positioned to learn about low-income families, which are the target of all four national models; pregnant women under age 21, who make up 37 percent of the MIHOPE sample so far; substance users (33 percent); and families where tobacco is used (36 percent).[1] MIHOPE will also be able to address additional questions concerning whom the programs benefit. For example, it will be able to address how program services and effects vary with mothers' depressive symptoms, whether programs are more effective if women enroll earlier in pregnancy, and how services vary by national model.

Chapter 5 also presents several contrasts in program implementation that can be explored in future analyses, including the extent to which programs focus services on different outcomes and the impacts they achieve, differences among the national models, and differences between the goals articulated by national model developers and the actual implementation plans of local programs. Here are some examples of hypotheses generated by these contrasts:

[1]The percentage relating to tobacco use includes women who reported using tobacco within the previous two years and those who reported permitting smoking in the home. The percentage relating to substance use includes women who reported using illegal drugs or binge drinking shortly before pregnancy.

- Do programs provide families with services aimed at achieving the outcomes identified in the authorizing legislation? This report indicated that local programs have modified their goals to address outcomes specified by the MIECHV authorizing legislation and that they have infrastructure in place to help families achieve these outcomes. However, the current report cannot provide information on whether these goals and infrastructure lead to services that are appropriate for the particular families being served. A future MIHOPE report on program implementation will explore that issue.

- Do families benefit more when home visiting programs make a high priority of a wide range of outcomes, or when they focus on a narrower set of outcomes? All four national models indicated that they give the highest priority to five outcome domains: positive parenting practices, child abuse and neglect, economic self-sufficiency, child preventive care, and child development. Both Nurse-Family Partnership and Healthy Families America consider several other areas to be high priorities as well. In contrast, the national Early Head Start and Parents as Teachers offices placed less emphasis on maternal health (other than prenatal care), health behaviors such as smoking, and some other outcomes. To the extent that the national models can help local programs achieve all of their goals, impacts for Nurse-Family Partnership and Healthy Families America should be spread widely across outcome domains. In comparison, the more focused approach advocated by Early Head Start and Parents as Teachers nationally may allow local programs running those models to put more resources into parenting and child outcomes, resulting in larger effects in those areas than are achieved by programs running Nurse-Family Partnership and Healthy Families America.

- Does allowing local sites discretion in whom they serve and how they provide services result in more or less effective local programs? Nurse-Family Partnership's national office provides precise guidance to local programs on whom they should enroll, the qualifications home visitors should have, and the curricula they should use, and it closely monitors the programs to make sure they comply with model requirements. In contrast, Early Head Start, Healthy Families America, and Parents as Teachers all allow local programs more discretion in whom they serve and how they

provide services. MIHOPE will explore whether programs with more discretion are better able to adapt to the needs of the families they serve (thus producing larger benefits to families) or whether they provide more widely variable services because staff members are not given either the clear guidance or the tools to support their work they might receive under a more prescriptive model.

This report indicates that MIECHV-funded home visiting programs serve a disadvantaged but varied group of families using service delivery strategies that also vary across programs. MIHOPE will aim to shed light on questions regarding the relationships among family risk factors, service delivery strategies, program costs, and program impacts. In so doing, the study will build on its rigorous research design to provide lessons for the MIECHV program and the home visiting field as they continue to look for new ways to improve outcomes for children and families in disadvantaged communities across the country.

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Appendix A

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessments

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The following tables present information on the home visiting programs operating prior to MIECHV, as identified by the states in their needs assessments.[1] In a few cases where information needed to complete the table was not included in the needs assessments, that information was drawn from the state plans or the first round of competitive grant applications. States were inconsistent in how they identified home visiting programs: Some states named home visiting models, while others named the organizations implementing the programs. Collectively, these are referred to as "state-identified programs."

States also varied widely in the information they provided about the programs they identified. When available, the tables include information reported in the needs assessments on the following program characteristics:

- **Model:** This row provides the name of the model(s) used by state-identified programs. The model in use was sometimes difficult to infer from a needs assessment, as many state-identified programs used local and homegrown approaches or did not specify a model. For these reasons, models included in this table are limited to the 35 that were reviewed by the Department of Health and Human Services Home Visiting Evidence of Effectiveness (HomVEE) project as of April 2014.[2] The table summarizes information as the needs assessments reported it; therefore, these programs may not have been accredited sites. If a state-identified program did not report using one of the models reviewed by HomVEE, that state-identified program's name is included in Appendix Table B.1.

- **Target population:** This row describes the populations that state-identified programs intended to serve. The information included is often taken directly from the needs assessments, repeating the language used in the assessments to describe target populations as much as possible, and therefore varies from state to state.

- **Number served:** This row presents the numbers served by the state-identified programs.

- **Counties (or communities) served:** This row presents the numbers of counties or communities served by the state-identified programs. When a

[1] "State" is used as shorthand to refer to all states, territories, and the District of Columbia, all of which are included in the analysis.

[2] A full list of these models is available here: http://homvee.acf.hhs.gov/programs.aspx.

state reported that target communities or counties were among the areas served, a footnote to that effect is included.

Some states provided information on a large number of programs, and in such cases the table typically shows information only for the 10 programs reported to be serving the most families.

These tables should not be considered comprehensive summaries of available home visiting programs in states prior to MIECHV. Many states acknowledged in their needs assessments that they were limited to reporting on a subset of all the home visiting programs operating within their borders because they could not get the required information from all programs or were not aware of all programs.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.1

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Alabama

Program Characteristic	State-Identified Programs			
	Home Instruction for Parents of Preschool Youngsters	Parents as Teachers	Nurse-Family Partnership	Healthy Families America
Model[a]	Home Instruction for Parents of Preschool Youngsters	Parents as Teachers	Nurse-Family Partnership	Healthy Families America
Target population	Parents of 3-, 4-, or 5-year-old educationally and financially at-risk children	Infants and young children (birth to 5 years) and their parents	Low-income pregnant first-time mothers	Overburdened families who are at risk for child abuse and neglect and other adverse childhood experiences
Number served	1,512 families with 1,601 children[b]	1,069 individuals[c]	100 individuals[d]	76 individuals[d]
Counties served[e]	26[f]	—[g]	1	1

SOURCE: Alabama 2010 MIECHV needs assessment.

NOTES: [a]Models were included in this row if they had been evaluated by the HomVEE project as of April 2014.
[b]These numbers come from program year 2008-2009.
[c]This number comes from the 2009-2010 annual report.
[d]These numbers come from 2009.
[e]The number of counties served was not available for all state-identified programs.
[f]Counties served include the target counties of Dallas, Barbour, Macon, Perry, Conecuh, Lowndes, and Tuscaloosa.
[g]Counties served include the target county of Chambers.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.2

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Alaska

	State-Identified Programs				
Program Characteristic	The Nutaqsiivik Program	Parents as Teachers	Early Head Start Home-Based	New Parent Support Program	Fairbanks Public Health Nursing, Family Health Team
Model[a]	—	Parents as Teachers	Early Head Start - Home Based Program Option	—	—
Target population[b]	Alaska Native or American Indian women who are pregnant, of high social risk, or first-time mothers	Families through pregnancy to age 3, or until child enters kindergarten. Half of the programs target high-risk communities.	—	Military families who are expecting a child or who have children up to 3 years of age (5 years of age for the Marine Corps)	Resident of the Fairbanks North Star Borough; pregnant, or family with children ages 0-5; unable to access equivalent care from another provider; could benefit from services within the scope of Public Health Nursing practice
Number served[c]	59,360 individuals, including 23,454 individuals under age 21[d]	1,130 families, 1,335 children[e]	417 children[f]	—	—
Geographic areas served[g]	—[h]	—[h]	—[h]	—[h]	—

(continued)

Appendix Table A.2 (continued)

SOURCE: Alaska 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]Information on the target population was not available for some state-identified programs.

[c]The number served was not available for some state-identified programs.

[d]The time period for this number is not specified.

[e]These numbers come from 2009-2010.

[f]These numbers come from 2008-2009.

[g]The Alaska needs assessment reported various geographic areas that were served by the state-identified programs. Since the unit of area differed for the different programs, numbers of geographic areas were not reported.

[h]Geographic areas served include the target community of Anchorage.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.3

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Arizona

Program Characteristics	State-Identified Programs					
	Bright Start	Choices for Families	Early Head Start	Family and Child Education Program	Health Start	Healthy FamiliesAz
Model[a]	—	—	Early Head Start - Home Based Program Option	—	—	Healthy Families America
Target population	Families with children ages birth to 5	Pregnant and parenting families with children ages birth through 5	Low-income, pregnant women, infants, and toddlers	American Indian parents and their children ages birth to 5, and children in grades K-3	Pregnant and postpartum women and their families	At-risk prenatal families and families with children ages birth through 5; child must be under 3 months of age at time of enrollment
Number served[b]	287 families[c]	1,162 clients[d]	1,527 children and pregnant women[e]	—	Over 2,000 pregnant women and young children[c]	4,417 families[f] (1,019 prenatal families)
Counties served[g]	3	4	15[h]	—[i]	11[j]	15[h]

(continued)

Appendix Table A.3 (continued)

Program Characteristics	State-Identified Programs				
	Healthy Steps	ADHS High-Risk Perinatal Program	Nurse-Family Partnership	Parents as Teachers	Fort Huachuca Parents as Teachers Heroes at Home
Model[a]	Healthy Steps	—	Nurse-Family Partnership	Parents as Teachers	Parents as Teachers
Target population	Children ages birth through 3	Families of infants recently discharged from the Neonatal Intensive Care Unit (NICU)	Low-income women in their first pregnancies	Prenatal through age 5 with a special focus on underserved populations, families in geographically isolated areas, and families with children who have special health care needs	Military families with children up to entry into kindergarten
Number served[b]	440 children[k]	Approximately 5,000 infants and their families[k]	1,760 women[k]	—	81 families[f]
Counties served[g]	3[l]	14[h]	3[m]	—	1

(continued)

Appendix Table A.3 (continued)

SOURCES: Arizona 2010 MIECHV needs assessment and FY 2011 state plan.

NOTES: Additional home visiting programs were named in the Arizona needs assessment. This table was limited to the programs for which information on program characteristics was provided.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The number served was not available for some state-identified programs.

[c]The time period for this number is not specified.

[d]This number is from FY 2010.

[e]This number is from 2008-2009 reporting year and represents children and pregnant women served.

[f]This number is from 2009.

[g]The number of counties served was not available for all state-identified programs.

[h]Counties served include all target communities.

[i]The Family and Child Education Program is supported by the White Mountain Apache Nation, the Gila River Indian Community, the Salt River Pima Indian Community, the Navajo Nation, and the Hopi Nation. Counties served include the target community of White Mountain Apache.

[j]Specific counties served were not provided.

[k]This number is from 2010.

[l]Counties served include the target communities of Holbrook, Winslow, and White Mountain Apache.

[m]Counties served include the target communities of Tucson Central, Tucson North Central, Tucson South East, Tucson East Central, and Tucson South West.

Appendix Table A.4

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Arkansas

	State-Identified Programs							
Program Characteristic	Maternal-Infant Program	Following Baby Back Home	Access, Inc.	Arkansas River Education Service Cooperative	Jefferson Comprehensive Care System Parents as Teachers	Easter Seals of Arkansas	Families and Children Together, Inc. Homebase Program	Children's Trust Fund/ Centers for Youth and Families
Model[a]	—	—	—	Parents as Teachers	Parents as Teachers	—	—	Healthy Families America
Target population[b]	Pregnant woman or new mothers and infants (<6 weeks old); adolescent mothers most frequently	Neonatal Intensive Care Unit (NICU) "graduates" and families	Pregnant and parenting adolescents ages 14-19 and their children ages 0-3 years	Pregnant adolescents, single parents, first-time parents, low-income families, and parents with a history of substance abuse	Pregnant/ parenting women age ≥16 and their children ages 0-2 years	High-risk infants and children ages 0-3 years old (developmental disabilities, preterm infants, failure to thrive)	Pregnant and parenting women ages 16 or younger and their children ages 0-2 years	—
Number served[c]	—	—	—	—	—	—	—	—
Counties served[d]	—	34[e]	—	—	—	—	—	29[f]

(continued)

Appendix Table A.4 (continued)

SOURCE: Arkansas 2010 MIECHV needs assessment and first-round competitive grant application.

NOTES: The programs presented in this table are from the Arkansas needs assessment, which only provided detailed information on the home visiting programs operating in the target counties identified therein: Lee, St. Francis, Jefferson, Crittenden, Phillips, Mississippi, Union, Monroe, and Woodruff counties. The Arkansas needs assessment also presented aggregate data on 31 home visiting programs in the state that participated in the Arkansas Home Visiting Network survey. The majority of programs (51.6 percent) used the Parents as Teachers model. The target populations of these programs were prenatal (70.0 percent), children ages 0-3 (90.0 percent), and children ages 3-5 (56.7 percent). The most common eligibility criteria for enrollment were the age of the mother, family income level, and other (which took in groups including first-time teen mothers, infants admitted to NICUs, and children 3 months or less at enrollment). The number of adults served by the 31 programs was approximately 12,116 and the number of children served was about 11,083. All counties in the state, except for Carroll County, were served by the programs.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The target population was not available for one state-identified program.

[c]Information on the number served was excluded because it was only available for some of the counties served by the state-identified program.

[d]Information on the number of counties served was excluded for some state-identified programs because it was only available for some of the counties served by the program.

[e]Counties served include the target communities of Benton, Craighead, Washington, Izard, Sharp, Lawrence, Independence, Crawford, Poinsett, Sebastian, Conway, Garland, Dallas, Lincoln, and Jefferson.

[f]Counties served include the target counties of Ashley, Benton, Boone, Calhoun, Chicot, Conway, Craighead, Dallas, Sharp, Van Buren, Independence, Lincoln, Sebastian, Pulaski, Polk, Jefferson, and Washington.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.5

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: California

Program Characteristic	State-Identified Programs			
	Parents as Teachers	Early Head Start	Healthy Families America	Healthy Start
Model[a]	Parents as Teachers	Early Head Start - Home Based Program Option	Healthy Families America	Healthy Start
Target population	Low-income, pregnant women, teens	Low-income, pregnant women, teens, children with developmental delays/disabilities, history of domestic violence, history of substance abuse, low student achievement/dropouts, parents with disabilities, and new immigrant families	Pregnant women identified as at risk and with families with preschool-age children.	Pregnant women and women who have just given birth, whose families have been identified as at risk for child abuse and neglect based on risk factors such as prenatal substance abuse, mental health issues, or a history of domestic abuse
Number served[b]	11,404 families	14,756 families	1,007 families	6,779 families
Counties served	20[c]	46[d]	10[e]	8[f]

(continued)

Appendix Table A.5 continued

Program Characteristic	State-Identified Programs			
	Parent-Child Home Program	SafeCare	Home Instruction for Parents of Preschool Youngsters	Nurse-Family Partnership
Model[a]	Parent-Child Home Program	SafeCare	Home Instruction for Parents of Preschool Youngsters	Nurse-Family Partnership
Target population	Primary caregivers	Families with infants and toddlers, families referred by Child Protective Services	Low student achievement/dropouts, children from low academic school districts, exempt care providers	First-time mothers during pregnancy through two years postpartum
Number served[b]	1,507 families	3,337 families	7,424 families	3,096 families
Counties served	5[g]	8[h]	5[i]	14[j]

SOURCE: California 2010 MIECHV needs assessment.

NOTES: The California needs assessment provided information on eight nationally recognized home visiting models operating in the state; however, it acknowledged that there were other home visiting programs operating as well.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014.

[b]These numbers come from FY 2010.

[c]Counties served include the target counties of Alameda, Butte, Contra Costa, Fresno, Los Angeles, Merced, San Diego, San Mateo, Shasta, and Stanislaus.

[d]Counties served include the target counties of Alameda, Butte, Contra Costa, Del Norte, Fresno, Humboldt, Imperial, Los Angeles, Madera, Merced, Nevada, Sacramento, San Diego, San Mateo, Shasta, Siskiyou, Solano, and Stanislaus.

[e]Counties served include the target counties of Butte, Contra Costa, Fresno, Humboldt, Los Angeles, Nevada, and San Diego.

[f]Counties served include the target counties of Fresno, Los Angeles, Sacramento, and San Diego.

[g]Counties served include the target counties of Fresno, Los Angeles, Sacramento, and Stanislaus.

[h]Counties served include the target counties of Fresno, Madera, Sacramento, San Diego, and Solano.

[i]Counties served include the target counties of Imperial, Los Angeles, and Sacramento.

[j]Counties served include the target counties of Fresno, Humboldt, Kern, Los Angeles, Madera, Sacramento, San Diego, and Solano.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.6

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Colorado

Program Characteristic	State-Identified Programs				
	Parents as Teachers	Home Instruction for Parents of Preschool Youngsters	Colorado Home Intervention Program	Nurse-Family Partnership	Early Head Start
Model[a]	Parents as Teachers	Home Instruction for Parents of Preschool Youngsters	—	Nurse-Family Partnership	Early Head Start - Home Based Program Option
Target population	Families from prenatal to age 5	Parents of preschool children, ages 3 to 5, through kindergarten	Children who are deaf or hard of hearing and their families, from birth to age 3	Low-income, first-time mothers and their children	Low-income pregnant women, and families with infants and toddlers
Number served	2,700 children[b]	898 children[b]	>350 children[c]	2,640 clients[b]	738 children[d]
Counties served	35[e]	8[f]	Statewide[e]	52[g]	16[h]

SOURCE: Colorado 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers come from FY 2009/10.

[c]This number comes from 2010.

[d]In FY 2009 Colorado funded enrollment for 738 children, but this number does not necessarily reflect the actual number served.

[e]Counties served include the target counties of Adams, Alamosa, Costilla, Crowley, Saguache, Otero, and Pueblo.

[f]Counties served include the target counties of Adams, Alamosa, Costilla, and Saguache.

[g]Counties served include the target counties of Adams, Alamosa, Costilla, Saguache, and Pueblo.

[h]Counties served include the target counties of Alamosa, Costilla, and Saguache.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.7

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Connecticut

Program Characteristic	State-Identified Programs					
	Child FIRST	Intensive In-Home Child and Adolescent Psychiatric Services	Family Services	State Healthy Start	Hartford Healthy Start	Head Start
Model[a]	Child FIRST	—	—	"Replicates Healthy Start: Home Visiting"	"Replicates Healthy Start: Home Visiting"	"Head Start, replicates the Parents as Teachers model"
Target population	Child emotional or behavioral problems, developmental or learning problems, or high-risk environment (e.g., [Department of Families and Children] involvement, maternal depression or psychiatric problems, parental substance abuse, domestic violence, teen parent, homelessness, cognitive limitations, etc.)	Program serves children and youth with Serious Emotional Disturbance who are at risk of requiring out-of-home treatment (e.g., psychiatric hospital or residential treatment facility), or who are returning home from an out-of-home treatment setting.	[Department of Families and Children] involved	Pregnant and postpartum woman and her children under 3 years of age; Healthy Start provides services to pregnant or postpartum women in incomes <185% of federal poverty level, by contract. Sites offer services to women with family incomes <250% of federal poverty level.	Low-income women, postpartum to 2 years, child to 2 years	At least 90% with incomes at or below federal poverty level, children in foster care or children experiencing homelessness; and at least 10% with identified disability
Number served[b]	Projected 500 families[c]	2,000 families	2,406 families	Over 440 families per month[d]	500 families	7,934 families[e]
Communities served[f]	6	Statewide[g]	18[h]	15[i]	1	Statewide[g]

(continued)

Appendix Table A.7 (continued)

Program Characteristic	State-Identified Programs					
	Early Head Start	Family Resource Centers	Birth to Three	Nurturing Families Home Visiting Program	Family Support Team	Intensive Family Preservation
Model[a]	"Early Head Start - Home Based Program Option, replicates the Parents as Teachers model"	"Replicates the Parents as Teachers model"	—	"Replicates the Parents as Teachers model"	—	—
Target population	At least 90% with incomes at or below federal poverty level, children in foster care or children experiencing homelessness; and at least 10% with identified disability	Pregnant women or mothers with children 0-kindergarten entry	(1) Age must be 0-3 and (2) child must have a significant delay in development or a condition that leads to a significant delay	Screened for social and economic risk factors including poor maternal and child health and development outcomes, child abuse and neglect, parental and financial stress, social isolation, history of abuse or neglect, substance or mental health problems, multiple stressors	Program serves children and youth with Serious Emotional Disturbance who are at risk of requiring out-of-home treatment (e.g., psychiatric hospital or residential treatment facility), or who are returning home from an out-of-home treatment setting.	This service is delivered to families with children at high risk of out-of-home care or families with children just reunified following a period of time spent in out-of-home care.
Number served[b]	653 families[e]	1,601 families	9,600 families	2,039 families	Approximately 515 families	1,122 families
Communities served[f]	16[i]	41[j]	Statewide[g]	Statewide[g]	Statewide[g]	Statewide[g]

(continued)

Appendix Table A.7 (continued)

SOURCE: Connecticut 2010 MIECHV needs assessment.

NOTES: Additional home visiting programs were named in the Connecticut needs assessment. This table was limited to the 12 programs that the state reported serving the most families.

[a]Models were included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers are annual, unless otherwise specified.

[c]This number, which represents projected annual numbers served in the home with current staffing, comes from 2008-2009.

[d]In addition to the three sites with intensive home visiting, which serve 440 families per month, there are additional sites with limited home visiting that provide about 12 to 20 visits per month for women who are in bed rest, fear domestic violence, or who miss most of their prenatal appointments.

[e]These numbers come from 2008-2009.

[f]The Connecticut needs assessment reported the number of towns served by the state-identified programs.

[g]Communities served include the target communities of the New Britain, New London, Windham, Ansonia, and Derby.

[h]Communities served include the target communities of the New Britain and Windham.

[i]Communities served include the target communities of New London and Windham.

[j]Communities served include the target communities of New Britain, New London, and Windham.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.8

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Delaware

	State-Identified Programs							
Program Characteristic	Home Visiting Program for First-Time Parents	Delaware Newborn Screening Program	New Directions Early Head Start	Parents as Teachers	Smart Start	Kids Kare	Children and Families First	Resource Mothers Program
Model[a]	—	—	Early Head Start - Home Based Program Option	Parents as Teachers	—	—	Nurse-Family Partnership	Resource Mothers Program
Target population	All Delaware first-time parents are offered services	All babies, per [Delaware Division of Public Health] regulations	Income-eligible pregnant women and families of children from birth to 3	Parents with firstborn children; those most at risk for later learning challenges are targeted	At-risk pregnant women	Children (ages 0-21) and families with medical, nutritional, psychosocial, or environmental risk factors that place a child at risk for poor growth or development	First-time, low-income, pregnant females, particularly teenagers	At-risk pregnant mothers
Number served[b]	—	—	229 mothers	1,699	—	—	—	—
Counties served	Statewide[c]	Statewide[c]	1[d]	Statewide[c]	Statewide[c]	Statewide[c]	Statewide[c]	3[e]

SOURCES: Delaware 2010 MIECHV needs assessment and FY 2011 state plan.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The number served was not available for some state-identified programs.

[c]Counties served include the following target communities of Southern Kent County/Northern Sussex County, Western Sussex County, Eastern Sussex County, and the Wilmington River Area, Center City Wilmington, and Western Wilmington areas in New Castle County.

[d]Counties served include the target community of Southern Kent County/Northern Sussex County.

[e]Counties served include the target communities of Wilmington River Area, Center City Wilmington, and Western Wilmington.

Appendix Table A.9

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: District of Columbia

Program Characteristic	State-Identified Programs			
	Mary's Center Healthy Start Healthy Families	Healthy Families/ Thriving Communities Collaboratives	Beyond Behaviors	HSC Home Care
Model[a]	"Combines aspects of Healthy Families America, Healthy Start: Home Visiting, and Parents as Teachers (birth and health modules, curriculum)"	—	"Based on Homebuilders model"	—
Target population	Families are recruited and screened into the program prenatally until 3 months after the child's birth; visits can stop when child is 2 to 5 years old	Families with children either in or at risk of entering the Child Welfare System	Families that have children with behavioral and mental health issues	Residents who are infants, children, and teens through age 21
Number served	211 families[b]	2,900 children and their families[c]	76 families[d]	70 children[e]
Wards served[f]	4[g]	8[h]	7[h]	8[h]

(continued)

Appendix Table A.9 (continued)

Program Characteristic	State-Identified Programs		
	District of Columbia Department of Health: Healthy Start	Washington Hospital Center: Healthy Foundations	Washington Hospital Center: Teen Alliance for Prepared Parenting
Model[a]	—	—	—
Target population	Pregnant and postpartum women with infants; visits can stop when child is 0-2 years old. Families are recruited and screened into the program prenatally until 3 months after the child's birth.	Families at greatest risk: Mother has chronic health problems (diabetes, high blood pressure, lupus, etc.) or a history of extremely premature deliveries, or baby is born extremely prematurely or with anomalies	Teen mothers with the highest risk: Screening factors include chronic mental health needs, involvement with the foster care or juvenile justice system, second or higher-order pregnancy for a teen mother, and mothers who are 16 years and under
Number served	330 families[i]	100 families[e]	50 families[e]
Wards served[f]	4[h]	8[h]	8[h]

SOURCE: District of Columbia 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]This number is as of June 2010.

[c]This number comes from FY 2009.

[d]The time period for this number was not specified.

[e]These numbers are annual.

[f]The District of Columbia needs assessment reported the number of wards served by the state-identified programs.

[g]Wards served include the target community of Ward 8.

[h]Wards served include the target communities of Wards 5, 7, and 8.

[i]This number was reported in the District of Columbia needs assessment as current. The needs assessment was written in August and September 2010.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.10

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Florida

Program Characteristic	State-Identified Programs					
	Healthy Families Florida	Home Instruction Program for Preschool Youngsters	Parents as Teachers	Early Steps	School and Family Support Services: Palm Beach	Florida Healthy Start
Model[a]	Healthy Families America	Home Instruction for Parents of Preschool Youngsters	Parents as Teachers	—	—	—
Target population[b]	Expectant families and families of newborns up to 3 months of age that are at high risk for child abuse and neglect	Families with children ages 3-5 in targeted at-risk communities	Families and children prenatal through age 5	Infants and children ages birth-36 months who meet eligibility criteria in accordance with the Individuals with Disabilities Education Act, Part C	Kindergarten and 1st-grade students; children who score most at risk on the Scale to Assess Emotional Disturbance Screener - SAED 2	Pregnant women and newborns up to age 3 who screen into the program based on the Healthy Start Prenatal or Infant Screen or who are referred for factors other than score
Number served[c]	13,254 clients	2,133 clients	1,885 clients	15,548 clients	869 clients	70,116 clients
Counties served	67[d]	18[e]	18[f]	67[d]	1	67[d]

(continued)

Appendix Table A.10 (continued)

Program Characteristic	State-Identified Programs			
	Helping People Succeed Building Readiness Among Infants Now: Martin County	Federal Healthy Start: St. Petersburg	Kids in Distress Family Strengthening KID First Program: Broward County	Federal Healthy Start REACHUP, Inc.: Hillsborough County
Model[a]	—	Healthy Start: Home Visiting	—	Healthy Start: Home Visiting
Target population[b]	—	—	Families at risk for child abuse and neglect and families in crisis that have their children living within the family	Families in East Tampa
Number served[c]	1,120 clients	750 clients	626 clients	571 clients
Counties served	1	1[g]	1	1

SOURCE: Florida 2010 MIECHV needs assessment.

NOTES: The Florida needs assessment reported on 40 programs that provided home visiting services. Information in this table is limited to the 10 programs reported to be serving the largest number of clients. The Florida needs assessment acknowledged that what was reported in the needs assessment did not reflect complete information for all home visiting programs in Florida.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The target population was not available for all state-identified programs.

[c]This number was calculated as the average of the number of clients served each year from 2007 through 2009.

[d]Counties served include the target counties of Alachua, Duval, Escambia, Pinellas, Bradford, and Putnam.

[e]Counties served include the target counties of Alachua, Bradford, and Pinellas.

[f]In addition to the 18 counties served, one agency operates the program in multiple counties. Specific counties served were not provided.

[g]County served is the target county of Pinellas.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.11

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Georgia

	State-Identified Programs				
Program Characteristic	Healthy Start	McIntosh Trail ECDC	Nurturing Georgia's Families	Heart of Georgia Healthy Start Initiative	Parents as Teachers
Model[a]	Healthy Start: Home Visiting	Early Head Start - Home Based Program Option	Nurturing Parenting Programs	Healthy Start: Home Visiting	Parents as Teachers
Target population	Pregnant women and at-risk infants	Families below federal poverty guidelines	Children ages 0-18 with an emphasis on children ages 0-5, any family/individual not currently receiving or have been identified to receive substance abuse treatment services	Infants 0-2 and pregnant or parenting adolescent women 10-20 years of age with history of a previous preterm birth, previous history of stillbirth or infant death, presence of a health condition associated with an increased risk of poor perinatal outcomes, e.g., hypertension, diabetes, obesity, substance abuse, autoimmune disorders, and mental illness	Families with children prenatal through kindergarten entry
Number served[b]	249 children 300 families[c]	749 children 749 families	220 children 195 parents	353 children 402 families[c]	1,962 children 1,635 families[c]
Counties served	1	7	13[d]	10	44[e]

(continued)

Appendix Table A.11 (continued)

Program Characteristic	State-Identified Programs				
	Concerted Services, Inc. Head Start/EHS/Pre-K	Atlanta Healthy Start	Community-Based Doula Program	Enterprise Community Health Start	Healthy Families Georgia
Model[a]	Early Head Start - Home Based Program Option	—	—	—	Healthy Families America
Target population	Early Head Start: pregnant moms to 2 years 11 months Head Start: children 3 to 5 years of age	Residents of counties served with children less than 2 years of age	First-time African-American and Latina teen mothers ages 10-19 in East and Southwest Atlanta	Teenage pregnancy, preexisting medical diagnosis, high-risk pregnancy, short interpregnancy interval, severe social situation, or NICU-admitted infant	Pregnant women and children prenatal to 5 years
Number served[b]	1,079 children 1,079 families	166 children 200 families	70-100 children	249 children 293 families	1,300 children 1,300 families[c]
Counties served	12	1	2[f]	2	13[g]

SOURCE: Georgia 2010 MIECHV needs assessment.

NOTES: Additional home visiting programs were named in the Georgia needs assessment. This table was limited to the 10 programs that were reported to be serving the most families.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The time period for these numbers was not specified, unless otherwise noted.

[c]The Georgia needs assessment reported these numbers as being from the previous year. The needs assessment was written in August and September 2010.

[d]Counties served include the target county of Houston.

[e]Counties served include the target counties of Clarke, Crisp, DeKalb, Houston, Muscogee, and Whitfield.

[f]Counties served include the target county of DeKalb.

[g]Counties served include the target counties of Clarke, Crisp, DeKalb, Glynn, and Whitfield.

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Appendix Table A.12

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Hawaii

	State-Identified Programs							
Program Characteristic	YWCA of Hawaii Island Healthy Start	Child and Family Service Health Start	Keiki O Ka Aina: HIPPY	Keiki O Ka Aina: Parents as Teachers	Honolulu Community Action Program	Parents and Children Together	Alu Like	Home Reach Services
Model[a]	Healthy Families America	Healthy Families America	Home Instruction for Parents of Preschool Youngsters	Parents as Teachers	Early Head Start - Home Based Program Option	Early Head Start - Home Based Program Option	—	—
Target population	Families with children ages 0-3	Families with children ages 0-3	High-risk native Hawaiian families with children 3-5 years	Families with children prenatal through 3	Income-eligible families in at-risk communities; priority given to children who are homeless, have special needs, or are in the foster care system, ages 3-5 years	Prenatal and birth to 3 years old	Children of Hawaiian ancestry, 1st or 2nd child	All parents statewide, with children ranging in age from newborns through teens
Number served[b]	46 families 62 children	63 families[c]	120 families	90 children	—[d]	—[d]	90 participants	11 families[c]
Geographic areas served[e]	—[f]	—[g]	—[h]	—[i]	—[j]	—[j]	—[k]	Statewide[l]

(continued)

Appendix Table A.12 (continued)

SOURCES: Hawaii 2010 MIECHV needs assessment and FY 2011 state plan.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The number served was not available for all state-identified programs. The time period for these numbers was not specified, unless otherwise noted.

[c]These numbers were reported by the Hawaii needs assessment as current. The needs assessment was written in 2010.

[d]The capacity for these two programs was 185 families at the time the needs assessment was written.

[e]The Hawaii state needs assessment reported various geographic areas that were served by the state-identified programs. Since the unit of area differed for the different programs, numbers of geographic areas were not reported.

[f]Geographic areas served include Hilo, which is a portion of a target community.

[g]Geographic areas served include the target community of Ewa/Waianae.

[h]Geographic areas served include the target community of Kalihi and Honolulu, portions of which are target communities.

[i]Geographic areas served include Honolulu, portions of which are target communities.

[j]Geographic areas served include Oahu island, portions of which are target communities.

[k]Geographic areas served include the target communities of Ewa/Waiane, Kalihi, and Maui County.

[l]Geographic areas served include the target communities of Ewa/Waianae, Hilo/Puna, Kalihi, Maui County, and Kona.

Appendix Table A.13

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Idaho

Program Characteristic	State-Identified Programs		
	Head Start/Early Head Start[a]	Parents as Teachers	Infant Toddler Program
Model[b]	Early Head Start - Home Based Program Option	Parents as Teachers	—
Target population[c]	—	—	Pregnant women or children ages 0-3 years with a developmental delay or who have conditions that may result in a developmental delay
Number served[d]	4,707 children	687 families 1,238 children	1,837 children
Counties served	14[e]	8[f]	Statewide[g]

SOURCE: Idaho 2010 MIECHV needs assessment and FY 2011 state plan.

NOTES: [a]All totals based on Early Head Start and Head Start combined enrollment from 2008-2009.

[b]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[c]The target population served was not available for some state-identified programs.

[d]These numbers come from 2008-2009.

[e]Only Home-Based Head Start and Early Head Start programs are counted in this figure. Counties served by home-based programs include the target counties of Kootenai and Twin Falls.

[f]Counties served include the target county of Kootenai.

[g]Counties served include the target counties of Kootenai, Shoshone, Twin Falls, and Jerome.

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Appendix Table A.14

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Illinois

	State-Identified Programs			
Program Characteristic	Healthy Families Illinois	Nurse-Family Partnership	Parents as Teachers	Early Head Start
Model[a]	Healthy Families America	Nurse-Family Partnership	Parents as Teachers	Early Head Start - Home Based Program Option
Target population	Pregnant women or new parents within 2 weeks of birth	First-time pregnant women <28 weeks gestation	Pregnant women and families with children up to kindergarten entry	Low-income pregnant women
Number served[b]	4,767 families	377 families	9,415[c]-12,972[d] families	1,000 families
Counties served	26[e]	3[f]	61[g]	16[h]

SOURCE: Illinois 2010 MIECHV needs assessment and FY 2010 state plan.

NOTES: The Illinois needs assessment provided information on the four evidence-based home visiting models operating in the state; however, it acknowledged that there were other home visiting programs operating as well, such as the Parent-Child Home Program.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014.

[b]These numbers come from 2008-2009.

[c]This figure is based on data reported by 137 Parents as Teachers programs participating in an Illinois State Board of Education-funded survey conducted by the Erickson Institute in Chicago.

[d]This figure is based on data reported by 190 Parents as Teachers programs to the national Parents as Teachers office.

[e]Counties served include the target communities of Macon County, Waukegan Township, and Joliet Township. Counties served also include Rock Island County, Winnebago County, and St. Clair County, portions of which are target communities.

[f]Counties served include the target communities of the city of Elgin, Englewood, West Englewood, and Greater Grand Crossing.

[g]Counties served include the target communities of Englewood, West Englewood, Greater Grand Crossing, North Lawndale, East Garfield Park, the city of Elgin, Thornton Township, Joliet Township, Macon County, and Vermilion County. Counties served also include Winnebago County, Rock Island County, and St. Clair County, portions of which are target communities.

[h]Counties served include the target communities of Englewood, West Englewood, Greater Grand Crossing, Cicero Township, Waukegan Township, Joliet Township, and Vermilion County. Counties served also include St. Clair County, a portion of which is a target community.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.15

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Indiana

Program Characteristic	State-Identified Programs			
	Early Head Start	Healthy Families Indiana	Healthy Families E-Parenting Project	Parents as Teachers
Model[a]	Early Head Start - Home Based Program Option	Healthy Families America	Healthy Families America	Parents as Teachers
Target population[b]	Low-income families with infants and toddlers and pregnant women	Eligible families of children prenatally to age 3	—	—
Number served[c]	2,636 available slots[d]	14,475 families	280 families[e]	5,688 families[f]
Counties served[g]	—	92[h]	2[i]	—

(continued)

Appendix Table A.15 (continued)

Program Characteristic	State-Identified Programs			
	Even Start	Healthy Start	First Steps	The Newborn Individualized Developmental Care and Assessment Program
Model[a]	Even Start: Home Visiting	Healthy Start: Home Visiting	—	—
Target population[b]	Parents must be 16 years or older, not enrolled or required to be enrolled in secondary school, and lack sufficient mastery of basic educational skills	Pregnant or parenting women residing in communities with infant mortality rates 1.5-2.5 times the national average	Infants and young children with disabilities or who are developmentally vulnerable	Infants in neonatal intensive care units (NICUs) and special care nurseries (SCNs)
Number served[c]	204 families	1,122 families	20,997 children	—
Counties served[g]	6[j]	2[k]	Statewide[h]	1[i]

SOURCE: Indiana 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The target population served was not available for some state-identified programs.

[c]The number served was not available for some state-identified programs. These numbers come from 2009-2010 unless otherwise noted.

[d]This number is as of fall 2010.

[e]The Indiana needs assessment reports that 420 families are involved the Healthy Families E-Parenting Project. However, a third of these families are in a control group that is not receiving any home visiting services, leaving 280 families that are receiving home visiting services. These numbers come from a time period that is not specified.

[f]Data reflect the number of families that received at least one Parents as Teachers home visit during the 2008-2009 program year.

[g]The number of counties served was not available for some state-identified programs.

[h]Counties served include the target counties of Lake, Marion, Scott, and St. Joseph.

[i]Counties served include the target county of Marion.

[j]Specific counties served were not provided.

[k]Counties served include the target counties of Lake and Marion.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.16

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Iowa

	State-Identified Programs						
Program Characteristic	Parents as Teachers	Nurse-Family Partnership	Healthy Opportunities for Parents to Experience Success (HOPES): Healthy Families Iowa	Early ACCESS	Head Start Home-Based	Early Head Start Home-Based	Healthy Start
Model[a]	Parents as Teachers	Nurse-Family Partnership	Healthy Families America	—	—	Early Head Start - Home Based Program Option	—
Target population	At-risk families; prenatal to age 5	First-time, low-income moms	At-risk families	Infants and toddlers with special needs	At-risk families	At-risk families and first-time mothers	At-risk families
Number served[b]	—	—	—	—	—	—	—
Counties served[c]	—[d]	—	—[e]	—	—	—[f]	1

(continued)

Appendix Table A.16 (continued)

Program Characteristic	State-Identified Programs			
	Family Development and Self Sufficiency	Prevent Child Abuse Iowa	Shared Visions	Parent Partners
Model[a]	—	—	—	—
Target population	At-risk families who are receiving Family Investment Program (FIP) benefits	At-risk families	At-risk families	Parents who have had children removed for safety concerns
Number served[b]	—	—	—	—
Counties served[c]	—	—	15[g]	—

SOURCE: Iowa 2010 MIECHV needs assessment.

NOTES: The programs included in this table were identified in the Iowa needs assessment as the most common home visiting models implemented. The needs assessment also reported additional home visiting programs operating in at-risk communities.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]Information on the number served was excluded because it was only available for some of the counties served by the state-identified programs.

[c]Information on the counties served was excluded for most of the state-identified programs because it was only available for some of the counties served.

[d]Counties served include the target counties of Appanoose and Wapello.

[e]Counties served include the target counties of Black Hawk and Lee.

[f]Counties served include the target county of Black Hawk.

[g]The Iowa needs assessment reported that approximately 15 counties were served. The specific counties served were not provided.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.17

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Kansas

Program Characteristic	State-Identified Programs							
	Early Head Start	Family Preservation	Healthy Families	Healthy Start	Infant Toddler Services	Parents as Teachers	Bright Beginnings	Healthy Babies
Model[a]	Early Head Start - Home Based Program Option	—	Healthy Families America	Healthy Start: Home Visiting	—	Parents as Teachers	"Based on Nurse-Family Partnership"	—
Target population	Pregnant women and families with infants and toddlers up to age 4 living at or below the federal poverty level	Families where one or more children are at risk of out-of-home placement	Parents with multiple risk factors who are expecting or who have just had a new baby	All pregnant women and women with infants up to age 1	Children ages birth to 3 with an identified developmental delay	All families with children prenatal to age 5 regardless of their risk levels	At-risk pregnant women and new moms	Pregnant women and families with infants and toddlers up to age 24 months
Number served[b]	2,718	2,135	351	9,675	7,054	15,197	101	617 mothers 402 babies and toddlers
Counties served	57[c]	Statewide[c]	16[d]	88[c]	Statewide[c]	89[c]	1	1

SOURCE: Kansas 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers come from 2009. The Kansas needs assessment reported that these numbers represented either individuals or families served, unless otherwise noted.

[c]Counties served include the target counties of Montgomery and Wyandotte.

[d]Counties served include the target county of Wyandotte.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.18

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Kentucky

	State-Identified Programs			
Program Characteristic	Health Access Nurturing Development Services	Community Collaborative for Children	Early Head Start	Federal Healthy Start
Model[a]	Health Access Nurturing Development Services Program	—	Early Head Start - Home Based Program Option	Healthy Start: Home Visiting
Target population	Expectant mothers and children ages 0-2 years to first-time parents	Children birth - 5 years of age	Expectant mothers and children from birth - 3 years of age	Mothers and children ages birth - 2 years of age to first-time parents
Number served[b]	11,000 families	600 families	550 families	700 families
Counties served	Statewide[c]	Statewide[c]	38[d]	2

(continued)

Appendix Table A.18 (continued)

	State-Identified Programs			
Program Characteristic	National Healthy Families	Nurse-Family Partnership	Parents as Teachers	Save the Children: Early Steps to School Success
Model[a]	Healthy Families America	Nurse-Family Partnership	Parents as Teachers	—
Target population	Expectant mothers and children from birth - 2 years of age to first-time parents	Expectant mothers prior to 28 weeks prenatal and children from birth - 2 years of age to first-time mothers	Parents of children birth - 3 years of age	Families with children pre-birth through 5 years of age living in rural communities
Number served[b]	450 families	300 families	1,100 families	600 families
Counties served	1	3	33	9[e]

SOURCE: Kentucky 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers are annual.

[c]Counties served include the target counties of Breathitt, Johnson, Knott, Lawrence, Lee, Leslie, Letcher, Magoffin, Owsley, Perry, Pike, and Wolfe.

[d]Counties served include the target counties of Knott, Letcher, and Owsley.

[e]Counties served include the target counties of Breathitt, Knott, Owsley, and Perry.

Appendix Table A.19

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Louisiana

	State-Identified Programs				
Program Characteristic	Home Instruction for Parents of Preschool Youngsters	Intensive Home-Based Services	Nurturing Parenting Program	Nurse-Family Partnership	Parents as Teachers
Model[a]	Home Instruction for Parents of Preschool Youngsters	"Based on Homebuilders"	Nurturing Parenting Program	Nurse-Family Partnership	Parents as Teachers
Target population	Parents of children ages 3-5 years	At-risk families	Families with children ages 0-5 years	Medicaid-eligible first-time mothers; children ages 0-2 years	Families with special-needs children
Number served[b]	323 families[c]	—	—	2,429 families[d]	826 families[e]
Parishes served[f]	4[g]	—	—	52[h]	—

SOURCE: Louisiana 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014.

[b]The number of families served was not available for some state-identified programs.

[c]The Louisiana needs assessment reported that this was the number served in the last full year.

[d]These numbers comes from FY 2008-2009.

[e]The Louisiana needs assessment reported that these numbers comes from the last complete fiscal year.

[f]The number of parishes served was not available for some state-identified programs.

[g]Parishes served include the target communities of Orleans, East Baton Rouge, and Rapides.

[h]Parishes served include the target communities of Jefferson, Orleans, East Baton Rouge, Iberville, Lafourche, St. Mary, Lafayette, St. Landry, Calcasieu, Vernon, Rapides, Winn, Avoyelles, Caddo, Webster, Natchitoches, Bienville, Ouachita, Morehouse, Franklin, Lincoln, Livingston, St. Tammany, and Tangipahoa.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.20

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Maine

Program Characteristic	State-Identified Programs						
	Maine Families	Home-Based Early Head Start	Public Health Nursing	Community Health Nursing	Maine Parent Federation Parents as Teachers	Project LAUNCH	Passages Program
Model[a]	Parents as Teachers	Early Head Start - Home Based Program Option	—	—	Parents as Teachers	—	—
Target population	First-time parents and children prenatal to 3 months; teen, foster, adoptive, or kinship parents	Federal poverty guidelines; prenatal and parenting up to 3 years	Women, infants, children with identified health needs	Women, infants, children with identified health needs	Parents and children prenatal to 5 years	High-risk, drug-addicted parents and high-risk children ages 0-8 years	Pregnant and parenting teens ages 14-20 years
Number served[b]	2,455 families	484 available slots	1,850 households	2,838 estimated households and 4,173 clients receiving a visit	175 families[c]	59 families[d]	53 families[e]
Counties served	Statewide[f]	10[g]	Statewide[f]	6[h]	2[i]	1[j]	4[k]

(continued)

Appendix Table A.20 (continued)

SOURCE: Maine 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers come from 2009-2010, unless otherwise noted.

[c]The Maine needs assessment reported that these numbers came from "the last fiscal year."

[d]The Maine needs assessment reported that this was the number of families served "to date."

[e]The Maine needs assessment reported that this was the number of families served "in the past year."

[f]Counties served include all target counties.

[g]Counties served include the target counties of Androscoggin, Aroostook, Cumberland, Franklin, Kennebec, Lincoln, Oxford, Sagadahoc, Waldo, and York.

[h]Counties served include the target counties of Androscoggin, Cumberland, Hancock, Penobscot, Washington, and York.

[i]Counties served include the target counties of Kennebec and Somerset.

[j]Counties served include the target county of Washington.

[k]Counties served include the target counties of Knox, Lincoln, Waldo, and Washington.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.21

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Maryland

Program Characteristic	State-Identified Programs				
	Garrett County Nurse-Family Partnership	Maryland Early Head Start	Parents as Teachers	Healthy Families Maryland	Infants and Toddlers Program
Model[a]	Nurse-Family Partnership	Early Head Start - Home Based Program Option	Parents as Teachers	Healthy Families America	—
Target population	Low-income, first-time mothers	Low-income families with infants and toddlers (0 to 3 years old) and pregnant women	Families from pregnancy through a child's school entry	At-risk pregnant or parenting families (with an infant up to age 3 months), (except first-time, low-income mothers who enroll prior to 28 weeks gestation)	Allegany: Special needs infants, toddlers, and preschoolers, birth to age 5 Dorchester: Individuals with 25% developmental delay or a diagnosed physical or mental condition that puts them at risk for delay Montgomery: Pregnant and postpartum women, infants, and children Worcester: Infants and children
Number served	68 families 57 target children[b]	296[c,d]	200 families[c,e]	81 mothers 79 fathers 94 children[c]	More than 123 individuals[f]
Communities served[g]	1	12[h]	3[i]	17[j]	4[k]

(continued)

Appendix Table A.21 (continued)

Program Characteristic	State-Identified Programs				
	Maternal Child Program	Maternal/Child Health/ Healthy Start	Healthy Start Case Management Program	Healthy Start/Infant At-Risk Programs	Maternal and Infant Nursing Program
Model[a]	—	—	—	—	—
Target population	All high-risk county residents that include: pregnant women, postpartum women, newborns, and children up to age 2	Women who are pregnant or postdelivery and families with children under the age of 2 years	Pregnant, postpartum women, infants and children up to the age of 2 years who are MA-eligible or potentially MA-eligible	At-risk pregnant women, postpartum/ interconception women, and at-risk infants to age 2 who live in the county	Pregnant women (and families) and infants 0-2
Number served	120[f]	123[f]	107[f]	200 families[f]	300 families[f]
Communities served[g]	1	1	1	1	1[l]

SOURCE: Maryland 2010 MIECHV needs assessment.

NOTES: Additional home visiting programs were named in the Maryland needs assessment. This table was limited to the 10 programs that were reported to be serving the most people. The acronym "MA" was not defined in the needs assessment.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers reflect families "currently served" as of June 2010.

[c]These numbers are from FY 2010.

[d]The Maryland needs assessment reported that these numbers represent the number of either individuals or families served.

[e]This number only includes those served in Garrett and Somerset Counties.

[f]These numbers reflect the average number of individuals or families served per month.

[g]These numbers represent counties and the city of Baltimore, which is an independent city considered to be the equivalent of a county.

[h]Communities served include the city of Baltimore, Dorchester County, and Washington County, portions of which are target communities.

[i]Communities served include Pocomoke City, which is a target community, and Somerset County, a portion of which is a target community.

[j]Communities served include the city of Baltimore, Dorchester County, Somerset County, Washington County, Wicomico County, and Worcester County, portions of which are target communities.

[k]Communities served include Dorchester County and Worcester County, portions of which are target communities.

[l]Communities served include the city of Baltimore, portions of which are target communities.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.22

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Massachusetts

Program Characteristic	State-Identified Programs				
	Boston Healthy Start Initiative	Early Head Start	Early Intervention	Early Intervention Partnership Program	F.O.R. Families
Model[a]	"Based on Healthy Start: Home Visiting"	Early Head Start - Home Based Program Option	—	—	—
Target population	Black pregnant women and their children up to the child's 2nd year after birth who reside in Boston	Children ages birth to 3 and pregnant women of any age (income-eligible families)	Children up to age 3 with a diagnosed medical or disabling condition or 30% delay, or who are at risk for delay	High-risk pregnant and postpartum women and their infants up until the age of 1	Homeless families receiving Emergency Assistance shelter benefits from the Department of Housing and Community Development
Number served[b]	1,792 families	358 families	33,346 families[c]	669 families	3,196 families
Cities and towns served[d]	1[e]	75[f]	Statewide as needed[g]	8[h]	Statewide in communities housing homeless families in hotels[i]

(continued)

Appendix Table A.22 (continued)

Program Characteristic	State-Identified Programs				
	Good Start/Connecting Families Social Services	Healthy Baby Healthy Child	Healthy Families Massachusetts	Parent-Child Home Program	Young Parents Support Program
Model[a]	—	—	Healthy Families America	Parent-Child Home Program	—
Target population	Pregnant women or parenting families with children up to the age of 16 who face challenges that could potentially put the child or family at risk	Pregnant and postpartum women of any age and parenting families with children through the age of 5 years	First-time teen parents, less than age 20 years	At-risk parents and children who are between the ages of 18 months and 4 years	Young parents up to the age of 23
Number served[b]	338[c] families	1,414 families	3,131 families	1,500 families	1,122[c] families
Cities and towns served[d]	6[j]	1[e]	Statewide as needed[g]	78[k]	27[l]

(continued)

Appendix Table A.22 (continued)

SOURCE: Massachusetts 2010 MIECHV needs assessment

NOTES: Additional home visiting programs were named in the needs assessment. This table was limited to the 12 programs that the state reported serving the most families.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]Unless otherwise noted, these numbers come from FY 2009.

[c]These numbers come from FY 2010.

[d]The Massachusetts needs assessment reported the number of cities and towns served by the state-identified programs.

[e]Communities served include the target community of Boston.

[f]Communities served include the target communities of Boston, Fall River, Holyoke, Lowell, Lynn, Southbridge, and Springfield.

[g]Communities served include all of the target communities.

[h]Communities served include the target communities of Fall River, Fitchburg, Lowell, Lynn, New Bedford, Southbridge, and Springfield.

[i]It is unclear which target communities are served by this program.

[j]Communities served include the target communities of Boston, Holyoke, Lawrence, Springfield, and Worcester.

[k]Communities served include the target communities of Boston, Fitchburg, Lawrence, Lowell, Lynn, New Bedford, Pittsfield/North Adams, Springfield, and Worcester.

[l]Communities served include the target communities of Boston, Brockton, Chelsea, Fitchburg, Holyoke, Lawrence, Lowell, New Bedford, Pittsfield/North Adams, Springfield, and Worcester.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.23

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Michigan

	State-Identified Programs			
Program Characteristic	Maternal-Infant Health Program	Community Mental Health Home-Based Services	Zero to Three Secondary Prevention Initiative[a]	Children's Trust Fund Direct Service Grants[b]
Model[c]	—	—	Parents as Teachers; Nurse-Family Partnership; Healthy Families America	Parents as Teachers; Nurse-Family Partnership; Healthy Families America; Healthy Start: Home Visiting
Target population	Pregnant Medicaid beneficiaries and infants with Medicaid insurance	Children ages 0-47 months who have a parent with mental illness	The target population varies by project, but all projects target expectant women or families with young children and require families to either be a "[Child Protection Services] Category III or IV case or have 3 or more identified child abuse and/or neglect risk factors" or to have "[Child Protection Services] involvement or risk factors for child maltreatment."	Varies by program
Number served[d]	27,164 pregnant women 10.000 infants[e]	1,031 families[f]	1,967 families[g]	777 individuals[h]
Counties served	Statewide[i]	Statewide[i]	5[j]	8[k]

(continued)

Appendix Table A.23 (continued)

Program Characteristic	State-Identified Programs				
	Prevention Pilot Home Visiting Programs	Nurse-Family Partnership	Healthy Start	Early Head Start	Parent-Child Assistance Program
Model[c]	—[l]	Nurse-Family Partnership	—	Early Head Start - Home Based Program Option	—
Target population	At-risk families with children ages 0-18 years; must have a [Child Protection Services] Category III or IV case or have 3 or more identified child abuse or neglect risk factors	Low-income, first-time mothers	Pregnant women and infants in communities with large minority populations with high rates of unemployment, poverty, and major crime	Pregnant women; children ages 0-3; income eligibility: 100% of federal poverty guidelines; 10% children with disabilities; categorical eligibility: homeless, foster care, public assistance	Pregnant women or women up to 6 months postpartum with previous alcohol-exposed birth
Number served[d]	—	197 families[e]	5,400[m]	89 pregnant women 2,566 children[n]	69 families[n]
Counties served	3[j]	5[o]	6[p]	64[q]	3[r]

(continued)

Appendix Table A.23 (continued)

SOURCE: Michigan 2010 MIECHV needs assessment.

NOTES: [a]Zero to Three supports seven home visiting projects, including projects that use national models such as Parents as Teachers, Nurse-Family Partnership, and Healthy Families America.

[b]Children's Trust Fund Direct Service Grants support seven home visiting projects, including projects that use national models such as Parents as Teachers, Nurse-Family Partnership, and Healthy Families America.

[c]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[d]The number served was not available for some state-identified programs.

[e]These numbers represent the number of people newly enrolled in 2009.

[f]The time period for this number is not specified.

[g]These numbers are FY 2009 quarterly service data.

[h]The number served was calculated by adding up the number served from the seven projects funded by this state-identified program. The time period for these numbers differ by project.

[i]Counties served include the target counties of Wayne, Kalamazoo, Berrien, Saginaw, Genesee, Kent, Ingham, and Muskegon.

[j]Counties served include the target counties of Genesee, Kent, and Wayne.

[k]Counties served include the target county of Berrien.

[l]The Michigan needs assessment reported that this program uses "evidence based/evidence informed home visitation models," but did not specify which ones.

[m]These numbers come from 2007.

[n]These numbers come from FY 2009.

[o]Counties served include the target counties of Kalamazoo, Berrien, and Kent.

[p]Counties served include the target counties of Wayne, Kalamazoo, Saginaw, Genesee, and Kent.

[q]Specific counties served were not provided.

[r]Counties served include the target counties of Berrien, Kent, and Muskegon.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.24

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Minnesota

Program Characteristic	State-Identified Programs					
	Baby Steps	Early Head Start	Health Care for the Homeless	Healthy Families America	Metro Alliance for Healthy Families	Healthy Families America-Like: Freeborn
Model[a]	—	Early Head Start - Home Based Program Option	—	Healthy Families America	Healthy Families America-like	"Healthy Families America-like"
Target population	Pregnant women and parents of newborns to 2 years who are 18 years or over with risk factors	Pregnant women and children birth to 3 whose family income is at or below the federal poverty threshold	Homeless at enrollment; children 0 to 6 years	Low-income families with identified risk; children 3 months to 4 years	First-time parents; prenatal to 4 years	Pregnant women, families with newborns, scoring 25 or + on Parent Survey
Number served[b]	23 families[c]	876 slots/families	215 families[d]	50 families	623 families	115 families
Counties served	1	37[e]	1[f]	2	7[g]	1

(continued)

Appendix Table A.24 (continued)

Program Characteristic	State-Identified Programs				
	Healthy Families America-Like: Steele	Home Instruction for Parents of Preschool Youngsters	Nurse-Family Partnership	Parents as Teachers	Minnesota Family Home Visiting Program
Model[a]	"Healthy Families America-like"	Home Instruction for Parents of Preschool Youngsters	Nurse-Family Partnership	Parents as Teachers	—[h]
Target population	Pregnant women, families with newborns up to 12 weeks, scoring 25 or + on Parent Survey	Low-income; children 3 to 5 years	Low-income, first-time pregnant women prior to 28 weeks gestation	Pregnant women and children ages 0-5 years	Families at or below 200% of the federal poverty guidelines and at-risk families
Number served[b]	37 families	100 families	372 clients 275 babies	Approximately 2,500 families	6,690 prenatal clients 12,592 primary caregivers 20,068 children[i]
Counties served	1	1[f]	18[j]	9[k]	Statewide[l]

(continued)

Appendix Table A.24 (continued)

SOURCE: Minnesota 2010 MIECHV needs assessment.

NOTES: [a]Models were included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]It is unclear what time period the information on number served represents for most state-identified programs.

[c]The Minnesota needs assessment reported that this was the number served "currently."

[d]Instead of reporting the number served annually for this program, the Minnesota needs assessment reported the number served in six months.

[e]Counties served include the target counties of Becker, St. Louis, Hennepin, Ramsey, and Beltrami.

[f]Counties served include the target county of Hennepin.

[g]Counties served include the target counties of Hennepin and Ramsey.

[h]The Minnesota Family Home Visiting Program is an organization that supports 28 local programs using nationally recognized home visiting models and 63 programs using other approaches.

[i]These numbers come from 2009.

[j]Counties served include the target counties of St. Louis and Ramsey.

[k]Counties served include the target counties of Hennepin, Ramsey, and St. Louis.

[l]Counties served include the target counties of Becker, St. Louis, Hennepin, Mower, Nobles, Ramsey, and Beltrami.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.25

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Mississippi

Program Characteristic	State-Identified Programs				
	Perinatal High Risk Management/ Infant Services System	Maternal Infant Health Outreach Worker	Parents as Teachers	Healthy Start	The Birthing Project
Model[a]	—	Maternal Infant Health Outreach Worker	Parents as Teachers	Healthy Start: Home Visiting	—
Target population	Medical high-risk and Medicaid-eligible families	Economically disadvantaged parents; teen moms; first-time moms; have to be pregnant to enroll	Varying target populations at programs across the state. Typically teen moms who are pregnant or have children under 3	Teen parents	African-American and Latino parents
Number served[b]	2,877 women 2,014 infants	103 families	543 families	162 families	45 families
Counties served	Statewide[c]	5	13[d]	7[e]	9

(continued)

Appendix Table A.25 (continued)

Program Characteristic	State-Identified Programs				
	Metropolitan Infant Mortality Elimination and the Delta Infant Mortality Elimination Demonstration Projects	Parent Child Ministry	Early Intervention Program	Take Baby Steps	Nurse-Family Partnership
Model[a]	—	—	—	—	Nurse-Family Partnership
Target population	Low-income African-American women with very low-birth-weight infants at University of Mississippi Medical Center	Open	First- or second-time parents; teen and single parents	Low-income families	First-time, low-income families
Number served[b]	103 families	75-100 pregnant women[f]	100 families	45 families	100 families
Counties served	21[g]	3	1	1	3

SOURCE: Mississippi 2010 MIECHV needs assessment.

NOTES: Additional home visiting programs were named in the Mississippi needs assessment. This table is limited to the 10 programs that the state reported serving the most families.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]Instead of reporting the number served annually, Mississippi reported the number of families enrolled in each program, unless otherwise noted.

[c]Counties served include the target counties of Claiborne, Copiah, Coahoma, Jefferson, Tallahatchie, Tunica, and Wilkinson.

[d]Counties served include the target county of Copiah.

[e]Counties served include the target counties of Coahoma, Tallahatchie, and Tunica.

[f]This number is annual.

[g]Counties served include the target counties of Copiah, Coahoma, Tallahatchie, and Tunica.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.26

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Missouri

Program Characteristic	State-Identified Programs				
	Healthy Start Program[a]	Missouri Community Based Home Visiting Program	Stay at Home Parent Program	Child Abuse and Neglect Prevention Program	Nurses for Newborns
Model[b]	Healthy Start: Home Visiting	—	Parents as Teachers, Healthy Families America	Parents as Teachers	Parents as Teachers
Target population	St. Louis Healthy Start: Pregnant women, preferably in 1st or 2nd trimester, who reside in the project area and have risk factors and children up to the age of 2 years; Kansas City Healthy Start: those located in selected zip codes of Jackson County, Missouri; the Missouri Bootheel Regional Consortium: at-risk African-American women who are between the ages of 15 and 44 and live in one of the 5 Missouri counties that the program serves	Families most at risk of infant mortality or morbidity and child abuse or neglect; low-income pregnant women (185% of federal poverty level or less) who are at risk of adverse pregnancy outcomes, reside in the counties served by the program, and meet community-established eligibility requirements	Families with a child less than 3 years of age in the home and household income under 185% of the federal poverty level and a parent who meets specific program requirements	Families with a child less than 3 years of age in the home, who may meet any of the criteria for the Stay at Home Parent Program but must be considered high risk, which includes but is not limited to: families living in poverty; teen parents; families in homeless or other crisis situations; or families with children with special needs	Prenatal women and children up to 3 years of age, medically fragile infants, moms with mental illness or disability, and teen parents
Number served	578 families[c] 300 women[d]	815 clients[e]	1,509 families 1,854 children[f]	453 families 530 children[f]	3,000 families[d]
Counties served[g]	7[h]	13	37	37	16

(continued)

Appendix Table A.26 (continued)

Program Characteristic	State-Identified Programs				
	Early Head Start/Head Start	WINGS (Women in Need Growing Stronger), International and Domestic Adoption Program	St. Louis County Department of Health Public Nursing	Parents as Teachers	Parents Learning Together
Model[b]	Early Head Start - Home Based Program Option	—	—	Parents as Teachers	—
Target population	Families with income at or below 100% of the federal poverty level	Families who are adopting internationally or through domestic programs	Residents of St. Louis County, regardless of age or medical home	Expectant mothers or families with children from birth to kindergarten	Parents with intellectual and developmental disabilities
Number served	979 children funded for enrollment[i]	600 families and children[d]	400 families per month	84,979 families with children prenatal to 3 years 60,417 families with children ages 3 to kindergarten[j]	125 families per month
Counties served[g]	31[k]	4	1	115[l]	2

(continued)

Appendix Table A.26 (continued)

SOURCE: Missouri 2010 MIECHV needs assessment.

NOTES: Additional home visiting programs were named in the Missouri needs assessment. This table was limited to the 10 programs that were reported to be serving the most families.

[a]There are three Healthy Start programs in the state. The information in this column reflects all three programs.

[b]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[c]This number comes from 2009.

[d]These numbers are annual.

[e]This number comes from federal FY 2009.

[f]These numbers come from FY 2009.

[g]The City of St. Louis is an independent city and considered to be the equivalent of a county. It is included in these counts as a county.

[h]Counties served include the target counties of Dunklin and Pemiscot. The program also serves an additional county in Kansas.

[i]This number comes from 2008-2009 and represents the funded enrollment, not the actual number served.

[j]These numbers come from state FY 2009.

[k]Counties served include the target county of Jasper.

[l]Counties served include the target counties of Butler, Dunklin, Jasper, Pemiscot, and Ripley.

Appendix Table A.27

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Montana

	State-Identified Programs					
Program Characteristic	Public Health Home Visiting	Parents as Teachers	Home Instruction for Parents of Preschool Youngsters	Nurturing Parents Program	Parent-Child Home Program	Healthy Families America
Model[a]	—	Parents as Teachers	Home Instruction for Parents of Preschool Youngsters	Nurturing Parents Program	Parent-Child Home Program	Healthy Families America
Target population[b]	—	—	—	—	—	—
Number served[c]	—	—	—	—	—	—
Counties served[d]	15	2+[e]	—[f]	—[f]	—[g]	—[h]

(continued)

Appendix Table A.27 (continued)

Program Characteristic	State-Identified Programs				
	Circle of Security	Parent Aid Program	Celebrating Families	Even Start	Other (Identified by County Health Departments)[i]
Model[a]	—	—	—	Even Start: Home Visiting	—
Target population[b]	—	—	—	—	—
Number served[c]	—	—		—	—
Counties served[d]	—[g]	—[g]	—[h]	—[h]	24

SOURCE: Montana 2010 MIECHV needs assessment.

NOTES: Montana conducted a survey of county health departments and solicited information from noncounty health department home visiting agencies or organizations. The Montana needs assessment presented the information in aggregate, so individual characteristics of each model could not be ascertained. The "state-identified programs" in this table were pulled from a list of models that counties or noncounty health department home visiting agencies or organizations reported using. Aggregate conclusions pulled from the Montana needs assessment are included in footnotes.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The target population was not available for any state-identified programs. Most programs reported serving children age 0-5, pregnant/postpartum women, or both.

[c]The number served was not available for any state-identified programs.

[d]The number of counties served was not available for some state-identified programs. Information on the specific counties served by each program was not provided.

[e]Two county health departments and 10 other organizations reported programs that used the Parents as Teachers model.

[f]Three organizations reported using this model.

[g]Two organizations reported using this model.

[h]One organization reported using this model.

[i]Thirty-nine county health departments reported that they intended to provide home visiting services in 2010. Of those, 19 indicated that they did not follow a model and 5 responded that they used a model other than the choices provided.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.28

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Nebraska

	State-Identified Programs				
Program Characteristic	Regional West Home Care: Regional West Medical Center	Healthy Start: Great Plains Regional Medical Center	Early Head Start: Community Action Partnership of Mid-Nebraska	St. Francis Healthy Start	MCH Healthy Homes, Parenting Support: Lincoln-Lancaster County Health Department
Model[a]	—	Nurse-Family Partnership, Healthy Families America	Early Head Start - Home Based Program Option	—	Healthy Families America
Target population	Prenatal, children 0-3	Prenatal, children 0-5	Children 0-5	Prenatal, children 0-5	Prenatal, children 0-3
Number served[b]	360 families	150 families	150 families	200+ families	1,507 families
Counties served	1[c]	1	10[d]	1	1

(continued)

Appendix Table A.28 (continued)

Program Characteristic	State-Identified Programs				
	Early Head Start: Omaha Public Schools	VNA Family Services: Visiting Nurse Association	Omaha Healthy Start: Charles Drew Health Center	Early Head Start and Sixpence: Central NE Community Services	Operation Great Start, Operation Building Blocks: Goldenrod Hills Community Action
Model[a]	Early Head Start - Home Based Program Option	Nurse-Family Partnership	Healthy Start: Home Visiting	Early Head Start - Home Based Program Option, Parents as Teachers	Early Head Start - Home Based Program Option, Healthy Families America
Target population	Prenatal, children 0-3	Prenatal, 0-13, and 13-44 years old; pregnant and parenting 0-3	Prenatal, children 0-3	Prenatal, children 0-3	Prenatal, children 0-8, teen parents
Number served[b]	1,013 families	2,336 families	400 families	150 families	200 families
Counties served	1	2	1	10	12

SOURCE: Nebraska 2010 MIECHV needs assessment.

NOTES: The Nebraska needs assessment provided information only on existing home visiting programs in its identified at-risk communities. Therefore, this table does not reflect the full range of home visiting programs available in the state. Additional home visiting programs were named in the needs assessment. This table was limited to the 10 programs that the state reported serving the most families.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]Number served represents number of families served in service area. The time period for these numbers was not specified.

[c]County served is Scotts Bluff, a county in the target community.

[d]In addition, this program also serves two counties in Kansas.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.29

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Nevada

	State-Identified Programs	
Program Characteristic	Nurse-Family Partnership	Early Head Start
Model[a]	Nurse-Family Partnership	Early Head Start - Home Based Program Option
Target population	—	—
Number served	—	—
Counties served	—	—

SOURCES: Nevada 2010 MIECHV needs assessment and the FY 2011 state plan.

NOTES: The Nevada needs assessment did not provide information on pre-MIECHV home visiting programs operating in the state. The FY 2011 state plan also did not provide any systematic information about home visiting programs operating in the state prior to MIECHV, but it did report that Nurse-Family Partnership was operating in the target county of Clark, and Early Head Start - Home Based Program Option was operating in the target counties of Clark and Washoe.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014.

Appendix Table A.30

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: New Hampshire

Program Characteristic	State-Identified Programs				
	Child and Family Health Supports	Comprehensive Child and Family Supports	Home Visiting New Hampshire	Family Centered Early Supports and Services	Head Start/ Early Head Start
Model[a]	—	—	"Based on Nurse-Family Partnership"	—	Early Head Start - Home Based Program Option
Target population[b]	Primarily for children from birth through age 10, but are available for children up to age 19	Families at risk with children 0-18 with some involvement with the Division for Children, Youth and Families	Pregnant women and their babies up to age 1 year	Families from prenatal period up to 3rd birthday	Pregnant women and children birth to age 3
Number served[c]	1,254 children	700 families	900 families	—	235 families 260 children 19 pregnant women[d]
Counties served[e]	Statewide[f]	Statewide[f]	Statewide[f]	—	4[f]

SOURCE: New Hampshire 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The target population was not available for some state-identified programs.

[c]The number served was not available for one state-identified program. These numbers come from FY 2010, unless otherwise specified.

[d]The time period for these numbers was not specified.

[e]The number of counties served was not available for some state-identified programs.

[f]Counties served include all of the target counties.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.31

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: New Jersey

	State-Identified Programs						
Program Characteristic	Healthy Families/ [Temporary Assistance for Needy Families] Initiative for Parents	Nurse-Family Partnership	Parents as Teachers	Home Instruction for Parents of Preschool Youth	Early Head Start: Home Visiting Program	Parent-Child Home Program	Family Connections
Model[a]	Healthy Families America	Nurse-Family Partnership	Parents as Teachers	Home Instruction for Parents of Preschool Youngsters	Early Head Start - Home Based Program Option	Parent-Child Home Program	Family Connections
Target population	Prenatal/birth (enrollment) to age 3; [Temporary Assistance for Needy Families] low-income families to age 1; bilingual (Spanish) capacity	Prenatal (enrollment) to age 2; bilingual (Spanish) capacity	Prenatal or early childhood (enrollment) to ages 3-5	Age 3 (enrollment) to age 5; bilingual (Spanish) capacity	Prenatal or early childhood (enrollment) to age 3; low-income families; bilingual (Spanish) capacity	Families [with children] … age 2.5-kindergarten	Special needs families from pregnancy to age 8
Number served[b]	1,970 slots for families	945 slots for families	278 slots for families	100 slots for families	150 slots for families[c]	—	—
Counties served	21[d]	12[e]	7[f]	1[g]	4[h]	1[i]	1[j]

(continued)

Appendix Table A.31 (continued)

SOURCE: New Jersey 2010 MIECHV needs assessment and the FY 2011 state plan.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014.

[b]These numbers were reported as the current capacity at the time the 2011 state plan was being written. The number served was not available for some state-identified programs.

[c]This number is the available slots for the Early Head Start sites that are solely home-based.

[d]Counties served include the target counties of Cape May, Salem, Sussex, and Warren. Counties served also include Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Gloucester, Hudson, Mercer, Middlesex, Monmouth, Ocean, Passaic, and Union, portions of which are target communities.

[e]Counties served includes the target county of Salem. Counties served also include Camden, Cumberland, Gloucester, Essex, Hudson, Mercer, Middlesex, Monmouth, Passaic, and Union, portions of which are target communities.

[f]Among the areas served are the target communities of Atlantic City, Camden, and Cape May. Counties served also include Cumberland and Essex, portions of which are target communities.

[g]Among the areas served is the target community of Englewood.

[h]Among the areas served are the target communities of Camden, Vineland, Newark, and Trenton.

[i]Among the areas served is the target community of New Brunswick.

[j]Among the areas served are the target communities of Camden and Winslow Township.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.32

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: New Mexico

	State-Identified Programs					
Program Characteristic	Pueblo of Laguna Department of Education Division of Early Childhood	Holy Cross Hospital First Steps Program	Partners In Education Early Intervention Program	Gila Regional Medical Center First Born Program	First Born Presbyterian Hospital	Central Consolidated Parents As Teachers
Model[a]	—	—	Parents as Teachers	—	—	Parents as Teachers
Target population	Universal (all Native American families); first-time parents; teen parents; low-income parents; families with risk factors (school dropout, substance abuse, domestic violence, etc.); families with children with special needs	First-time parents	Universal (all families)	First-time parents	First-time parents	Universal access to community but target teen parents; families with risk factors (school dropout, substance abuse, domestic violence, etc.)
Number served[b]	240 families	107 families	400 families	100 families	144 families	1,581 families
Counties served	1	2	1	1[c]	1	1

(continued)

Appendix Table A.32 (continued)

Program Characteristic	State-Identified Programs				
	Presbyterian Medical Services: Early Head Start	Healthy Families Home Visitation Program	United Way of Santa Fe County	Las Cumbres Community Services/Santa Fe Community Infant Program	City of Albuquerque Early Head Start
Model[a]	Early Head Start - Home Based Program Option	Healthy Families America	—	—	Early Head Start - Home Based Program Option
Target population	Teen parents; low-income parents; families with risk factors (school dropout, substance abuse, domestic violence, etc.); families with children with special needs	Universal (all families); teens over 18; low-income; families with risk factors (school dropout, substance abuse, domestic violence, etc.)	First-time parents; teen parents; low-income parents; families with risk factors (school dropout, substance abuse, domestic violence, etc.)	Universal (all families); first-time parents; teen parents; low-income parents; families with risk factors (school dropout, substance abuse, domestic violence, etc.); families with children with special needs; pregnant women, families involved with [the New Mexico Children, Youth, and Families Department]	Teen parents; low-income parents; families with risk factors (school dropout, substance abuse, domestic violence, etc.)
Number served[b]	179 families	100 families	150 families	120 families	164 families
Counties served	4	1	1	1	1[d]

SOURCE: New Mexico 2010 MIECHV needs assessment.

NOTES: Additional home visiting programs were named in the New Mexico needs assessment. This table was limited to the 11 programs that were reported to be serving the most families.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The time period for these numbers is not specified.

[c]Counties served include the target county of Grant.

[d]Counties served include Bernalillo, a portion of which is a target community.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.33

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: New York

Program Characteristic	State-Identified Programs			
	Home Instruction for Parents of Preschool Youngsters	Nurse-Family Partnership	Parent-Child Home Program	Healthy Families New York
Model[a]	Home Instruction for Parents of Preschool Youngsters	Nurse-Family Partnership	Parent-Child Home Program	Healthy Families America
Target population	Low-income, single-parent families with a history of child abuse/child welfare services who use tobacco, have children with low student achievement and developmental delays, current depression, history of domestic violence, or unemployment; families with children between 3 and 5 years of age at time of enrollment	At-risk first-time mothers, their infants, and families; teens in foster care, women and teens in homeless shelters, and women at the Rikers Island Correctional Facility; Medicaid-eligible	Families with 2- and 3-year-olds who face multiple obstacles to educational and economic success; low-income families challenged by limited parental education levels, literacy and language barriers, lack of transportation, history of child abuse/child welfare services, or domestic violence; older children with low student achievement; women with late/no prenatal care; 2-parent, single parent, teen parent, foster parent, and grandparent families	Expectant parents and parents with children less than 3 months of age considered at high risk for child abuse and neglect; low-income, single parents with a history of child abuse/child welfare services, substance abuse, late/no prenatal care, mental issues, and domestic violence
Number served[b]	78 families[c]	3,700 families	—	Nearly 6,000 families
Counties served	1[d]	7[e]	9[f]	31[g]

(continued)

Appendix Table A.33 (continued)

Program Characteristic	State-Identified Programs					
	Building Healthy Children	Parents as Teachers	Early Head Start	Head Start	Federal Healthy Start	Community Health Worker Program
Model[a]	—	Parent as Teachers	Early Head Start - Home Based Program Option	—	Healthy Start: Home Visiting	—
Target population	Low-income, pregnant women under age 21	Pregnant women under age 21 with a history of child abuse/child welfare services	Low-income pregnant women and families with children birth to age 3	Low-income children, as well as their families and communities	Pregnant and parenting women	Women with late or no prenatal care or poor compliance with prenatal care
Number served[b]	197 families	—	—	—	1,262 families[c]	3,500
Counties served	1[h]	4[i]	41[j]	55[k]	7[l]	19[m]

SOURCE: New York 2010 MIECHV needs assessment.

NOTES: Additional home visiting programs were named in the needs assessment. This table was limited to the 10 programs that the state reported serving the most families.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers are annual, unless otherwise noted. The number served was not available for some state-identified programs.

[c]The time period for this number was not specified.

[d]Counties served include the target county of Bronx.

[e]Counties served include the target counties of Bronx, Kings, Monroe, New York, Onondaga, Queens, and Richmond.

[f]Counties served include the target counties of Bronx, Erie, Kings, Nassau, New York, Queens, Suffolk, and Westchester.

[g]Counties served include the target counties of Albany, Bronx, Erie, Kings, New York, Oneida, Orange, Queens, Richmond, Suffolk, and Westchester.

[h]County served is Monroe, a target county.

[i]Counties served include the target counties of Kings and Monroe.

[j]Counties served include the target counties of Bronx, Erie, Kings, Monroe, New York, Oneida, Onondaga, Orange, Queens, Richmond, Suffolk, Westchester, and Orange.

[k]Counties served include the target counties of Albany, Bronx, Erie, Kings, Monroe, Nassau, New York, Onondaga, Oneida, Orange, Queens, Richmond, Suffolk, Westchester, and Orange.

[l]Counties served include the target counties of Kings, Monroe, Nassau, New York, Onondaga, Queens, and Suffolk.

[m]Counties served include the target counties of Albany, Bronx, Erie, Kings, Nassau, New York, Oneida, Onondaga, Orange, Queens, Suffolk, and Westchester.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.34

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: North Carolina

	State-Identified Programs				
Program Characteristic	Early Head Start	Healthy Families America	Nurse-Family Partnership	Parents as Teachers	Parent Aide
Model[a]	Early Head Start - Home Based Program Option	Healthy Families America	Nurse-Family Partnership	Parents as Teachers	—
Target population	Children birth to age 3, expectant mothers, and their families with incomes below 100% of the federal poverty level, families receiving [Temporary Assistance for Needy Families], children in foster care, homeless families; and children with special needs	Families with young children who are at risk for child abuse and neglect and other adverse childhood experiences	First-time, low-income mothers (Medicaid births); prenatal until child's 2nd birthday	Families prenatally through age 5 with at least 1 risk factor[b]	Families at risk for child maltreatment … must have at least 1 child 12 years old or younger be considered at risk for abuse (either through the presence of dynamics common in abusive families or the presence of substantiated abuse or neglect)
Number served[c]	2,973 slots for children, expectant mothers and their families[d]	427 slots for families	825 slots for mothers	5,813 slots for families	288 slots
Counties served	38[e]	6[f]	10[g]	67[h]	10[i]

(continued)

Appendix Table A.34 (continued)

Program Characteristic	State-Identified Programs				
	Eastern Baby Love Plus	Northeastern Baby Love Plus	Triad Baby Love Plus	Stepping Stones	Healthy Start Corps
Model[a]	—	—	—	—	—
Target population	African-American women of childbearing age, their infants, and families	African-American and Native American women (ages 15-44) and their families	African-American women (ages 15-44) and their families	First-time pregnant or parenting adolescents parents 19 years old or younger	Women of childbearing age (14-44 years), children under age 2, and their families with at least 3 risk factors related to infant mortality or morbidity
Number served[c]	—[j]	—[j]	—[j]	75 slots for families	—[j]
Counties served	7[k]	5[l]	2	1	1[m]

SOURCE: North Carolina 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]Groups with risk factors include low-income parents, children with special needs, parents with mental health or substance abuse issues, teen parents, first-time parents, and parents at risk for perpetrating child maltreatment.

[c]These numbers were reported as the current capacity at the time the North Carolina needs assessment was written in 2010. The number served was not available for some state-identified programs.

[d]According to the North Carolina need assessment "this number is both a duplicated and overestimated: duplicated as some Early Head Start sites employ [Healthy Families America, Nurse-Family Partnership, or Parents as Teachers] as their home visiting modality; overestimated as not all [Early Head Start] programs employ the home-based option."

[e]Counties served include the target counties of Buncombe, Durham, Northampton, Halifax, Hertford, and Robeson.

[f]Counties served include the target counties of Burke and Durham.

[g]Counties served include the target counties of Buncombe and Robeson.

[h]Counties served include the target counties of Burke, Northampton, Hertford, Edgecombe, Robeson, and Columbus.

[i]Counties served include the target county of Durham.

[j]The three Baby Love Plus programs and the Healthy Start Corps Program are all initiatives within the federally funded Healthy Start program in North Carolina. In total their current capacity at the time the needs assessment was being written was reported as 323.5.

[k]Counties served include the target county of Edgecombe.

[l]Counties served include the target counties of Northampton, Halifax, and Hertford.

[m]Counties served include the target county of Robeson.

Appendix Table A.35

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: North Dakota

Program Characteristic	State-Identified Programs				
	Nurse-Family Partnership	Healthy Families America	Family and Child Education Program	Head Start/ Early Head Start	Healthy Start
Model[a]	Nurse-Family Partnership	Healthy Families America	Parents as Teachers	Early Head Start - Home Based Program Option	—
Target population[b]	Serves families in the city of Fargo, ages prenatal to 2 years … first-time mothers and families of low income	Women admitted prenatally or within 2 weeks of birth, until age 3	American Indian families are served ages prenatal through 5	—	American Indian families
Number served[c]	182 children	66 clients[d]	41 families	At least 114 children[e]	71 prenatal clients 170 postpartum families[d]
Counties served	1	4	1	At least 17[f]	5[g]

SOURCE: North Dakota 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The target population served was not available for some state-identified programs.

[c]These numbers come from 2008, unless otherwise noted. The number served was not available for some state-identified programs.

[d]These numbers come from 2009 and include some clients and families served in Montana.

[e]The North Dakota needs assessment reported the number of children served by some, but not all, of its Head Start/Early Head Start programs.

[f]The North Dakota needs assessment reported the geographic areas served by some, but not all, of its Head Start/Early Head Start programs.

[g]In addition to the five counties in North Dakota, the program also serves three counties in Montana.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.36

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Ohio

	State-Identified Programs						
Program Characteristic	Help Me Grow	Ohio Infant Mortality Reduction Initiative	Head Start/ Early Head Start	Columbus Healthy Start: Caring for 2	Cleveland Healthy Start: The Moms First Project	Healthy Connections Home Visitation	Ohio Children's Trust Fund Projects[a]
Model[b]	—	"Based on Healthy Start: Home Visiting"	Early Head Start - Home Based Program Option	—	—	Healthy Families America	Parents as Teachers, Nurse-Family Partnership
Target population	Pregnant women and their children up to age 3	Pregnant women, infants, and children up to age 2	Head Start: young children from birth to compulsory school age, pregnant women and their families; Early Head Start: young children, birth to 3, and pregnant women	Pregnant women and their children up to age 2	Pregnant women and infants up to age 1	Parents and guardians with children under 3 months of age	Pregnant women, and women with newborns and young children
Number served[c]	12,000[d]	750[d]	Head Start: 500[d] Early Head Start: 2,190	180 women and their children	2,373 families[e]	52 families	650[d]
Counties served[f]	88[g]	—[h]	42[i]	1[j]	1	1[k]	20[l]

(continued)

Appendix Table A.36 (continued)

SOURCE: Ohio 2010 MIECHV needs assessment.

NOTES: [a]According to the Ohio needs assessment, "The [Ohio Children's Trust Fund (OCTF)] invests in a number of home visiting programs at the local level, through partnerships with Ohio's Family and Children First Councils, including Newborn Home Visiting programs, Help Me Grow, Parents as Teachers, Nurse-Family Partnership, Incredible Years Home Visitation, and Home-Based Parenting Programs."

[b]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[c]The time period for these numbers is not specified unless otherwise noted.

[d]The Ohio needs assessment reported that these numbers represent the approximate number of either individuals or families served.

[e]This number comes from 2009.

[f]The number of counties served was not available for some state-identified programs.

[g]Counties served include the target counties of Clark, Franklin, Hamilton, Lucas, Marion, Montgomery, Pike, Ross, Trumbull, and Vinton.

[h]Counties served include the target counties of Clark, Franklin, Hamilton, Lucas, and Montgomery.

[i]Counties served include the target counties of Clark, Hamilton, Lucas, Montgomery, Pike, and Vinton.

[j]The county served is the target county of Franklin.

[k]The county served is the target county of Lucas.

[l]Counties served include the target county of Clark.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.37

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Oklahoma

Program Characteristic	State-Identified Programs			
	Child Maltreatment Prevention in High Risk Families Pilot Project	Evidence-Based Home Visitation Federal Grant	Sooner Start Early Intervention Program	Start Right
Model[a]	SafeCare	SafeCare	—	Healthy Families America
Target population	Parents/caregivers at high risk must have at least 1 of the following conditions: an active substance abuse disorder, a history of domestic violence, a mental health diagnosis, a physical or developmental disability resulting in impaired parenting, or a combination of the above. Families can have multiple children with at least 1 child 5 years or younger. Parents must not have a history of more than 2 prior child abuse or neglect referrals or have an open child welfare case.	Latino families with at least 1 child 5 years of age or younger; Parents must not have a history of more than 2 prior child abuse or neglect referrals or have an open child welfare case.	Infant and toddlers who exhibit delay in their developmental age compared to their chronological age of 50% or score 2 standard deviations below the mean in one of the following domains: cognitive, physical, communication, social/emotional, or adaptive development; or exhibit a delay in their developmental age compared to their chronological age of 25 percent or score 1.5 standard deviations below the mean in 2 or more of the above reported areas; or have a diagnosed physical or mental condition that has a high probability of resulting in delays	First-time, pregnant women beyond their 28th week of pregnancy; women pregnant with a child other than their first (regardless of gestational age); any parents with a child less than 1 year of age who assesses positively on the Kempe Stress Scale
Number served[b]	39[c]	25[c]	13,534 infants and toddlers	1,247 families
Counties served	1[d]	1[d]	77[e]	40[f]

(continued)

Appendix Table A.37 (continued)

Program Characteristic	State-Identified Programs			
	Oklahoma Parents as Teachers	Healthy Start	Early Head Start Home Visiting	Children First: Oklahoma's Nurse-Family Partnership
Model[a]	Parents as Teachers	Healthy Start: Home Visiting	Early Head Start - Home Based Program Option	Nurse-Family Partnership
Target population	All families with children, birth to 36 months of age, who reside in participating school districts	Medically/socially high-risk, pregnant women	Low-income (100% of the federal poverty level) pregnant women and families with infants and toddlers less than 3 years of age	Low-income pregnant women who are expecting to parent for the first time; women must enroll prior to the 29th week of pregnancy and the family's household income must be at or below 185% of the federal poverty level.
Number served[b]	4,338 families 5,027 children[g]	954 clients 4,741 community participants	1,856 children 58 pregnant women	4,590 families
Counties served	37[h]	2[i]	22[j]	69[k]

SOURCE: Oklahoma 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers come from FY 2009, unless otherwise noted.

[c]The time period for these numbers is not specified.

[d]Counties served include the target county of Oklahoma.

[e]Counties served include the target counties of Garfield, Kay, Comanche, Muskogee, Oklahoma, and Tulsa.

[f]Counties served include the target counties of Kay, Comanche, Oklahoma, and Tulsa.

[g]These numbers come from the 2008-2009 school year.

[h]Counties served include the target counties of Garfield, Muskogee, Oklahoma, and Tulsa.

[i]Counties served include the target counties served include the target counties of Oklahoma and Tulsa.

[j]Counties served include the target counties of Comanche, Muskogee, Oklahoma, and Tulsa.

[k]Counties served include all target counties.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.38

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Oregon

Program Characteristic	State-Identified Programs				
	Babies First!	CaCoon	Family Support and Connections Program	Early Head Start	Head Start/Oregon Head Start Prekindergarten
Model[a]	—	—	—	Early Head Start - Home Based Program Option	—
Target population	Children 0-5 years at risk for poor health and development outcomes	Birth to 21 years old identified with special health needs	[Temporary Assistance for Needy Families (TANF) recipients] at risk for child welfare intervention; 10% may be non-TANF families at risk for child welfare intervention	Pregnant mothers and families with infants and toddlers up to age 3 who are living in poverty	Families of preschool-age children who are living in poverty
Number served[b]	9,284[c]	1,634[c]	4,000	1,200[d]	13,000
Counties served[e]	36[f]	36[f]	36[f]	20[g]	36[f]

(continued)

Appendix Table A.38 (continued)

Program Characteristic	State-Identified Programs				
	American Indian and Alaskan Native Early Head Start and Head Start	Migrant and Seasonal Early Head Start and Head Start	Healthy Start/ Healthy Families Oregon	Maternity Case Management	Nurse-Family Partnership/ Multnomah County Health Department
Model[a]	Early Head Start - Home Based Program Option	Early Head Start - Home Based Program Option	Healthy Families America	—	Nurse-Family Partnership
Target population	American Indian and Alaskan Native pregnant mothers and families with infants and toddlers up to age 3 and families of preschool-age children who are living in poverty	Children of migrant and seasonal farm workers	First-birth families screened as high risk for adverse childhood outcomes	Client must be enrolled before delivery; prenatal through 2 months postpartum	Low-income, first-time parents and their children; services begin in early pregnancy (prior to 28 weeks gestational age)
Number served[b]	395	2,741 children 352 pregnant women	3,388 families[d]	3,733[d]	194 families[h]
Counties served[e]	—[i]	Early Head Start: 7; Head Start: 12[j]	35[j]	30[j]	1[k]

SOURCE: Oregon 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers come from the 2009-2010 program year, unless otherwise specified.

[c]These numbers come from FY 2009.

[d]The time period for these numbers is not specified.

[e]The number of counties served was not available for some state-identified programs.

[f]Counties served include the target counties of Jefferson, Lane, Lincoln, Malheur, Morrow, Umatilla, Multnomah, and Tillamook.

[g]Counties served include the target counties of Lane, Morrow, Multnomah, and Umatilla.

[h]This number comes from 2009.

[i]Services are offered to five of nine recognized tribes.

[j]Specific counties served were not provided.

[k]The county served is the target county of Multnomah.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.39

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Pennsylvania

Program Characteristic	State-Identified Programs						
	Nurse-Family Partnership	Parent-Child Home Program	Early Head Start	Family Centers	Project ELECT	Family Literacy/ Even Start[a]	Healthy Start/ Other[b]
Model[c]	Nurse-Family Partnership	Parent-Child Home Program	Early Head Start - Home Based Program Option	Parents as Teachers	—	Even Start: Home Visiting	Healthy Start: Home Visiting
Target population[d]	Low-income, first-time pregnant women	Families with children ages 2-3 challenged by low levels of income, education, and literacy	Low-income families with infants and toddlers, and pregnant women	High-risk families (due to economic, health or educational circumstances)	Teen parents	—	High-risk pregnant women
Number served[e]	Over 4,600 women and children	Over 1,300 children	Over 4,370 families	4,225 families	Nearly 3,200 teen parents[f,g]	Over 2,000 families[f,g]	Over 7,300 women[g]
Counties served	40[h]	25[i]	42[j]	29[k]	36[l]	53[m]	12[n]

(continued)

Appendix Table A.39 (continued)

SOURCE: Pennsylvania 2010 MIECHV needs assessment

NOTES: [a]Two Family Literacy programs are administered by the Pennsylvania Department of Education, one through state funds and one, Even Start, through federal funds.

[b]County/municipal health departments offer home visiting services. Some sites use the Healthy Start model, but others do not.

[c]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[d]The target population was not available for some state-identified programs.

[e]These numbers come from 2009-2010, unless otherwise noted.

[f]These numbers include some families who did not receive home visiting services.

[g]The time period for these numbers was not specified.

[h]Counties served include the target counties of Berks, Dauphin, Erie, Jefferson, and Perry.

[i]Counties served include the target counties of Clinton, Erie, and Mifflin.

[j]Counties served include the target counties of Berks, Dauphin, Jefferson, Mifflin, and Venango.

[k]Counties served include the target counties of Berks, Cameron, Clarion, Dauphin, Erie, McKean, and Perry.

[l]Counties served include the target counties of Berks, Cameron, Dauphin, Erie, and Forest.

[m]Counties served include the target counties of Berks, Cameron, Crawford, Jefferson, Dauphin, and Erie.

[n]Counties served by Healthy Start include the target county of Dauphin.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.40

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Rhode Island

Program Characteristic	State-Identified Programs					
	First Connections	Evidence-Based Home Visiting Nurse-Family Partnership Program	Project Connect	Early Head Start	Families First	Rhode Island Home Instruction for Parents of Preschool Youngsters
Model[a]	—	Nurse-Family Partnership	—	Early Head Start - Home Based Program Option	—	Home Instruction for Parents of Preschool Youngsters
Target population	Children birth to age 3 who are at risk for poor developmental outcomes	Pregnant, low-income, first-time mothers younger than 25 years of age	Department of Children, Youth and Families (DCYF)-involved parents dealing with issues of substance abuse	Pregnant women and children up to age 3 with income less than 130% of the federal poverty level; DCYF foster child; families who receive [Supplemental Security Income] or [Temporary Assistance for Needy Families]; homeless families; 10% over income limits; 10% with special needs	Pregnant women in the late stages of pregnancy or with a child up to 11 months old	Children ages 3 to 5
Number served[b]	3,179 families	100 mothers	84 families	376 children	89 families	256 children
Cities served[d]	Statewide[e]	4[f]	Statewide[e]	18[g]	Statewide[e]	4[h]

(continued)

Appendix Table A.40 (continued)

Program Characteristic	State-Identified Programs			
	Great Beginnings	Rhode Island Parents as Teachers	Family Care Community	Youth Success
Model[a]	—	Parents as Teachers	—	—
Target population	At-risk women in their 2nd trimester of pregnancy until the child's first birthday	All families with young children including pregnant women	(1) Families with children and youth who are at risk for child abuse, neglect and or dependency and DCYF involvement, (2) children birth to age 18 years old who meet the criteria for having a serious emotional disturbance, (3) youth concluding sentence to the Rhode Island Training School (RITS) who agree to participate, including youth leaving the RITS and youth leaving temporary community placement	Pregnant and parenting teens who are cash assistance or medical assistance recipients
Number served[b]	14 families	20 pregnant women 836 children	644 families	791 clients[c]
Cities served[d]	4[i]	14[j]	Statewide[e]	Statewide[e]

SOURCE: Rhode Island 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers come from 2009, unless otherwise noted.

[c]These numbers come from April 1, 2009 to December 31, 2009.

[d]The Rhode Island needs assessment reported the number of cities served by the state-identified programs.

[e]Cities served include the target communities of Central Falls, Pawtucket, Providence, Woonsocket, Newport, and West Warwick.

[f]Cities served include the target communities of Central Falls, Pawtucket, and Providence.

[g]Cities served include the target communities of Central Falls, Pawtucket, Providence, Newport, and West Warwick.

[h]Cities served include the target communities of Central Falls and Pawtucket.

[i]Cities served include the target community of Woonsocket.

[j]Cities served include the target communities of Pawtucket, Providence, Woonsocket, and Newport.

Appendix Table A.41

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: South Carolina

Program Characteristic	State-Identified Programs			
	Early Head Start	Early Steps to School Success	Healthy Families America	Healthy Start
Model[a]	Early Head Start - Home Based Program Option	—	Healthy Families America	Healthy Start: Home Visiting
Target population	Families and children through entrance to school	Pregnant women and children birth to age 5; families facing geographic isolation, a limited tax base to fund early childhood programs, limited access to reading materials, high transportation costs, and a lack of understanding about the importance of early childhood development	At-risk families prenatally through year 5	High-risk women who are prenatal or have a child through 2 years of age
Number served[b]	140	200	90	2,420
Counties served	14[c]	6	2[d]	10

(continued)

Appendix Table A.41 (continued)

	State-Identified Programs		
Program Characteristic	Nurse-Family Partnership	Parents as Teachers	Parent-Child Home Program
Model[a]	Nurse-Family Partnership	Parents as Teachers	Parent-Child Home Program
Target population	First-time, low-income pregnant mothers	Families from pregnancy through kindergarten	Children between 3 and 5 years of age
Number served[b]	820	3,900	700
Counties served	8[e]	43[f]	11[g]

SOURCE: South Carolina 2010 MIECHV needs assessment.

NOTES: The South Carolina needs assessment provided information on its seven primary home visiting programs in operation; however, it acknowledged that there were other home visiting programs operating as well.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers are approximate number of clients served annually.

[c]Counties served include the target counties of Edgefield, Greenville, Greenwood, Saluda, Spartanburg, and Union.

[d]Counties served include the target counties of Greenwood and Pickens.

[e]Counties served include the target counties of Berkeley, Charleston, Dorchester, Greenville, and Spartanburg.

[f]Counties served include the target counties of Abbeville, Berkeley, Charleston, Dorchester, Edgefield, Greenville, Greenwood, McCormick, Pickens, Saluda, Spartanburg, and Union.

[g]Counties served include the target counties of Charleston and Dorchester.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.42

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: South Dakota

	State-Identified Programs		
Program Characteristic	South Dakota Bright Start Initiative	Parents as Teachers	Head Start
Model[a]	"A component of the program is Nurse-Family Partnership"	Parents as Teachers	Early Head Start - Home Based Program Option
Target population	Expectant mothers	Parents and children from conception to kindergarten	Low-income families with children under 3 years old and … pregnant women
Number served	583 mothers 486 infants/children[b]	390 children 285 families[c]	1,393 funded slots for children[d]
Counties served	3[e]	13[f]	65[g]

SOURCE: South Dakota 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014.

[b]These numbers come from FY 2010.

[c]These numbers come from the *2009-2010 Annual Parents as Teachers Program Report* for South Dakota.

[d]Instead of number served, the South Dakota needs assessment provided the number of funded slots between 2009 and 2010. This figure only includes slots for children to receive at least some home-based services.

[e]Counties served include the county of Shannon. Specifically, the program serves Pine Ridge, which is a target community located in Shannon.

[f]Counties served include the county of Shannon. Specifically, the program serves Kyle and Pine Ridge, which are target communities located in Shannon.

[g]Counties served include the counties of Bennett, Jackson, and Shannon, portions of which are target communities. This number represents only counties where at least some home-based services were provided: 35 counties were served by both home-based Head Start and Early Head Start - Home Based Program Option, 28 counties were served only by home-based Head Start, and 2 counties were served only by Early Head Start - Home Based Program Option.

Appendix Table A.43

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Tennessee

Program Characteristic	State-Identified Programs				
	Child Health and Development Program	Healthy Families America: Credentialed	Healthy Start: Healthy Families America	Help Us Grow Successfully	Tennessee Early Intervention System
Model[a]	—	Healthy Families America	Healthy Families America	—	—
Target population[b]	Teen parents under the age of 18, other parents at risk of abuse and neglect ([Department of Children's Services]-referred), [Aid to Families with Dependent Children], [Supplemental Security Income], or [federal poverty level] families	First-time mothers with little or no prenatal care and limited support systems	Prenatal women and teens, infants less than 4 months, families with children under 5 years with low incomes	Prenatal women and teens, families with children under 6, women up to 2 years postpartum, loss of a child before age 2	Children with disabilities with a 25% delay in 2 developmental areas or 40% delay in 1 area
Number served[c]	1,298 children	620 families 777 children	857 families with 1,060 children	5,895 children	7,688 families with 7,792 children
Counties served[d]	22[e]	10[f]	19[g]	95[h]	95[h]

(continued)

Appendix Table A.43 (continued)

Program Characteristic	State-Identified Programs				
	Early Head Start and Home Based Head Start	Healthy Start: Federal	Nurse for Newborns	Parents as Teachers	Porter-Leath Mental Health Services
Model[a]	Early Head Start - Home Based Program Option	Healthy Start: Home Visiting	—	Parents as Teachers	—
Target population[b]	—	Families with low-birth-weight babies, little or no prenatal care, medically fragile	Medically fragile teen mothers, drug-involved families	Teen mothers, first-time mothers, pregnant teens, drug-involved families	Pregnant teens with little or no prenatal care with limited support systems
Number served[c]	568 children	219 families with 218 children	837 families with 738 children	600 families with 816 children	753 families with 1,083 children
Counties served[d]	21[f]	2[i]	16[j]	6[k]	1[f]

SOURCE: Tennessee 2010 MIECHV needs assessment and FY 2011 state plan.

NOTES: Additional home visiting programs were named in the Tennessee needs assessment. This table was limited to the 10 programs that the state reported serving the most families.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The target population was not available for some state-identified programs.

[c]These numbers come from 2009.

[d]The information on target counties served was derived from multiple tables in the Tennessee needs assessment and the FY 2011 state plan. Since state-identified programs were sometimes referred to in different ways in the different tables, it was sometimes difficult to determine which state-identified programs were offered in which target counties.

[e]Counties served include the target county of Campbell.

[f]Counties served include the target county of Shelby.

[g]Counties served include the target counties of Davidson and Montgomery.

[h]Counties served include all of the target counties.

[i]Counties served include the target counties of Davidson and Shelby.

[j]Counties served include the target counties of Davidson, Maury, and Montgomery.

[k]Counties served include the target county of Hamilton.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.44

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Texas

Program Characteristic	State-Identified Programs			
	AVANCE Parent Child Education Program	Healthy Families	Home Instruction for Parents of Preschool Youngsters	Nurse-Family Partnership
Model[a]	—	Healthy Families America	Home Instruction for Parents of Preschool Youngsters	Nurse-Family Partnership
Target population	Primarily Hispanic families with children ages 0-3 years in low-income, at-risk communities	Pregnant and parenting teens with children ages 0-5 years	Parents of children ages 3-5 years with limited financial resources or lack of education; however, enrollment is not limited to low-income families	All Medicaid-eligible (at or below 185% of the federal poverty level), first-time mothers from the 28th week of pregnancy through the child's 2nd birthday
Number served[b]	—	100 children, 188 families	1,700 children, 1,700 families	418 children, 1,317 families
Geographic areas served[c]	40 sites in 9 locations[d]	180 sites[e]	7 communities (including 7 cities and 6 school districts)[e]	11 sites in 7 cities[e]

(continued)

Appendix Table A.44 (continued)

Program Characteristic	State-Identified Programs		
	Parents as Teachers	Parent-Child Home Program	Positive Parenting Program
Model[a]	Parents as Teachers	Parent-Child Home Program	—
Target population	Pregnancy through the child's entrance into kindergarten (ages 0-5 years)	Families with children ages 16 months to 4 years and 1 or more of the following risk factors: low income, low education level, teen or single parent, social isolation, homeless, or language barrier	Children under age 12 who are at risk for child neglect and residing in Dickinson, Texas City, Santa Fe, or La Marque in Galveston County
Number served[b]	—	80 families	—
Geographic areas served[c]	108 sites[f]	1 site serving 8 counties	1 county

SOURCES: Texas 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: Additional home visiting programs were named in the Texas needs assessment. This table was limited to the seven programs/models that were highlighted in Table 20 of the needs assessment ("Summary of Current Inventory of State Home Visiting Programs/Models").

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers are annual. The number served was not available for some state-identified programs.

[c]The Texas needs assessment reported various geographic areas that were served by the state-identified programs.

[d]Geographic areas served include the target communities of Dallas, McAllen, and Corpus Christi.

[e]Geographic areas served include the target community of Dallas.

[f]Geographic areas served include the target communities of Dallas, McAllen, and Amarillo.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.45

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Utah

	State-Identified Programs				
Program Characteristic	Salt Lake Valley Health Department	Salt Lake Community Action Program	DDI Vantage	Utah Parents as Teachers	Salt Lake City School District
Model[a]	Nurse-Family Partnership	Early Head Start - Home Based Program Option	Early Head Start - Home Based Program Option; Parents as Teachers	Parents as Teachers	Parents as Teachers
Target population	First-time, low-income, pregnant women at or before 28 weeks of pregnancy	Pregnant women and families with children from birth to 3 years old	Women at or below 100% of the federal poverty level who are pregnant or have a child under age 3	Low-income families with children from birth to 5 years of age	Families with children from birth to age 5
Number served	100 families[b]	73 families[b]	92 families 118 children[c]	51 families 69 children[b]	157-189 families[d]
Counties served	1[e]	1[e]	1[e]	1[e]	1[e]

(continued)

Appendix Table A.45 (continued)

Program Characteristic	State-Identified Programs				
	Family Support Center	Bright Beginnings	The Learning Center	Rural Utah Child Development Center	Outreach
Model[a]	—	—	Early Head Start - Home Based Program Option; Parents as Teachers	Early Head Start - Home Based Program Option	—
Target population	Families of children ages 0-18 years	Parents of children from birth to 6 years	Children ages 0-3 years referred from Division of Child and Family Services; must meet Early Head Start federal poverty guidelines	Pregnant women and families with children from birth to age 3	Any referred parent
Number served	434 adults 283 children[f]	85 families[f]	132 children[f]	60 families[b]	60 families 89 children[f]
Counties served	1[e]	1[g]	1[h]	3[i]	1[i]

SOURCE: Utah 2010 MIECHV needs assessment.

NOTES: The Utah needs assessment provided information only on existing home visiting programs in its identified at-risk communities. Therefore, this table does not reflect the full range of home visiting programs available in the state. Additional home visiting programs were named in the needs assessment. This table was limited to the 10 programs that were reported to be serving the most families.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The time period for these numbers was not specified.

[c]These numbers come from 2007-2008.

[d]These numbers are annual.

[e]The county served is the target county of Salt Lake.

[f]These numbers come from 2009.

[g]The county served is the target county of Weber.

[h]The county served is the target county of Washington. In addition, the program serves a city in northern Arizona.

[i]Counties served include the target county of Carbon.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.46

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Vermont

Program Characteristic	State-Identified Programs									
	Children's Integrated Services One-Plan Pilot Program	Head Start/ Early Head Start	Learning Together	Homebuilders	Parents as Teachers	Touchpoints	Building Bright Futures	Healthy Families America	Nurse-Family Partnership	Life Skills
Model[a]	—	Early Head Start - Home Based Program Option	—	Homebuilders	Parents as Teachers	—	—	Healthy Families America	Nurse-Family Partnership	—
Target population[b]	—	—	—	—	—	—	—	—	—	—
Number served[c]	—	—	—	—	—	—	—	—	—	—
Counties served[d]	—	—	—	—	—	—	—	—	—	—

SOURCE: Vermont 2010 MIECHV needs assessment.

NOTES: Vermont conducted a survey of its home visiting programs and presented all of the information in aggregate, so individual characteristics of each model could not be ascertained. The "state-identified programs" in this table were pulled from a list of models and curricula that survey respondents reported that they used. Aggregate conclusions pulled from the Vermont needs assessment are included in footnotes.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]According to the Vermont needs assessment "almost three-quarters of the Vermont [Maternal, Infant, and Early Childhood Home Visiting Programs] define their target service population as 'young parents' and 'at-risk families.' Approximately half also describe their service population as 'first-time mothers' (61%), 'rural families' (52%), or in terms of their programs specific eligibility criteria."

[c]The number of children served by Vermont's home visiting programs in the 2009-2010 program year was reported as follows: 3,977 children ages 0-3, 1,843 children ages 4 to 5, and 685 children ages 6+.

[d]According to the Vermont needs assessment "every county has at a minimum three home visiting programs serving mothers and/or children from ages 0 to 5 years old. Orange and Washington Counties are served by the largest number of programs - Orange County has reportedly 13 and Washington County 12. The average number of [Maternal, Infant, and Early Childhood Home Visiting Programs] per county is six."

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.47

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Virginia

	State-Identified Programs					
Program Characteristic	Resource Mothers Program	Project LINK	BabyCare	Virginia Healthy Start (Loving Steps)	Comprehensive Health Investment Project of Virginia (CHIP of VA)	Early Childhood Special Education
Model[a]	Resource Mothers Program	—	—	—	—	—
Target population[b]	Pregnant and parenting teenagers 19 years and under	Pregnant parenting and "at-risk" substance-using women and their children	Medicaid-eligible pregnant women or infants up to 2 years of age	Pregnant teens and women, interconceptional teens and women, high-risk infants living in communities with high infant mortality, poverty, teen pregnancy, and fetal deaths	Pregnant woman or family with at least 1 child under the age of 6 with family below 200% of poverty, residing in a community with CHIP services	Children age 2 by Sept. 30 through age 5 with an identified disability
Number served[c]	Approximately 2,400 teen mothers and their families (includes own parents and partner)[d]	1,851 women 823 children[e]	—	500 to 600 program participants (pregnant women/teens, interconceptional women/teens and their infants) and infants/toddlers with high-risk conditions[f]	4,000 children and 600 pregnant women in 3,000 families[g]	Approximately 15,000[d]
Communities served[h]	63[i]	30[j]	—	3[k]	30[l]	Statewide[m]

(continued)

Appendix Table A.47 (continued)

Program Characteristic	State-Identified Programs				
	Early Head Start/ Head Start	Parents as Teachers	Healthy Families	Home Instruction Program for Preschool Youngsters	Part C Early Intervention
Model[a]	Early Head Start - Home Based Program Option	Parents as Teachers	Healthy Families America	Home Instruction Program for Parents of Preschool Youngsters	—
Target population[b]	Children ages: Early Head Start, 0-3 years old; Head Start, 3-5 years old	—	Pregnant women and new parents with children under 3 months age	—	Infants and toddlers, birth through 2 who meet Virginia's Part C definition of eligibility, i.e. diagnosed handicapping condition, or 25% delay in one or more developmental areas, or a typical development
Number served[c]	Head Start, 14,448; Early Head Start, 1,648 and 171 pregnant women[f]	150 families[n]	Over 4,500 families[d]	—	10,704 infants, toddlers, and families[o]
Communities served[h]	46[p]	—	75[q]	1	Statewide[m]

(continued)

Appendix Table A.47 (continued)

SOURCE: Virginia 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The target population was not available for all state-identified programs.

[c]The number served was not available for all state-identified programs.

[d]These numbers are annual.

[e]These numbers come from FY 2004.

[f]The time period for these numbers was not specified.

[g]These numbers come from FY 2009.

[h]These numbers represent counties and independent cities, which are considered to be the equivalent of counties. The number of communities served was not available for some of the state-identified programs. The Virginia needs assessment reported that BabyCare was operated by 60 active providers and that Parents as Teachers was operating in two places.

[i]Communities served include the target cities of Danville, Norfolk, and Suffolk.

[j]Communities served include the target city of Fredericksburg.

[k]Communities served include the target city of Norfolk.

[l]Communities served include the target cities of Norfolk and Radford, and the target county of Montgomery.

[m]Communities served include the target cities of Danville, Fredericksburg, Norfolk, Radford, and Suffolk, and the target counties of Montgomery and Southampton.

[n]The Virginia needs assessment reported that not all families received home visiting services.

[o]This number comes from 2006.

[p]Communities served include the target city of Radford and the target counties of Montgomery and Southampton.

[q]Communities served include the target cities of Danville, Fredericksburg, Norfolk, and Suffolk.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.48

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Washington

	State-Identified Programs				
Program Characteristic	Early Head Start	Nurse-Family Partnership	Parents as Teachers	First Steps: Maternity Support Services and Infant Case Management	Children with Special Health Care Needs
Model[a]	Early Head Start - Home Based Program Option	Nurse-Family Partnership	Parents as Teachers	—	—
Target population[b]	Low-income, pregnant women and children to age 3 years	Women with low incomes and pregnant with their 1st child	All pregnant women and children ages 0-5 years	Low-income women and infants	Children ages 0-18 years who have serious physical, behavioral, or emotional conditions that require health and related services beyond those required by children generally
Number served	976 children[c]	1,640 clients[d]	2,109 children; 1,782 families[c]	21,247 women[e]	Approximately 4,000 children[d]
Counties served	29[f,g]	11[h]	18[f]	39[f,i]	39[f]

(continued)

Appendix Table A.48 (continued)

Program Characteristic	State-Identified Programs				
	Early Family Support Services	Early Intervention Program	Early Support for Infants and Toddlers	Parent Child Assistance Program	Early Steps to School Success
Model[a]	—	—	—	—	—
Target population[b]	—	Accepted referrals to Child Protective Services that are low risk; families with children ages 0-5 years; children who have identified health or developmental need and could benefit from a home visitation nurse; children may also be in relative or foster care	Families with children ages 0-3 years who have developmental disabilities or developmental delays	Women who abuse alcohol or drugs during pregnancy, from pregnancy until the child is 3 years old	Pregnant women and children birth to age 5 [in] … poor, rural communities
Number served	1,406 families[d]	1,404 families[d]	5,242 children and families[j]	734 slots[k]	200 children >300 families[l]
Counties served	20[m]	17[n]	39[f]	9[o]	3

(continued)

Appendix Table A.48 (continued)

SOURCE: Washington 2010 MIECHV needs assessment.

NOTES: Additional home visiting programs were named in the needs assessment. This table was limited to the 10 programs that the state reported serving the most families.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The target population served was not available for one state-identified programs.

[c]These numbers come from the 2008-2009 school year.

[d]These numbers come from 2009.

[e]This number represents women who gave birth in 2008. Visits may have taken place in 2007, 2008, or 2009.

[f]Counties served include the target counties of Clallam, Pend Oreille, and Yakima. Counties served also include King, Pierce, and Snohomish, portions of which are target communities

[g]Children in these counties may have received center-based services, home-based services, or a combination of the two.

[h]Counties served include the target county of Yakima. Counties served also include King, Pierce and Snohomish, portions of which are target communities.

[i]Women in these counties may have received services through home visits or at clinic sites.

[j]This number is "as of December 1, 2009." Between October 1, 2008 and September 30, 2009, the program served 9,395 children and families.

[k]This number is "as of December 31, 2009." According to the Department of Social and Health Services, the slots are usually filled.

[l]This number is "as of July 6, 2010."

[m]Counties served include the target counties of Clallam and Pend Oreille, as well as Pierce, Snohomish, and King counties, portions of which are target communities.

[n]Counties served include the target county of Pend Oreille. Counties served also include King, Pierce, and Snohomish, portions of which are target communities.

[o]Counties served include the target counties of Clallam and Yakima. Counties served also include King and Pierce, portions of which are target communities.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.49

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: West Virginia

	State-Identified Programs					
Program Characteristic	Healthy Families America	Maternal Infant Health Outreach Workers	Parents as Teachers	Head Start/Early Head Start	Right From The Start Program	Healthy Start/Helping Appalachian Parents and Infants Project
Model[a]	Healthy Families America	Maternal Infant Health Outreach Worker	Parents as Teachers	Early Head Start - Home Based Program Option	—	Healthy Start: Home Visiting
Target population	Overburdened families who are at risk for child abuse and neglect and other adverse childhood experiences. The model is designed to work with families having a history of trauma, intimate partner violence, mental health issues, or substance abuse. Services can begin during pregnancy and for 3 to 5 years after birth of baby.	Any pregnant woman who voluntarily chooses to participate … Clients enter the program prenatally and continue with home visiting services through the child's 3rd year of life.	Voluntary to any and all families prenatal through age 5	Low-income families with infants and toddlers and pregnant women	West Virginia residents with positive pregnancy test, an estimated due date, with income less than 185% of the federal poverty level, eligible for West Virginia Medicaid, infants less than 1 year of age	Women, infants, and families at highest risk (up to 2 years following birth of infants)
Number served[b]	88 prenatal 88 children ages 0-3 13 children ages 3-5	99 prenatal 176 children ages 0-3 25 children ages 3-5	—	511 children	3,382 prenatal 3,499 children ages 0-1	521 prenatal 308 children ages 0-2
Counties served	2[c]	5	16	Statewide[d]	Statewide[d]	8

(continued)

Appendix Table A.49 (continued)

SOURCE: West Virginia 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers come from 2009. The number served was not available for one program.

[c]Counties served include the target counties of Cabell and Wayne.

[d]Counties served include the target counties of Boone, Cabell, Mason, McDowell, and Wayne.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.50

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Wisconsin

Program Characteristic	State-Identified Programs		
	Honoring Our Children	MCH Home Visitation Services	Healthy Families and Early Head Start
Model[a]	—	—	Healthy Families America; Early Head Start - Home Based Program Option
Target population	Parents of newborns; pregnant teens/teen mothers; low-income families; mothers who are/were PNCC participants; pregnant women; parents affected by substance-related or substance-use disorders; pregnant women referred for addiction, mental health, or emotional well-being counseling; children affected by prenatal alcohol or drug exposure	Pregnant and parenting teens; low-income families; mothers who are/were PNCC participants; parents with cognitive limitations; children/families with special medical/developmental needs; parents at risk of child abuse or neglect; fathers as primary caretakers; parents affected by substance-related or substance-use disorders; pregnant women referred for addiction, mental health, or emotional well-being counseling; children affected by prenatal alcohol or drug exposure	Pregnant teens/teen mothers; low-income families; mothers who are/were PNCC participants; parents with cognitive limitations; children/families with special medical/developmental needs; parents at risk of child abuse or neglect; fathers as primary caretakers; first-time parents; parents affected by substance-related or substance-use disorders; children affected by prenatal alcohol or drug exposure
Number served[b]	602	616	265
Counties served[c]	10[d]	1[e]	1[e]

(continued)

Appendix Table A.50 (continued)

Program Characteristic	State-Identified Programs			
	The Family Enrichment Program	Families First	Empowering Families of Milwaukee	Home Visiting
Model[a]	Nurturing Parenting Program; Healthy Families America	—	Parents as Teachers	—
Target population	Universal service to parents of newborns; pregnant teens/mothers; low-income families; mothers who are/were PNCC participants; parents with cognitive limitations; parents at risk of child abuse or neglect; pregnant women; first-time parents	Pregnant teens/teen mothers; low-income families; mothers who are/were PNCC participants; parents with cognitive limitations; children/families with special medical/developmental needs; parents at risk of child abuse or neglect; fathers as primary caretakers; grandparents as primary caretakers; first-time parents; parents affected by substance-related or substance-use disorders; pregnant women referred for addiction, mental health, or emotional well-being counseling; children affected by prenatal alcohol or drug exposure	Pregnant and parenting teens; low-income families; mothers who are/were PNCC participants; parents with cognitive limitations; children/families with special medical/developmental needs; parents at risk of child abuse or neglect; pregnant women	Parents affected by substance use/abuse and risk factors with children ages 3 years and older
Number served[b]	1,012 families	350	380 families	570 families
Counties served[c]	1[f]	1[g]	1[f]	1[f]

(continued)

Appendix Table A.50 (continued)

Program Characteristic	State-Identified Programs		
	Parent Connection	Milwaukee Healthy Beginnings Project	Parent Support
Model[a]	Parents as Teachers	—	—
Target population	Pregnant teens/teen mothers; low-income families; mothers who are/were PNCC participants; parents with cognitive limitations; children/families with special medical/developmental needs; parents at risk of child abuse or neglect; fathers as primary caretakers; first-time parents; parents affected by substance-related or substance-use disorders; pregnant women referred for addiction, mental health, or emotional well-being counseling; children affected by prenatal alcohol or drug exposure	Parents of newborns; pregnant and parenting teens; low-income families; mothers who are/were PNCC participants; parents with cognitive limitations; children/families with special medical/developmental needs	Low-income families; parents affected by substance-related or substance-use disorders
Number served[b]	555	408 families	314 families
Counties served[c]	3	1[f]	1[f]

SOURCE: Wisconsin 2010 MIECHV needs assessment.

NOTES: The Wisconsin needs assessment only provided information on the home visiting programs operating in each of the 18 at-risk communities that were identified in the needs assessment. This table was limited to the 10 programs that the state reported serving the most families. The acronym "PNCC" was not defined in the needs assessment.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]Programs sometimes reported the number served as the sum of the number of pregnant women, new mothers and fathers, infants, toddlers, preschoolers, and children over 5 served by the program. In these cases, the table lists the number served without specifying all of the different categories of clients served. The time period for these numbers was not specified.

[c]Number of counties served was only available for some of the counties served by the state-identified program.

[d]Counties served include the target counties of Ashland, Burnett, Forest, and Sawyer. This program also serves tribes that are not limited to one county.

[e]Counties served include the target county of Brown.

[f]Counties served include the target county of Milwaukee.

[g]Counties served include the target county of Rock.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.51

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Wyoming

Program Characteristic	State-Identified Programs					
	Best Beginnings for Wyoming Babies	Nurse-Family Partnership	Parents as Teachers	Head Start	Early Head Start	Even Start
Model[a]	—	Nurse-Family Partnership	Parents as Teachers	—	Early Head Start - Home Based Program Option	Even Start: Home Visiting
Target population	Pregnant women	Temporary Assistance to Needy Families (TANF)-eligible teens who are first-time mothers and high risk, as determined by the Best Beginnings for Wyoming Babies program risk assessment	Families throughout pregnancy until their child enters kindergarten	Low-income children 3 to 5 years of age; children of families who meet 100% of federal poverty guidelines; children in foster care or who are homeless	Low-income families with pregnant women and infants and toddlers through the age of 3 years	Low-income families with young children
Number served[b]	—	386 families[c]	570 families 805 children	386 participants[d]	221 participants[e]	441 children[f]
Counties served	Statewide[g]	12[g]	13[h]	—[g]	3[h,i]	5[h]

(continued)

Appendix Table A.51 (continued)

SOURCE: Wyoming 2010 MIECHV needs assessment.

NOTES: The Wyoming needs assessment only provided information on the home visiting programs operating in each of the seven at-risk counties that were identified in the needs assessment.

[a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The number served was not available for some state-identified programs.

[c]This number comes from 2009.

[d]These numbers come from 2007-2008. This table only includes the participants with funded enrollment in home-based or combination Head Start or Early Head Start programs.

[e]These numbers come from 2007-2008.

[f]These numbers come from 2008-2009.

[g]Counties served include the target counties of Carbon, Sweetwater, Albany, and Natrona.

[h]Counties served include the target county of Natrona.

[i]In addition, the program serves tribes on the Wind River Reservation.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.52

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: American Samoa

	State-Identified Programs			
Program Characteristic	Children with Special Health Needs	Child Protective Services Program	Early Childhood Education/ Head Start Program	Helping Hands Program
Model[a]	—	—	—	—
Target population	Families and children who are diagnosed conditions with significant medical problems that require skilled nursing care, developmental disabilities, cerebral palsy, and neurological disorders	Children under 18 year of age who are at risk or are the victims of child abuse or neglect	Children 3-5 years of age	Children with a medically established condition, developmental delay, or a biological/medical risk
Number served[b]	20 children[c]	—	919 initial home visits[d]	77 children[e]
Geographic areas served[f]	Entire territory	Entire territory	Entire territory	—

SOURCES: American Samoa 2010 MIECHV needs assessment and FY 2011 state plan.

NOTES: [a]Models were included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The number served was not available for some state-identified programs.

[c]This number comes from 2009, and only includes children who received home visiting services.

[d]This number comes from 2009-2010. Most children in the program are served in classrooms. Family advocates at each of the Early Childhood Education Centers conduct home visits a minimum of two times per year and conduct additional home visits for families when the need exists.

[e]This number comes from 2008. Not all of these children received home visiting services.

[f]Most state-identified programs seemed to serve the whole territory of American Samoa, though geographic area served was not available for one state-identified program. The American Samoa FY 2011 state plan identified the entire territory as its target community. Therefore all programs in this table serve the target community.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.53

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Guam

	State-Identified Programs				
Program Characteristic	Department of Public Heath and Social Services Bureau of Social Services Administration	Maternal and Child Health Bureau/Title V: Maternal and Child Health Program	Guam Part C Early Intervention Program	Guam Part B Special Education Services and Support	Head Start
Model[a]	—	—	—	—	—
Target population	Children ages 0-17 who are victims of abuse or neglect, who are being adopted or subjects in home studies, applicants for child care or foster homes, and victims of family violence and homelessness	Pregnant and postpartum women	Infants and toddlers, from birth to age 3, with or at risk for a disability, and their families	Preschoolers with a disability and in need of special education services	Low-income children and families; homeless or [child protection services]-involved children and families; foster children
Number served[b]	Over 1,500 referrals[c]	6,000 clients	167	421 children	534 families[d]
Villages served[e]	Entire territory[f]	3[f]	3[f]	3[f]	Entire territory[f]

(continued)

Appendix Table A.53 (continued)

Program Characteristic	State-Identified Programs				
	Parent Information Resource Center	Sanctuary, Inc.	I' Famaguonta	Department of Youth Affairs	360 Family Supports
Model[a]	—	—	—	—	—
Target population	Low-income, high-risk, [English as a Second Language/Limited English Proficient] parents and guardians of children ages 0-5 years who are not receiving educational services	Runaway, homeless, or troubled youth between the ages of 12 to 17 and parents	Children and youth ages 5-21 years old with serious emotional and behavioral disorders who require multiagency involvement	5 years and older for all families; juvenile (at risk)	Military families or military retirees [with] a kid with a disability
Number served[b]	36	4,273	150-200 cases	Average 45-60 individuals served monthly	50
Villages served[e]	3[f]	Entire territory[f]	Entire territory[f]	3[f]	3

SOURCE: Guam 2010 MIECHV needs assessment.

NOTES: [a]Models were included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The time period for this number was not specified, unless otherwise noted.

[c]This number is annual.

[d]This number comes from 2010.

[e]The Guam needs assessment reported the villages that were served by the state-identified programs.

[f]Villages served includes the target community of Dededo.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.54

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Northern Mariana Islands

	State-Identified Programs				
Program Characteristic	Head Start Home Visiting Component	Department of Community and Cultural Affairs, Division of Youth Services: Child Protection Unit	Department of Cultural Community Affairs and Child Care Program	Department of Public Health, Title V Maternal and Child Health Program	Early Intervention Services Program
Model[a]	—	—	—	—	—
Target population	3- to 4-year-old children	Children and youth 0-17 years old	Children accessing provider homes	Birth-5 years old; families with children with special health care needs 0-21 years	Infants and toddlers ages 0-3 with developmental delays and disabilities
Number served[b]	462	556	255	462	48[c]
Municipalities served	3[d]	3[d]	3[d]	3[d]	3[d]

SOURCE: Northern Mariana Islands 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]Number served represents individuals or families; however, the Northern Mariana Islands needs assessment did not specify whether numbers represented individuals or families for each program, nor did it specify the time period they represented.

[c]This number does not include data from Rota and Tinian islands.

[d]Municipalities served include Saipan, where the target communities of Kagman and Koblerville/San Antonio are located.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table A.55

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: Puerto Rico

Program Characteristic	State-Identified Programs			
	Nurse Home Visiting Program	Nidos Seguros (Safe Nests)	Early Head Start	VITA Health Care
Model[a]	"Based on Nurse-Family Partnership"	"Based on Nurse-Family Partnership"	Early Head Start - Home Based Program Option	—
Target population	Pregnant women at increased risk for adverse perinatal outcomes; those having had a previous adverse birth outcome; and infants and children up to 24 months of age at risk for morbidity or mortality	Pregnant teen and adolescent mothers	Low-income infants, toddlers, pregnant women and their families	Pregnant women at high risk for preterm labor; limited to women holding the Humana Public Health Plan in the east and southeast of Puerto Rico
Number served[b]	—	128 families	424 pregnant women 1,261 infants and toddlers	—
Municipalities served[c]	69[d]	19[e]	—[e]	—[e]

SOURCE: Puerto Rico MIECHV 2010 needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]These numbers come from 2009-2010. The number served was not available for some state-identified programs.

[c]The Puerto Rico needs assessment reported the municipalities served by the state-identified programs. The number of municipalities served was not available for some state-identified programs.

[d]Municipalities served include the target municipality of Orocovis.

[e]Information on which municipalities were served is not available.

Appendix Table A.56

Home Visiting Programs in Existence Before MIECHV, as Reported in the 2010 State Needs Assessment: U.S. Virgin Islands

	State-Identified Programs			
Program Characteristic	Early Head Start	Inter-Island Coalition for Change: Parents as Teachers	Virgin Islands Perinatal, Inc./ Healthy Families Healthy Babies Initiative	Maternal Child Health Program
Model[a]	Early Head Start - Home Based Program Option	Parents as Teachers	"Adapted from Healthy Start: Home Visiting"	—
Target population	Low-income families with infants and toddlers; pregnant women	—	Low-income, uninsured and underinsured residents diagnosed with high-risk pregnancy, diabetes, or hypertension	Children ages 0-21 with disabilities and chronic conditions
Number served[b]	12 pregnant women 12 children and families	Funded to serve 75 children and families	12 clients	142 home visits
Islands served[c]	1[d]	2[e]	1[f]	Territory-wide[g]

SOURCE: U.S. Virgin Islands 2010 MIECHV needs assessment.

NOTES: [a]Models were only included in this row if they had been evaluated by the HomVEE project as of April 2014. A dash indicates that the needs assessment did not identify a model that had been evaluated by HomVEE.

[b]The time period for these numbers was not specified.

[c]The Virgin Islands needs assessment reported the islands that were served by the state-identified programs. It was unclear whether target communities were served by these programs.

[d]The island served is St. Croix, portions of which are target communities.

[e]Islands served include the target island of St. John. Islands served also include St. Thomas, a portion of which is a target community.

[f]The island served is St. Thomas, a portion of which is a target community.

[g]Islands served include the target island of St. John. Islands served also include St. Croix and St. Thomas, portions of which are target communities.

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Appendix B

Programs in Use in Only One State Prior to MIECHV, as Reported in the 2010 State Needs Assessments

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The Mother and Infant Home Visiting Program Evaluation

Appendix Table B.1

Programs Available Prior to MIECHV in Use in Only One State, as Reported in the 2010 State Needs Assessments

State	State-Identified Program	Model, If Specified
Alaska	New Parent Support Program	New Parent Support Program
	Fairbanks Public Health Nursing, Family Health Team	
	The Nutaqsiivik Program	
Arizona	ADHS High Risk Perinatal Program	
	Bright Start	
	Choices for Families	
	Family and Child Education Program	
	Health Start	
	Building Blocks for Children	
	Building Bright Futures	
	First Steps	
	Healthy Babies	
	In-home Parent Aide	
	Parent Connection	
	Parent Partners	
	Pregnancy, Parenting and Play	
	Raising Healthy Kids	
	Smart and Healthy	
	Teen Outreach Pregnancy Services	
Arkansas	Access, Inc.	Thrive
	Easter Seals of Arkansas	
	Families and Children Together, Inc. Homebase Program	Families and Children Together, Inc. Homebase Program
	Following Baby Back Home	Following Baby Back Home
	Maternal-Infant Program	Maternal-Infant Program
	A Woman's Place	
	Arkansas Department of Health	
	Arkadelphia Public Schools	
	Arkansas Department of Health/In Home Services	
	Benton County Sunshine School	
	Child Development, Inc.	
	Delta Counseling Associates	
	Family Network, Inc.	
	Healthy Connections, Inc.	
	Newton County Special Services Corporation	
	Ozark Mountain Health Network	
	Paces, Inc.	
	Partners/UAMS	
	Project FOCUS	

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
Colorado	Colorado Home Intervention Program	
Connecticut	Birth To Three	
	Building Blocks	Replicates Child FIRST
	Case Management for Pregnant Women	
	Early Childhood: Parents in Partnership	
	Early Childhood Consultation Partnership	Early Childhood Consultation Partnership
	Family Enrichment Services	
	Family Reunification Services	Family-Based Recovery Program
	Family Support Team	
	Foster and Adoptive Support Team	
	Healthy Choices for Women and Children	
	Integrated Family Violence Services	
	Intensive Community Family Support Services	
	Intensive Family Preservation	
	Intensive Home Based Services: Family-Based Recovery	
	Intensive In-Home Child and Adolescent Psychiatric Services	Intensive In-Home Child and Adolescent Psychiatric Services
	Minding the Baby Home Visiting Program	Minding the Baby
	Parent Assessment and Clinical Education Services: Meriden	
	Putting on AIRS Asthma Program	Asthma Control: Home-Based Environmental Interventions
	Young Adult Services Young Parents Program	
Delaware	Delaware Newborn Screening Program	
	Home Visiting Program for First-Time Parents	
	Kids Kare	Kids Kare
	Smart Start	
District of Columbia	DC DOH Healthy Start	Healthy Start
	Beyond Behaviors	Based on Homebuilders model
	Healthy Families/Thriving Communities Collaboratives	
	HSC Home Care	
	Washington Hospital Center: Healthy Foundations	
	Washington Hospital Center: Teen Alliance for Prepared Parenting	
Florida	Children's Harbor Family Strengthening Program: Broward County	
	Children's Home Society Family Strengthening Program: Broward County	
	Exchange Club Castle Safe Families	
	Family Central Nurturing Parenting Program Family Strengthening Program: Broward County	
	Family Reunification Services	
	Father Flanigan's Boys Town Family Strengthening Program: Broward County	

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
Florida (continued)	First Step to Success: Palm Beach County	Promoting First Relationships Program
	Florida Healthy Start	
	Friends of Children Family Strengthening Program: Broward County	Effective Black Parenting National Best Practice Model
	Gulf Coast Community Care: Family Strengthening: Family Skill Builder's Program: Broward County	Family Skill Buildings model
	Healthy Beginnings Nurses: Palm Beach County	Support Plus Mother
	Healthy Homes	
	Healthy Mothers, Healthy Babies: Family Strengthening Prenatal/Infant Home Visiting Program: Broward County	
	Healthy Mothers, Healthy Babies: Mothers Overcoming Maternal Stress (M.O.M.S.) Maternal Nurturing Program: Broward County	
	Helping People Succeed Building Readiness Among Infants Now: Martin County	
	Helping People Succeed Development Intervention Program: Martin County	
	Henderson Mental Health Center, Family Strengthening, Family Resource Team: Broward County	
	Henderson Mental Health Clinic Family Strengthening Multisystemic Therapy Program: Broward County	
	Inspiring Family Foundations: Palm Beach County	
	Institute for Family Centered Services Family Strengthening Project BRIDGE Program: Broward County	
	Jewish Adoption and Foster Care Options (JAFCO) Family Strengthening Multisystemic Therapy Program: Broward County	
	Kids in Distress: Family Strengthening: KID First Program: Broward County	
	Magnolia Project: Duval County	
	Memorial Healthcare System Family Strengthening Family TIES Program: Broward County	
	Memorial Healthcare System, Mothers Overcoming Maternal Stress (M.O.M.S.): Broward County	
	Parenting Smart Babies: Palm Beach County	
	School and Family Support Services: Palm Beach County	
Georgia	Atlanta Healthy Start	Atlanta Healthy Start Initiative
	Children 1st	
	Community-Based Doula Program	G-CAPP's community-based doula home visiting model
	Enterprise Community Health Start	Enterprise Community Health Start
	Project Healthy Grandparents	

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
Hawaii	Alu Like	Alu Like
	Home Reach Services	
Idaho	Infant Toddler Program	
Indiana	First Steps	
	The Newborn Individualized Developmental Care and Assessment Program	
Iowa	Baby Building Blocks	
	Bright Beginnings	
	Building Healthy Families	
	Crittenton Center's Westside Resource Center	
	Des Moines County Home Visitor	
	Early ACCESS	
	Emmet County Public Health	
	Family Connection	
	Family Connections (HFA-Like)	Healthy Families America-like
	Family Development and Self Sufficiency	
	Family Nutrition Program	
	Family STEPS (Modified HOPES)	
	Growing Strong Families	
	Healthy Babies	
	Healthy Start	
	Helping Hands Nurturing Program	Parenting Nurturing
	Home Visiting	Universal Screen
	HOPES Affiliate	
	Horizons Family Support	
	Hugs/Newborn Visits	
	In-Home Parent Education	PCAI/none
	K.I.D.S. Program	Locally developed (PAT/PCAI)
	New Mom/New Babe	
	Parent Partners	
	Perfect Beginnings	
	Prairie Lakes AEA K.I.D.S. Program	
	Prevent Child Abuse	
	Remedial Services: Skills Building	
	Remedial Services: Skills Building Intervention	
	Shared Visions	Models the Head Start program
	Teen Parent Program	
	VNA Family Support: Abuse Prevention and Parent Education	
	VNA Maternal Health Program	
	Well Baby Visits	
	WIN (Welcoming Infants in the Neighborhood)	
	Young House Family Services Resource Program	

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
Kansas	Bright Beginnings	Based on Nurse-Family Partnership
	Family Preservation	
	Healthy Babies	
	Infant Toddler Services	
Kentucky	Community Collaborative for Children	
	Health Access Nurturing Development Services	Health Access Nurturing Development Services
Louisiana	Intensive Home Based Services	Based on Homebuilders
Maine	Community Health Nursing	
	Passages Program	
	Project LAUNCH	
	Public Health Nursing	
Maryland	Baltimore City Healthy Start	
	Infants and Toddlers Program	
	Healthy Start Case Management Program	Modeled after the State Healthy Start Program
	Healthy Start/Infant at Risk Programs	
	Maternal and Infant Nursing Program	
	Maternal/Child Health/Healthy Start	The Healthy Start model
	Babies Born Healthy Home Visiting	
	BabyNet Home Visiting	
	Children With Special Health Care Needs Program	
	Chronic Disease Management Program	
	DHHS PHS/CHS Nurse Case Management Program.	
	Early Care: (WCHD)	Based on the State of Maryland's previous Healthy Start program
	Early Intervention Services (WCHD): Mental Health Program	
	Even Start	
	Family OPTIONS Program	Nurturing program for teen parents and their children
	Family Preservation Program, Families Now, Family Stabilization Services	
	Family Services, Inc., Help Me Learn Program.	
	Family Support of Queen Anne's County	
	Healthy Start: County Funded	Modeled after original Healthy Start Program
	Healthy Start/Baby Matters	
	Judy Center	
	Maternal and Child Home Visiting	
	Maternal Child Health	
	Maternal Child Program	Healthy Start Nurse home visiting
	Mental Health Association's Families Foremost Center	
	Parent-Child Center	
	Perinatal Substance Use Intervention Program	

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
Maryland (continued)	SMILE, the African American Health Infant Mortality Reduction Program	
	Washington County Family Center	
Massachusetts	Boston Healthy Start Initiative	Based on Healthy Start
	Boston Home Visiting Collaborative	In-Home Cognitive Behavioral Therapy
	Early Connections	Parent-Child Psychotherapy
	Early Intervention	
	Early Intervention Partnership Program	
	F.O.R. Families	
	Good Start/Connecting Families Social Services	
	Healthy Baby Healthy Child	
	Parenting Works	
	Visiting Moms	
	Young Parents Support Program	
Michigan	Community Mental Health Home-Based Services	
	Healthy Start	
	Maternal-Infant Health Program	
	Parent-Child Assistance Program	
	Prevention Pilot Home Visiting Programs	
	Zero to Three Secondary Prevention Initiative	Fussy Baby; Infant Mental Health
Minnesota	Baby Steps	
	Health Care for the Homeless	
	Minnesota Family Home Visiting Program	
	Healthy Families America-Like: Freeborn	Healthy Families America-like
	Healthy Families America-Like: Steele	Healthy Families America-like
Mississippi	Early Intervention Program	
	Metropolitan Infant Mortality Elimination and the Delta Infant Mortality Elimination Demonstration Projects	
	Parent Child Ministry	
	Perinatal High Risk Management/Infant Services System	
	Take Baby Steps	
	The Birthing Project	Birthing Project, USA
	Welcome Baby	National Exchange Club Child Abuse Prevention model
Missouri	Child Abuse and Neglect Prevention Program	
	Missouri Community Based Home Visiting Program	
	Nurses for Newborns	
	Parents Learning Together	
	St. Louis County Department of Health Public Nursing	
	Stay at Home Program	Early Intervention Policy
	WINGS (Women in Need Growing Stronger), International and Domestic Adoption Program	
	Lower Bootheel Community-Based Child Abuse	

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
Missouri (continued)	T.E.A.M.S.: Together for Empowerment and Accountability to Maximize Self-Sufficiency	
	Project CARE	
	Project Cope	
	StartRight Teen MOMs Program	
	Queen of Peace Center: Community-Based Doula Program	Community-Based Doula Model: Health Connect One
	Team for Infants Endangered by Substance Abuse Program	
	Springfield-Greene County Health Department	
	Doula Foundation of Mid-America, Inc.	Community-Based Doula Model
	Family Support Network	Based on Cognitive Behavioral Family Intervention and draws from other programs such as Active Parenting Families First and Parent Child Interactive Therapy
	Whole Kids Outreach	Based on Healthy Families America
	Capable Kids and Families	
	Pemiscot County Initiative	
Montana	Best Beginnings	
	Celebrating Families	
	Circle of Security	
	Follow Me	
	NCAST	
	Parent Aid Program	
	Public Health Home Visiting	Public Health Home Visiting Model
Nebraska	Good Beginnings: Community Medical Center, Falls City	
	Operation Great Start, Operation Building Blocks: Goldenrod Hills Community Action	Uses LA Babies and Utah Department of Health Preconception Care standards
	Public Health Nursing: Fred Leroy Health and Wellness Center	IHS Public Health Nursing Home Visiting
	Public Health Nursing: Winnebago Tribe of NE	
	Regional West Home Care: Regional West Medical Center	
	St. Francis Healthy Start	Hawaii Healthy Start
New Hampshire	Child and Family Health Supports	
	Comprehensive Child and Family Supports	
	Family Centered Early Support and Services	
	Home Visiting New Hampshire	Based on Nurse-Family Partnership

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
New Mexico	Gila Regional Medical Center First Born Program	First Born
	United Way of Santa Fe	First Born
	Las Cumbres Community Services/Santa Fe Community Infant Program	Growing Birth to 3: Portage Project
	First Born Presbyterian Espanola Program	First Born
	Holy Cross First Steps Program	
	Pueblo of Laguna, Department of Education, Divison of Early Childhood	
	Peanut, Butter and Jelly Therapeutic Family Services	Growing Birth to 3: Portage Project
	UNM Young Children's Health Center	Growing Birth to 3: Portage Project
	University of New Mexico Center for Development and Disability: VISION Program	Growing Birth to 3: Portage Project
	Native American Professional Parent Resources, Inc.	Growing Birth to 3: Portage Project
	St. Joseph Community Health	First Born
	Reach 2000/Secure Beginnings	Growing Birth to 3: Portage Project
	Ben Archer Health Center/Welcome Baby and Promotora Prenatal Home Visiting Program	Growing Birth to 3: Portage Project; Partners for A Healthy Baby
	AVANCE-NM	
	Hobbs Children's Services Home Visiting Program: Presbyterian Medical Services	Growing Birth to 3: Portage Project
	First Born Los Alamos County	First Born
	Many Mothers of Santa Fe	
	Socorro General Hospital's Healthy Family Initiative: First Born	First Born
	Torrance County Amigas de la Familia	Growing Birth to 3: Portage Project
New York	Baby Steps	
	Building Healthy Children	
	CCH Home Care and Palliative Services	
	Certified Home Health Agencies	
	Community Health Worker Program	
	County Public Health Nursing	
	Gentiva	
	Home Health Services	
	Newborn Home Visiting	
	Regional Home Care Services, Inc.	
	Sisters of Charity Home Health Care	
	St. Camillus Health and Rehabilitation Center	
	St. Joseph's Certified Home Health Care Agency	
	Universal Home Visiting	
	Visiting Angels	
	Visiting Nurse	
	Kings County Home Care	
	Nursing Sisters Home Visiting	
	Americare Certified Special Services	
	Excellent Home Care Services	
	Healthy Moms	
	Baby Love/Strong	

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
New York (continued)	Perinatal Home Visiting Program	
	Monroe Plan for Medical Care and Visiting Nurse	
	Home Care Assessment Unit and Personal Care Aide Program	
	The Newborn Home Visiting Program	
	Brooklyn Home Care	
	Peer Home Visiting	
	HHC/Health and Home Care	
North Carolina	Healthy Start Corps.	
	Parent Aide	
	Stepping Stones	
	Eastern Baby Love Plus	
	Northeastern Baby Love Plus	
	Triad Baby Love Plus	
North Dakota	Healthy Start	
Ohio	Help Me Grow	
	Ohio Infant Mortality Reduction Initiative	Based on Healthy Start-Home Visiting
	Columbus Healthy Start: Caring for 2	
	Cleveland Healthy Start: The Moms First Project	Community Health Worker Model
	Ohio Children's Trust Fund Projects	Incredible Years Home Visitation; Newborn Home Visitation; The Child Focus, Inc. Home Visitor Program, Help Me Grow; Parent Project and After Care Services Program; BRIDGE (Birthing Readiness Individualized Development and Growth through Education) Program; Family Mentor via Strengthening Families Connections; Parent Aide Program; Parenting Passport Program
Oklahoma	Sooner Start Early Intervention	
Oregon	Babies First!	
	CaCoon	
	Family Support and Connections Program	Family Support and Connections
	Maternity Case Management	
Pennsylvania	Family Literacy/Even Start	
	Project ELECT	

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
Rhode Island	Families First	
	Family Care Community	
	First Connections	
	Great Beginnings	
	Project Connect	
	Youth Success	
South Dakota	South Dakota Bright Start Initiative	
Tennessee	Child Health and Development Program	
	Help Us Grow Successfully	
	La Paz de Dios	
	Nurses for Newborns	
	Porter-Leath Mental Health Center Home Visiting Services	
	Prevent Child Abuse Tennessee	
	Tennessee Early Intervention System	
Texas	AVANCE Parent Child Education Program	AVANCE Parent Child Education Program
	Boys Town Texas	Common Sense Parenting
	Catholic Charities Diocese of Fort Worth	Parents and Children Together
	Child Crisis Center of El Paso	Systematic Training for Effective Parenting
	DePelchin Children's Center/Healthy Solutions	Systematic Training for Effective Parenting
	Pinnacle, Inc.	Strengthening Families Program
	Strengthening Families	Parent Child Program
Utah	Bright Beginnings	Bavolek Nurturing Program
	Family Support Center	Parent Advocate Program
	Outreach	
Vermont	Building Bright Futures	
	Children's Integrated Services One-Plan Pilot Program	Healthy Babies, Kids and Families home visiting program
	Learning Together	
	Life Skills	
	Touchpoints	
Virginia	BabyCare MICC	
	Comprehensive Health Investment Project of Virginia	
	Early Childhood Special Education	
	Early Intervention Part C	
	Project LINK	
	Virginia Healthy Start Initiative (Loving Steps)	

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
Washington	Bonding Right from the Start: Catholic Family and Child Services	
	CAPA Attachment Doula Project (Charities of Spokane)	
	Child-Parent Psychotherapy: Ferry County Connections	
	Children with Special Health Care Needs	
	Cowlitz Healthy Baby Home Visiting Project	
	Early Family Support Services	
	Early Intervention Program	Early Intervention Program
	Early Support for Infants and Toddlers	
	Family Preservation Services	
	Family Support Case Management (Brigid Collins)	
	First Steps Maternity Support Services and Infant Case Management	
	Hearing, Speech and Deafness Center	
	Improving Parent-Child Relations (Ukrainian Community Center)	
	Integrated Services for Families of Young Children with Developmental Disabilities and Behavioral Emotional Problems: Brigid Collins Family Support Center	
	Kitsap Mental Health Services: Home-Based Family Services	
	Mental Health Services for Parents of Young Children with Special Needs (Boyer Children's Clinic)	
	Navy New Parent Support	
	Navy/Marine Corps Relief Society (U.S. Navy)	
	North, Central and South Kitsap School Districts: Teen Parent Programs	
	Parent Coaching for Parents of Preschoolers: Little Red Schoolhouse	
	Parent Enrichment Program: PCIT (Deaconess Children's Service)	
	Parent-Child Assistance Program	
	Parent-Child Interaction Therapy	
	Parenting Partnership Program	An adaptation of Steps to Effective, Enjoyable Parenting
	Partnering with Families for Early Learning	
	Positive Behavioral Support (some home-based): Yakima Valley Farm Workers Clinic (Project LAUNCH)	
	Prenatal to 3 Years Program (San Juan Island Family Resource Center)	
	Progress Center	
	Readiness to Learn	
	Safe Babies Safe Moms	
	Secure Families Project (Wellspring Family Services)	
	Strengthening Fragile Families	
	Washington Elks Therapy Program for Children	
	Welcome Home Baby	

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
West Virginia	Right From the Start Program	
Wisconsin	ABC Healthy Families	Growing Great Kids
	Baby's Building Blocks	
	Bridges to Learning	
	Families First	
	Family Links	
	Family Services	
	Family Skills Specialist Unit	
	Family Support Program	
	Helping Urban Beloit Teen Parent Connections	
	Home Visiting	
	Home Visiting Program	
	Honoring Our Children	
	In Touch Parents Teen Mom Program	
	In-Home Mental Health Services	
	Invisible Children's Program	Invisible Children's Program
	MCH Home Visitation Services	
	Milwaukee Healthy Beginnings Project	
	New Born Home Visitation Program	
	Northern Lights Family Resource Center	Portage Project
	Nurtured Mom: Nurtured Baby/ Mamanutrida: Nutrio el Bebe	
	Nurturing Skills for Children, Adolescents, and Families	
	Parent Mentoring	
	Parent Support	
	Supporting Teen Families	
	Supportive Parenting Program	
	Teen Parent Program	
	The Child Management Program	
	Time for Parents	EFNEP Expanded Food and Nutrition Program
Wyoming	Best Beginning for Wyoming Babies	
American Samoa	Child Protective Services Program	
	Children with Special Health Needs	
	Helping Hands Program	
Guam	360 Family Supports	
	Department of Public Health and Social Services Bureau of Social Services	
	Department of Youth Affairs	Youth System
	Guam Part B Special Education Services and Support	
	Guam Part C Early Intervention Program	
	I' Famaguonta	System of Care
	Parent Information Resource Center	
	Sanctuary, Inc.	
	MCHB/Title V: Maternal and Child Health Program	

(continued)

Appendix Table B.1 (continued)

State	State-Identified Program	Model, If Specified
Northern Mariana Islands	Department of Community and Cultural Affairs, Division of Youth Services: Child Protection Unit	
	Department Cultural Community Affairs Child Care Program	
	Department of Public Health, Title V Maternal and Child Health Program	
	Early Intervention Services Program	
Puerto Rico	Nidos Seguros (Safe Nests)	Based on Nurse-Family Partnership
	Nurse Home Visiting Program	Based on Nurse-Family Partnership
	VITA Health Care	
U.S. Virgin Islands	Maternal Child Health Program	
	Virgin Islands Perinatal, Inc./Healthy Families Healthy Babies	Adapted from Healthy Start

SOURCE: 2010 MIECHV needs assessments.

NOTES: In this table, "state" is used as shorthand for states, territories, and the District of Columbia.

This table includes programs identified in the needs assessments as operating before MIECHV that were not reported to be using a model named by more than one state. Some programs were reported to be using a model that was based on a common model, but since it was an adaptation, those programs are included in this table. Some programs may have used models that operated in other states as well, but they were not reported in those states' needs assessments.

This table, in conjunction with the information in Appendix A, should not be considered a comprehensive list of all home visiting programs offered by states prior to MIECHV. Many states explicitly acknowledged in their needs assessments that they were not reporting on all existing home visiting programs, while others stated that they collected this information via survey, which resulted in underreporting.

If a state needs assessment identified a program as using a specific model or adaptation of a model, it is included in the table in the "model, if specified" column. If a program was reported as using more than one model, they are separated by a semicolon.

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Appendix C

Indicators of Community Risk in Communities Chosen for MIECHV Funding

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The Patient Protection and Affordable Care Act required states and territories to assess which of their communities might need home visiting services because they had concentrations of premature birth, school dropouts, substance abuse, and other indicators. The following tables present the indicators of risk requested by the Health Resources and Services Administration in the Supplemental Information Request for the state needs assessment. The information is presented for each state's and territory's target communities: the communities chosen to receive MIECHV funding. While states were allowed flexibility in how they defined their target communities, in practice most states identified counties or groups of counties as their at-risk communities and provided information at the county level (though some identified other geographic entities, such as cities or groups of counties).

Information on the indicators was collected from the needs assessments submitted by states and territories, while information on the communities states planned to target was collected from the fiscal year 2010 and 2011 state plans for each state and territory, as well as the first round of competitive grant applications for those that were awarded this funding. In a few cases where information on indicators was not included in the needs assessments, it was taken from the state plans or the first round of competitive grant applications. The requested indicators and metrics are shown in Box C.1 as they appeared in the Supplemental Information Request.

Sometimes, when states and territories were unable to provide data on a requested indicator, they included data that were a close substitute. States and territories were also allowed to include other indicators of risk to prenatal, maternal, newborn, or child health to demonstrate the needs of their target communities. Substitute indicators, as well as some additional indicators, are included in the Appendix C table for each state and territory that provided them. Additional indicators are not included if there were concerns about the quality of the data, if the data were not available at the level of the target community, or if a large number of additional indicators were presented (in which case only a sample are included in the table).

Appendix Box C.1

Metrics and Indicators as Defined by the *Supplemental Information Request for the Submission of the Statewide Needs Assessment*

Indicator	Metric(s)
Premature birth	Percent: # live births before 37 weeks/total # live births
Low-birth-weight infants	Percent: # resident live births less than 2,500 grams/ # resident live births
Infant mortality (includes death due to neglect)	# infant deaths ages 0-1/1,000 live births
Poverty	# residents below 100% FPL/total # residents
Crime	# reported crimes/1,000 residents # crime arrests ages 0-19/100,000 juveniles age 0-19
School drop-out rates	Percent high school drop-outs grades 9-12 Other school drop-out rates as per State/local calculation
Substance abuse	Prevalence rate: Binge alcohol use in past month* Prevalence rate: Marijuana use in past month Prevalence rate: Nonmedical use of prescription drugs in past month past month Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month
Unemployment	Percent: # unemployed and seeking work/total workforce
Child maltreatment†	Rate of reported substantiated maltreatment (substantiated/indicated/alternative response victim) Rate of reported substantiated maltreatment by type
Domestic Violence	Appropriate metrics for each State should be determined in conjunction with the State agencies administering the Family Violence Prevention and Services Act (FVPSA). Useful sources of data may include State service statistics, State and local hotline statistics, fatality review teams, social service agencies, and other data already collected by State and local domestic violence service providers.
Other indicators of at risk prenatal, maternal, newborn, or child health	As available

(continued)

Appendix Box C.1 (continued)

[*]*Binge drinking*: five or more drinks on the same occasion — or within a couple of hours of each other — on at least one day in the past 30 days

[†]*Child Victim*: A child for whom an incident of abuse or neglect has been substantiated or indicated by an investigation or assessment. A state may include some children with alternative dispositions as victims.

Substantiated: A type of investigation disposition that concludes that the allegation of maltreatment or risk of maltreatment was supported or founded by State law or State policy. This is the highest level of finding by a State Agency.

Indicated or Reason to Suspect: A report disposition that concludes that maltreatment cannot be substantiated under State law or policy, but there is reason to suspect that the child may have been maltreated or was at risk of maltreatment. This is applicable only to States that distinguish between substantiated and indicated dispositions.

Alternative Response Victim: A conclusion that the child was identified as a victim when a response other than investigation was provided.

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Appendix Table C.1

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Alabama

Indicator of Risk	Target Counties													Target County Average	State Average
	Greene	Sumter	Tuscaloosa	Dallas	Barbour	Macon	Perry	Russell	Wilcox	Bullock	Conecuh	Chambers	Lowndes		
Live births before 37 weeks of gestation[a] (%)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	17.1
Total live births less than 2,500 grams (%)	21.0	16.1	11.1	12.1	11.6	13.3	10.8	8.1	16.8	12.4	15.2	10.3	13.4	13.2	10.6
Infant deaths ages 0-1[b]	2.5	9.8	13.1	7.0	14.5	17.2	16.5	12.2	3.9	6.9	6.1	7.4	7.3	9.6	9.5
Residents living below the federal poverty level (%)	30.3	32.9	17.3	29.9	24.5	30.5	31.7	23.3	30.2	33.6	24.9	18.7	25.4	27.2	15.9
Index crime rate[c]	48.3	51.7	52.2	53.3	26.1	52.1	35.5	43.8	16.1	27.3	13.3	39.8	42.5	38.6	40.3
Violent crime arrests ages 0-17[d]	0	63	390	161	65	171	0	118	0	0	211	391	0	121	157
Dropout rate grades 9-12 (%)	8.8	4.6	11.1	6.6	16.0	1.8	0.6	12.9	5.0	7.5	10.1	10.6	3.6	7.6	1.6
Other school dropout rate per state/ local calculation[e] (%)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

(continued)

Appendix Table C.1 (continued)

Indicator of Risk	Target Counties													Target County Average	State Average
	Greene	Sumter	Tuscaloosa	Dallas	Barbour	Macon	Perry	Russell	Wilcox	Bullock	Conecuh	Chambers	Lowndes		
Prevalence of activities in the past month[f] (%)															
Binge alcohol use	20.7	20.7	18.8	20.7	19.3	20.7	20.7	20.7	20.7	20.7	19.3	20.7	20.7	20.4	18.7
Marijuana use ages 12+	5.1	5.1	4.7	5.1	4.9	5.1	5.1	5.1	5.1	5.1	4.9	5.1	5.1	5.0	4.6
Nonmedical use of prescription drugs ages 12+	5.4	5.4	6.2	5.4	5.5	5.4	5.4	5.4	5.4	5.4	5.5	5.4	5.4	5.5	5.6
Other illicit drug use ages 12+	4.1	4.1	4.3	4.1	3.8	4.1	4.1	4.1	4.1	4.1	3.8	4.1	4.1	4.0	3.9
Residents unemployed and seeking work (%)	13.5	13.8	9.1	19.7	13.0	11.2	18.2	11.2	24.2	14.3	18.4	18.2	17.6	15.6	10.0
Child maltreatment ages 0-17[g]	6.5	3.9	8.6	4.1	8.2	10.3	5.9	16.1	7.8	9.5	9.5	2.1	10.7	7.9	9.0
Child maltreatment by type[e]	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Domestic violence[h]	1,089	694	944	2,000	1,069	969	634	1,182	296	288	417	798	362	826	689

(continued)

Appendix Table C.1 (continued)

Indicator of Risk	Target Counties													Target County Average	State Average
	Greene	Sumter	Tuscaloosa	Dallas	Barbour	Macon	Perry	Russell	Wilcox	Bullock	Conecuh	Chambers	Lowndes		
Other indicators															
Pregnancy rate ages 10-17[i]	9.8	22.2	15.1	26.9	16.8	21.5	12.1	10.4	25.2	53.7	13.4	19.1	13.6	20.0	16.0
Births to unmarried women[j] (%)	67.2	69.1	41.3	71.5	54.4	50.0	75.8	44.8	73.9	60.8	62.1	57.7	77.7	62.0	39.6
Maternal smoking during pregnancy (%)	8.5	4.6	10.0	8.2	7.9	8.1	7.6	15.3	9.9	4.9	10.3	12.5	8.4	8.9	12.0
Births to undereducated women[k] (%)	10.2	12.7	14.9	19.6	34.9	17.4	22.4	17.2	17.7	30.3	13.6	17.0	12.4	18.5	18.6
Average 3rd-grade Stanford score[l]	40.5	31.9	46.7	40.0	36.5	35.4	46.8	51.7	44.6	29.8	41.9	40.6	23.1	39.2	54.5
Women receiving less than adequate prenatal care[m] (%)	33.6	25.3	30.5	39.2	33.5	27.0	40.7	29.0	41.0	49.7	32.6	22.9	33.0	33.7	30.3

(continued)

Appendix Table C.1 (continued)

SOURCES: Alabama 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Data were not reported for this indicator for any counties in this state.
[b]Per 1,000 live births.
[c]Instead of reporting the total number of reported crimes per 1,000 residents, the Alabama needs assessment reported an index crime rate per 1,000 residents.
[d]Instead of reporting the rate of juvenile crime arrests per 100,000 juveniles ages 0-19, the Alabama needs assessment reported the rate of juvenile violent crime arrests per 100,000 juveniles ages 0-17.
[e]Data were not reported for this indicator in this state.
[f]Data were not available at the county level. Data included in this table are for the Substance Abuse and Mental Health Services Administration (SAMHSA) regions to which each target county belongs.
[g]The Alabama needs assessment reported the number of children with indication of abuse or neglect per 1,000 children ages 0-17. This measure involves instances of child abuse or neglect where both credible evidence and the professional judgment of the social worker substantiate that an alleged perpetrator is responsible for harming the child.
[h]The Alabama needs assessment reported the rate of domestic violence per 100,000 as its metric for domestic violence.
[i]Per 1,000 females ages 10-17.
[j]Denominator is based on those births with information about marital status.
[k]At least two years less than expected for age.
[l]Stanford Achievement Test, average of reading and math.
[m]Based on Adequacy of Prenatal Care Utilization Index (APNCU).

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Appendix Table C.2

Indicators of Community Risk in the Community Chosen for MIECHV Funding: Alaska

Indicator of Risk	Target Community[a] Anchorage	Target Community Average	State Average
Live births before 37 weeks of gestation (%)	10.8	10.8	10.7
Total live births less than 2,500 grams (%)	6.2	6.2	5.9
Infant deaths ages 0-1[b]	5.3	5.3	6.3
Residents living below the federal poverty level (%)	7.2	7.2	9.2
Arrests[c]	24.1	24.1	59.7
Crime referrals ages 0-19[d]	1,407	1,407	1,455
Dropout rate grades 7-12[e] (%)	3.4	3.4	5.2
Other school dropout rate per state/local calculation[f] (%)	-	-	-
Prevalence of activities in the past month ages 18+[g] (%)			
Binge alcohol use	-	-	24.6
Marijuana use	-	-	10.8
Nonmedical use of prescription drugs	-	-	4.8
Other illicit drug use	-	-	3.8
Residents unemployed and seeking work (%)	6.6	6.6	8.0
Child maltreatment ages 0-14[h]	67.1	67.1	61.2

(continued)

Appendix Table C.2 (continued)

Indicator of Risk	Target Community[a] Anchorage	Target Community Average	State Average
Child maltreatment ages 0-14 by type[h]			
Neglect	51.6	51.6	45.5
Physical abuse	16.1	16.1	12.6
Sexual abuse	9.7	9.7	7.5
Domestic violence[i]			
Physical abuse 12 months before pregnancy (%)	4.4	4.4	4.4
Physical abuse during pregnancy (%)	3.7	3.7	3.3

SOURCES: Alaska 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The target community of Anchorage is a borough of Alaska.

[b]Per 1,000 live births.

[c]Instead of reporting the total number of reported crimes per 1,000 residents, the Alaska needs assessment reported the number of arrests per 1,000 residents.

[d]Instead of reporting the rate of arrests per 100,000 juveniles ages 0-19, the Alaska needs assessment reported the rate of juvenile crime referrals per 100,000 juveniles ages 0-19. A "referral" is a request by a law enforcement agency for a Department of Juvenile Justice response following the arrest of a juvenile or as a result of the submission of a police investigation report alleging the commission of a crime or violation of a court order.

[e]Instead of reporting the percentage of high school dropouts grades 9-12, the Alaska needs assessment reported the percentage of school dropouts grades 7-12.

[f]Data were not reported for this indicator in the state.

[g]Data were not reported for this indicator for the target community of Anchorage.

[h]The Alaska needs assessment reported the rate of reported maltreatment per 1,000 children ages 0-14. The measure includes substantiated cases and cases where maltreatment was suspected based on Office of Children's Services records and law enforcement records.

[i]The Alaska needs assessment reported the percentage of women experiencing physical abuse 12 months before and during pregnancy as its two metrics for domestic violence. The denominator is women who recently had a live birth in Anchorage/Matsu.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.3

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Arizona

	Target Communities[a]						
Indicator of Risk	Tucson Central	Tucson North Central	Tucson South East	Tucson East Central	Tucson South West	Tucson West	White Mountain Apache
Live births before 37 weeks of gestation (%)	9.9	8.9	9.0	10.0	10.2	8.8	15.1
Total live births less than 2,500 grams (%)	7.8	6.4	7.6	8.5	7.8	6.1	10.6
Infant deaths ages 0-1[b]	5.9	5.4	4.5	7.1	8.8	5.4	12
Residents living below the federal poverty level (%)	25.0	17.2	26.9	13.1	14.8	7.8	42.2
Reported crimes[c]	114.6	71.4	45.8	122.6	35.2	22.4	9.1
Arrests ages 0-19[d]	-	-	-	-	-	-	-
Dropout rate grades 9-12 (%)	18.6	8.5	6.2	5.8	0.0	38.3	7.0
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-
Prevalence of activities in the past month by youth (%)							
Binge alcohol use	20.9	18.9	24.5	18.1	20.8	20.7	22.6
Marijuana use	13.7	13.7	13.7	13.7	13.7	13.7	18.3
Nonmedical use of prescription drugs	9.8	9.3	9.2	9.8	9.2	10.3	12.9
Other illicit drug use	22.2	22.9	19.0	22.4	23.0	21.8	24
Alcohol use	36.6	33.4	39.1	35.1	35.8	36.0	33.8
Cigarette use	16.3	15.3	15.1	17.1	14.8	16.8	19.4
Residents unemployed and seeking work (%)	8.0	8.0	8.0	8.0	8.0	8.0	14.0

(continued)

Appendix Table C.3 (continued)

Indicator of Risk	Target Communities[a]				Target Community Average	State Average
	Casa Grande	Coolidge	Holbrook	Winslow		
Live births before 37 weeks of gestation (%)	9.6	10.3	11.3	9.9	10.3	10.2
Total live births less than 2,500 grams (%)	5.8	8.6	7.5	4.3	7.4	7.1
Infant deaths ages 0-1[b]	9.6	17.2	7.5	0.0	7.6	6.5
Residents living below the federal poverty level (%)	12.2	20.0	15.8	18.4	19.4	14.7
Reported crimes[c]	85.1	80.1	57.7	85.8	66.3	40.0
Arrests ages 0-19[d]	-	-	-	-	-	4,623
Dropout rate grades 9-12 (%)	4.9	5.8	7.0	10.3	10.2	4.9
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-
Prevalence of activities in the past month by youth (%)						
Binge alcohol use	22.5	21.8	22.1	22.4	21.4	20.0
Marijuana use	13.9	13.9	19.3	19.3	15.2	13.0
Nonmedical use of prescription drugs	13.1	11.5	11.6	10.4	10.6	10.8
Other illicit drug use	23.9	18.6	24.3	23.5	22.3	18.9
Alcohol use	36.5	32.0	32.0	32.1	34.8	33.3
Cigarette use	16.2	11.5	20.0	21.1	16.7	15.0
Residents unemployed and seeking work (%)	11.2	11.2	14.0	14.0	10.2	9.6

(continued)

Appendix Table C.3 (continued)

Indicator of Risk	Target Communities[a] Tucson Central	Tucson North Central	Tucson South East	Tucson East Central	Tucson South West	Tucson West	White Mountain Apache
Child maltreatment ages 0-4[f]	51.1	95.9	17.0	31.0	8.9	21.8	17.1
Child maltreatment ages 0-4 by type[f]							
Negligence	44.0	79.0	14.9	28.5	7.2	16.5	17.1
Physical abuse	7.1	15.8	2.1	2.5	1.6	5.0	0.0
Sexual abuse	0.0	1.0	0.1	0.0	0.1	0.3	0.0
Assault-related injuries[g]	1,620	1,622	1,621	1,371	1,537	907	
Other indicators							
Unintentional injuries ages 0-17[h]	18,730	13,375	25,013	16,861	27,173	13,761	5,511
Teen birth rate ages 15-17[i]	54.0	62.8	62.4	44.2	45.2	27.6	97.3
Initiation of prenatal care in the 1st trimester (%)	66.7	65.0	64.5	69.6	69.3	75.0	58.0

(continued)

Appendix Table C.3 (continued)

Indicator of Risk	Target Communities[a]				Target Community Average	State Average
	Casa Grande	Coolidge	Holbrook	Winslow		
Child maltreatment ages 0-4[f]	10.9	36.5	18.8	37.9	31.5	10.0
Child maltreatment ages 0-4 by type[f]						
Negligence	9.2	30.2	17.2	30.1	26.7	8.1
Physical abuse	1.8	5.2	1.6	7.8	4.6	1.7
Sexual abuse	0.0	1.0	0.0	0.0	0.2	0.1
Assault-related injuries among women[g]	1,011	1,538	1,678	4,834	1,774	965
Other indicators						
Unintentional injuries ages 0-17[h]	17,007	3,750	2,678	3,054	13,356	6,145
Births to women ages 15-17[i]	30.7	37.7	19.5	38.1	47.2	31.5
Initiation of prenatal care in the 1st trimester (%)	71.8	67.7	62.9	65.4	66.9	79.4

SOURCES: Arizona 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: The Arizona FY 2011 state plan reported that the state would meet with Holbrook and Winslow to determine their interest in implementing home visiting. They are included in this table as target communities. The first-round competitive grant application proposed serving 50 percent of the remaining communities identified as at risk in the Arizona needs assessment. However, because these communities had not yet been selected, they are not included in this table.

[a]The target communities identified by Arizona are Community Health Analysis Areas (CHAAs).
[b]Per 1,000 live births.
[c]Per 1,000 residents.
[d]Per 100,000 juveniles ages 0-19. Data were not reported for this indicator for any target communities in the state.
[e]Data were not reported for this indicator in this state.
[f]The Arizona needs assessment reported the rate per 1,000 children ages 0-4.
[g]The Arizona needs assessment reported the number of assault-related injuries per 100,000 women ages 15-44 as its metric for domestic violence.
[h]Per 100,000 children ages 0-17.
[i]Per 1,000 females ages 15-17.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.4

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Arkansas

Indicator of Risk	Target Counties							
	Crittenden	Jefferson	Lee	Mississippi	Monroe	Phillips	St. Francis	Union
Live births before 37 weeks of gestation[a] (%)	18.2	16.9	19.7	18.0	15.7	18.1	19.0	15.2
Total live births less than 2,500 grams (%)	14.4	12.0	13.0	11.8	9.9	13.1	14.1	10.5
Infant deaths ages 0-1[b]	15.0	10.4	12.4	8.5	12.1	9.3	11.6	5.8
Residents living below the federal poverty level[a] (%)	20.5	20.6	38.6	23.5	26.0	34.9	31.4	19.8
Reported crimes[a,c]	79.4	82.0	25.5	56.2	21.2	65.3	64.1	47.5
Arrests ages 0-19[a,d]	36.7	28.5	19.9	30.1	0.9	27.8	49.3	25.7
Dropout rate grades 9-12[a] (%)	4.9	6.9	8.6	8.0	7.1	9.3	6.6	3.1
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[a]								
Binge alcohol use	21.2	21.2	21.2	21.5	21.2	21.2	21.2	21.3
Marijuana use	6.0	6.0	6.0	4.9	6.0	6.0	6.0	5.3
Nonmedical use of prescription drugs	5.5	5.5	5.5	7.5	5.5	5.5	5.5	6.1
Other illicit drug use	3.9	3.9	3.9	5.2	3.9	3.9	3.9	4.0

(continued)

Appendix Table C.4 (continued)

Indicator of Risk	Target Counties								
	Ashley	Benton	Boone	Bradley	Calhoun	Chicot	Crawford	Cleveland	Conway
Live births before 37 weeks of gestation[a] (%)	-	-	-	-	-	-	-	-	-
Total live births less than 2,500 grams (%)	10.9	7.3	5.1	9.3	9.5	13.2	7.6	16.8	7.0
Infant deaths ages 0-1[b]	13.5	5.4	14.1	5.5	0.0	10.0	5.2	9.3	12.7
Residents living below the federal poverty level[a] (%)	-	-	-	-	-	-	-	-	-
Reported crimes[a,c]	-	-	-	-	-	-	-	-	-
Arrests ages 0-19[a,d]	-	-	-	-	-	-	-	-	-
Dropout rate grades 9-12[a] (%)	-	-	-	-	-	-	-	-	-
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[a]									
Binge alcohol use	-	-	-	-	-	-	-	-	-
Marijuana use	-	-	-	-	-	-	-	-	-
Nonmedical use of prescription drugs	-	-	-	-	-	-	-	-	-
Other illicit drug use	-	-	-	-	-	-	-	-	-

(continued)

Appendix Table C.4 (continued)

Indicator of Risk	Target Counties								
	Craighead	Clark	Dallas	Drew	Hempstead	Independence	Fulton	Garland	Izard
Live births before 37 weeks of gestation[a] (%)	-	-	-	-	-	-	-	-	-
Total live births less than 2,500 grams (%)	8.4	6.7	17.0	11.7	10.6	9.9	9.0	8.6	10.8
Infant deaths ages 0-1[b]	6.1	0.0	0.0	0.0	3.0	5.9	0.0	4.2	0.0
Residents living below the federal poverty level[a] (%)	-	-	-	-	-	-	-	-	-
Reported crimes[a,c]	-	-	-	-	-	-	-	-	-
Arrests ages 0-19[a,d]	-	-	-	-	-	-	-	-	-
Dropout rate grades 9-12[a] (%)	-	-	-	-	-	-	-	-	-
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[a]									
Binge alcohol use	-	-	-	-	-	-	-	-	-
Marijuana use	-	-	-	-	-	-	-	-	-
Nonmedical use of prescription drugs	-	-	-	-	-	-	-	-	-
Other illicit drug use	-	-	-	-	-	-	-	-	-

(continued)

Appendix Table C.4 (continued)

Indicator of Risk	Target Counties								
	Lincoln	Lawrence	Little River	Pike	Miller	Montgomery	Nevada	Ouachita	Poinsett
Live births before 37 weeks of gestation[a] (%)	-	-	-	-	-	-	-	-	-
Total live births less than 2,500 grams (%)	5.6	8.4	13.0	7.0	11.6	5.6	6.3	9.3	11.4
Infant deaths ages 0-1[b]	0.0	4.8	0.0	0.0	4.5	32.3	8.2	8.1	14.1
Residents living below the federal poverty level[a] (%)	-	-	-	-	-	-	-	-	-
Reported crimes[a,c]	-	-	-	-	-	-	-	-	-
Arrests ages 0-19[a,d]	-	-	-	-	-	-	-	-	-
Dropout rate grades 9-12[a] (%)	-	-	-	-	-	-	-	-	-
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[a]									
Binge alcohol use	-	-	-	-	-	-	-	-	-
Marijuana use	-	-	-	-	-	-	-	-	-
Nonmedical use of prescription drugs	-	-	-	-	-	-	-	-	-
Other illicit drug use	-	-	-	-	-	-	-	-	-

(continued)

Appendix Table C.4 (continued)

Indicator of Risk	Target Counties							Target County Average	State Average
	Pulaski	Saline	Sebastian	Sharp	Polk	Van Buren	Washington		
Live births before 37 weeks of gestation[a] (%)	-	-	-	-	-	-	-	17.6	13.6
Total live births less than 2,500 grams (%)	10.6	8.2	8.1	9.2	7.8	7.7	7.1	9.9	9.1
Infant deaths ages 0-1[b]	9.0	6.7	5.3	0.0	8.1	0.0	5.9	6.8	8.1
Residents living below the federal poverty level[a] (%)	-	-	-	-	-	-	-	26.9	17.3
Reported crimes[a,c]	-	-	-	-	-	-	-	55.2	42.4
Arrests ages 0-19[a,d]	-	-	-	-	-	-	-	27.4	19.9
Dropout rate grades 9-12[a] (%)	-	-	-	-	-	-	-	6.8	4.8
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[a]									
Binge alcohol use	-	-	-	-	-	-	-	21.2	21.5
Marijuana use	-	-	-	-	-	-	-	5.7	5.8
Nonmedical use of prescription drugs	-	-	-	-	-	-	-	5.8	6.7
Other illicit drug use	-	-	-	-	-	-	-	4.1	4.5

(continued)

Appendix Table C.4 (continued)

Indicator of Risk	Target Counties							
	Crittenden	Jefferson	Lee	Mississippi	Monroe	Phillips	St. Francis	Union
Residents unemployed and seeking work (%)	11.2	10.1	9.1	11.5	7.8	9.6	9.9	9.7
Child maltreatment ages 0-18[a,f]	7.5	8.9	7.5	11.8	4.9	7.0	6.1	8.5
Child maltreatment ages 0-18 by type[e]	-	-	-	-	-	-	-	-
Domestic abuse petitions filed[a,g]	39.0	71.2	32.5	32.7	27.0	27.8	31.1	70.6
Other indicators[a]								
Total live births less than 1,500 grams (%)	4.4	2.2	3.6	2.4	1.2	3.0	2.7	2.1
Births to mothers with 1st-trimester prenatal care (%)	52.0	68.5	71.6	76.2	78.4	55.2	79.1	73.3
Pregnant women who received no 1st-trimester health care (%)	-	-	-	-	-	-	-	-
Births to unwed mothers (%)	63.0	63.0	69.8	58.0	55.4	74.1	63.3	47.9
Births to women ages 15-19[h]	85.6	68.2	78.4	98.9	72.8	95.0	97.8	65.5
Child deaths ages 1-14[i]	-	-	-	-	-	-	-	-
Children under 18 living in poverty (%)	-	-	-	-	-	-	-	-

(continued)

Appendix Table C.4 (continued)

Indicator of Risk	Target Counties								
	Ashley	Benton	Boone	Bradley	Calhoun	Chicot	Crawford	Cleveland	Conway
Residents unemployed and seeking work (%)	10.9	5.5	6.5	8.5	8.9	9.5	7.4	8.6	6.4
Child maltreatment ages 0-18[a,f]	-	-	-	-	-	-	-	-	-
Child maltreatment ages 0-18 by type[e]	-	-	-	-	-	-	-	-	-
Domestic abuse petitions filed[a,g]	-	-	-	-	-	-	-	-	-
Other indicators[a]									
Total live births less than 1,500 grams (%)	-	-	-	-	-	-	-	-	-
Births to mothers with 1st-trimester prenatal care (%)	-	-	-	-	-	-	-	-	-
Pregnant women who received no 1st-trimester health care (%)	12.8	19.4	12.0	11.2	31.0	7.4	34.0	11.6	14.8
Births to unwed mothers (%)	-	-	-	-	-	-	-	-	-
Births to women ages 15-19[h]	-	-	-	-	-	-	-	-	-
Child deaths ages 1-14[i]	24.1	4.1	15.1	0.0	121.2	0.0	16.1	0.0	77.0
Children under 18 living in poverty (%)	31.4	18.1	25.3	36.2	23.4	44.3	26.2	23.6	28.0

(continued)

Appendix Table C.4 (continued)

Indicator of Risk	Target Counties								
	Craighead	Clark	Dallas	Drew	Hempstead	Independence	Fulton	Garland	Izard
Residents unemployed and seeking work (%)	6.0	7.4	12.0	10.3	8.3	7.4	6.3	6.9	7.7
Child maltreatment ages 0-18[a,f]	-	-	-	-	-	-	-	-	-
Child maltreatment ages 0-18 by type[e]	-	-	-	-	-	-	-	-	-
Domestic abuse petitions filed[a,g]	-	-	-	-	-	-	-	-	-
Other indicators[a]									
Total live births less than 1,500 grams (%)	-	-	-	-	-	-	-	-	-
Births to mothers with 1st-trimester prenatal care (%)	-	-	-	-	-	-	-	-	-
Pregnant women who received no 1st-trimester health care (%)	22.2	24.2	27.7	8.2	21.8	30.6	20.1	26.8	36.0
Births to unwed mothers (%)	-	-	-	-	-	-	-	-	-
Births to women ages 15-19[h]	-	-	-	-	-	-	-	-	-
Child deaths ages 1-14[i]	32.7	0.0	0.0	29.2	21.7	15.3	0.0	18.6	0.0
Children under 18 living in poverty (%)	24.9	27.3	33.2	34.6	41.9	29.1	38.6	23.6	33.9

(continued)

Appendix Table C.4 (continued)

Indicator of Risk	Target Counties								
	Lincoln	Lawrence	Little River	Pike	Miller	Montgomery	Nevada	Ouachita	Poinsett
Residents unemployed and seeking work (%)	8.9	8.1	5.8	6.8	5.1	6.6	9.1	7.5	7.8
Child maltreatment ages 0-18[a,f]	-	-	-	-	-	-	-	-	-
Child maltreatment ages 0-18 by type[e]	-	-	-	-	-	-	-	-	-
Domestic abuse petitions filed[a,g]	-	-	-	-	-	-	-	-	-
Other indicators[a]									
Total live births less than 1,500 grams (%)	-	-	-	-	-	-	-	-	-
Births to mothers with 1st-trimester prenatal care (%)	-	-	-	-	-	-	-	-	-
Pregnant women who received no 1st-trimester health care (%)	13.6	17.9	29.0	30.5	45.1	32.2	36.6	33.6	26.5
Births to unwed mothers (%)	-	-	-	-	-	-	-	-	-
Births to women ages 15-19[h]	-	-	-	-	-	-	-	-	-
Child deaths ages 1-14[i]	0.0	67.8	45.0	55.7	12.4	68.5	0.0	88.6	20.8
Children under 18 living in poverty (%)	34.1	34.5	25.1	28.3	31.1	34.9	32.8	31.1	39.4

(continued)

Appendix Table C.4 (continued)

Indicator of Risk	Target Counties							Target County Average	State Average
	Pulaski	Saline	Sebastian	Sharp	Polk	Van Buren	Washington		
Residents unemployed and seeking work (%)	6.0	5.8	7.4	8.3	6.8	9.2	9.5	8.1	7.7
Child maltreatment ages 0-18[a,f]	-	-	-	-	-	-	-	7.8	9.0
Child maltreatment ages 0-18 by type[e]	-	-	-	-	-	-	-	-	-
Domestic abuse petitions filed[a,g]	-	-	-	-	-	-	-	41.5	31.8
Other indicators[a]									
Total live births less than 1,500 grams (%)	-	-	-	-	-	-	-	2.7	1.7
Births to mothers with 1st-trimester prenatal care (%)	-	-	-	-	-	-	-	69.3	78.3
Pregnant women who received no 1st-trimester health care (%)	10.9	10.6	43.0	26.1	13.0	13.4	31.3	23.1	-
Births to unwed mothers (%)	-	-	-	-	-	-	-	61.8	40.5
Births to women ages 15-19[h]	-	-	-	-	-	-	-	82.8	61.2
Child deaths ages 1-14[i]	22.8	10.8	11.7	35.1	27.1	76.7	31.8	27.9	-
Children under 18 living in poverty (%)	25.4	14.4	24.0	36.3	33.9	29.1	24.3	30.1	-

(continued)

Appendix Table C.4 (continued)

SOURCES: Arkansas 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: Data for the state and the following counties come from the Arkansas 2010 MIECHV needs assessment: Lee, St. Francis, Jefferson, Crittenden, Phillips, Mississippi, Union, Woodruff, and Monroe. Data for the following counties come from the first-round competitive grant application: Ashley, Benton, Bradley, Boone, Calhoun, Chicot, Clark, Cleveland, Craighead, Crawford, Conway, Dallas, Drew, Fulton, Garland, Hempstead, Independence, Izard, Lawrence, Little River, Nevada, Ouachita, Polk, Pulaski, Sebastian, Sharp, Van Buren, Washington, Miller, and Saline.

[a]Data were not reported for this indicator for some target counties in the state.

[b]Per 1,000 live births.

[c]Per 1,000 residents.

[d]Instead of reporting the number of arrests per 100,000 juveniles ages 0-19, the Arkansas needs assessment reported the number of arrests per 1,000 juveniles ages 0-19.

[e]Data were not reported for this indicator in the state.

[f]The Arkansas needs assessment reported the number of substantiated cases of child maltreatment per 1,000 children ages 0-18.

[g]The Arkansas needs assessment reported the number of domestic abuse petitions filed per 10,000 population as its metric for domestic violence.

[h]Per 1,000 females ages 15-19.

[i]Per 100,000 children ages 1-14.

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Appendix Table C.5

Indicators of Community Risk in Communities Chosen for MIECHV Funding: California

	Target Communities[a]										
Indicator of Risk	Alameda	Butte	Contra Costa	Fresno	Imperial	Kern	Los Angeles	Madera	Sacramento	Merced	Nevada
Live births before 37 weeks of gestation (%)	9.5	9.8	10.0	14.4	10.4	13.9	11.4	11.9	9.8	10.8	8.3
Total live births less than 2,500 grams (%)	7.1	5.3	6.5	7.9	6.8	7.1	7.3	6.1	6.5	6.6	4.9
Infant deaths ages 0-1[b,c]	4.2	-	4.1	6.7	-	7.2	5.0	-	5.2	6.3	-
Residents living below the federal poverty level (%)	10.4	20.7	9.4	22.1	21.5	20.5	15.3	18.2	13.3	21.5	9.2
Reported crimes[d]	4,663	3,397	3,725	4,434	3,769	4,437	3,087	2,633	4,286	4,125	1,703
Arrests ages 10-17[e]	3,941	5,953	3,218	6,197	4,361	5,473	4,260	3,353	3,109	9,058	6,621
Estimated dropout rate grades 9-12[f] (%)	16.7	15.0	16.0	24.0	13.0	26.9	21.0	17.1	21.4	17.5	73.5
Other school dropout rate per state/local calculation[g] (%)	-	-	-	-	-	-	-	-	-	-	-
Prevalence of activities ages 12+[h] (%)											
Binge alcohol use in the past month	19.9	22.7	19.9	20.9	24.4	25.3	20.4	20.9	22.6	22.5	22.6
Marijuana use in the past month	8.2	8.5	8.2	6.0	7.1	9.0	5.4	6.0	8.9	6.6	8.9
Nonmedical use of pain relievers in the past year[i]	5.2	5.9	5.2	4.9	5.8	5.5	4.7	4.9	6.6	5.8	6.6
Other illicit drug use in the past month	4.1	4.7	4.1	4.3	4.5	4.2	3.6	4.3	4.6	4.2	4.6

(continued)

Appendix Table C.5 (continued)

Indicator of Risk	Target Communities[a]									Target Community Average	State Average
	North Coast Tri-County Consortium			San	San		San				
	Del Norte	Humboldt	Siskiyou	Diego	Francisco	Shasta	Mateo	Solano	Stanislaus		
Live births before 37 weeks of gestation (%)	10.1	7.7	11.9	10.0	9.2	9.8	9.0	10.1	11.7	10.6	10.7
Total live births less than 2,500 grams (%)	6.4	6.1	8.4	6.6	7.3	5.5	6.3	7.2	6.4	6.6	6.8
Infant deaths ages 0-1[b,c]	-	-	-	4.9	5.3	-	3.8	6.2	6.1	5.4	5.1
Residents living below the federal poverty level (%)	23.6	19.8	16.4	12.6	11.2	17.7	6.5	9.0	14.4	15.2	13.3
Reported crimes[d]	2,361	3,106	2,069	3,074	5,210	3,391	2,578	4,022	4,944	3,666	3,320
Arrests ages 10-17[e]	5,367	8,169	6,544	4,981	5,901	8,200	4,087	8,049	5,342	5,489	4,973
Estimated dropout rate grades 9-12[f] (%)	16.1	16.9	16.9	17.1	20.8	17.5	12.3	22.4	22.8	21.8	18.9
Other school dropout rate per state/local calculation[g] (%)	-	-	-	-	-	-	-	-	-	-	-
Prevalence of activities ages 12+[h] (%)											
Binge alcohol use in the past month	22.7	22.7	22.7	24.4	21.0	22.7	21.0	22.6	22.5	22.2	21.5
Marijuana use in the past month	8.5	8.5	8.5	7.1	9.3	8.5	9.3	8.9	6.6	7.8	7.0
Nonmedical use of pain relievers in the past year[i]	5.9	5.9	5.9	5.8	4.5	5.9	4.5	6.6	5.8	5.6	5.3
Other illicit drug use in the past month	4.7	4.7	4.7	4.5	3.7	4.7	3.7	4.6	4.2	4.3	4.1

(continued)

Appendix Table C.5 (continued)

Indicator of Risk	Target Communities[a]										
	Alameda	Butte	Contra Costa	Fresno	Imperial	Kern	Los Angeles	Madera	Sacramento	Merced	Nevada
Residents unemployed and seeking work (%)	10.7	12.5	10.3	15.1	28.2	14.4	11.6	13.7	11.3	17.2	10.7
Child maltreatment[j]	4.0	17.0	5.2	8.1	9.9	18.5	9.7	11.8	10.9	10.9	5.5
Child maltreatment by type[k]											
Sexual abuse	8.5	2.2	3.0	5.7	0.6	1.7	6.7	8.7	5.8	6.1	1.0
Physical abuse	14.5	4.8	6.9	7.2	2.5	4.8	11.4	6.7	11.8	7.9	9.0
Severe neglect	2.4	7.6	0.6	0.8	0.2	1.3	2.4	1.2	4.3	1.3	1.0
General neglect	27.5	67.1	70.5	65.6	84.9	84.3	36.7	62.2	45.5	59.8	51.0
Exploitation	0.1	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0
Emotional abuse	4.3	2.9	0.0	1.9	0.0	0.3	16.5	0.2	5.5	4.5	2.0
Caretaker absence/incapacity	27.2	10.6	5.0	0.7	6.2	3.1	5.6	6.7	4.3	8.8	9.0
At risk, sibling abused	1.6	1.6	10.4	10.5	1.9	3.5	12.3	10.0	2.9	3.4	2.0
Substantial risk	13.8	3.3	3.4	7.6	3.6	0.9	8.4	4.3	19.9	8.3	25.0
Clients receiving face-to-face domestic violence services[c,l]	20.2	60.7	14.5	51.1	63.2	36.7	10.5	23.6	38.9	-	57.8
Other indicators											
Births with 1st-trimester prenatal care (%)	86.7	71.5	83.3	87.8	59.7	74.9	85.9	72.3	80.1	62.2	74.9
Prenatal substance abuse[c,m]	13.1	13.1	23.7	13.8	9.3	12.9	6.8	11.2	22.5	16.2	22.8
Maternal depression[c,n]	9.3	6.4	14.3	4.9	-	3.6	3.8	3.1	17.9	4.8	20.3
Birth interval less than 24 months[o] (%)	10.4	13.7	11.4	16.7	14.4	15.2	12.7	15.3	14.3	16.5	11.0
Breastfeeding[p] (%)	72.8	71.6	64.0	38.9	12.6	25.8	24.4	49.1	53.3	27.7	77.1
Students enrolled in special education[q] (%)	10.5	12.4	11.7	9.4	8.6	9.6	11.2	10.1	11.1	9.7	9.1
Child-welfare-supervised foster care[r]	5.2	13.1	4.7	8.6	6.8	8.2	6.7	5.5	10.2	8.0	3.9

(continued)

Appendix Table C.5 (continued)

Indicator of Risk	Target Communities[a]									Target Community Average	State Average
	North Coast Tri-County Consortium			San	San		San				
	Del Norte	Humboldt	Siskiyou	Diego	Francisco	Shasta	Mateo	Solano	Stanislaus		
Residents unemployed and seeking work (%)	12.2	11.0	14.8	9.7	9.0	14.8	8.6	10.9	16.0	13.2	11.9
Child maltreatment[j]	49.1	8.7	31.7	9.6	9.3	19.1	2.4	6.3	13.5	11.2	9.1
Child maltreatment by type[k]											
Sexual abuse	1.3	0.8	2.0	5.0	3.4	2.6	4.1	3.6	3.5	4.1	5.9
Physical abuse	3.9	9.6	3.3	7.5	12.2	4.6	15.6	14.1	2.7	8.3	9.0
Severe neglect	2.6	2.1	0.7	5.3	1.5	4.1	4.1	1.0	1.0	2.3	3.0
General neglect	76.2	49.2	83.4	34.8	35.0	50.9	47.3	50.7	77.3	56.7	52.0
Exploitation	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Emotional abuse	1.0	5.4	0.0	16.8	12.8	28.7	3.8	4.8	0.3	6.0	8.5
Caretaker absence/incapacity	7.7	2.5	8.3	4.4	10.3	4.6	9.2	9.4	2.4	7.4	5.6
At risk, sibling abused	3.2	4.2	0.0	5.3	5.1	2.2	7.4	7.8	9.6	5.6	7.8
Substantial risk	4.2	26.3	2.3	20.8	19.8	2.3	8.4	8.6	3.0	9.6	8.2
Clients receiving face-to-face domestic violence services[c,l]	155.5	20.3	158.9	39.1	29.2	136.6	51.9	20.2	52.6	48.1	26.3
Other indicators											
Births with 1st-trimester prenatal care (%)	50.2	76.5	82.3	81.3	84.7	67.8	88.6	77.2	76.9	77.0	82.4
Prenatal substance abuse[c,m]	21.2	39.8	-	10.3	13.6	54.3	8.4	26.5	22.8	18.4	11.9
Maternal depression[c,n]	-	21.9	-	8.6	13.5	16.1	-	14.2	4.0	10.4	7.3
Birth interval less than 24 months[o] (%)	22.8	11.0	16.3	12.8	9.3	15.2	10.7	12.6	14.5	13.5	13.2
Breastfeeding[p] (%)	56.1	66.7	77.9	58.9	76.7	83.7	76.6	53.2	42.9	54.2	42.7
Students enrolled in special education[q] (%)	11.7	14.8	11.8	11.9	10.6	10.7	11.6	11.7	11.9	10.8	10.8
Child-welfare-supervised foster care[r]	13.6	8.0	13.7	5.3	10.8	13.6	1.8	3.5	3.6	7.3	6.0

(continued)

Appendix Table C.5 (continued)

SOURCES: California 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]The California needs assessment identified individual counties, portions of counties, and one group of counties as its target communities. Since the needs assessment did not report information on indicators below the county level for the noncounty target communities, the table presents information for the counties to which the target communities belong.

[b]Per 1,000 live births.

[c]Data were not reported for this indicator in counties with rates too low to be included in the California needs assessment.

[d]Instead of the number of crimes reported to the police per 1,000 residents, the California needs assessment provided the number of crimes reported per 100,000 residents.

[e]Instead of reporting the rate of juvenile crime arrests per 100,000 juveniles ages 0-19, California reported the rate of juvenile crime arrests per 100,000 juveniles ages 10-17.

[f]The four-year derived dropout rate is an estimate of the percentage of students who would drop out in a four-year period based on data collected for a single year. Rates are adjusted for reenrollments and lost transfers.

[g]Data were not reported for this indicator in this state.

[h]Information on substance abuse is only available for residents ages 12 and older. Data were not available at the county level. Data included in this table are for the Substance Abuse and Mental Health Service Administration (SAMHSA) region to which each target county belongs.

[i]Instead of reporting the rate of nonmedical use of prescription drugs in the past month, the California needs assessment reported the rate of nonmedical use of pain relievers in the past year.

[j]The data presented here represent rates of substantiated cases of child maltreatment per 1,000 children. The rate of substantiated child maltreatment is calculated by dividing the unduplicated count of substantiated victims of maltreatment by the child population and then multiplying by 1,000.

[k]The denominator is the total number of unduplicated children with substantiated maltreatment for that county. The numerator is the number of unduplicated children, counted only once, in the category of highest severity, for that county. The maltreatment severity hierarchy recorded in the child-welfare data system ranks these types from highest to lowest severity: sexual abuse, physical abuse, severe neglect, general neglect, exploitation, emotional abuse, caretaker absence/incapacity, at risk/sibling abused, and substantial risk.

[l]The California needs assessment reported the number of clients receiving face-to-face domestic violence services per 10,000 residents as its metric for domestic violence.

[m]Rate of labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) per 1,000.

[n]Rate of labor/delivery hospital discharges with a diagnosis of depression per 1,000.

[o]Percentage of mothers ages 15-44 with birth intervals less than 24 months per total number of mothers ages 15-44.

[p]Percentage of mothers who breastfed, exclusively, while in the hospital.

[q]Percentage of public school students who are enrolled in special education.

[r]Rate of children ages 0-17 in child-welfare-supervised foster care per 1,000.

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Appendix Table C.6

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Colorado

	Target Communities[a]							Target	
			Costilla/Saguache/Alamosa			Otero/Crowley		Community	State
Indicator of Risk	Pueblo	Adams	Costilla	Saguache	Alamosa	Otero	Crowley	Average	Average
Live births before 37 weeks of gestation (%)	9.2	9.8	14.7	10.2	8.7	11.3	12.8	10.6	9.7
Total live births less than 2,500 grams (%)	9.4	9.1	14.9	9.4	10.2	9.4	10.6	10.0	9.0
Infant deaths ages 0-1[b]	6.3	6.8	-	17.8	3.9	8.2	0.0	7.0	6.2
Residents living below the federal poverty level (%)	16.8	12.0	24.8	29.9	21.4	22.2	46.2	22.1	11.2
Reported crimes[c]	45.8	74.7	0.0	12.2	51.6	35.3	1.9	40.1	34.6
Arrests ages 10-17[d]	9.8	212.6	0.0	37.8	77.9	63.0	6.1	73.9	75.0
Dropout rate grades 9-12 (%)	6.3	8.0	0.6	5.5	3.7	1.8	3.1	5.0	5.0
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[f] (%)									
Binge alcohol use ages 12-20	20.3	20.6	20.3	20.3	20.3	20.3	20.3	20.4	21.1
Marijuana use ages 12+	5.0	7.9	5.0	5.0	5.0	5.0	5.0	5.7	7.3
Nonmedical use of prescription drugs ages 12+	6.4	5.5	6.4	6.4	6.4	6.4	6.4	6.2	5.6
Other illicit drug use ages 12+	3.9	4.2	3.9	3.9	3.9	3.9	3.9	4.0	4.3
Residents unemployed and seeking work (%)	9.8	9.1	12.4	11.6	7.2	8.1	9.9	9.6	8.0

(continued)

Appendix Table C.6 (continued)

Indicator of Risk	Target Communities[a]							Target Community Average	State Average
			Costilla/Saguache/Alamosa			Otero/Crowley			
	Pueblo	Adams	Costilla	Saguache	Alamosa	Otero	Crowley		
Child maltreatment ages 0-17[g]	7.7	13.2	0.0	15.2	22.8	7.9	15.2	11.3	8.6
Child maltreatment ages 0-17 by type[g]									
Neglect	6.3	10.0	0.0	9.9	15.4	4.9	14.2	8.6	6.0
Medical neglect	0.1	0.0	0.0	0.0	0.0	0.2	0.0	0.1	0.1
Physical abuse	0.8	1.8	0.0	4.1	3.1	1.6	0.0	1.5	1.3
Sexual abuse	0.3	0.6	0.0	0.6	3.1	0.4	1.0	0.7	0.7
Psychological abuse	0.1	0.1	0.0	0.6	0.7	0.0	0.0	0.2	0.2
Unknown/missing	0.1	0.6	0.0	0.0	0.5	0.8	0.0	0.3	0.4
Domestic violence[f]	-	-	-	-	-	-	-	-	-
Other indicators									
Infant deaths from neglect and abuse[h]	33.5	18.9	0.0	0.0	0.0	0.0	0.0	13.1	10.6
Children born to high-risk mothers[i] (%)	13.0	8.5	12.9	13.8	8.9	9.2	10.0	10.7	6.7
Child deaths ages 1-14[j]	24.2	13.8	0.0	0.0	32.5	15.4	0.0	14.1	17.7
Children ages 0-18 living in poverty (%)	23.9	16.6	37.4	43.9	27.8	31.5	34.4	27.5	14.4

SOURCES: Colorado 2010 MIECHV statewide needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The Colorado needs assessment identified four target communities, which included individual counties as well as groups of counties.
[b]Per 1,000 live births. Data were not reported for this indicator for some target counties in the state.
[c]Per 1,000 residents.
[d]Instead of reporting the rate of juvenile crime arrests per 100,000 juveniles ages 0-19, the Colorado needs assessment reported the rate of juvenile crime arrests per 1,000 juveniles ages 10-17.
[e]Data were not reported for this indicator in this state.
[f]Data were not available at the county level. Data included in this table are for the Substance Abuse and Mental Health Service Administration (SAMHSA) region to which each target county belongs.
[g]The Colorado needs assessment reported an overall child maltreatment rate per 1,000 children ages 0-17.
[h]Per 100,000 live births.
[i]"High-risk" is defined by the presence of three risk factors: unmarried, under age 25, and less than high school graduate.

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Appendix Table C.7

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Connecticut

Indicator of Risk	Target Communities[a]					Target Community Average	State Average
	New Britain	New London	Windham	Ansonia/Derby			
				Ansonia	Derby		
Live births before 37 weeks of gestation (%)	13.4	9.9	8.9	8.8	15.1	11.0	10.8
Total live births less than 2,500 grams (%)	11.1	9.1	9.5	9.7	7.2	9.5	8.0
Infant deaths ages 0-1[b]	8.4	8.3	5.9	7.0	-	7.4	5.7
Children ages 0-17 living below the federal poverty level[c] (%)	26.5	21.9	30.7	17.7	13.4	23.7	11.6
Reported crimes[d]	51.6	43.8	29.8	19.7	29.3	37.4	27.2
Arrests ages 0-19[e]	-	-	-	-	-	-	-
Dropout rate grades 9-12 (%)	6.0	8.9	4.3	3.2	1.3	5.4	1.9
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-
Substance abuse[f]							
Individuals in active substance abuse treatment	16.0	21.6	5.7	-	-	14.4	5.7
Residents unemployed and seeking work (%)	8.5	7.1	7.6	7.1	10.2	8.0	5.7
Child maltreatment ages 0-17[g]	27.9	25.3	42.0	19.3	11.7	27.7	1.3
Child maltreatment ages 0-17 by type[e]	-	-	-	-	-	-	-
Emergency room visits related to domestic violence[h] (%)	3.1	1.3	1.0	0.9	0.5	1.5	0.1

(continued)

Appendix Table C.7 (continued)

Indicator of Risk	Target Communities[a]					Target Community Average	State Average
	New Britain	New London	Windham	Ansonia/Derby Ansonia	Ansonia/Derby Derby		
Other indicators							
Children ages 0-4 living below the federal poverty level (%)	31.6	7.4	38.6	20.7	13.4	23.7	15.6
Excess low birth weight[i]	32	6	3	0	2	11	0
Excess nonprivate insurance at birth[j]	323	119	87	21	6	136	0
Excess child maltreatment[k]	259	70	150	28	-4	123	0
Number of low Connecticut Mastery Test scores[l]	3	3	3	2	3	3	0

SOURCES: Connecticut 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The target communities identified by Connecticut are cities and towns.

[b]Per 1,000 live births. Data were not reported for this indicator for some counties in this state.

[c]Instead of reporting the percentage of residents living below the federal poverty level, the Connecticut needs assessment reported children ages 0-17 living in poverty, relative to all children ages 0-17.

[d]Per 1,000 residents.

[e]Data were not reported for this indicator in this state.

[f]Instead of reporting the prevalence rates of binge alcohol use, marijuana use, nonmedical use of prescription drugs, and other illicit drug use in the past month, the Connecticut needs assessment reported the prevalence of individuals in active substance abuse treatment per 1,000 residents. Data were not reported for this indicator for some counties in this state.

[g]The Connecticut needs assessment defined child maltreatment as any type of substantiated case and included educational, medical, physical, or sexual maltreatment cases. The Connecticut needs assessment reported the number of cases per 1,000 children ages 0-17.

[h]The Connecticut needs assessment reported the percentage of emergency room visits related to domestic violence as its metric for domestic violence.

[i]Excess low birth weight is defined as the number of observed low-birth-weight babies above the expected number of low-birth-weight occurrences, given the statewide average rate of 5.8 per 100 live births.

[j]Excess nonprivate insurance at birth is defined as the number of observed births paid by nonprivate sources beyond the number of births expected, given the size of the birth cohort.

[k]Excess child maltreatment is defined as the number of substantiated cases, annually, above the number expected, given the statewide annual average rate of 1.3 per 1,000 children.

[l]Number of low Connecticut Mastery Test scores is defined as the number of the three Connecticut Mastery Tests (mathematics, reading, and writing) that fell below the state averages of 80.7 percent, 68.4 percent, and 82.9 percent, respectively, of students who met proficiency standards.

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Appendix Table C.8

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Delaware

Indicator of Risk	Target Communities[a]							
	Wilmington River Area	Center City Wilmington	Western Wilmington	Southern Kent County/ Northern Sussex County	Western Sussex County	Eastern Sussex County	Target Community Average	State Average
Live births before 37 weeks of gestation (%)	14.7	18.1	14.8	13.1	13.6	14.3	14.8	13.8
Total live births less than 2,500 grams (%)	10.7	15.1	10.2	8.2	8.4	7.3	10.0	9.3
Infant deaths ages 0-1[b]	11.2	14.2	9.7	8.0	7.5	9.5	10.0	8.5
Residents living below the federal poverty level (%)	6.7	21.6	13.8	9.9	13.7	8.0	12.3	10.3
Reported crimes[c]	-	-	-	-	-	-	-	115
Arrests ages 0-18[d]	-	-	-	-	-	-	-	2,680
Adults ages 18-24 without a high school degree[e] (%)	17.4	28.5	37.9	24.8	23.2	22.0	25.6	18.1
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-	-
Prevalence of activities in the past month among surveyed 11th graders (%)								
Binge alcohol use	17.9	9.7	24.6	23.2	18.1	24.6	19.7	21.0
Marijuana use	28.9	24.9	26.0	22.2	20.7	25.3	24.6	23.7
Nonmedical use of prescription drugs[f]	-	-	-	-	-	-	-	-
Cocaine or crack use[g]	0.0	0.0	0.0	0.2	1.1	0.9	0.4	0.5
Residents unemployed and seeking work (%)	2.7	5.6	4.3	3.1	3.3	2.8	3.6	8.2

(continued)

Appendix Table C.8 (continued)

Indicator of Risk	Target Communities[a]							
	Wilmington River Area	Center City Wilmington	Western Wilmington	Southern Kent County/ Northern Sussex County	Western Sussex County	Eastern Sussex County	Target Community Average	State Average
Child maltreatment ages 0-17[h] (%)	0.89	1.13	1.05	0.8	0.8	0.9	0.9	1.0
Child maltreatment by type[f]	-	-	-	-	-	-	-	-
11th-graders who witnessed domestic violence in the past month[i] (%)	2.5	5.3	7.4	3.6	5.0	7.3	5.2	5.2

SOURCES: Delaware 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]The target communities identified by Delaware are regions within counties. The Wilmington River Area, Center City Wilmington, and Western Wilmington are all regions within New Castle County.

[b]Per 1,000 live births.

[c]Per 1,000 residents. Data were not reported for this indicator for any communities in the state.

[d]Per 100,000 juveniles ages 0-18. Instead of reporting on juveniles ages 0-19, the Delaware needs assessment reported on juveniles ages 0-18. Data were not reported for this indicator for any communities in the state.

[e]Instead of reporting the percentage of high school dropouts grades 9-12, the Delaware needs assessment reported the percentage of the population ages 18-24 with less than a high school degree.

[f]Data were not reported for this indicator in this state.

[g]Instead of reporting the percentage of people using illicit drugs in past month, the Delaware needs assessment reported on the percentage of youth who reported using cocaine or crack in the past month.

[h]The Delaware needs assessment reported the number of substantiated maltreatment investigations as a percentage of children ages 0-17 years.

[i]The Delaware needs assessment reported the percentage of eleventh-graders who witnessed domestic violence in the past month as its metric for domestic violence.

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Appendix Table C.9

Indicators of Community Risk in Communities Chosen for MIECHV Funding: District of Columbia

Indicator of Risk	Target Communities[a]			Target Community Average	District Average
	Ward 5	Ward 7	Ward 8		
Live births before 37 weeks of gestation (%)	13.3	14.5	16.0	14.6	12.2
Total live births less than 2,500 grams (%)	10.8	13.8	14.2	12.9	10.4
Infant deaths ages 0-1[b]	16.3	16.6	19.2	17.4	11.8
Residents living below the federal poverty level (%)	20.0	25.0	36.0	27.0	13.0
Reported crimes[c]	59.9	57.7	62.7	60.1	58.4
Arrests ages 0-19[d]	6,264	6,800	5,976	6,347	5,502
Less than a high school degree[e] (%)	6.6	15.5	15.7	12.6	8.4
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-
Prevalence of activities (%)					
Binge alcohol use in the past month	50.9	45.0	42.9	46.3	60.8
Marijuana use in the past month	10.4	7.8	10.3	9.5	9.1
Nonmedical use of pain relievers in the past year[g]	15.3	12.7	15.5	14.5	15.5
Other illicit drug use in the past month	5.1	4.3	4.5	4.6	4.7
Residents unemployed and seeking work (%)	13.6	17.3	25.4	18.8	10.2

(continued)

Appendix Table C.9 (continued)

Indicator of Risk	Target Communities[a]			Target Community Average	District Average
	Ward 5	Ward 7	Ward 8		
Number of child maltreatment cases[h]	251	382	598	410	-
Child maltreatment by type[f]	-	-	-	-	-
Intimate partner violence[i] (%)	13.9	15.9	15.2	15.0	12.0
Other indicators (%)					
Births to mothers ages 15-19	16.6	19.0	20.6	18.7	12.3
Prenatal care in the 1st trimester	73.7	72.8	67.9	71.5	74.7
No or 3rd-trimester prenatal care	4.5	5.7	7.7	6.0	5.8
Births to unmarried women	71.1	85.9	88.9	82.0	58.5
Receiving food stamps	19.7	28.5	38.7	29.0	15.4
Receiving Temporary Assistance for Needy Families (TANF)	8.4	14.0	21.1	14.5	12.6

SOURCES: District of Columbia 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The target communities identified by the District of Columbia are wards.
[b]Per 1,000 live births.
[c]Per 1,000 residents.
[d]Per 100,000 juveniles ages 0-19.
[e]Instead of reporting the dropout rate for grades 9-12, the District of Columbia needs assessment reported the percentage of the population with less than a high school degree.
[f]Data were not reported for this indicator in this state.
[g]Instead of reporting the rate of nonmedical use of prescription drugs in the past month, the District of Columbia needs assessment reported the rate of nonmedical use of pain relievers in the past year.
[h]The District of Columbia needs assessment reported the number of substantiated child physical abuse and neglect cases. The state average for this indicator was not reported.
[i]The District of Columbia needs assessment reported the percentage of all residents reporting intimate partner violence as its metric for domestic violence.

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Appendix Table C.10

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Florida

Indicator of Risk	Target Communities[a]						Target Community Average	State Average
					Putnam/Bradford			
	Alachua	Duval	Escambia	Pinellas	Putnam	Bradford		
Live births before 37 weeks of gestation (%)	13.6	14.7	16.7	12.9	13.7	13.4	14.3	14.2
Total live births less than 2,500 grams (%)	9.1	9.5	10.7	8.6	9.7	9.5	9.5	8.7
Infant deaths ages 0-1[b]	8.3	9.4	8.6	8.4	7.6	9.3	8.6	7.2
Households with children ages 0-4 living below the federal poverty level[c] (%)	22.4	20.3	28.6	21.6	39.3	26.0	25.1	22.4
Reported crimes[d]	5,082	6,195	4,877	5,114	6,052	2,701	5,129	4,587
Arrests ages 0-17[e]	3,738	2,670	3,495	3,711	2,408	1,665	3,130	2,751
Dropout rate grades 9-12 (%)	4.4	4.4	3.2	2.5	4.0	4.4	3.7	2.7
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[g]								
Binge alcohol use	5,660	10,400	7,020	4,650	4,650	5,660	6,577	5,540
Marijuana use	24,010	26,950	27,740	21,820	21,820	24,010	24,687	23,030
Nonmedical use of prescription drugs	3,930	4,540	4,840	3,630	3,630	3,930	4,144	3,630
Other illicit drug use	5,420	5,350	5,700	4,880	4,880	5,420	5,300	4,341

(continued)

Appendix Table C.10 (continued)

Indicator of Risk	Target Communities[a]						Target Community Average	State Average
					Putnam/Bradford			
	Alachua	Duval	Escambia	Pinellas	Putnam	Bradford		
Residents unemployed and seeking work (%)	4.8	6.9	6.5	7.0	8.0	5.4	6.4	7.0
Child maltreatment ages 0-17[h]	56.4	40.7	37.2	62.6	57.7	55.5	50.7	40.1
Reported child maltreatment by type ages 0-17[h]								
Physical abuse	4.6	3.4	4.0	4.4	3.7	3.7	4.0	3.1
Neglect	21.6	17.2	17.8	32.0	25.1	24.5	22.7	17.8
Medical neglect	1.0	0.6	0.9	1.0	0.7	1.4	0.9	0.5
Sexual abuse	1.6	1.3	1.3	1.2	2.2	2.7	1.6	1.2
Psychological/emotional	1.8	1.2	1.0	2.0	1.5	1.9	1.5	1.3
Other	25.8	17.1	12.2	21.9	24.5	21.4	20.0	16.3
Domestic violence instances[i]	6.8	8.2	8.4	8.3	12.0	7.0	8.2	6.1
Other indicators (%)								
Individuals in need of substance abuse services ages 15-44	13.1	10.4	11.6	10.6	11.0	10.5	11.3	10.3
Child maltreatment: infants[j]	10.8	6.9	6.3	10.5	7.7	5.7	8.2	6.0
Child maltreatment ages 1-4[j]	5.2	4.0	3.2	5.1	6.0	5.9	4.7	3.8

(continued)

Appendix Table C.10 (continued)

SOURCES: Florida 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The Florida needs assessment identified five target communities, which included individual counties as well as a group of two counties.
[b]Per 1,000 live births.
[c]Instead of reporting residents living below the poverty level, the Florida needs assessment reported households with children ages 0-4 living below the federal poverty level.
[d]Instead of reporting crimes per 1,000 residents, the Florida needs assessment reported crimes per 100,000.
[e]Instead of reporting arrests per 100,000 juveniles ages 0-19 the Florida needs assessment reported arrests per 100,000 juveniles ages 0-17.
[f]Data were not reported for this indicator in this state.
[g]Rates per 100,000 individuals ages 15-44.
[h]The Florida needs assessment reported the rate of reported maltreatment (verified, some indication, and not substantiated) per 1,000 children ages 0-17.
[i]The Florida needs assessment reported instances of domestic violence per 1,000 residents as its metric for domestic violence.
[j]Children with "verified" or "some indication" findings of maltreatment.

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Appendix Table C.11

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Georgia

Indicator of Risk	Target Counties							Target County Average	State Average
	Clarke	Crisp	DeKalb	Glynn	Houston	Muscogee	Whitfield		
Live births before 37 weeks of gestation (%)	12.3	19.2	13.4	14.5	11.7	18.1	11.7	14.4	13.3
Total live births that are less than 2,500 grams (%)	8.7	16.0	10.4	9.4	9.5	10.9	7.8	10.4	9.6
Infant deaths ages 0-1[a]	7.2	8.9	7.9	10.0	9.4	12.9	7.2	9.1	8.0
Residents living below the federal poverty level (%)	28.4	27.0	15.3	16.8	11.1	17.6	13.9	18.6	14.3
Arrests[b]	56.9	67.4	53.4	62.4	40.5	85.3	34.3	57.2	39.8
Crime arrests ages 0-19[c]	1,522	1,262	1,128	574	2,514	2,679	859	1,505	848
Dropout rate grades 9-12 (%)	4.7	6.1	5.1	3.8	2.6	3.3	5.8	4.5	3.5
Mothers with less than 12 years of education[d] (%)	28.8	31.2	18.9	26.6	16.1	17.6	54.4	27.7	22.7
Prevalence of activities in the past month (%)									
Binge alcohol use	15.8	6.4	13.6	13.3	10.3	15.9	6.6	11.7	19.7
Marijuana use[e]	-	-	-	-	-	-	-	-	6.2
Nonmedical use of prescription drugs[e]	-	-	-	-	-	-	-	-	4.7
Other illicit drug use[e]	-	-	-	-	-	-	-	-	3.4
Residents unemployed and seeking work (%)	7.3	11.7	9.6	8.2	6.9	8.8	12.4	9.3	9.6
Reported domestic violence cases[f]	26.7	113.9	69.9	108.4	68.4	58.4	122.9	81.2	59.9
Child maltreatment ages 0-17[g]	5.9	11.0	4.5	9.7	8.1	9.4	10.3	8.4	13.2

(continued)

Appendix Table C.11 (continued)

Indicator of Risk	Target Counties							Target County Average	State Average
	Clarke	Crisp	Dekalb	Glynn	Houston	Muscogee	Whitfield		
Child maltreatment ages 0-17 by type									
Neglect[g]	5.1	9.2	3.2	6.5	5.5	6.9	7.4	6.3	6.6
Physical abuse[h]	65.6	98.3	105.1	212.8	175.0	185.4	67.5	130.0	115.6
Sexual abuse[h]	23.4	98.3	20.1	36.3	65.6	39.9	32.0	45.1	40.3
Emotional abuse[h]	0.0	0.0	20.1	109.0	65.6	97.7	266.6	79.9	136.7
Other indicators									
Births to unmarried parents (%)	48.2	67.2	50.7	53.5	41.3	55.1	45.3	51.6	45.2
Birth interval less than 24 months (%)	27.6	28.9	25.0	27.6	19.5	24.8	23.1	25.2	23.5
Repeat adolescent pregnancy[i] (%)	26.0	41.5	30.5	30.5	17.9	29.4	28.8	29.2	20.9
Children receiving free or reduced-price lunch (%)	77.6	74.0	68.5	54.4	49.9	61.5	96.1	68.9	58.6
Single-parent households (%)	10.5	17.6	12.2	11.2	12.1	16.8	10.8	13.0	11.3
Liquor-store density[j]	0.2	0.0	1.1	0.0	0.2	0.0	1.6	0.4	0.9
Inpatient hospitalization for substance abuse[k]	3.6	19.0	6.1	4.9	8.4	6.9	2.2	7.3	8.2
Emergency-room encounters for substance abuse[k]	69.1	65.2	35.2	133.8	91.8	52.0	76.0	74.7	60.2

SOURCES: Georgia 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]Per 1,000 live births.
[b]Instead of the number of crimes reported per 1,000 residents, the Georgia needs assessment provided the number of arrests per 1,000 residents.
[c]Per 100,000 juveniles age 0-19.
[d]The Georgia needs assessment reported the percentage of mothers with less than 12 years of education as its "other school dropout rate."
[e]Data were not reported for this indicator for any target counties in the state.
[f]The Georgia needs assessment reported the number of reported domestic violence cases per 10,000 households as its metric for domestic violence.
[g]For this measure, the Georgia needs assessment reported the rate of substantiated child abuse and neglect cases per 1,000 children ages 0-17.
[h]For this measure, the Georgia needs assessment reported the rate of substantiated child abuse and neglect cases per 100,000 children ages 0-17.
[i]Number of women ages 15-19 delivering a second child/number of resident live births to women ages 15-19.
[j]Per 10,000 people.
[k]Per 100,000 residents.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.12

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Hawaii

	Target Communities[a]								Target Community Average	State Average
	Waianae/Ewa		Hilo/Puna			Maui	Kona			
Indicator of Risk	Waianae	Ewa	Hilo	Puna	Kalihi	County	South Kona	North Kona		
Live births before 37 weeks of gestation[b] (%)	12.1	11.7	11.7	12.3	-	-	10.1	8.7	11.1	10.8
Total live births less than 2,500 grams[b] (%)	8.0	8.5	8.9	8.7	-	-	7.0	7.2	8.1	8.2
Infant deaths ages 0-1[b,c] (%)	9.3	6.1	5.7	5.7	-	-	6.5	5.2	6.4	6.3
Residents living below the federal poverty level[b] (%)	44.1	18.2	34.3	48.0	-	-	31.7	24.4	33.5	10.7
Reported crimes (survey)[b,d] (%)										
Any crimes[e]	37.0	37.0	21.6	25.0	47.1	29.5	40.9	40.9	35.6	-
Property crimes	29.6	29.6	17.6	-	30.9	25.3	29.5	29.5	26.6	24.0
Violent crimes	11.1	11.1	5.9	-	11.8	7.4	9.1	9.1	9.1	6.6
Arrests ages 0-19[f]	-	-	-	-	-	-	-	-	-	-
Persons ages 18+ with no high school diploma[b,g] (%)	21.7	14.1	15.8	18.2	-	-	16.8	13.6	16.7	15.3
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-	-	-	-
Residents unemployed and seeking work[b] (%)	8.8	3.0	7.1	8.3	-	-	3.9	2.6	5.6	6.3

(continued)

Appendix Table C.12 (continued)

Indicator of Risk	Target Communities[a]								Target Community Average	State Average
	Waianae/Ewa		Hilo/Puna			Maui	Kona			
	Waianae	Ewa	Hilo	Puna	Kalihi	County	South Kona	North Kona		
Prevalence of activities[h] (%)										
Binge alcohol use	-	-	-	-	-	-	-	-	-	-
Marijuana use	-	-	-	-	-	-	-	-	-	-
Nonmedical use of prescription drugs	-	-	-	-	-	-	-	-	-	-
Other illicit drug use	-	-	-	-	-	-	-	-	-	-
Sold or used illegal drugs[b] (%)	43.2	43.2	31.4	26.0	42.6	-	52.3	52.3	41.7	8.7
Child maltreatment ages 0-19[b,i] (%)	13.0	17.0	4.0	5.0	-	-	1.0	2.0	7.0	1.0
Number of child maltreatment reports by type[e,j]										
Physical abuse	512	512	147	147	512	110	147	147	286	-
Neglect	563	563	148	148	563	87	148	148	302	-
Medical neglect	52	52	10	10	52	7	10	10	26	-
Sexual abuse	188	188	80	80	188	42	80	80	116	-
Psychological abuse	37	37	14	14	37	7	14	14	22	-
Threatened harm	2,485	2,485	815	815	2,485	498	815	815	1,420	-
Reported domestic violence[b,k] (%)	34.6	34.6	21.6	61.0	20.6	-	34.1	34.1	32.7	23.4
Other indicators[b]										
Receiving Temporary Assistance for Needy Families (TANF) (%)	10.4	2.1	3.6	3.6	-	-	1.8	1.8	3.9	2.2
Receiving food stamps (%)	42.0	8.7	18.6	36.9	-	-	13.7	9.8	21.6	11.6

(continued)

Appendix Table C.12 (continued)

SOURCES: Hawaii 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]The Hawaii FY 2010 and FY 2011 state plans and first-round competitive grant application identified four island communities and one county spanning multiple islands as its target communities. Hilo/Puna and Kona are communities on the island of Hawaii, and Kalihi and Ewa/Waianae are communities on the island of Oahu. Maui County consists of the islands of Maui, Lanai, Molokai, Kahoolawe, and Molokini. The Hawaii needs assessment provided more extensive indicator information for the Ewa/Waianae, Hilo/Puna, and Kona communities than for the other target communities. While Kona is one target community, the Hawaii needs assessment sometimes reported data separately for South Kona and North Kona.

[b]Data were not reported for this indicator for some communities in this state.

[c]Instead of reporting infant mortality as a rate per 1,000 births, the Hawaii needs assessment reported infant deaths as a percentage of the number of live births.

[d]Instead of the number of crimes reported to police per 1,000 residents, the Hawaii needs assessment provided the percentage of survey respondents who recounted property and violent crimes in a crime victimization survey. These rates were not available at the community level and were instead provided for the county districts to which communities belong.

[e]The state average for this indicator was not reported.

[f]Data were not reported for this indicator in this state.

[g]Instead of reporting the percentage of high school dropouts grades 9-12, the Hawaii needs assessment reported the percentage of residents 18 and over with no high school diploma.

[h]Instead of reporting the prevalence of binge alcohol, marijuana, prescription drug, and other illicit drug abuse, the Hawaii needs assessment reported the percentage of survey respondents who admitted to selling or using illegal drugs in a crime victimization survey.

[i]The Hawaii needs assessment reported the number of confirmed, unduplicated reports of child abuse and neglect as a percentage of the total number of children ages 0-19 for the seven previous years (2003-2009).

[j]The Hawaii needs assessment reported the number of unduplicated, confirmed reports of child maltreatment by type. The data were reported at the county level, so each community shows the value for its county.

[k]The Hawaii needs assessment provided the percentage of survey respondents who recounted incidents of domestic violence in a crime victimization survey. These rates were not available at the community level and were instead provided for the county districts to which communities belong.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.13

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Idaho

Indicator of Risk	Target Counties				Target County Average	State Average
	Kootenai	Shoshone	Twin Falls	Jerome		
Live births before 37 weeks of gestation (%)	8.1	11.4	11.6	11.5	10.7	9.8
Total live births less than 2,500 grams (%)	5.4	8.9	7.4	8.0	7.4	6.5
Infant deaths ages 0-1[a]	5.5	8.1	11.9	11.5	9.3	5.8
Residents living below the federal poverty level (%)	9.4	18.2	14.5	12.9	13.8	12.5
Reported crimes[b]	52.3	33.5	64.2	42.7	48.2	50.9
Arrests ages 0-19[c]	69.2	24.4	53.0	59.1	51.4	56.1
Dropout rate grades 9-12 (%)	0.0	0.6	3.5	6.0	2.5	1.7
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-
Prevalence of activities ages 18+ (%)						
Binge alcohol use in the past month	12.6	18.1	10.9	15.4	14.3	11.5
Marijuana use in the past year[e]	3.8	5.9	4.1	2.6	4.1	3.9
Nonmedical use of prescription drugs[d]	-	-	-	-	-	-
Other illicit drug use in the past year[e]	1.1	6.0	2.0	0.0	2.3	1.6
Residents unemployed and seeking work (%)	9.6	12.0	8.4	7.8	9.5	8.8
Child maltreatment ages 0-17[f]	4.0	9.6	8.9	5.0	6.9	3.7

(continued)

Appendix Table C.13 (continued)

Indicator of Risk	Target Counties				Target County Average	State Average
	Kootenai	Shoshone	Twin Falls	Jerome		
Child maltreatment ages 0-17 by type[f]						
Abandonment	0.2	0.0	0.1	0.0	0.1	0.1
Hazardous home	0.4	1.5	1.9	2.4	1.6	0.8
Homelessness	0.6	0.4	0.3	0.0	0.3	0.1
Neglect	12.0	6.5	5.9	1.9	6.6	2.1
Physical abuse	4.7	1.5	0.6	0.7	1.9	0.7
Sexual abuse	0.7	0.0	0.8	0.1	0.4	0.3
Other	1.7	0.8	0.5	0.0	0.8	0.2
Domestic violence[g]						
Victims of intimate partner violence	5.1	2.9	4.2	3.2	3.9	4.0
Physically abused pregnant women (%)	5.3	4.8	4.5	3.5	4.5	4.3

SOURCES: Idaho 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Per 1,000 live births.
[b]Per 1,000 residents.
[c]Per 100,000 juveniles ages 0-19.
[d]Data were not reported for this indicator in this state.
[e]Instead of reporting the percentage using this substance in the past month, the Idaho needs assessment reported the percentage of people ages 18+ using this substance in the past year.
[f]The Idaho needs assessment reported the rate of maltreatment per 1,000 children ages 0-17.
[g]The Idaho needs assessment reported the number of victims of intimate partner violence per 1,000 residents and the percentage of mothers ages 18+ who reported physical abuse during pregnancy as its metrics for domestic violence.

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Appendix Table C.14

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Illinois

	Target Communities[a]					
Indicator of Risk	Chicago: Englewood	Chicago: West Englewood	Chicago: Greater Grand Crossing	Chicago: North Lawndale	Chicago: East Garfield Park	City of Elgin
Live births before 37 weeks of gestation (%)	Q4 (14.0-20.4)	Q4 (14.0-20.4)	Q4 (14.0-20.4)	Q4 (14.0-20.4)	Q4 (14.0-20.4)	Q3 (10.0-10.7)
Total live births less than 2,500 grams (%)	Q4 (13.3-18.5)	Q4 (13.3-18.5)	Q4 (13.3-18.5)	Q4 (13.3-18.5)	Q4 (13.3-18.5)	Q2 (7.1-7.6)
Infant deaths ages 0-1[b]	-	Q3 (11.2-15.0)	-	-	-	Q1 (5.2-7.1)
Residents living below the federal poverty level[c] (%)	-	-	-	-	-	-
Arrests[d,e]	Q4 (829-1,998)	Q4 (829-1,998)	Q4 (829-1,998)	Q4 (829-1,998)	Q4 (829-1,998)	Q2 (343-518)
Arrests ages 0-19[c]	-	-	-	-	-	-
9th-grade cohort members who did not graduate in 4 years[f] (%)	Q3 (12.3-16.7)	Q4 (16.8-24.5)	Q4 (16.8-24.5)	Q4 (16.8-24.5)	Q2 (8.2-12.2)	Q4 (2.9-9.6)
Other school dropout rate per state/local calculation[c] (%)	-	-	-	-	-	-
Prevalence of activities in the past month[c]						
Binge alcohol use	-	-	-	-	-	-
Marijuana use	-	-	-	-	-	-
Nonmedical use of prescription drugs						
Other illicit drug use	-	-	-	-	-	-
Residents unemployed and seeking work[g] (%)	Q4 (17.1-34.0)	Q4 (17.1-34.0)	Q4 (17.1-34.0)	Q4 (17.1-34.0)	Q4 (17.1-34.0)	Q3 (10.2-11.2)

(continued)

Appendix Table C.14 (continued)

Indicator of Risk	Target Communities[a]					
	Cicero Township	Waukegan Township	Thornton Township	Joliet Township	City of Rockford	Vermilion County
Live births before 37 weeks of gestation (%)	Q1 (5.1-8.9)	Q1 (5.1-8.9)	Q4 (10.8-15.3)	Q2 (9.0-9.9)	Q3 (10.0-11.8)	Q4 (11.9-17.3)
Total live births less than 2,500 grams (%)	Q2 (7.1-7.6)	Q3 (7.7-8.6)	Q4 (8.7-15.3)	Q4 (8.7-15.3)	Q4 (9.1-15.0)	Q4 (9.1-15.0)
Infant deaths ages 0-1[b]	-	Q1 (5.2-7.1)	Q4 (9.9-13.2)	Q4 (9.9-13.2)	Q3 (6.2-8.5)	-
Residents living below the federal poverty level[c] (%)	-	-	-	-	-	-
Arrests[d,e]	Q4 (829-1,998)	Q3 (518-829)	Q4 (829-1,998)	Q3 (518-829)	Q4 (829-1,998)	Q4 (829-1,998)
Arrests ages 0-19[c]	-	-	-	-	-	-
9th-grade cohort members who did not graduate in 4 years[f] (%)	Q4 (2.9-9.6)	Q4 (2.9-9.6)	Q3 (1.5-2.8)	Q4 (2.9-9.6)	Q3 (2.5-3.0)	Q4 (3.1-7.1)
Other school dropout rate per state/local calculation[c] (%)	-	-	-	-	-	-
Prevalence of activities in the past month[c]						
Binge alcohol use	-	-	-	-	-	-
Marijuana use	-	-	-	-	-	-
Nonmedical use of prescription drugs						
Other illicit drug use	-	-	-	-	-	-
Residents unemployed and seeking work[g] (%)	Q3 (10.2-11.2)	Q3 (10.2-11.2)	Q3 (10.2-11.2)	Q3 (10.2-11.2)	Q4 (11.3-15.1)	Q4 (11.3-15.1)

(continued)

Appendix Table C.14 (continued)

Indicator of Risk	Target Communities[a]			Target Community Average[i]	State Average[j]
	Macon County	City of Moline	City of East St. Louis		
Live births before 37 weeks of gestation (%)	Q4 (11.9-17.3)	Q2 (8.3-9.9)	Q1 (4.7-8.2)	-	-
Total live births less than 2,500 grams (%)	Q4 (9.1-15.0)	Q2 (6.8-7.6)	Q2 (6.8-7.6)	-	-
Infant deaths ages 0-1[b]	Q3 (6.2-8.5)	Q4 (8.6-10.1)	Q1 (3.4-4.4)	-	-
Residents living below the federal poverty level[c] (%)	-	-	-	-	-
Arrests[d,e]	Q4 (829-1,998)	Q4 (829-1,998)	Q4 (829-1,998)	-	-
Arrests ages 0-19[c]	-	-	-	-	-
9th-grade cohort members who did not graduate in 4 years[f] (%)	Q3 (2.5-3.0)	Q1(1.7-2.4)	Q1(1.7-2.4)	-	-
Other school dropout rate per state/local calculation[c] (%)	-	-	-	-	-
Prevalence of activities in the past month[c]					
Binge alcohol use	-	-	-	-	-
Marijuana use	-	-	-	-	-
Nonmedical use of prescription drugs					
Other illicit drug use	-	-	-	-	-
Residents unemployed and seeking work[g] (%)	Q4 (11.3-15.1)	Q2 (9.2-10.1)	Q3 (10.2-11.2)	-	-

(continued)

Appendix Table C.14 (continued)

Indicator of Risk	Target Communities[a]					
	Chicago: Englewood	Chicago: West Englewood	Chicago: Greater Grand Crossing	Chicago: North Lawndale	Chicago: East Garfield Park	City of Elgin
Child maltreatment ages 0-5[h]	Q4 (15.8-36.7)	Q4 (15.8-36.7)	Q4 (15.8-36.7)	Q4 (15.8-36.7)	Q3 (9.7-15.7)	Q4 (9.8-37.1)
Child maltreatment by type[c]	-	-	-	-	-	-
Domestic violence incidents[d,k]	Q4 (569-2,743)	Q4 (569-2,743)	Q4 (569-2,743)	Q4 (569-2,743)	Q4 (569-2,743)	Q2 (138-310)
Other indicators (%)						
Births covered by Medicaid	Q4 (82.9-90.5)	Q4 (82.9-90.5)	Q4 (82.9-90.5)	Q4 (82.9-90.5)	Q4 (82.9-90.5)	Q4 (48.4-83.4)
Births to single parents	Q4 (77.3-92.8)	Q4 (77.3-92.8)	Q4 (77.3-92.8)	Q4 (77.3-92.8)	Q4 (77.3-92.8)	Q4 (36.5-67.7)
Births to mothers under age 17	Q4 (8.1-13.0)	Q4 (8.1-13.0)	Q4 (8.1-13.0)	Q4 (8.1-13.0)	Q4 (8.1-13.0)	Q3 (2.9-5.0)

Indicator of Risk	Target Communities[a]					
	Cicero Township	Waukegan Township	Thornton Township	Joliet Township	City of Rockford	Vermilion County
Child maltreatment ages 0-5[h]	Q3 (6.3-9.7)	Q4 (9.8-37.1)	Q3 (6.3-9.7)	Q4 (9.8-37.1)	Q4 (27.9-42.8)	Q4 (27.9-42.8)
Child maltreatment by type[c]	-	-	-	-	-	-
Domestic violence incidents[d,k]	Q4 (569-2,743)	Q3 (310-569)	Q4 (569-2,743)	Q3 (310-569)	Q1 (0-138)	Q4 (569-2,743)
Other indicators (%)						
Births covered by Medicaid	Q4 (48.4-83.4)	Q4 (48.4-83.4)	Q4 (48.4-83.4)	Q4 (48.4-83.4)	Q3 (55.8-63.6)	Q4 (63.7-75.5)
Births to single parents	Q4 (36.5-67.7)	Q4 (36.5-67.7)	Q4 (36.5-67.7)	Q4 (36.5-67.7)	Q4 (45.0-56.9)	Q4 (45.0-56.9)
Births to mothers under age 17	Q3 (2.9-5.0)	Q4 (5.1-10.8)	Q4 (5.1-10.8)	Q4 (5.1-10.8)	Q4 (4.3-6.7)	Q3 (3.6-4.2)

(continued)

Appendix Table C.14 (continued)

Indicator of Risk	Target Communities[a]			Target Community Average[i]	State Average[j]
	Macon County	City of Moline	City of East St. Louis		
Child maltreatment ages 0-5[h]	Q3 (21.0-27.8)	Q4 (27.9-42.8)	Q1 (4.4-15.8)	-	-
Child maltreatment by type[c]	-	-	-	-	-
Domestic violence incidents[d,k]	Q4 (569-2,743)	Q4 (569-2,743)	Q3 (310-569)	-	-
Other indicators (%)					
Births covered by Medicaid	Q3 (55.8-63.6)	Q4 (63.7-75.5)	Q3 (55.8-63.6)	-	-
Births to single parents	Q4 (45.0-56.9)	Q4 (45.0-56.9)	Q4 (45.0-56.9)	-	-
Births to mothers under age 17	Q4 (4.3-6.7)	Q3 (3.6-4.2)	Q4 (4.3-6.7)	-	-

(continued)

Appendix Table C.14 (continued)

SOURCES: Illinois 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]The Illinois FY 2011 state plan named 15 target communities, including areas of Chicago, cities and townships, and counties. Instead of providing data for each indicator in each community, Illinois provided the range of risk observed for each community. Communities were divided into four quartiles based on the range of risk observed in the area, with Quartile 4 (Q4) representing those areas in the highest quartile (the top 25%) of risk indicators. For some indicators, the City of Chicago was analyzed at the community-area level and Cook and the "collar counties" were analyzed at the township level. Therefore, the quartile ranges for those communities differ from the rest of the state. Unless otherwise noted, indicators for Englewood, West Englewood, Greater Grand Crossing, North Lawndale, and East Garfield Park are for those communities, indicators for Elgin, Cicero Township, Waukegan Township, Thornton Township, and Joliet Township are for those cities and towns, indicators for Vermilion and Mason Counties are for those counties, and indicators for Rockford, Moline, and East St. Louis are for the counties to which the cities belong.

[b]Per 1,000 live births. Data were not provided for communities where rates were too low to report.

[c]Data were not reported for this indicator in this state.

[d]For all target communities, data for this indicator were reported for the counties to which the target communities belong.

[e]Instead of the number of reported crimes per 1,000 residents, the Illinois needs assessment provided the number of arrests per 100,000 residents. This indicator was only provided at the county level, so target communities that are smaller than counties were given the value for their counties.

[f]Instead of reporting the percentage of high school dropouts grades 9-12, the Illinois needs assessment reported the percentage of ninth-grade cohort members who did not graduate in four years.

[g]Data for this indicator were reported for each target community in Chicago. For all other target communities, data for this indicator were reported for the county to which the target community belongs.

[h]The Illinois needs assessment reported the number of indicated child abuse and neglect victims per 1,000 children ages 0-5.

[i]Target community averages were not calculated because Illinois did not give the exact indicator values for its target communities.

[j]The Illinois needs assessment did not provide state averages for any indicators.

[k]The Illinois needs assessment reported the number of domestic violence incidents per 100,000 population as its metric for domestic violence.

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Appendix Table C.15

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Indiana

Indicator of Risk	Target Counties				Target County Average	State Average
	Lake	Marion	Scott	St. Joseph[a]		
Live births before 37 weeks of gestation (%)	13.7	12.0	10.7	-	12.1	10.8
Total live births less than 2,500 grams (%)	10.6	9.4	7.5	-	9.2	8.5
Infant deaths ages 0-1[b,c]	9.9	9.1	-	-	9.5	7.5
Residents living below the federal poverty level (%)	24.7	24.0	24.7	-	24.5	17.2
Reported crimes[d]	-	-	-	-	-	-
Arrests ages 0-19[e] (%)	4.1	6.2	2.4	-	4.2	3.8
Dropout rate grades 9-12 (%)	0.5	0.7	1.0	-	0.7	0.6
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-
Prevalence of activities in the past month (%)						
Binge alcohol use[f]	-	-	-	-	-	17.4
Binge alcohol use among youth	17.0	17.0	8.0	-	14.0	14.1
Marijuana use[f]	-	-	-	-	-	6.3
Nonmedical use of prescription drugs[f]	-	-	-	-	-	6.0
Other illicit drug use[f]	-	-	-	-	-	4.2
Residents unemployed and seeking work (%)	24.2	18.9	22.7	-	21.9	19.1
Child maltreatment[f,g]	-	-	-	-	-	11.1

(continued)

Appendix Table C.15 (continued)

Indicator of Risk	Target Counties				Target County Average	State Average
	Lake	Marion	Scott	St. Joseph[a]		
Child maltreatment by type[h] (%)						
Neglect	18.0	31.0	19.0	-	22.7	20.0
Physical abuse	6.0	9.0	14.0	-	9.7	16.0
Domestic violence[f,i]	-	-	-	-	-	1.3
Other indicators (%)						
Prenatal care in the 1st trimester	59.6	60.6	57.8	-	59.3	67.5

SOURCES: Indiana 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: The Indiana needs assessment does not give information on the units for many of its reported indicators. Unless the needs assessment explicitly states otherwise, this table assumes that the indicators were measured in the units as requested by the U.S. Department of Health and Human Services.

[a]Data were not reported for any indicators in this county.

[b]Per 1,000 live births.

[c]Data were not reported for this indicator for Scott or St. Joseph Counties.

[d]Data were not reported for this indicator in this state.

[e]Instead of reporting the number of juvenile arrests per 100,000 juveniles, the Indiana needs assessment reported juvenile arrests as a percentage of the juvenile population.

[f]Data were not reported for this indicator for any counties in this state.

[g]The Indiana needs assessment reported the rate of child abuse and neglect per 1,000 children.

[h]It appears that the Indiana needs assessment reported the percentage of neglect and abuse cases that were substantiated.

[i]Per 1,000 sheltered.

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Appendix Table C.16

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Iowa

Indicator of Risk	Target Counties				Target County Average	State Average
	Black Hawk	Wapello	Lee	Appanoose		
Live births before 37 weeks of gestation (%)	11.5	8.9	8.9	12.3	10.4	9.4
Total live births less than 2,500 grams (%)	8.9	6.7	7.3	8.2	7.8	6.7
Infant deaths ages 0-1[a]	4.0	-	-	0.0	2.0	4.5
Residents living below the poverty level (%)	14.7	15.2	14.6	18.1	15.7	11.4
Reported crimes[b]	83.2	64.5	65.4	62.7	69.0	53.9
Arrests ages 0-18[c]	39.8	56.6	46.0	20.2	40.7	27.4
Dropout rate grades 9-12 (%)	3.9	7.6	6.0	1.7	4.8	3.2
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-
Prevalence of activities in the past month (%)						
Binge alcohol use	21.7	12.0	19.8	38.5	23.0	20.3
Marijuana use[e]	-	-	-	-	-	4.4
Nonmedical use of prescription drugs[d]	-	-	-	-	-	-
Other illicit drug use[e]	-	-	-	-	-	2.9
Residents unemployed and seeking work (%)	6.5	8.7	10.1	7.8	8.3	6.8
Child maltreatment[f]	25.9	39.3	27.4	41.0	33.4	17.9

(continued)

Appendix Table C.16 (continued)

Indicator of Risk	Target Counties				Target County Average	State Average
	Black Hawk	Wapello	Lee	Appanoose		
Child maltreatment ages 0-18 by type[e,g]						
Neglect	-	-	-	-	-	214.4
Exposure to manufacturing of methamphetamine	-	-	-	-	-	1.2
Mental injury	-	-	-	-	-	0.3
Physical abuse	-	-	-	-	-	24.6
Presence of illegal drugs in child's system	-	-	-	-	-	9.7
Sexual abuse	-	-	-	-	-	10.1
Cohabitation with a registered sex offender	-	-	-	-	-	1.6
Allows access to registered sex offender	-	-	-	-	-	1.9
Reported domestic violence[h]	261.3	271.1	228.0	423.9	296.1	217.7
Other indicators (%)						
Mothers smoking through 3rd trimester of pregnancy	17.9	17.3	24.2	22.3	20.4	14.3
Mothers who gave birth who have high school education	83.5	74.7	84.6	81.0	80.9	85.6
4th-grade students proficient in reading	74.3	78.3	81.0	77.7	77.8	79.1
Children under 18 living below the federal poverty level	17.3	20.3	21.5	23.9	20.8	14.2

SOURCES: Iowa 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Per 1,000 live births. Data were not reported for this indicator for some counties in this state.
[b]Per 1,000 residents.
[c]Instead of reporting the number of arrests ages 0-19 per 100,000 juveniles ages 0-19, Iowa reported the juvenile crime rate ages 0-18 per 1,000.
[d]Data were not reported for this indicator in this state.
[e]Data were not reported for this indicator for any counties in this state.
[f]The Iowa needs assessment reported the rate of confirmed child abuse and neglect per 1,000 children.
[g]The Iowa needs assessment reported the rate of maltreatment by type reported per 1,000 children ages 0-18.
[h]The Iowa needs assessment reported the rate of reported domestic violence per 100,000 as its metric for domestic violence.

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Appendix Table C.17

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Kansas

Indicator of Risk	Target Counties		Target County Average	State Average
	Montgomery	Wyandotte		
Live births before 37 weeks of gestation (%)	10.7	10.2	10.5	9.3
Total live births less than 2,500 grams (%)	8.7	9.1	8.9	7.2
Infant deaths ages 0-1[a]	2.0	8.8	5.4	7.3
Residents living below the federal poverty level (%)	12.4	19.2	15.8	11.3
Arrests[b]	36.1	49.3	42.7	36.8
Arrests ages 0-19[c]	3,286	267	1,776	2,179
Dropout rate grades 9-12	11.1	18.8	15.0	9.9
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-
Prevalence of activities among 12th-graders (%)				
Binge alcohol use in the past two weeks[e]	30.1	27.8	29.0	31.8
Marijuana use in the past month	15.4	19.1	17.3	16.7
Nonmedical use of pain relievers in the past month[f]	9.3	-	9.3	6.9
Methamphetamine use in the past month[g]	1.6	3.8	2.7	1.8
Cocaine/crack use in the past month[g]	2.0	6.9	4.5	2.4
Heroin use in the past month[g]	1.5	-	1.5	1.5
Residents unemployed and seeking work (%)	10.7	10.3	10.5	6.9
Child maltreatment[h]	7.3	4.3	5.8	2.9
Domestic violence incidents[i]	194	125	160	-

(continued)

Appendix Table C.17 (continued)

Indicator of Risk	Target Counties		Target County Average	State Average
	Montgomery	Wyandotte		
Number of child maltreatment reports by type[j]				
Emotional abuse	97	363	230	-
Lack of supervision	103	398	251	-
Physical abuse	153	700	427	-
Medical neglect	27.0	96.0	61.5	-
Physical neglect	101	305	203	-
Sexual abuse	57	204	131	-
Abandonment	1.0	18.0	9.5	-

SOURCES: Kansas 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Per 1,000 live births.

[b]Instead of the number of reported crimes per 1,000 residents, the Kansas needs assessment provided the number of arrests per 1,000 residents.

[c]Per 100,000 juveniles ages 0-19.

[d]Data were not reported for this indicator in this state.

[e]Instead of reporting binge alcohol use in the past month, this state reported binge alcohol use in the past two weeks.

[f]Instead of reporting the rate of nonmedical use of prescription drugs in the past month, the Kansas needs assessment reported the rate of nonmedical use of pain relievers in the past month. Data were not reported for this indicator for some target counties in the state.

[g]Instead of reporting the percentage using other illicit drugs in the past month, the Kansas needs assessment reported the percentage of twelfth-graders who used methamphetamine, cocaine/crack, and heroin in the past month. Data were not reported for heroin use for one target county in the state.

[h]The Kansas needs assessment reported the number of substantiated incidents of child maltreatment per 1,000 children.

[i]The Kansas needs assessment reported the rate of domestic violent incidents per 1,000 residents ages 5-64 as its metric for domestic violence. There appears to be a mistake in how the Kansas needs assessment reported the state average for this indicator, so the number is excluded from this table.

[j]The Kansas needs assessment provided the number of child maltreatment reports by type. The state average for this indicator was not provided.

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Appendix Table C.18

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Kentucky

Indicator of Risk	Target Counties												Target County Average	State Average
	Breathitt	Johnson	Knott	Lawrence	Lee	Leslie	Letcher	Magoffin	Owsley	Perry	Pike	Wolfe		
Live births before 37 weeks of gestation (%)	14.3	17.8	14.9	32.7	18.7	17.0	15.3	18.6	28.3	15.8	19.2	16.7	19.1	13.9
Total live births less than 2,500 grams (%)	10.6	9.6	15.4	22.2	13.3	8.8	13.2	5.6	0.0	11.2	11.7	11.1	11.1	8.1
Infant deaths ages 0-1[a]	7.0	7.5	5.0	12.7	8.7	8.8	8.7	12.5	0.0	6.8	8.5	3.1	7.4	5.1
Residents living below the federal poverty level (%)	31.5	26.0	30.2	27.1	33.9	30.0	29.4	34.9	37.6	27.2	25.1	36.1	30.8	20.3
Reported crimes[b]	11.5	7.0	17.1	7.8	7.3	7.3	26.1	18.0	11.0	20.8	20.3	19.2	14.5	17.9
Arrests ages 0-19[c]	1,301	1,850	567	1,169	1,684	<10	787	398	1,848	1,573	1,448	1,378	1,168	1,720
Dropout rate grades 9-12 (%)	2.0	1.2	2.2	3.3	2.3	3.8	2.0	3.0	1.2	1.6	4.3	0.5	2.3	2.2
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Prevalence of activities in the past month (%)														
Binge alcohol use	17.9	17.9	17.9	17.9	17.9	17.9	17.9	17.9	17.9	17.9	17.9	17.9	17.9	21.6
Marijuana use	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	4.3	5.8
Nonmedical use of prescription drugs	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	5.4	6.0
Other illicit drug use	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8

(continued)

Appendix Table C.18 (continued)

Indicator of Risk	Target Counties												Target County Average	State Average
	Breathitt	Johnson	Knott	Lawrence	Lee	Leslie	Letcher	Magoffin	Owsley	Perry	Pike	Wolfe		
Residents unemployed and seeking work (%)	12.7	13.0	14.1	14.6	13.8	14.5	12.5	22.5	11.9	12.3	11.2	16.5	14.1	12.8
Child maltreatment[e]	24.1	38.9	37.6	39.3	19.6	19.6	43.3	20.6	63.2	25.9	27.2	28.4	32.3	17.3
Child maltreatment by type[e]														
Neglect	22.0	24.0	32.0	53.0	26.0	20.0	39.0	46.0	27.0	24.0	31.0	23.0	30.6	35.0
Physical abuse	13.0	5.0	6.0	42.0	29.0	14.0	13.0	30.0	10.0	7.0	21.0	14.0	17.0	18.1
Sexual abuse	13.0	20.0	27.0	8.0	25.0	5.0	24.0	20.0	7.0	13.0	16.0	6.0	15.3	26.3
Domestic violence calls to shelters[f]	5.3	4.2	5.3	6.0	5.3	5.3	5.3	4.2	5.3	5.3	4.2	5.3	5.1	9.0
Other indicators														
Infant mortality due to abuse/neglect[a]	0.7	0.7	0.7	0.4	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.3
Substance abuse clients (%)	8.1	6.7	3.8	8.8	7.8	12.2	6.2	9.6	6.7	6.6	5.5	11.2	7.8	5.1
Women who smoked while pregnant (%)	43.1	36.9	35.4	32.0	58.7	40.6	38.2	31.7	47.2	37.6	35.2	36.1	39.4	25.4

SOURCES: Kentucky 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Per 1,000 live births.
[b]Per 1,000 residents.
[c]Per 100,000 juveniles ages 0-19.
[d]Data were not reported for this indicator in this state.
[e]The Kentucky needs assessment reported the rate of substantiated incidents of child maltreatment per 1,000 children.
[f]The Kentucky needs assessment reported the number of domestic violence calls to shelters per 1,000 persons as its metric for domestic violence.

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Appendix Table C.19

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Louisiana

	Target Communities[a]							
Indicator of Risk	Jefferson	Orleans	East Baton Rouge	Iberville	St. Charles[b]	St. John the Baptist	Lafourche	St. Mary
Live births before 37 weeks of gestation[c] (%)	-	14.8	-	12.9	-	13.9	13.7	13.6
Total live births less than 2,500 grams[c] (%)	-	13.3	-	11.1	-	12.3	-	12.0
Infant deaths ages 0-1[c,d]	-	9.3	10.8	6.0	-	-	-	-
Residents living below the federal poverty level[c] (%)	-	22.9	-	21.6	-	-	-	-
Reported crimes[c,e]	-	75.7	-	42.5	-	-	-	-
Arrests ages 0-19[c,f]	-	18	-	589	-	-	-	-
Dropout rate grades 7-12[c,g]	7.2	7.4	8.7	9.0	-	9.4	-	-
Other school dropout rate per state/local calculation[h] (%)	-	-	-	-	-	-	-	-
Prevalence of activities among youth in the past month[c,i] (%)								
Binge alcohol use	-	13.8	-	16.6	-	-	-	-
Marijuana use	-	4.4	-	5.0	-	-	-	-
Nonmedical use of prescription drugs	-	2.6	-	4.5	-	-	-	-
Other illicit drug use	-	3.0	-	4.7	-	-	-	-
Residents unemployed and seeking work[c] (%)	-	10.3	-	11.1	-	-	-	-

(continued)

Appendix Table C.19 (continued)

Indicator of Risk	Target Communities[a]							
	Lafayette[b]	St. Landry	Calcasieu	Cameron	Rapides	Vernon[b]	Winn	Avoyelles
Live births before 37 weeks of gestation[c] (%)	-	14.0	-	15.7	13.8	-	-	14.4
Total live births less than 2,500 grams[c] (%)	-	12.2	-	15.0	-	-	-	12.4
Infant deaths ages 0-1[c,d]	-	10.6	10.0	-	-	-	-	9.5
Residents living below the federal poverty level[c] (%)	-	25.6	-	-	-	-	23.9	21.9
Reported crimes[c,e]	-	32.6	-	-	-	-	-	8.4
Arrests ages 0-19[c,f]	-	405	-	-	-	-	-	-
Dropout rate grades 7-12[c,g]	-	5.8	-	-	-	-	-	9.2
Other school dropout rate per state/local calculation[h] (%)	-	-	-	-	-	-	-	-
Prevalence of activities among youth in the past month[c,i] (%)								
Binge alcohol use	-	20.6	-	-	-	-	-	22.5
Marijuana use	-	5.9	-	-	-	-	-	2.0
Nonmedical use of prescription drugs	-	3.9	-	-	-	-	-	2.7
Other illicit drug use	-	4.0	-	-	-	-	-	3.4
Residents unemployed and seeking work[c] (%)	-	9.1	7.8	-	-	-	8.9	9.0

(continued)

Appendix Table C.19 (continued)

Indicator of Risk	Target Communities[a]							
	Webster	Caddo	Natchitoches	Bienville	Ouachita	Morehouse	Franklin	Lincoln
Live births before 37 weeks of gestation[c] (%)	14.5	18.9	14.6	14.6	16.1	13.9	15.7	-
Total live births less than 2,500 grams[c] (%)	13.5	14.4	12.7	12.7	14.0	11.5	9.5	-
Infant deaths ages 0-1[c,d]	13.0	12.6	9.0	12.0	13.8	7.2	12.0	12.2
Residents living below the federal poverty level[c] (%)	-	19.8	31.7	21.0	21.9	25.2	26.1	-
Reported crimes[c,e]	-	62.8	26.3	-	42.9	27.8	10.9	-
Arrests ages 0-19[c,f]	-	4,738	836	405	1,170	1,143	1,880	-
Dropout rate grades 7-12[c,g]	-	8.3	9.8	5.8	5.6	11.8	11.0	-
Other school dropout rate per state/local calculation[h] (%)	-	-	-	-	-	-	-	-
Prevalence of activities among youth in the past month[c,i] (%)								
Binge alcohol use	-	11.9	19.1	15.5	11.9	14.4	8.3	-
Marijuana use	-	6.1	5.7	4.3	4.3	4.8	1.0	-
Nonmedical use of prescription drugs	-	4.3	3.7	3.6	4.4	3.6	5.1	-
Other illicit drug use	-	4.9	3.0	5.8	4.0	2.3	5.1	-
Residents unemployed and seeking work[c] (%)	-	8.3	8.9	9.7	8.7	15.4	12.0	9.9

(continued)

Appendix Table C.19 (continued)

Indicator of Risk	Target Communities[a] Caldwell	Union	St. Tammany[b]	Livingston[b]	Tangipahoa	Target Community Average	State Average
Live births before 37 weeks of gestation[c] (%)	13.8	15.6	-	-	12.3	14.6	13.5
Total live births less than 2,500 grams[c] (%)	-	11.5	-	-	11.9	12.5	11.4
Infant deaths ages 0-1[c,d]	-	-	-	-	7.7	10.4	9.7
Residents living below the federal poverty level[c] (%)	21.5	-	-	-	22.2	23.5	17.6
Reported crimes[c,e]	-	-	-	-	54.1	38.4	40.3
Arrests ages 0-19[c,f]	-	-	-	-	3,194	1,438	2,345
Dropout rate grades 7-12[c,g]	-	-	-	-	7.5	8.3	6.9
Other school dropout rate per state/local calculation[h] (%)	-	-	-	-	-	-	-
Prevalence of activities among youth in the past month[c,i] (%)							
Binge alcohol use	-	-	-	-	15.6	15.5	14.9
Marijuana use	-	-	-	-	5.4	4.4	5.5
Nonmedical use of prescription drugs	-	-	-	-	4.7	3.9	4.3
Other illicit drug use	-	-	-	-	4.2	4.0	4.3
Residents unemployed and seeking work[c] (%)	10.3	-	-	-	10.2	10.0	7.2

(continued)

Appendix Table C.19 (continued)

Indicator of Risk	Target Communities[a]							
	Jefferson	Orleans	East Baton Rouge	Iberville	St. Charles[b]	St. John the Baptist	Lafourche	St. Mary
Child maltreatment[c,j] (%)	-	30.9	-	19.7	-	-	-	-
Child maltreatment by type[c,j] (%)								
Neglect	-	26.0	-	26.5	-	-	-	-
Physical	-	15.3	-	5.7	-	-	-	-
Sexual	-	14.0	-	21.4	-	-	-	-
Death	-	28.6	-	0.0	-	-	-	-
Number of domestic violence cases[c,k]	-	1,346	-	36	-	-	-	-
Other indicators[c]								
Gini coefficient of income inequality[l]	-	54.0	-	44.0	-	-	-	-
Alcohol use while pregnant (%)	-	0.3	-	0.5	-	-	-	-
Smoking while pregnant (%)	-	-	-	-	-	-	-	-
Prenatal care in the 1st trimester (%)	-	80.5	-	85.9	-	-	-	-
Pregnant women with sexually transmitted diseases (%)	-	8.0	-	10.2	-	-	-	-
Parents on Medicaid at time of birth (%)	-	77.0	-	76.4	-	-	-	-
Teen births[m]	-	48.7	-	60.5	-	-	-	-

Appendix Table C.19 (continued)

Indicator of Risk	Target Communities[a]							
	Lafayette[b]	St. Landry	Calcasieu	Cameron	Rapides	Vernon[b]	Winn	Avoyelles
Child maltreatment[c,j] (%)	-	30.9	-	-	-	-	-	40.6
Child maltreatment by type[c,j] (%)								
Neglect	-	27.1	-	-	-	-	-	36.6
Physical	-	13.3	-	-	-	-	-	27.6
Sexual	-	10.1	-	-	-	-	-	38.2
Death	-	0.0	-	-	-	-	-	0.0
Number of domestic violence cases[c,k]	-	179	-	-	-	-	-	264
Other indicators[c]								
Gini coefficient of income inequality[l]	-	51.0	-	-	-	-	-	46.0
Alcohol use while pregnant (%)	-	0.3	-	-	-	-	-	-
Smoking while pregnant (%)	-	11.8	-	-	-	-	-	16.8
Prenatal care in the 1st trimester (%)	-	78.6	-	-	-	-	-	88.8
Pregnant women with sexually transmitted diseases (%)	-	6.2	-	-	-	-	-	3.5
Parents on Medicaid at time of birth (%)	-	81.3	-	-	-	-	-	78.7
Teen births[m]	-	71.7	-		-	-	-	83.3

Appendix Table C.19 (continued)

Indicator of Risk	Target Communities[a]							
	Webster	Caddo	Natchitoches	Bienville	Ouachita	Morehouse	Franklin	Lincoln
Child maltreatment[c,j] (%)	-	29.6	24.7	34.3	33.1	24.7	26.9	-
Child maltreatment by type[c,j] (%)								
Neglect	-	23.2	22.7	-	30.5	44.7	31.1	-
Physical	-	22.0	15.6	-	27.9	23.1	33.8	-
Sexual	-	17.7	12.1	-	27.0	33.3	32.1	-
Death	-	17.6	0.0	-	72.7	0.0	0.0	-
Number of domestic violence cases[c,k]	-	65	505	150	668	121	125	-
Other indicators[c]								
Gini coefficient of income inequality[l]	-	50.0	50.0	47.0	49.0	49.0	46.0	-
Alcohol use while pregnant (%)	-	0.4	0.6	-	0.5	0.0	0.4	-
Smoking while pregnant (%)	-	9.6	11.7	17.2	11.1	14.6	14.8	-
Prenatal care in the 1st trimester (%)	-	82.9	76.8	88.5	86.7	88.3	79.6	-
Pregnant women with sexually transmitted diseases (%)	-	13.4	10.7	8.9	8.5	8.9	7.8	-
Parents on Medicaid at time of birth (%)	-	70.9	81.3	82.6	75.2	84.6	83.3	-
Teen births[m]	-	72.9	60.4	78.1	56.9	73.9	80.2	-

Appendix Table C.19 (continued)

Indicator of Risk	Target Communities[a]					Target Community Average	State Average
	Caldwell	Union	St. Tammany[b]	Livingston[b]	Tangipahoa		
Child maltreatment[c,j] (%)	-	-	-	-	42.9	30.8	31.9
Child maltreatment by type[c,j] (%)							
Neglect	-	-	-	-	31.7	30.0	29.2
Physical	-	-	-	-	21.2	20.6	21.8
Sexual	-	-	-	-	18.4	22.4	21.6
Death	-	-	-	-	0.0	11.9	33.0
Number of domestic violence cases[c,k]	-	-	-	-	1,314	433.9	-
Other indicators[c]							
Gini coefficient of income inequality[l]	-	-	-	-	50.0	48.7	48.0
Alcohol use while pregnant (%)	-	-	-	-	0.2	0.4	0.3
Smoking while pregnant (%)	-	-	-	-	11.0	13.2	10.3
Prenatal care in the 1st trimester (%)	-	-	-	-	86.9	84.0	87.0
Pregnant women with sexually transmitted diseases (%)	-	-	-	-	6.8	8.4	5.7
Parents on Medicaid at time of birth (%)	-	-	-	-	75.0	78.8	69.7
Teen births[m]	-	-	-	-	54.7	67.4	53.5

Appendix Table C.19 (continued)

SOURCES: Louisiana 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: The Louisiana needs assessment reported data only for the target communities that had been identified as at risk at that time: Franklin, Caddo, Orleans, Natchitoches, St. Landry, Bienville, Morehouse, Avoyelles, Iberville, Ouachita, and Tangipahoa. Data for the remaining target communities come from the first-round competitive grant application: Jefferson, East Baton Rouge, St. Charles, St. John the Baptist, Lafourche, St. Mary, Lafayette, Calcasieu, Cameron, Rapides, Vernon, Winn, Webster, Caldwell, Union, St. Tammany, and Livingston.

[a]Louisiana identified parishes as its target communities. Louisiana is divided into parishes in the same way that other states are divided into counties.

[b]Data were not reported for any indicators in this parish.

[c]Data were not reported for this indicator for some parishes in this state.

[d]Per 1,000 live births.

[e]Per 1,000 residents.

[f]Per 100,000 juveniles ages 0-19.

[g]Instead of reporting the percentage of high school dropouts grades 9-12, the Louisiana needs assessment reported the percentage of school dropouts for grades 7-12.

[h]Data were not reported for this indicator for any parishes in this state.

[i]Instead of reporting the overall prevalence of alcohol and drug use, the Louisiana needs assessment reported the prevalence of alcohol and drug use for youth in grades 6, 8, 10, and 12.

[j]The Louisiana needs assessment reported the percentage of child maltreatment cases that were substantiated out of all reported cases.

[k]The Louisiana needs assessment reported the number of domestic violence cases as its metric for domestic violence. The state average for this indicator was not reported.

[l]The Gini Index ranges from 0 to 1, where 0 represents complete equality in resources and 1 represents that one individual (or household) has all the wealth. The values in the Louisiana needs assessment are the Gini Index multiplied by 100, giving the measure a range from 0 to 100, in order to make the numbers more easily comparable.

[m]Per 1,000 females ages 15-19.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.20

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Maine

	Target Communities[a]								
	Penquis Region		Somerset/Kennebec						
Indicator of Risk	Penobscot	Piscataquis	Somerset	Kennebec	Washington	Aroostook	Androscoggin	Cumberland	Franklin
Live births before 37 weeks of gestation (%)	10.0	9.4	10.2	8.2	7.7	7.1	8.2	8.9	8.8
Total live births less than 2,500 grams (%)	6.7	7.5	8.6	6.2	5.9	5.6	6.4	6.4	7.0
Infant deaths ages 0-1[b,c]	6.9	-	6.8	5.3	4.7	6.7	7.3	6.3	5.6
Residents living below the federal poverty level (%)	15.9	16.2	18.7	11.8	20.1	15.2	13.1	10.4	17.5
Reported crimes[d]	33.4	25.5	28.7	29.4	26.8	18.4	24.8	28.3	28.1
Arrests ages 0-19[e]	4,774	3,886	3,588	4,838	2,991	7,159	4,017	4,525	4,741
Dropout rate grades 9-12 (%)	4.5	5.3	4.8	4.5	4.3	3.6	5.5	2.4	3.1
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-	-	-
Prevalence of activities ages 12+[g] (%)									
Binge alcohol use in the past month	22.9	22.9	18.3	18.3	21.6	21.6	20.9	24.1	20.9
Marijuana use in the past month	9.5	9.5	8.2	8.2	6.9	6.9	8.0	8.8	8.0
Nonmedical use of pain relievers in the past year[h]	4.1	4.1	4.2	4.2	4.2	4.2	4.4	3.8	4.4
Other illicit drug use in the past month	3.2	3.2	2.9	2.9	2.8	2.8	2.8	3.0	2.8

(continued)

Appendix Table C.20 (continued)

Indicator of Risk	Target Communities[a]							Target Community Average	State Average
	Hancock	Knox	Lincoln	Oxford	Sagadahoc	Waldo	York		
Live births before 37 weeks of gestation (%)	7.3	7.0	9.7	8.2	8.0	8.5	9.3	8.5	8.7
Total live births less than 2,500 grams (%)	6.0	4.9	7.5	6.1	5.8	7.8	6.3	6.5	6.4
Infant deaths ages 0-1[b,c]	3.4	4.9	-	7.0	6.5	5.9	6.3	6.0	6.1
Residents living below the federal poverty level (%)	10.8	13.4	10.9	14.1	9.8	12.6	9.4	13.7	12.6
Reported crimes[d]	20.5	25.4	15.3	24.6	19.2	16.2	23.5	24.3	25.8
Arrests ages 0-19[e]	2,634	3,153	4,637	2,719	4,451	2,185	5,199	4,094	4,452
Dropout rate grades 9-12 (%)	4.2	3.2	2.6	3.2	3.4	1.8	3.0	3.7	3.6
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-	-	-
Prevalence of activities ages 12+[g] (%)									
Binge alcohol use in the past month	21.6	20.5	20.5	20.9	20.5	20.5	24.5	21.3	22.1
Marijuana use in the past month	6.9	7.5	7.5	8.0	7.5	7.5	8.8	8.0	8.3
Nonmedical use of pain relievers in the past year[h]	4.2	4.4	4.4	4.4	4.4	4.4	4.6	4.3	4.2
Other illicit drug use in the past month	2.8	2.7	2.7	2.8	2.7	2.7	3.2	2.9	3.0

(continued)

Appendix Table C.20 (continued)

Indicator of Risk	Target Communities[a]								
	Penquis Region		Somerset/Kennebec						
	Penobscot	Piscataquis	Somerset	Kennebec	Washington	Aroostook	Androscoggin	Cumberland	Franklin
Residents unemployed and seeking work[i] (%)	8.6	12.2	11.6	7.9	12.2	10.5	8.6	6.8	10.4
Child maltreatment ages 0-17[j]	18.1	21.8	24.9	13.2	12.9	14.9	16.6	7.8	13.1
Child maltreatment by type ages 0-17[j]									
Neglect	12.4	15.9	19.4	9.1	6.3	11.2	12.7	5.7	9.9
Physical abuse	3.2	3.5	7.1	2.3	1.6	1.6	2.6	0.9	2.2
Psychological abuse	9.2	11.5	12.1	5.4	10.2	4.6	5.7	3.1	6.2
Sexual abuse[c]	1.4	-	1.3	0.8	-	0.6	0.7	0.5	1.0
Reported domestic assaults[k]	34.0	16.4	44.3	56.0	29.0	26.0	58.1	37.7	46.9
Other indicators									
Intimate partner violence before/during pregnancy (%)	5.0	5.4	4.2	8.4	9.9	4.7	7.0	5.3	9.3
Births without prenatal care in the 1st trimester (%)	15.9	16.8	18.7	13.6	18.8	11.3	10.1	11.4	10.8
Newborn hospital discharges with drug-withdrawal syndrome[c] (%)	2.8	-	2.4	1.3	2.5	0.9	0.8	1.6	-
Births to women ages 15-19[l]	24.6	35.8	43.2	30.3	37.7	29.9	40.3	16.2	19.7
Current smoker ages 18-44 (%)	24.3	29.9	37.3	17.9	27.3	29.2	24.6	16.3	20.3
Poor mental health ages 18-44[m] (%)	9.8	18.9	13.9	9.5	13.7	14.6	10.2	11.5	10.8
Emergency department visits ages 0-4[n]	504	899	1,021	644	1,001	1,014	742	421	677
No current health insurance ages 18-44 (%)	18.0	12.4	23.6	15.8	22.7	14.9	18.6	12.0	18.1
Children eligible for free or reduced-price lunch program (%)	46.9	57.7	57.5	42.9	59.3	52.4	49.8	30.8	52.6
Children in state care/custody ages 0-17[o]	7.1	5.5	8.3	7.3	7.7	7.0	4.3	5.0	8.0

(continued)

Appendix Table C.20 (continued)

Indicator of Risk	Target Communities[a]							Target Community Average	State Average
	Hancock	Knox	Lincoln	Oxford	Sagadahoc	Waldo	York		
Residents unemployed and seeking work[i] (%)	10.2	8.5	8.3	10.9	7.3	10.0	8.3	9.5	8.6
Child maltreatment ages 0-17[j]	15.2	9.7	6.2	15.8	4.3	6.8	11.6	13.3	13.3
Child maltreatment by type ages 0-17[j]									
Neglect	11.4	7.2	3.7	9.5	3.7	4.4	8.4	9.4	9.5
Physical abuse	2.8	1.0	1.0	2.0	0.8	0.9	2.0	2.2	2.2
Psychological abuse	5.2	4.4	1.0	6.5	1.2	2.4	5.5	5.9	5.8
Sexual abuse[c]	1.7	1.2	1.0	0.7	-	1.2	0.6	1.0	1.0
Reported domestic assaults[k]	20.5	27.0	34.8	45.0	24.2	29.0	49.6	36.2	40.3
Other indicators									
Intimate partner violence before/during pregnancy (%)	3.3	5.0	5.4	5.9	6.0	5.7	2.6	5.8	5.5
Births without prenatal care in the 1st trimester (%)	13.1	7.5	11.0	13.9	9.5	11.6	11.2	12.8	12.4
Newborn hospital discharges with drug-withdrawal syndrome[c] (%)	3.1	2.9	-	1.2	2.1	-	1.0	1.9	1.6
Births to women ages 15-19[l]	23.0	32.4	21.3	30.7	20.0	33.2	20.4	28.7	25.7
Current smoker ages 18-44 (%)	23.4	22.3	27.1	34.6	18.1	25.6	21.5	25.0	23.1
Poor mental health ages 18-44[m] (%)	13.3	11.0	14.1	14.9	11.7	12.5	9.0	12.5	11.5
Emergency department visits ages 0-4[n]	588	651	571	646	385	630	484	680	614
No current health insurance ages 18-44 (%)	19.9	27.1	20.0	21.5	8.9	18.7	10.2	17.7	16.1
Children eligible for free or reduced-price lunch program (%)	41.4	41.7	43.8	56.8	35.5	56.4	34.8	47.5	43.0
Children in state care/custody ages 0-17[o]	4.4	4.0	5.1	3.9	2.8	6.8	5.2	5.8	5.8

(continued)

Appendix Table C.20 (continued)

SOURCES: Maine 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]The Maine FY 2010 and FY 2011 state plans identified as its target communities two individual counties, Aroostook and Washington, and two groups of counties, the Penquis Region (Penobscot and Piscataquis Counties) and Somerset and Kennebec Counties. In its 2011 competitive grant application, it expanded its target communities to include all counties in the state. Therefore, all counties are included in this table and contribute equally to the target community average.

[b]Per 1,000 live births.

[c]Data were not reported for this indicator for counties in this state when the count was less than six.

[d]Per 1,000 residents.

[e]Per 100,000 juveniles ages 0-19.

[f]Data were not reported for this indicator in this state.

[g]Data were not available at the county level. Data included in this table are for the Substance Abuse and Mental Health Services Administration (SAMHSA) regions to which each target county belongs.

[h]Instead of the percentage reporting nonmedical use of prescription drugs in the past month, the Maine needs assessment provided the percentage reporting nonmedical use of pain relievers in the past year.

[i]Average monthly rate (not seasonally adjusted).

[j]The Maine needs assessment reported the rate of substantiated maltreatment per 1,000 children ages 0-17.

[k]The Maine needs assessment provided the number of domestic assaults reported to the police per 10,000 residents as its metric for domestic violence.

[l]Per 1,000 females ages 15-19.

[m]Defined as having poor mental health for 14 or more of the past 30 days.

[n]Per 1,000 children ages 0-4.

[o]Children in Department of Health and Human Services care or custody per 1,000 children ages 0-17.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.21

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Maryland

	Target Communities[a]							
	City of Baltimore							
Indicator of Risk	Irvington	Cherry Hill	Mondawmin	Rosemont	Greenmount	Madison/ East End	Pimlico	Sandtown-Winchester
Live births before 37 weeks of gestation[b] (%)	17.7	20.7	18.9	18.8	23.8	18.5	21.5	21.9
Total live births less than 2,500 grams[b] (%)	18.9	20.7	20.0	20.0	20.4	16.8	18.8	20.0
Infant deaths ages 0-1[b,c]	30.6	37.7	23.0	27.6	20.8	28.7	18.2	27.6
Families with children ages 0-17 living below the federal poverty level[b,d] (%)	51.1	59.7	44.1	45.7	65.9	57.2	44.0	56.5
Reported crimes[b,e]	-	-	-	-	-	-	-	-
Arrests ages 0-19[f]	-	-	-	-	-	-	-	-
Dropout rate grades 9-12[b,g] (%)	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[h]								
Binge alcohol use (%)	-	-	-	-	-	-	-	-
Marijuana use (%)	-	-	-	-	-	-	-	-
Nonmedical use of pain relievers (%)	-	-	-	-	-	-	-	-
Other illicit drug use (%)	-	-	-	-	-	-	-	-

(continued)

Appendix Table C.21 (continued)

Indicator of Risk	Target Communities[a] City of Baltimore							
	Southwest	Clifton	Walbrook	Oldtown	Midtown	Midway	Patterson Park	Hollins Market
Live births before 37 weeks of gestation[b] (%)	21.2	23.8	18.6	23.3	20.0	23.8	18.6	25.0
Total live births less than 2,500 grams[b] (%)	19.7	20.4	18.3	25.6	20.4	20.4	16.8	19.7
Infant deaths ages 0-1[b,c]	32.6	-	29.7	-	-	29.2	28.7	-
Families with children ages 0-17 living below the federal poverty level[b,d] (%)	58.8	57.2	39.9	68.0	65.9	48.8	48.8	61.4
Reported crimes[b,e]	-	-	-	-	-	-	-	-
Arrests ages 0-19[f]	-	-	-	-	-	-	-	-
Dropout rate grades 9-12[b,g] (%)	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[h]								
Binge alcohol use (%)	-	-	-	-	-	-	-	-
Marijuana use (%)	-	-	-	-	-	-	-	-
Nonmedical use of pain relievers (%)	-	-	-	-	-	-	-	-
Other illicit drug use (%)	-	-	-	-	-	-	-	-

(continued)

Appendix Table C.21 (continued)

Indicator of Risk	Target Communities[a]							
	City of Baltimore							
	Southeastern	Park Heights	Upton	Belair-Edison	Brooklyn	Claremont	Dorchester	Charles Village
Live births before 37 weeks of gestation[b] (%)	18.6	19.4	21.9	23.8	-	18.4	18.6	20.0
Total live births less than 2,500 grams[b] (%)	15.9	17.7	18.3	20.0	13.9	-	17.7	20.4
Infant deaths ages 0-1[b,c]	13.2	18.2	26.0	29.2	-	-	-	-
Families with children ages 0-17 living below the federal poverty level[b,d] (%)	71.8	43.8	65.6	-	50.0	56.9	43.8	48.8
Reported crimes[b,e]	-	-	-	-	-	-	-	-
Arrests ages 0-19[f]	-	-	-	-	-	-	-	-
Dropout rate grades 9-12[b,g] (%)	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[h]								
Binge alcohol use (%)	-	-	-	-	-	-	-	-
Marijuana use (%)	-	-	-	-	-	-	-	-
Nonmedical use of pain relievers (%)	-	-	-	-	-	-	-	-
Other illicit drug use (%)	-	-	-	-	-	-	-	-

(continued)

Appendix Table C.21 (continued)

Indicator of Risk	Target Communities[a]							
	City of Baltimore							
	Penn North	Perkins	Washington Village	Westport	Cedonia	Edmonson Village	Highlandtown: CSA 27	Lauraville
Live births before 37 weeks of gestation[b] (%)	19.4	23.3	25.0	-	18.0	20.9	18.6	20.6
Total live births less than 2,500 grams[b] (%)	20.6	25.6	20.7	20.7	16.9	18.3	-	19.0
Infant deaths ages 0-1[b,c]	-	-	-	37.7	22.8	-	-	26.7
Families with children ages 0-17 living below the federal poverty level[b,d] (%)	44.1	68.0	47.9	59.7	41.3	-	39.1	-
Reported crimes[b,e]	-	-	-	-	-	-	-	-
Arrests ages 0-19[f]	-	-	-	-	-	-	-	-
Dropout rate grades 9-12[b,g] (%)	7.1	7.1	7.1	7.1	7.1	7.1	7.1	7.1
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[h]								
Binge alcohol use (%)	-	-	-	-	-	-	-	-
Marijuana use (%)	-	-	-	-	-	-	-	-
Nonmedical use of pain relievers (%)	-	-	-	-	-	-	-	-
Other illicit drug use (%)	-	-	-	-	-	-	-	-

(continued)

Appendix Table C.21 (continued)

Indicator of Risk	Target Communities[a]						
	City of Baltimore						
	Hampden	Beechfield	Waverlies	Downtown	Fells Point	Govans	Highlandtown: CSA 41
Live births before 37 weeks of gestation[b] (%)	20.0	20.9	19.1	25.0	-	-	-
Total live births less than 2,500 grams[b] (%)	-	17.4	18.3	-	-	15.8	-
Infant deaths ages 0-1[b,c]	-	30.6	-	-	24.0	-	-
Families with children ages 0-17 living below the federal poverty level[b,d] (%)	43.8	-	48.8	65.9	-	-	71.8
Reported crimes[b,e]	-	-	-	-	-	-	-
Arrests ages 0-19[f]	-	-	-	-	-	-	-
Dropout rate grades 9-12[b,g] (%)	7.1	7.1	7.1	7.1	7.1	7.1	7.1
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-
Prevalence of activities in the past month[h]							
Binge alcohol use (%)	-	-	-	-	-	-	-
Marijuana use (%)	-	-	-	-	-	-	-
Nonmedical use of pain relievers (%)	-	-	-	-	-	-	-
Other illicit drug use (%)	-	-	-	-	-	-	-

(continued)

Appendix Table C.21 (continued)

Indicator of Risk	Target Communities[a]: Dorchester County: City of Cambridge	Somerset County: City of Crisfield	Washington County: City of Hagerstown	Wicomico County: City of Salisbury	Worcester County: Pocomoke City	Target Community Average	State Average
Live births before 37 weeks of gestation[b] (%)	17.6	16.3	15.0	16.6	-	17.3	11.2
Total live births less than 2,500 grams[b] (%)	13.8	14.0	13.8	15.5	-	15.3	9.3
Infant deaths ages 0-1[b,c]	31.0	19.9	-	16.1	-	23.5	7.9
Families with children ages 0-17 living below the federal poverty level[b,d] (%)	30.4	34.6	46.2	42.3	-	41.5	9.5
Reported crimes[b,e]	7,125	-	-	10,731	7,003	8,286	4,317
Arrests ages 0-19[f]	-	-	-	-	-		-
Dropout rate grades 9-12[b,g] (%)	-	-	-	5.5	-	6.3	3.0
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-
Prevalence of activities in the past month[h]							
Binge alcohol use (%)	-	-	-	-	-	-	21.7
Marijuana use (%)	-	-	-	-	-	-	4.9
Nonmedical use of pain relievers (%)	-	-	-	-	-	-	3.9
Other illicit drug use (%)	-	-	-	-	-	-	3.1

(continued)

Appendix Table C.21 (continued)

Indicator of Risk	Target Communities[a]							
	City of Baltimore							
	Irvington	Cherry Hill	Mondawmin	Rosemont	Greenmount	Madison/ East End	Pimlico	Sandtown-Winchester
Residents unemployed and seeking work[b,g] (%)	10.2	10.2	10.2	10.2	10.2	10.2	10.2	10.2
Child maltreatment[b,i]	8.7	7.8	5.4	5.7	10.1	10.1	5.3	6.2
Child maltreatment by type ages 0-17[j]								
Physical abuse	-	-	-	-	-	-	-	-
Sexual abuse	-	-	-	-	-	-	-	-
Neglect	-	-	-	-	-	-	-	-
Protective and peace order filings[b,g,k]	108	108	108	108	108	108	108	108
Other indicators[b]								
Women ages 15-44 receiving substance abuse treatment[l]	52.6	37.9	45.4	52.6	51.6	51.6	33.3	52.6
Births with late or no prenatal care[m] (%)	9.8	8.9	9.9	10.6	9.1	8.0	8.6	8.2
Births to women ages 15-19[n]	119	142	136	136	133	138	100	200
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation[o]	51.7	53.7	48.6	51.7	67.2	67.2	43.3	51.7
Medicaid enrollment[o]	484	396	437	484	497	488	362	484
Kindergartners ready to learn[g] (%)	64.0	64.0	64.0	64.0	64.0	64.0	64.0	64.0

(continued)

Appendix Table C.21 (continued)

Indicator of Risk	Target Communities[a] City of Baltimore							
	Southwest	Clifton	Walbrook	Oldtown	Midtown	Midway	Patterson Park	Hollins Market
Residents unemployed and seeking work[b,g] (%)	10.2	10.2	10.2	10.2	10.2	10.2	10.2	10.2
Child maltreatment[b,i]	9.1	10.1	-	8.8	8.8	6.7	9.6	7.4
Child maltreatment by type ages 0-17[j]								
Physical abuse	-	-	-	-	-	-	-	-
Sexual abuse	-	-	-	-	-	-	-	-
Neglect	-	-	-	-	-	-	-	-
Protective and peace order filings[b,g,k]	108	108	108	108	108	108	108	108
Other indicators[b]								
Women ages 15-44 receiving substance abuse treatment[l]	52.6	51.6	33.3	51.6	45.4	38.1	51.6	52.6
Births with late or no prenatal care[m] (%)	9.3	11.5	11.1	8.1	7.7	8.5	-	7.7
Births to women ages 15-19[n]	125	138	124	200	133	89	144	200
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation[o]	51.7	67.2	45.0	67.2	48.6	-	67.2	51.7
Medicaid enrollment[o]	484	497	375	488	437	497	488	484
Kindergartners ready to learn[g] (%)	64.0	64.0	64.0	64.0	64.0	64.0	64.0	64.0

(continued)

Appendix Table C.21 (continued)

Indicator of Risk	Target Communities[a]							
	City of Baltimore							
	Southeastern	Park Heights	Upton	Belair-Edison	Brooklyn	Claremont	Dorchester	Charles Village
Residents unemployed and seeking work[b,g] (%)	10.2	10.2	10.2	10.2	10.2	10.2	10.2	10.2
Child maltreatment[b,i]	5.0	5.3	7.0	5.6	8.2	5.6	-	6.7
Child maltreatment by type ages 0-17[j]								
Physical abuse	-	-	-	-	-	-	-	-
Sexual abuse	-	-	-	-	-	-	-	-
Neglect	-	-	-	-	-	-	-	-
Protective and peace order filings[b,g,k]	108	108	108	108	108	108	108	108
Other indicators[b]								
Women ages 15-44 receiving substance abuse treatment[l]	23.3	45.4	52.6	38.1	37.9	51.6	33.3	32.9
Births with late or no prenatal care[m] (%)	-	-	-	-	10.2	11.5	14.1	8.0
Births to women ages 15-19[n]	129	100	200	131	137	137	100	104
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation[o]	44.4	48.6	51.7	45.3	53.7	67.2	45.0	-
Medicaid enrollment[o]	278	437	484	497	396	497	375	392
Kindergartners ready to learn[g] (%)	64.0	64.0	64.0	64.0	64.0	64.0	64.0	64.0

(continued)

Appendix Table C.21 (continued)

Indicator of Risk	Target Communities[a]							
	City of Baltimore							
	Penn North	Perkins	Washington Village	Westport	Cedonia	Edmonson Village	Highlandtown: CSA 27	Lauraville
Residents unemployed and seeking work[b,g] (%)	10.2	10.2	10.2	10.2	10.2	10.2	10.2	10.2
Child maltreatment[b,i]	5.4	10.1	8.7	7.8	-	5.0	-	-
Child maltreatment by type ages 0-17[j]								
Physical abuse	-	-	-	-	-	-	-	-
Sexual abuse	-	-	-	-	-	-	-	-
Neglect	-	-	-	-	-	-	-	-
Protective and peace order filings[b,g,k]	108	108	108	108	108	108	108	108
Other indicators[b]								
Women ages 15-44 receiving substance abuse treatment[l]	45.4	51.6	52.6	37.9	-	29.8	23.3	-
Births with late or no prenatal care[m] (%)	-	-	-	-	-	-	8.7	7.3
Births to women ages 15-19[n]	98	200	142	142	90	124	144	90
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation[o]	48.6	67.2	51.7	53.7	45.3	45.0	44.4	45.3
Medicaid enrollment[o]	437	497	484	396	497	375	278	497
Kindergartners ready to learn[g] (%)	64.0	64.0	64.0	64.0	64.0	64.0	64.0	64.0

(continued)

Appendix Table C.21 (continued)

Indicator of Risk	Target Communities[a]						
	City of Baltimore						
	Hampden	Beechfield	Waverlies	Downtown	Fells Point	Govans	Highlandtown: CSA 41
Residents unemployed and seeking work[b,g] (%)	10.2	10.2	10.2	10.2	10.2	10.2	10.2
Child maltreatment[b,i]	5.1	-	6.7	8.8	-	4.2	7.4
Child maltreatment by type ages 0-17[j]							
Physical abuse	-	-	-	-	-	-	-
Sexual abuse	-	-	-	-	-	-	-
Neglect	-	-	-	-	-	-	-
Protective and peace order filings[b,g,k]	108	108	108	108	108	108	108
Other indicators[b]							
Women ages 15-44 receiving substance abuse treatment[l]	45.4	19.0	25.6	32.9	32.9	25.6	51.6
Births with late or no prenatal care[m] (%)	-	-	-	-	15.4	7.8	7.7
Births to women ages 15-19[n]	100	-	86	200	200	93	144
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation[o]	48.6	39.3	-	-	44.4	-	67.2
Medicaid enrollment[o]	437	288	304	392	288	304	497
Kindergartners ready to learn[g] (%)	64.0	64.0	64.0	64.0	64.0	64.0	64.0

(continued)

Appendix Table C.21 (continued)

Indicator of Risk	Target Communities[a] Dorchester County: City of Cambridge	Somerset County: City of Crisfield	Washington County: City of Hagerstown	Wicomico County: City of Salisbury	Worcester County: Pocomoke City	Target Community Average	State Average
Residents unemployed and seeking work[b,g] (%)	10.7	9.4	9.7	-	10.9	10.2	7.0
Child maltreatment[b,i]	6.5	6.3	11.5	5.0	6.6	7.2	1.6
Child maltreatment by type ages 0-17[j]							
Physical abuse	-	-	-	-	-	-	1.0
Sexual abuse	-	-	-	-	-	-	0.8
Neglect	-	-	-	-	-	-	2.5
Protective and peace order filings[b,g,k]	-	-	115	-	-	111	78
Other indicators[b]							
Women ages 15-44 receiving substance abuse treatment[l]	28.9	22.8	19.1	30.7	18.0	26.9	7.1
Births with late or no prenatal care[m] (%)	9.2	-	7.9	8.4	-	8.7	4.3
Births to women ages 15-19[n]	124	74	145	133	-	122	33
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) participation[o]	45.0	41.1	42.6	42.7	36.2	43.4	16.8
Medicaid enrollment[o]	316	315	258	266	276	310	112
Kindergartners ready to learn[g] (%)	66.0	-	73.0	-	-	67.7	81.6

(continued)

Appendix Table C.21 (continued)

SOURCES: Maryland 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The target communities identified by the Maryland needs assessment include the City of Baltimore, in particular 39 out of the city's 55 community statistical areas (CSAs), which Baltimore uses to define neighborhoods. The target communities also include five cities in five other counties.

[b]Data were not reported for this indicator for some communities in this state.

[c]Per 1,000 live births.

[d]Instead of reporting the percentage of residents living below the federal poverty level, the Maryland needs assessment reported the percentage of families with children ages 0-17 living below the federal poverty level.

[e]Instead of the number of reported crimes per 1,000 residents, the Maryland needs assessment provided the number of crimes per 100,000 residents.

[f]Data were not reported for this indicator in this state.

[g]Data were not available at the neighborhood level. For the neighborhoods in the target community of Baltimore, the data included in this table are for Baltimore. For the other target communities, the data included are for the counties to which they belong.

[h]Data were not reported for this indicator for any communities in this state. The Maryland needs assessment did provide the standard indicators at the state level, except that it provided information on the nonmedical use of pain relievers rather than the nonmedical use of prescription drugs.

[i]The Maryland needs assessment reported the number of indicated and unsubstantiated child abuse and neglect investigations per 1,000 children.

[j]The Maryland needs assessment reported the rate of indicated maltreatment by type per 1,000 children ages 0-17. Data were not reported for this indicator for any communities in the state.

[k]The Maryland needs assessment reported the number of protective and peace order filings per 10,000 residents as its metric for domestic violence.

[l]Data reflect the number of women receiving Alcohol and Drug Abuse Administration (ADAA)-funded treatment for substance abuse treatment per 1,000 women ages 15-44.

[m]Late prenatal care is defined as care in the third trimester.

[n]Per 1,000 females.

[o]Per 1,000 residents.

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Appendix Table C.22

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Massachusetts

Indicator of Risk	Target Communities[a]							
	Pittsfield	North Adams	Holyoke	Springfield	Fitchburg	Southbridge	Worcester	Lawrence
Live births before 37 weeks of gestation (%)	7.8	10.2	8.2	11.3	8.1	8.7	8.3	9.5
Total live births less than 2,500 grams (%)	8.9	8.6	9.3	10.5	8.4	10.2	8.2	8.9
Infant deaths ages 0-1[b]	3.8	3.7	8.9	9.0	5.8	9.5	8.9	6.7
Residents living below the federal poverty level (%)	11.4	18.2	26.4	23.1	15.0	15.4	17.9	24.3
Violent crimes[c]	700	617	1,135	1,255	-	474	970	653
Arrests ages 0-19[d]	-	-	-	-	-	-	-	-
Dropout rate grades 9-12 (%)	3.9	5.9	9.8	9.6	6.1	5.2	5.1	10.2
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[e]								
Binge alcohol use	-	-	-	-	-	-	-	-
Marijuana use	-	-	-	-	-	-	-	-
Nonmedical use of prescription drugs	-	-	-	-	-	-	-	-
Other illicit drug use	-	-	-	-	-	-	-	-
Residents unemployed and seeking work (%)	8.5	8.2	8.7	7.9	8.0	8.1	8.6	8.4
Child maltreatment ages 0-8[f]	66.8	74.3	56.6	58.8	37.8	51.8	37.7	12.9

(continued)

Appendix Table C.22 (continued)

Indicator of Risk	Target Communities[a]							
	Lowell	Chelsea	Everett	Lynn	Brockton	Fall River	New Bedford	Revere
Live births before 37 weeks of gestation (%)	8.9	8.7	7.9	9.1	11.5	8.3	9.7	9.1
Total live births less than 2,500 grams (%)	8.9	8.5	7.7	8.3	10.6	8.9	10.1	8.9
Infant deaths ages 0-1[b]	6.1	6.2	3.9	5.2	8.5	7.6	7.4	7.9
Residents living below the federal poverty level (%)	16.8	23.3	11.8	16.5	14.5	17.1	20.2	14.6
Violent crimes[c]	1,060	1,732	506	906	-	1,199	1,302	420
Arrests ages 0-19[d]	-	-	-	-	-	-	-	-
Dropout rate grades 9-12 (%)	4.4	9.4	3.8	6.1	5.4	6.2	8.4	5.2
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[e]								
Binge alcohol use	-	-	-	-	-	-	-	-
Marijuana use	-	-	-	-	-	-	-	-
Nonmedical use of prescription drugs	-	-	-	-	-	-	-	-
Other illicit drug use	-	-	-	-	-	-	-	-
Residents unemployed and seeking work (%)	8.3	7.8	9.1	7.6	7.7	8.9	8.4	8.5
Child maltreatment ages 0-8[f]	32.4	30.1	25.4	29.0	32.7	44.6	64.5	16.9

(continued)

Appendix Table C.22 (continued)

Indicator of Risk	Boston	Target Community Average	State Average
Live births before 37 weeks of gestation (%)	10.2	9.1	9.0
Total live births less than 2,500 grams (%)	9.3	9.1	7.9
Infant deaths ages 0-1[b]	6.1	6.8	4.9
Residents living below the federal poverty level (%)	19.5	18.0	9.3
Violent crimes[c]	1,104	935	449
Arrests ages 0-19[d]	-	-	-
Dropout rate grades 9-12 (%)	7.3	6.6	2.9
Other school dropout rate per state/local calculation[d] (%)	-	-	-
Prevalence of activities in the past month[e]			
Binge alcohol use	-	-	26.6
Marijuana use	-	-	8.1
Nonmedical use of prescription drugs	-	-	5.7
Other illicit drug use	-	-	4.1
Residents unemployed and seeking work (%)	8.1	8.3	8.5
Child maltreatment ages 0-8[f]	22.9	40.9	19.5

(continued)

Appendix Table C.22 (continued)

Indicator of Risk	Target Communities[a]							
	Pittsfield	North Adams	Holyoke	Springfield	Fitchburg	Southbridge	Worcester	Lawrence
Child maltreatment ages 0-8 by type (%)								
Neglect	97	97	94	93	91	91	90	82
Physical abuse	6	6	9	10	26	15	16	25
Sexual abuse	2	2	2	3	2	3	3	3
Court filings related to abuse prevention[g] (%)	8.1	8.9	13.2	9.6	10.3	8.7	3.5	10.2

Indicator of Risk	Target Communities[a]							
	Lowell	Chelsea	Everett	Lynn	Brockton	Fall River	New Bedford	Revere
Child maltreatment ages 0-8 by type (%)								
Neglect	90	95	93	92	91	93	94	95
Physical abuse	14	8	16	14	14	11	10	8
Sexual abuse	2	1	3	2	2	3	2	1
Court filings related to abuse prevention[g] (%)	9.8	9.7	6.7	9.3	6.9	10.4	8.6	9.7

Indicator of Risk	Boston	Target Community Average	State Average
Child maltreatment ages 0-8 by type (%)			
Neglect	86	92	92
Physical abuse	19	13	13
Sexual abuse	2	2	2
Court filings related to abuse prevention[g] (%)	3.4	8.6	5.5

(continued)

Appendix Table C.22 (continued)

SOURCES: Massachusetts 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]The Massachusetts needs assessment identified cities and towns as its target communities.

[b]Per 1,000 live births.

[c]Instead the number of reported crimes per 1,000 residents, the Massachusetts needs assessment provided the number of violent crimes per 100,000 residents. Data were not provided for this indicator for some target communities in this state.

[d]Data were not reported for this indicator in this state.

[e]Data were not reported for this indicator for any target communities in this state.

[f]The Massachusetts needs assessment reported the rate of substantiated maltreatment per 1,000 children ages 0-8 years. The measure used unduplicated counts of children with supported investigations added to unduplicated counts of assessed children with "concerned" findings.

[g]The Massachusetts needs assessment reported the percentage of filings of abuse prevention/restraining orders out of all district court filings as its metric for domestic violence.

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Appendix Table C.23

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Michigan

Indicator of Risk	Target Counties								Target County Average	State Average
	Kalamazoo	Berrien	Genesee	Saginaw	Kent	Ingham	Wayne	Muskegon		
Live births before 37 weeks of gestation (%)	9.8	10.3	14.0	12.0	9.7	13.6	12.0	10.2	11.5	10.6
Total live births less than 2,500 grams (%)	8.9	7.9	10.1	10.0	7.3	7.8	10.6	8.4	8.9	8.4
Infant deaths ages 0-1[a]	7.0	7.9	9.8	9.2	7.7	7.4	10.5	6.9	8.3	7.6
Residents living below the federal poverty level (%)	15.9	17.5	16.6	19.1	14.6	18.1	20.5	17.9	17.5	14.4
Reported crimes[b]	130.5	138.6	110.1	128.6	96.6	113.6	116.8	147.7	122.8	97.1
Arrests ages 0-19[c]	100.8	84.7	70.1	82.3	95.3	107.7	83.0	31.1	81.9	75.7
Dropout rate grades 9-12 (%)	11.1	10.5	13.3	11.1	12.3	11.8	16.1	11.1	12.2	11.3
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-	-	-	-	-
Prevalence of activities in the past month ages 12+ (%)										
Binge alcohol use	25.1	23.9	22.4	25.7	24.4	28.0	25.0	23.9	24.8	25.0
Marijuana use	6.8	6.3	7.6	7.0	5.8	7.6	6.0	6.3	6.7	6.9
Nonmedical use of prescription drugs	5.9	5.9	6.0	5.6	5.2	6.9	5.5	5.9	5.9	5.6
Other illicit drug use	3.7	4.0	4.0	3.8	3.7	4.3	3.7	4.0	3.9	3.7
Residents unemployed and seeking work (%)	10.9	13.1	14.1	12.3	17.0	11.2	15.4	13.9	13.5	13.6

(continued)

Appendix Table C.23 (continued)

Indicator of Risk	Target Counties								Target County Average	State Average
	Kalamazoo	Berrien	Genesee	Saginaw	Kent	Ingham	Wayne	Muskegon		
Child maltreatment ages 0-17[e]	18.0	19.0	8.9	22.9	12.0	19.1	9.3	16.8	15.8	12.0
Number of child maltreatment cases by type ages 0-17[f]										
Abandonment	8	8	32	11	14	21	230	8	41.5	-
Domestic violence	513	53	425	249	379	330	416	100	308.1	-
Drug positive infant	42	77	194	58	103	55	548	42	139.9	-
Drug residence	143	59	13	27	49	57	80	25	56.6	-
Exploitation[g]	-	-	9	11	-	-	18	-	12.7	-
Failure to protect	221	209	620	224	259	298	1347	92	408.8	-
Improper supervision	309	149	631	265	389	241	1050	154	398.5	-
Intrafamilial family violence[g]	7	-	19	-	11	9	36	-	16.4	-
Maltreatment	19	17	60	28	23	18	117	40	40.3	-
Medical	14	14	53	28	67	42	242	18	59.8	-
Mental injury	-	-	11	9	15	11	89	22	26.2	-
Methamphetamine[g]	73	10	-	-	-	-	-	-	41.5	-
Munchausen by proxy	-	-	-	-	-	-	-	-	-	-
Other than methamphetamine	50	38	6	11	36	26	49	14	28.8	-
Physical	1221	518	1616	921	1998	1212	3687	527	1,463	-
Severe physical injury[g]	10	-	12	11	17	10	127	6	27.6	-
Sexual	48	16	45	51	96	26	195	28	63.1	-
Sexual contact	28	11	21	29	62	17	141	17	40.8	-
Sexual penetration	14	6	13	19	36	7	69	13	22.1	-
Shaken baby syndrome[g]	-	-	-	-	-	-	6	-	6.0	-
Substance abuse	241	94	462	296	244	270	605	92	288	-
Threatened harm	459	203	676	607	817	597	824	93	535	-
Domestic violence incidents[h]	13.5	12.4	13.2	17.2	6.2	11.5	14.7	10.0	12.3	10.0

(continued)

Appendix Table C.23 (continued)

SOURCES: Michigan 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]Per 1,000 live births.
[b]Per 1,000 residents.
[c]Instead of reporting the rate of juvenile crime arrests per 100,000 juveniles ages 0-19, the Michigan needs assessment reported the rate of juvenile crime arrests per 1,000 juveniles age 0-19.
[d]Data were not reported for this indicator in this state.
[e]The Michigan needs assessment provided the rate of reported substantiated maltreatment per 1,000 children ages 0-17.
[f]Instead of the rate of reported substantiated maltreatment by type per 1,000 children, the Michigan needs assessment provided the total number of maltreatment cases by type. In this section, hyphens represent numbers that were too small to report, except for the state average, for which the indicator was not reported.
[g]Data were not reported for this indicator for some counties in this state.
[h]The Michigan needs assessment reported the number of domestic violence incidents per 1,000 residents as its metric for domestic violence.

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Appendix Table C.24

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Minnesota

Indicator of Risk	Target Counties							Target County Average	State Average
	Becker	St. Louis	Hennepin	Mower	Nobles	Ramsey	Beltrami		
Live births before 37 weeks of gestation (%)	9.3	10.0	9.7	9.4	13.1	10.1	10.7	10.3	9.6
Total live births less than 2,500 grams (%)	6.1	5.8	7.4	6.5	5.5	7.5	6.3	6.4	6.4
Infant deaths ages 0-1[a,b]	-	4.6	5.8	-	-	6.9	7.4	6.2	5.3
Residents living below the federal poverty level[c] (%)	11.6	14.4	11.0	12.4	13.4	13.5	17.0	13.3	9.5
Reported crimes[d]	53.5	93.4	98.1	122.0	65.3	64.2	11.8	72.6	75.0
Arrests ages 0-19[e]	2,209	3,361	5,061	6,135	2,654	5,369	5,158	4,278	3,500
Dropout rate grades 9-12 (%)	6.7	8.9	15.8	9.2	12.4	13.7	16.5	11.9	8.4
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-	-	-
Prevalence of activities ages 12+[g] (%)									
Binge alcohol use in the past month	31.0	31.0	28.4	30.9	30.9	25.6	31.0	29.8	29.1
Marijuana use in the past month	7.4	7.4	7.8	5.1	5.1	8.3	7.4	7.0	6.8
Nonmedical use of prescription pain relievers in the past year[h]	5.2	5.2	4.6	4.6	4.6	4.8	5.2	4.9	4.7
Other illicit drug use in the past month	3.9	3.9	3.5	3.1	3.1	3.3	3.9	3.5	3.3
Residents unemployed and seeking work (%)	6.8	6.4	4.9	4.6	4.1	5.3	6.9	5.6	5.4
Child maltreatment[i]	11.7	7.8	5.6	1.7	2.1	4.2	6.4	5.6	3.7

(continued)

Appendix Table C.24 (continued)

Indicator of Risk	Target Counties							Target County Average	State Average
	Becker	County	Hennepin	Mower	Nobles	Ramsey	Beltrami		
Child maltreatment by type[i]									
Nonmedical neglect	5.6	3.0	4.5	0.4	0.9	3.1	2.7	2.9	2.7
Physical abuse	1.9	1.6	0.8	0.2	0.7	0.9	0.5	0.9	0.8
Sexual abuse	0.6	0.0	0.9	0.7	0.2	0.6	0.5	0.5	0.6
Mental injury	0.9	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Medical neglect	0.0	0.0	0.1	0.0	0.0	0.1	0.3	0.1	0.1
Report physical violence in the home[j] (%)									
6th-grade males	13.0	13.0	12.0	10.0	10.0	15.0	20.0	13.3	12.0
6th-grade females	8.0	14.0	13.0	15.0	18.0	16.0	15.0	14.1	13.0
9th-grade males	14.0	10.0	9.0	7.0	8.0	11.0	11.0	10.0	9.0
9th-grade females	19.0	16.0	13.0	19.0	17.0	18.0	16.0	16.9	15.0
12th-grade males	10.0	8.0	8.0	10.0	6.0	8.0	12.0	8.9	8.0
12th-grade females	6.0	11.0	10.0	17.0	7.0	13.0	20.0	12.0	12.0
Other indicators[k]									
Pregnancy in women ages 15-19[b,l]	37.3	31.1	48.5	59.5	-	54.6	65.9	49.5	38.1
Births funded by Medicaid[b] (%)	58.3	48.8	39.6	56.4	-	48.2	68.0	53.2	38.5
Prenatal care in the 1st trimester[b] (%)	86.4	88.6	84.4	62.4	-	79.1	66.0	77.8	85.6
Child poverty[c] (%)	17.7	14.5	12.8	16.0	15.3	18.7	25.2	17.2	11.9
Tobacco users (%)	33.9	33.9	27.3	31.9	31.9	28.4	33.9	31.6	30.3

(continued)

Appendix Table C.24 (continued)

SOURCES: Minnesota 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Per 1,000 live births.
[b]Data were not reported for this indicator for some counties in this state.
[c]County-level data reflect 2008 poverty levels while state-level data reflect poverty levels from 2007.
[d]Per 1,000 residents.
[e]Per 100,000 juveniles ages 0-19.
[f]Data were not reported for this indicator in this state.
[g]Data were not available at the county level. Data included in this table are for the Substance Abuse and Mental Health Services Administration (SAMHSA) regions to which each target county belongs.
[h]Instead of reporting the percentage who reported nonmedical use of prescription drugs in the past month, the Minnesota needs assessment reported the percentage who reported nonmedical use of prescription pain relievers in the past year.
[i]The Minnesota needs assessment reported the rate of substantiated maltreatment per 1,000 children.
[j]As its metric for domestic violence, the Minnesota needs assessment reported the results of a survey that asked of sixth-, ninth-, and twelfth-graders whether anyone in their families ever hit anyone else in the family so hard or so often that they had marks or were afraid of that person.
[k]The Minnesota needs assessment reported on a large number of other indicators. This table includes a sample of those indicators.
[l]Per 1,000 females ages 15-19.

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Appendix Table C.25

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Mississippi

	Target Communities[a]							Target Community Average	State Average
	Southwest Mississippi				Northwest Mississippi				
Indicator of Risk	Claiborne	Copiah	Jefferson	Wilkinson	Coahoma	Tallahatchie	Tunica		
Live births before 37 weeks of gestation (%)	23.4	24.1	22.1	19.5	26.1	20.7	16.5	21.7	17.8
Total live births less than 2,500 grams (%)	16.4	17.2	16.7	16.7	15.9	17.2	13.8	16.2	12.2
Infant deaths ages 0-1[b]	10.3	10.9	14.2	7.1	15.5	15.0	20.1	13.7	10.3
Residents living below the federal poverty level (%)	33.8	23.3	35.2	35.1	34.4	30.6	25.4	31.0	20.9
Reported crimes[c]	-	-	-	-	-	-	-	-	-
Delinquent referrals ages 10-19[d] (%)	4.0	4.7	2.5	5.5	9.6	11.0	7.0	6.7	4.1
Dropout rate grades 9-12 (%)	6.2	19.4	14.4	10.2	16.8	32.1	31.1	19.6	16.8
Other school dropout rate per state/local calculation[c] (%)	-	-	-	-	-	-	-	-	-
Prevalence of activities ages 12+[e] (%)									
Binge alcohol use in the past month	16.6	17.8	16.6	16.4	18.4	18.4	18.4	17.6	18.8
Marijuana use in the past month	4.1	3.9	4.1	4.1	4.7	4.7	4.7	4.4	4.4
Nonmedical use of pain relievers in the past year[f]	3.6	3.9	3.6	3.6	3.9	3.9	3.9	3.8	4.0
Other illicit drug use in the past month	3.3	3.2	3.3	3.3	3.9	3.9	3.9	3.6	3.5

(continued)

Appendix Table C.25 (continued)

Indicator of Risk	Target Communities[a]							Target Community Average	State Average
	Southwest Mississippi				Northwest Mississippi				
	Claiborne	Copiah	Jefferson	Wilkinson	Coahoma	Tallahatchie	Tunica		
Residents unemployed and seeking work (%)	12.4	8.1	14.3	9.0	10.1	9.0	10.4	10.4	7.3
Child maltreatment[c]	-	-	-	-	-	-	-	-	-
Child maltreatment by type[c]	-	-	-	-	-	-	-	-	-
Women served per domestic violence shelter[g]	< 20	< 20	< 20	< 20	< 20	< 20	< 20	< 20	1,039
Other indicators									
Teen pregnancy[h]	37.0	50.0	45.6	38.5	57.7	61.2	83.2	55.1	41.5

SOURCES: Mississippi 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The target communities identified by Mississippi are two groups of counties.

[b]Per 1,000 live births.

[c]Data were not reported for this indicator in this state.

[d]Instead of reporting the number of juvenile arrests per 100,000 juveniles ages 0-19, the Mississippi needs assessment reported the number of delinquent juvenile referrals as a percentage of juveniles ages 10-19.

[e]Data were not available at the county level. Data included in this table are for the Substance Abuse and Mental Health Service Administration (SAMHSA) regions to which each target county belongs.

[f]Instead of reporting the percentage who reported nonmedical use of prescription drugs in the past month, the Mississippi needs assessment reported the percentage who reported nonmedical use of pain relievers in the past year.

[g]The Mississippi needs assessment reported the average number of women served annually per domestic violence shelter as its metric for domestic violence. Because none of Mississippi's 14 domestic violence shelters are located in counties selected for MIECHV funding, the domestic violence rate for these counties is listed as less than 20 per year.

[h]It is unclear from the Mississippi needs assessment how this was measured.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.26

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Missouri

Indicator of Risk	Target Counties					Target County Average	State Average
	Butler	Dunklin	Jasper[a]	Pemiscot	Ripley		
Live births before 37 weeks of gestation (%)	18.1	17.4	11.6	19.4	18.7	17.0	13.1
Total live births less than 2,500 grams (%)	10.0	11.2	6.6	13.5	10.5	10.4	8.1
Infant deaths ages 0-1[b]	8.1	11.2	3.6	10.4	16.0	9.9	7.4
Residents living below the federal poverty level (%)	20.8	25.0	17.9	31.7	25.6	24.2	13.5
Crime Index offenses[c]	4,615	3,287	4,896	4,450	2,373	3,924	3,923
Arrests ages 0-19[d]	955	126	-	276	469	456	1,597
Dropout rate grades 9-12 (%)	7.2	6.1	5.3	6.9	4.5	6.0	4.1
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-
Prevalence of activities in the past month[f] (%)							
Binge alcohol use	23.3	23.3	22.2	23.3	23.3	23.1	24.2
Marijuana use	4.8	4.8	5.1	4.8	4.8	4.9	5.6
Nonmedical use of pain relievers[g]	4.9	4.9	5.0	4.9	4.9	4.9	4.8
Other illicit drug use	4.1	4.1	3.8	4.1	4.1	4.0	4.0
Residents unemployed and seeking work (%)	6.2	8.0	5.2	7.5	6.8	6.7	6.1
Child maltreatment ages 0-17[h]	6.1	6.5	5.5	6.3	7.9	6.5	4.8
Child maltreatment ages 0-17 by type[h]							
Neglect	3.1	3.6	2.5	2.5	2.5	2.8	2.5
Physical abuse	1.2	1.6	1.6	2.1	1.7	1.6	1.4
Sexual abuse	2.0	1.7	1.8	1.8	3.7	2.2	1.1

(continued)

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.26

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Missouri

Indicator of Risk	Target Counties					Target County Average	State Average
	Butler	Dunklin	Jasper[a]	Pemiscot	Ripley		
Live births before 37 weeks of gestation (%)	18.1	17.4	11.6	19.4	18.7	17.0	13.1
Total live births less than 2,500 grams (%)	10.0	11.2	6.6	13.5	10.5	10.4	8.1
Infant deaths ages 0-1[b]	8.1	11.2	3.6	10.4	16.0	9.9	7.4
Residents living below the federal poverty level (%)	20.8	25.0	17.9	31.7	25.6	24.2	13.5
Crime Index offenses[c]	4,615	3,287	4,896	4,450	2,373	3,924	3,923
Arrests ages 0-19[d]	955	126	-	276	469	456	1,597
Dropout rate grades 9-12 (%)	7.2	6.1	5.3	6.9	4.5	6.0	4.1
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-
Prevalence of activities in the past month[f] (%)							
Binge alcohol use	23.3	23.3	22.2	23.3	23.3	23.1	24.2
Marijuana use	4.8	4.8	5.1	4.8	4.8	4.9	5.6
Nonmedical use of pain relievers[g]	4.9	4.9	5.0	4.9	4.9	4.9	4.8
Other illicit drug use	4.1	4.1	3.8	4.1	4.1	4.0	4.0
Residents unemployed and seeking work (%)	6.2	8.0	5.2	7.5	6.8	6.7	6.1
Child maltreatment ages 0-17[h]	6.1	6.5	5.5	6.3	7.9	6.5	4.8
Child maltreatment ages 0-17 by type[h]							
Neglect	3.1	3.6	2.5	2.5	2.5	2.8	2.5
Physical abuse	1.2	1.6	1.6	2.1	1.7	1.6	1.4
Sexual abuse	2.0	1.7	1.8	1.8	3.7	2.2	1.1

(continued)

Appendix Table C.26 (continued)

Indicator of Risk	Target Counties					Target County Average	State Average
	Butler	Dunklin	Jasper[a]	Pemiscot	Ripley		
Domestic violence incidents[i]	891	237	934-1,138	604	622	678	614
Other indicators							
Alcohol and drug abuse treatment admissions women ages 18-44[j]	20.7	22.5	12.7	21.4	11.6	17.8	8.3
Teen pregnancy rate[k]	89.4	106.9	72.5	115.8	72.5	91.4	55.3
Early prenatal care[l] (%)	75.2	73.7	79.1	68.9	72.4	73.9	83.8
Smoking during pregnancy (%)	31.1	29.4	22.8	27.6	31.2	28.4	18.0

SOURCES: Missouri 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Though Jasper was not identified as an at-risk community in the Missouri needs assessment, it was added as a target county in the FY 2011 state plan in light of the tornado that struck the city of Joplin in Jasper County in May 2011. The data included in this table for Jasper are from the FY 2011 state plan and differ slightly from what was presented for other counties: crime arrests ages 0-19 were not available and the rate of domestic violence incidents per 100,000 residents was provided as a range.

[b]Per 1,000 live births.

[c]Instead of the rate of reported crimes, the Missouri needs assessment provided the rate of Crime Index offenses per 100,000 residents. The Crime Index is the sum of eight major offenses and is used to measure the magnitude of crime in the United States. These Index offenses are: murder, rape, robbery, aggravated assault, burglary, theft, motor vehicle theft, and arson.

[d]Per 100,000 juveniles ages 0-19.

[e]Data were not reported for this indicator in this state.

[f]Data were not available for these indicators at the county level, so the Missouri needs assessment approximated the data for counties by providing the data available for the National Survey on Drug Use and Health substate regions in which these counties were located. Butler, Dunklin, Pemiscot, and Ripley counties are in the Southeast region, and Jasper is in the Southwest region.

[g]Instead of reporting the rate of nonmedical use of prescription drugs, the Missouri needs assessment reported the rate of nonmedical pain reliever use.

[h]The Missouri needs assessment reported substantiated maltreatment per 1,000 residents ages 0-17.

[i]The Missouri needs assessment reported the rate of domestic violence incidents per 100,000 residents as its metric for domestic violence.

[j]Per 1,000 women ages 18-44.

[k]Per 1,000 ages 15-19.

[l]Rate of pregnant women receiving prenatal care during the first trimester.

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Appendix Table C.27

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Montana

	Target Counties										
Indicator of Risk	Lake	Hill	Silver Bow	Cascade	Deer Lodge	Flathead	Lewis and Clark	Richland	Yellowstone	Dawson	Missoula
Live births before 37 weeks of gestation (%)	11.0	6.5	6.9	9.7	7.5	5.7	9.2	10.0	7.9	7.1	8.5
Total live births less than 2,500 grams (%)	8.9	5.9	7.7	7.9	8.6	6.3	8.8	9.4	7.2	6.5	7.0
Infant deaths ages 0-1[a]	5.9	6.4	4.7	5.3	10.4	5.1	7.1	8.8	5.8	6.1	3.8
Children ages 0-17 living below the federal poverty level[b] (%)	31.1	24.5	20.4	19.6	23.3	18.1	13.6	14.6	14.5	15.6	17.5
Serious crimes[c,d]	2,988	4,365	4,874	3,663	1,959	3,561	2,602	1,757	4,090	2,871	2,867
Arrests ages 0-19[e]	-	-	-	-	-	-	-	-	-	-	-
Dropout rate grades 9-12 (%)	8.0	5.7	6.3	5.7	6.9	6.2	6.4	3.5	5.0	3.4	4.5
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-	-	-	-
Within region of high use in the past month[t]											
Binge alcohol	Yes	No	Yes	No	Yes	Yes	Yes	No	No	No	Yes
Marijuana	Yes	No	Yes	No	Yes	Yes	Yes	No	No	No	Yes
Nonmedical use of pain relievers	Yes	No	No	No	No	Yes	No	No	No	No	Yes
Other illicit drugs	Yes	No	No	No	No	Yes	No	No	No	No	Yes
Residents unemployed and seeking work (%)	9.3	5.5	6.2	5.8	7.8	10.8	5.5	3.4	5.4	3.8	6.6

(continued)

Appendix Table C.27 (continued)

Indicator of Risk	Target Counties								Target County Average	State Average
	Gallatin	Custer	Park	Roosevelt	Mineral	Glacier	Lincoln	Rosebud		
Live births before 37 weeks of gestation (%)	7.1	9.0	7.7	12.0	6.0	9.8	7.0	10.1	8.4	8.1
Total live births less than 2,500 grams (%)	6.2	9.0	5.9	7.8	9.2	8.9	7.3	6.8	7.6	7.2
Infant deaths ages 0-1[a]	6.6	4.2	6.2	10.6	8.4	5.3	5.8	8.0	6.6	6.1
Children ages 0-17 living below the federal poverty level[b] (%)	10.8	21.6	16.5	40.1	27.6	33.8	32.0	31.5	22.5	19.2
Serious crimes[c,d]	2,499	3,544	1,647	2,032	-	1,165	1,870	1,375	2,763	2,813
Arrests ages 0-19[e]	-	-	-	-	-	-	-	-	-	-
Dropout rate grades 9-12 (%)	3.6	11.3	5.0	8.3	5.0	7.4	2.8	9.1	6.0	5.0
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-	-	-
Within region of high use in the past month[f]										
Binge alcohol	Yes	No	Yes	No	Yes	No	Yes	No	-	-
Marijuana	Yes	No	Yes	No	Yes	No	Yes	No	-	-
Nonmedical use of pain relievers	No	No	No	No	Yes	No	Yes	No	-	-
Other illicit drugs	No	No	No	No	Yes	No	Yes	No	-	-
Residents unemployed and seeking work (%)	6.6	4.6	7.0	8.0	9.8	10.9	14.8	7.2	7.3	6.8

(continued)

Appendix Table C.27 (continued)

Indicator of Risk	Target Counties										
	Lake	Hill	Silver Bow	Cascade	Deer Lodge	Flathead	Lewis and Clark	Richland	Yellowstone	Dawson	Missoula
Child maltreatment ages 0-17[g]	26.0	37.0	69.0	36.0	80.0	54.0	53.0	20.0	33.0	53.0	38.0
Child maltreatment by type[e]	-	-	-	-	-	-	-	-	-	-	-
Reports of domestic violence against women ages 15-44[h]	425	490	342	274	210	224	209	339	268	320	193
Other indicators (%)											
High school student cigarette use in past two weeks[d]	47.1	50.5	41.9	36.0	39.0	33.9	33.0	36.1	34.4	34.9	28.0
High school student binge alcohol use in past two weeks[d]	30.5	33.1	28.2	22.8	30.2	23.1	21.5	27.7	21.6	25.1	23.1
Smoked during pregnancy	26.0	23.0	26.3	19.5	31.4	17.1	19.0	20.5	18.5	21.9	14.6

Indicator of Risk	Target Counties								Target County Average	State Average
	Gallatin	Custer	Park	Roosevelt	Mineral	Glacier	Lincoln	Rosebud		
Child maltreatment ages 0-17[g]	12.0	36.0	33.0	247.0	64.0	5.0	45.0	33.0	51.3	38.0
Child maltreatment by type[e]	-	-	-	-	-	-	-	-	-	-
Reports of domestic violence against women ages 15-44[h]	114	239	313	265	0	229	258	260	262	229
Other indicators (%)										
High school student cigarette use in past two weeks[d]	22.1	-	35.6	67.5	48.0	64.3	56.5	40.2	43.8	35.8
High school student binge alcohol use in past two weeks[d]	17.2	-	27.8	35.6	24.8	27.7	27.6	28.6	26.5	23.5
Smoked during pregnancy	9.1	20.4	13.3	33.0	33.6	19.9	23.6	14.4	21.3	18.0

(continued)

Appendix Table C.27 (continued)

SOURCES: Montana 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: In addition to Lake County, which was proposed to receive funding in the FY 2011 state plan, Montana's grant application for the first round of competitive funding proposed to use those funds to target an additional 7-10 communities that would be selected from 18 identified counties. All 18 counties are included in this table.

[a]Per 1,000 live births.

[b]Instead of reporting the percentage of residents living below the federal poverty level, the Montana needs assessment reported the percentage of children under 18 years old living below the federal poverty level.

[c]Instead of the number of reported crimes per 1,000 residents, the Montana needs assessment provided the number of serious crimes per 100,000 residents. The types of crime included in this measure are: homicide, rape, robbery, aggravated assault, burglary, larceny, and motor vehicle theft.

[d]Data were not reported for this indicator for some counties in this state.

[e]Data were not reported for this indicator in this state.

[f]Instead of reporting the overall prevalence of alcohol and drug use, the Montana needs assessment reported which counties were in regions of high alcohol and drug use.

[g]The Montana needs assessment reported the rate of substantiated child abuse reports per 10,000 children ages 0-17.

[h]The Montana needs assessment reported the number of reports of domestic violence against women per 10,000 women ages 15-44 as its metric for domestic violence.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.28

Indicators of Community Risk in the Community Chosen for MIECHV Funding: Nebraska

Indicator of Risk	Target Community[a] Box Butte/Morrill/Scotts Bluff			Target Community Average	State Average
	Box Butte	Morrill	Scotts Bluff		
Live births before 37 weeks of gestation	8.5	9.1	7.8	8.5	9.7
Total live births less than 2,500 grams (%)	7.3	8.6	7.1	7.7	6.9
Infant deaths ages 0-1[b]	0.0	10.1	6.6	5.6	6.0
Residents living below the federal poverty level (%)	11.7	15.2	15.5	14.1	10.3
Reported crimes[c]	307	241	466	338	424
Arrests ages 0-19[d]	68.6	48.1	65.2	60.6	35.0
Dropout rate grades 9-12 (%)	0.0	1.0	2.0	1.0	1.0
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-
Prevalence of activities in the past month (%)					
Binge alcohol use	17.5	15.6	10.1	14.4	18.0
Marijuana use[e]	-	-	-	-	-
Nonmedical use of prescription drugs[e]	-	-	-	-	-
Other illicit drug use[e]	-	-	-	-	-
Residents unemployed and seeking work (%)	3.7	3.2	3.7	3.5	3.3
Child maltreatment ages 0-18[f] (%)	9.1	9.7	12.5	10.4	7.2
Child maltreatment by type[e]	-	-	-	-	-
Domestic violence crisis calls[g] (%)	32.3	32.3	32.3	32.3	19.8

(continued)

Appendix Table C.28 (continued)

SOURCES: Nebraska 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The Nebraska FY 2011 state plan identified a target community composed of three counties.
[b]Per 1,000 live births.
[c]Per 1,000 residents.
[d]Per 100,000 juveniles ages 0-19.
[e]Data were not reported for this indicator in this state.
[f]The Nebraska needs assessment reported the percentage of substantiated reports of child maltreatment among children ages 0-18.
[g]The Nebraska needs assessment reported the number of domestic violence crisis calls as a percentage of total residents as its metric for domestic violence.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.29

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Nevada

Indicator of Risk	Target Counties		Target County Average	State Average
	Clark	Washoe		
Live births before 37 weeks of gestation (%)	11.4	10.1	10.8	11.0
Total live births less than 2,500 grams (%)	2.0	7.9	5.0	8.3
Infant deaths ages 0-1[a]	5.4	6.5	6.0	5.3
Residents living below the federal poverty level (%)	11.1	12.2	11.7	11.2
Reported crimes[b]	66.9	67.7	67.3	64.6
Arrests ages 0-19[c]	4,581	5,059	4,820	5,076
Dropout rate grades 9-12 (%)	4.5	3.5	4.0	4.2
Average dropout rate grades 6-8[d] (%)	1.5	0.2	0.9	3.0
Prevalence of activities in the past month (%)				
Binge alcohol use	24.2	25.8	25.0	24.7
Marijuana use	6.0	7.9	7.0	6.5
Nonmedical use of prescription drugs	6.3	5.8	6.1	6.3
Other illicit drug use	4.4	4.2	4.3	4.3
Residents unemployed and seeking work (%)	14.8	13.6	14.2	14.4
Child maltreatment[e] (%)	17.7	7.6	12.7	10.1

(continued)

Appendix Table C.29

Indicator of Risk	Target Counties		Target County Average	State Average
	Clark	Washoe		
Child maltreatment by type[f] (%)				
Emotional abuse/neglect	2.2	2.7	2.5	3.0
Medical neglect	0.2	0.7	0.5	0.4
Mental injury/abuse	0.6	0.7	0.7	1.1
Mental injury/neglect	0.3	1.3	0.8	0.7
Neglect	18.1	25.4	21.8	21.6
Negligent treatment	31.6	43.7	37.7	41.9
Physical injury/abuse	16.7	9.0	12.9	11.7
Physical injury/neglect	11.7	9.7	10.7	8.7
Physical abuse	4.3	2.6	3.5	3.4
Sexual abuse[g]	6.9	2.7	4.8	3.9
Sexual abuse/neglect	3.6	0.2	1.9	1.7
Sexual exposure: infant	3.9	1.3	2.6	1.9
Domestic violence[h]	5.0	5.9	5.5	4.9

SOURCES: Nevada 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Per 1,000 live births.

[b]Per 1,000 residents.

[c]Per 100,000 juveniles age 0-19.

[d]The Nevada needs assessment reported the average dropout rate for grades 6-8 as its "other school dropout rate."

[e]The Nevada needs assessment appears to have reported the percentage of cases of child maltreatment that were substantiated out of all reported cases.

[f]The Nevada needs assessment reported the percentage of each type of maltreatment out of all substantiated child maltreatment cases.

[g]The Nevada needs assessment reported two percentages for sexual abuse for each county. The sum of those percentages is included in this row.

[h]It was not clear what metric or unit of measurement the Nevada needs assessment used for its domestic violence indicator.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.30

Indicators of Community Risk in Counties Chosen for MIECHV Funding: New Hampshire

Indicator of Risk	Target Counties										Target County Average	State Average
	Carroll	Coos	Strafford	Sullivan	Belknap	Cheshire	Grafton	Hillsborough	Merrimack	Rockingham		
Live births before 37 weeks of gestation[a] (%)	10.4	10.7	9.6	9.8	-	-	-	-	-	-	10.1	9.7
Total live births less than 2,500 grams[b] (%)	5.7	7.8	7.8	6.6	6.5	6.3	5.8	6.8	6.1	6.5	6.6	6.5
Infant deaths ages 0-1[c]	6.6	5.6	6.8	3.9	3.0	6.2	6.1	4.9	6.1	4.8	5.4	5.2
Residents living below the federal poverty level[a] (%)	9.2	13.0	10.7	9.9	-	-	-	-	-	-	10.7	7.8
Reported crimes[a,d]	43.7	34.0	49.7	29.1	-	-	-	-	-	-	39.1	37.4
Arrests ages 0-19[a,e]	6,602	4,881	6,481	3,017	-	-	-	-	-	-	5,245	4,523
Dropout rate grades 9-12[a] (%)	6.3	10.8	12.7	11.8	-	-	-	-	-	-	10.4	8.9
Early exiters who have not earned a General Educational Development (GED) certificate or enrolled in college[a,f] (%)	3.8	8.7	9.4	10.6	-	-	-	-	-	-	8.1	6.7

(continued)

Appendix Table C.30 (continued)

Indicator of Risk	Target Counties										Target County Average	State Average
	Carroll	Coos	Strafford	Sullivan	Belknap	Cheshire	Grafton	Hillsborough	Merrimack	Rockingham		
Prevalence of activities in the past month[a] (%)												
Binge alcohol use	27.5	27.5	26.9	27.6	-	-	-	-	-	-	27.4	25.9
Marijuana use	9.6	9.6	9.1	8.7	-	-	-	-	-	-	9.3	8.8
Nonmedical use of prescription drugs	5.5	5.5	5.2	5.5	-	-	-	-	-	-	5.4	5.1
Other illicit drug use	3.3	3.3	3.8	3.6	-	-	-	-	-	-	3.5	3.4
Residents unemployed and seeking work[a] (%)	5.1	7.0	5.5	5.3	-	-	-	-	-	-	5.7	5.9
Child maltreatment ages 0-18[a,g]	530	673	366	611	-	-	-	-	-	-	545	315
Child maltreatment ages 0-18 by type[g]												
Physical abuse[h]	-	-	-	-	-	-	-	-	-	-	-	37.0
Neglect[a]	440	575	327	456	-	-	-	-	-	-	449	240
Sexual abuse[h]	-	-	-	-	-	-	-	-	-	-	-	50.2
Number of domestic violence victims receiving services[a,i]	605	585	1,057	785	-	-	-	-	-	-	758	-

(continued)

Appendix Table C.30 (continued)

Indicator of Risk	Target Counties										Target County Average	State Average
	Carroll	Coos	Strafford	Sullivan	Belknap	Cheshire	Grafton	Hillsborough	Merrimack	Rockingham		
Other indicators[a,j]												
Poor mental health days in past 30 days	3.5	3.9	3.7	3.6	-	-	-	-	-	-	3.7	3.2
Inadequate social support[k] (%)	15.0	24.0	20.0	20.0	-	-	-	-	-	-	19.8	17.0
Births to unmarried mother (%)	39.1	47.8	35.8	41.0	-	-	-	-	-	-	40.9	32.2

SOURCES: New Hampshire 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: Six counties were identified for funding in the first-round competitive grant application. These counties are Belknap, Cheshire, Grafton, Hillsborough, Merrimack, and Rockingham. New Hampshire did not provide information on most of the requested indicators of risk for these counties.

[a]Data were not reported for this indicator for some target counties in the state.

[b]For the six counties identified in the first-round competitive grant application (Belknap, Grafton, Hillsborough, Merrimack, Cheshire, and Rockingham), instead of reporting the percentage of low-birth-weight infants, New Hampshire reported on the rate of low-birth-weight infants per 1,000. These numbers were converted to percentages.

[c]Per 1,000 live births.

[d]Per 1,000 residents.

[e]Per 100,000 juveniles ages 0-19.

[f]The New Hampshire needs assessment reported the percentage of early exiters who have not earned a GED certificate or enrolled in college as its "other school dropout rate."

[g]The New Hampshire needs assessment reported the number of child maltreatment cases per 100,000 children ages 0-18.

[h]Data were not reported for this indicator for any target counties in the state.

[i]The New Hampshire needs assessment reported the number of domestic violence victims receiving services as its metric for domestic violence. The state average for this indicator was not reported.

[j]Other indicators were limited to those presented in the New Hampshire needs assessment.

[k]Percentage of adult population who responded that they "never," "rarely," or "sometimes" get the support they need.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.31

Indicators of Community Risk in Communities Chosen for MIECHV Funding: New Jersey

Indicator of Risk	Target Communities[a]							
	Atlantic City	City of Pleasantville	Egg Harbor Township	Galloway Township	Hamilton Township	City of Garfield[b]	City of Englewood[b]	Willingboro Township
Live births before 37 weeks of gestation (%)	9.3	9.6	7.9	7.7	7.7	-	-	11.5
Total live births less than 2,500 grams (%)	9.5	9.9	8.8	8.3	6.3	-	-	11.2
Infant deaths ages 0-1[c]	6.2	8.9	13.3	5.4	7.6	-	-	7.7
Residents living below the federal poverty level (%)	23.7	15.8	5.4	6.6	6.6	-	-	5.9
Reported crimes[d]	16.9	9.7	2.1	2.2	3.7	-	-	21.3
Arrests ages 0-19[e]	-	-	-	-	-	-	-	-
Dropout rate grades 9-12[f] (%)	11.5	11.5	11.5	11.5	11.5	-	-	4.1
Other school dropout rate per state/local calculation[e]	-	-	-	-	-	-	-	-
Prevalence of activities in the past month								
Binge alcohol use[f] (%)	17.1	17.1	17.1	17.1	17.1	-	-	13.8
Marijuana use[e]	-	-	-	-	-	-	-	-
Nonmedical use of prescription drugs[e]	-	-	-	-	-	-	-	-
Other illicit drug use[e]	-	-	-	-	-	-	-	-
Residents unemployed and seeking work (%)	8.8	8.0	5.1	5.4	4.8	-	-	5.7

(continued)

Appendix Table C.31 (continued)

Indicator of Risk	Target Communities[a]							
	Township of Pemberton[g]	City of Camden	Lindenwold Borough	Pennsauken Township	Winslow Township	Cape May County[g]	City of Millville	City of Bridgeton
Live births before 37 weeks of gestation (%)	-	11.6	12.8	10.9	11.5	-	12.4	9.5
Total live births less than 2,500 grams (%)	-	10.7	10.7	11.5	9.7	-	10.6	8.6
Infant deaths ages 0-1[c]	-	13.9	9.1	12.4	7.2	-	16.1	5.2
Residents living below the federal poverty level (%)	-	35.5	11.8	8.0	6.0	-	15.2	26.6
Reported crimes[d]	-	87.2	49.7	45.2	23.9	-	8.4	13.6
Arrests ages 0-19[e]	-	-	-	-	-	-	-	-
Dropout rate grades 9-12[f] (%)	4.1	10.4	10.4	10.4	10.4	10.6	30.1	30.1
Other school dropout rate per state/local calculation[e]	-	-	-	-	-	-	-	-
Prevalence of activities in the past month								
Binge alcohol use[f] (%)	13.8	17.1	17.1	17.1	17.1	14.4	17.0	17.0
Marijuana use[e]	-	-	-	-	-	-	-	-
Nonmedical use of prescription drugs[e]	-	-	-	-	-	-	-	-
Other illicit drug use[e]	-	-	-	-	-	-	-	-
Residents unemployed and seeking work (%)	-	9.6	7.7	5.5	5.8	-	8.1	8.5

(continued)

Appendix Table C.31 (continued)

Indicator of Risk	Target Communities[a]							
	City of Vineland	Township of Irvington	City of Newark	Orange Township	City of East Orange	Borough of Glassboro	Jersey City	Township of North Bergen[g]
Live births before 37 weeks of gestation (%)	8.5	13.4	13.4	12.4	15.9	8.3	11.7	-
Total live births less than 2,500 grams (%)	7.6	13.1	10.9	11.1	14.2	7.9	10.3	-
Infant deaths ages 0-1[c]	1.2	9.4	5.5	10.4	6.7	4.3	9.7	-
Residents living below the federal poverty level (%)	13.8	17.4	28.4	18.8	19.2	15.2	18.6	-
Reported crimes[d]	48.8	77.0	48.2	55.7	32.2	35.0	40.9	-
Arrests ages 0-19[e]	-	-	-	-	-	-	-	-
Dropout rate grades 9-12[f] (%)	30.1	15.3	15.3	15.3	15.3	6.7	12.0	12.0
Other school dropout rate per state/local calculation[e]	-	-	-	-	-	-	-	-
Prevalence of activities in the past month								
Binge alcohol use[f] (%)	17.0	11.9	11.9	11.9	11.9	15.4	15.2	15.2
Marijuana use[e]	-	-	-	-	-	-	-	-
Nonmedical use of prescription drugs[e]	-	-	-	-	-	-	-	-
Other illicit drug use[e]	-	-	-	-	-	-	-	-
Residents unemployed and seeking work (%)	6.2	6.6	7.9	6.2	2.2	5.8	5.4	-

(continued)

Appendix Table C.31 (continued)

Indicator of Risk	Target Communities[a]							
	City of Trenton	City of New Brunswick	City of Asbury Park	Toms River[g]	City of Paterson	City of Passaic	Salem County[g]	Sussex County[g]
Live births before 37 weeks of gestation (%)	13.2	10.8	10.7	-	11.1	6.9	-	-
Total live births less than 2,500 grams (%)	11.8	7.5	9.1	-	9.6	6.4	-	-
Infant deaths ages 0-1[c]	14.1	10.8	2.5	-	7.3	6.1	-	-
Residents living below the federal poverty level (%)	21.1	27.1	30.1	-	22.2	21.2	-	-
Reported crimes[d]	45.5	58.4	76.3	-	41.1	32.2	-	-
Arrests ages 0-19[e]	-	-	-	-	-	-	-	-
Dropout rate grades 9-12[f] (%)	18.6	5.8	2.3	7.7	15.6	15.6	11.6	5.1
Other school dropout rate per state/local calculation[e]	-	-	-	-	-	-	-	-
Prevalence of activities in the past month								
Binge alcohol use[f] (%)	13.3	13.6	16.9	11.9	14.2	14.2	12.8	15.2
Marijuana use[e]	-	-	-	-	-	-	-	-
Nonmedical use of prescription drugs[e]	-	-	-	-	-	-	-	-
Other illicit drug use[e]								
Residents unemployed and seeking work (%)	9.9	4.2	9.8	-	8.3	7.0	-	-

(continued)

Appendix Table C.31 (continued)

Indicator of Risk	Target Communities[a] City of Elizabeth	City of Rahway	City of Plainfield	Warren County[g]	Target Community Average	State Average
Live births before 37 weeks of gestation (%)	8.8	15.6	10.4	-	10.9	9.7
Total live births less than 2,500 grams (%)	8.2	12.8	9.3	-	9.8	7.7
Infant deaths ages 0-1[c]	5.8	2.8	4.1	-	7.9	5.1
Residents living below the federal poverty level (%)	17.8	7.1	15.9	-	17.1	6.0
Reported crimes[d]	46.5	23.2	33.1	-	36.2	20.9
Arrests ages 0-19[e]	-	-	-	-	-	-
Dropout rate grades 9-12[f] (%)	17.3	17.3	17.3	6.6	13.0	7.5
Other school dropout rate per state/local calculation[e]	-	-	-	-	-	-
Prevalence of activities in the past month						
Binge alcohol use[f] (%)	14.4	14.4	14.4	13.5	15.0	14.5
Marijuana use[e]	-	-	-	-	-	-
Nonmedical use of prescription drugs[e]	-	-	-	-	-	-
Other illicit drug use[e]	-	-	-	-	-	-
Residents unemployed and seeking work (%)	6.2	4.8	6.0	-	6.6	4.0

(continued)

Appendix Table C.31 (continued)

Indicator of Risk	Target Communities[a]							
	Atlantic City	City of Pleasantville	Egg Harbor Township	Galloway Township	Hamilton Township	City of Garfield[b]	City of Englewood[b]	Willingboro Township
Child maltreatment[h]	8.7	6.0	11.1	2.4	12.0	-	-	3.6
Child maltreatment by type[e]	-	-	-	-	-	-	-	-
Domestic violence[f,i] (%)								
Domestic violence offenses per residence	0.1	0.1	0.1	0.1	0.1	-	-	0.0
Domestic violence arrests per residence	0.0	0.0	0.0	0.0	0.0	-	-	0.0

Indicator of Risk	Target Communities[a]							
	Township of Pemberton[g]	City of Camden	Lindenwold Borough	Pennsauken Township	Winslow Township	Cape May County[g]	City of Millville	City of Bridgeton
Child maltreatment[h]	-	16.0	23.7	5.1	9.0	-	20.1	13.3
Child maltreatment by type[e]	-	-	-	-	-	-	-	-
Domestic violence[f,i] (%)								
Domestic violence offenses per residence	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1
Domestic violence arrests per residence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

(continued)

Appendix Table C.31 (continued)

Indicator of Risk	Target Communities[a] City of Vineland	Township of Irvington	City of Newark	Orange Township	City of East Orange	Borough of Glassboro	Jersey City	Township of North Bergen[g]
Child maltreatment[h]	9.7	7.1	8.3	4.5	7.3	8.2	6.6	-
Child maltreatment by type[e]	-	-	-	-	-	-	-	-
Domestic violence[f,i] (%)								
Domestic violence offenses per residence	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Domestic violence arrests per residence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Indicator of Risk	Target Communities[a] City of Trenton	City of New Brunswick	City of Asbury Park	Toms River[g]	City of Paterson	City of Passaic	Salem County[g]	Sussex County[g]
Child maltreatment[h]	11.5	20.5	6.9	-	7.1	3.0	-	-
Child maltreatment by type[e]	-	-	-	-	-	-	-	-
Domestic violence[f,i] (%)								
Domestic violence offenses per residence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Domestic violence arrests per residence	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

(continued)

Appendix Table C.31 (continued)

Indicator of Risk	Target Communities[a] City of Elizabeth	City of Rahway	City of Plainfield	Warren County[g]	Target Community Average	State Average
Child maltreatment[h]	8.1	5.0	7.2	-	9.3	5.2
Child maltreatment by type[e]	-	-	-	-	-	-
Domestic violence[f,i] (%)						
Domestic violence offenses per residence	0.0	0.0	0.0	0.1	0.0	0.0
Domestic violence arrests per residence	0.0	0.0	0.0	0.0	0.0	0.0

SOURCES: New Jersey 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The New Jersey FY 2011 state plan named 36 target communities, including 32 municipalities/communities and 4 counties.
[b]Data were not reported for this target community because it was not identified as an "at-risk community" in the New Jersey needs assessment.
[c]Per 1,000 live births.
[d]Per 1,000 residents.
[e]Data were not reported for this indicator in this state.
[f]This indicator was only reported at the county level so target communities that are smaller than counties were given the value for their county in this table.
[g]Data were not reported for a large number of indicators for this target community because it was not identified as an "at-risk community" in the New Jersey needs assessment and information was not reported for it. Four indicators that were reported at the county level are included in this table for this community.
[h]It was not clear what metric or unit the New Jersey needs assessment used to report this indicator.
[i]The New Jersey needs assessment reported the number of domestic violence offenses and arrests as percentages of total residences as its metrics for domestic violence.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.32

Indicators of Community Risk in Communities Chosen for MIECHV Funding: New Mexico

Indicator of Risk	Target Communities[a] Albuquerque's South Valley/ South Central Community[b]	McKinley County	Grant County	Quay County	Luna County	Target Community Average	State Average
Live births before 37 weeks of gestation (%)	10.4	13.5	13.6	10.2	12.1	12.0	10.7
Total live births less than 2,500 grams (%)	9.6	8.7	11.3	7.1	8.4	9.0	8.6
Infant deaths ages 0-1[c]	-	9.5	7.0	11.1	7.6	8.8	6.2
Residents living below the federal poverty level (%)	25.1	30.8	19.0	19.9	28.0	24.6	17.0
Reported crimes[d]	-	-	-	-	-	-	-
Arrests ages 0-19[e]	-	2,032	5,676	7,329	3,991	4,757	4,227
Dropout rate grades 9-12 (%)	-	6.2	3.3	7.5	3.9	5.2	3.8
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-	-
Prevalence of activities in the past month[f] (%)							
Binge alcohol use	23.5	20.6	21.0	20.9	21.0	21.4	21.3
Marijuana use	5.8	6.3	7.4	5.2	7.4	6.4	6.8
Nonmedical use of pain relievers[g]	6.0	5.5	6.2	5.9	6.2	6.0	5.9
Other illicit drug use	4.0	3.3	3.9	3.9	3.9	3.8	3.7
Residents unemployed and seeking work (%)	5.1	9.8	11.4	8.0	19.0	10.7	8.2

(continued)

Appendix Table C.32 (continued)

Indicator of Risk	Target Communities[a]					Target Community Average	State Average
	Albuquerque's South Valley/ South Central Community[b]	McKinley County	Grant County	Quay County	Luna County		
Child maltreatment[h]	11.9	9.0	13.5	84.3	15.2	26.8	16.5
Child maltreatment by type[h]							
Neglect	8.7	6.6	9.9	56.2	12.1	18.7	12.3
Physical abuse	2.7	2.2	3.7	25.7	2.9	7.4	3.7
Sexual abuse	0.5	0.2	0.0	2.4	0.2	0.7	0.5
Domestic violence[i]	-	13.2	7.6	30.5	1.1	13.1	11.3
Other indicators							
Teen birth rate ages 15-19[j]	95.5	55.3	60.9	56.0	92.8	72.1	60.1

SOURCES: New Mexico 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]The New Mexico FY 2011 competitive grant application identified five target communities, including one area of Albuquerque and four counties.

[b]Data were not reported for some indicators for this target community. The child maltreatment data are for Bernalillo County, the county to which this target community belongs.

[c]Per 1,000 live births.

[d]Data were not reported for this indicator in this state.

[e]Per 100,000 juveniles ages 0-19.

[f]Data were not available at the county level and were reported regionally instead. Data included in this table are for the regions to which each target community belongs.

[g]Instead of reporting the rate of nonmedical use of prescription drugs in the past month, the New Mexico needs assessment reported the rate of nonmedical use of pain relievers in the past month.

[h]The New Mexico needs assessment reported the rate of substantiated abuse per 1,000 children.

[i]The New Mexico needs assessment reported a rate of domestic violence per 1,000 as its metric for domestic violence.

[j]Per 1,000 adolescents ages 15-19.

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Appendix Table C.33

Indicators of Community Risk in Counties Chosen for MIECHV Funding: New York

Indicator of Risk	Target Counties							
	Albany	Bronx	Erie	Kings	Monroe	Nassau	New York	Oneida
Live births before 37 weeks of gestation (%)	10.5	13.7	11.1	12.6	9.2	11.2	12.4	12.6
Total live births less than 2,500 grams (%)	8.6	10.0	8.2	8.6	8.1	7.9	8.7	7.8
Infant deaths ages 0-1[a]	9.7	6.1	7.4	5.4	7.6	5.3	4.7	7.3
Residents living below the federal poverty level (%)	10.6	30.7	12.2	25.1	11.1	5.2	20.0	13.0
Reported Crime Index offenses[b]	3,486	2,242	3,606	2,242	3,513	1,597	2,242	2,827
Arrests ages 0-16[c]	53.2	-	34.1	-	23.3	13.2	-	52.5
Dropout rate grades 9-12 (%)	2.4	4.0	3.9	4.5	3.5	0.9	4.0	2.4
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-	-	-
Prevalence of activities in the past month (%)								
Binge alcohol use	24.2	20.9	28.5	20.8	23.4	24.3	27.5	24.1
Marijuana use	10.3	5.9	8.4	5.9	6.5	6.7	9.6	8.0
Nonmedical use of prescription drugs	4.7	3.2	4.9	3.6	4.4	4.5	4.1	4.6
Other illicit drug use	4.1	3.5	4.2	3.9	3.7	3.4	4.5	3.9
Residents unemployed and seeking work (%)	4.8	7.3	5.6	5.8	5.4	4.7	4.7	5.3
Child maltreatment ages 0-17[e]	191	264	164	150	120	92	135	301

(continued)

Appendix Table C.33 (continued)

Indicator of Risk	Target Counties						Target County Average	State Average
	Onondaga	Orange	Queens	Richmond	Suffolk	Westchester		
Live births before 37 weeks of gestation (%)	10.7	9.7	12.2	11.7	11.0	13.1	11.6	11.6
Total live births less than 2,500 grams (%)	7.4	7.5	8.3	8.4	7.2	8.9	8.3	8.2
Infant deaths ages 0-1[a]	7.7	4.4	4.5	3.5	3.9	5.4	5.9	5.5
Residents living below the federal poverty level (%)	12.2	10.5	14.6	10.0	5.9	8.7	13.6	14.5
Reported Crime Index offenses[b]	2,961	2,268	2,242	2,242	2,100	1,718	2,520	2,296
Arrests ages 0-16[c]	52.6	23.5	-	-	11.8	15.4	31.1	25.7
Dropout rate grades 9-12 (%)	3.5	2.6	3.8	3.3	1.6	1.5	3.0	2.9
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-		-
Prevalence of activities in the past month (%)								
Binge alcohol use	24.1	25.3	20.1	20.8	24.3	21.0	23.5	23.6
Marijuana use	8.0	7.7	4.8	5.9	6.7	5.3	7.1	7.0
Nonmedical use of prescription drugs	4.6	4.6	3.4	3.6	4.5	3.5	4.2	4.1
Other illicit drug use	3.9	3.6	3.2	3.9	3.4	3.4	3.8	3.7
Residents unemployed and seeking work (%)	5.1	5.3	4.9	4.9	4.9	4.7	5.2	5.3
Child maltreatment ages 0-17[e]	174	91	118	148	127	109	156	169

(continued)

Appendix Table C.33 (continued)

Indicator of Risk	Target Counties							
	Albany	Bronx	Erie	Kings	Monroe	Nassau	New York	Oneida
Number of child maltreatment reports by type ages 0-17[f]								
Physical abuse	125	-	376	-	321	293	-	174
Neglect	1,103	-	3,169	-	1,959	2,748	-	1,390
Domestic violence victims[g]	84.7	46.2	65.5	33.8	79.1	14.6	21.9	65.1
Other indicators								
Unique children in Child Protective Services reports ages 0-17[h]	716	558	596	346	497	287	301	854
Unique children admitted to foster care ages 0-17[h]	28.0	59.1	22.0	30.1	25.0	14.0	35.3	53.0
Admissions to certified chemical dependence programs[i]	248	279	189	154	152	107	255	147
Drug-related hospital discharges[i]	21.3	96.4	33.2	38.6	19.2	16.7	63.8	16.2
Late or no prenatal care (%)	4.3	9.1	4.2	8.8	2.9	3.2	6.9	4.6
Births to teenage women[j]	6.6	11.1	8.9	6.6	10.3	3.9	5.1	10.3
Chlamydia[j]	424	1,139	522	661	638	194	668	325
Lead exposure/lead poisoning[j]	15.4	4.4	20.1	6.5	16.7	2.7	3.5	34.1

(continued)

Appendix Table C.33 (continued)

Indicator of Risk	Target Counties						Target County Average	State Average
	Onondaga	Orange	Queens	Richmond	Suffolk	Westchester		
Number of child maltreatment reports by type ages 0-17[f]								
Physical abuse	207	79	-	-	414	258	250	-
Neglect	1,775	889	-	-	4,451	2,415	2,211	-
Domestic violence victims[g]	70.5	36.2	25.7	22.8	50.6	26.0	45.9	39.0
Other indicators								
Unique children in Child Protective Services reports ages 0-17[h]	670	394	290	367	376	324	470	484
Unique children admitted to foster care ages 0-17[h]	22.0	18.0	25.4	26.9	14.0	15.0	27.7	28.0
Admissions to certified chemical dependence programs[i]	184	153	88	199	143	112	172	160
Drug-related hospital discharges[i]	14.8	29.5	21.1	33.9	20.6	30.8	32.6	32.5
Late or no prenatal care (%)	3.3	4.9	9.9	5.9	4.7	4.7	5.5	6.3
Births to teenage women[j]	9.9	6.6	5.4	5.6	5.2	5.0	7.2	7.0
Chlamydia[j]	524	217	506	202	207	268	464	455
Lead exposure/lead poisoning[j]	12.6	12.7	4.9	4.2	1.6	4.9	10.3	6.7

(continued)

Appendix Table C.33 (continued)

SOURCES: New York 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Per 1,000 live births.

[b]Instead of the number of arrests per 1,000 residents, the New York needs assessment provided the number of Crime Index offenses reported to the police per 100,000 residents. The Crime Index is the sum of eight major offenses and is used to measure the magnitude of crime in the United States. These Index offenses are: murder, rape, robbery, aggravated assault, burglary, theft, motor vehicle theft, and arson.

[c]Instead of reporting the number of arrests per 100,000 juveniles ages 0-19, the New York needs assessment reported the number of arrests per 100,000 juveniles ages 0-16. The state average does not include data from New York City.

[d]Data were not reported for this indicator in this state.

[e]The New York needs assessment reported the number of unique children in "indicated" Child Protective Services reports of abuse/maltreatment per 10,000 children ages 0-17.

[f]The New York needs assessment reported the number of unique children in "indicated" Child Protective Services reports by type ages 0-17. Data were not reported for this indicator for some counties. The state average for this indicator was not reported.

[g]The New York needs assessment reported the number of domestic violence victims per 10,000 as its metric for domestic violence.

[h]Per 10,000 children ages 0-17.

[i]Per 10,000 residents.

[j]The New York needs assessment did not specify the units of these indicators.

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Appendix Table C.34

Indicators of Community Risk in Communities Chosen for MIECHV Funding: North Carolina

	Target Communities[a]									
					Northampton/Halifax/Hertford/Edgecombe				Robeson/Columbus	
Indicator of Risk	Buncombe	Burke	Durham	Gaston	Northampton	Halifax	Hertford	Edgecombe	Robeson	Columbus
Live births before 37 weeks of gestation (%)	13.0	13.1	14.1	11.9	14.4	14.5	16.5	17.3	16.5	16.6
Total live births less than 2,500 grams (%)	8.7	7.7	9.5	9.2	11.9	11.1	12.6	13.7	10.9	13.4
Infant deaths ages 0-1[b]	6.4	8.0	6.7	10.1	11.5	16.8	17.2	13.9	14.1	11.2
Residents living below the federal poverty level (%)	13.9	15.5	13.8	15.1	26.6	23.7	22.7	22.6	30.4	21.9
Reported Crime Index offenses[c]	35.3	26.2	63.0	51.5	34.4	53.9	43.6	53.6	73.3	62.8
Delinquent complaints ages 6-15[d]	2,744	1,946	2,402	2,758	2,926	5,113	1,047	3,812	4,143	2,731
Dropout rate grades 9-12 (%)	4.7	2.2	4.5	5.9	3.2	5.9	2.3	5.7	5.9	3.7
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-	-	-
Prevalence of activities in the past month ages 18+[f] (%)										
Binge alcohol use	20.1	20.1	19.6	20.1	22.9	19.6	22.9	22.9	20.1	20.1
Marijuana use	5.2	5.2	5.8	5.2	7.3	5.8	7.3	7.3	4.8	4.8
Nonmedical use of prescription drugs	4.8	4.8	4.9	4.8	5.2	4.9	5.2	5.2	4.2	4.2
Other illicit drug use	3.3	3.3	4.2	3.3	3.8	4.2	3.8	3.8	3.9	3.9
Residents unemployed and seeking work (%)	8.6	14.5	7.9	14.0	10.9	13.1	9.3	16.1	11.4	12.4

(continued)

Appendix Table C.34 (continued)

Indicator of Risk	Target Communities[a] Yancey/Mitchell Yancey	Mitchell	Target Community Average	State Average
Live births before 37 weeks of gestation (%)	14.1	10.1	14.1	12.9
Total live births less than 2,500 grams (%)	7.3	8.4	9.6	9.1
Infant deaths ages 0-1[b]	6.6	7.3	9.3	8.4
Residents living below the federal poverty level (%)	18.4	17.2	18.1	14.6
Reported Crime Index offenses[c]	13.2	28.0	43.4	45.8
Delinquent complaints ages 6-15[d]	1,870	2,169	2,626	2,914
Dropout rate grades 9-12 (%)	5.6	5.9	4.6	4.6
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-
Prevalence of activities in the past month ages 18+[f] (%)				
Binge alcohol use	20.1	20.1	20.3	20.5
Marijuana use	5.2	5.2	5.5	5.7
Nonmedical use of prescription drugs	4.8	4.8	4.7	4.7
Other illicit drug use	3.3	3.3	3.6	3.6
Residents unemployed and seeking work (%)	11.7	11.8	11.6	10.7

(continued)

Appendix Table C.34 (continued)

Indicator of Risk	Target Communities[a]									
					Northampton/Halifax/Hertford/Edgecombe				Robeson/Columbus	
	Buncombe	Burke	Durham	Gaston	Northampton	Halifax	Hertford	Edgecombe	Robeson	Columbus
Child maltreatment[g]	35.9	42.6	20.0	33.1	55.7	51.5	7.0	33.1	31.6	38.0
Child maltreatment by type[g]										
Abuse and neglect	2.6	0.3	0.6	0.4	0.0	1.4	0.0	0.7	0.7	1.6
Abuse[h]	0.4	2.0	1.6	0.6	1.8	1.5	0.0	0.4	0.7	2.4
Neglect	9.5	8.3	2.4	8.9	2.7	5.5	0.4	3.3	11.4	17.7
Dependency	0.0	0.2	0.1	0.4	0.0	0.2	0.0	0.4	0.7	0.6
Services needed	19.6	19.5	7.3	13.1	24.7	20.5	2.2	22.9	10.9	0.7
Services provided, no longer needed	3.7	12.3	8.0	9.7	26.5	22.5	4.4	5.4	7.2	15.0
Clients in state-sponsored domestic violence programs[i]	6.6	16.3	1.1	1.8	9.1	1.0	3.4	3.5	9.1	10.1

Indicator of Risk	Target Communities[a]		Target Community Average	State Average
	Yancey/Mitchell			
	Yancey	Mitchell		
Child maltreatment[g]	88.2	39.9	38.2	29.6
Child maltreatment by type[g]				
Abuse and neglect	0.5	0.0	0.8	0.9
Abuse[h]	1.5	0.0	1.1	0.9
Neglect	9.1	18.4	8.6	7.5
Dependency	0.0	2.4	0.4	0.3
Services needed	50.7	8.3	16.1	12.1
Services provided, no longer needed	26.4	10.7	11.2	8.0
Clients in state-sponsored domestic violence programs[i]	33.5	76.2	13.5	5.7

(continued)

Appendix Table C.34 (continued)

SOURCES: North Carolina 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The North Carolina FY 2011 state plan named seven target communities: four individual counties and three groups of counties.

[b]Per 1,000 live births.

[c]Instead of the number of reported crimes per 1,000 residents, the North Carolina needs assessment provided the number of Crime Index offenses reported to law enforcement agencies per 1,000 residents. The Crime Index is the sum of eight major offenses and is used to measure the magnitude of crime in the United States. These Index offenses are: murder, rape, robbery, aggravated assault, burglary, theft, motor vehicle theft, and arson.

[d]Instead of reporting the number of arrests per 100,000 juveniles ages 0-19, the North Carolina needs assessment reported the number of delinquent complaints per 100,000 juveniles ages 6-15. According to the needs assessment, "delinquent complaints are the juvenile version of 'arrest' in North Carolina."

[e]Data were not reported for this indicator in this state.

[f]Data were not available at the county level. Data included in this table are for the Substance Abuse and Mental Health Service Administration (SAMHSA) regions to which each target county belongs.

[g]The North Carolina needs assessment reported the rate of substantiated maltreatment per 1,000 children.

[h]The North Carolina needs assessment suggests that this category is comparable to physical abuse, as defined by the U.S. Department of Health and Human Services.

[i]The North Carolina needs assessment reported the number of clients in state-sponsored domestic violence programs per 1,000 as its metric for domestic violence.

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Appendix Table C.35

Indicators of Community Risk in the State of North Dakota

Indicator of Risk	State Average
Live births before 37 weeks of gestation (%)	9.5
Total live births less than 2,500 grams (%)	6.5
Infant deaths ages 0-1[a]	6.2
Children ages 0-17 living below the federal poverty level[b] (%)	14.2
Reported crimes[c]	-
Youth ages 10-17 referred to juvenile court[d] (%)	9.0
Dropout rate grades 9-12 (%)	2.4
Other school dropout rate per state/local calculation[c] (%)	-
Prevalence of activities in the past month for students in grades 9-12 (%)	
Binge alcohol use	30.7
Marijuana use	16.9
Nonmedical use of prescription drugs[c]	-
Other illicit drug use[c]	-
Cigarette use	22.4
Smokeless tobacco use[e]	15.3
Residents unemployed and seeking work (%)	4.3
Child maltreatment ages 0-17[f] (%)	0.9
Child maltreatment by type[c]	-

(continued)

Appendix Table C.35 (continued)

Indicator of Risk	State Average
Children affected by domestic violence[g] (%)	3.4
Other indicator (%)	
Students in grades 9-12 who were offered, sold, or given an illegal drug by someone on school property in past year	19.5

SOURCE: North Dakota 2010 MIECHV needs assessment.

NOTES: North Dakota did not apply for MIECHV funding. Therefore, no target communities were identified and these data are presented only at the state level.

[a]Per 1,000 live births.

[b]Instead of reporting the percentage of residents living below the federal poverty level, the North Dakota needs assessment reported the percentage of children ages 0-17 living below the federal poverty level.

[c]Data were not reported for this indicator in this state.

[d]Instead of reporting the number of arrests per 100,000 juveniles ages 0-19, the North Dakota needs assessment reported the percentage of youth ages 10-17 referred to juvenile court.

[e]Includes use of chewing tobacco, snuff, or dip.

[f]The North Dakota needs assessment reported the number of children requiring immediate services for child abuse and neglect as a percentage of all children ages 0-17.

[g]The North Dakota needs assessment reported the percentage of children ages 0-17 affected by domestic violence as its metric for domestic violence.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.36

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Ohio

Indicator of Risk	Target Counties										Target County Average	State Average
	Clark	Franklin	Hamilton	Lucas	Marion	Montgomery	Pike	Ross	Trumbull	Vinton		
Live births before 37 weeks of gestation (%)	13.3	13.4	14.6	12.6	12.7	12.4	14.8	13.9	11.7	18.6	13.8	12.8
Total live births that are less than 2,500 grams (%)	8.9	9.6	10.3	9.4	9.0	8.8	9.2	9.2	9.0	10.1	9.4	8.7
Infant deaths ages 0-1[a]	6.0	8.7	10.6	8.2	6.2	7.5	7.6	6.0	7.8	9.4	7.8	7.7
Residents living below the federal poverty level (%)	13.8	15.1	13.6	18.6	16.9	15.0	19.6	16.3	15.5	23.0	16.7	13.3
Reported crimes[b]	47.2	58.7	48.9	64.4	42.0	44.0	17.5	56.5	34.3	39.0	45.3	37.6
Arrests ages 0-19[c]	-	-	-	-	-	-	-	-	-	-	-	-
Dropout rate grades 9-12 (%)	16.0	23.0	14.0	21.0	17.0	9.0	9.0	8.0	10.0	10.0	13.7	14.0
Mothers with less than 12 years of school[d] (%)	16.3	16.1	15.2	15.0	14.5	13.8	20.3	13.0	15.9	19.0	15.9	12.9
Prevalence of activities (%)												
Binge alcohol use in the past month ages 18-64	22.6	20.8	22.4	22.3	16.5	19.6	16.8	15.7	19.3	17.7	19.4	20.8
Marijuana use in the past month[e]												
Ages 12-17	7.6	8.3	9.6	8.1	7.1	8.1	5.9	5.9	7.1	6.4	7.4	7.4
Ages 18-25	16.8	20.8	19.0	18.3	14.6	18.2	12.8	12.8	15.5	17.2	16.6	16.7
Ages 26 and older	4.0	5.7	5.4	5.2	3.4	4.4	3.1	3.1	3.5	3.9	4.2	4.1

(continued)

Appendix Table C.36 (continued)

Indicator of Risk	Target Counties										Target County Average	State Average
	Clark	Franklin	Hamilton	Lucas	Marion	Montgomery	Pike	Ross	Trumbull	Vinton		
Prevalence of activities (%)												
Nonmedical use of pain relievers in the past year[e,f]												
Ages 12-17	8.2	8.0	7.0	7.5	7.4	8.8	8.7	8.7	8.4	8.5	8.1	7.6
Ages 18-25	16.3	17.0	13.7	13.2	15.2	17.7	14.8	14.8	15.8	14.1	15.3	14.9
Ages 26 and older	3.7	4.6	3.1	3.2	3.6	3.9	4.1	4.1	3.6	3.8	3.8	3.6
Other illicit drug use[e]												
Ages 12-17	4.7	4.5	4.3	4.2	4.5	4.7	4.9	4.9	4.8	4.7	4.6	4.5
Ages 18-25	8.5	8.2	8.7	7.3	9.2	9.1	8.1	8.1	8.5	8.6	8.4	8.3
Ages 26 and older	2.6	3.2	2.6	2.3	2.5	2.8	2.6	2.6	2.3	2.5	2.6	2.5
Residents unemployed and seeking work (%)	9.9	8.2	8.9	11.3	10.2	11.0	14.7	11.5	13.5	11.3	11.1	10.4
Child maltreatment ages 0-17[g]	9.0	7.8	9.7	9.3	13.0	10.6	15.1	16.3	6.5	11.7	10.9	9.0
Number of child maltreatment allegations by type[h]												
Neglect	294	3,932	1,575	1,978	362	1,891	116	157	136	42	1,048	-
Physical abuse	300	3,914	3,109	2,254	159	1,095	34	247	320	14	1,145	-
Sexual abuse	170	1,537	764	644	118	349	24	88	243	13	395	-
Emotional abuse	10	73	9	50	4	481	0	6	0	4	64	-
Domestic violence caseload[i]	5.4	1.7	2.2	2.7	1.8	3.2	2.7	1.9	1.6	32.2	5.5	2.1

(continued)

Appendix Table C.36 (continued)

Indicator of Risk	Target Counties										Target County Average	State Average
	Clark	Franklin	Hamilton	Lucas	Marion	Montgomery	Pike	Ross	Trumbull	Vinton		
Other indicators[j] (%)												
Birth spacing less than 18 months	15.2	15.0	13.2	15.5	14.3	12.5	17.2	14.5	15.2	12.9	14.6	13.4
No intent to breastfeed	42.9	35.8	37.6	41.4	50.6	33.5	57.2	51.2	43.3	56.4	45.0	37.2
Any medical risk during pregnancy	13.9	23.3	29.8	23.6	14.7	29.3	23.2	23.8	21.1	26.4	22.9	24.2
No prenatal care in the 1st trimester	35.9	33.5	36.9	29.9	30.9	25.4	26.8	27.0	33.5	26.9	30.7	29.0
Smoked during pregnancy	25.9	15.3	15.5	19.7	32.0	17.9	30.1	29.9	26.7	32.9	24.6	19.3
Single women who are mothers	53.0	43.9	50.7	52.0	49.9	49.2	46.6	45.9	47.0	41.3	48.0	41.8
Children ages 0-17 in foster care	8.6	12.8	10.3	16.1	5.6	10.1	8.9	10.7	5.8	16.6	10.6	9.2
Children ages 0-5 with elevated lead levels	1.6	0.5	1.5	2.6	1.4	0.7	1.0	0.9	0.8	0.0	1.1	1.5

SOURCES: Ohio 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Per 1,000 live births.

[b]Per 1,000 residents.

[c]Data were not reported for this indicator in this state.

[d]The Ohio needs assessment reported the percentage of mothers ages 20 and older with less than 12 years of school as its "other school drop-out rate."

[e]Data were not available at the county level. Data included in this table are for the Substance Abuse and Mental Health Services Administration (SAMHSA) regions to which each target county belongs.

[f]Instead of reporting the rate of nonmedical use of prescription drugs in the past month, the Ohio needs assessment reported the rate of nonmedical use of pain relievers in the past year.

[g]The Ohio needs assessment reported the number of substantiated abused/neglected children per 1,000 children ages 0-17.

[h]The Ohio needs assessment reported the number of child maltreatment allegations by type. The state average for this indicator was not reported.

[i]The Ohio needs assessment reported the domestic violence caseload per 1,000 residents as its metric for domestic violence.

[j]The Ohio needs assessment reported on a large number of other indicators. This table includes a sample of those indicators.

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Appendix Table C.37

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Oklahoma

Indicator of Risk	Target Counties						Target County Average	State Average
	Garfield	Kay	Comanche	Muskogee	Oklahoma	Tulsa		
Live births before 37 weeks of gestation (%)	11.1	10.3	10.8	11.3	10.4	11.4	10.9	10.7
Total live births less than 2,500 grams (%)	8.0	7.2	8.5	8.6	8.9	8.2	8.2	8.2
Infant deaths ages 0-1[a]	10.4	7.8	7.6	6.2	8.9	8.0	8.2	8.0
Residents living below the federal poverty level (%)	16.7	17.2	18.3	19.7	16.1	13.6	16.9	15.7
Reported crimes[b]	47.9	40.6	57.7	42.0	59.7	53.9	50.3	40.5
Arrests ages 0-19[c]	809	1962	826	601	911	733	974	617
Dropout rate grades 9-12 (%)	1.6	6.7	2.6	3.7	3.1	4.5	3.7	3.3
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-	-	-
Prevalence of activities ages 12+[e] (%)								
Binge alcohol use in the past month	21.8	21.6	21.8	19.3	22.8	20.9	21.4	21.5
Marijuana use in the past month	4.5	4.2	4.5	4.3	6.7	4.8	4.8	4.8
Nonmedical use of pain relievers in the past year[f]	6.9	6.8	6.9	7.9	7.9	7.1	7.3	7.3
Other illicit drug use in the past month	4.8	4.3	4.8	4.8	4.5	4.9	4.7	4.6
Residents unemployed and seeking work (%)	5.2	8.4	6.5	8.3	7.0	7.7	7.2	6.8
Child maltreatment ages 0-17[g]	11.4	26.7	9.0	19.9	18.2	9.4	15.8	14.5
Child maltreatment by type[d]	-	-	-	-	-	-	-	-
Domestic violence offenses[h]	21.7	9.2	13.7	11.7	7.5	9.2	12.2	6.8

(continued)

Appendix Table C.37 (continued)

SOURCES: Oklahoma 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]Per 1,000 live births.
[b]Per 1,000 residents.
[c]Per 100,000 juveniles ages 0-19.
[d]Data were not reported for this indicator in this state.
[e]Data were not available at the county level. Data included in this table are for the Substance Abuse and Mental Health Services Administration (SAMHSA) regions to which each target county belongs.
[f]Instead of reporting the rate of nonmedical use of prescription drugs in the past month, the Oklahoma needs assessment reported the rate of nonmedical use of pain relievers in the past year.
[g]The Oklahoma needs assessment reported the number of child abuse and neglect confirmations per 1,000 children ages 0-17.
[h]The Oklahoma needs assessment reported the number of domestic violence offenses between family and household members per 1,000 residents as its metric for domestic violence.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.38

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Oregon

	Target Communities[a]								Target Community	State
					Morrow/Umatilla					
Indicator of Risk	Jefferson	Lane[b]	Lincoln	Malheur	Morrow	Umatilla	Multnomah[b]	Tillamook[b]	Average	Average
Live births before 37 weeks of gestation (%)	15.5	-	9	9.7	12	9.1	-	-	11.2	9.7
Total live births less than 2,500 grams (%)	9.2	-	6.7	4.2	1.6	3.7	-	-	5.7	6.2
Infant deaths ages 0-1[c]	9.5	-	6.4	0.0	16.0	4.3	-	-	6.5	5.2
Residents living below the federal poverty level (%)	16.4	-	16.7	21.3	14.2	15.2	-	-	17.3	13.5
Reported crimes[d]	287	-	366	346	262	324	-	-	323	347
Arrests ages 0-19[e]	13.4	-	18.0	28.9	13.4	20.9	-	-	19.4	14.7
Dropout rate grades 9-12 (%)	5.0	-	5.0	3.8	3.7	2.8	-	-	4.3	3.4
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-	-	-	-	-	-	-
Substance abuse[g]										
Abusing or dependent on alcohol or illicit drugs (%)	8.3	-	7.8	8.2	8.4	8.3	-	-	8.2	8.3
Residents unemployed and seeking work (%)	14.7	-	10.4	10.8	9.3	9.5	-	-	11.3	11.1
Child maltreatment[h]	12.7	-	23.2	21.5	17.4	15.6	-	-	18.5	12.5

(continued)

Appendix Table C.38 (continued)

Indicator of Risk	Target Communities[a]								Target Community Average	State Average
	Jefferson	Lane[b]	Lincoln	Malheur	Morrow/Umatilla: Morrow	Morrow/Umatilla: Umatilla	Multnomah[b]	Tillamook[b]		
Child maltreatment by type[f]	-	-	-	-	-	-	-	-	-	-
Experienced abuse before or during pregnancy[i]	4.5	-	9.8	10.8	9.6	9.2	-	-	8.6	5.0

SOURCES: Oregon 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]The Oregon FY 2011 state plan and competitive grant application identified seven target communities: six individual counties and one group of two counties.

[b]Data were not reported for this target community because it was not identified as an "at-risk community" in the Oregon needs assessment.

[c]Per 1,000 live births.

[d]Instead of reporting the total number of crimes per 1,000 residents, the Oregon needs assessment reported the total number of crimes per 10,000 residents.

[e]Instead of reporting the rate of juvenile crime arrests per 100,000 juveniles ages 0-19, the Oregon needs assessment reported the rate of juvenile arrests per 1,000 juveniles ages 0-19.

[f]Data were not reported for this indicator in this state.

[g]Instead of reporting the prevalence rates of binge alcohol use, marijuana use, nonmedical use of prescription drugs, and other illicit drug use in the past month, the Oregon needs assessment reported the percentage of people abusing or dependent on alcohol or illicit drugs.

[h]The Oregon needs assessment reported the child victim rate per 1,000 children.

[i]The Oregon needs assessment reported the percentage of women experiencing abuse before or during pregnancy as its metric for domestic violence.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.39

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Pennsylvania

	Target Communities[a]							
		Clarion/Jefferson		Cameron/Clinton/McKean			Dauphin/Perry	
Indicator of Risk	Berks	Clarion	Jefferson	Cameron	Clinton	McKean	Dauphin	Perry
Live births before 37 weeks of gestation	11.0	13.1	12.8	7.5	11.0	13.6	12.7	9.8
Total live births less than 2,500 grams (%)	8.0	6.9	7.2	3.4	8.0	11.5	9.5	7.0
Infant deaths ages 0-1[a]	7.0	4.8	11.7	-	7.1	6.4	9.8	11.1
Residents living below the federal poverty level (%)	11.3	14.4	12.6	13.0	16.0	17.7	10.8	9.3
Reported crimes[b]	55.9	52.6	33.5	59.4	46.5	59.8	75.9	52.7
Juvenile disposition rate[c]	3.6	3.6	2.9	4.5	1.5	2.5	5.3	2.6
Dropout rate grades 7-12[d] (%)	2.2	1.2	1.7	1.5	0.5	1.1	1.8	1.5
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-
Substance abuse								
Alcohol violation rate[f]	542	771	524	2,085	857	893	961	364
Drug violation rate[g]	341	726	118	227	189	192	853	285
Residents unemployed and seeking work (%)	10.2	11.1	11.1	17.3	10.3	11.0	8.7	9.7
Child maltreatment ages 0-17[h]	1.2	3.6	2.0	2.8	2.8	5.8	2.1	1.4
Child maltreatment ages 0-17 by type[e]	-	-	-	-	-	-	-	-

(continued)

Appendix Table C.39 (continued)

Indicator of Risk	Target Communities[a]					Target Community Average	State Average
			Crawford/Forest/Venango				
	Erie	Mifflin	Crawford	Forest	Venango		
Live births before 37 weeks of gestation	11.8	8.9	9.6	15.1	10.1	11.2	10.3
Total live births less than 2,500 grams (%)	8.6	6.7	7.6	12.5	6.9	7.9	8.3
Infant deaths ages 0-1[a]	10.3	9.8	6.3	-	3.3	8.2	7.3
Residents living below the federal poverty level (%)	14.6	13.1	15.9	24.2	15.4	13.8	12.1
Reported crimes[b]	49.4	57.6	35.6	36.9	56.5	52.6	53.0
Juvenile disposition rate[c]	3.1	2.3	3.1	6.9	2.5	3.3	3.3
Dropout rate grades 7-12[d] (%)	1.5	1.6	1.3	-	1.4	1.5	1.6
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-
Substance abuse							
Alcohol violation rate[f]	769	835	723	303	836	765	665
Drug violation rate[g]	227	379	207	83	346	336	302
Residents unemployed and seeking work (%)	10.6	11.2	10.8	12.6	10.1	10.9	9.3
Child maltreatment ages 0-17[h]	2.1	2.3	2.4	2.0	3.0	2.3	1.4
Child maltreatment ages 0-17 by type[e]	-	-	-	-	-	-	-

(continued)

Appendix Table C.39 (continued)

Indicator of Risk	Berks	Target Communities[a]						
		Clarion/Jefferson		Cameron/Clinton/McKean			Dauphin/Perry	
		Clarion	Jefferson	Cameron	Clinton	McKean	Dauphin	Perry
Domestic violence[i,j]								
Domestic violence victim fatalities	1.2	0.0	4.5	0.0	0.0	0.0	0.8	0.0
Offenses against families and children	18.2	7.6	4.5	-	2.7	27.8	23.6	13.2
Other indicators[k]								
Very low birth weight[j] (%)	1.6	1.9	1.0	0.0	0.9	1.1	1.9	1.1
Births to mothers receiving prenatal care in the 1st trimester (%)	77.4	78.3	70.7	84.2	77.5	87.9	76.6	75.3
Live births to mothers with gestational diabetes (%)	7.1	10.6	5.7	9.7	2.5	3.9	3.7	3.4
Births to mothers ages 15-17[l]	21.4	8.2	12.9	6.6	13.1	14.0	22.3	17
Births to mothers who did not smoke during pregnancy (%)	84.8	76.1	73.3	61.1	76.0	63.3	82.8	75.8
Students eligible for free and reduced-price lunch[j] (%)	38.9	39.1	41.7	49.0	49.3	43.9	41.2	31.6
Births to mothers with less than a high school education	22.3	20.3	23.0	12.5	24.2	16.9	18.3	16
Child maltreatment ages 0-4[m]	0.9	2.5	1.2	3.6	0.9	9.7	1.5	0.7

(continued)

Appendix Table C.39 (continued)

Indicator of Risk	Target Communities[a]					Target Community Average	State Average
			Crawford/Forest/Venango				
	Erie	Mifflin	Crawford	Forest	Venango		
Domestic violence[i,j]							
Domestic violence victim fatalities	0.4	0.0	0.0	0.0	0.0	0.6	-
Offenses against families and children	6.4	2.2	9.0	14.8	1.9	10.7	-
Other indicators[k]							
Very low birth weight[j] (%)	2.1	1.3	1.5	3.1	0.5	1.5	-
Births to mothers receiving prenatal care in the 1st trimester (%)	80.3	71.1	76.4	78.6	75.5	77.0	79.7
Live births to mothers with gestational diabetes (%)	5.9	4.9	5.4	9.1	5.7	6.0	4.2
Births to mothers ages 15-17[l]	22.8	19.4	8.0	0.0	16.2	15.9	16.1
Births to mothers who did not smoke during pregnancy (%)	71.7	77.2	74.0	69.7	66.0	74.9	82.7
Students eligible for free and reduced-price lunch[j] (%)	50.2	44.9	44.3	49.8	48.9	43.8	-
Births to mothers with less than a high school education	16.3	36.1	24.7	3.1	15.6	20.4	16.1
Child maltreatment ages 0-4[m]	2.4	1.3	1.5	0.0	2.6	1.9	1.2

(continued)

Appendix Table C.39 (continued)

SOURCES: Pennsylvania 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The Pennsylvania needs assessment identified individual counties and groups of counties as its target communities.

[a]Per 1,000 live births. Data were not reported for this indicator for some target counties in this state.

[b]Per 1,000 residents.

[c]Instead of reporting the number of arrests per 100,000 juveniles ages 0-19, the Pennsylvania needs assessment reported the juvenile disposition rate per 1,000 juveniles.

[d]Instead of reporting the percentage of high school dropouts grades 9-12, the Pennsylvania needs assessment reported the percentage of school dropouts grades 7-12. Data were not reported for this indicator for some target counties in this state.

[e]Data were not reported for this indicator in this state.

[f]Instead of reporting the prevalence of binge alcohol use in the past month, the Pennsylvania needs assessment reported the alcohol violation rate (arrests per 100,000 residents).

[g]Instead of reporting the prevalence of marijuana use, nonmedical use of prescription drugs, and other illicit drug use in the past month, the Pennsylvania needs assessment reported the drug violation rate (arrests per 100,000 residents).

[h]The Pennsylvania needs assessment reported the number of substantiated cases of child abuse and neglect per 1,000 children ages 0-17.

[i]The Pennsylvania needs assessment reported the rates of domestic violence victim fatalities per 100,000 and arrests for offenses against families and children per 100,000 as its metrics for domestic violence. Data were not reported for this indicator for some target counties in this state.

[j]The state average for this indicator was not reported.

[k]The Pennsylvania needs assessment reported on a large number of other indicators. This table includes a sample of those indicators.

[l]Per 1,000 women ages 15-17.

[m]Per 1,000 children ages 0-4.

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Appendix Table C.40

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Rhode Island

Indicator of Risk	Target Communities[a]						Target Community Average	State Average
	Central Falls	Pawtucket	Providence	Woonsocket	Newport	West Warwick		
Live births before 37 weeks of gestation (%)	12.0	12.1	13.8	13.8	11.9	10.9	12.4	11.9
Total live births less than 2,500 grams (%)	6.9	8.5	9.4	10.0	8.0	7.0	8.3	8.0
Infant deaths ages 0-1[b]	8.4	6.7	9.3	5.1	4.0	4.0	6.3	6.2
Residents living below the federal poverty level (%)	29.0	16.8	29.1	19.4	14.4	11.2	20.0	11.9
Reported crimes[c]	32.3	38.6	59.8	36.4	48.4	25.2	40.1	30.2
Arrests for assault and weapons offenses ages 0-18[d]	380	556	771	347	601	347	500	395
Dropout rate grades 9-12 (%)	33.0	21.0	22.0	24.0	11.0	20.0	21.8	14.0
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-
Prevalence of activities ages 18+[f]								
Binge alcohol use in the past month	-	-	-	-	-	-	-	18.2
Marijuana use in the past month	-	-	-	-	-	-	-	11.1
Nonmedical use of	-	-	-	-	-	-	-	6.3
pain relievers in the past year[g]	-	-	-	-	-	-	-	
Other illicit drug use in the past month	-	-	-	-	-	-	-	5.9
Residents unemployed and seeking work (%)	14.4	13.4	13.3	13.3	10.4	12.0	12.8	11.2
Child maltreatment ages 0-17[h]	19.3	17.6	14.1	26.6	17.3	21.7	19.4	11.7

(continued)

Appendix Table C.40 (continued)

Indicator of Risk	Target Communities[a]						Target Community Average	State Average
	Central Falls	Pawtucket	Providence	Woonsocket	Newport	West Warwick		
Number of indicated allegations ages 0-17 by type[i]								
Neglect	142	439	1,000	435	151	219	398	-
Physical abuse	43	133	385	120	53	58	132	-
Sexual abuse	12	27	78	25	8	10	27	-
Other	<5	10	26	11	8	<5	14	-
Domestic violence arrests[j]	9.6	7.4	4.8	8.9	6.6	11.3	8.1	5.0
Other indicators								
Any breastfeeding[k] (%)	73.0	70.0	73.0	55.0	76.0	58.0	67.5	70.0
Children born at "high risk"[l] (%)	10.0	7.0	9.0	10.0	6.0	4.0	7.7	5.0
Births to women ages 15-19[m]	95.5	58.7	48.0	65.2	25.1	39.1	55.3	30.7
Number of children ages 0-17 receiving Supplemental Nutrition Assistance Program (SNAP) benefits[n]	2,917	5,790	20,771	4,696	1,202	1,472	6,141	-
Eligible women and children in the Women, Infants, and Children Program (WIC)[o] (%)	77.0	78.0	80.0	87.0	79.0	70.0	78.5	77.0
Children with lead poisoning[p] (%)	4.8	3.3	5.1	3.1	1.2	0.5	3.0	2.4

(continued)

Appendix Table C.40 (continued)

SOURCES: Rhode Island 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]The target communities identified by Rhode Island are cities.
[b]Per 1,000 live births.
[c]Per 1,000 residents.
[d]Instead of reporting the number of arrests per 100,000 juveniles ages 0-19, the Rhode Island needs assessment reported the number of arrests for assault and weapons offenses per 100,000 juveniles ages 0-18.
[e]Data were not reported for this indicator in this state.
[f]Data were not reported for this indicator for any target communities in this state.
[g]Instead of reporting the rate of nonmedical use of prescription drugs in the past month, the Rhode Island needs assessment reported the rate of nonmedical use of pain relievers in the past year.
[h]The Rhode Island needs assessment reported the number of maltreatment victims per 1,000 children ages 0-17.
[i]Number of indicated allegations of each type of maltreatment. The state average for this indicator was not reported.
[j]The Rhode Island needs assessment reported the number of domestic violence incidents resulting in arrests per 1,000 people as its metric for domestic violence.
[k]Percentage of mothers with any breastfeeding out of the total number screened.
[l]High risk is defined by the presence of three maternal risk factors: unmarried, teenager, and less than a high school education.
[m]Per 1,000 women ages 15-19.
[n]The state average for this indicator was not reported.
[o]Percentage of eligible women and children participating in WIC.
[p]Percentage of children confirmed with blood lead level greater than or equal to 10 mcg/dL among children entering kindergarten who were tested.

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Appendix Table C.41

Indicators of Community Risk in Communities Chosen for MIECHV Funding: South Carolina

	Target Communities[a]						
	Catchment Area 1		Catchment Area 2				
Indicator of Risk	Greenville	Pickens	Greenwood	Abbeville	McCormick	Edgefield	Saluda
Live births before 37 weeks of gestation (%)	10.7	11.6	16.3	14.9	13.2	9.4	12.9
Total live births less than 2,500 grams (%)	8.9	9.0	10.5	10.6	11.2	9.5	6.2
Infant deaths ages 0-1[b]	6.6	4.5	13.1	18.2	18.7	9.6	4.8
Residents living below the federal poverty level (%)	18.5	17.9	24.1	22.7	37.8	24.0	24.7
Violent crimes[c]	7.2	3.5	9.0	6.4	12.9	2.7	5.7
Arrests ages 0-17[d]	104.0	70.0	91.0	57.0	68.0	20.0	25.0
Dropout rate grades 9-12 (%)	17.5	26.0	21.8	22.9	30.5	23.5	24.5
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-
Prevalence of activities in the past month[f] (%)							
Binge alcohol use	18.3	18.3	21.9	21.9	21.9	21.9	21.9
Marijuana use	5.3	5.3	5.4	5.4	5.4	5.4	5.4
Nonmedical use of prescription drugs	5.3	5.3	5.2	5.2	5.2	5.2	5.2
Other illicit drug use	3.8	3.8	4.0	4.0	4.0	4.0	4.0
Residents unemployed and seeking work (%)	13.3	11.7	14.2	16.7	24.3	12.3	11.0
Child maltreatment ages 0-17[g]	7.0	11.0	2.8	5.2	4.0	2.9	6.5
Reported incidents of domestic violence[h]	5.5	6.2	15.7	4.9	34.2	7.4	5.6

(continued)

Appendix Table C.41 (continued)

Indicator of Risk	Target Communities[a]					Target Community Average	State Average
	Catchment Area 3			Catchment Area 4			
	Berkeley	Charleston	Dorchester	Union	Spartanburg		
Live births before 37 weeks of gestation (%)	11.9	12.6	11.6	13.8	11.8	12.3	12.4
Total live births less than 2,500 grams (%)	9.5	8.9	8.8	11.8	9.8	9.6	10.2
Infant deaths ages 0-1[b]	8.7	11.7	4.4	8.8	7.8	8.7	8.8
Residents living below the federal poverty level (%)	19.8	21.6	14.2	26.4	19.6	21.6	15.7
Violent crimes[c]	5.0	9.1	4.8	8.3	6.5	6.6	7.3
Arrests ages 0-17[d]	102.0	168.0	75.0	52.0	59.0	77.4	106.2
Dropout rate grades 9-12 (%)	24.1	27.4	26.6	28.7	26.9	25.1	30.1
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-
Prevalence of activities in the past month[f] (%)							
Binge alcohol use	23.1	23.1	23.1	18.5	18.5	20.4	20.8
Marijuana use	5.3	5.3	5.3	5.3	5.3	5.3	5.3
Nonmedical use of prescription drugs	4.5	4.5	4.5	5.3	5.3	5.1	4.9
Other illicit drug use	3.2	3.2	3.2	3.8	3.8	3.7	3.5
Residents unemployed and seeking work (%)	13.3	10.6	10.9	22.1	13.8	14.4	12.6
Child maltreatment ages 0-17[g]	7.2	7.3	4.7	9.9	5.5	6.8	5.9
Reported incidents of domestic violence[h]	7.9	6.0	7.3	6.4	5.8	8.1	8.9

(continued)

Appendix Table C.41 (continued)

Indicator of Risk	Target Communities[a]						
	Catchment Area 1		Catchment Area 2				
	Greenville	Pickens	Greenwood	Abbeville	McCormick	Edgefield	Saluda
Child maltreatment by type (%)							
Educational neglect	1.7	8.6	1.7	0.0	0.0	10.0	2.6
Medical neglect	5.9	3.0	3.3	0.0	16.7	10.0	0.0
Neglect	69.6	73.8	61.7	70.8	66.7	30.0	66.7
Physical abuse	16.2	8.8	23.3	29.2	16.7	30.0	12.8
Sexual abuse	6.1	1.7	3.3	0.0	0.0	0.0	15.4
Other	0.5	4.1	6.7	0.0	0.0	20.0	2.6
Other indicators (%)							
3rd-graders with low school readiness in English and language arts[i]	12.4	9.6	17.9	9.1	14.3	12.8	17.2
3rd-graders with low school readiness in math[i]	18.3	16.6	26.5	14.5	27.6	23.7	28.9
Live births to first-time Medicaid mothers	19.6	19.5	27.2	21.6	34.7	16.5	16.5

Indicator of Risk	Target Communities[a]					Target Community Average	State Average
	Catchment Area 3			Catchment Area 4			
	Berkeley	Charleston	Dorchester	Union	Spartanburg		
Child maltreatment by type (%)							
Educational neglect	5.5	3.9	8.7	7.0	3.7	4.8	4.8
Medical neglect	2.5	3.6	1.6	3.5	3.2	4.1	4.1
Neglect	64.1	64.9	67.1	54.4	68.9	64.5	67.6
Physical abuse	23.6	23.8	16.7	29.8	17.4	20.0	16.8
Sexual abuse	3.4	1.9	4.4	3.5	4.9	3.8	4.2
Other	0.9	1.9	1.6	1.8	1.9	2.9	2.4
Other indicators (%)							
3rd-graders with low school readiness in English and language arts[i]	11.8	12.4	9.0	10.2	12.5	11.9	13.3
3rd-graders with low school readiness in math[i]	23.4	22.2	17.0	20.7	19.7	20.7	22.8
Live births to first-time Medicaid mothers	18.7	16.3	18.6	28.2	18.7	21.0	19.9

(continued)

Appendix Table C.41 (continued)

SOURCES: South Carolina 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: The South Carolina needs assessment reported on a number of other indicators. This table includes a sample of those indicators.

[a]The South Carolina needs assessment identified four catchment areas, each composed of several counties, as its target communities.

[b]Per 1,000 live births.

[c]Per 1,000 residents.

[d]Per 100,000 juveniles ages 0-17.

[e]Data were not reported for this indicator in this state.

[f]Data were not available at the county level. Data included in this table are for the Substance Abuse and Mental Health Service Administration (SAMHSA) region to which each target county belongs.

[g]The South Carolina needs assessment provided the rate of the reported and substantiated child maltreatment per 1,000 children ages 0-17.

[h]The South Carolina needs assessment provided the reported incidents of domestic violence per 1,000 residents as its metric for domestic violence. To calculate this number, the South Carolina needs assessment used the number of reported incidents of domestic violence from the South Carolina Coalition Against Domestic Violence and Sexual Assault and population estimates. These should not be considered official state rates.

[i]Low school readiness was measured by the percentage of third-graders performing below "basic" on the Palmetto Achievement Challenge Tests (PACT) in English and language arts and in math.

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Appendix Table C.42

Indicators of Community Risk in Communities Chosen for MIECHV Funding: South Dakota

Indicator of Risk	Target Communities[a]				Target Community Average	State Average
	Kyle	Pine Ridge	Martin	Wanblee		
Live births before 37 weeks of gestation (%)	19.0	19.0	9.5	16.9	16.1	11.6
Total live births less than 2,500 grams[b] (%)	7.1	7.1	-	4.1	6.1	6.5
Infant deaths ages 0-1[b,c]	32.7	32.7	0.0	-	21.8	8.3
Residents living below the federal poverty level (%)	46.0	46.0	33.8	32.4	39.6	12.7
Reported homicides[d]	24.0	24.0	8.0	10.0	16.5	3.0
Arrests ages 0-19[e]	-	-	-	-	-	-
9th-graders who do not graduate high school in 4 years[b,f] (%)	-	-	23.8	28.6	26.2	15.5
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-
Prevalence of activities in the past month (%)						
Binge alcohol use	26.0	26.0	26.0	18.1	24.0	18.0
Marijuana use by youth[g]	-	-	-	-	-	21.0
Nonmedical use of prescription drugs[e]	-	-	-	-	-	-
Other illicit drug use by youth[g,h]	-	-	-	-	-	3.0-5.0
Residents unemployed and seeking work (%)	10.7	10.7	5.3	6.7	8.4	4.8
Child maltreatment[g,i] (%)	-	-	-	-	-	0.7

(continued)

Appendix Table C.42 (continued)

Indicator of Risk	Target Communities[a]				Target Community Average	State Average
	Kyle	Pine Ridge	Martin	Wanblee		
Child maltreatment by type[g] (%)						
Neglect	-	-	-	-	-	87.3
Physical	-	-	-	-	-	10.3
Psychological	-	-	-	-	-	2.0
Sexual	-	-	-	-	-	5.2
Clients served for domestic violence-related cases[g,j] (%)	-	-	-	-	-	1.5
Other indicators (%)						
Inhalant use by youth[f]	-	-	-	-	-	13.0
Children living in poverty	50.4	50.4	47.1	46.4	48.6	17.5
Single-parent households	28.7	28.7	15.9	12.7	21.5	8.3
Teen births[k]	120	120	79	84	101	38
Inadequate social support[l]	33.8	33.8	19.3	25.3	28.0	17.3

SOURCES: South Dakota 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: The South Dakota needs assessment reported data for the counties in which the target communities are located: Kyle and Pine Ridge are in Shannon County, Martin is in Bennett County, and Wanblee is in Jackson County.

[a]The South Dakota FY 2010 and FY 2011 state plans identified three Census-Designated Places (Kyle, Pine Ridge, and Wanblee) and one city (Martin) as its target communities, all of which are located on or adjacent to Pine Ridge Indian Reservation.

[b]Data were not reported for this indicator in one county.

[c]Per 1,000 live births.

[d]Instead of the number of reported crimes per 1,000 residents, the South Dakota needs assessment provided the homicide death rate per 100,000 residents.

[e]Data were not reported for this indicator in this state.

[f]Instead of reporting the dropout rate for grades 9-12, the South Dakota needs assessment reported the percentage of ninth-graders who do not graduate high school in four years.

[g]Data were not reported for this indicator for any counties in this state.

[h]The South Dakota needs assessment presented a range for this indicator.

[i]The South Dakota needs assessment provided a percentage as its child maltreatment indicator without additional information.

[j]The South Dakota needs assessment reported clients served for domestic violence-related cases as a percentage of all residents as its metric for domestic violence.

[k]Per 1,000 female population.

[l]According to the South Dakota needs assessment, this indicator is derived from the Behavioral Risk Factor Surveillance System (BRFSS).

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Appendix Table C.43

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Tennessee

Indicator of Risk	Target Counties						Target County Average	State Average
	Hamilton	Davidson	Maury	Campbell	Shelby	Montgomery		
Live births before 37 weeks of gestation (%)	14.8	11.5	11.6	13.7	13.2	10.2	12.5	12.2
Total live births less than 2,500 grams (%)	11.1	9.3	9.8	9.4	11.3	8.4	9.9	9.5
Infant deaths ages 0-1[a]	9.5	7.7	7.3	6.6	12.6	8.0	8.6	8.5
Residents living below the federal poverty level (%)	12.1	13.0	14.1	22.8	16.0	10.0	14.7	13.5
Reported crimes[b]	106.2	136.1	109.2	121.8	149.9	96.3	119.9	95.4
Arrests ages 0-17[c]	1,682	1,427	2,504	404	2,915	1,630	1,760	1,541
Students in grades 9-12 who dropped out of school during the school year[d] (%)	6.5	5.9	4.3	4.1	8.5	1.5	5.1	3.5
Students from the 9th-grade cohort who dropped out of school before graduating[e] (%)	16.8	16.8	15.1	10.5	14.4	5.5	13.2	10.2
Prevalence of activities in the past month (%)								
Binge alcohol use age 18+	12.2	8.9	12.6	7.5	13.0	10.7	10.8	10.5
Marijuana use[f]	-	-	-	-	-	-	-	-
Nonmedical use of prescription drugs[f]	-	-	-	-	-	-	-	-
Other illicit drug use[f]	-	-	-	-	-	-	-	-
Total illicit drug use age 12+[g]	8.6	11.1	8.4	8.1	8.9	8.4	8.9	8.5
Residents unemployed and seeking work (%)	9.0	9.0	15.3	12.7	10.3	8.5	10.8	10.5
Child maltreatment ages 0-17[h] (%)	2.5	8.0	5.1	13.8	8.6	8.8	7.8	7.6

(continued)

Appendix Table C.43 (continued)

Indicator of Risk	Target Counties						Target County Average	State Average
	Hamilton	Davidson	Maury	Campbell	Shelby	Montgomery		
Child maltreatment by type[f]	-	-	-	-	-	-	-	-
Violent domestic violence crimes[i]	1,023	2,143	2,068	1,228	2,442	1,506	1,735	1,367
Other indicators								
Live births to women who smoked during the 3rd trimester (%)	12.9	9.3	18.4	31.1	6.0	15.6	15.6	16.0
Teen pregnancy rate[j]	36.5	52.1	29.4	29.9	52.3	29.8	38.3	33.9

SOURCES: Tennessee 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Per 1,000 live births.

[b]Per 1,000 residents.

[c]Instead of reporting the number of arrests per 100,000 juveniles ages 0-19, the Tennessee needs assessment reported the number of arrests per 100,000 juveniles ages 0-17.

[d]Instead of reporting the percentage of high school dropouts grades 9-12, the Tennessee needs assessment reported the percentage of students in grades 9-12 who dropped out of school during the school year.

[e]The Tennessee needs assessment reported the percentage of students from the ninth-grade cohort who dropped out of school before graduating as its "other school dropout rate."

[f]Data were not reported for this indicator in this state.

[g]Instead of reporting separate statistics for different types of drug use, the Tennessee needs assessment reported this number, which includes marijuana use, nonmedical use of prescription drugs, and other illicit drug use.

[h]The Tennessee needs assessment reported the percentage of unique substantiated child abuse victims ages 0-17.

[i]The Tennessee needs assessment reported the number of violent crimes involving domestic violence per 100,000 residents as its metric for domestic violence.

[j]Per 1,000 females ages 15-17.

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Appendix Table C.44

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Texas

	Target Communities[a]									
Indicator of Risk	Amarillo	Dallas	Longview	Jacksonville	Odessa	McAllen	Corpus Christi	Lower Rio Grande Valley	Target Community Average	State Average
Live births before 37 weeks of gestation (%)	14.8	12.8	14.4	14.4	13.5	15.5	15.5	15.5	14.6	13.6
Total live births less than 2,500 grams (%)	9.7	8.0	8.6	8.6	8.8	8.2	8.2	8.2	8.5	8.4
Infant deaths ages 0-1[b]	7.7	6.8	6.8	6.8	5.6	6.0	6.0	6.0	6.5	6.2
Residents living below the federal poverty level (%)	15.9	13.5	13.7	13.7	20.9	29.2	29.2	29.2	20.7	15.8
Reported crimes[c]	47.6	42.0	36.1	36.1	35.7	52.6	52.6	52.6	44.4	45.0
Arrests ages 0-17[d]	38.0	22.3	16.7	16.7	40.5	33.7	33.7	33.7	29.4	26.9
Dropout rate grades 7-12[e] (%)	2.2	1.9	1.3	1.3	2.4	2.0	2.0	2.0	1.9	2.0
Longitudinal dropout rate for a 9th-grade cohort[f] (%)	9.3	9.0	7.4	7.4	11.1	10.1	10.1	10.1	9.3	9.4
Prevalence of activities[g] (%)										
Binge alcohol use in the past month	27.6	-	-	-	-	23.2	23.2	23.2	24.3	23.3
Marijuana use in the past month	5.2	-	-	-	-	3.0	3.0	3.0	3.6	3.6
Nonmedical use of pain relievers in the past year[h]	5.8	-	-	-	-	3.6	3.6	3.6	4.2	4.6
Other illicit drug use in the past month	3.8	-	-	-	-	3.2	3.2	3.2	3.4	3.6

(continued)

Appendix Table C.44 (continued)

Indicator of Risk	Target Communities[a]									
	Amarillo	Dallas	Longview	Jacksonville	Odessa	McAllen	Corpus Christi	Lower Rio Grande Valley	Target Community Average	State Average
Residents unemployed and seeking work (%)	5.6	7.7	8.0	8.0	8.1	9.4	9.4	9.4	8.2	7.6
Child maltreatment[i]	19.7	10.1	12.7	12.7	12.7	14.5	14.5	14.5	13.9	10.5
Child maltreatment by type[j]	-	-	-	-	-	-	-	-	-	-
Domestic violence[k]										
Family violence incidents	10.0	6.6	6.9	6.9	15.4	8.8	8.8	8.8	9.0	8.0
Clients served in shelters and nonresidential centers	6.0	2.9	4.5	4.5	3.9	3.9	3.9	3.9	4.2	3.2

SOURCES: Texas 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]The target communities identified by Texas are cities and the Lower Rio Grande Valley region. The Texas needs assessment reported indicators by Health Service Region (HSR) rather than by target community. In this table, target communities are given the value for their HSRs.

[b]Per 1,000 live births.

[c]Per 1,000 residents.

[d]Instead of reporting the number of arrests per 100,000 juveniles ages 0-19, the Texas needs assessment reported the number of arrests per 100,000 juveniles ages 0-17.

[e]Instead of reporting the percentage of high school dropouts grades 9-12 at the HSR level, the Texas needs assessment reported the percentage of school dropouts grades 7-12. The state average for this indicator was not reported.

[f]The Texas needs assessment reported the percentage of students from the same class of beginning ninth-graders who drop out before completing their high school education as its "other school dropout rate."

[g]Data were not reported for this indicator for some HSRs in this state.

[h]Instead of reporting the rate of nonmedical use of prescription drugs in the past month, the Texas needs assessment reported the rate of nonmedical use of pain relievers in the past year.

[i]The Texas needs assessment reported the number of confirmed victims of child abuse/neglect per 1,000 children.

[j]Data were not reported for this indicator in this state.

[k]The Texas needs assessment reported the rate of family violence incidents per 1,000 residents and the number of clients served in shelters and nonresidential centers per 1,000 residents as its metrics for domestic violence.

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Appendix Table C.45

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Utah

Indicator of Risk	Target Counties					Target County Average	State Average
	Salt Lake	Weber	Washington	Carbon	Uintah		
Live births before 37 weeks of gestation (%)	9.9	11.1	10.5	13.6	13.5	11.7	9.7
Total live births less than 2,500 grams (%)	8.3	7.2	5.7	8.9	8.9	7.8	7.4
Infant deaths ages 0-1[a]	5.2	5.7	4.9	4.5	5.9	5.2	4.9
Residents living below the federal poverty level (%)	8.8	10.5	9.6	13.3	10.1	10.5	9.7
Reported crimes[b]	52.9	38.2	25.3	31.8	23.1	34.3	35.3
Arrests ages 0-19[c]	3,691	4,497	4,562	6,249	6,024	5,005	3,483
Dropout rate grades 9-12 (%)	4.0	5.0	2.0	1.0	7.0	3.8	2.0
Other school dropout rate per state/local calculation[d] (%)	-	-	-	-	-	-	-
Prevalence of activities (%)							
Binge alcohol use	17.5	17.5	14.0	14.0	15.4	15.7	15.8
Marijuana use	5.5	4.0	3.0	3.0	3.5	3.8	4.4
Nonmedical use of pain relievers[e]	6.6	7.0	5.0	5.0	6.3	6.0	6.3
Other illicit drug use	3.9	3.9	3.6	3.8	3.6	3.7	3.9
Residents unemployed and seeking work[f] (%)	-	-	-	-	-	-	7.2
Child maltreatment[g]	14.4	22.0	20.6	62.8	33.8	30.7	14.5

(continued)

Appendix Table C.45 (continued)

Indicator of Risk	Target Counties					Target County Average	State Average
	Salt Lake	Weber	Washington	Carbon	Uintah		
Child maltreatment by type[g]							
Medical neglect	0.1	0.0	0.0	0.0	0.0	0.0	0.0
Neglect	4.6	0.0	2.2	7.7	2.7	3.4	0.0
Nonsupervision	2.0	0.0	1.9	2.7	2.0	1.7	1.1
Other abuse	4.7	0.0	1.9	24.5	6.6	7.5	3.1
Physical abuse	4.0	0.0	0.3	9.6	1.9	3.2	2.1
Emotional/psychological abuse	2.6	0.0	0.8	9.8	1.7	3.0	1.7
Sexual abuse	3.3	0.0	1.3	6.4	2.9	2.8	2.4
Number of domestic violence events[h]	4,376	578	451	89	148	1,128	-
Other indicators							
Child witnessed domestic violence[i]	7.5	0.0	3.6	28.7	9.4	9.8	5.9
Prenatal care in the 1st trimester (%)	77.3	82.6	67.1	66.6	79.3	74.6	79.2
Teen pregnancy rate ages 15-19	40.3	50.3	36.4	45.8	60.0	46.5	33.9
Women reporting unintended pregnancies (%)	33.7	38.4	40.6	36.5	47.5	39.3	32.7
Inadequate social support (%)	17.0	15.0	16.0	17.0	13.0	15.6	15.0

(continued)

Appendix Table C.45 (continued)

SOURCES: Utah 2010 MIECHV needs assessment, and FY 2010 and FY 2011 state plans.

NOTES: The Utah needs assessment does not give information on the units for most of its reported indicators. Unless the needs assessment explicitly stated otherwise, this table assumes that the indicators were measured in the units as requested by the Supplemental Information Request. The other indicators at the bottom of the table are also sometimes missing detail on how they were measured.

[a]Per 1,000 live births.

[b]Per 1,000 residents.

[c]Per 100,000 juveniles ages 0-19.

[d]Data were not reported for this indicator in this state.

[e]Instead of reporting the rate of nonmedical use of prescription drugs in the past month, the Utah needs assessment reported the rate of nonmedical use of pain relievers.

[f]There appears to be a mistake in how the Utah needs assessment reported unemployment rates for counties, so those numbers were excluded from this table.

[g]The Utah needs assessment did not specify how its child maltreatment rate was calculated.

[h]The Utah needs assessment reported the number of domestic violence events as its metric for domestic violence. This includes measures such as number of crisis calls, protective orders granted, and domestic charges filed in court. The state average for this indicator was not reported.

[i]The Utah needs assessment did not specify units for this rate.

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Appendix Table C.46

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Vermont

	Target Communities[a]							Target	
			Northeast Kingdom[b]			Franklin/Grand Isle[c]		Community	State
Indicator of Risk	Rutland	Bennington	Caledonia	Essex	Orleans	Franklin	Grand Isle	Average	Average
Live births before 37 weeks of gestation (%)	10.0	12.5			9.4		-	10.6	9.4
Total live births less than 2,500 grams (%)	6.6	7.5			7.5		-	7.2	6.7
Infant deaths ages 0-1[d]	6.4	6.3			2.4		-	5.0	5.2
Residents living below 100% federal poverty level (%)	10.9	10.0			13.2		-	11.4	9.4
Reported crimes[e]	51.6	46.9			35.3		-	44.6	48.1
Juvenile delinquency charges ages 0-19[f]	1,482	1,538			1,149		-	1,390	1,104
Dropout rate grades 9-12 (%)	3.4	4.0			2.7		-	3.4	3.1
Dropout rate grades 7-12[g] (%)	-	-			-		-	-	2.2
Prevalence of activities									
Binge alcohol use in the past month ages 18+ (%)	16.1	14.9			17.5		-	16.2	17.3
Marijuana use in the past month ages 18+ (%)	6.3	4.6			5.6		-	5.5	7.8
Nonmedical use of prescription drugs in the past month ages 18+ (%)	1.3	1.0			1.0		-	1.1	1.4
Treated for substance abuse (other than alcohol and marijuana)[h]	57.1	26.9			56.5		-	46.8	43.8
Residents unemployed and seeking work (%)	8.3	8.0			8.7		-	8.3	6.9
Child maltreatment ages 0-17[i]	3.9	7.7			6.0		-	5.9	5.3

(continued)

Appendix Table C.46 (continued)

Indicator of Risk	Target Communities[a]							Target Community Average	State Average
			Northeast Kingdom[b]			Franklin/Grand Isle[c]			
	Rutland	Bennington	Caledonia	Essex	Orleans	Franklin	Grand Isle		
Child maltreatment ages 0-17 by type[i]									
Physical abuse	1.1	0.7			1.1		-	1.0	1.2
Sexual abuse	1.7	4.1			2.6		-	2.8	2.5
Risk of harm	1.2	2.3			3.0		-	2.2	2.5
Neglect	0.3	0.2			0.3		-	0.3	0.4
Domestic violence[j] (%)									
Threatened with or victim of attempted or actual physical intimate partner violence	18.7	14.2			19.5		-	16.5	17.1
Threatened with or victim of actual physical intimate partner violence	14.4	13.4			20.2		-	16.0	16.3
Other indicators									
Prenatal care in the 1st trimester (%)	80.7	82.5			83.9		-	82.4	83.2
Smoking during pregnancy (%)	24.6	25.0			22.4		-	24.0	18.7
Teen pregnancy[k]	42.2	51.2			45.5		-	46.3	32.6
Births to women ages 15-19[k]	22.8	35.9			31.9		-	30.2	21.4
Children born at high risk[l] (%)	6.9	11.6			7.3		-	8.6	6.1
Newborn infants diagnosed with drug withdrawal[d]	8.0	4.5			12.1		-	8.2	12.5
Emergency room visits by children[m]	425	407			394		-	409	334
Primary care physicians[n]	63.4	90.8			64.8		-	73.0	79.3
Uninsured (%)	8.5	7.6			9.3		-	8.5	7.6

(continued)

Appendix Table C.46 (continued)

SOURCES: Vermont 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The target communities identified by Vermont are sometimes counties and sometimes groups of counties.

[b]The Vermont needs assessment reported indicators for the Northeast Kingdom community, but not for the individual counties of Caledonia, Essex, and Orleans.

[c]The Vermont needs assessment did not report indicators for the Franklin or Grand Isle counties.

[d]Per 1,000 live births.

[e]Per 1,000 residents.

[f]Instead of reporting the rate of arrests per 100,000 juveniles ages 0-19, the Vermont needs assessment reported the number of juvenile delinquency charges per 100,000 juveniles ages 0-19.

[g]The Vermont needs assessment reported the school dropout rate in grades 7-12 as its "other school drop-out rate." Data were not reported for this indicator for any target communities in this state.

[h]Instead of reporting the percentage using other illicit drugs in the past month, the Vermont needs assessment reported the number of individuals treated for substance abuse (excluding alcohol and marijuana) per 10,000 individuals.

[i]The Vermont needs assessment reported the number of substantiated cases of child abuse and neglect per 1,000 children ages 0-17.

[j]The Vermont needs assessment reported as its metrics of domestic violence the percentage of individuals ages 18+ who have ever been threatened with intimate partner violence or been a victim of attempted or actual physical intimate partner violence, as well as the percentage of individuals ages 18+ who have ever been threatened with intimate partner violence or been a victim of actual physical intimate partner violence.

[k]Per 1,000 females ages 15-19.

[l]High risk is defined as first births to unmarried women who are under 20 with less than a high school education.

[m]Per 1,000 children ages 0-17.

[n]Per 100,000 population.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.47

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Virginia

Indicator of Risk	Target Communities[a]							Target Community Average	State Average
	City of Danville	City of Fredericksburg	Montgomery County	City of Norfolk	City of Radford	Southampton County	City of Suffolk		
Live births before 37 weeks of gestation (%)	12.6	11.3	8.7	12.8	14.2	14.2	11.2	12.1	10.5
Total live births less than 2,500 grams (%)	11.8	9.2	6.7	11.1	7.9	12.2	8.2	9.6	8.3
Infant deaths ages 0-1[b]	6.3	24.3	1.1	10.8	0.0	4.9	8.3	8.0	6.7
Residents living below the federal poverty level (%)	20.8	15.4	20.6	19.5	26.7	17.5	10.8	18.8	10.2
Reported crimes[c]	13,641	12,238	4,902	10,100	10,171	4,635	7,327	9,002	6,590
Arrests ages 0-19[d]	2,611	2,300	851	5,592	1,476	85	524	1,920	2,232
Dropout rate grades 9-12 (%)	10.1	11.8	13.9	12.1	17.9	12.9	6.1	12.1	8.1
Other school dropout rate per state/local calculation[e] (%)	-	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[f] (%)									
Binge alcohol use	-	-	-	-	-	-	-	-	22.9
Marijuana use	-	-	-	-	-	-	-	-	6.0
Nonmedical use of prescription drugs	-	-	-	-	-	-	-	-	4.9
Other illicit drug use	-	-	-	-	-	-	-	-	7.6
Residents unemployed and seeking work (%)	9.6	6.2	4.1	5.3	5.3	4.8	4.2	5.6	4.0

(continued)

Appendix Table C.47 (continued)

Indicator of Risk	Target Communities[a]							Target Community Average	State Average
	City of Danville	City of Fredericksburg	Montgomery County	City of Norfolk	City of Radford	Southampton County	City of Suffolk		
Child maltreatment[g]	3.4	9.3	6.2	5.5	9.0	0.2	4.3	5.4	3.2
Child maltreatment by type[g]									
Medical neglect	0.2	0.0	0.2	0.1	0.0	0.0	0.2	0.1	0.1
Mental abuse/neglect	0.0	0.0	0.1	0.0	0.0	0.0	0.2	0.0	0.1
Physical abuse	1.1	2.7	1.0	2.1	1.4	0.2	1.2	1.4	1.1
Physical neglect	3.4	5.7	5.3	4.8	9.0	0.2	4.6	4.7	2.5
Sexual abuse	1.0	1.3	2.4	0.4	0.0	0.0	0.8	0.8	0.6
Domestic violence[e]	-	-	-	-	-	-	-	-	-
Other indicators[h] (%)									
Children meeting the Virginia Standards of Learning Grade 3 Reading Scores	74.0	82.0	82.0	78.0	91.0	74.0	78.0	79.9	84.0
Children estimated to be uninsured	11.2	14.7	27.7	14.2	25.8	14.6	14.2	17.5	10.4
Children enrolled in Medicaid	56.9	35.9	23.3	34.8	28.3	34.6	25.4	34.2	25.4
Children under age 5 living below the federal poverty level	36.2	19.5	18.7	32.3	18.7	29.2	18.2	24.7	17.0

SOURCES: Virginia 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The target communities identified by Virginia include both counties and independent cities, which are considered to be equivalent to counties.
[b]Per 1,000 live births.
[c]There appeared to be an error in the unit that the Virginia needs assessment reported using for this indicator; therefore, the unit for this indicator is excluded from this table.
[d]Per 100,000 juveniles ages 0-19.
[e]Data were not reported for this indicator in this state.
[f]Data were not reported for this indicator for any counties in this state.
[g]The Virginia needs assessment reported the rate of substantiated maltreatment per 1,000 children.
[h]The Virginia needs assessment reported on a large number of other indicators. This table includes a sample of those indicators.

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Appendix Table C.48

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Washington

	Target Communities[a]										
	Pierce County City Council Districts				Snohomish County:	King County			Pend	Target	
Indicator of Risk	2	4	5	6	North Everett	South	Yakima County	Clallam County	Oreille County	Community Average	State Average
Live births before 37 weeks of gestation (%)	9.5	10.4	11.7	13.3	10.7	10.5	13.0	8.1	17.1	11.6	10.5
Total live births less than 2,500 grams (%)	5.8	6.9	6.5	7.8	5.6	6.8	6.8	5.0	6.2	6.4	6.4
Infant deaths ages 0-1[b]	6.4	7.0	7.7	7.6	6.7	5.7	7.5	4.8	5.8	6.6	5.3
Residents living below the federal poverty level (%)	10.1	16.6	14.9	12.6	16.6	11.5	18.6	13.6	18.8	14.8	11.3
Reported crimes[c]	68.8	79.9	39.6	19.5	62.7	46.6	49.4	28.4	26.9	46.9	39.8
Arrests ages 0-19[d,e]	1,372	2,645	2,083	3,012	3,855	-	3,835	4,972	746	2,815	3,052
Dropout rate grades 9-12[f] (%)	7.3	6.8	6.4	5.9	3.1	4.4	5.2	18.7	2.1	6.7	5.1
Other school dropout rate per state/local calculation[g] (%)	-	-	-	-	-	-	-	-	-	-	-
Prevalence of activities in the past month[e,h] (%)											
Binge alcohol use	20.3	20.3	20.3	20.3	21.5	-	20.3	22.9	22.7	21.1	21.4
Marijuana use	6.5	6.5	6.5	6.5	7.2	-	6.3	7.6	7.1	6.8	7.4
Nonmedical use of prescription drugs	6.8	6.8	6.8	6.8	6.2	-	6.5	6.7	6.9	6.7	6.5
Other illicit drug use	3.7	3.7	3.7	3.7	3.9	-	3.7	3.9	3.9	3.8	3.9
Residents unemployed and seeking work (%)	10.4	15.4	17.3	15.2	9.2	8.1	9.2	9.8	12.7	11.9	9.0

(continued)

Appendix Table C.48 (continued)

Indicator of Risk	Target Communities[a] Pierce County City Council Districts 2	4	5	6	Snohomish County: North Everett	King County South	Yakima County	Clallam County	Pend Oreille County	Target Community Average	State Average
Child maltreatment ages 0-17[i]	84.9	64.6	63.4	74.9	134.3	40.2	60.5	60.5	73.2	72.9	44.4
Child maltreatment by type ages 0-17[e,j]											
Physical abuse only	1.0	1.0	1.0	0.6	0.5	-	0.7	0.8	-	0.8	0.6
Neglect only	2.5	2.5	2.5	6.7	3.2	-	4.6	4.0	4.6	3.8	2.8
Sexual abuse only	0.2	0.2	0.2	0.2	0.1	-	0.1	-	-	0.2	0.1
Neglect with any other type but sexual abuse	0.5	0.5	0.5	0.8	0.5	-	0.8	0.9	-	0.6	0.5
Sexual abuse with any other type	0.2	0.2	0.2	0.2	0.2	-	0.2	-	-	0.2	0.2
Domestic violence offenses[k]	11.2	15.4	10.6	17.2	8.9	5.0	6.8	5.8	5.0	9.5	5.6
Other indicators											
Substance use women 15-44[l] (%)	13.1	18.6	13.6	14.0	13.2	10.7	11.6	18.9	9.7	13.7	12.6
10th-grade illicit drug use[e,m]	22.9	25.5	22.3	19.9	24.0	18.4	20.6	-	20.2	21.7	20.4
10th-grade binge drinking[e,n]	17.6	17.7	19.5	14.5	18.7	14.7	21.9	-	25.3	18.7	18.4
Late or no prenatal care[o] (%)	6.7	6.9	7.4	6.1	8.2	7.4	4.9	3.5	6.5	6.4	5.5
Births to women ages 15-17[p]	16.3	19.8	30.4	20.0	15.3	16.2	41.4	13.4	15.9	21.0	15.5
3rd-grade students meeting state reading standard (%)	78.0	68.8	61.9	62.8	62.2	70.3	59.0	76.3	77.1	68.5	71.4

(continued)

Appendix Table C.48 (continued)

SOURCES: Washington 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]The Washington FY 2010 and FY 2011 state plans identified both whole counties and portions of counties as the state's target communities: Yakima, Clallam, and Pend Oreille Counties, portions of Snohomish and King Counties, and four city council districts in Pierce County. Data reported are for each community.

[b]Per 1,000 live births.

[c]Per 1,000 residents.

[d]Per 100,000 juveniles ages 0-19. Juvenile arrest data underestimate the juvenile arrest rates because not all police departments or sheriff's offices in the state provided data to the Washington Association of Sheriffs and Police Chiefs Uniform Crime Reporting system.

[e]Data were not reported for this indicator for some counties.

[f]This represents all high school students (less transfers, juvenile detention, or deceased) who are recorded with one of the following terms: dropout, unknown completion, or General Educational Development (GED) certificate earned.

[g]Data were not reported for this indicator in this state.

[h]Data were not available at the target community level. Data included in this table are for the Substance Abuse and Mental Health Services Administration (SAMHSA) regions to which each target community belongs.

[i]The Washington needs assessment reported the rate of unduplicated children ever receiving Child Protective Services, case management, or Child and Family Welfare services per 1,000 children ages 0-17.

[j]Substantiated maltreatment by type per 1,000 children ages 0-17. Data included in this table are for the counties to which each target community belongs. The Washington needs assessment did not report rates if there were fewer than five cases.

[k]The Washington needs assessment reported the rate of domestic violence offenses per 1,000 residents as its metric for domestic violence.

[l]Women ages 15-44 who received one or more months of Department of Social and Health Services medical coverage who needed substance use treatment.

[m]Tenth-grade students reporting using any illicit drug, including marijuana, in past 30 days.

[n]Tenth-grade students reporting drinking five or more drinks in a row on at least one occasion in past two weeks.

[o]Live-born infants who were born to women beginning prenatal care in the third trimester or not at all.

[p]Per 1,000 females ages 15-17.

The Mother and Infant Home Visiting Program Evaluation

Appendix Table C.49

Indicators of Community Risk in Counties Chosen for MIECHV Funding: West Virginia

Indicator of Risk	Target Counties					Target County Average	State Average
	Boone	Cabell	Mason	McDowell	Wayne		
Live births before 37 weeks of gestation (%)	14.2	15.1	11.5	13.3	19.8	14.8	11.9
Total live births less than 2,500 grams (%)	11.6	11.1	9.0	12.9	14.4	11.8	9.6
Infant deaths ages 0-1[a]	11.3	10.3	6.4	16.6	8.7	10.7	7.7
Residents living below the federal poverty level (%)	21.3	20.6	18.1	32.8	17.6	22.1	17.4
Reported crimes[b,c]	476	1,032	468	253	439	533	-
Arrests ages 0-19[d,e]	-	-	-	-	-	-	2,244
Dropout rate grades 9-12[e] (%)	-	-	-	-	-	-	17.0
Dropout rate grades 7-12[f] (%)	3.4	3.5	3.1	3.5	3.5	3.4	2.8
Prevalence of activities in the past month[g] (%)							
Binge alcohol use	18.7	19.3	19.3	16.9	19.3	18.7	19.7
Marijuana use	4.9	5.7	5.7	4.6	5.7	5.3	5.4
Nonmedical use of prescription drugs	4.0	5.0	5.0	4.0	5.0	4.6	5.5
Other illicit drug use	7.4	9.1	9.1	7.3	9.1	8.4	4.3
Residents unemployed and seeking work (%)	8.0	6.8	12.1	11.8	8.0	9.3	10.3
Child maltreatment[e,h]	-	-	-	-	-	-	13.7
Child maltreatment by type[i]	-	-	-	-	-	-	-
Intimate partner violence[j]	8.1	5.1	3.8	4.8	4.6	5.3	4.7

(continued)

Appendix Table C.49 (continued)

Indicator of Risk	Target Counties					Target County Average	State Average
	Boone	Cabell	Mason	McDowell	Wayne		
Other indicators							
Number of maltreatment incidents[c,k]	115	106	45.0	99.0	103	93.6	-
Child fatalities[e,l]	-	-	-	-	-	-	1.3
Residents living below the federal poverty level (%)							
Under 18	27.5	25.9	25.7	46.3	24.2	29.9	23.9
Ages 5-17	23.3	22.9	23.4	42.8	20.6	26.6	20.6

SOURCES: West Virginia 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]Per 1,000 live births.
[b]Per 1,000 residents.
[c]The state average for this indicator was not reported.
[d]Per 100,000 juveniles ages 0-19.
[e]Data were not reported for this indicator for any counties in this state.
[f]The West Virginia needs assessment reported the dropout rate grades 7-12 as its "other school dropout rate."
[g]Data were not available at the county level and were reported regionally instead. Data included in this table are for the regions to which each target county belongs.
[h]The West Virginia needs assessment reported the child maltreatment rate per 1,000 children.
[i]Data were not reported for this indicator in this state.
[j]The West Virginia needs assessment reported the rate of intimate partner violence and non-intimate partner violence per 1,000 as its metrics for domestic violence. This table includes only the intimate partner violence rate.
[k]Maltreatment referrals received where maltreatment was determined to have occurred.
[l]Per 100,000 children.

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Appendix Table C.50

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Wisconsin

Indicator of Risk	Target Counties											Target County Average	State Average
	Ashland[a]	Brown	Burnett	Forest	Green	Lincoln	Milwaukee	Oneida	Racine	Rock	Sawyer		
Live births that occur before 37 weeks of gestation (%)	9.9	11.3	12.7	14.0	12.7	12.5	13.4	8.9	12.9	10.9	10.9	11.8	11.1
Total live births less than 2,500 grams (%)	4.9	6.6	7.1	8.7	7.0	7.2	9.0	6.7	8.6	6.7	5.1	7.1	7.0
Infant deaths ages 0-1[b]	6.0	6.2	-	-	5.6	5.7	9.7	6.2	10.0	6.1	7.9	7.0	6.5
Residents living below the federal poverty level (%)	14.9	8.8	14.1	15.7	7.7	9.2	17.0	10.3	10.3	11.3	15.3	12.2	10.5
Violent offenses[c]	3.4	2.3	1.8	41.0	1.1	2.1	7.7	0.8	3.0	2.5	1.9	6.1	2.6
Arrests ages 0-19[d]	10,406	6,749	749	5,188	2,514	12,391	7,723	6,781	7,770	10,277	7,898	7,131	5,920
Students who dropped out during school term[e] (%)	1.9	2.7	1.9	1.3	3.6	1.7	5.1	3.3	4.1	2.5	2.6	2.8	2.1
Other school dropout rate per state/local calculation[f] (%)	-			-	-	-	-	-	-		-		-

(continued)

Appendix Table C.50 (continued)

Indicator of Risk	Target Counties											Target County Average	State Average
	Ashland[a]	Brown	Burnett	Forest	Green	Lincoln	Milwaukee	Oneida	Racine	Rock	Sawyer		
Prevalence of activities ages 12+[g] (%)													
Binge alcohol use in the past month	28.1	31.1	26.3	28.1	30.6	28.1	26.3	28.1	27.0	30.6	28.1	28.4	28.5
Marijuana use in the past month	5.0	5.1	6.2	5.0	6.5	5.0	6.7	5.0	6.3	6.5	5.0	5.7	6.0
Nonmedical use of pain relievers in the past year[h]	5.8	5.3	6.0	5.8	5.9	5.8	5.4	5.8	6.5	5.9	5.8	5.8	5.8
Other illicit drug use in the past month	4.1	3.8	4.0	4.1	4.0	4.1	4.2	4.1	3.9	4.0	4.1	4.0	4.0
Residents unemployed and seeking work (%)	9.9	7.7	10.8	10.3	8.7	11.0	9.3	9.6	10.1	12.5	9.9	10.0	8.5
Child maltreatment[i]	2.7	3.0	1.9	4.2	4.2	2.9	4.6	8.7	4.1	6.5	4.1	4.3	3.7
Child maltreatment by type[i]													
Emotional abuse	50.0	0.0	0.0	0.0	13.0	33.0	2.0	0.0	0.0	0.0	0.0	8.9	4.0
Neglect	17.0	15.0	6.0	19.0	12.0	12.0	9.0	38.0	9.0	13.0	22.0	15.6	13.0
Physical abuse	14.0	11.0	3.0	5.0	6.0	0.0	8.0	8.0	11.0	7.0	6.0	7.2	9.0
Sexual abuse	21.0	20.0	63.0	43.0	10.0	17.0	21.0	12.0	24.0	16.0	33.0	25.5	24.0
Incidents of domestic violence[j]	5.1	4.8	4.5	6.2	6.0	2.3	8.7	3.4	3.9	7.3	4.4	5.2	5.2

(continued)

Appendix Table C.50 (continued)

SOURCES: Wisconsin 2010 MIECHV needs assessment, FY 2010 and FY 2011 state plans, and first-round competitive grant application.

NOTES: [a]While the Wisconsin FY 2011 state plan reported that Ashland County would not be funded with MIECHV funds, it also said that the Great Lakes Intertribal Council would be funded and that part of the funded services would be delivered in Ashland County. Therefore Ashland County is considered a target county in this table.

[b]Per 1,000 live births. Data were not reported for this indicator for some target counties in the state.

[c]Instead of the number of reported crimes per 1,000 residents, the Wisconsin needs assessment provided the number of violent offenses per 1,000 estimated residents.

[d]Per 100,000 juveniles ages 0-19.

[e]Instead of reporting the percentage of high school dropouts grades 9-12, the Wisconsin needs assessment reported the percentage of students who dropped out during the school term out of the total expected to complete the school term in that school or district.

[f]Data were not reported for this indicator in this state.

[g]Information on substance abuse is only available for residents ages 12 and older. Data were not available at the county level. Data included in this table are for the Substance Abuse and Mental Health Service Administration (SAMHSA) region to which each target county belongs.

[h]Instead of reporting the rate of nonmedical use of prescription drugs in the past month, the Wisconsin needs assessment reported the rate of nonmedical use of pain relievers in the past year.

[i]The Wisconsin needs assessment reported the number of Child Protective Services reports substantiated per 1,000 children.

[j]The Wisconsin needs assessment reported the number of incidents of domestic violence per 1,000 estimated residents as its metric for domestic violence.

Appendix Table C.51

Indicators of Community Risk in Counties Chosen for MIECHV Funding: Wyoming

Indicator of Risk	Target Counties				Target County Average	State Average
	Carbon	Sweetwater	Albany	Natrona		
Live births before 37 weeks of gestation (%)	10.8	10.1	11.2	10.0	10.5	10.5
Total live births less than 2,500 grams (%)	9.5	9.3	10.4	8.0	9.3	8.7
Infant deaths ages 0-1[a]	15.4	9.5	6.9	7.2	9.7	7.5
Residents living below the federal poverty level (%)	11.5	7.3	16.4	10.4	11.4	10.0
Reported crimes[b]	29.5	36.8	31.5	43.3	35.3	29.7
Arrests ages 0-17[c]	3,747	3,065	1,394	4,100	3,076	2,603
Dropout rate grades 9-12 (%)	3.4	5.6	2.4	7.4	4.7	3.8
Dropout events grades 9-12[d] (%)	3.5	5.6	2.4	7.3	4.7	4.7
Prevalence of activities (%)						
Binge alcohol use in the past month ages 18+	15.6	19.3	17.6	15.0	16.9	15.6
Binge alcohol use in the past month ages 12+	28.0	26.5	28.4	24.4	26.8	25.3
Marijuana use in the past month ages 12+	8.9	6.0	8.9	7.1	7.7	6.3
Nonmedical use of prescription drugs in the past year ages 12+[e]	5.7	5.3	5.7	5.7	5.6	5.3
Other illicit drug use in the past month ages 12+	3.7	4.2	4.4	3.9	4.1	3.9
Residents unemployed and seeking work (%)	7.3	6.5	4.1	6.6	6.1	6.4
Child maltreatment ages 0-17[f]	5.5	6.3	0.9	6.1	4.7	4.0

(continued)

Appendix Table C.51 (continued)

Indicator of Risk	Target Counties				Target County Average	State Average
	Carbon	Sweetwater	Albany	Natrona		
Child maltreatment ages 0-17 by type[g]						
Medical neglect	20.7	3.5	2.3	8.5	8.7	5.1
Neglect	404	444	70	474	348	281
Other	0.0	5.8	0.0	2.8	2.1	3.8
Physical abuse	72.5	127.6	11.6	48.8	65.1	70.9
Psychological abuse	0.0	6.9	0.0	12.0	4.7	6.8
Sexual abuse	48.3	43.7	7.0	61.5	40.1	30.6
Domestic violence incidents[h]	8.9	9.0	7.1	6.7	7.9	6.0
Other indicators						
Students eligible for free and reduced lunch (%)	33.9	24.7	27.7	32.3	29.6	31.3
Homeless school-age children (%)	0.4	0.6	0.9	1.8	0.9	0.8
Kindergartners who are school ready[i] (%)	47.7	51.7	48.3	59.6	51.8	51.7
Women who reported smoking while pregnant (%)	24.2	22.3	21.4	30.0	24.5	24.2
Residents without health insurance (%)	17.0	16.4	22.8	13.4	17.4	16.1

(continued)

Appendix Table C.51 (continued)

SOURCES: Wyoming 2010 MIECHV needs assessment and FY 2010 and FY 2011 state plans.

NOTES: [a]Per 1,000 live births.
[b]Per 1,000 residents.
[c]Instead of reporting the number of arrests per 100,000 juveniles ages 0-19, the Wyoming needs assessment reported the number of arrests per 100,000 juveniles ages 0-17.
[d]The Wyoming needs assessment reported the percentage of school dropout events for grades 9-12 per Department of Education formula as its "other school dropout rate."
[e]Instead of reporting the percentage using nonmedical prescription drugs in the past month, the Wyoming needs assessment reported the percentage using nonmedical prescription drugs in the past year.
[f]The Wyoming needs assessment reported the number of substantiated child abuse cases per 1,000 children ages 0-17.
[g]The Wyoming needs assessment reported overall maltreatment rates per 1,000 children ages 0-17, but maltreatment rates by type are reported per 100,000 children ages 0-17.
[h]The Wyoming needs assessment reported the number of incidents of domestic violence per 1,000 people as its metric for domestic violence.
[i]Kindergarten students scoring "proficient" in nine foundational areas.

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Appendix Table C.52

Indicators of Community Risk in the Territory of American Samoa

Indicator of Risk	Territory Average[a]
Live births before 37 weeks of gestation[b] (%)	-
Total live births less than 2,500 grams (%)	3.8
Infant deaths ages 0-1[c]	12.7
Residents living below the federal poverty level (%)	61.0
Reported crimes[d]	28.2
Arrests ages 0-19[e]	1,053
Dropout rate grades 9-12 (%)	0.7
Other school dropout rate per state/local calculation[b]	-
Prevalence of activities among students[f] (%)	
Binge alcohol use in the past month	18.2
Marijuana use in the past month	21.7
Nonmedical use of prescription drugs[b]	-
Ever used methamphetamine[g]	7.0
Residents unemployed and seeking work (%)	29.8
Number of child maltreatment cases ages 0-17[h]	-

(continued)

Appendix Table C.52 (continued)

Indicator of Risk	Territory Average[a]
Substantiated child maltreatment cases ages 0-17 by type (%)	
Physical abuse	24.6
Neglect	29.2
Medical neglect	1.5
Sexual abuse	3.1
Psychological/emotional abuse	0.0
Number of reported domestic violence cases[i]	-
Other indicators[j] (%)	
Initiated prenatal care by the 1st trimester	21.9
Received adequate prenatal care[k]	40.7
Infants born to women ages 15-19	9.8
Births to unmarried parents	38.0
Overweight or obese schoolchildren	55.6
Children living below the federal poverty level	66.5
Prevalence of binge alcohol use among adult women in the past month	33.9
Prevalence of binge alcohol use among adult men in the past month	49.6
Current smoker (among adults)	39.4

(continued)

Appendix Table C.52 (continued)

SOURCES: American Samoa 2010 MIECHV needs assessment and FY 2010 and FY 2011 territory plans.

NOTES: [a]The American Samoa FY 2011 territory plan identified the entire territory as its target community.
[b]Data were not reported for this indicator in this territory.
[c]Per 1,000 live births.
[d]Per 1,000 residents.
[e]Per 100,000 juveniles ages 0-19.
[f]The American Samoa needs assessment reported substance use among the student population.
[g]Instead of reporting the percentage using other illicit drugs in the past month, the American Samoa needs assessment reported the percentage of students who had ever used methamphetamine.
[h]The American Samoa needs assessment reported the number of substantiated child maltreatment cases for children ages 0-17; however, it did not provide an average number for the territory. The total number of substantiated cases was 65.
[i]The American Samoa needs assessment reported the number of reported domestic violence cases as its metric for domestic violence; however, it did not provide an average number for the territory. The total number of cases reported was 45.
[j]The American Samoa needs assessment reported on a large number of other indicators. This table includes a sample of those indicators.
[k]The American Samoa needs assessment defined this as determined by the Kotelchuk Index.

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Appendix Table C.53

Indicators of Community Risk in the Community Chosen for MIECHV Funding: Guam

Indicator of Risk	Target Community[a] Dededo	Target Community Average	Territory Average
Live births before 37 weeks of gestation (%)	2.7	2.7	5.0
Total live births less than 2,500 grams (%)	2.3	2.3	13.0
Infant deaths ages 0-1[b]	2.6	2.6	10.2
Residents living below the federal poverty level[c] (%)	59.6	59.6	20.0
Number of reported crimes[d]	1,035	1,035	-
Arrests ages 0-19[e]	-	-	-
Teens ages 16-19 who are dropouts[f] (%)	15.7	15.7	-
Other school dropout rate per state/local calculation[e] (%)	-	-	-
Prevalence of activities in the past year (%)			
Binge alcohol use[g,h]	-	-	20.2
Marijuana use[e]	-	-	-
Nonmedical use of prescription drugs[e]	-	-	-
Other illicit drug use[e]	-	-	-
Residents unemployed and seeking work[c] (%)	24.5	24.5	-
Child maltreatment[g,i] (%)	-	-	2.2
Child maltreatment by type[e]	-	-	-

(continued)

Appendix Table C.53 (continued)

Indicator of Risk	Target Community[a] Dededo	Target Community Average	Territory Average
Number of family violence cases[j]	-	-	-
Other indicators			
Children living below poverty level (%)	29.0	29.0	32.0

SOURCES: Guam 2010 MIECHV needs assessment and FY 2010 and FY 2011 territory plans.

NOTES: [a]The target community identified by the Guam needs assessment is the village of Dededo. Some indicators are available at the village level while some are only available at the regional level.

[b]Per 1,000 live births.

[c]Data for this indicator are reported at the regional level rather than the village level. The state average for this indicator was not reported.

[d]Instead of the number of reported crimes per 1,000 residents, the Guam needs assessment provided the total number of offenses (violent and property). The territory average for this indicator was not provided. The total number of reported crimes was 3,240.

[e]Data were not reported for this indicator in the territory.

[f]Instead of reporting the percentage of high school dropouts grades 9-12, the Guam needs assessment reported the number of teenagers ages 16-19 who were high school dropouts and the total number of teenagers. A percentage was calculated from these numbers. The territory average for this indicator was not reported.

[g]Data were not reported for this indicator for the target community in the territory.

[h]Instead of reporting the percentage engaging in binge alcohol use in the past month, the Guam needs assessment reported the percentage engaging in binge alcohol use in the past year.

[i]The Guam needs assessment reported the number of child maltreatment occurrences as a percentage of the population.

[j]The Guam needs assessment reported the number of family violence cases as its metric for domestic violence. However, data were not reported for this indicator for the target community in the territory, and the needs assessment did not provide an average value for the territory. The total number of cases was 587.

Appendix Table C.54

Indicators of Community Risk in Communities Chosen for MIECHV Funding: Northern Mariana Islands

Indicator of Risk	Target Communities[a]			Target Community Average	Territory Average
		Koblerville/San Antonio			
	Kagman	Koblerville	San Antonio		
Live births before 37 weeks of gestation (%)	7.0	11.0	3.0	7.0	8.2
Total live births less than 2,500 grams (%)	8.0	10.0	6.0	8.0	8.9
Infant deaths ages 0-1[b,c]	-	-	-	-	1.8
Residents living below the federal poverty level[d] (%)	59.0	48.0	56.0	55.5	40.4
Reported crimes[e]	323	225	175	262	3,077
Arrests ages 0-19[f]	14.0	18.0	5.0	12.8	118.0
Dropout rate grades 9-12[g] (%)	2.5	-	-	2.5	3.0
Other school dropout rate per state/local calculation[b,h] (%)	-	-	-	-	13.0
Prevalence of activities in the past month (%)					
Binge alcohol use[b]	-	-	-	-	70.0
Marijuana use[b]	-	-	-	-	55.0
Nonmedical use of prescription drugs[i]	-	-	-	-	-
Other illicit drug use[b]	-	-	-	-	<8.0
Residents unemployed and seeking work[b] (%)	-	-	-	-	8.2
Child maltreatment[d,j]	102	53	31	72	223
Child maltreatment by type[i]	-	-	-	-	-

(continued)

Appendix Table C.54 (continued)

Indicator of Risk	Target Communities[a]			Target Community Average	Territory Average
		Koblerville/San Antonio			
	Kagman	Koblerville	San Antonio		
Domestic violence[b,k]	-	-	-	-	288-347
Other indicators[l]					
Diagnosed with substance-related disorder[m]	64.0	43.0	29.0	50.0	-

SOURCES: Northern Mariana Islands 2010 MIECHV needs assessment and FY 2010 and FY 2011 territory plans.

NOTES: [a]The Northern Mariana Islands needs assessment identified one village and one group of two villages as its target communities.

[b]Data were not reported for this indicator for any target communities in this territory.

[c]States were asked to report this indicator per 1,000 live births. The Northern Mariana Islands needs assessment did not specify the unit it used.

[d]The Northern Mariana Islands needs assessment used different data sources for this indicator for the target communities and for the territory.

[e]Per 1,000 residents.

[f]Per 100,000 juveniles ages 0-19.

[g]Data were not reported for this indicator for some target communities in this territory.

[h]The Northern Mariana Islands needs assessment reported its "other school dropout rate" from the Head Start Program Information Report; however, the definition of this rate was unclear.

[i]Data were not reported for this indicator in this territory.

[j]The Northern Mariana Islands needs assessment did not specify the unit used for child maltreatment.

[k]The Northern Mariana Islands needs assessment did not provide a definition for its metric for domestic violence. Data were reported from Guma Esperansa and Domestic Violence Intervention Center.

[l]The Northern Mariana Islands needs assessment reported on several other indicators, but these were provided only for the territory and not for the target communities. Additionally, the definitions of the indicators were sometimes unclear. For these reasons, they are not included in this table.

[m]Per the Diagnostic and Statistical Manual of Mental Disorders IV classification book. The Northern Mariana Islands needs assessment did not specify the unit used. The territory average for this indicator was not reported.

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Appendix Table C.55

Indicators of Community Risk in the Community Chosen for MIECHV Funding: Puerto Rico

Indicator of Risk	Target Community[a] Barranquitas/Orocovis: Barranquitas	Target Community[a] Barranquitas/Orocovis: Orocovis	Target Community Average	Territory Average
Live births that occur before 37 weeks of gestation (%)	12.4	17.3	14.9	19.9
Total live births less than 2,500 grams (%)	10.3	17.3	13.8	13.0
Infant deaths ages 0-1[b]	12.0	13.9	13.0	9.1
Residents living below the federal poverty level (%)	58.9	64.1	61.5	44.6
Reported crimes[c]				
Aggravated assault	85.1	132.6	108.9	78.8
Rape	3.3	0.0	1.7	4.1
Robbery	32.7	24.0	28.4	138.3
Arrests ages 0-17[d]	3,124.7	2,862.2	2,993.5	1,047.0
Individuals ages 26+ with less than a high school diploma[e] (%)	45.8	52.5	49.2	40.0
Other school dropout rate per state/local calculation[f] (%)	-	-	-	-
Prevalence of activities[g] (%)				
Binge alcohol use in past month	31.1	30.7	30.9	33.0
Marijuana use in past year	5.8	6.0	5.9	6.8
Nonmedical use of prescription drugs in past year	2.7	2.6	2.7	2.8
Other illicit drug use in past year	1.7	2.1	1.9	1.8
Residents unemployed and seeking work (%)	25.0	26.0	25.5	19.1

(continued)

Appendix Table C.55 (continued)

Indicator of Risk	Target Communities[a] Barranquitas/Orocovis Barranquitas	Target Communities[a] Barranquitas/Orocovis Orocovis	Target Community Average	Territory Average
Child maltreatment[h]	36.2	24.0	30.1	41.1
Child maltreatment by type[h]				
Neglect	17.4	12.1	14.8	20.8
Physical abuse	6.8	0.0	3.4	5.4
Sexual abuse	1.3	3.9	2.6	2.2
Emotional abuse	6.2	3.9	5.1	4.9
Multiple types	4.4	4.2	4.3	7.8
Domestic violence cases[i]	-	-	-	16.9
Other indicators (%)				
Residents not participating in the labor force	64.7	70.5	67.6	59.3
Families with children under 18 living in poverty	63.9	72.0	68.0	52.6
Families with children under 5 living in poverty	67.4	74.3	70.9	54.8
Experiencing alcohol/drug abuse and dependency	13.4	14.3	13.9	17.9
Received adequate prenatal care[j]	69.6	70.5	70.1	75.8
Adolescent mothers	23.9	23.4	23.7	18.3

(continued)

Appendix Table C.55 (continued)

SOURCES: Puerto Rico 2010 MIECHV needs assessment and FY 2010 and FY 2011 territory plans.

NOTES: [a]The target community identified by the Puerto Rico needs assessment is composed of two municipalities.

[b]Per 1,000 live births.

[c]Instead of the total number of reported crimes per 1,000 residents, the Puerto Rico needs assessment provided the number of reported aggravated assaults, rapes, and robberies per 1,000 residents.

[d]Instead of reporting the rate of juvenile crime arrests per 100,000 juveniles ages 0-19, the Puerto Rico needs assessment reported the rate of juvenile crime arrests per 100,000 juveniles ages 0-17.

[e]Instead of reporting the percentage of high school dropouts grades 9-12, Puerto Rico reported the percentage of individuals over 25 years of age with less than a high school degree.

[f]Data were not reported for this indicator in this territory.

[g]Instead of reporting the percentage using marijuana, nonmedical prescription drugs, and other illicit drugs in the past month, the Puerto Rico needs assessment reported the percentage using these substances in the past year.

[h]The Puerto Rico needs assessment reported the rate of child maltreatment per 1,000 minors.

[i]The Puerto Rico needs assessment reported the number of domestic violence cases per 1,000 residents as its metric for domestic violence. Data were not reported for this indicator for the target community in the territory.

[j]The Puerto Rico needs assessment defined this as 80 percent or more on the Kotelchuck Index.

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Appendix Table C.56

Indicators of Community Risk in Communities Chosen for MIECHV Funding: U.S. Virgin Islands

Indicator of Risk	Target Communities[a]					Target Community Average	Territory Average
	Christiansted	Mid-Island	Frederiksted	East End	St. John		
Live births before 37 weeks of gestation (%)	-	-	-	-	-	-	0.8
Total live births less than 2,500 grams (%)	-	-	-	-	-	-	5.6
Infant deaths ages 0-1[b] (%)	-	-	-	-	-	-	0.6
Residents living below the federal poverty level (%)	-	-	-	-	-	-	28.5
Reported crimes[c]	-	-	-	-	-	-	-
Arrests ages 0-19[d] (%)	-	-	-	-	-	-	1.0
Dropout rate grades 9-12 (%)	-	-	-	-	-	-	7.4
Mothers without a high school degree[e] (%)	-	-	-	-	-	-	44.4
Prevalence of activities in the past month (%)							
Binge alcohol use	-	-	-	-	-	-	6.6
Marijuana use	-	-	-	-	-	-	34.0
Nonmedical use of prescription drugs[c]	-	-	-	-	-	-	-
Other illicit drug use	-	-	-	-	-	-	1.4
Residents unemployed and seeking work (%)	-	-	-	-	-	-	8.4
Child maltreatment ages 0-18[f]	-	-	-	-	-	-	13.6
Child maltreatment by type[c]	-	-	-	-	-	-	-
Ever experienced intimate partner violence[g] (%)	-	-	-	-	-	-	19.0

(continued)

Appendix Table C.56 (continued)

SOURCES: U.S. Virgin Islands 2010 MIECHV needs assessment and FY 2010 and FY 2011 territory plans.

NOTES: [a]The Virgin Islands FY 2011 territory plan lists four target communities: Christiansted, Mid-Island, and Frederiksted on the island of St. Croix and East End on the island of St. Thomas. The plan later discusses services that would be expanded to the island of St. John; therefore St. John is also considered a target community. The Virgin Islands needs assessment did not include information on indicators for any target communities.

[b]Instead of reporting the rate of infant deaths per 1,000 live births, the Virgin Islands needs assessment reported infant deaths as a percentage of live births.

[c]Data were not reported for this indicator in this territory.

[d]Instead of reporting the rate of arrests per 100,000 juveniles ages 0-19, the Virgin Islands needs assessment reported juvenile arrests as a percentage of juveniles ages 0-19.

[e]The Virgin Islands needs assessment reported the percentage of mothers without a high school degree as its "other school dropout rate."

[f]The Virgin Islands needs assessment reported the number of maltreatment cases per 1,000 children ages 0-18.

[g]The Virgin Islands needs assessment reported the percentage of adults who have experienced some type of intimate partner violence in their lifetimes as its metric for domestic violence.

Appendix D

Fiscal Year 2010 and 2011 State Plans for MIECHV Funding

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The following table presents a summary of how each state proposed to use its MIECHV funding in its fiscal year (FY) 2010 and 2011 state plans and, for states that were awarded the funding, its first-round competitive grant application.[1] It should be noted that state plans for MIECHV funding continued to evolve after these documents were submitted, and this summary does not reflect changes in plans made in more recent years.

States were required to use a majority of MIECHV funds on "evidence-based" models, defined as ones that met the Department of Health and Human Services criteria for evidence of effectiveness.[2] The first section of Appendix Table D.1 summarizes how states proposed to direct this funding by providing the following information for each state:

- **Number of target communities:** These were the communities that states proposed to serve with MIECHV funding.
- **Number of target counties:** These were the counties in which target communities where located. Most states identified individual counties as their target communities, but in some states target communities covered areas in more than one county (in which case the count of target counties includes all of these), and in others target communities were only portions of counties (in which case the count of target counties includes the counties to which these communities belonged).
- **Number of proposed local programs:** These were the programs selected to implement home visiting programs with MIECHV funding in target communities. In this table, local organizations are counted once for each model they were funded to operate in each target community; for example, if a local organization was funded to operate two models in one target community, those would be counted as two local programs. In cases where states' plans and competitive grant applications did not specify how many local programs would be operating in each target community, it was assumed that one local program would be operating in each target community for each model being implemented in that community.

[1] "State" is used as shorthand to refer to states, territories, and the District of Columbia, all of which are included in the analysis.

[2] To determine which home visiting models would be defined as evidence-based, HHS commissioned the Home Visiting Evidence of Effectiveness (HomVEE) review. See http://homvee.acf.hhs.gov.

The table also includes information on additional characteristics of the target counties and proposed local programs.

The last section of the table notes whether the state proposed to use a portion of its MIECHV funding to implement a model that had not been designated as evidence-based. States were allowed to spend up to 25 percent of their funding to support promising approaches that did not qualify as evidence-based models at the time they were writing their plans. A state was counted as planning to use a promising approach if it mentioned an intention to use a promising approach in its FY 2011 state plan or first-round competitive grant application, even if the state had not yet decided on a particular model to use.

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Appendix Table D.1

FY 2010 and FY 2011 State Plans for MIECHV Funding

Characteristic	Alabama[a]	Alaska	Arizona[b]	Arkansas[c]	California	Colorado	Connecticut	Delaware	District of Columbia[d]
Target communities	13	1	21	42	21	4	4	6	3
Target counties	13	1	5	42	20	7	5	3	1
Target counties with home visiting services reported prior to MIECHV[e] (%)	61.5	100.0	100.0	100.0	95.0	100.0	100.0	100.0	100.0
Counties in state targeted (%)	19.4	3.4	33.3	56.0	34.5	10.9	62.5	100.0	100.0
To fund evidence-based models									
Proposed local programs[f]	13	1	26	56	21	14	4	18	4
In metropolitan counties[g]	4	1	14	21	19	7	3	12	4
In nonmetropolitan counties[g]	9	0	2	28	2	7	1	6	0
Proposed local programs using[h]									
Early Head Start - Home Based Program Option	0	0	0	0	0	3	1	0	0
Healthy Families America	0	0	10	15	5	0	0	6	0
Nurse-Family Partnership	1	1	6	7	16	4	1	6	0
Parents as Teachers	1	0	0	20	0	4	2	6	2
Family Check-Up	0	0	0	0	0	0	0	0	0
Healthy Steps	0	0	0	0	0	0	0	0	0
Home Instruction for Parents of Preschool Youngsters	1	0	0	14	0	3	0	0	2
To fund promising approaches									
Proposed using promising approaches			x	x			x		

(continued)

Appendix Table D.1 (continued)

Characteristic	Florida	Georgia	Hawaii	Idaho	Illinois[i]	Indiana	Iowa	Kansas	Kentucky
Target communities	5	7	5	4	15	4	4	2	12
Target counties	6	7	3	4	8	4	4	2	12
Target counties with home visiting services reported prior to MIECHV[e] (%)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Counties in state targeted (%)	9.0	1.9	60.0	9.1	7.8	4.3	4.0	1.9	10.0
To fund evidence-based models									
Proposed local programs[f]	5	10	6	10	27	5	5	9	12
In metropolitan counties[g]	4	9	2	3	27	5	2	5	0
In nonmetropolitan counties[g]	1	1	4	7	0	0	3	4	12
Proposed local programs using[h]									
Early Head Start - Home Based Program Option	0	1	3	4	3	0	1	2	0
Healthy Families America	1	5	3	0	14	4	4	3	12
Nurse-Family Partnership	1	2	0	2	2	1	0	0	0
Parents as Teachers	3	2	0	4	8	0	0	4	0
Family Check-Up	0	0	0	0	0	0	0	0	0
Healthy Steps	0	0	0	0	0	0	0	0	0
Home Instruction for Parents of Preschool Youngsters	0	0	0	0	0	0	0	0	0
To fund promising approaches									
Proposed using promising approaches								x	

(continued)

Appendix Table D.1 (continued)

Characteristic	Louisiana	Maine	Maryland	Massachusetts	Michigan	Minnesota[j]	Mississippi	Missouri	Montana[k]
Target communities	29	14	6	17	8	7	2	5	11
Target counties	29	16	6	8	8	7	7	5	11
Target counties with home visiting services reported prior to MIECHV[e] (%)	82.8	100.0	100.0	100.0	100.0	100.0	100.0	100.0	-
Counties in state targeted (%)	45.3	100.0	25.0	57.1	9.6	8.0	8.5	4.3	19.6
To fund evidence-based models									
Proposed local programs[f]	18	14	7	22	13	9	2	9	11
In metropolitan counties[g]	13	3	5	22	13	3	0	1	1
In nonmetropolitan counties[g]	5	11	2	0	0	4	2	8	10
Proposed local programs using[h]									
Early Head Start - Home Based Program Option	0	0	0	2	3	0	0	5	1
Healthy Families America	0	0	6	15	3	5	2	0	1
Nurse-Family Partnership	18	0	1	0	7	1	0	2	1
Parents as Teachers	0	14	0	3	0	0	0	2	1
Family Check-Up	0	0	0	0	0	0	0	0	0
Healthy Steps	0	0	0	2	0	0	0	0	0
Home Instruction for Parents of Preschool Youngsters	0	0	0	0	0	0	0	0	0
To fund promising approaches									
Proposed using promising approaches				x	x				

(continued)

Appendix Table D.1 (continued)

Characteristic	Nebraska	Nevada	New Hampshire	New Jersey	New Mexico[l]	New York[m]	North Carolina	North Dakota[n]	Ohio
Target communities	1	2	11	36	5	14	7	-	10
Target counties	3	2	10	18	5	14	12	-	10
Target counties with home visiting services reported prior to MIECHV[e] (%)	100.0	100.0	100.0	100.0	80.0	100.0	75.0	-	100.0
Counties in state targeted (%)	3.2	11.8	100.0	85.7	15.2	22.6	12.0	-	11.4
To fund evidence-based models									
Proposed local programs[f]	1	4	11	22	2	4	7	-	10
In metropolitan counties[g]	0	4	4	22	1	4	5	-	6
In nonmetropolitan counties[g]	1	0	7	0	1	0	2	-	4
Proposed local programs using[h]									
Early Head Start - Home Based Program Option	0	2	0	0	0	0	0	-	0
Healthy Families America	1	0	11	5	0	2	3	-	8
Nurse-Family Partnership	0	1	0	7	1	2	4	-	2
Parents as Teachers	0	0	0	9	1	0	0	-	0
Family Check-Up	0	0	0	0	0	0	0	-	0
Healthy Steps	0	0	0	0	0	0	0	-	0
Home Instruction for Parents of Preschool Youngsters	0	1	0	1	0	0	0	-	0
To fund promising approaches									
Proposed using promising approaches					x				

(continued)

Appendix Table D.1 (continued)

Characteristic	Oklahoma[o]	Oregon	Pennsylvania	Rhode Island	South Carolina	South Dakota	Tennessee	Texas[p]	Utah[q]
Target communities	6	7	7	6	4	4	6	8	5
Target counties	6	8	13	3	12	3	6	8	5
Target counties with home visiting services reported prior to MIECHV[e] (%)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	50.0	80.0
Counties in state targeted (%)	7.8	22.2	19.4	60.0	26.1	4.5	6.3	3.1	17.2
To fund evidence-based models									
Proposed local programs[f]	18	9	13	16	8	4	8	23	6
In metropolitan counties[g]	9	3	7	16	8	0	6	21	4
In nonmetropolitan counties[g]	9	6	6	0	0	4	2	2	2
Proposed local programs using[h]									
Early Head Start - Home Based Program Option	0	2	5	0	0	0	0	3	0
Healthy Families America	6	3	1	6	2	0	4	0	2
Nurse-Family Partnership	6	4	3	6	4	4	2	6	1
Parents as Teachers	6	0	4	4	1	0	2	7	3
Family Check-Up	0	0	0	0	0	0	0	0	0
Healthy Steps	0	0	0	0	1	0	0	0	0
Home Instruction for Parents of Preschool Youngsters	0	0	0	0	0	0	0	7	0
To fund promising approaches									
Proposed using promising approaches									

(continued)

Appendix Table D.1 (continued)

Characteristic	Vermont	Virginia	Washington	West Virginia	Wisconsin[r]	Wyoming	American Samoa	Guam
Target communities	4	7	9	5	11	4	1	1
Target counties	7	7	6	5	11	4	5	1
Target counties with home visiting services reported prior to MIECHV[e] (%)	100.0	100.0	100.0	100.0	90.9	100.0	100.0	100.0
Counties in state targeted (%)	50.0	5.2	15.4	9.1	15.3	17.4	100.0	100.0
To fund evidence-based models								
Proposed local programs[f]	4	7	7	5	11	6	5	1
In metropolitan counties[g]	1	6	5	3	8	1	0	0
In nonmetropolitan counties[g]	3	1	2	2	3	5	5	1
Proposed local programs using[h]								
Early Head Start - Home Based Program Option	0	0	0	0	2	0	0	0
Healthy Families America	0	2	0	3	8	0	5	1
Nurse-Family Partnership	4	2	4	0	1	4	0	0
Parents as Teachers	0	3	3	2	0	2	0	0
Family Check-Up	0	0	0	0	0	0	0	0
Healthy Steps	0	0	0	0	0	0	0	0
Home Instruction for Parents of Preschool Youngsters	0	0	0	0	0	0	0	0
To fund promising approaches								
Proposed using promising approaches				x				

(continued)

Appendix Table D.1 (continued)

Characteristic	Northern Mariana Islands	Puerto Rico	U.S. Virgin Islands
Target communities	2	1	5
Target counties	1	2	3
Target counties with home visiting services reported prior to MIECHV[e] (%)	100.0	50.0	100.0
Counties in state targeted (%)	25.0	2.6	100.0
To fund evidence-based models			
Proposed local programs[f]	2	1	5
In metropolitan counties[g]	0	1	0
In nonmetropolitan counties[g]	2	0	5
Proposed local programs using[h]			
Early Head Start - Home Based Program Option	0	0	0
Healthy Families America	2	1	1
Nurse-Family Partnership	0	0	3
Parents as Teachers	0	0	1
Family Check-Up	0	0	0
Healthy Steps	0	0	0
Home Instruction for Parents of Preschool Youngsters	0	0	0
To fund promising approaches			
Proposed using promising approaches			

(continued)

Appendix Table D.1 (continued)

SOURCES: FY 2010 and FY 2011 state plans for all states and first-round competitive grant applications for states awarded the funding.

NOTES: In this table, "state" is used as shorthand for states, territories, and the District of Columbia.

The information in this table is limited to what was proposed in the FY 2010 and FY 2011 state plans and the first round of competitive grant applications. State plans for MIECHV funding continued to evolve after these documents were submitted.

Target communities are the communities that states selected to receive MIECHV funding. They can cover areas in one or more target counties. Proposed local programs are the programs that have been selected to implement home visiting programs with MIECHV funding. In some cases, a target community or county will have more than one local program.

For states or territories that are not divided solely into counties, other geographic subdivisions were substituted for counties, as recommended by the U.S. Census Bureau. The following alternatives were used for the following states: in Alaska, organized boroughs, cities and boroughs, municipalities, and census areas are considered to be equivalent to counties; in Louisiana, parishes are considered to be equivalent to counties; the District of Columbia and Guam are each considered to be equivalent to a county; in Virginia, independent cities are considered to be equivalent to counties; in Puerto Rico and the Northern Mariana Islands, municipalities are considered to be equivalent to counties; in American Samoa, districts and islands are considered to be equivalent to counties; and in the U.S. Virgin Islands, islands are considered to be equivalent to counties.

[a]Neither the Alabama FY 2011 state plan nor its first-round competitive grant application specifies which counties would be served by which models. Both documents said that MIECHV funding would be used for Nurse-Family Partnership, Parents as Teachers, and Home Instruction for Parents of Preschool Youngsters, so the table lists one program for each of those three models.

[b]The Arizona FY 2011 state plan reported that the state would meet with Holbrook and Winslow to determine their interest in implementing Healthy Families America. They are included in this table as target communities. In addition, the first-round competitive grant application proposed to serve 50 percent of the identified high-risk communities that were not already served by MIECHV funding. However, these communities were not specified and it is unknown which counties they belong to and which models they will implement (Nurse-Family Partnership or Healthy Families America).

[c]The Arkansas first-round competitive grant application did not specify the location of all the Parents as Teachers programs that would receive MIECHV funding. Therefore, it is unknown whether seven local programs are in metropolitan or nonmetropolitan counties.

[d]The District of Columbia FY 2011 district plan stated that the District of Columbia would implement up to four evidence-based home visiting programs, including Parents as Teachers and Home Instruction for Parents of Preschool Youngsters. This table assumes the District will implement two programs using each model.

[e]Montana and the U.S. Virgin Islands did not provide information on which counties were served by pre-MIECHV home visiting programs. Therefore, this value cannot be calculated for these states.

[f]Local organizations are counted once for each model they are funded to operate. For example, if a local organization is funded to operate two models, it is counted as two local programs. In cases when the state plans and competitive grant applications did not specify how many local programs would be operating in each target community, it was assumed that one local program would be operating in each target community for each model being implemented in that community.

(continued)

Appendix Table D.1 (continued)

NOTES (continued): [g]To designate counties as metropolitan or nonmetropolitan, this report follows the Department of Agriculture Economic Research Service's Rural-Urban Continuum Codes classification scheme. See Economic Research Service (2013a). American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands were not designated under this scheme. The local programs in those territories were assumed to be nonmetropolitan, based on definitions from the Office of Management and Budget. See Economic Research Service (2013b).

[h]This table includes information for only the first seven models that were designated as evidence-based. Additional models have since been designated as evidence-based, but they were not able to be included in the FY 2010 and FY 2011 state plans.

[i]The Illinois first-round competitive grant application proposed funding two enhancements to existing programs in target communities. However, it was sometimes unclear which local programs would be funded; therefore, this table makes various assumptions, such as that the two enhancements would not be implemented in the same local program.

[j]The Minnesota FY 2011 state plan did not specify which models would be used in three of its target communities. Therefore the sum of the models being used does not add up to the total number of local programs.

[k]The Montana FY 2011 competitive grant application reported that funding will be available for an additional 7 to 10 communities with the competitive grant (in addition to the 1 community being funded through formula funding). This table records 11 target communities and assumes that 10 of the 11 will be in nonmetropolitan counties since the vast majority of counties that Montana was considering funding are nonmetropolitan counties. The Montana first-round competitive grant application said that sites would be able to select from Early Head Start - Home Based Program Option, Parents as Teachers, Healthy Families America, and Nurse-Family Partnership. Therefore this table shows one local program using each of those four models.

[l]The New Mexico first-round competitive grant application reported that there would be five target communities; however, two of these target communities had not yet selected models to operate, and one selected a promising approach.

[m]In its FY 2011 state plan, New York proposed allowing its 14 target communities to pick which models to implement locally through a competitive Request for Applications process, so the number of local programs using each model was unknown. Information is included in this table from New York's FY 2010 state plan, which proposed implementing Nurse-Family Partnership in two communities and Healthy Families America in two communities.

[n]North Dakota did not apply for MIECHV funding.

[o]The Oklahoma FY 2011 state plan and first-round competitive grant application reported that for the target communities, Healthy Families America or Parents as Teachers would be implemented, or both. This table assumes that both models would be implemented in each of the state's target communities.

[p]The lower Rio Grande Valley area includes four counties: Hidalgo, Willacy, Cameron, and Gregg. However, the Texas needs assessment said that services would be offered primarily in Hidalgo and Willacy counties. Therefore, this table counts the lower Rio Grande Valley as two target counties.

[q]The Utah FY 2011 state plan reported that MIECHV funds would support PAT or HFA in two target communities, to be determined through an RFP. This table assumes that one target community will implement PAT and the other will implement HFA.

[r]The count of target counties includes Ashland County. While the Wisconsin FY 2011 state plan said that Ashland County would not receive MIECHV funds, it also said that the Great Lakes Intertribal Council would be funded, and that part of that organization's funded services would be delivered in Ashland County.

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Appendix E

Chapter 5 Supplement: Additional Information on the Home Visiting Implementation Policies of National Models and Local Programs

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Mother and Infant Home Visiting Program Evaluation

Appendix Table E.1

Local Programs' Policies for Information Gathering, Education and Support, and Referrals: Early Head Start - Home Based Program Option

Program Policy (%)	Maternal Mental Health	Maternal Substance Use	Intimate Partner Violence	Parenting Behavior	Developmental Delays
Information gathering					
Formal screening is required[a]	100	65	59	76	100
At a specified time before or after a child's birth or enrollment[b]	94	65	59	76	100
When home visitor or parent has a concern[b]	41	24	24	12	53
Education and support[c]					
Family education and support when screening detects a problem					
Specified in written protocol[b]	29	24	18	29	59
Determined in consultation with supervisor[b]	65	29	41	41	41
Referral[c]					
Role of home visitor in making referral					
Provide information to families	29	30	20	38	24
Help family gain access to the resource	71	70	80	62	76
No policy	0	0	0	0	0
Role of home visitor in following through on referral					
Home visitor expected to monitor	100	100	90	100	100
Home visitor not expected to monitor	0	0	10	0	0
No policy	0	0	0	0	0
Sample size					17

SOURCE: Calculations based on data from the MIHOPE policies and procedures inventory.

NOTES: [a]Possible screening tools included options for many commonly used tools, state- or model-specific tools, and respondent write-in options.

[b]Response categories are not mutually exclusive, so percentages can total more than 100. Within each domain, some sites might use more than one tool and might have different policies for each tool.

[c]Only for local programs where formal screening is required.

Mother and Infant Home Visiting Program Evaluation

Appendix Table E.2

Local Programs' Policies for Information Gathering, Education and Support, and Referrals: Healthy Families America

Program Policy (%)	Maternal Mental Health	Maternal Substance Use	Intimate Partner Violence	Parenting Behavior	Developmental Delays
Information gathering					
Formal screening is required[a]	91	70	73	65	100
At a specified time before or after a child's birth or enrollment[b]	91	70	73	65	100
When home visitor or parent has a concern[b]	26	4	18	0	43
Education and support[c]					
Family education and support when screening detects a problem					
Specified in written protocol[b]	48	26	36	35	65
Determined in consultation with supervisor[b]	61	39	32	26	43
Referral[c]					
Role of home visitor in making referral					
Provide information to families	38	63	69	40	36
Help family gain access to the resource	52	38	31	47	64
No policy	10	0	0	13	0
Role of home visitor in following through on referral					
Home visitor expected to monitor	95	94	100	87	95
Home visitor not expected to monitor	0	0	0	0	5
No policy	5	6	0	13	0
Sample size					23

SOURCE: Calculations based on data from the MIHOPE policies and procedures inventory.

NOTES: [a]Possible screening tools included options for many commonly used tools, state- or model-specific tools, and respondent write-in options.

[b]Response categories are not mutually exclusive, so percentages can total more than 100. Within each domain, some sites might use more than one tool and might have different policies for each tool.

[c]Only for local programs where formal screening is required.

Mother and Infant Home Visiting Program Evaluation

Appendix Table E.3

Local Programs' Policies for Information Gathering, Education and Support, and Referrals: Nurse-Family Partnership

Program Policy (%)	Maternal Mental Health	Maternal Substance Use	Intimate Partner Violence	Parenting Behavior	Developmental Delays
Information gathering					
Formal screening is required[a]	93	93	93	93	93
At a specified time before or after a child's birth or enrollment[b]	93	93	93	93	93
When home visitor or parent has a concern[b]	47	33	27	27	80
Education and support[c]					
Family education and support when screening detects a problem					
Specified in written protocol[b]	27	13	20	20	33
Determined in consultation with supervisor[b]	20	33	27	27	20
Referral[c]					
Role of home visitor in making referral					
Provide information to families	29	43	29	36	31
Help family gain access to the resource	50	36	50	43	54
No policy	21	21	21	21	15
Role of home visitor in following through on referral					
Home visitor expected to monitor	79	77	79	71	71
Home visitor not expected to monitor	0	0	0	0	7
No policy	21	23	21	29	21
Sample size					15

SOURCE: Calculations based on data from the MIHOPE policies and procedures inventory.

NOTES: [a]Possible screening tools included options for many commonly used tools, state- or model-specific tools, and respondent write-in options.

[b]Response categories are not mutually exclusive, so percentages can total more than 100. Within each domain, some sites might use more than one tool and might have different policies for each tool.

[c]Only for local programs where formal screening is required.

Mother and Infant Home Visiting Program Evaluation

Appendix Table E.4

Local Programs' Policies for Information Gathering, Education and Support, and Referrals: Parents as Teachers

Program Policy	Maternal Mental Health	Maternal Substance Use	Intimate Partner Violenc	Parenting Behavior	Developmental Delays
Information gathering					
Formal screening is required[a]	95	63	63	79	100
At a specified time before or after a child's birth or enrollment[b]	84	58	63	79	100
When home visitor or parent has a concern[b]	58	21	21	26	53
Education and support[c]					
Family education and support when screening detects a problem					
Specified in written protocol[b]	32	26	16	16	53
Determined in consultation with supervisor[b]	58	21	37	37	47
Referral[c]					
Role of home visitor in making referral					
Provide information to families	33	55	42	33	16
Help family gain access to the resource	44	36	50	53	74
No policy	22	9	8	13	11
Role of home visitor in following through on referral					
Home visitor expected to monitor	89	92	92	93	95
Home visitor not expected to monitor	0	0	0	0	0
No policy	11	8	8	7	5
Sample size					19

SOURCE: Calculations based on data from the MIHOPE policies and procedures inventory.

NOTES: [a]Possible screening tools included options for many commonly used tools, state- or model-specific tools, and respondent write-in options.

[b]Response categories are not mutually exclusive, so percentages can total more than 100. Within each domain, some sites might use more than one tool and might have different policies for each tool.

[c]Only for local programs where formal screening is required.

Mother and Infant Home Visiting Program Evaluation

Appendix Table E.5

Supervisor and Home Visitor Caseload-Size Policies of National Models and Local Programs

	National Model Developer				Percentage That Are the Same					Percentage That Are Lower Than National Model				
	EHS	HFA	NFP	PAT	EHS	HFA	NFP	PAT	Overall	EHS	HFA	NFP	PAT	Overall
Policy on the maximum number of home visitors per supervisor[a]	NA	6	8	12	NA	53	88	77	71	NA	47	12	23	29
Policy on maximum caseload size for home visitors[b,c]	12	25	25	NA	56	38	89	NA	59	44	63	11	NA	41

SOURCES: Calculations based on data from the MIHOPE national model developer survey, the MIHOPE program manager baseline survey, and the MIHOPE site-selection team.

NOTES: EHS = Early Head Start - Home Based Program Option, HFA = Healthy Families America, NFP = Nurse-Family Partnership, PAT = Parents as Teachers.

NA = not applicable.

Percentages that are the same and that are lower than the national model reflect the share of local programs whose program managers' reports are in agreement with or lower than the maximums specified by their national model developers. No local programs reported having caseload limits higher than their national model maximums.

[a]Sample size of local programs: EHS: NA, HFA: 19, NFP: 17, PAT: 13.

[b]Sample size of local programs: EHS: 18, HFA: 24, NFP: 19, PAT: NA.

[c]HFA: maximum of 15 when visits are weekly; no more than 25 on any schedule. PAT: 48 visits per month for first-year parent educators; 60 visits per month for second-year (or beyond) parent educators.

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