FLORIDA HOME VISITING STATEWIDE NEEDS ASSESSMENT UPDATE

Florida Association of Healthy Start Coalitions

2020

September 11, 2020

Health Resources and Services Administration
5600 Fishers Lane
Rockville, MD 20857

To Whom It May Concern,

The Florida Department of Health is pleased to provide this letter confirming the Florida Association of Healthy Start Coalitions (FAHSC) is conducting the 2020 Statewide Home Visiting Needs Assessment Update and submitting it to the Health Resources a Services Administration on the State's behalf. The Florida Department of Health was the original recipient of the Florida Maternal, Infant and Early Childhood Home Visiting (MIECHV) funding. However, FAHSC, a 501(c)3, has been the lead organization for the Florida MIECHV Initiative since 2013. Anna Simmons, the Maternal and Child Health Section Administrator for the Florida Department of Health, has participated on the Home Visiting Needs Assessment Steering Committee and has collaborated with FAHSC on the Title V Needs Assessment. This collaboration continues to build on the existing strong relationship and continue to work in partnership across many endeavors.

This Statewide Home Visiting Needs Assessment Update will assist Florida's state and local stakeholders responsible for the provision of critical home visiting services to better understand the current needs of our children and families living in high-risk communities. The results will also help funders and administrators strategically plan for expansion of appropriate services to fill identified gaps.

Sincerely,

Shay Chapman, BSN, MBA
Chief, Bureau of Family Health Services
Florida Maternal and Child Health Title V Director

cc: Allison Parish, FAHSC Chief Program Officer and Florida MIECHV Project Director

ACKNOWLEDGMENTS

This needs assessment was accomplished through a team effort. Hundreds of home visiting staff, community stakeholders, and parents provided data and information to make this report meaningful and as complete as possible.

The steering committee members provided guidance and recommendations throughout the project. Their advice was invaluable and helped guarantee that this report will be beneficial to all home visiting programs in Florida, not just those funded by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative. A list of the individuals who dedicated their time and expertise, as part of the steering committee, can be found in Appendix 1. Additional research information was provided by Kim Brown and Lorraine Austin, Florida Department of Children and Families, Office of Substance Abuse and Mental Health, and Dr. Ghasi Phillips-Bell with the Florida Department of Health.

The completion of this statewide home visiting needs assessment was overseen by Florida MIECHV staff at the Florida Association of Healthy Start Coalitions. Katie Hood, MIECHV Quality Improvement and Implementation Manager, served as staff lead and Marianna Tutwiler, a consultant, was hired to help facilitate its completion.

The University of South Florida College of Public Health research team spent countless hours compiling, analyzing, and reporting the data for the numerous domains and indicators to determine the high-risk areas in Florida. The team included: Dr. Jennifer Marshall (lead), Dr. William Sappenfield, Dr. Jean Paul Tanner, Dr. Jason Salemi, Dr. Russell Kirby, Dr. Roneé Wilson, Acadia Buro, Vidya Chandran, Barbara Dorjulus, Medinah Nabadduka, Saloni Mehra, Tara Foti, Weiliang Cen, and Blake Scott.

INTRODUCTION

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Initiative is authorized by Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c)) to support voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry.[1]

Section 50601 of the Bipartisan Budget Act (BBA) of 2018 extended appropriated funding for the MIECHV Program through 2022, while section 50603 of the BBA required states to conduct a statewide needs assessment. The BBA further established that conducting a MIECHV statewide needs assessment update is a condition of receiving Title V Maternal and Child Health (MCH) Block Grant funding.

The purpose of this needs assessment update is to identify and understand the diverse needs of families living in high-risk communities and assessing the communities' own capacity for addressing the need. The results will help administrators strategically hone the existing continuum of home visiting and early intervention services, as well as thoughtfully plan for expansion of appropriate services to fill the identified gaps, if additional funding becomes available.

Conducting the Statewide Home Visiting Needs Assessment

The completion of the statewide home visiting needs assessment update was overseen by Florida MIECHV staff at the Florida Association of Healthy Start Coalitions (FAHSC). Katie Hood, MIECHV Quality Improvement and Implementation Manager, served as the staff lead and Marianna Tutwiler, a consultant, was hired to help facilitate its completion. FAHSC contracted with the University of South Florida College of Public Health to spearhead the data analysis, with Dr. Jennifer Marshall as the team lead. A steering committee was formed to guide the completion of the project. The committee was comprised of 15 individuals from varying levels within home visiting (home visitors, supervisors, administrators, and state-level staff), state agencies/funders, model developers, university researchers, and parent representatives. See Appendix 1 for a full list of committee members.

Importance of Home Visiting

Experiences in the earliest years of life form the foundation of brain architecture, executive function, and social emotional health, for better or for worse. Learning, behavior, and health across the lifespan are all built on that foundation. For society, many costly problems, ranging from failure to complete high school to incarcerations to homelessness, could be dramatically reduced if attention were paid to improving children's environments of relationships and experiences early in life. All families need support to be stable, secure, and healthy. For many families, help is available from other family members, friends, and the community. Yet most families, especially those with newborns, can benefit from resources delivered through health care and human service systems. Home visiting is an evidence-based strategy to promote maternal and child health and can offer additional support directly in the context of families' lives to improve the health and well-being of both children and parents.

The US Department of Health and Human Services Health Resources and Services Administration (HRSA) defines home visiting as programs that people voluntarily participate in to improve the health of their families and provide better opportunities for their children.[2] Numerous evidence-based home visiting programs exist, and their services are delivered by a variety of professionals. The focus of home visiting activities includes providing prenatal and preventative care, increasing parents' awareness of appropriate child development, and teaching positive parenting strategies. The common feature shared by all programs is the supportive relationships formed between the home visitor and the family.

Despite the increased awareness of the benefits to health, family, and education outcomes, as well as cost savings that result from broad expansion of home visiting programs, the potential public health impact has not been fully realized in either the United States or in Florida. Barriers to the successful uptake of these programs have included challenges posed by the fragmented prenatal and early childhood systems, disparate funding streams, challenges with model implementation, and a poor system for matching families with programs beyond those identified through the Prenatal and Infant Risk Screens administered by the Florida Department of Health that are referred to Connect (a coordinated intake and referral system). Given the growing interest in and support for home visiting, it is possible that a tipping point is within reach. A universally available comprehensive continuum of early childhood family services is possible. A better understanding of home visiting in Florida, and the services provided to families, is critical not only for future policy planning but also for identifying strategies to maximize home visiting efficiency and effectiveness.

Parents are a child's first and most important teachers. With a growing amount of information about the importance of early experiences, many parents would like more knowledge, skills, and resources to support their child's development. Ensuring families who seek information have access to a continuum of education and support can strengthen and reinforce the critical role parents play in early learning.

Evidence-Based Home Visiting in Florida

Florida invests state, federal, and local dollars in evidence-based home visiting programs aimed at improving family and child health, preventing child abuse and neglect, and promoting school readiness. There are currently seven evidence-based program models, according to the US Department of Health and Human Services, operating in Florida that are funded to serve nearly 17,000 families. The Florida MIECHV initiative funds three of these models. More specific information on funding will be provided later in this section.

Child First

The Child First intervention addresses the highest risk families, decreases stress within the family, increases stability, facilitates connection to growth-promoting services, and supports the development of healthy, nurturing, protective relationships. The intervention is conducted in the home with the child, parents or other primary caregivers, and other family members. Families receive visits twice per week during the first month for an assessment and then once a week or more, depending on the needs of the child and family. Visits last 60 to 90 minutes. Services generally continue for six to twelve months but may be longer based on individual family needs.

Child First home-based intervention has seven major components:

- Engagement of family,
- Comprehensive Assessment of Child and Family,
- Development of Child and Family Plan of Care,
- Parent-Child Psychotherapeutic Intervention,
- Enhancement of Executive Functioning,
- Mental Health Consultation in Early Care and Education, and
- Care Coordination.

A Child First team consists of a licensed, master's level mental health/developmental clinician and a bachelor's level care coordinator, both with significant expertise with very vulnerable, young children and families.

Child First operates in Palm Beach County and is funded to serve 305 families.

Early Head Start (Home-based)

Early Head Start (EHS) programs serve infants and toddlers under the age of three, and pregnant women. EHS programs provide intensive, comprehensive child development and family support services to low-income infants and toddlers and their families, and pregnant women and their families. There is a home-based option for EHS that allows children and parents to receive services in their own home. Home visitors go to the home once a week to work with parents and their children. Together, the home visitor and parents watch and think about the child. They plan ways to help the child learn using parent-child interactions, daily routines, and household materials. A small group of children, parents, and their home visitors also get together on a monthly basis for group socializations.

According to the Program Information Report (PIR), home-based slots are currently available in 30 counties in Florida and serving a total of 843 families. Due to program restructuring and staff vacancies at the state level, data for all home-based EHS programs could not be collected. Data are reported for EHS programs that self-identified as having a home-based option and returned the requested documentation.

Healthy Families Florida

Healthy Families Florida (HFF), an affiliate of Healthy Families America, is an evidence-based parent coaching and support program for expectant parents and parents of newborns experiencing stressful life situations. HFF services are anchored in promoting positive parent-child interactions. Home visitors use motivational interviewing techniques and research-based curricula to address challenging topics and family risks. Activities that take place during each home visit promote protective factors, positive discipline, child health and development, economic self-sufficiency, and family functioning.

HFF home visitors, called Family Support Workers, must have, at a minimum, a high school diploma or GED and experience providing services to families and children. Intensive training is a critical element of the HFF model and is included in national standards. All home visiting staff are required to complete pre-service training prior to providing services to families, followed by a combination of instructor-led and web-based training.

HFF operates in all 67 of Florida's counties, with two teams funded by MIECHV, and is funded to serve 10,653 families.

Home Instruction for Parents of Preschool Youngsters

Home Instruction for Parents of Preschool Youngsters (HIPPY) is a home visiting, early intervention program that helps parents create experiences for their children that lay the foundation for success in school and later life. Parents of children ages two to five commit to participating for a period between two and four years, depending on the child's age at the time of enrollment. It is one of the few programs that enrolls children older than two. The HIPPY curriculum is cognitively based, focusing on language development, problem solving, and perceptual discrimination skills.

For parents in the program, HIPPY provides:

- Activities across five early learning domains;
- Weekly parent training on implementing the curriculum with model fidelity;
- Monthly group meetings that provide additional training, materials, and an opportunity to network within the HIPPY community;
- The support, guidance, and mentorship of training professionals, many of whom were once parents in the program; and
- A bridge to other agencies and organizations that may assist in addressing unmet needs or concerns.

Home visitors must have a high school diploma or GED and receive ongoing professional development and coaching by the University of South Florida's Training & Technical Assistance Center. All home visitors participate in weekly training with the coordinator where they use the HIPPY Role Play Instructional Cycle to practice the curriculum that home visitors will deliver to families during the week.

HIPPY currently operates in 18 Florida counties and is funded to serve 1,230 families.

Nurse-Family Partnership

Nurse-Family Partnership (NFP) is an evidence-based, community health program that serves low-income women pregnant with their first child. Each new mom is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits. Throughout the partnership, the nurse provides new moms with the confidence and the tools they need not only to assure a healthy start for their babies, but to envision a life of stability and opportunities for success for both mom and child.

The primary goals of NFP are to:

- Improve pregnancy outcomes by helping women engage in good preventative health practices, including through prenatal care from their healthcare providers, improving their diets and reducing their use of cigarettes, alcohol, and illegal substances;
- Improve the child health and development by helping parents provide responsible and competent care; and
- Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education, and find work.

NFP enrolls mothers early in pregnancy, typically no later than the 28th week of pregnancy, and serves the family until the child's second birthday. Nurse home visitors are registered professional nurses with a minimum of a baccalaureate degree in nursing. In addition to their schooling, nurse home visitors also receive extensive training by the Nurse-Family Partnership National Service Office.

NFP operates in 20 Florida counties, 13 of which are funded by MIECHV, and is funded to serve 1,787 families.

Parents as Teachers

The Parents as Teachers (PAT) model is an evidence-based early childhood home visiting model that builds strong communities, thriving families, and children who are healthy, safe, and ready to learn. Certified parent educators implement the PAT model using their fundamental approach: partner, facilitate, and reflect.

There are four integrated components of the PAT model: personal visits, group connections, screening, and resource network. Parent educators emphasize parent-child interaction, development-centered parenting, and family well-being across all four components.

The PAT model is designed to achieve four primary goals:

- Increase parent knowledge of early childhood development and improve parenting practices,
- Provide early detection of developmental delays and health issues,
- Prevent child abuse and neglect, and
- Increase children's school readiness and school success.

PAT affiliates are designed to provide at least two years of services to families whose children are prenatal to kindergarten age. The Foundational curriculum allows programs to serve families prenatally to age three. Foundational 2 expands services to cover children ages three to kindergarten age. Parent educators must have at least a high school diploma or equivalency and two years' previous supervised work experience with young children and/or parents. Upon hire, parent educators are trained on the Foundational curriculum and model implementation. Parent educators and supervisors who carry a caseload must receive at least 20 hours of annual professional development.

PAT operates in 18 Florida counties, 14 of which are funded by MIECHV, and is funded to serve 1,786 families.

Play and Learning Strategies (Infant)

Play and Learning Strategies (PALS) is a home-based, preventative intervention program to strengthen the bond between parent and child and to stimulate early language, cognitive, and social development. The PALS curriculum was developed by the Children's Learning Institute in Houston, Texas, and the coaches' training and certification is provided by Children's Learning Institute staff. The program is facilitated by a trained parent educator (coach) who presents each session to the parent(s) and coaches the parent(s) in using specific techniques. In coaching sessions, PALS uses videotaped examples of real mothers and children to demonstrate each concept and allows the parent to critique these examples before practicing the new skills with their own child. Guided practice opportunities during each session help the parent move from watching, listening, and talking, to doing. Coaches are bilingual to be able to serve families in Spanish and English. The PALS Infant curriculum consists of 11 sessions and is appropriate for parents of infants from 4 months to 15 months.

The Pals developers recommend that parent coaches have at minimum an associate degree in early childhood (or related field) or a high school diploma and work experience commensurate with education. Coaches are recommended to attend monthly training (webinar or courses) related to children, families, coaching, or other topics of interest to help them improve the PALS goals and their work with families.

PALS operates in Manatee County and is currently funded to serve 24 families.

Primary Funding Sources for Evidence-Based Home Visiting in Florida

Florida utilizes federal, state, and local dollars to fund evidence-based home visiting in Florida. The primary funding for these services flows through three state agencies – Department of Children and Families (DCF), Department of Health (DOH), and the Office of Early Leaning (OEL) – and the Florida Association of Healthy Start Coalitions (FAHSC), which administers the Florida MIECHV Initiative.

The largest investment in evidence-based home visiting is from DCF - the primary funding source for Healthy Families Florida at nearly $30 million. Funding is authorized through the Florida State Legislature, but derives from several federal and state sources: Temporary Assistance for Needy Families (TANF); Title IV-B, Subpart 2, of the Social Security Act, Promoting Safe and Stable Families (PSSF); Child Abuse Prevention and Treatment Act (CAPTA); and Community-Based Child Abuse Prevention (CBCAP). Since the latter two sources are being utilized to expand home visiting services, more detail is provided below.

Community-Based Child Abuse Prevention (CBCAP) programs were established by Title II of the Child Abuse Prevention and Treatment Act Amendments of 1996. CAPTA has been amended several times and was last reauthorized on December 20, 2010, by the CAPTA Reauthorization Act of 2010 (P.L. 111-320). It was amended in 2015, 2016, and 2018, and most recently, certain provisions of the act were amended on January 7, 2019, by the Victims of Child Abuse Act Reauthorization Act of 2018 (P.L. 115-424).

Child abuse prevention and family support programs administered under the Community-Based Child Abuse Prevention (CBCAP) program focus on the provision of support and services to promote positive parenting and healthy family functioning and family self-sufficiency. Statewide and regional projects focus on the public awareness and community education initiatives, training for professionals, and support of statewide resources for family violence prevention. DCF, along with its providers, continue to focus on the expansion of evidence-based home visiting programs through the use of both CBCAP funds and Child Abuse Prevention Treatment Act (CAPTA) funds.

Using both CBCAP and CAPTA grant funds, DCF has awarded seven contracts covering several counties in the state for delivery of home visiting services for pregnant women with substance use and families with infants affected by parental substance exposure. FAHSC administers one of these contracts and subcontracts with four Healthy Start Coalitions (Northeast Florida, Southwest Florida, Orange, and Hillsborough) to deliver home visiting by nurses. Hillsborough also receives funds through the local Community-Based Care (CBC) agency. The five remaining contracts were provided to CBCs serving Pasco/Pinellas, Flagler/Volusia, Brevard, and West Florida. Each team must have a nurse and deliver home visiting services. Some programs are using NFP, while others are implementing HFF or PAT with a nurse added to the team, and others use Healthy Start nurses who implement an evidence-based curriculum for individuals with a substance use disorder. Programs will focus on strengthening the parenting skills of this population, delivering critical service needs and linkages, as well as the creation and/or modification of Plans of Safe Care.

Eight of the 12 NFP sites in Florida receive MIECHV funding, and many of the 12 sites receive funding from more than one source to fully fund their teams. DOH provides $500,000 in state NFP funding for four sites that are administered through FAHSC, and several NFP sites are receiving funds from the NFP NSO (approximately $855,000). Four NFP sites are receiving CAPTA/CBCAP funding through FAHSC ($929,000), which will be discussed below, and many receive funding through local contributions from Healthy Start Coalitions, Children's Services Councils, and foundations. The total investment in Florida is approximately $9 million.

EHS if funded directly through the Office of Head Start, within the Administration for Children and Families, a division of the US Department of Health and Human Services, and goes directly to the providers. The Florida Head Start State Collaboration Office is housed at OEL.

OEL administers $3.9 million in funding to HIPPY. HIPPY receives a combination of state and federal dollars -- $1.4 million in recurring funds and $2.5 million in nonrecurring funds from the Welfare Transition Trust Fund.

FAHSC is a nonprofit organization that is responsible for the implementation of the Florida MIECHV Initiative. Florida's MIECHV funds currently support three evidence-based models – HFF, NFP, and PAT – implemented by community agencies in 25 high-risk counties (based on the 2010 Needs Assessment) and four high-need communities in contiguous counties. Federal funding for MIECHV is awarded in overlapping two-year periods. In federal fiscal years (FFY) 18-20, the amount was $10.2 million and decreased to $9.2 million for FFY19-21, when funds were reallocated across the states and territories. Sequestration further reduced funding to $9.1 million for FFY20-22. In FFY19-20, Florida MIECHV funded over 2,000 home visiting slots. There will be a reduction in funded slots for FFY20-21, due to federal budget cuts. Additional reductions will be seen for FFY21-22, unless FAHSC receives an increase in funding.

SECTION 1. IDENTIFYING COMMUNITIES WITH CONCENTRATIONS OF NEED

This section gives a brief overview of Florida's cultural and geographic diversity and describes the overall methodology for using composite state, county, and sub-county indicator data to identify Florida populations and communities that would most benefit from perinatal and early childhood home visiting services.

FLORIDA'S CULTURAL AND GEOGRAPHIC DIVERSITY

Florida has the 3rd largest population, with high racial, ethnic, and linguistic diversity. Florida exceeds the US rates for:

- Renters (vs. home ownership)
- High school dropout
- Maternal mortality
- Poor birth outcomes: SGA, PTB, LBW
- Infant mortality
- Uninsured children
- Prescription pain reliever misuse
- Crime

Of the 50 United States, Florida has the 3rd largest population with 21,477,737 people (6% of the total U.S. population).[3] Since 2010, Florida continues to be one of the top 10 fastest growing states with an annual growth rate of 1.8%.[4] Florida's residents are culturally diverse; 20.5% of residents were born in foreign countries, with the majority from Latin America.[5] The population identifies as 77.3% White, 16.9% Black or African American, 2.6% two or more races, and <1% Native American or Native Hawaiian/Pacific Islander. About 70% of Floridians report English as their primary language spoken at home, with the remaining 30% of languages spoken including Spanish, Haitian Creole, French, Portuguese, Chinese, Tagalog, German, Vietnamese, Arabic, and Italian.[6] The most common non-English language spoken in Florida is Spanish (21.6% of the population), which is above the national average of 13%.[7,3] Florida is ranked as a favorite travel destination, not only in the United States but also worldwide, with five large urban area attractions (Miami, Tampa-St. Petersburg, Orlando, Jacksonville, and Sarasota-Bradenton). The South Florida metropolitan area in Florida has about six million people.

Selection of Indicators and Domains

The USF data analysis team collaborated with MIECHV leadership and the steering committee to select seven domains consisting of a total of 25 indicators that were inclusive of the eight constructs specified in section 511(b)(1)(A) of Title V. County and census tract level data were obtained to identify high-risk communities throughout Florida. Statewide counts and rates for each indicator were calculated, and a description of data sources, definitions, and derivations was provided.

Considerations

Several sources were considered in development of a full conceptual framework of domain/indicators. These constructs represent factors that serve as risk or protective factors, maternal or child health outcomes, or special populations or health issues that home visiting programs are specifically designed to address.

Title V, section 511 indicators. The following eight constructs are specified in section 511(b)(1)(A) of Title V legislation for inclusion in the MIECHV needs assessment: 1) premature birth, low birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; 2) poverty; 3) crime; 4) domestic violence; 5) high rates of high-school drop-outs; 6) substance abuse; 7) unemployment; and 8) child maltreatment.

Supplemental Information Request (SIR). The SIR released by HRSA specified five domains that were aligned with HRSA indicators representing the above eight constructs specified in sections 511(b)(1)(A) of Title V legislation, based on nationally available county-level data: 1) low socioeconomic status; 2) adverse perinatal outcomes; 3) child maltreatment; 4) crime; and 5) substance use disorder. Florida renamed the crime domain "Family and Community Violence" to include the intimate partner violence indicator.

MIECHV Benchmark Areas and Indicators. The Florida MIECHV Initiative reports on 19 performance measures (indicators) and six benchmark areas (domains) annually.[8] The measures include data from all families with a completed home visit during the reporting year. Each performance measure relates to one of six benchmark areas which include: 1) maternal and newborn health; 2) child injuries; child abuse, neglect, or maltreatment; and emergency department visits; 3) school readiness and achievement; 4) family violence; 5) family economic self-sufficiency; and 6) coordination and referrals for other community resources and supports. From this list, the team identified five MIECHV benchmark areas and 13 indicators for consideration. Ultimately, four indicators were selected from the MIECHV 2018 performance measure report (intimate partner violence, tobacco, and preventable hospitalizations – for asthma, for injury).

Findings from the MIECHV 2014-2018 Evaluation Reports Compendium. The team also systematically reviewed all MIECHV evaluation reports from 2014 to 2018 coding for participant needs and outcomes, MIECHV services and referrals, and specific populations served using MAXQDA qualitative analysis software to identify additional relevant indicators for consideration.

Public Health Frameworks. The team also reviewed constructs within the Life Course Model[9] and Adverse Childhood Experiences (ACEs) Framework[10] and determine that the indicators considered above were aligned with these frameworks.

Rationale for including Priority Populations Domain. Populations identified as requiring specific needs within the MIECHV program include immigrant families and migrant workers. Additionally, participants who have an incarcerated family member were identified as a subpopulation with specific needs.

Rationale for including a Child Health and Development Domain. As MIECHV aims to promote child health and development – in addition to preventing child abuse and neglect and improving pregnancy outcomes – the child health and development domain was a necessary addition to the framework.

As a result, two domains – "Child Health and Development" and "Priority Populations" – and seven indicators were added after coding the compendium to address emergent themes regarding child needs reported by MIECHV participants and priority populations that MIECHV serves: promotion of residents who are incarcerated or working in the agriculture industry (farmworkers), ALICE households, home ownership, maternal mortality, child insurance, and kindergarten readiness.

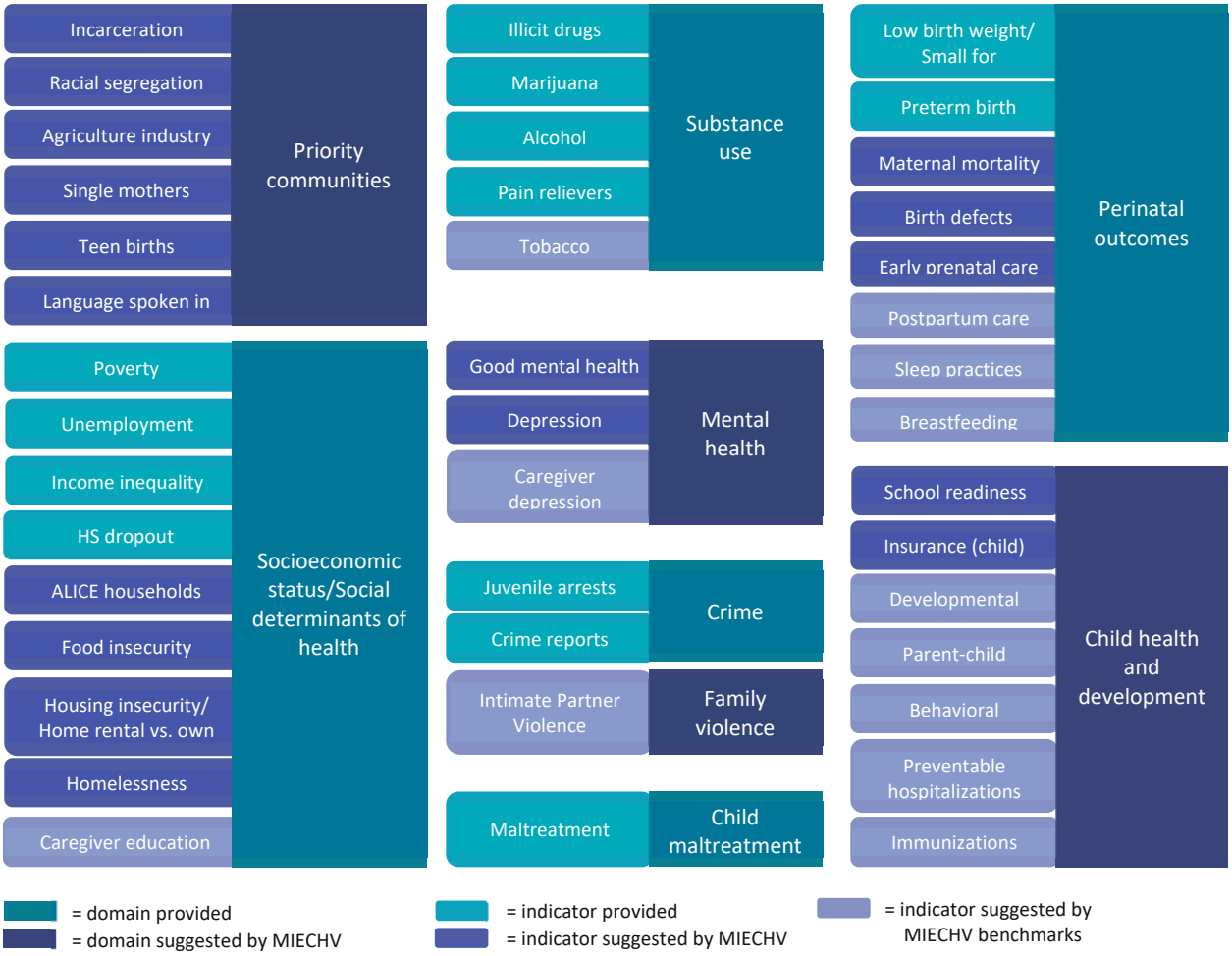


Figure 1: Full initial conceptual framework of indicators considered for the needs assessment.

Selection Process

A comprehensive list of all considered indicators was presented to the steering committee in December 2019. The committee members completed a survey to rank order indicators within each domain and suggest any additional indicators. As a result, maternal mortality and infant mortality were added.

The USF team then reduced the list of indicators to those with accurate, up-to-date, and population-wide data available at the county level (and if possible, at the sub-county level). Indicators that did not meet the three criteria were removed. The team members had biweekly meetings to choose appropriate data indicators that align with these constructs and to determine accessibility and quality of the data. Through the biweekly meetings and guidance from leadership, the data analysis team aligned each indicator with the five HRSA-recommended domains (socioeconomic status, perinatal outcomes, child maltreatment, crime, and substance use disorder) and the two added domains (priority populations and child health and development).

Final List of Indicators

The final list includes seven domains and 25 indicators. Descriptions of each indicator, including data source, definition, and derivation, as well as population data used as the denominator to calculate indicator rates statewide by county and tract level, can be found in Appendix 2.

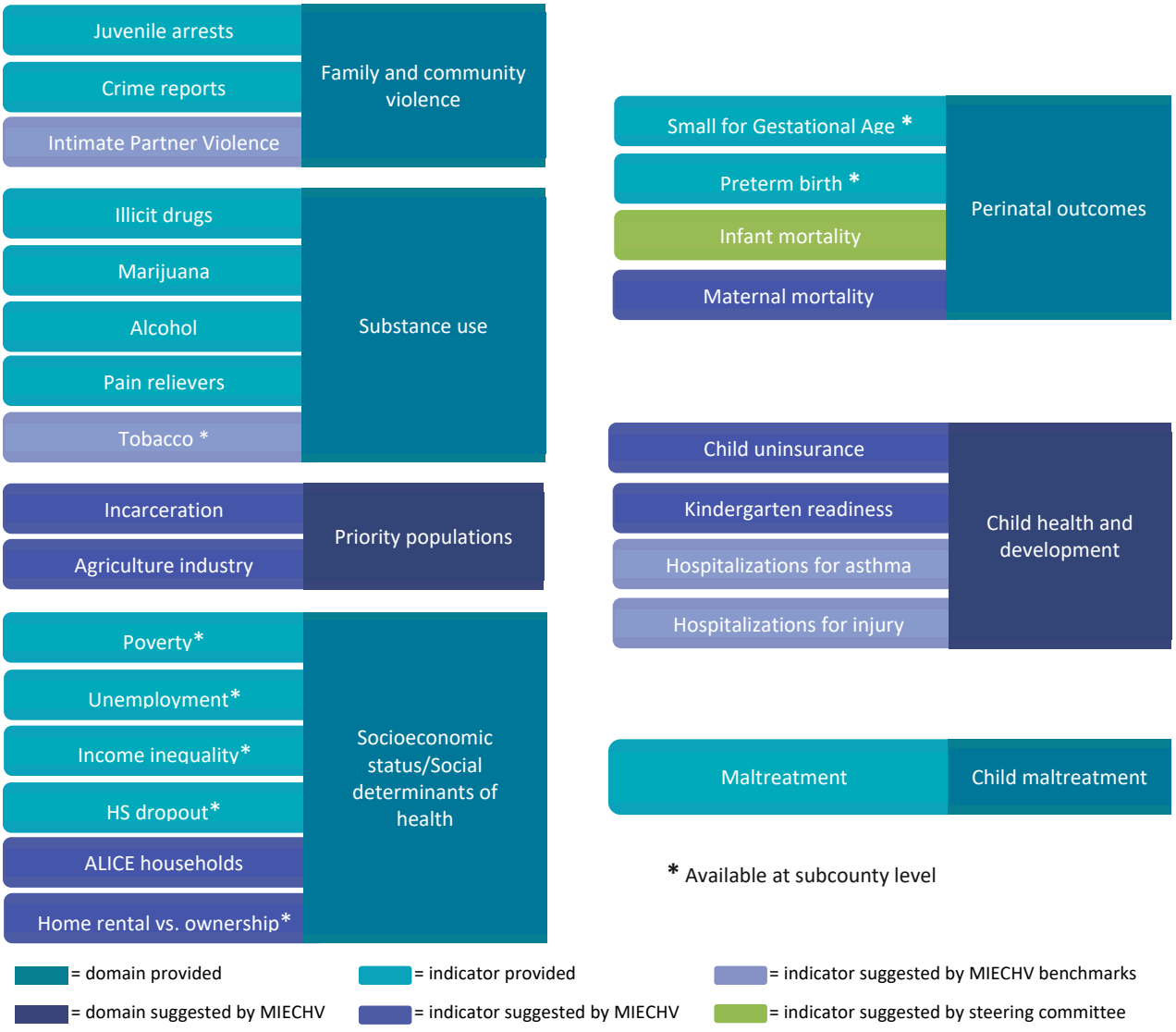


Figure 2: Final Indicator Framework

Unit of Analysis Selection

The data analysis team also carefully considered the unit of analysis for determined need. Based on data availability, county or census tract was chosen as the unit of analysis. Sub-county data at the census tract level were obtained for the following indicators: unemployment, poverty, high school dropout, tobacco, income inequality, home ownership, small for gestational age, preterm birth. Indicator descriptions with level of analysis are found on Tab 2. Description of Indicators of the **Florida Needs Assessment Data Summary**.

Description of Methodology for Assessing High-Risk Populations

The "simplified method", an option which utilizes data provided by HRSA, was adapted to account for the seven domains that were selected for the analysis and census tract level analysis for indicators for which data were available. The means of counties and standard deviation, state mean, and other descriptive statistics (number of missing, range, etc.) were calculated for each indicator. Z-scores (standardized indicator value) were calculated for each county level indicator value. For each county, the proportion of indicators with a z-score greater than one within each domain was calculated. Counties were considered high-risk for a given domain if at least half of the indicators within a domain has z-scores greater than or equal to one. Counties with two or more high-risk domains were identified as high-risk. For data extracted from the American Community Survey, 5-year estimates were used.

The County-Level Approach to Identifying High-Risk Counties

1. Obtain raw, county-level data for each indicator from the listed data source(s) as defined in Tab 2. Description of Indicators and compute the indicator for each county.
2. Compute mean and standard deviation (SD) of indicator values across all counties, as well as other descriptive statistics (number of missing values, range, etc.) (Tab 3. Descriptive Statistics; Tab 4a. Raw Indicators (County)).
3. Standardize indicator values (compute z-score) for each county. Z-score = (county value-mean of all counties)/ SD of all counties. (Tab 5a. Standardized (County)).
4. Using the resulting z-scores for each county, calculate the proportion of indicators within each domain for which that county's z-score was greater than or equal to one; that is, the proportion of indicators for which a given county is in the "worst" 16% of all counties in the state (16% is the percentage of values greater than one SD above the mean in the standard normal distribution).
5. If at least half of the indicators within a domain have z-scores greater than or equal to one, then a county is considered high-risk on that domain.
6. For each county, the total number of high-risk domains (out of seven) is summed. Counties with two or more high-risk domains are identified as a high-risk county. (Tab 7. At-Risk Domains (County)).

Note: All tabs are found on the **Florida Needs Assessment Data Summary**.

Florida Needs Assessment Maps

Maps 1-7 show the high-risk counties in each of the seven domains selected for the needs assessment. Map 8 shows the number of domains out of the seven domains that are high-risk in each county. Maps 9 and 10 show the distribution of the special populations (incarcerated population and farm worker

population) across Florida at the county level. Maps 11-13 show the counties that are determined as high-risk on the county and tract-level analyses, and map 14 shows the final selected counties that are high-risk. Maps 1-14 can be found in Appendix 3.

The Tract-Level Analysis Approach to Identifying Additional High-Risk Counties

To supplement identification of counties deemed high-risk due to their comparatively worse scores on indicators comprising more than one domain, when available, census tract level data were used to identify larger concentrations of risk within counties. That is, a purely county-level analyses may mask high-risk communities, particularly in counties with large populations. We operationalized the "sub-county" or "community" concept with data collected at the census tract level. Although census tract level data were not available for most of the indicators in this needs assessment, we were able to obtain reliable data for seven of the 25 county-level indicators, and data on an additional education indicator that serves as a proxy for another county-level education indicator. The hybrid county- and tract-level analysis approach was taken due to lack of recent, quality data at the sub-county level for all 25 indicators and because selecting county alone as the unit of analysis may not identify high-risk communities in higher population counties. Counties identified by our method reflect the level of risk in Florida by highlighting communities that met the threshold for at-risk domains or indicators based on county- and tract-level analyses.

We followed these steps to determine which domains were high-risk based on sub-county areas:

1. Census tract level analysis was conducted on eight indicators: seven that were used in the county-level assessment (poverty, unemployment, income inequality, home ownership, small for gestational age, preterm birth, and tobacco) and a new indicator (% of those aged 25 or older without a high school diploma) to replace another education-based indicator for which there was a high level of missingness at the tract level (% high school dropout among 16-19-year-olds). (Tab 4b. Raw Indicators (Tract) – Data not shown).
2. The same procedures as used for the county-level analysis were followed for translating raw values to standardized indicator values (z-scores) for each tract. Tracts were deemed high-risk for an indicator if the z-score for that indicator was greater than or equal to one. (Tab 5b. Standardized (Tract) – Data not shown).
3. Tracts that were high-risk for at least three of the eight indicators were themselves classified as high-risk as the 50% rule (4 of 8) was overly restrictive given the relatively fewer numbers of indicators available at the tract level.

Counties with 150 or more births in high-risk tracts in 2019 were identified as high-risk counties (Tab 6b. At-Risk Indicators (Tract)).

Counties Identified Based on Levels of Need

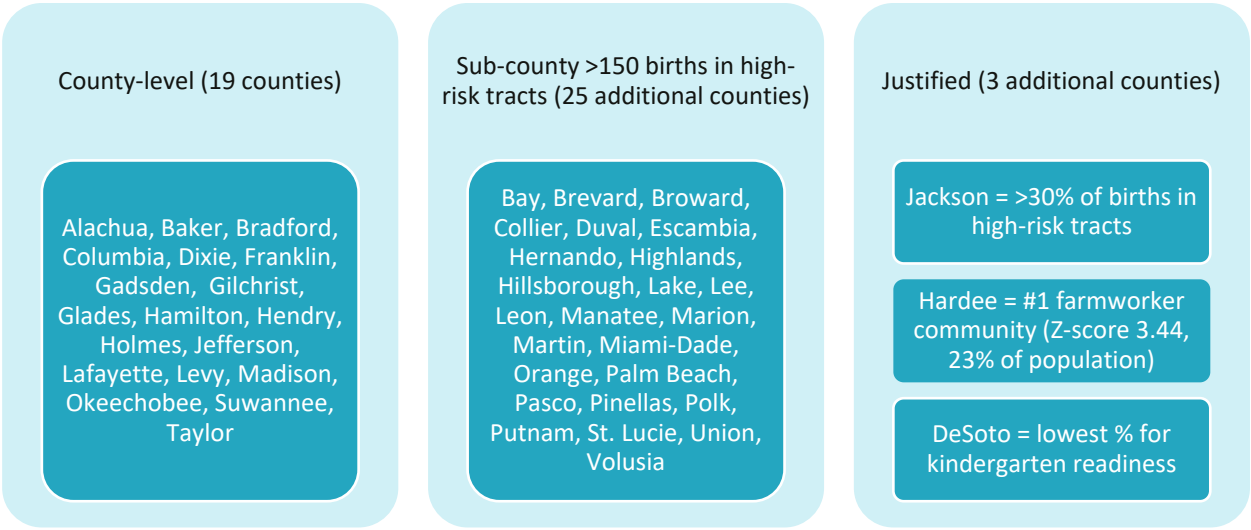
State-Level Statistics

State-level statistics for all 25 indicators are summarized in Tab 3. Descriptive Statistics of the **Florida Needs Assessment Data Summary**. Based on the data described above (as specified by population and year(s) in Tab 2. Description of Indicators), 13.7% of Florida's families with children under 5 years live in poverty, 3.1% of the civilian labor force (civilian noninstitutional population ages 16 and older) are unemployed, 32.0% of households are ALICE households, and 43.2% of families with children under 18 years live in renter-occupied housing units. The high school dropout rate is 4.7% and 12.0% of Florida

residents over age 25 have less than a high school education. Regarding priority populations for MIECHV services, 414.9 per 100,000 residents aged 15-64 years are incarcerated, and 1.27 per 100,000 of the labor force population aged 16-54 years are hired farm workers. Adverse perinatal outcomes include an infant mortality rate of 6.1 per 1,000 live births, a maternal mortality death ratio of 21.3 per 100,000, 8.3% of births are pre-term (before 37 weeks), and 8.7% are low birth weight (born less than 2500 grams). Statewide, the prevalence rate of binge alcohol use was 21.2%; of marijuana use in the past month was 7.7%; of other illicit drugs in the past month was 3.0%; nonmedical use of pain medication in the past year was 3.5%; and 4.4% of resident live births have an indication of maternal smoking during pregnancy. Regarding family and community violence, the reported crime rate is 2,551 per 100,000 residents, total juvenile arrests is 2,351 per 100,000 population ages 10-17 years, and intimate partner violence is 503 per 100,000. Child maltreatment impacts 10.3 per 1,000 children ages 1-17 years. There are 7.6% of children under 19 years of age who are uninsured, 46.6% who lack kindergarten readiness, 594 per 100,000 ages 1-5 hospitalized for asthma, and 160 per 100,000 ages 2-5 years are hospitalized for non-fatal unintentional injuries.

High-Risk Counties

A total of 47 counties were identified as high-risk; 19 identified with county-level data, 25 counties identified with tract-level analyses, and an additional three counties with justification, as illustrated below.

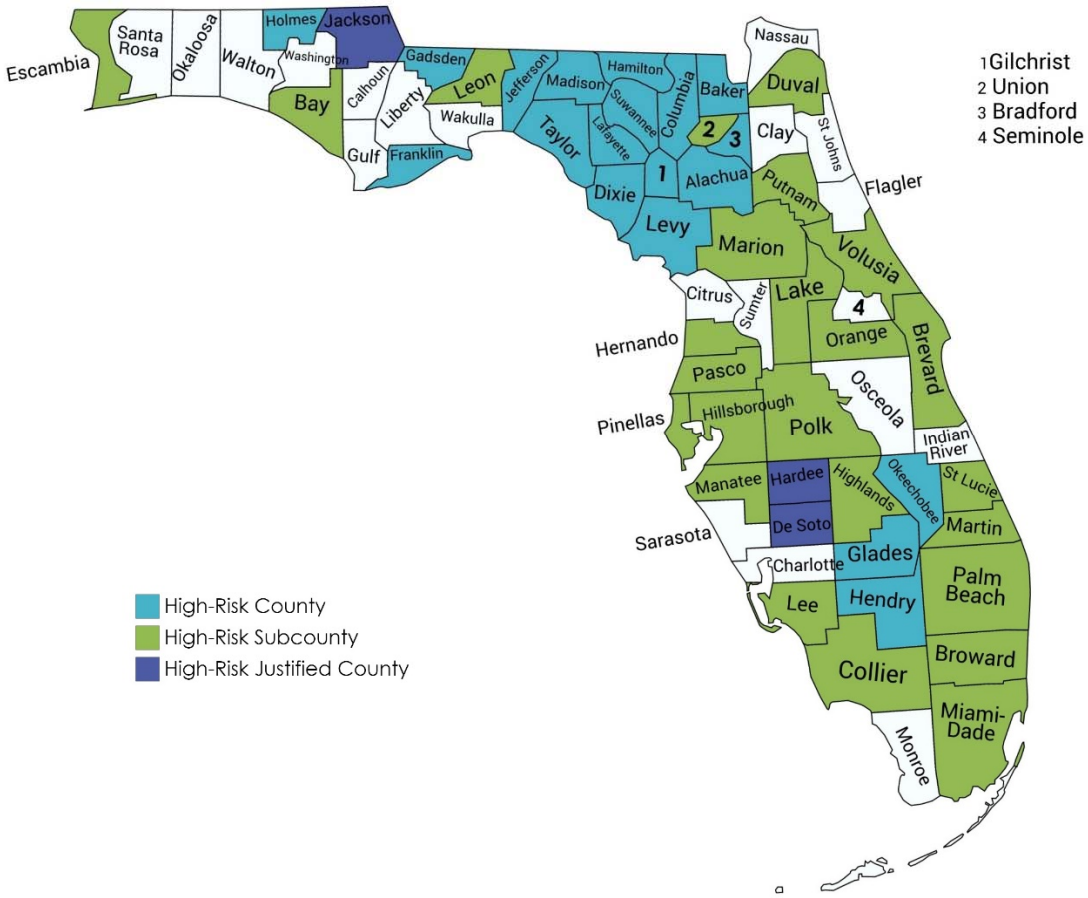


The decision to justify three additional counties was made for varying reasons. More than 30% of births in Jackson County are in high-risk census tracts. Hardee County has the highest percent of farmworkers (23% of population) living in its communities. And Desoto County has the highest percentage of children (71.7%) who scored less than a 500 on the Star Early Literacy assessment, which means only 28.3% of the children in DeSoto County are considered “ready for kindergarten.” Given that all three of these counties are currently implementing MIECHV-funded programs and additional risks are known, both with quantitative and qualitative data, the decision was made to classify them as high-risk and continue services to these counties.

There are two additional counties that are currently served by MIECHV – Clay and Sarasota – that did not show as high-risk during the county- and tract-level analysis. Due to the small amount of data supporting a high-risk classification and a recent reduction in funding, the decision was made in

conjunction with the providers to discontinue MIECHV-funded services in these counties by FY21-22. The few families being served in these counties are completing the program or are being transferred to other services. A rank ordered list of counties all domains and indicators can be found in Appendix 4.

Florida's identified high-risk counties are depicted in the map below.



SECTION 2. IDENTIFYING THE QUALITY AND CAPACITY OF EXISTING PROGRAMS

COLLECTION OF INFORMATION

In order to determine the quality and capacity of existing programs, data were collected from evidence-based models that are eligible for MIECHV funding and surveys were completed by home visiting programs, community stakeholders, and parents in the identified high-risk counties.

Data from Evidence-Based Models

The type of data needed to assess the quality and capacity of existing home visiting programs in Florida were unavailable in a format that was comparable across programs. Therefore, the steering committee came up with a list of information that was important, and the needs assessment team developed an

Excel spreadsheet to capture the requested information. To assess the quality and capacity, the following information was requested:

- Number of funded family slots
- Number of families served in the most recently completed program year
- Funding sources
- Age criteria for enrollment
- 12-month retention of families served
- Demographic characteristics (race, ethnicity, and language) of participants and home visitors

This information was collected for each program at the county level – some adjustments were necessary for multi-county programs. It was ultimately decided by the team not to include the retention rates in the report because programs had varying levels of ability to accurately track the information, programs calculate retention differently, and two of the programs (Child First and PALS) can be completed in less than a year.

In early March 2020, the spreadsheet was disseminated to the programs. A master spreadsheet was sent to the state offices for HFF, HIPPY, and NFP that included all counties served. FAHSC staff completed the document for MIECHV-funded PAT programs. The spreadsheet was also shared with the Executive Director of the Florida Head Start Association to disseminate to local EHS programs because there has been an extended vacancy for the Executive Director of the Florida Head Start Collaboration Office, who was originally selected to be on the steering committee.

By mid-March, Florida and the nation were grappling with the spread of the COVID-19 virus and governmental decisions to limit gathering of people. Many Florida counties enacted stay-at-home orders and on April 1, Governor DeSantis issued a statewide stay-at-home order. This had a profound impact on home visiting programs as they had to struggle to adjust to serving families remotely, as well as assisting families and staff who contracted the virus. The team extended the deadline for submitting completed spreadsheets until mid-May and continued to work with programs through the rest of summer to collect as complete data as possible.

Assessing the Results of the Statewide Capacity Survey

As part of their work on the needs assessment, HRSA estimated the number of families who are likely to be eligible for MIECHV services in each state. That number was based on the following criteria:

- Number of families with children under the age of six living below 100% of the poverty line plus the number of families in poverty with a child under the age of one and no other children under the age of six (a proxy for families with a pregnant woman that would also be eligible for MIECHV services)

AND

- Belongs to one or more of the following at-risk sub-populations:
    - Mothers with low education (high school diploma or less)
    - Young mothers under the age of 21
    - Families with an infant (child under the age of 1)

Based on this methodology, Florida has an estimated 111,366 families who are eligible for MIECHV services. According to the spreadsheets collected from the evidence-based programs operating in Florida, there is funding to serve 16,639 families. We are currently serving only 15% of the estimated families in need of services. Only 12 (18%) counties have enough funded slots to serve 50% or more of their families. Almost 27% (18) of all of Florida's counties can only serve 10% or less of their families in need.

It is important to note that the estimate of need is solely based on the priorities of HRSA, the funder of MIECHV – other funding sources may prioritize different factors and, therefore, have a different estimate of need.

Identifying Gaps in Staffing

At the time of collection, roughly 93% of home visiting positions statewide were filled. A minimal number of vacancies ensures that programs can maximize funding and serve the full capacity of families. Demographic information was collected for the currently employed home visitors and compared to the demographic information of families served to ensure that the cultural and linguistic needs of families are met and that programs are provided in a relevant and appropriate way.

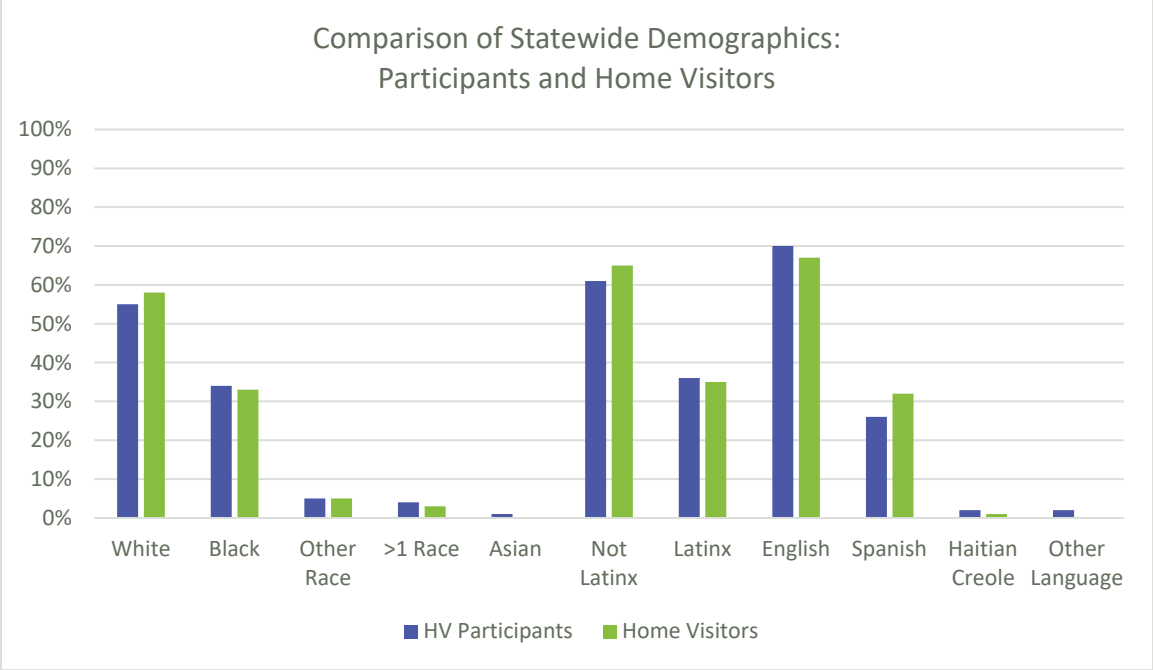


Figure 3: Comparison of Statewide Demographics

The data depict a diverse population of families receiving services and an equally diverse core of professional home visitors who serve them. It appears that the cultural and language needs of families are met in a relevant and appropriate manner as the largest difference is that there are six percent more Spanish speaking staff than Spanish speaking families. All other characteristics match very closely across the state. It should be noted that larger variances can be seen in specific counties. To review the comparisons broken down by county, see the county profiles in Appendix 5.

Assessing the Results of the Stakeholder Surveys from the High-Risk Communities

To obtain more detailed information about the counties identified as high-risk, surveys were distributed to home visiting programs, community partners, and parents in those communities. The surveys for home visiting programs and community partners were designed to assess the quality and capacity of the home visiting programs; the availability of community resources, including substance abuse and mental health services; and community readiness and capacity to expand home visiting services. They were piloted in Jefferson, Madison, and Taylor Counties. The parent survey was designed to capture their opinions of home visiting programs and other needs and services within the community. The parent survey was available in English, Spanish, and Haitian Creole. See Appendix 6 for the survey questions. Further analysis of the qualitative data is planned to follow the completion of the initial report.

Home Visiting Program Respondent Characteristics

The home visiting staff survey was completed by 100 respondents from 37 of 47 counties, though not all respondents answered every question. Miami-Dade, Broward, St. Lucie, Duval, and Alachua Counties had the highest frequencies of responses (44% of respondents were from these counties). Over half of the respondents were Healthy Start (23%) or Healthy Families (26%) program staff. Staff from NFP (19%), HIPPY (10%), and PAT (8%) programs also participated. Other programs mentioned included: Nurturing Parenting Program, PALS, Prenatal Plus Mental Health Services, and the NewboRN Home Visiting Program. Most respondents (75%) were administrators or supervisors, while 25% were home visitors or other staff.

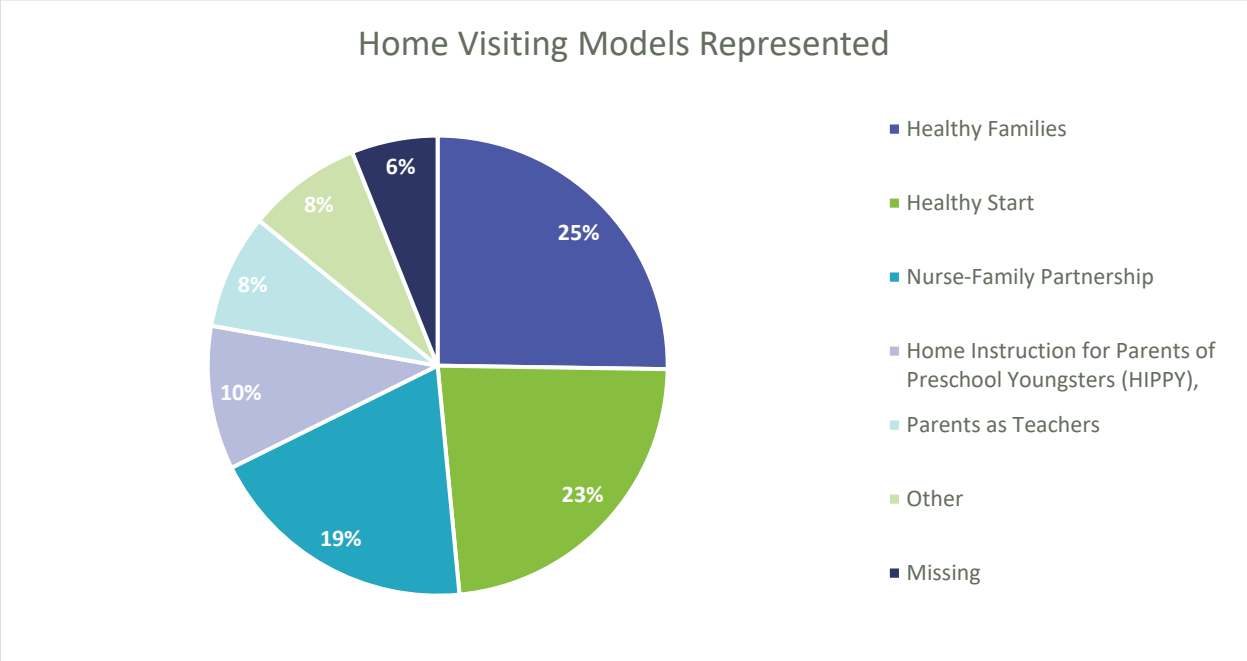


Figure 4: Home Visiting Models Represented

Community Partner Respondent Characteristics

A total of 202 respondents from 26 counties and 50 cities throughout Florida completed the community partner survey. Almost 60% of the respondents were from four counties: Miami-Dade (53), Manatee (26), Palm Beach (22), and Hernando (20).

These community stakeholders and leaders included representatives from diverse sectors including: Early Learning Coalitions, early care and education, school districts, and technical schools; social services and family support providers; parent advocates; small business owners; city and county officials; health department staff; child welfare and Guardian ad Litem; juvenile justice; elder care; faith-based organizations; disability serving organizations; pregnancy care centers, health care coverage organizations, and hospitals; children's services councils; fire and rescue; Salvation Army; local community coalitions; and the YMCA.

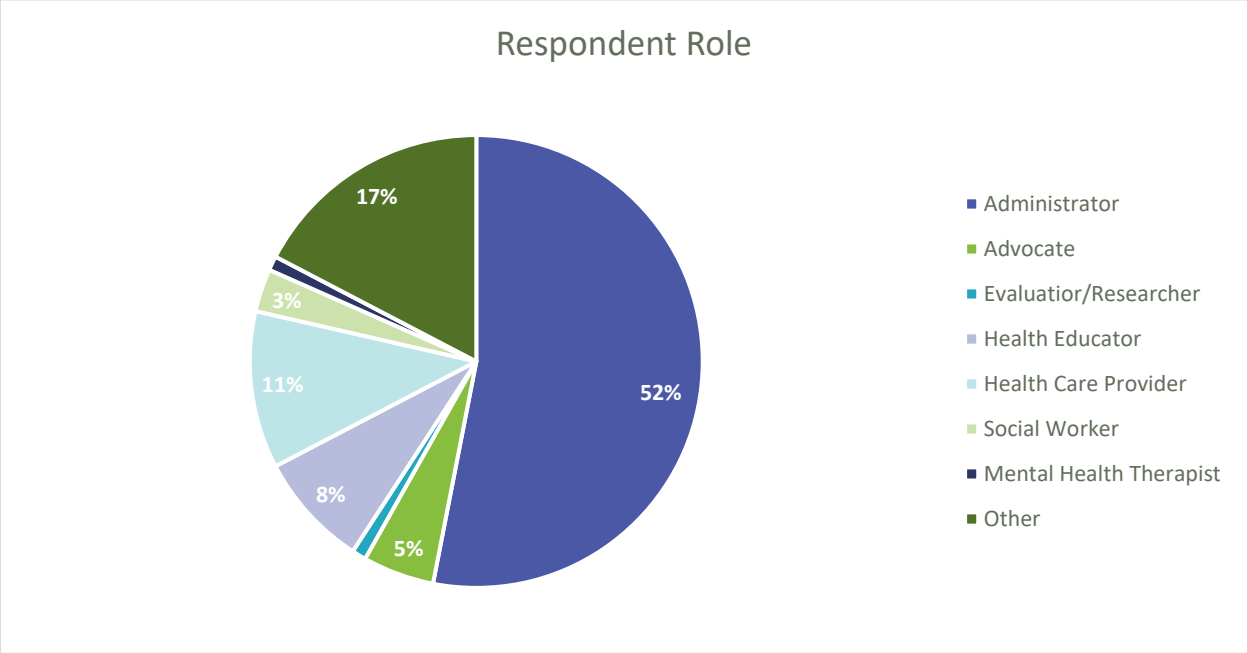


Figure 5: Community Partner Respondent Role

*"Other" includes board of directors, Child Welfare, Child Care provider/staff, Child Development Inclusion Coordinator., Clinical community outreach (4), Community Partner/liaison/relations manager, County Government, Facilitator for Parenting Program, Financial Aid Coordinator, Health & Wellness Specialist, Health plan, Program Analyst, Law Clerk, Librarian, Marketing and Public Relations (3), Multicultural Outreach Coordinator, Policy Coordinator, Senior Volunteer, Training Specialist, etc.

Parent Survey Respondent Characteristics

The survey was completed by 455 respondents from at least 33 counties, though not all respondents answered every question. Manatee County had the highest frequency of parent responses (210), followed by Broward, Hillsborough, Alachua, Miami-Dade, and Bay Counties; 25 reported their county as "Florida" or "United States".

Most respondents were 30-38 years old (42%) with 29% under 30 (132) and 29% (130) age 39 or older. Most parents surveyed were female (431, 95%), with 18 (4%) male, one Gender Variant/Non-Conforming, and five who preferred not to answer. While 66% of respondents were White, 20% (89) were Black, and 13% (55) identified as "Other" or "More than one race". Nearly a third (148, 33%) of the parents identified as Hispanic or Latino/a. Most respondents were married (246, 54.1%) or living with a partner (84, 19%), had one or two children under the age of six (300, 88.45%), including pregnancy. Children's ages ranged with majority aged four (24%) or 5 (25%); 24 respondents noted that they are currently pregnant.

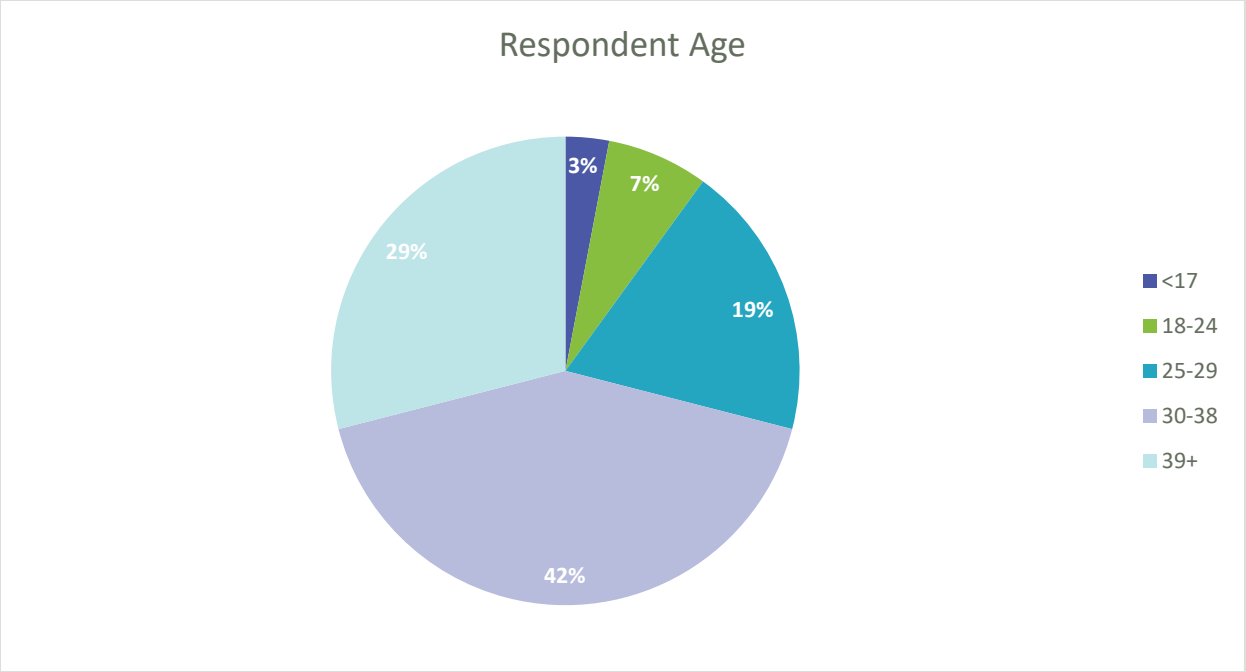


Figure 6: Parent Respondent Age

Identified Gaps in Community Resources

Overall, an equal number of the community partner survey participants responded that there are (43, 37.7%) or are not (42, 36.8%) sufficient providers to serve clients with early childhood services in their communities. An additional 29 (25.4%) were not sure. Across the board, the home visiting program respondents perceive early childhood services to be less available than the community partners. Survey respondents were also asked to indicate if specific early childhood services are available, not available, or inaccessible to meet the needs of families in their communities.

Table 1: Early Childhood Services

	Community Responses							Home Visiting Responses						
Programs & Services	**Services Available**		**Insufficient**		**Not Available**		**Total**	**Services Available**		**Insufficient**		**Not available**		**Total**
Head Start	89%	97	3%	3	8%	9	109	74%	70	24%	23	2%	2	95
Early Head Start	85%	93	4%	4	11%	12	109	62%	59	36%	34	2%	2	95
Pediatric health centers/clinics	n/a	n/a	n/a	n/a	n/a	n/a	n/a	69%	67	28%	27	3%	3	97
Quality childcare providers	77%	83	8%	9	15%	16	108	51%	49	47%	45	2%	2	96
Speech and language therapeutic services	76%	77	11%	11	13%	13	101	52%	49	39%	37	9%	8	96
Early Steps (Part C)	77%	72	6%	6	16%	15	93	68%	60	27%	24	5%	4	88
Child Find (Part B) and Transition - Local education agency (LEA)	67%	58	17%	15	15%	13	86	53%	40	28%	21	20%	15	76

Mental health services for 3-5-year-old children	51%	50	23%	23	26%	25	98	29%	26	48%	43	23%	21	90
Infant and toddler mental health services	43%	43	32%	32	25%	25	100	26%	23	43%	37	31%	27	87
Other, please specify:	27%	3	36%	4	36%	4	11	40%	2	20%	1	40%	2	5
Median responses	76%	72	11%	9	15%	13	100	52%	49	36%	34	9%	4	90

Community partner survey respondents perceived that Head Start/Early Head Start, quality childcare, speech/language therapy, and early intervention services were available in their communities. Most home visiting program survey participants reported that Head Start, pediatric health care, and early intervention were available in their communities, although at a lower rate. However, quality childcare, speech/language therapy, and Child Find (Part B) services were perceived as available, but insufficient. Notably, mental health serves for infants, toddlers, and preschoolers were reported more often as insufficient or unavailable by a large proportion of community partners and home visiting staff.

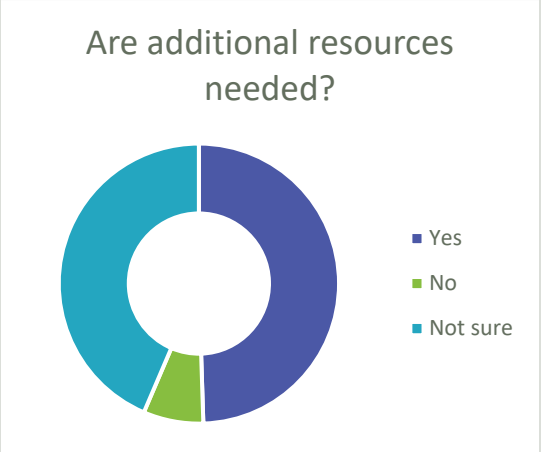
With respect to utilization of other needed services, a community stakeholder question asked, "Which services are needed the most? Select all that apply." It is unclear if the top three answers are due to the economic and mental health stressors brought on by the pandemic or if these would be the primary concerns in "normal" times. As one of the home visiting survey respondents noted, *"With [the COVID-19] pandemic, need for emergency assistance is through the roof with limited funds to support families that are struggling to make ends meet."*

Table 2: Services Needed Most According to Community Partners and Home Visiting Staff

Answer	%	Count
Economic self-sufficiency	15.57%	95
Mental health treatment	13.77%	84
Employment opportunities	12.95%	79
Quality childcare	12.62%	77
Transportation	11.15%	68
Home visiting	10.33%	63
Substance use treatment	10.00%	61
Health care	10.00%	61
Other, please specify:	3.61%	22
Total	100%	610

When asked in an open-ended question whether their community has the resources they need for their families, many parents answered that their community does not. While nearly half of respondents answered that their community does have family resources, the main barriers to access included inflated costs and a need for more resources, especially quality and affordable childcare, which respondents listed as difficult to find. Parents mentioned that there were a few parks, but they could use more recreational opportunities for younger children, and available options are too expensive. Parents reported that the fees were too expensive for childcare and that they need more childcare assistance and local health care providers for families in need. Many respondents noted that

transportation is an issue, and reliable and trustworthy transportation is difficult to find. Health care was also reported to be too expensive, especially for children.



Parents noted that resources are especially hard to find during the COVID-19 pandemic.

Affordable childcare may be found but these daycare facilities lack many other things. The safety and well-being of my children is more important, some cheaper daycares have major flaws.

I appreciate the VPK offerings, but there could be more educational support, especially now.

We have been on the waiting list for years.

Figure 7: Need for Additional Resources According to Parents

For non-English speakers, respondents noted that organizations could do more to provide information/education on the programs and services available to them, and the frequent use of acronyms without explanations is confusing. For example, one respondent has not been approved for resources, even though they are a single, disabled parent. It was noted that foster children do not receive sufficient resources. Parents also indicated that there could be more educational support and that qualifications for resources are too specific, which severely limits access to resources for community members. Parents also mentioned that the waiting lists for services take too long. One participant said: *"You either pay out a ton or go to the health department where you are treated like a number. Getting vaccines done there is just as bad. They do not have sympathy or patience…they just stab and go."*

Parents also have mixed opinions about whether resources in the community are easy to access. A third (34%) of parents strongly agreed or agreed, 22.4% were neutral, and 19% disagreed or strongly disagreed.

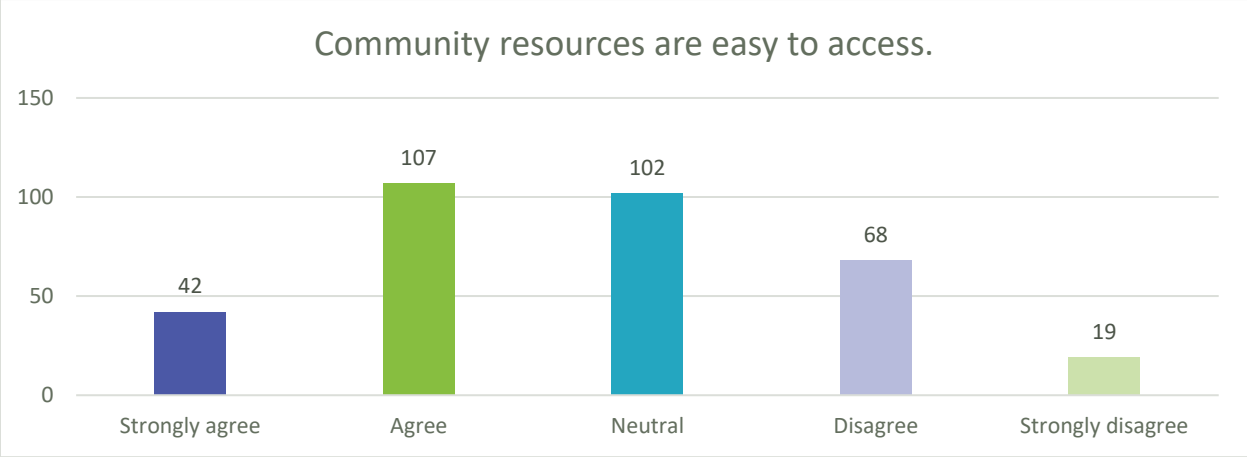


Figure 8: Access to Community Resources

Note: 116 (26%) did not respond to the question.

The most common barriers to accessing community resources were waiting lists, mentioned by 87 (19.1%) and not qualifying because of income, mentioned by 66 parents (14.5%). There were 93 parents (20.4%) who mentioned other barriers that were not listed. These other barriers included: COVID-19, lack of information/knowledge or advertising about programs, too many steps to maintain services, being new to the area, income caps are too low, services are not offered in another language, and resources are needed for families fostering their displaced relatives. A positive comment in this regard was that MIECHV does not limit their access and maintains it simply as with remote video calls. Other comments regarding childcare include:

Only for the lowest income families. Families that can't afford childcare but make just above income requirements are out of luck.

Jumping through all the hoops to get childcare and maintain it. I did everything I needed and have been waiting for weeks for a response on the next step!

Regarding specific resources that would help their families, most parent respondents recommended more mental health services (13.76%), quality childcare providers (12.83%), and Early Head Start (10.85%). Other possible resources mentioned include: more help for families that step in to take care of a relative taken by the state, affordable recreational activities for kids, better transportation, a bigger or better community center, clothing assistance, diaper program, college, low cost insurance for all children with disabilities, affordable housing, night nurse, assistance for disabilities and bills, higher income cap for services, free swimming classes, more clinics, more education on available resources, assistance with homelessness, assistance with teenagers with behavioral problems, post adoption therapy, evening or after hours care, dental services, affordable childcare providers for non-migrant families, more resources for single working or married struggling parents, and food stamps. Parents of low income are often unable to leave work to take a child to the service being provided.

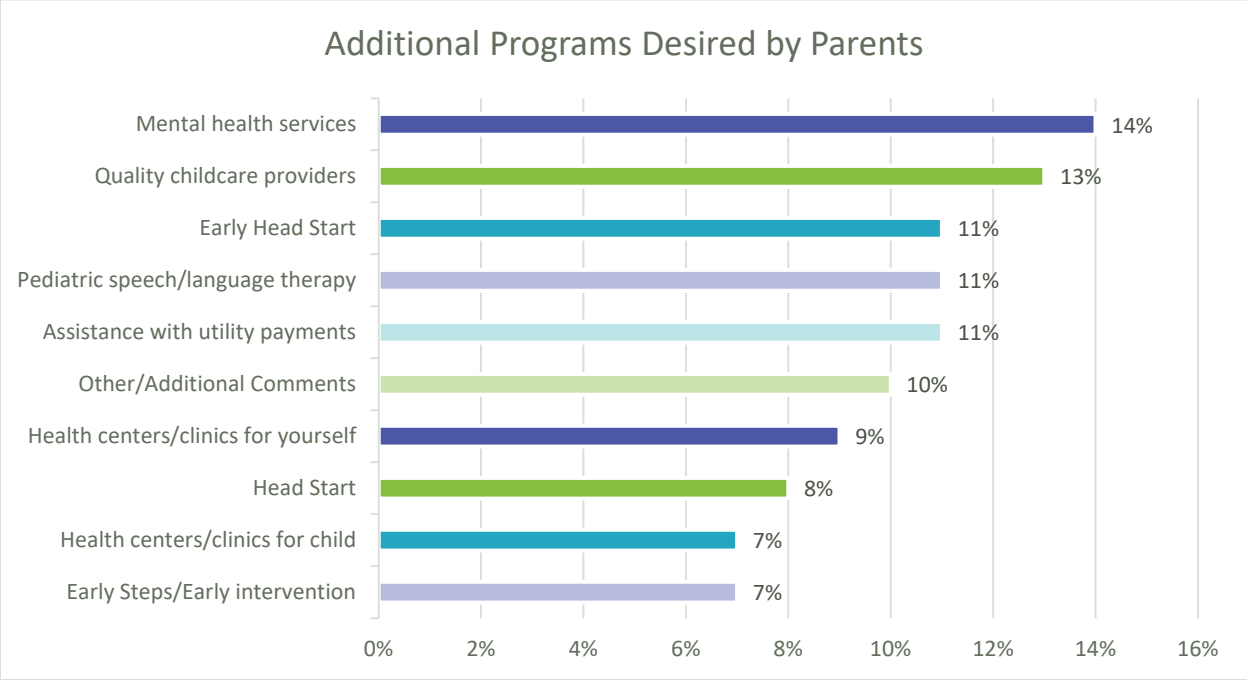


Figure 9: Additional Programs Desired by Parents

Strengths and Weaknesses in Utilization of Home Visiting Services

According to the home visiting program survey responses, the primary strengths of their county's home visiting programs were that parents learn child development and positive parenting (89, 13%) and that they connect families to needed services (89, 13%), families get the services they need (84, 12%), children have better outcomes (82, 12%), and there is improved family engagement (75, 11%). Also noted was a reduction in child deaths and maltreatment (67, 10%), improved school readiness (62, 9%), and improved birth outcomes (62, 9%). Other outcomes mentioned in comments included more father involvement, social connection, increased child spacing/family planning, healthy pregnancies and postpartum, psychosocial counseling, and access to prenatal care.

It was perceived by most that home visiting program staff reflect the community they serve in terms of race and ethnicity "a great deal" (73, 79%) and "somewhat" (17, 18%), with two (2%) reporting "not at all."

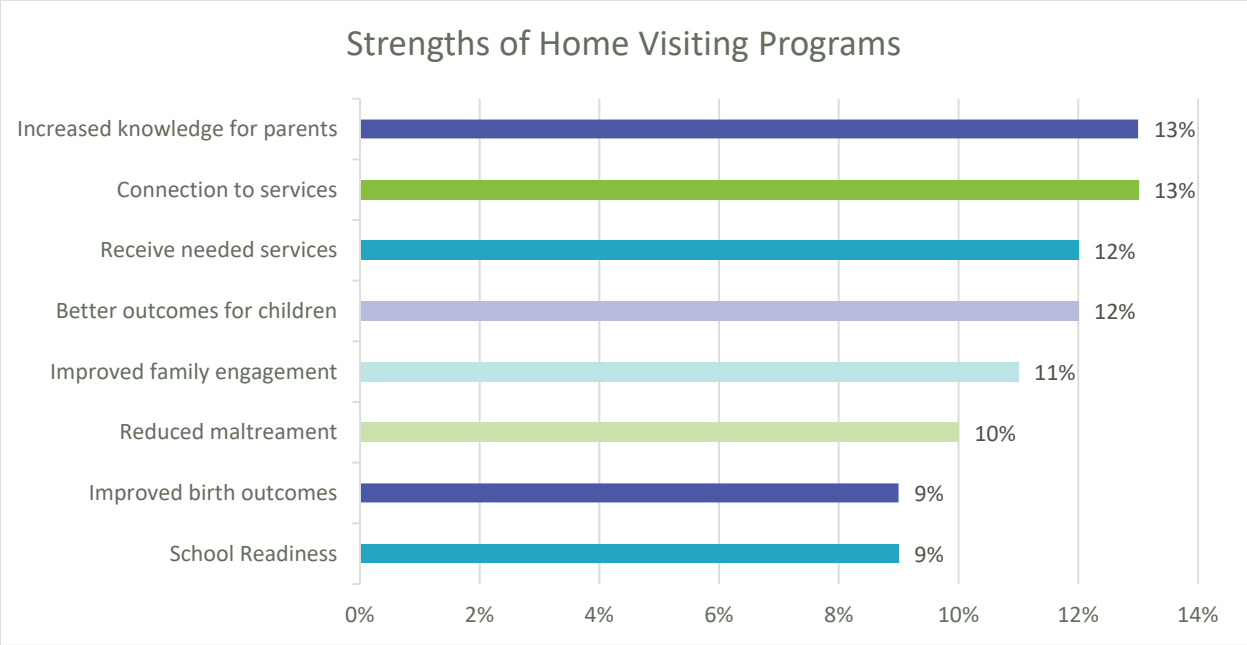


Figure 10: Strengths of Home Visiting Programs

Weaknesses noted in communities' home visiting programs by home visiting survey respondents were the limited ability to provide families with needed money or supplies (55, 23%), the inability to serve all who are eligible (37, 16%), waiting lists (31, 13%), and eligibility restrictions/limitations (31/ 13%). Challenges related to referral processes include that families are referred to a service, but there is little to no follow up (21, 9%), that it is a complicated process to connect to a program (15, 6%), or, within a model, there are too many visits required (14, 6%).

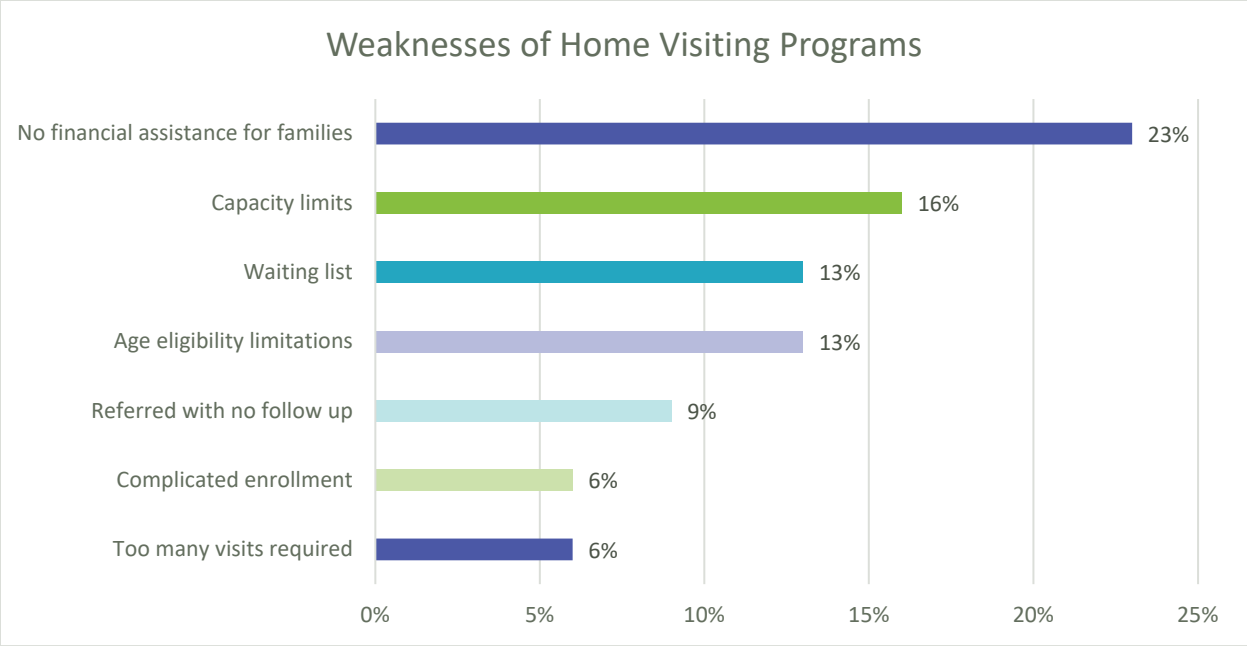


Figure 11: Weaknesses of Home Visiting Programs

Barriers Faced by Home Visiting Programs in High-Risk Counties

The primary barriers noted by the home visiting program survey respondents are lack of funding to pay home visitors a competitive salary and inconsistency or lack of funding in general. Additionally, limited availability or accessibility of health and social services and family supports, inactive or no parent groups were noted. Other barriers were geographic location, lack of quality referrals, availability or retention of qualified staff, and lack of community support or understanding of the program. Respondents also noted turnover in other agency staff and disengagement of the board or advisory group can cause impediments. Some open-ended responses include:

Availability of affordable housing for clients, inadequate housing, transient homeless population.

Unrealistic expectations from funders; excessive reporting requirements; program designs that turn away eligible families – too much free time commitment when free time is limited.

Lack of services for undocumented clients.

Poor quality of internet connection.

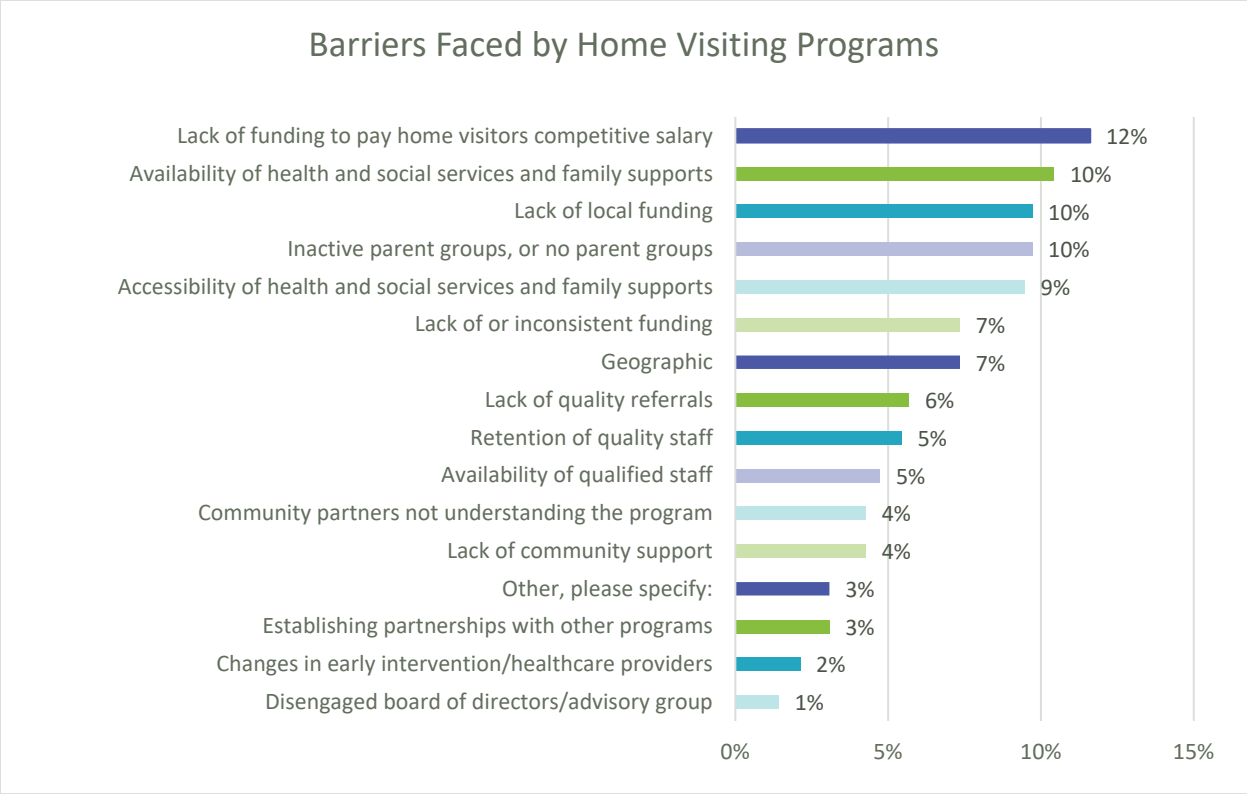


Figure 12: Barriers Faced by Home Visiting Programs

The community partner respondents noted barriers that made it difficult for expectant or new parents to access services were: unaware of services (78, 18.8%), lack of transportation (76, 18.3%), wait list (70, 16.9%), limited number of providers (59, 14.2%), and services are unaffordable (54, 13.0%).

Presence of Local Early Childhood Systems Coordination

Early childhood systems primarily address indicators of high need (i.e., low birth weight, teen births, substance use, child maltreatment, etc.) via interdisciplinary care coordination and linkage to available providers. Numerous agencies (e.g., health department, local hospitals, early learning coalitions, school district) collaborate to offer services to at-risk parents in communities.

More than half (56, 56%) of the home visiting survey respondents reported that they knew of a coordinating council for early childhood systems, with the most often reported being Head Start/Early Head Start, Early Steps, or the local Children's Services Council. Other coordinating entities mentioned were a Child Abuse Prevention & Permanency Advisory Council (14 respondents noted), the school district, Part B/LEA, Healthy Start Coalitions, childcare providers, foundations, and the Early Childhood Comprehensive Systems Impact Project. Most home visiting survey respondents (55, 59%) do not know if their county has a system of care grant; 11 respondents (16%) reported that they are participating as a stakeholder with the system of care leadership. Similarly, the community stakeholder survey respondents were less sure about whether there was a system of care grant (66% don't know) but 24 (21% of those who responded) did participate in system of care leadership in their community.

Assessing Community Readiness

Utilizing the community survey mentioned earlier, questions were developed to assess the community resources available in the high-risk areas, as well as their readiness to implement a new home visiting program.

Nearly 83% (99) of community partner survey respondents think that there is a need for additional home visiting services in their communities. Interestingly, many commented that due to the pandemic, home visiting services are needed more, and that society may be more accepting of the services during this unprecedented time. Comments include:

> *Children that have not had access to the school system may need to be checked on due to parents not having work and additional stress.*
>
> *Especially currently with COVID and additional stressors.*
>
> *I'm not 100% of any true need, but with school not being in session at the end of the last school year and parents possibly choosing virtual learning, then home visits may need to be done to ensure the safety and well-being of some of our students here in the community.*

Half (44, 50%) of the home visiting survey participants thought more home visiting services were needed (19/22% disagreed and 25/28% were unsure). Small counties noted that:

> *We currently have Healthy Start, Healthy Families, and HIPPY; our low birth rate and small population would not support another HV program (we currently struggle with low referrals as is).*
>
> *Not enough referrals to support other than Healthy Start or Healthy Families.*

An urban county noted:

> *We have 22,000 births annually. While we have several programs that serve high risk – there is still a great need to serve that population – while hardly any bandwidth to serve those in moderate need.*

Related to expansion of home visiting services, the majority of community partner survey respondents (65, 42%) felt that their community is ready and has the capacity to expand; 36 (23%) felt that they did not, and a third (53, 34%) were unsure. More than half of the home visiting survey respondents noted the same. Comments included:

> *There are several agencies that provide home visiting well in our community. Most focus on children 0-5. Our agency fills the gap for older children. With several well qualified agencies, expansion efforts would be well led and run. – Community Partner*
>
> *There's currently a few in the area that encompasses multiple types of family needs. I don't see how adding another would help. If it was added maybe for older children after 1 or 2 that supports school readiness would be beneficial but prenatally, I think it's pretty saturated. – Community Partner*

We are in the year of 2020, how impressive are we especially with how technology has expanded so grandly. This pandemic showed how swiftly and willingly we can come as a community to get things done for use to have some form of normalcy within the changes of uncertainty. So, I can only imagine if much attention is put in really coming together as a community to figure out what is needed, we can push the needle. – Community Partner

There are already established home visiting programs that could expand their services. – Home Visiting Staff

Most home visiting respondents (88, 70%) and community partner respondents (120, 64%) felt that community members in their counties think providing services for expectant and new parents and their young children is a priority and would support new or expanded efforts to meet their needs (rated seven or higher on 1-10 scale). Additionally, 41% (48) of community partners felt that community members and leaders would provide support (financially, in-kind resources, training, etc.) for community resources. Few respondents (10, 8.3%) felt that they would not provide support, and half (51, 50.8%) did not know. Similarly, when asked "How would you assess the level of potential resources in the community to support home visiting services for expectant or new parents and their young children?" 39% of 120 community partners felt that support was evident in their counties (rated seven or higher on a 1-10 scale).

There were 206 parents (45.3%) who strongly agreed or agreed that their community cares about families with young children. Only 26 strongly disagreed or disagreed (5.7%), while 107 (23.5%) were neutral.

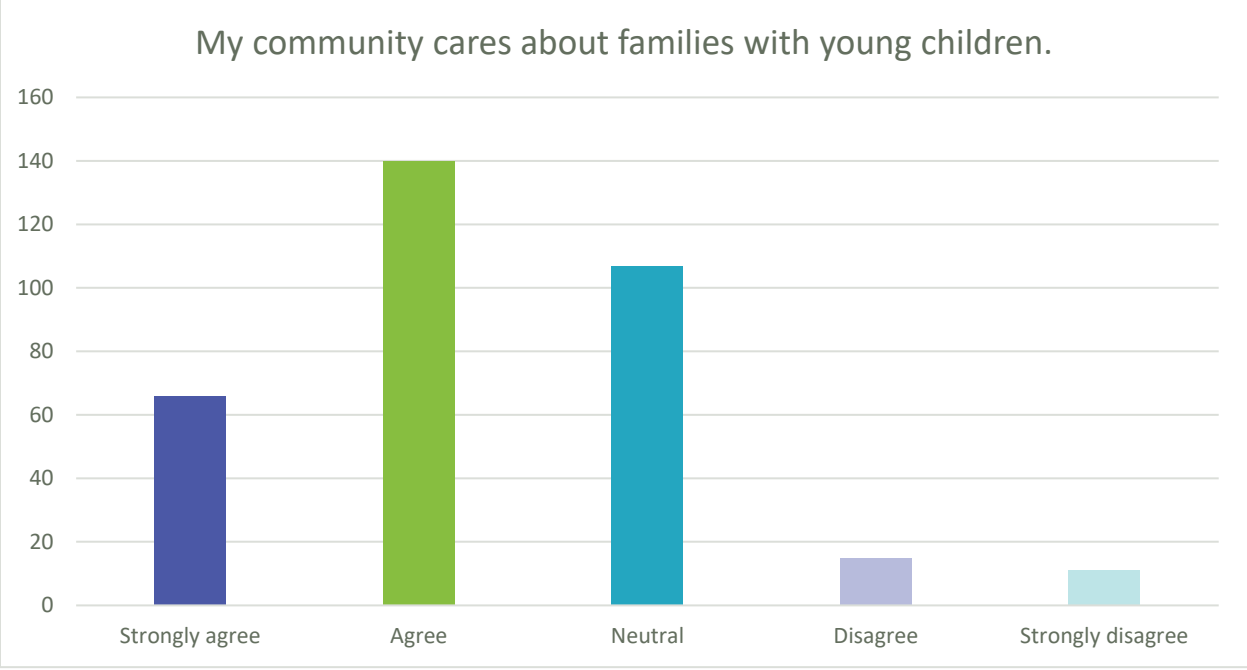


Figure 13: Community Response to Families

Note: 116 did not respond to the question

Other Programs that Serve Families

While this needs assessment focuses on the availability of evidence-based home visiting services, it is important to note other programs also provide services to our priority populations.

Early Steps

Early Steps is Florida's early intervention system, providing services to families of eligible infants and toddlers (birth to 36 months) in accordance with the Individuals with Disabilities Education Act (IDEA), Part C. Early Steps is housed within the Division of Children's Medical Services at the Florida Department of Health. Florida initiated Part C, IDEA in September 1993. In 2016, Florida law was amended to provide a comprehensive framework for the operation and administration of Florida's infants and toddlers early intervention program. To the maximum extent possible, support must be provided in natural environments and within the context of daily routines, activities, and places – which could be the family home, a childcare or community center, or another location familiar to the family. There were 57,009 active children in the Early Steps Program during FY18-19.[11]

Available in all 67 counties in Florida and supported by local, state, and federal funds, Early Steps defines all eligible children as its population in need, unless the Individualized Family Support Plan (IFSP) determines that desired outcomes are unlikely to be achieved in a natural environment. Children are eligible for the Early Steps Program if meeting one of the following eligibility criteria:

1. A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay (e.g. autism spectrum disorder, cerebral palsy, deafness and hard of hearing, Down syndrome, and visual impairment).
2. A specified physical or medical condition known to create a risk of developmental delay (e.g., low birth weight, neonatal abstinence syndrome).
3. A developmental delay as measured by appropriate diagnostic instruments and procedures and informed clinical opinion that exceeds:
    - 1.5 standard deviations below the mean in two or more developmental domains or
    - 2.0 standard deviations below the mean in one or more developmental domains

Effective January 1, 2018, Early Steps began serving infants with neonatal abstinence syndrome with evidence of clinical symptoms such as tremors, excessive high-pitched crying, hyperactive reflexes, seizures, and poor feeding. Early Steps utilizes a team-based primary service approach to service delivery, focusing on direct service through consultation/coaching and joint visits.

Federal Healthy Start

Florida has six federal Healthy Start projects that aim to eliminate perinatal health disparities. The sites are among the 100 communities nationwide that received five-year grants to implement comprehensive initiatives aimed at improving health outcomes before, during, and after pregnancy, and reducing racial and ethnic disparities in rates of infant death. Florida sites receive more than $6.3 million annually to support their efforts.

The awardees include:

- The Center for Health Equity, Inc. – Gadsden County
- The Florida Department of Health, Orange County – Orlando
- Johns Hopkins All Children's Hospital, Inc. – St. Petersburg
- Northeast Florida Healthy Start Coalition, Inc., The Magnolia Project – Jacksonville

- REACH UP, Inc. – Tampa
- University of Miami, The Jasmine Project – Miami

The federal Healthy Start program targets communities with infant mortality rates at least 1.5 times the U.S. national average, and with high rates of other negative maternal and infant outcomes. Funding is used to support a wide range of services for women, children, and families, including: healthcare coordination; case management; linkage to social services; screening and counseling for alcohol, tobacco, and other drug use; breastfeeding support; interconception education; child development education; and parenting support. In addition, funding will strengthen the health workforce to provide such services, build a more effective and efficient service-delivery system, reduce barriers to access, and promote and improve health equity across participating organizations.

Florida Healthy Start

Florida Healthy Start is a program that provides education, support, and proven interventions to expecting families who are at-risk of a poor birth outcome or delay in development. The program focuses on common issues or conditions that occur during pregnancy or in infancy. Risk screening, offered by prenatal care providers and birthing hospitals, helps to identify families that could benefit from Healthy Start or other home visiting programs. Healthy Start is available statewide to all eligible families, regardless of their insurance coverage or citizenship. Families can participate in Healthy Start beginning in pregnancy or in the first year after the birth of a baby, and can continue until the infant turns one. Services can be extended, if needed, up to age three. Healthy Start offers:

- Home visiting
- Prenatal education and support
- Free screening and services
- Parenting education and support
- Care coordination
- Health and well-being

Healthy Start services for non-Medicaid families are funded by the Florida Department of Health. Services for Medicaid families are paid for by the Agency for Health Care Administration. Statewide implementation is overseen by the Florida Association of Healthy Start Coalitions. The Association is made up of 32 individual coalitions across the state that are responsible for the local implementation of the program in all 67 counties.

In July 2018, Florida implemented a statewide, coordinated intake and referral system (Connect) that is housed within the local Healthy Start Coalitions. Connect is a one-stop entry point for services, including home visiting. Designated staff receive information from prenatal providers through the Prenatal Risk Screen and through Infant Risk Screens, as well as pregnant women on Medicaid. Parents can also self-refer or be referred by community providers. The Connect staff contacts the parent (usually a pregnant woman or parents of a newborn) to determine their needs and desires for services, and then offers an array of options available in their community. Staff are to remain neutral by presenting all home visiting programs for which the family is eligible. Assuming she accepts a referral for home visiting, she is referred to that program who then calls her to schedule an appointment. Local advisory groups consisting of representatives from all local home visiting programs meet at least quarterly to work on improving Connect. Additionally, representatives from local programs are working with FAHSC staff to improve the quality of this system.

Because of their long-standing presence and active role in the maternal and child health field, the local Healthy Start Coalitions were asked to take the lead on distributing the surveys utilized to assess the quality and capacity of existing programs.

ParentChild+

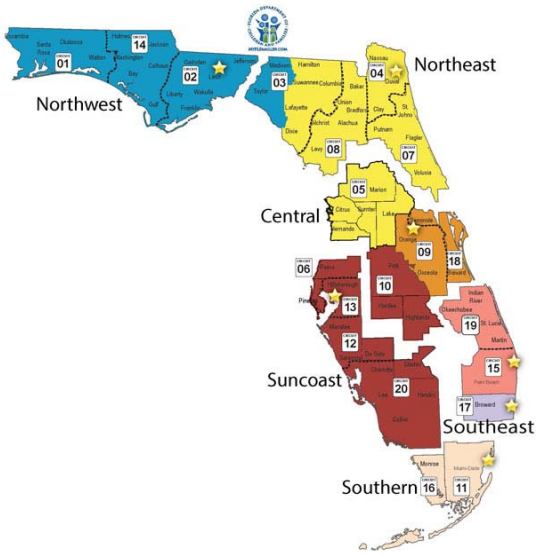
ParentChild+ does not meet the criteria established by the Department of Health and Human Services to be deemed an evidence-based model and is, therefore, not eligible for MIECHV funding. However, it does receive the same scientific ranking from the California Evidence-Based Clearinghouse for Child Welfare as EHS, PAT, and PALS and is therefore an important program in the continuum of home visiting services in Florida. ParentChild+ is an intensive two-year home visiting program aimed at increasing school readiness among young children from families who face multiple obstacles to educational and economic success, such as poverty, low literacy, limited education, and language barriers. Families enroll when children are about two years old and receive two 30-minute visits per week for 23 weeks in each year of the program, for a total of 92 visits. During these visits, a home visitor who shares a language and cultural background with the family uses a non-directive approach and a high-quality toy or book, which is left as a gift for the family, to model behaviors for parents that enhance children's development. A unique aspect of the program is that ParentChild+ emphasizes hiring former parents in the program and people who live and work in the community as the early learning specialists (home visitors). Because of this approach, ParentChild+ has a unique capacity to support families with home languages other than English (over 60% of the families they serve).

There are currently six sites in Florida, serving three high-risk counties. Four sites are in Palm Beach County, one in Hillsborough County, (both high need sub-county areas with large populations of immigrants) and one in rural Jefferson County.

SECTION 3. CAPACITY FOR PROVIDING SUBSTANCE USE DISORDER TREATMENT AND COUNSELING SERVICES

Department of Children and Families Substance Abuse and Mental Health Office

The Office of Substance Abuse and Mental Health (SAMH) is housed within the Florida Department of Children and Families (DCF) and serves as the single state agency for the provision of mental health and substance use disorder prevention, treatment, and recovery services. DCF is committed to preventing substance use disorders and promoting emotional health and wellness to improve the lives of families across Florida.



In Florida, DCF provides treatment for substance abuse through a community-based provider system that offers detoxification, treatment, and recovery support for adolescents and adults affected by substance misuse, abuse, or dependence.

Community-based behavioral health services are provided through contracts with seven nonprofit Managing Entities. The purpose of the Managing Entities is to plan, coordinate, and subcontract for the delivery of community mental health and substance abuse services, to improve access to care, to promote service continuity, to purchase services, and to support efficient and effective delivery of services. Services are provided by a

network of local behavioral health providers.[12] Managing Entities are private, non-profit organizations responsible for overseeing contracts with local network service providers for the provision of prevention, treatment, and recovery support services in each respective region. DCF's regional SAMH offices administer Managing Entity contracts with support from the Office of SAMH headquarters office.

Each of DCF's six regions develop a comprehensive regional plan with local stakeholder participation, which aligns state and local level priorities and initiatives. The regional plans describe the local behavioral health delivery system, service needs and resources available to meet those needs, and the total funds available through DCF for mental health and substance abuse services. The Office of SAMH's overarching goal is to transform behavioral healthcare in Florida into a Recovery-Oriented System of Care (ROSC). A ROSC is a network of clinical and nonclinical services and supports that sustain long-term, community-based recovery. As local entities, ROSCs implement the guiding principles of recovery orientation while reflecting the unique variations in each community's vision, institutions, resources, and priorities. Behavioral health systems and communities form ROSCs to:

- Promote good quality of life, community health, and wellness for all;
- Prevent the development of behavioral health conditions;
- Intervene earlier in the progression of illnesses;
- Reduce the harm caused by substance use disorders and mental health conditions on individuals, families, and communities;
- Provide the resources to assist people with behavioral health conditions to achieve; and
- Sustain their wellness and build meaningful lives for themselves in their communities.

Except for the DCF-operated mental health treatment facilities in northern Florida, most behavioral health services are provided through contracts and subcontracts. These contracts are executed and administered by either the Office of SAMH or a regional SAMH office. In consultation with the Office of SAMH, the Regional SAMH Director ensures Managing Entities meet statewide goals and are responsive to the community needs.

Overall Funding

State Funds

Nearly $774 million is expended to carry out the provision of community substance abuse and mental health services. Just over $700 million ($422 million for mental health and $255 million for substance abuse services) is allocated to the managing entities to provide community substance abuse and mental health services. During FY18-19, 339,093 individuals were served. Just over 197,000 adults received mental health care and nearly 98,000 received substance abuse services. For children/adolescents, 26,518 were treated for substance abuse issues and 7,100 received mental health treatment.

For FY18-19, $9.8 million of recurring funds was appropriated from the general revenue fund to DCF to competitively procure for additional Community Action Treatment (CAT) Teams to ensure reasonable access among all counties. For FY17-18, there was a $10 million appropriation to increase community-based teams and two additional CAT Teams were funded that year: 1) Smith Community Mental Health (Broward); and 2) Clay Behavioral Health Center (Clay and Putnam) – all high-risk areas. This increased appropriation provided a significant increase in services for children and young adults, as well as services for individuals with opioid use disorders.

Federal Funds

In addition to funding appropriated by the Florida Legislature, DCF also oversees and implements the following federal grants:

Florida's State Opioid Targeted Response (STR) Grant was awarded in 2017 and is funded at $27 million per year for up to 2 years and is designed to address the opioid crisis by providing evidence-based prevention, medication-assisted treatment (MAT), and recovery support services.

Florida's State Opioid Response (SOR) Grant was awarded in 2018, funded initially at $50 million per year for up to 2 years, with a $26 million supplement awarded in 2019. The SOR grant is designed to continue the work of the STR grant by addressing the opioid crisis and providing evidence-based prevention, medication-assisted treatment, and recovery support services. The SOR grant aims to address the opioid crisis by increasing access to MAT, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery support services for individuals with opioid use disorders and opioid misuse. The project will supplement other grants received by DCF related to opioid use disorders, including the STR grant, to support a comprehensive response to the opioid epidemic.[13]

The Florida Healthy Transitions Grant is a five-year federal grant, funded by SAMHSA at $999,750 per year (September 30, 2014- September 29, 2019). The Florida Healthy Transitions grant aims to engage and assist youth and young adults between the ages of 16-25, who are living with or at-risk of developing a serious mental illness or co-occurring substance use disorder to successfully transition to adulthood. The grant is administered by Central Florida Behavioral Health Network, in partnership with DCF. Florida Healthy Transitions' services are implemented in Hillsborough and Pinellas Counties. Since its implementation, the program has provided behavioral health and related linkages to over 20,431 youth, young adults, and their families. Florida Healthy Transitions differs from other behavioral health programs, as it utilizes a peer-to-peer approach to services. Over 75% of the program's direct service staff are young adults themselves.

Florida's System of Care Expansion and Sustainability Project is a four-year federal grant funded by the US Health and Human Services' Substance Abuse and Mental Health Administration (SAMHSA) at $3 million per year (September 30, 2016 – September 29, 2020). The purpose of the project is to improve behavioral health outcomes for children and youth (birth - age 21) with serious emotional disturbances, and their families. The project is working to strengthen the existing array of behavioral health services and to integrate the System of Care (SOC) approach into the Florida service delivery system. The SOC employs a family-driven, youth-guided approach that expands and organizes community-based services and supports into a coordinated network, builds meaningful partnerships with families and youth, addresses cultural and linguistic needs, and improves functioning at home, in school, in the community, and throughout life. Through the grant, DCF convened an SOC State Advisory Group who produced a strategic plan with goals and strategies that guide implementation. Four DCF Regions and the corresponding Managing Entity are implementing the values and services locally through this grant. The Central and Southern Region implemented the values and services through other SOC grants in Orange, Seminole, and Miami-Dade Counties. More than half of grant funds are dedicated to behavioral health services for eligible individuals who have no insurance or are underinsured. Grant funded services include counseling, case management, recovery peer support, medication management, and other mental health services.

Partnership for Success (PFS) is a 5-year, $1.2 million dollar grant awarded from SAMHSA in 2016. The PFS grant is designed to reduce prescription drug misuse among Floridians ages 12-25, strengthen prevention capacity and infrastructure at the state and community levels, and increase awareness of opioid overdose prevention.

Services for Pregnant Women and Women with Dependent Children

Integration of child welfare and behavioral health is essential to successful outcomes for children and families served by DCF. Parental substance use and or mental health conditions are evident in over 60 percent of the cases of child maltreatment. Access to quality treatment and recovery support is critical as children and youth in these families are more vulnerable to maltreatment as parental capacities are diminished. Additionally, children exposed to these issues in their caregiving adults are at high risk for behavioral disorders themselves.

Block Grant regulations stipulate that Florida must expend at least $9.3 million in federal and state funds on services for pregnant women and women with dependent children. In FY17-18, Florida expended $15.1 million on services for this population and served 1,977 pregnant women. The most commonly provided services were residential treatment, methadone maintenance, day treatment, and outpatient groups. Among those discharged from services, about 67% successfully completed services.

DCF is currently working to provide additional information on residential programs that offer services for women and their children, but it will not be available until later this year. Based on information from other sources, it is estimated that roughly half (49%) of Florida's counties have treatment facilities that offer programs for pregnant and postpartum women.[14] However, only 18% of Florida's counties are known to have a family residential treatment facility[15], meaning the child(ren) can live in the facility with their mother. Of the 15 counties that were identified as high-risk in the substance use disorder domain, only one has a family residential treatment facility. It is unknown at this time as to which of these facilities receive funding from DCF. See Appendix 7 for an overlay of the substance use disorder map (included in Appendix 4) and the counties with a family residential treatment facility.

Child Welfare

To support families involved in the child welfare system in accessing treatment and support services, Behavioral Health Consultants (BHCs) are co-located with Child Protective Investigators (CPIs). Through SOR funding, 12 BHCs have been hired, with two staffing each of the six regions. The BHCs are licensed or certified behavioral health professionals who provide technical assistance and consultation to CPIs and child welfare case managers on the identification of behavioral health conditions, their effects on parenting capacity, and engagement techniques. Consultants also assist investigative staff and dependency case managers in understanding the signs and symptoms of opioid use disorders and the best practices to engage and treat, including the use of MAT; provide clinical expertise and assist with the identification of parents with opioid disorders in the child welfare system. To help ensure coordination of services, their role is also to develop contacts, facilitate referrals, and assist investigative staff with engaging clients in recommended services and improving timely access to treatment.[16] In addition to expanding the cohort of BHCs, DCF has allocated $8 million of SOR supplemental funds to each region to address the treatment needs of families who are involved in the child welfare system.

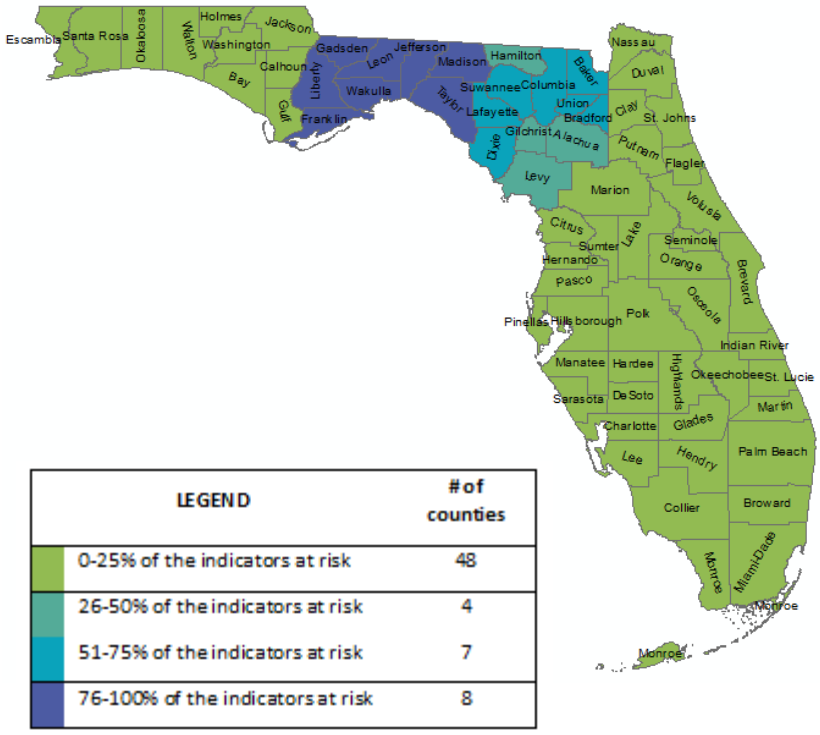
Family Intensive Treatment (FIT) teams have been piloted throughout the state to provide specialized treatment for parents with primary substance use disorders who come in contact with the child welfare system and who have young children ages birth to eight. FIT is family focused and integrated across the

child welfare, behavioral health and judicial systems. Treatment involves joint planning and case management by a team of professionals which include child welfare workers, alcohol and drug treatment professionals, court representatives, and medical professionals. Families are provided wraparound and comprehensive community services to address the multiple needs of parents and children, including parenting skills to increase protective capacity, mental health, health, childcare, housing, and other services.

Florida Department of Health

The Department of Health (DOH) partners with the Florida Department of Children and Families to ensure a concerted effort to focus on behavioral health disorders and to prevent and reduce substance abuse and its negative effects on health. Goals include decreasing the number of infants born with neonatal abstinence syndrome and to reduce the number of opioid overdose deaths. Strategies include increasing the number of pregnant women in treatment for opioid disorders and increasing access to naloxone kits for first responders.

In late 2017, DOH released its five-year Florida State Health Improvement Plan (SHIP). Nine SHIP priority areas were identified – three of which directly relate to families eligible for home visiting services: 1) health equity; 2) maternal and child health, and 3) behavioral health.



LEGEND	# of counties
0-25% of the indicators at risk	48
26-50% of the indicators at risk	4
51-75% of the indicators at risk	7
76-100% of the indicators at risk	8

Health equity is the attainment of the highest level of health for all people and requires focusing on avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities. It provides the foundation for success in all the other health-issue priorities. Three goals and five strategies were developed to strengthen the capacity of state and local agencies to reduce disparities in social determinants of health.

The well-being of women, infants, children, and families determines the health of the next generation. Events over the life course influence maternal and child health risks and outcomes. Differences in health outcomes such as infant mortality, by race and ethnicity, can predict future public health challenges for families, communities, and the healthcare system. Two goals and five strategies were identified to reduce infant mortality, prevent pregnancy related mortality, and reduce related racial disparities.

Mental and emotional well-being enables individuals to realize their own abilities, cope with the normal stresses of life, work productively and contribute to his or her community. Increasing the number of child welfare-involved families (both parents and children) with access to behavioral health services is a

priority. Decreasing the number of newborns experiencing neonatal abstinence syndrome and the number of opioid overdose deaths are also goals for this priority area.[17]

Florida's Early Childhood Court

Florida's Early Childhood Court addresses child welfare cases involving children under the age of three. Using the National ZERO TO THREE organization's Safe Babies Court Team approach and the Miami Child Well-Being model, the goal of Florida's Early Childhood Court is to:

- Improve child safety and well-being,
- Heal trauma and repair the parent-child relationship,
- Promote timely permanency, and
- Stop the Intergenerational cycle of maltreatment.

Core components in Early Childhood Court include judicial leadership, a community coordinator, monthly court reviews, evidence-based child-parent therapy, frequent parent-child contact, and the use of multidisciplinary family team meetings. Florida's Early Childhood Court currently has 27 sites across the state. Despite evaluations showing success across many indicators, less than 1,000 families have benefited from these enhanced services each year.[18] Funding has been a challenge, but there is no doubt that increasing access to these teams would benefit children and families.

Survey Respondents' Identified Gaps in the Current Level of Substance Abuse and Mental Health Treatment and Counseling Services

The needs assessment revealed that 16 (24%) rural counties in the north central area of the state have at least 26% of the indicators at risk for substance abuse. This is problematic in that rural areas lack adequate medical care, community resources, and providers and faciliities that specialize in treating substance use disorders.

The majority of home visiting program survey respondents (55, 61%) answered that there are not sufficient substance use prevention, treatment, recovery, and relapse prevention support services in their counties, while 21% (19) did not know and 18% (16) reported yes. Services reported as available in respondents' counties included: mental health counseling (66, 18%), case management services (59, 16%), crisis intervention (50, 13%), HIV testing or counseling (47, 12%), medical care (46, 12%), and fewer than 10% reported availability of support services such as childcare, housing assistance, legal assistance, and financial assistance for treatment.

Available Substance Use Treatment, Including for Pregnant Women and Families with Young Children

According to 91 community partners, only 25% (23) think there are sufficient substance use providers for providing intervention, treatment, and recovery services to meet the needs of pregnant women and families with young children who may be eligible for home visiting services. Forty-five percent (41) responded that there were insufficient providers and almost 30% (27) did not know.

When asked to specify the types of service providers that are available in their communities to treat this population, the majority of both the community partners and the home visiting programs indicate that most services are insufficient to meet the need. Most notably was the lack of clinics or services for substance exposed newborns. Outpatient counseling, residential treatment, and care coordination were noted as the most available.

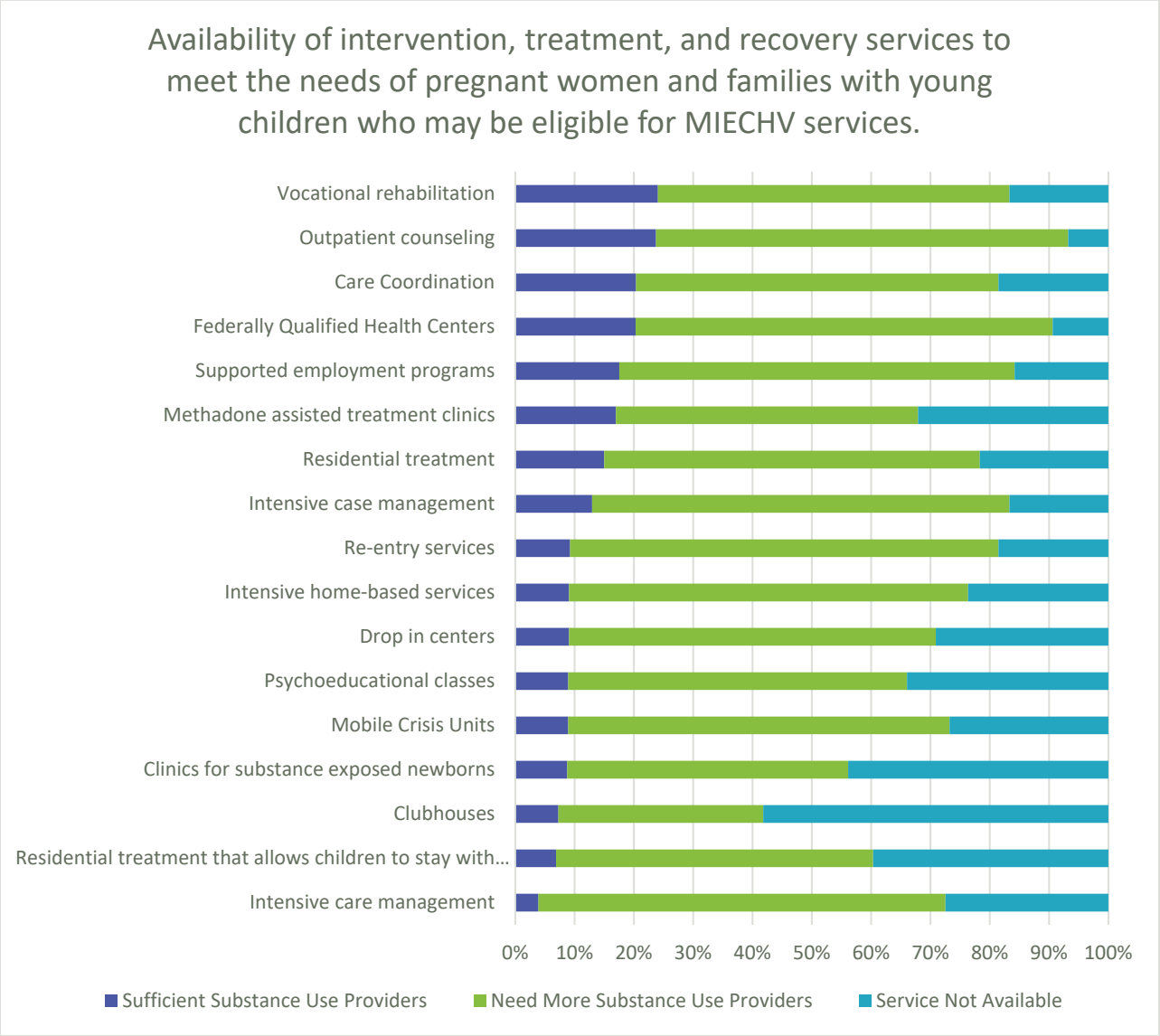


Figure 14: Availability of Interventions for Pregnant Women and Families

Available Mental Health Services

Both the home visiting program respondents and community partners reported that there are clearly not enough providers to serve the mental health needs of respondents' clients. Specific services available were outpatient or in-home counseling, residential treatment, or psycho-educational classes. However, 32% of home visiting program respondents noted that residential treatment was not available in their county and 72% noted that residential treatment *that allows children to stay with parent* is not available in their county. Half (48%) of the same respondents noted a lack of psychoeducational classes for mental health, and others reported that in-home counseling (29%) and residential treatment (25%) was unavailable in their county.

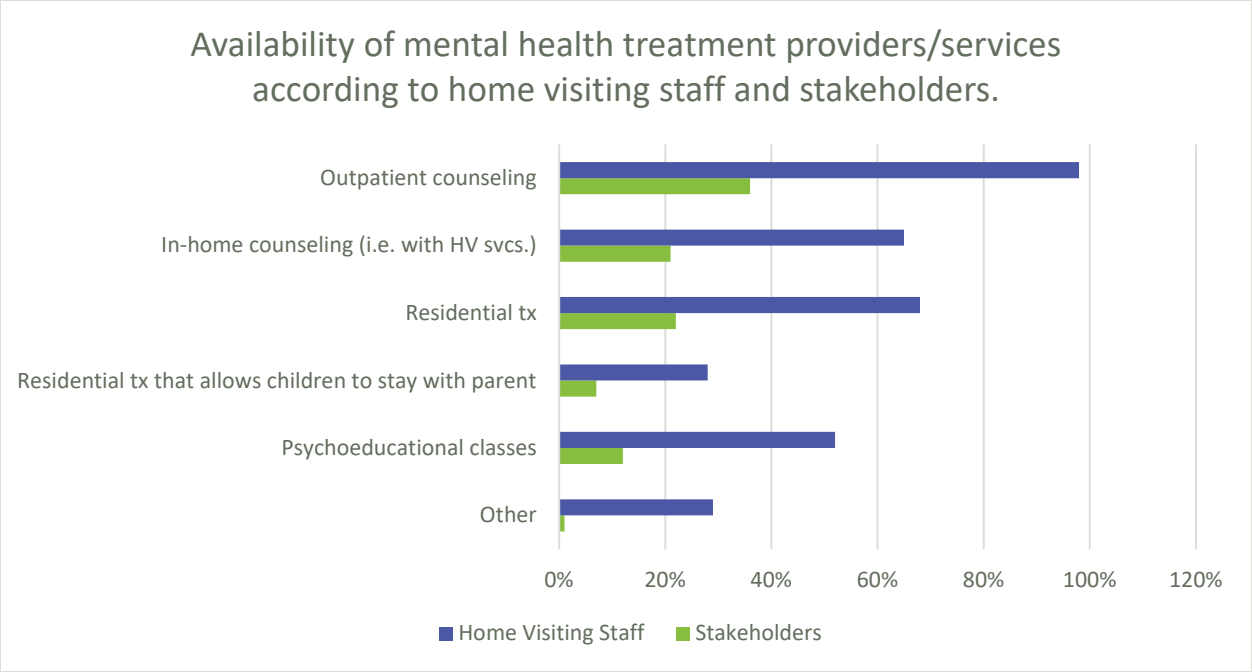
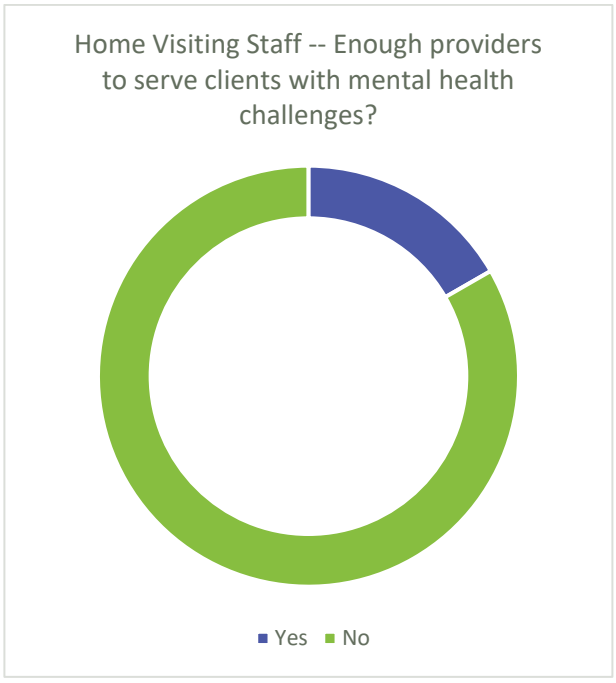


Figure 15: Availability of Mental Health Treatment

Far fewer community stakeholders reported that these services are available.

Almost 69% (66) of community partners noted that there are not enough providers to serve clients who have mental health challenges; 18 (19%) said yes and 12 (13%) were unsure. Seventy-five (83%) of home visiting program staff reported inadequate number of providers, while 15 (17%) said there were enough providers.



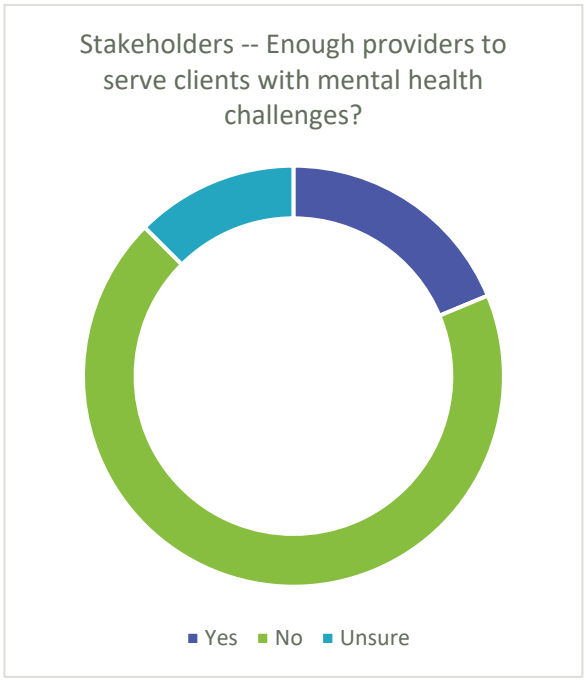


Figure 16: Availability of Providers

Barriers to Receiving Treatment and Counseling Services for Substance Use Disorders

Responses from both the home visiting program survey and the community partner survey are similar when describing the barriers to receiving substance use disorder treatment and counseling services. The home visiting programs noted that some communities have efforts in place to address gaps and barriers to services, focusing on pregnant women and families with young children. Often there is a partnership with local hospitals, courts, child welfare agencies and providers. About 40% of home visiting program survey respondents reported that they participate in these community efforts, through activities such as community meetings, outreach, courts, task forces/coalitions, or direct care. Only half (46) of the community partner survey participants stated that they participate in any community efforts to collaborate with state or local partners, i.e., hospitals, court system, child welfare agencies, substance use treatment providers, to address the gaps and barriers to care for pregnant women and families with young children impacted by substance use issues.

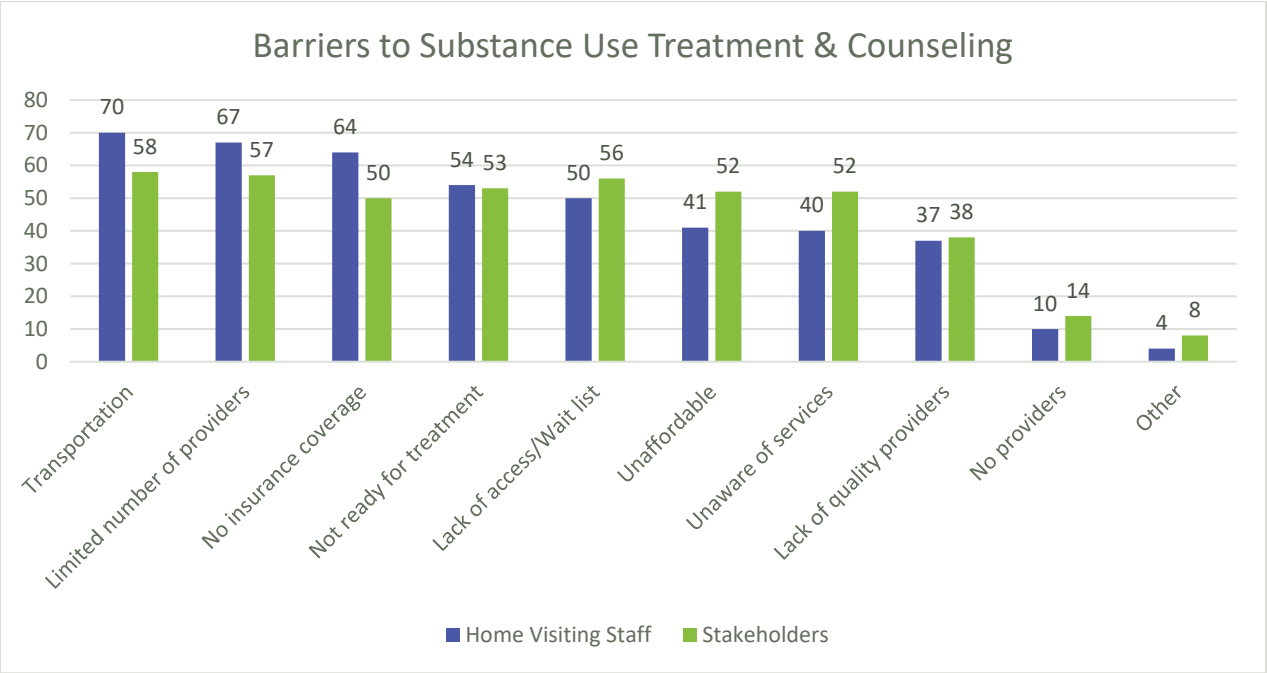


Figure 17: Barriers to Substance Use Treatment and Counseling

As noted earlier, the respondents provided a wealth of information regarding substance abuse treatment in the survey and, given the space limitation for this report, FAHSC will continue to examine and analyze the qualitative data provided and compile an ancillary report to share with stakeholders, such and the Office of SAMH at the Department of Children and Families and the Department of Health.

SECTION 4. COORDINATION WITH OTHER STATE AGENCIES

In December 2019, the Project Director of the Florida MIECHV Initiative increased her responsibilities when she became the Chief Program Officer (CPO) of FAHSC. She was already overseeing programmatic operations for MIECHV, the Early Childhood Comprehensive Systems (ECCS) Impact Project, and Nemours Project HOPE, but added Florida Healthy Start, state-funded NFP, Moving Beyond Depression©, and DCF-funded nurse home visiting services for families affected by substance use. What all of these grants have in common is the need for coordination at the state and local level. While each of these programs has had partnerships with other agencies, FAHSC is improving the delivery of services across programs and coordination with other agencies funding services for pregnant women, children and families.

Coordination has been occurring through efforts listed elsewhere in this document, as well as the Home Visiting Advisory Group started by MIECHV as a way to provide input on the Coordinated Intake and Referral system (Connect) that was being developed in Florida. As Connect was rolled out in 2018, this group is transitioning into addressing a broader range of topics, most recently focusing on home visiting during COVID-19 and the need to promote home visiting. After getting through this crisis, members agree that this group will be able to take on a greater role.

While much effort has been put into working with the Needs Assessment Steering Committee, efforts to share all of the findings with them as an opportunity for contextualizing the results will occur after this report is submitted to HRSA. After the Needs Assessment has been finalized, FAHSC plans to develop a summary of the findings, based on input from the Steering Committee, that will be widely distributed. This summary will include a hyperlink to where the full report, including appendices, will be posted on the Florida MIECHV website. Below is a summary of the efforts to coordinate with other agencies on their federally-required needs assessments and other activities, including Title V, Head Start, CAPTA, as well as coordination on the Preschool Development Grant.

Florida Department of Health, Maternal Child Health

The Florida Department of Health (DOH) is Florida's Title V agency and receives the federal Title V Maternal and Child Health (MCH) Block grant to fund, support, and facilitate MCH intervention, initiatives, and system of care, and care coordination in local health departments, and Florida's network of Healthy Start Coalitions. Also, at the DOH are the state's Title X Family Planning program; Women, Infant, and Children program; Chronic Disease Prevention Program; School Health Program; Child and Adolescent Health Program; and Children's Medical Services, a medical program for children with special health care needs. Part C is part of the Children's Medical Services section. Together these programs, along with many other DOH programs, serve a large proportion of Florida population.

The Title V MCH Services Block Grant legislation (section 505[a][1]) requires the state, as part of its application, to prepare and transmit a comprehensive statewide needs assessment every five years that identifies (consistent with the health status goals and national health objectives) the need for the following:

- Preventive and primary care services for pregnant women, mothers, and infants up to age one
- Preventive and primary care services for children
- Services for children with special health care needs
- Preventive and primary care services for adolescents

2020 Title V Needs Assessment MCH Topic Briefs

For the 2020 Maternal Child Health Block Grant Application the Florida Department of Health identified health priorities for women of childbearing age, pregnant women, infants, children, and adolescents in Florida. The DOH identified 19 Maternal Child Health (MCH) and seven Children with Special Health Care Needs (CSHCN) priorities. Topics that are pertinent to the home visitation population include:

- Well woman visit
- Low cesarean delivery
- Perinatal regionalization
- Infant breastfeeding
- Infant safe sleep practices
- Developmental screening
- Injury hospitalizations, ages 0-9 years
- Mental health
- Early access to services
- Smoking during pregnancy
- Adequate insurance coverage
- Low income dental access
- Young children (age 0-5 years) read to by family
- Black-white disparities in Infant mortality
- Black-white disparities in maternal mortality
- Injury prevention

MCH Survey Results

In October 2019, as part of the 2020 Title V Needs Assessment process, DOH disseminated an electronic survey to 43 MCH stakeholders, professionals, and partners to obtain the public's opinion on the priorities of health issues and conditions related to Florida's MCH populations, including children with special health care needs. The survey provided the 26 identified priorities as selection options. The survey was later forwarded to the community. There were 404 survey responses. The analysis revealed that the top five MCH issues are:

1. Well-woman visits
2. Risk-appropriate perinatal care
3. Adequate insurance
4. Breastfeeding
5. Safe sleep

The top five issues related to children with serious health care needs were identified as:

1. Mental health
2. Early access to services
3. Adequate insurance
4. Early screening
5. Medical home

During the 2020 Needs Assessment process, the MCH Section developed a capacity survey that was sent to 43 MCH stakeholders, professionals, and partners. The purpose of the capacity survey was:

1. Determine strengths, weaknesses, opportunities, and threats in performing the 10 essential services of public health for maternal and child health
2. Better coordinate MCH activities
3. Provide a basis for planning, policy, and funding decisions

The capacity survey showed that the state a has high capacity to carry out most of the essential services of public health to promote maternal and child health in Florida. For more information, visit: http://www.floridahealth.gov/programs-and-services/womens-health/pregnancy/mch-block-grant.html.

Efforts to Coordinate

The Section Administrator for MCH in the DOH Bureau of Family Healthy Services participated on the 2020 MIECHV Needs Assessment Steering Committee. The FAHSC CPO, as well as several Healthy Start Coalition Executive Directors, participated in aspects of the Needs Assessment, such as reviewing the topic briefs and scoring them, based on a set of criteria. These results were presented in April. Likewise, the results of the 2020 MIECHV Needs Assessment will be shared with the Bureau and its counterparts to utilize in their decision making. Beyond the respective needs assessment processes, FAHSC collaborates with the DOH MCH Section in multiple ways. First, DOH is a funder of Healthy Start, NFP and training for Moving Beyond Depression©, an evidence-based intervention that includes pairing home visiting programs with a clinician who provides in-home cognitive-behavioral therapy for home visiting clients. The Section Administrator also participates in the ECCS Advisory Group and the Home Visiting Advisory Group.

Opportunities

While there is much coordination already occurring, there are always areas for improvement. While ECCS has always used a racial equity lens to focus on opportunities for improving the systems and policies that impact maternal and child health and development, not all programs have taken this approach. FAHSC is embarking on an effort to infuse equity throughout all of our work. As there are efforts already underway at DOH through the 2017-2021 State Health Improvement Plan (SHIP), we are partnering with them on how we can approach the maternal and child health priorities more effectively as part of the Health Equity Priority Area Workgroup. DOH has also asked Healthy Start Coalitions to pilot a tool on increasing health equity within their organizations. Additionally, since prenatal screening rates have declined, we are working with DOH on promoting prenatal screening to providers and pregnant women, and the benefits of home visiting, which we hope will increase the volume of pregnant women referred by prenatal providers via the Prenatal Risk Screen.

Florida Head Start State Collaboration Office

The Florida Head Start State Collaboration Office (FLHSSCO) is housed at Florida's Office of Early Learning, Florida Department of Education. FLHSSCO is federally funded with the specific purpose of supporting and improving collaboration between Head Start and other providers of educational, medical, and social services in Florida. The Office coordinates federal, state, and local policy to help ensure a unified early care and education system. FLHSSCO also works to coordinate activities with the governor's office, key state agencies, and other early childhood associations and advocacy groups.

Efforts to Coordinate

The FHSSCO director served on the Needs Assessment Steering Committee until she found employment elsewhere. Unfortunately, another director was not hired prior to completing the needs assessment. What we gathered from her prior to her departure was the 2018 Needs Assessment for Head Start and she indicated that Head Start programs are mandated to coordinate with community resources to reduce costs and to increase quality supports for families and children.

Opportunities

In the past, the FLHSSCO has been an active participant on the ECCS Advisory Group, as well as the Home Visiting Advisory Group. While home visitors refer families to Head Start, we could potentially do a better job of information sharing. As soon as a new director is identified, we will invite him/her to participate and discuss greater opportunities for collaboration.

Office of Early Learning

The Florida Department of Education, Office of Early Learning (OEL) is the recipient of the Preschool Development Grant Birth Through Five (PDG B-5). As part of the planning phase of the grant, OEL and the State Advisory Council (SAC) developed a unified Early Childhood Strategic Plan for early childhood services with extensive input from stakeholders throughout the state. This plan reflects a convergence of the state's existing plans and priorities and creates a shared vision for addressing the most pressing needs of children birth through age five and their families. The SAC is comprised of key leaders from every sector that implements services for young children, including the FAHSC Executive Director.

Key findings from the 2019 efforts to develop the strategic plan include many important opportunities for improvement. Stakeholder focus groups and family access surveys provided information on specific challenges, gaps, and successes of how home visiting and early care and education (ECE) programs can be aligned to provide a system of supports for families. Family access surveys revealed that, of the families surveyed, only five percent of respondents reported using a home visiting program. Results from focus groups show that, while home visiting programs provide tremendous positive outcomes for both children and parents, clearer communication is needed about home visiting benefits and increased cross-collaboration among other service partners is also needed to better support families.

Florida's experience and the stakeholder feedback points to a need to increase parent and ECE provider awareness about the benefits of home visiting and the documented impact of supporting the long-term success of families. This awareness is critical to successfully engaging and serving families facing the greatest challenges. Finally, there is a need to further strengthen coordination of services statewide and locally, and adopt strategies to more effectively link home visiting and other ECE programs and services.

Efforts to Coordinate

The manager for the OEL Child Care Resource and Referral served on the Needs Assessment Steering Committee and was a valuable asset. Researchers from the University of Florida who are working on the PDG B-5 also provided input on the data. As OEL was preparing to submit the PDG B-5 application, the FAHSC CPO met with the OEL team and provided input on how to better capture the collaboration needs for home visiting, as well as those of infant/early childhood mental health. There are currently efforts underway to collect data on the availability of infant/early childhood mental health services and FAHSC staff are assisting in that area. The CPO is also serving on a workgroup that is focusing on improving developmental screening, coordination and referrals. OEL has been a strong partner on the ECCS Advisory Group with the Early Learning Program & Policy Manager of the School Readiness Program serving as the co-chair of the ECCS Policy Workgroup. She and the Coordinator for Early Learning System Building are both part of the ECCS State Improvement Team, which meets monthly with FAHSC staff.

Opportunities

As part of the PDG B-5, FAHSC and OEL will be partnering on efforts to increase awareness amongst local home visiting and ECE staff on how they can better coordinate and collaborate for families. In addition

to training opportunities on available services, staff can do a better job of referring to each other and collaborating when both are serving the same family. For example, both home visiting programs and ECE providers receiving School Readiness funds are required to conduct developmental screens. However, very rarely do the providers coordinate with each other on screening and follow-up. Ideally, all parents of infants and toddlers will be aware of home visiting and high quality ECE opportunities, but we know that is not yet true. Together, these two sectors can help increase awareness so that more families receive services that will benefit them.

Department of Children and Families

Child Abuse Prevention and Treatment Act

DCF continues to be the lead agency to administer CAPTA. The Office of Child Welfare within the DCF also oversees the Community-based Child Abuse Prevention federal grant and the Children's Justice Act grant. These three grants support the technical assistance for the implementation of effective practices to facilitate and promote achievement of Florida's statewide goals:

- Prevent children from experience abuse or neglect
- Endure the safety of children through improved investigative processes
- Ensure the safety of children while preserving the family structure

The Child Abuse Prevention and Treatment Act Reauthorization (2010) and P.L. 114-198, Comprehensive Addiction and Recovery Act of 2016, Title V, Section 503, makes several changes to CAPTA:

- Expands exposure criteria beyond "illegal substances" to include alcohol and prescribed medications
- Requires that the Plan of Safe Care address the needs of both the infant and the affected family or caregiver
- Requires development of policies and procedures to address the needs of infants identified as being affected by substance use or withdrawal symptoms
- Requires health care providers involved in the delivery and care of substance affected infants to notify the child protective services system 1-3.

Florida funds myriad unique community-based services designed by community leaders and administered by child welfare professionals. Each of the 19 community-based lead agencies under contract with the DCF use CAPTA funds to support case management and service delivery that includes in-home supports, counseling, parent education, family team conferencing, homemaker services, and support groups. In addition to CAPTA funding, the DCF uses a blend and braided funding approach, using federal, trust, and state monies to provide a broad continuum of child welfare services. Florida continues to address the service program areas defined in the CAPTA State Plan.[19]

As required by CAPTA, DCF has provisions and procedures for referring children under the age of three who are involved in substantiated cases of child abuse or neglect to early intervention services under Part C of the Individuals with Disabilities Education Act {42 U.S.C. 5106a, Sec. 106(b)(2)(A)(xxii)}. Florida defines "substantiated" as any case with verified findings of child abuse or neglect.

DOH has primary responsibility to deliver services under Part C in Florida. Florida's Early Steps, as described earlier ensures children under the age of three who are involved in substantiated cases of child abuse or neglect, and are potentially eligible for early intervention services, are referred for assessment and appropriate services.

Title V, Section 503, Infant Plan of Safe Care, P.L. 114-198, Comprehensive Addiction and Recovery Act of 2016 (CARA) went into effect July 22, 2016. This federal legislation made several changes to the CAPTA. A multidisciplinary and multi-agency leadership team comprised of DCF's Office of Child Welfare and Substance Abuse Mental Health Office, DOH, AHCA, Healthy Families, Healthy Start, MIECHV, Florida Hospital Association, Early Steps, behavioral health care providers and associations, and the University of Florida was established. The goals of the leadership team for the 2020-2024 plan period include:

- Developing best practices for implementation of the CAPTA/CARA requirement to address the needs of infants born with and identified as being affected by substance or abuse or withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum.
- Determining and implementing best practices for the completion of a Plan of Safe Care.
- Strengthening the behavioral health providers' ability to work effectively with pregnant women.
- Improving the among and quality of screening for substance use during pregnancy.

Child Abuse Prevention Efforts

Funded by CBCAP, the Ounce of Prevention Fund of Florida manages the Florida Circle of Parents Network. The Ounce provides training and technical assistance to local providers throughout Florida that agrees to host and facilitate a local meeting using the Circle of Parents model, sometimes in conjunction with a home visiting program. This free, self-help parent support group:

- Provides facilitation skills, support group dynamics and parent leadership training to Florida network members
- Offers technical assistance and parenting resources to local providers to conduct the meetings
- Provides social support, reduces isolation, and builds self-esteem within parents
- Practices shared leadership among facilitators and parents for participants to both receive and provide help others
- Services a diverse population which provides the opportunity to apply "field setting experiences constructed to include the diverse provide of families in collaborative planning, designing, and evaluating of prevention programs

Currently there are more than 50 Circle of Parents programs throughout Florida in Brevard, Broward, Citrus, Clay, Duval, Glades, Hendry, Madison, Leon, Pasco, Putnam, Seminole, St. Johns, Lake, Levy, Marion, Miami-Dade, Nassau, Okaloosa, Osceola, Orange, and Palm Beach Counties.

Efforts to Coordinate

DCF staff actively participated in the Needs Assessment Steering Committee and contributed greatly to this report. Prevention staff are also a part of other collaborative groups such as the ECCS Advisory Group and the Home Visiting Advisory Group. Additionally, the FAHSC CPO, DCF, DOH, HFF, the Governor's Office, and PCA Florida are working together on a Prevention Strategies Workgroup. CAPTA continues to highlight the need for more and improved services for families affected by substance use. FAHSC, DOH and DCF, as well as other representatives are working with the Florida Perinatal Quality Collaborative to enhance efforts to expand Plans of Safe Care for families.

Opportunities

While DCF has been very collaborative in efforts outside of the agency, there is more that could be done to increase the input external staff have on the internal processes. A pending opportunity is the Family First Prevention Services Act (FFPSA). This important legislation was signed into law as part of the

Bipartisan Budget Act on February 9, 2018. As a result of this legislation, Florida will have the ability to use Title IV-E funding to support evidence-based prevention services for children such as mental health, substance abuse, kinship navigator, and in-home parent skill-based services. Currently, the Title IV-E Prevention Services Clearinghouse has rated HFA, NFP and PAT as "well supported" in the latter category. In a document produced by the Alliance for Early Success titled, "What Early Childhood Advocates Should Know", they recommend that "child welfare agencies rely on the MIECHV Needs Assessment and the Strategic Plan for the Preschool Development Grant Birth-Five to inform the needs in each state. Because of our strong partnerships, we are well positioned to improve opportunities and services for children and families at risk of entering the child welfare system." While there are many aspects to the FFPSA, the plans will benefit from coordination with these other entities.

CONCLUSION

As one of the largest and most diverse states in the US, the need for home visiting services in Florida is great. There are currently seven evidence-based models operating in Florida that were funded to serve 16,639 in FY19-20. This comes nowhere close to meeting the estimated need of 111,366 families and the gap will continue to grow. In FY20-21, Florida MIECHV will see a reduction in funded family slots with larger cuts looming for FY21-22 unless there is an increase in funding. We also anticipate additional need as a result of the pandemic, and home visiting could benefit those families – especially the newly poor who are not familiar with resources they have never needed to access. Additionally, parents are facing increased stressors that compete with their ability to effectively meet the health and developmental needs of their children.

Following an extensive data analysis, 47 counties in Florida were determined to have concentrations of risk – 19 counties were identified through the initial county-level risk assessment, 25 counties were identified following the subcounty analysis, and an additional three counties were included due to special circumstances. Each of the 47 counties has a unique set of risk factors and varying levels of available home visiting services. A snapshot of county-specific information can be found in the county profiles in Appendix 5.

A set of three surveys were utilized to gain the input of over 700 stakeholders living and working in high-risk counties, including home visiting staff, community partners, and parents with young children. Community partners overwhelmingly recognize the need for additional home visiting services in their community, while home visiting staff are split down the middle. The primary concern shared by home visiting staff were over saturating counties with smaller populations and low birth rates. Concerns were also raised about the lack of available programs that enroll older children (2-3 years old). In order to take these concerns into account and assist with future planning, the estimated need for MIECHV-eligible families, as well as the total number of current slots for evidence-based home visiting, are included for all high-risk counties in the county profiles. The surveys also indicate a need for better coordination within the continuum of early childhood services.

Although Florida is already investing a substantial amount of resources into providing substance use disorder treatment and counseling services for pregnant women and families, the surveys indicate that it is not nearly enough. Surveys also show that even where services are available, there are still substantial barriers for accessing services.

The good news is that state agencies and non-profits that serve pregnant women and families with young children are working together more than they ever have in the past to collaborate on efforts to

better coordinate services, and to meet the needs of families. Numerous organizations are working together on efforts to promote equity and reduce implicit bias so that we can improve outcomes for the diverse families in Florida.

FAHSC plans to develop a summary of the findings, based on input from the Steering Committee, that will be widely distributed through the Healthy Start Coalitions, the Home Visiting Advisory Group, MIECHV local implementing agencies, state agencies that fund home visiting, and the Early Childhood Comprehensive Systems Advisory Group. This summary will include a hyperlink to where the full report, including appendices, will be posted on the Florida MIECHV website.

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APPENDIX 1

STEERING COMMITTEE MEMBERS

2020 Florida Home Visiting Statewide Needs Assessment Steering Committee Members

Gabrielle Bargerstock, Florida Executive Director, Nurse Family Partnership

Lo Berry, President/CEO, REACHUP, Inc. (Joined in Spring 2020 to replace Vanessa Rowland-Mishkit.)

Denise Brown, Parent Representative

Devin Coleman, Parent Representative

Vanessa Fischel, Director of Home Visiting, Florida Department of Health in Hendry and Glades Counties

Wendy Giron, Family Support Worker, Healthy Families Orange

Helena Girouard, Parent Representative

Michelle Grant Harris, Program Manager, Parents as Teachers Program, Department of Obstetrics and Gynecology, College of Medicine, University of Florida

Theresa Harrison, Executive Director, Chipola Healthy Start Coalition

Erin Hough, Prevention Specialist, Department of Children and Families, Office of Child Welfare

Tracy Payne Jordan, State Director, Florida HIPPY Training & Technical Assistance Center, College of Behavioral and Community Sciences, University of South Florida

Vanessa Rowland-Mishkit, Clinical Director, REACHUP, Inc. (Retired in Spring 2020.)

Jennifer Ohlsen, Executive Director, Healthy Families Florida

Anna Simmons, Section Administrator, Maternal and Child Health, Bureau of Family Health Services, Florida Department of Health

Courtnie Wheeless, Manager, Office of Early Learning, Child Care Resource and Referral

Allison Parish, Chief Program Officer and MIECHV Project Director, Florida Association of Healthy Start Coalitions

<u>Committee Staff:</u>

Katie Hood, MIECHV Quality Improvement and Implementation Manager, Florida Association of Healthy Start Coalitions

Jennifer Marshall, Associate Professor, Chiles Center, University of Florida College of Public Health

Marianna Tutwiler, Consultant

APPENDIX 2

FINAL INDICATION DEFINITIONS AND SOURCES

Domain	Indicator	HRSA	Added	County Level	Tract Level	Indicator Definition	Year	Source
Family and Community Violence	Crime Reports FCV-CRIME	X		X		# reported crimes/100,000 residents	2019	FDLE
	Juvenile Arrests FCV-JUVE	X		X		total juvenile arrests per 100,000 population aged 10-17	Num: 2019 (1-yr) Denom: 2014-18 (5-yr)	FDLE (N) ACS (D)
	Intimate Partner Violence FCV-IPV		X	X		Rate per 100,000	2018	FDLE
Substance Use and Smoking	Alcohol SUD-ALC	X		X		Prevalence rate: Binge alcohol use in past month	2012-2014 (3-yr)	SAMHSA
	Marijuana SUD-MAR	X		X		Prevalence rate: Marijuana use in past month	2014-2016 (3-yr)	SAMHSA
	Illicit Drugs UD-DRG	X		X		Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month	2012-2014 (3-yr)	SAMHSA
	Pain Relievers SUD-PAIN	X		X		Prevalence rate: Nonmedical use of pain medication in past year	2012-2014 (3-yr)	SAMHSA
	Tobacco SUD-TOB		X	X	X	% of resident live births with an indication of maternal smoking during pregnancy among all those with a non-missing smoking indicator (i.e., missings for smoking excluded from denominator)	2018 (1-yr)	FL VS
Priority Populations	Incarceration SP-JAIL		X	X		Jail population per 100,000 residents aged 15-64	2013-2017 (5-yr)	Vera Institute
	Agriculture Industry SP-FARM		X	X		Number of hired farm workers per 100,000 labor force population aged 16-54	Num:2017 (1-yr) Denom: 2013-17 (5-yr)	Census of Agriculture, ACS
Socioeconomic Status/ Social Determinants of Health	Poverty SES-POV	X		X	X	% of families with related children of household under 5 years of age that are in poverty	2014-18 (5-yr)	ACS
	Unemployment SES-EMP	X		X	X	Unemployed percent of the civilian labor force (civilian noninstitutional population ages 16 and older)	2014-18 (5-yr)	ACS
	HS Dropout SES-HS	X		X		% of 16-19 year olds not enrolled in school with no high school diploma	2014-18 (5-yr)	ACS
	Educational Attainment SES-EDU		X		X	% of population 25 years and older who have less than high school graduate education attainment	2014-18 (5-yr)	ACS
	Income Inequality SES-INC	X			X	Gini Coefficient	2014-18 (5-yr)	ACS
	ALICE Households SES-ALICE		X			Alice households as a proportion of all households	2016 (1-yr)	United Way
	Housing Security/Home Ownership SES-OWN		X		X	Percent renter-occupied housing units; Estimate; With related children under 18 years	2014-18 (5-yr)	ACS
Adverse Perinatal Outcomes	Small-for-Gestational Age APO-SGA		X	X	X	% live births SGA	2018 (1-yr)	FLVS
	Infant Mortality APO-IM		X	X		Resident Infant Death Rate/ 1,000 live births	2014-2018 (5-yr)	FL CHARTS
	Maternal Mortality APO-MM		X	X		Resident maternal mortality death ratio per 100,000	2009-2018 (10-yr)	FL CHARTS
	Preterm Birth APO-PTB	X		X	X	% live births <37 weeks	2018 (1-yr)	FLVS

Domain	Indicator	HRSA	Added	County Level	Tract Level	Indicator Definition	Year	Source
Child Health & Development	Child Uninsurance CHD-INS		X	X		% of children under 19 uninsured	2014-18 (5-yr)	ACS
	Kindergarten Readiness SCD-KGT		X	X		Percentage "Not Ready for Kindergarten" (Scoring <500 on Star Early Literacy Assessment) *	2019 (1-yr)	FLDOE
	Hospitalizations for Asthma CHD-ASTH		X	X		Asthma Hospitalizations ages 1-5, 3-yr discrete rate per 100,000 (2016-2018)	2016-2018 (3-yr)	FL CHARTS
	Hospitalizations for Unintentional Injuries CHD-INJ		X	X		Hospitalizations ages 1-5 for all non-fatal unintentional injuries, 3-yr discrete Rate Per 100,000 (2016-2018)	2016-2018 (3-yr)	FL CHARTS
Child Maltreatment	Child Maltreatment CM-MALTX	X	X	X		Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	2016	ACF

APPENDIX 3

MAPS

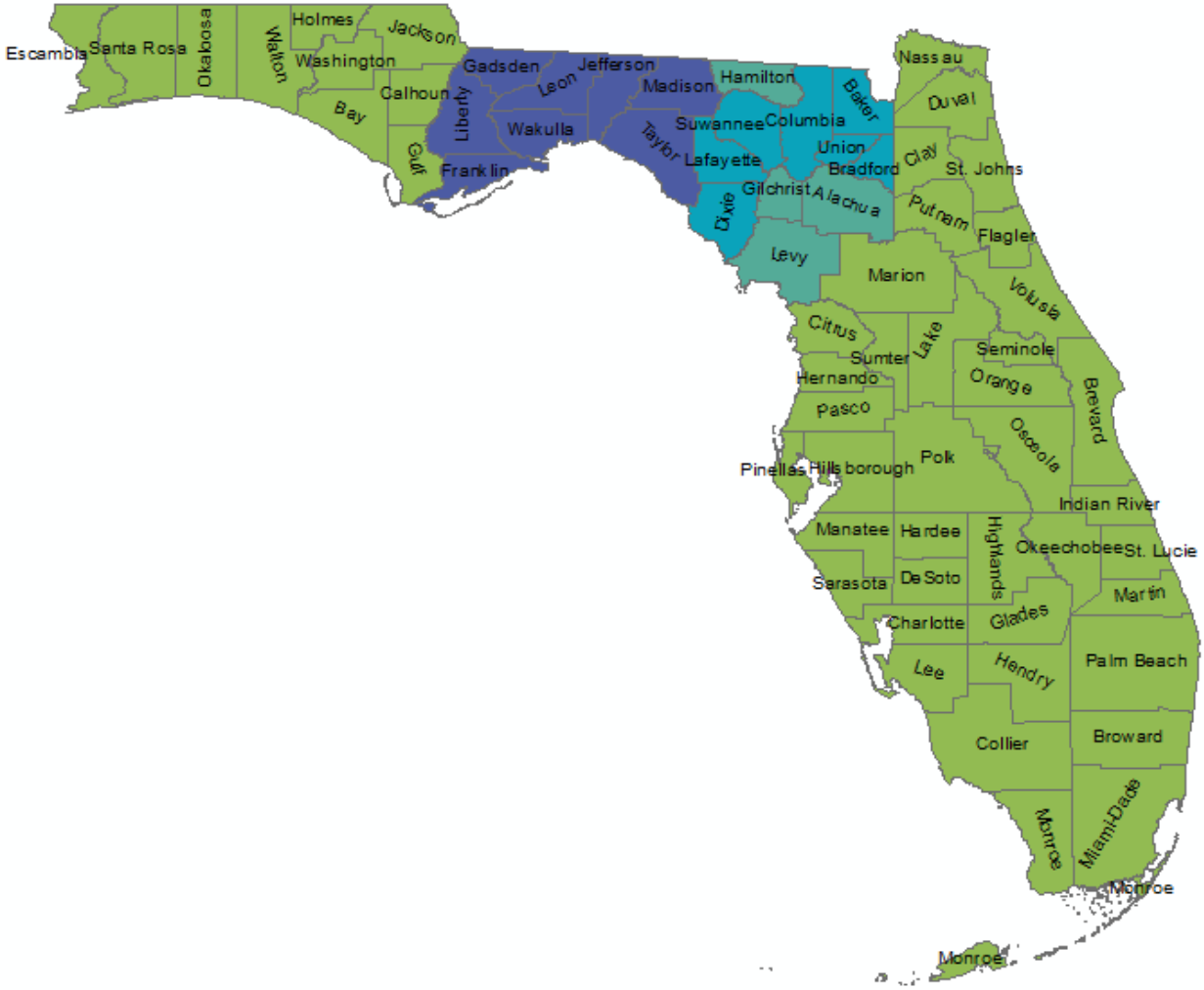
1. **At-risk Counties – Socioeconomic Status (SES):** The map shows the percentage of indicators that are at risk within the SES domain. There are six indicators in the SES domain: Poverty, Unemployment, High School Dropout, Income Inequality, ALICE Households, Home Ownership.

LEGEND		# of counties
	0-25% of the indicators at risk	52
	26-50% of the indicators at risk	15
	51-75% of the indicators at risk	0
	76-100% of the indicators at risk	0

2. **At-risk Counties – Adverse Perinatal Outcomes (APO):** The map shows the percentage of indicators that are at risk within the APO domain. There are four indicators in the APO domain: Small-for-Gestational Age, Infant Mortality, Maternal Mortality, Preterm Birth.

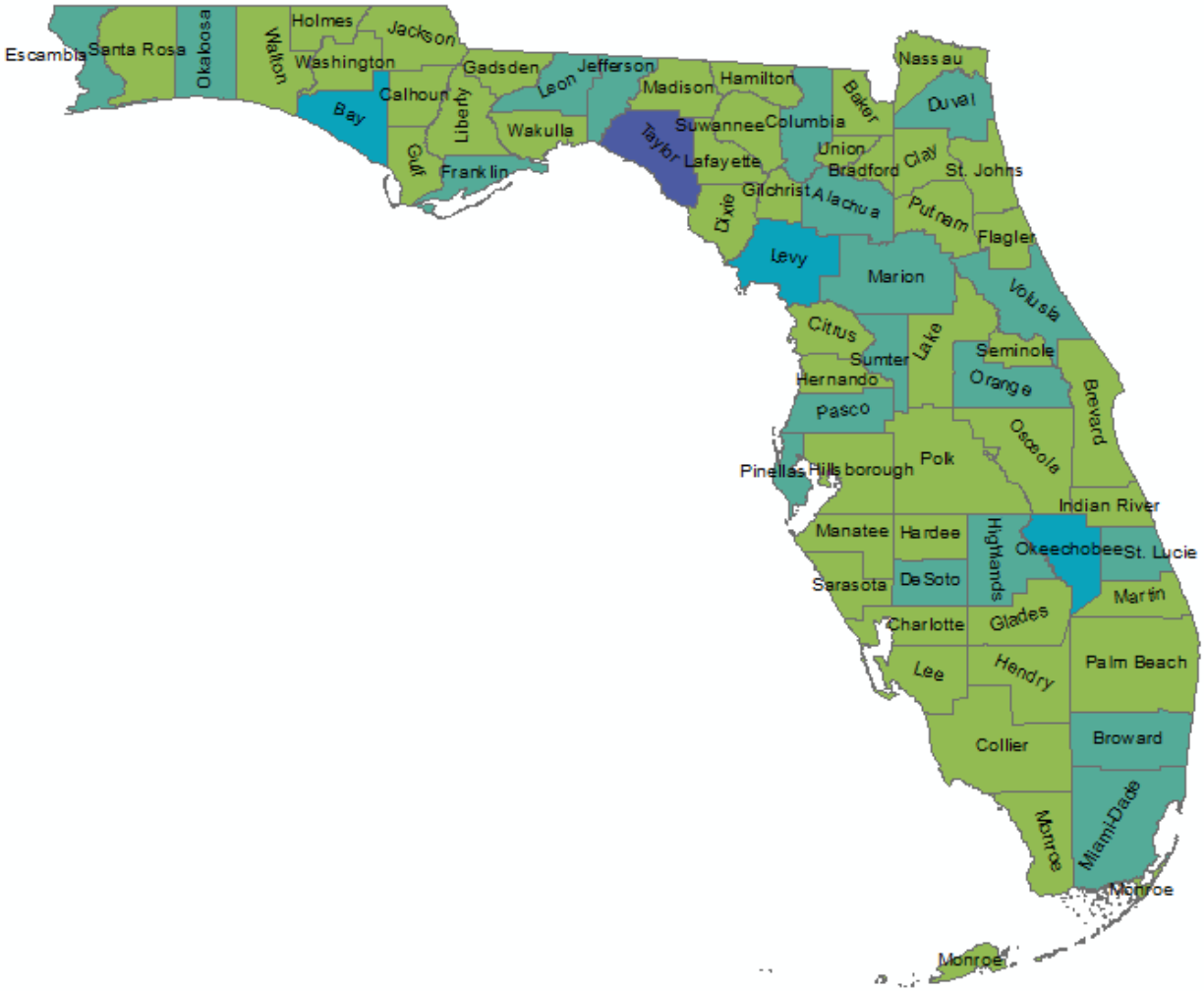
LEGEND		# of counties
	0-25% of the indicators at risk	57
	26-50% of the indicators at risk	9
	51-75% of the indicators at risk	1
	76-100% of the indicators at risk	0

3. **At-risk Counties – Substance Use Disorder (SUD):** The map shows the percentage of indicators that are at risk within the SUD domain. There are five indicators in the SUD domain: Alcohol, Marijuana, Illicit Drugs, Pain Relievers, Tobacco during pregnancy.



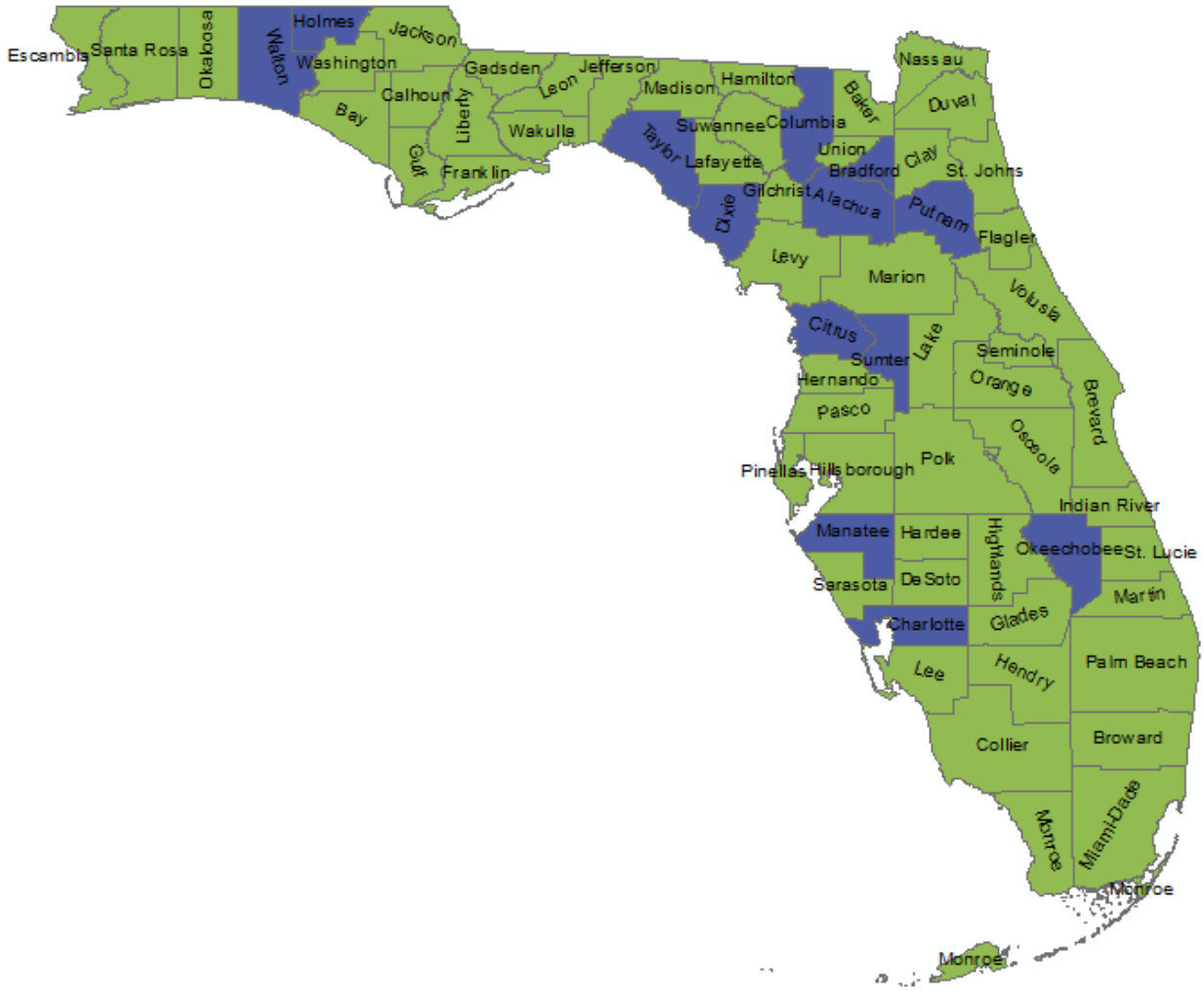
LEGEND	# of counties
0-25% of the indicators at risk	48
26-50% of the indicators at risk	4
51-75% of the indicators at risk	7
76-100% of the indicators at risk	8

4. **At-risk Counties – Family and Community Violence (FCV):** The map shows the percentage of indicators that are at risk within the FCV domain. There are three indicators in the FCV domain: Crime Reports, Juvenile Arrests, Intimate Partner Violence.



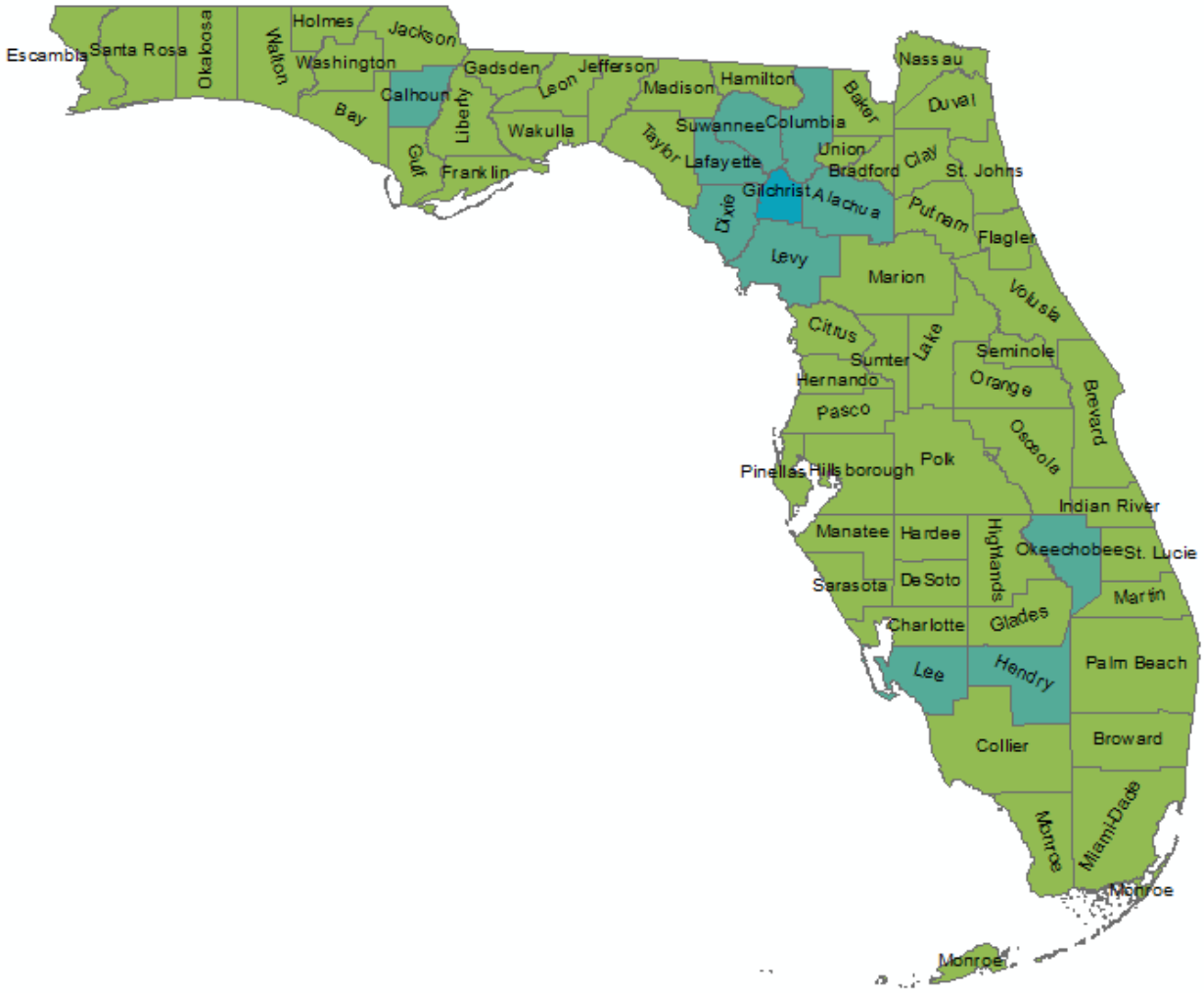
LEGEND		# of counties
	0-25% of the indicators at risk	44
	26-50% of the indicators at risk	19
	51-75% of the indicators at risk	3
	76-100% of the indicators at risk	1

5. **At-risk Counties – Child Maltreatment (CM):** The map shows the percentage of indicators that are at risk within the CM domain. There is one indicator in the CM domain: Child Maltreatment.



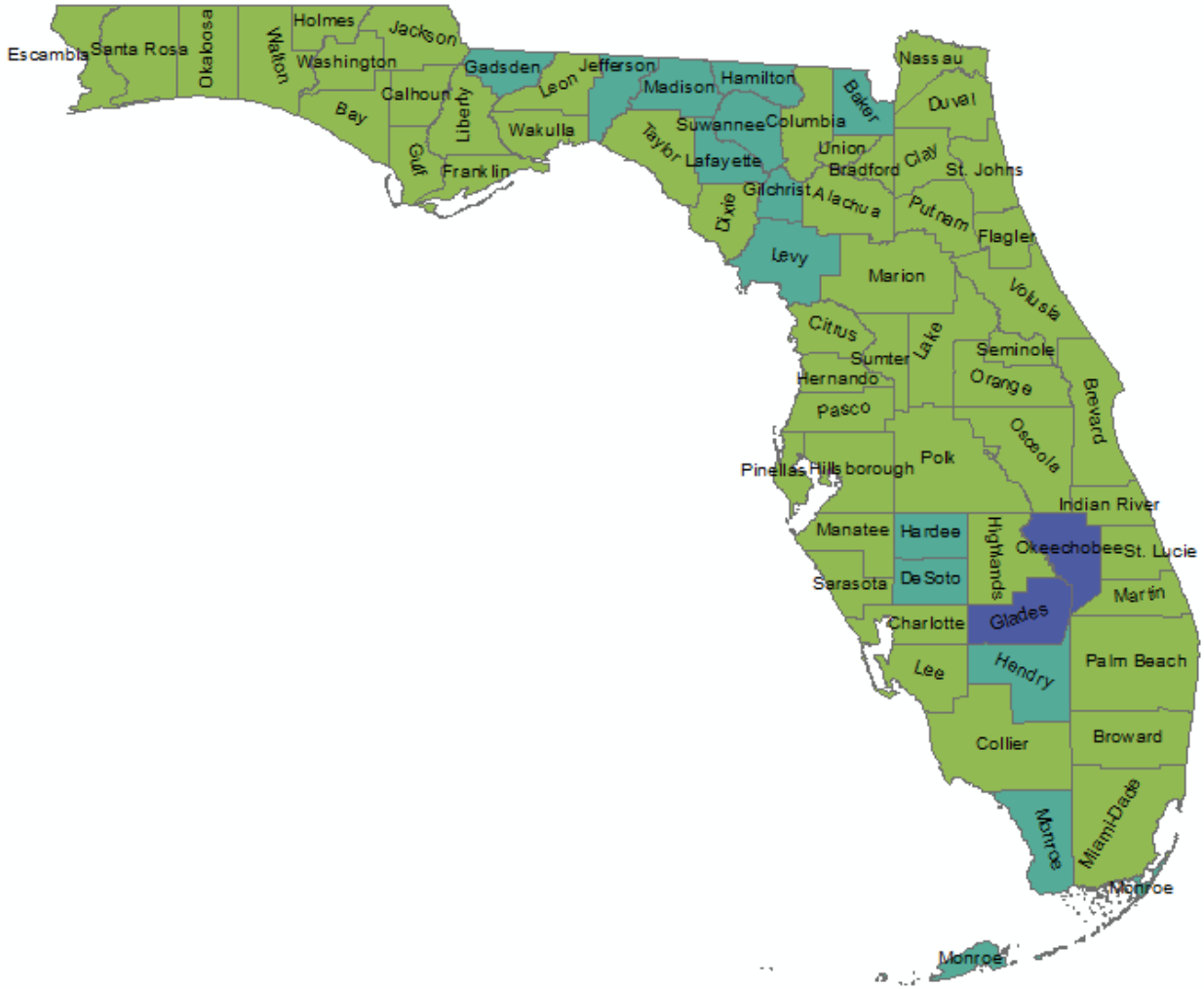
LEGEND		# of counties
	0-25% of the indicators at risk	54
	26-50% of the indicators at risk	0
	51-75% of the indicators at risk	0
	76-100% of the indicators at risk	13

6. **At-risk Counties – Child Health and Development (CHD):** The map shows the percentage of indicators that are at risk within the CHD domain. There are four indicators in the CHD domain: Child Uninsurance, Kindergarten Readiness, Hospitalizations for Asthma, Hospitalizations for Unintentional Injuries.



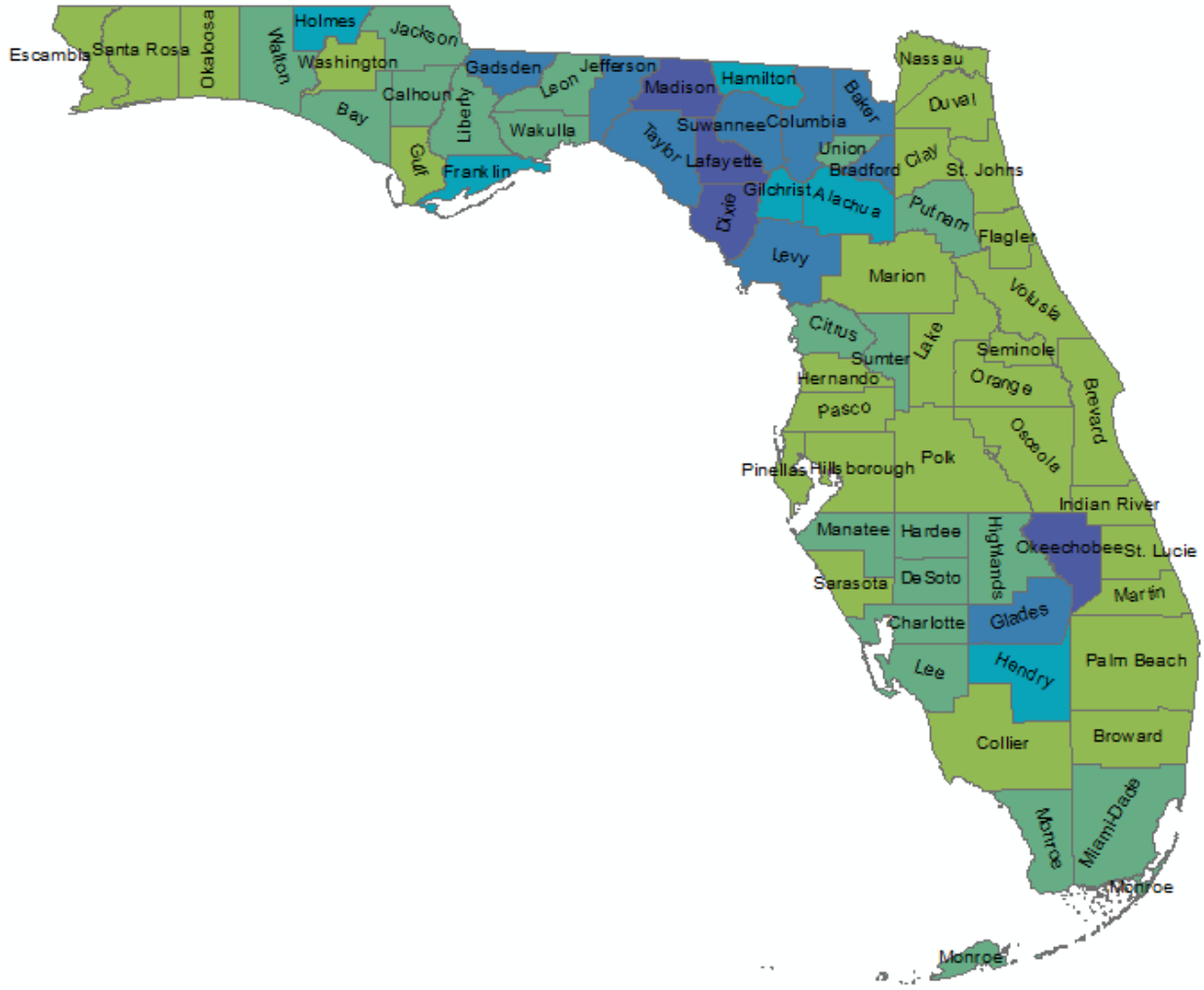
LEGEND		# of counties
	0-25% of the indicators at risk	56
	26-50% of the indicators at risk	10
	51-75% of the indicators at risk	1
	76-100% of the indicators at risk	0

7. **At-risk Counties – Special Populations (SP):** The map shows the percentage of indicators that are at risk within the SP domain. There are two indicators in the SP domain: Incarceration, Agriculture Industry.



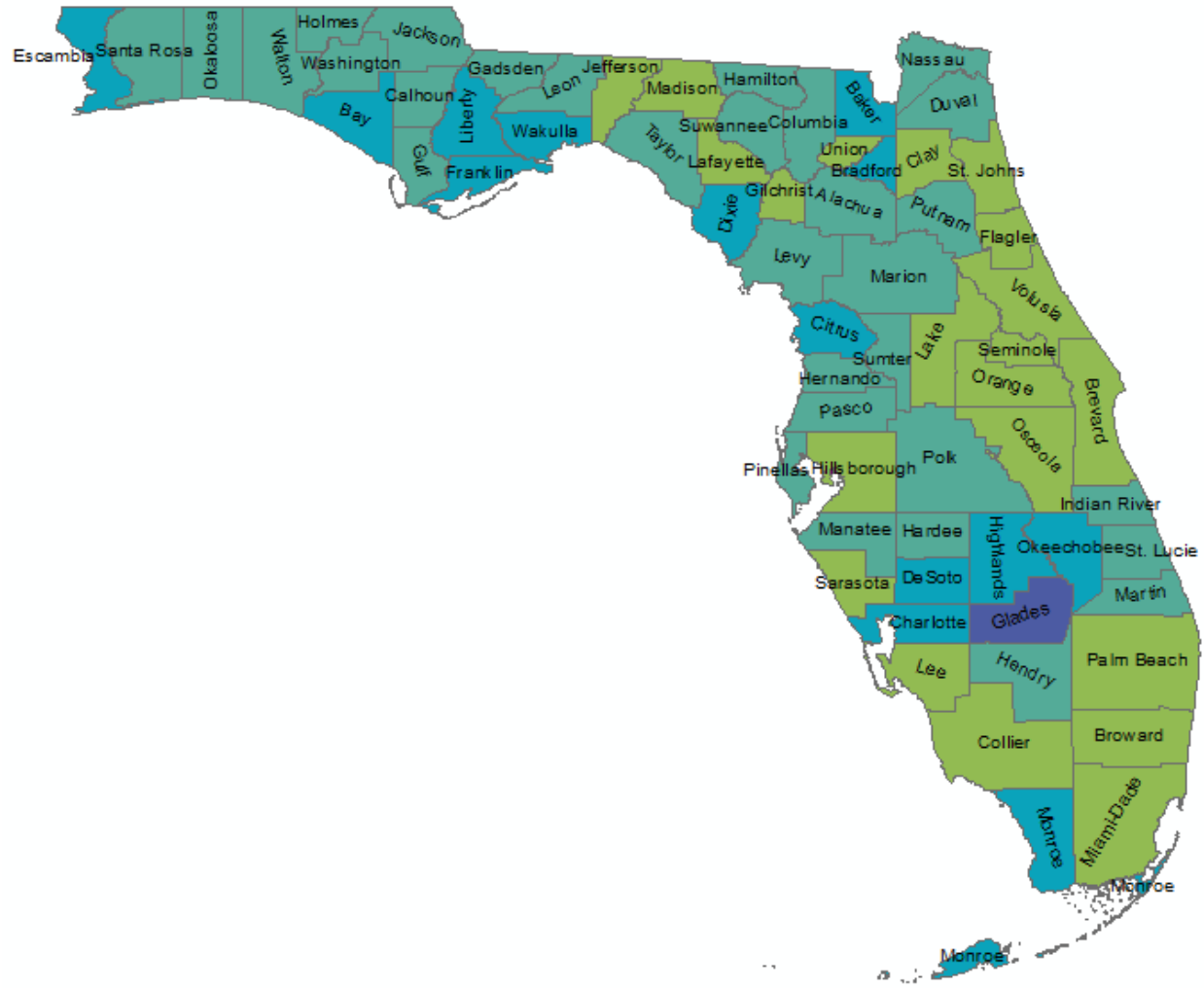
LEGEND		# of counties
	0-25% of the indicators at risk	52
	26-50% of the indicators at risk	13
	51-75% of the indicators at risk	0
	76-100% of the indicators at risk	2

8. **Number of at-risk domains:** The map shows the number of domains at risk in each county.



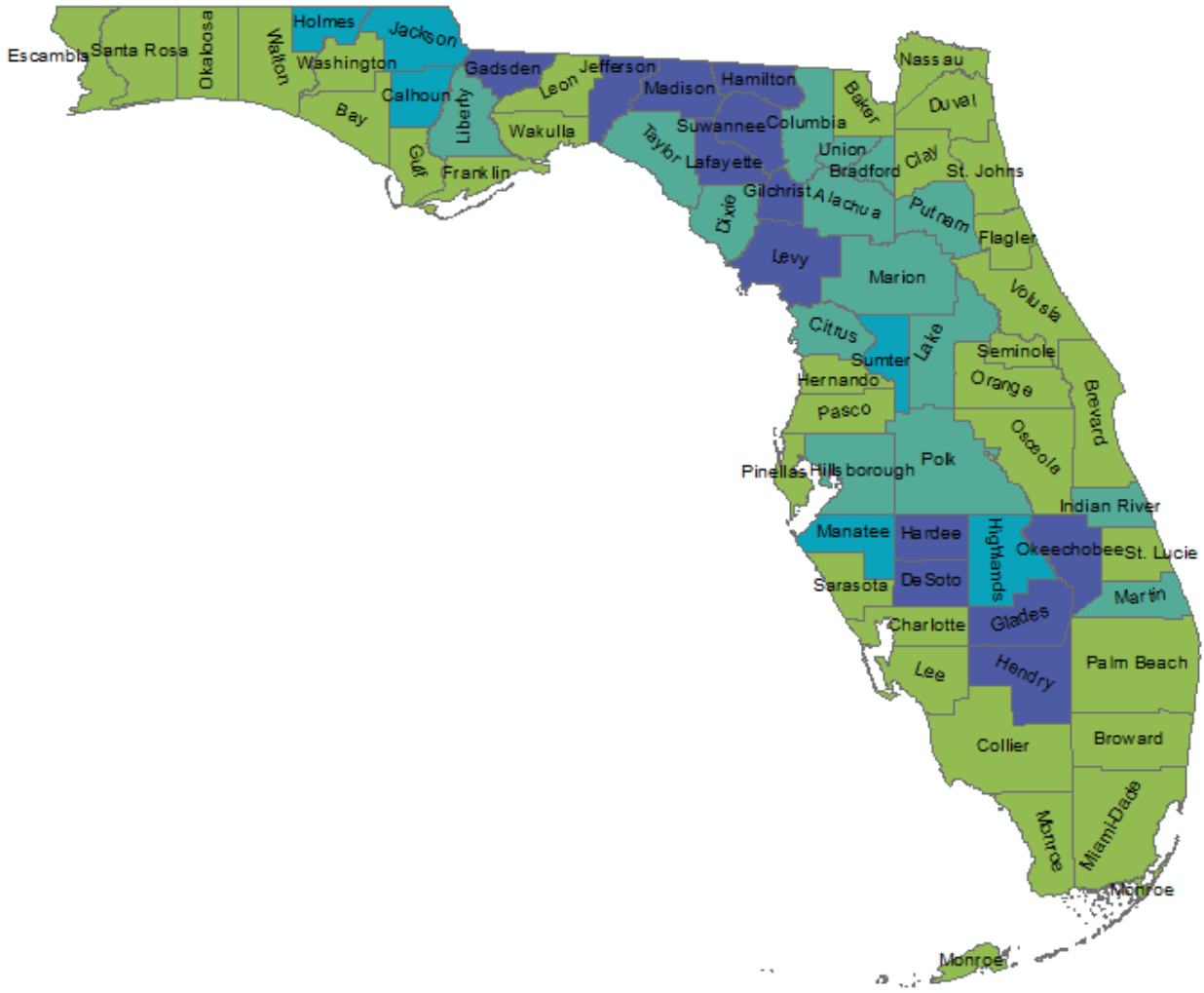
LEGEND	# of counties
No domain at risk	29
1 domain at risk	19
2 domains at risk	6
3 domains at risk	9
4 domains at risk	4

9. Special population (Incarcerated population): Jail population per 100,000 residents aged 15-64



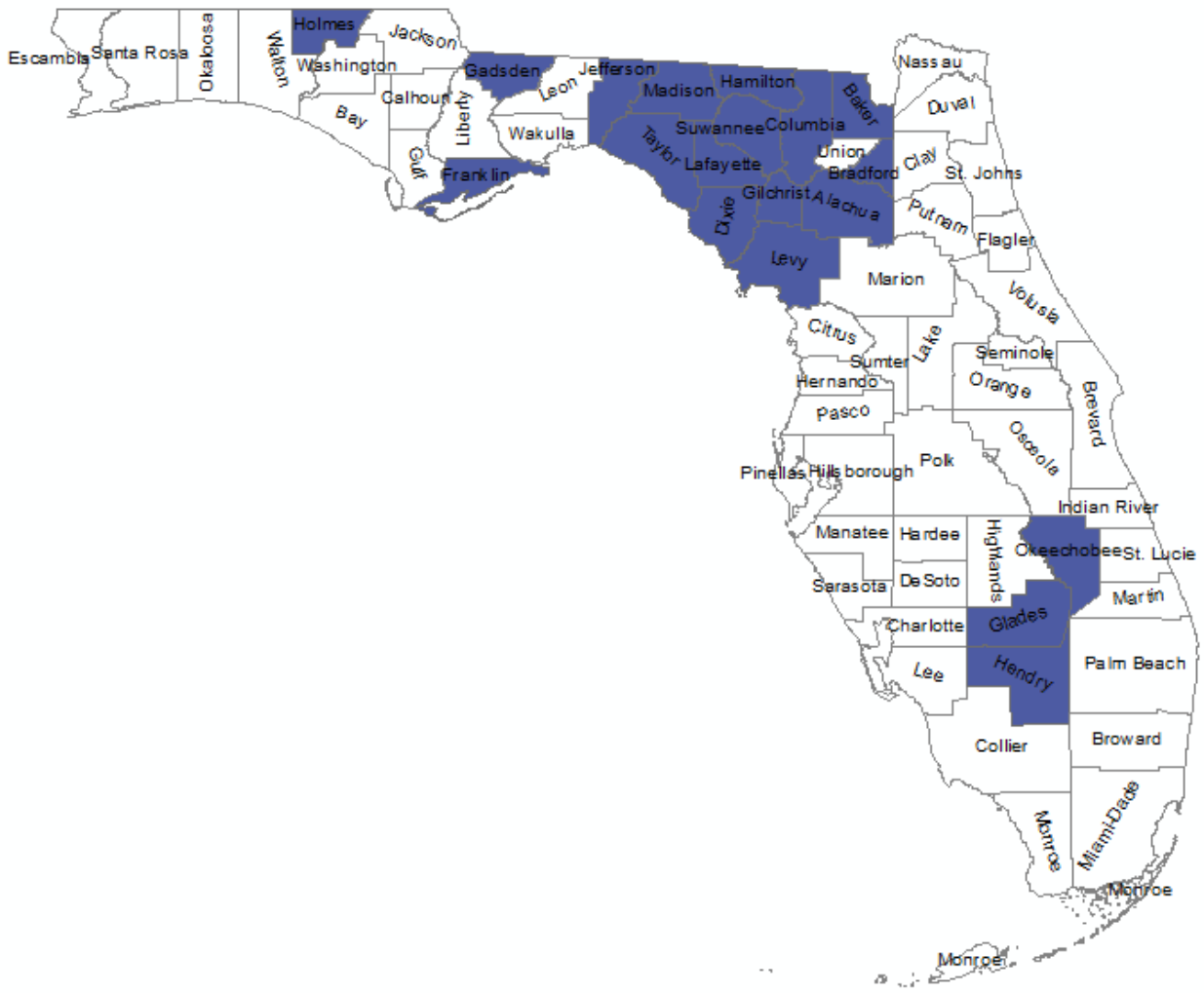
LEGEND		# of counties
	193 – 443.5	21
	443.6 – 725.3	31
	725.4 - 2169	14
	2169 - 4450	1

10. Special population (Agriculture Industry): Number of hired farm workers per 100,000 labor force population aged 16-54



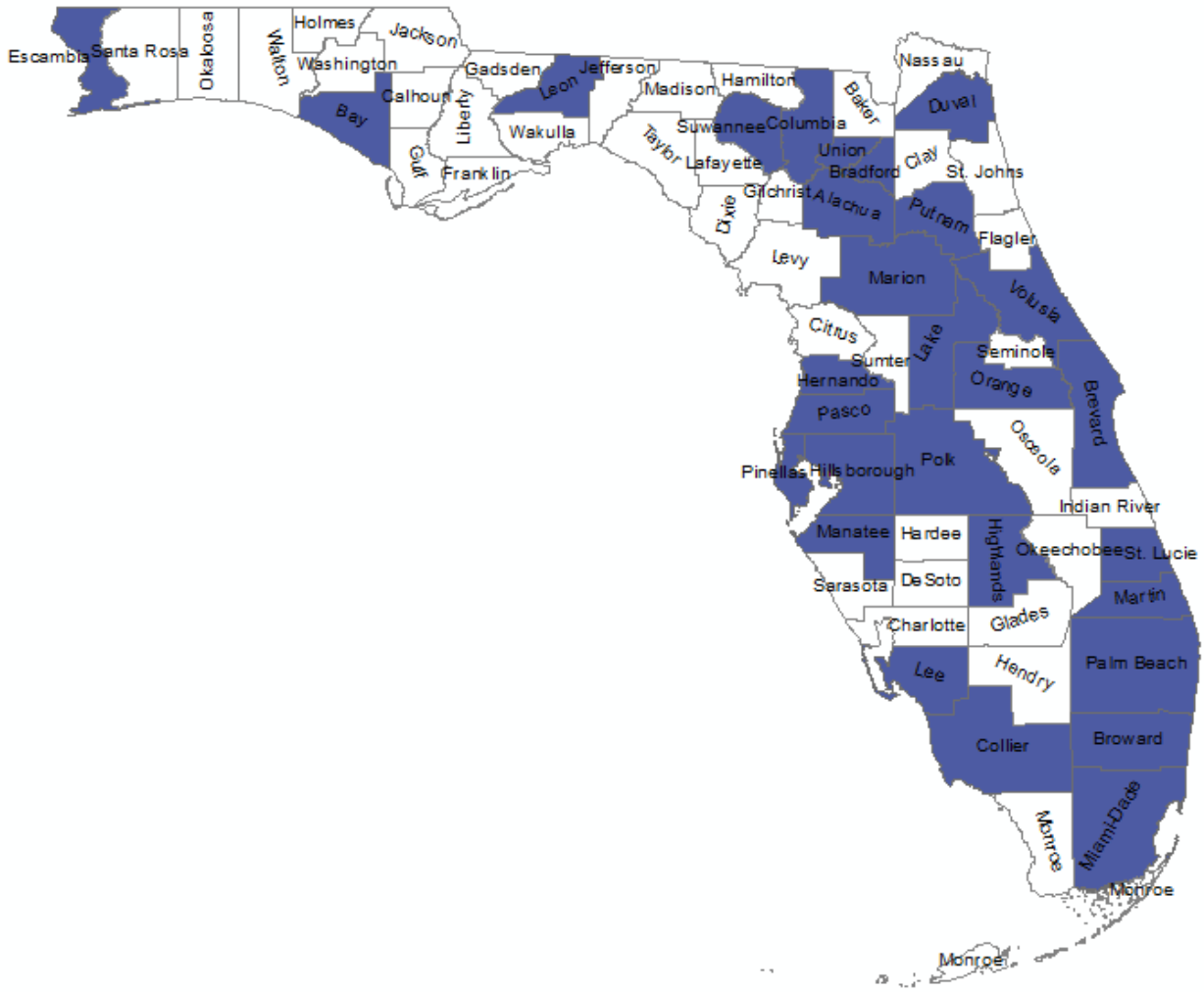
LEGEND		# of counties
	0 - 1.6	33
	1.7 - 4.0	15
	4.1 - 7.3	6
	7.4 - 23.3	13

11. At-risk counties based on county-level analyses



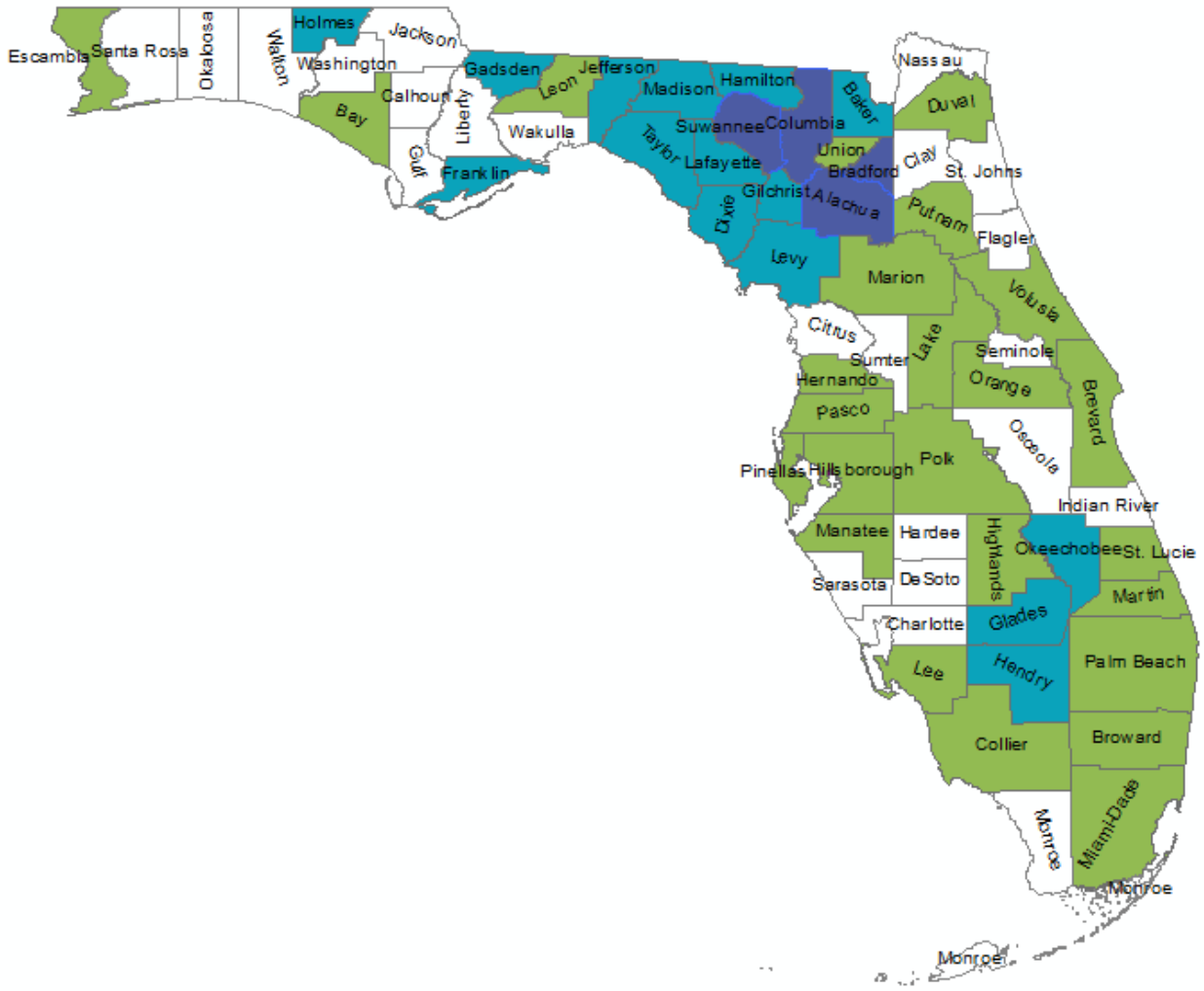
LEGEND		# of counties
	Counties at-risk based on county-level analyses	19

12. At risk counties based on tract-level analyses



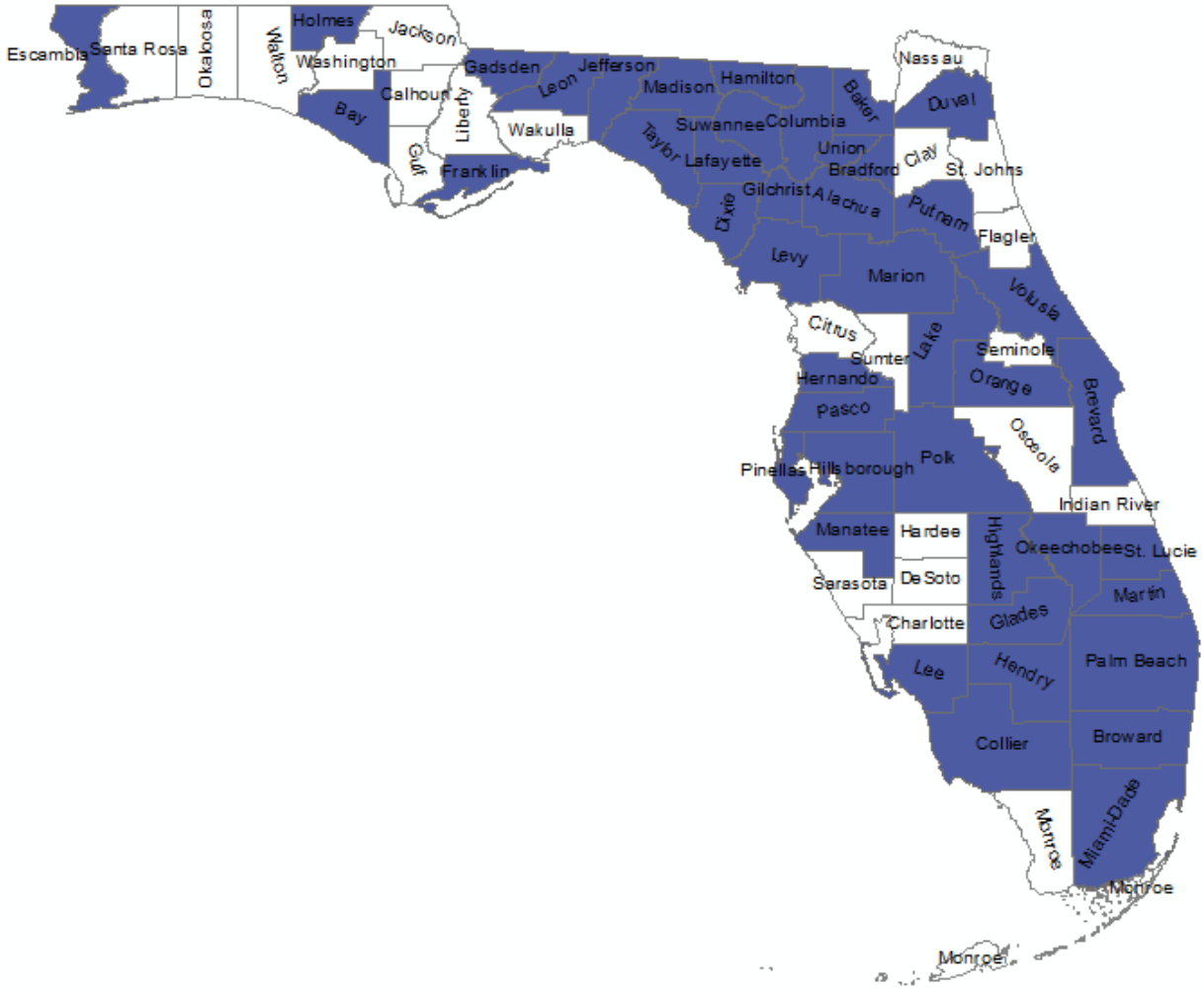
LEGEND		# of counties
	Counties at-risk based on tract-level analyses	29

13. At-risk counties based on county level and tract level analyses



LEGEND		# of counties
	Not at-risk county	23
	At-risk based on county level analyses	15
	At-risk based on tract level analyses	25
	At-risk based on county and tract level analyses	4

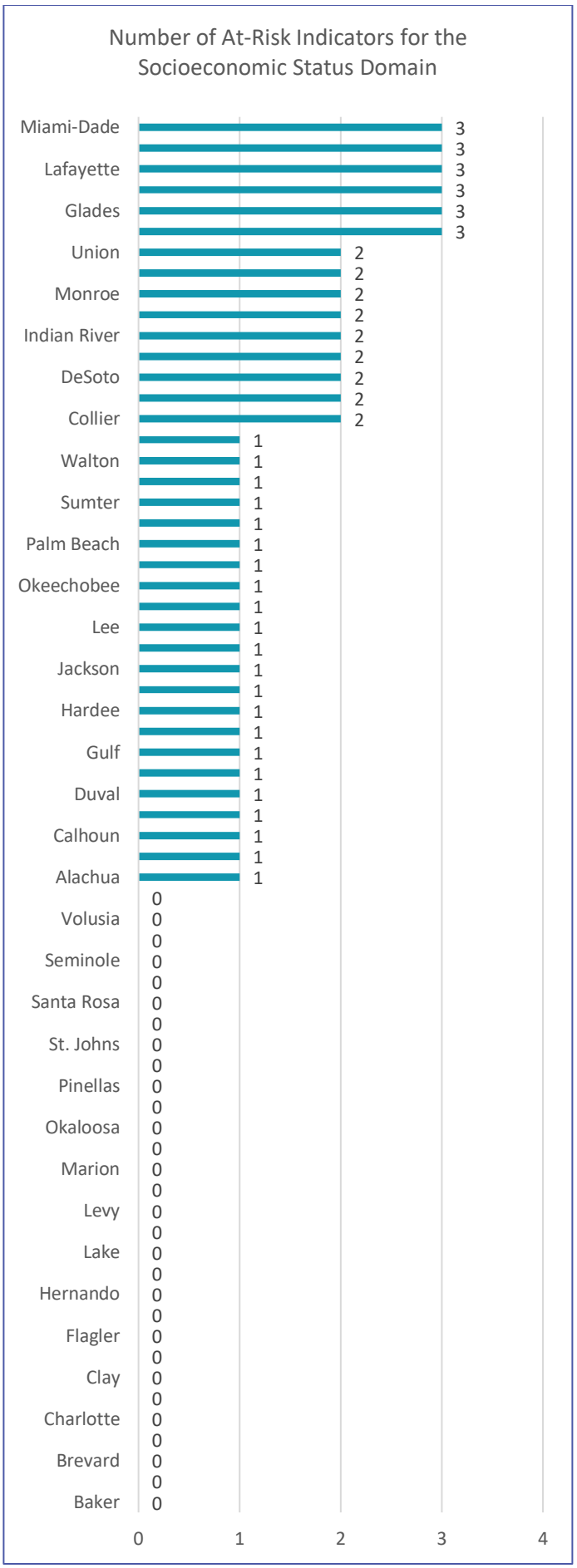
14. Final County List

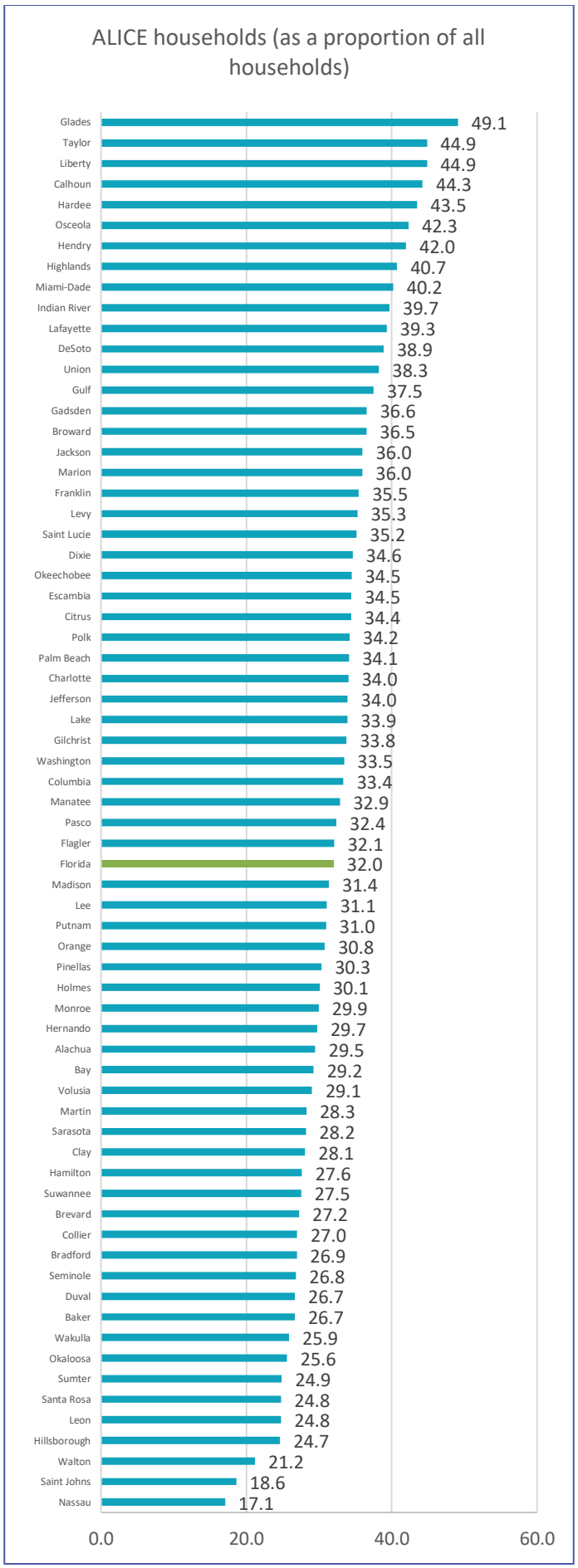


LEGEND		# of counties
	Final county list	44

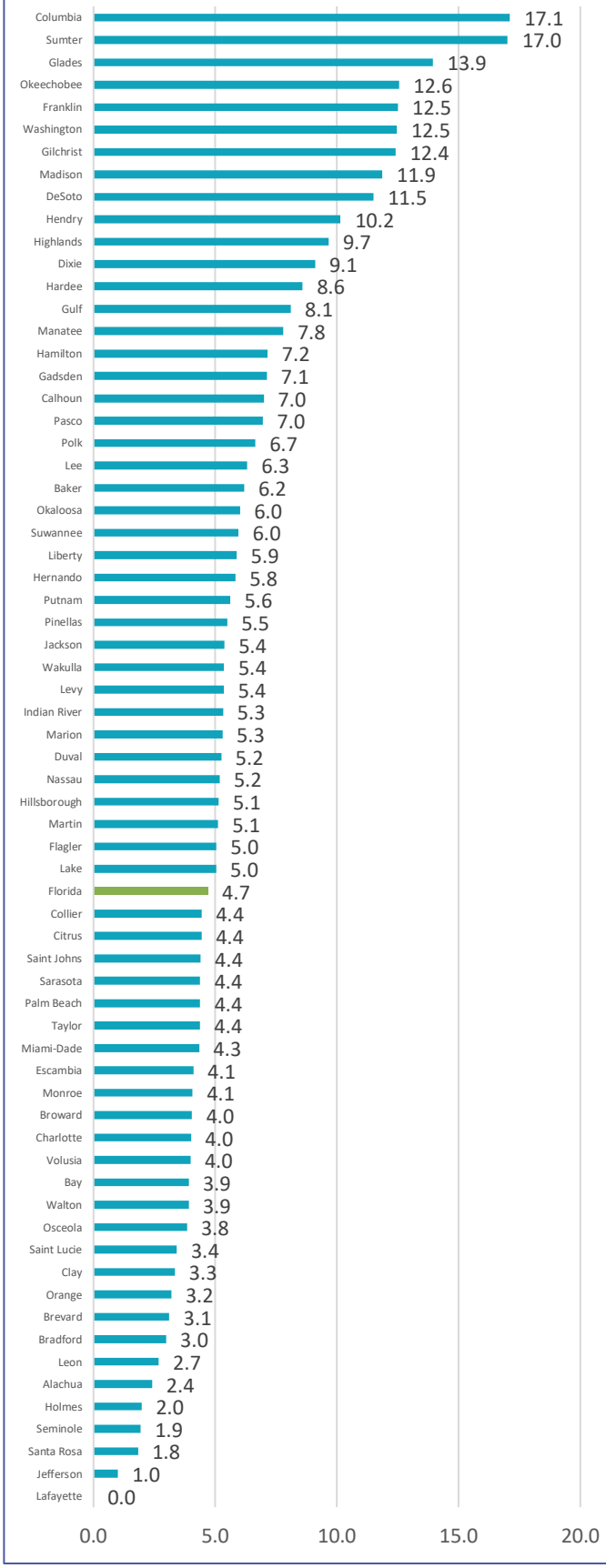
APPENDIX 4

Rank Ordered County Rates for Domains and Indicators

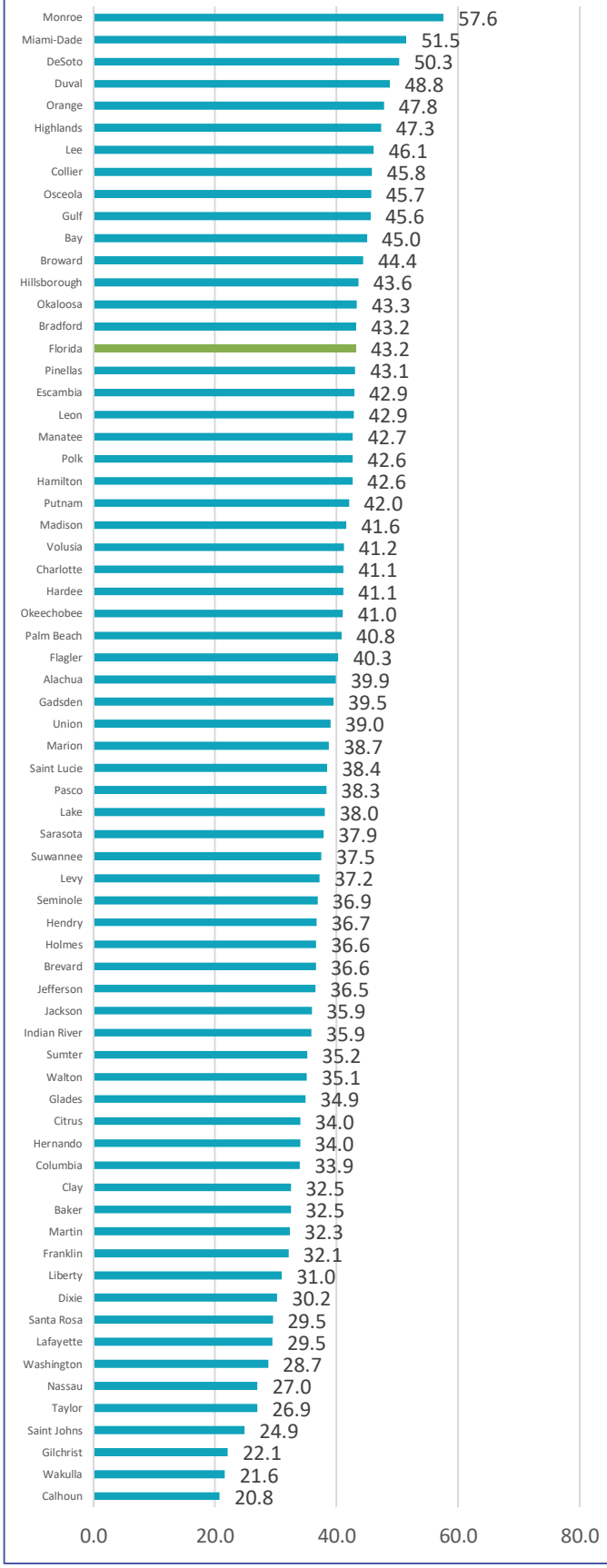

Number of At-Risk Indicators for the Socioeconomic Status Domain
Miami-Dade 3
Lafayette 3
Glades 3
Union 3
Monroe 2
Indian River 2
DeSoto 2
Collier 2
Walton 2
Sumter 1
Palm Beach 1
Okeechobee 1
Lee 1
Jackson 1
Hardee 1
Gulf 1
Duval 1
Calhoun 1
Alachua 1
Volusia 1
Seminole 0
Santa Rosa 0
St. Johns 0
Pinellas 0
Okaloosa 0
Marion 0
Levy 0
Lake 0
Hernando 0
Flagler 0
Clay 0
Charlotte 0
Brevard 0
Baker 0
0
1
2
3
4

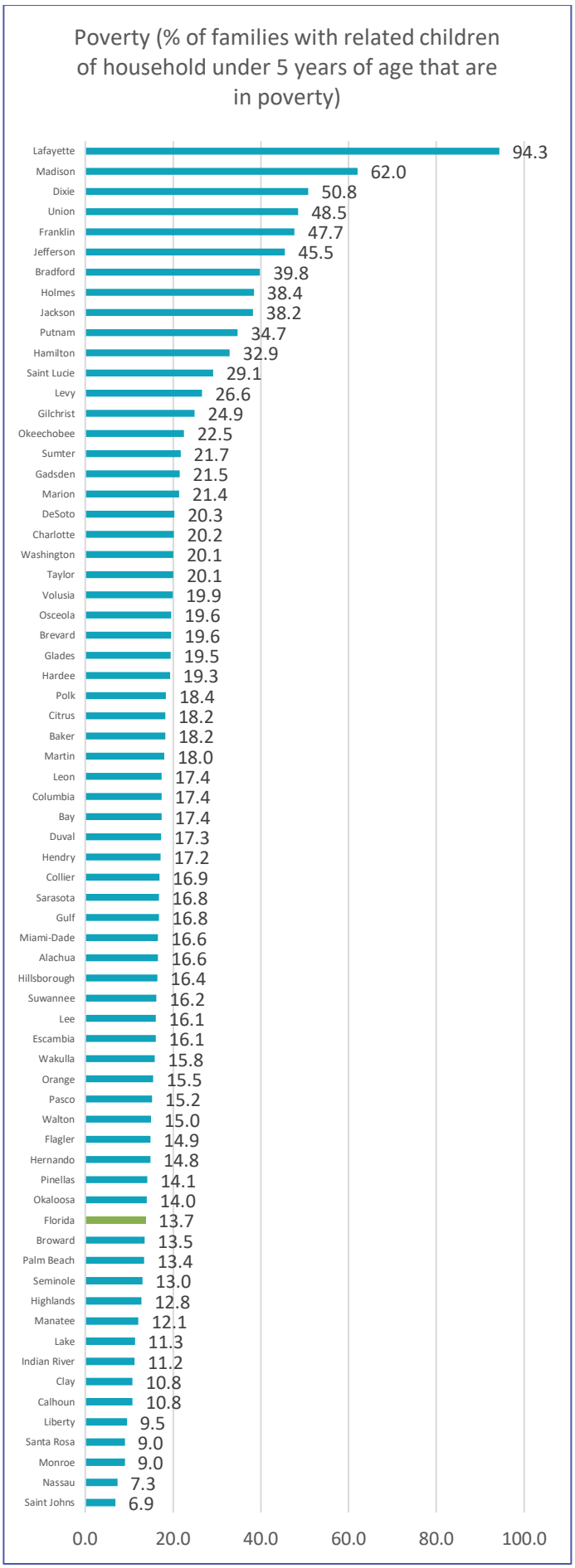

ALICE households (as a proportion of all households)
Glades 49.1
Taylor 44.9
Liberty 44.9
Calhoun 44.3
Hardee 43.5
Osceola 42.3
Hendry 42.0
Highlands 40.7
Miami-Dade 40.2
Indian River 39.7
Lafayette 39.3
DeSoto 38.9
Union 38.3
Gulf 37.5
Gadsden 36.6
Broward 36.5
Jackson 36.0
Marion 36.0
Franklin 35.5
Levy 35.3
Saint Lucie 35.2
Dixie 34.6
Okeechobee 34.5
Escambia 34.5
Citrus 34.4
Polk 34.2
Palm Beach 34.1
Charlotte 34.0
Jefferson 34.0
Lake 33.9
Gilchrist 33.8
Washington 33.5
Columbia 33.4
Manatee 32.9
Pasco 32.4
Flagler 32.1
Florida 32.0
Madison 31.4
Lee 31.1
Putnam 31.0
Orange 30.8
Pinellas 30.3
Holmes 30.1
Monroe 29.9
Hernando 29.7
Alachua 29.5
Bay 29.2
Volusia 29.1
Martin 28.3
Sarasota 28.2
Clay 28.1
Hamilton 27.6
Suwannee 27.5
Brevard 27.2
Collier 27.0
Bradford 26.9
Seminole 26.8
Duval 26.7
Baker 26.7
Wakulla 25.9
Okaloosa 25.6
Sumter 24.9
Santa Rosa 24.8
Leon 24.8
Hillsborough 24.7
Walton 21.2
Saint Johns 18.6
Nassau 17.1
0.0
20.0
40.0
60.0

High school dropout (% of 16-19 year olds not enrolled in school with no high school diploma)

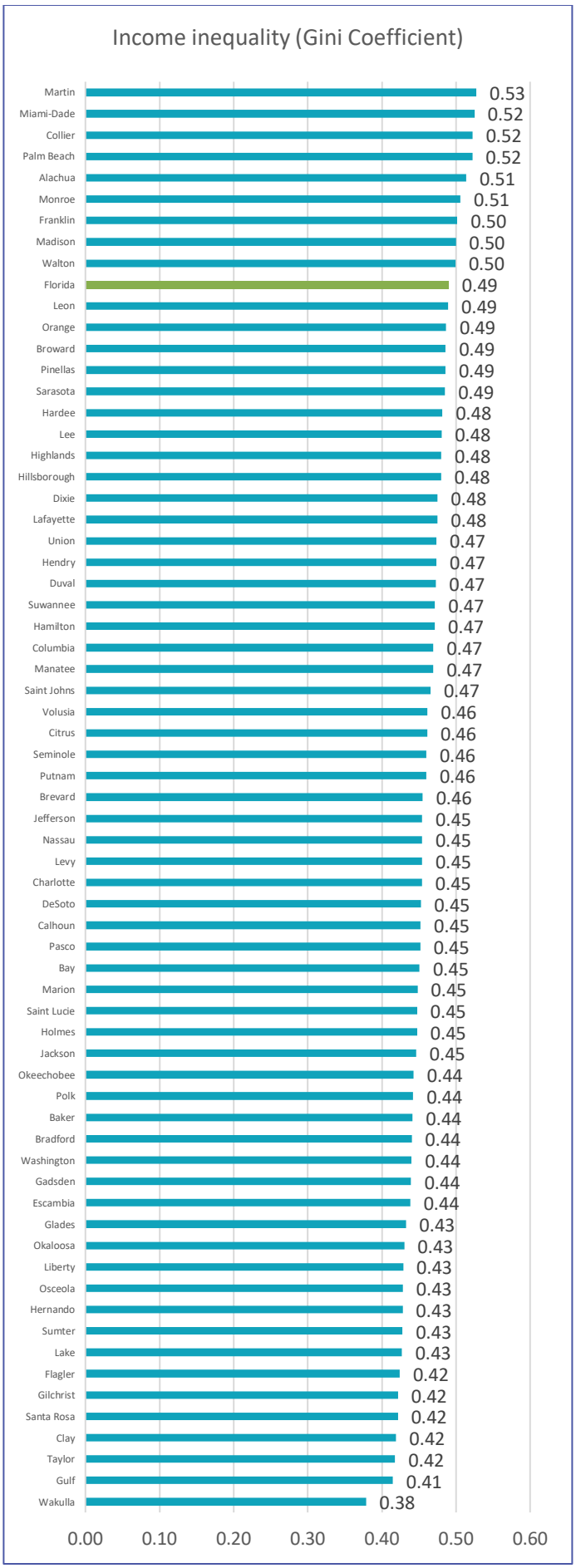


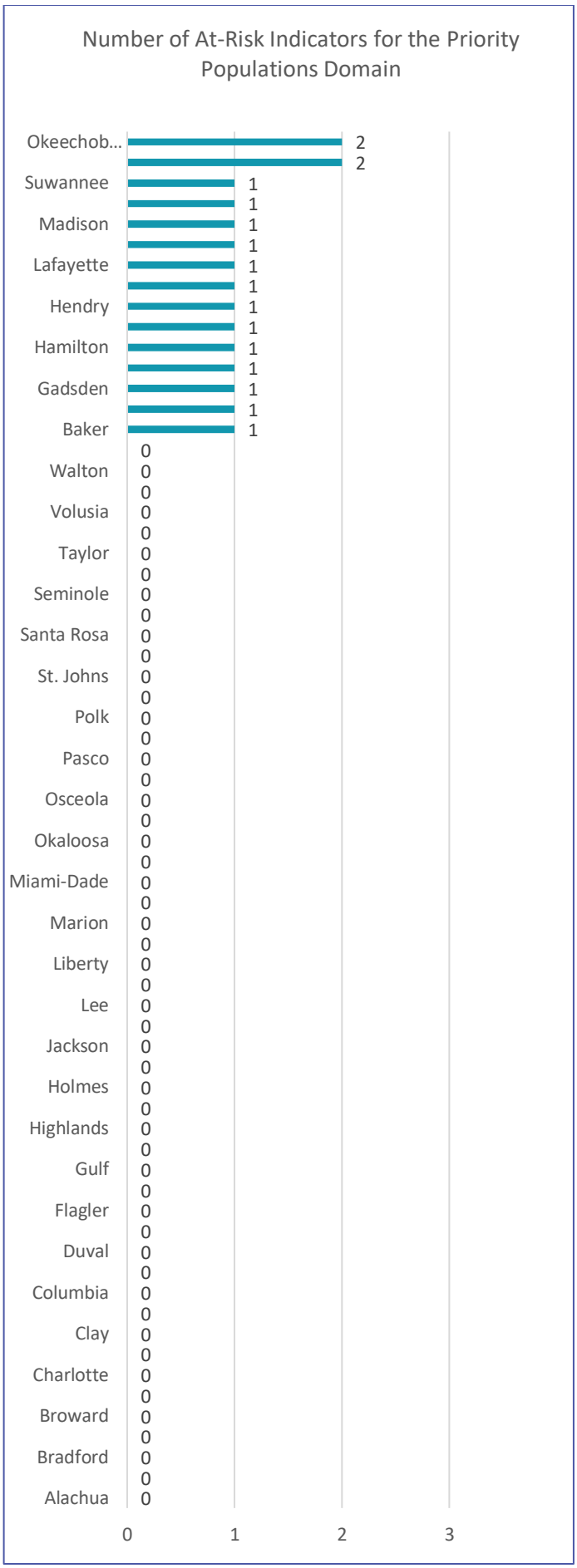
Home ownership (% renter-occupied housing units with related children under 18 years)

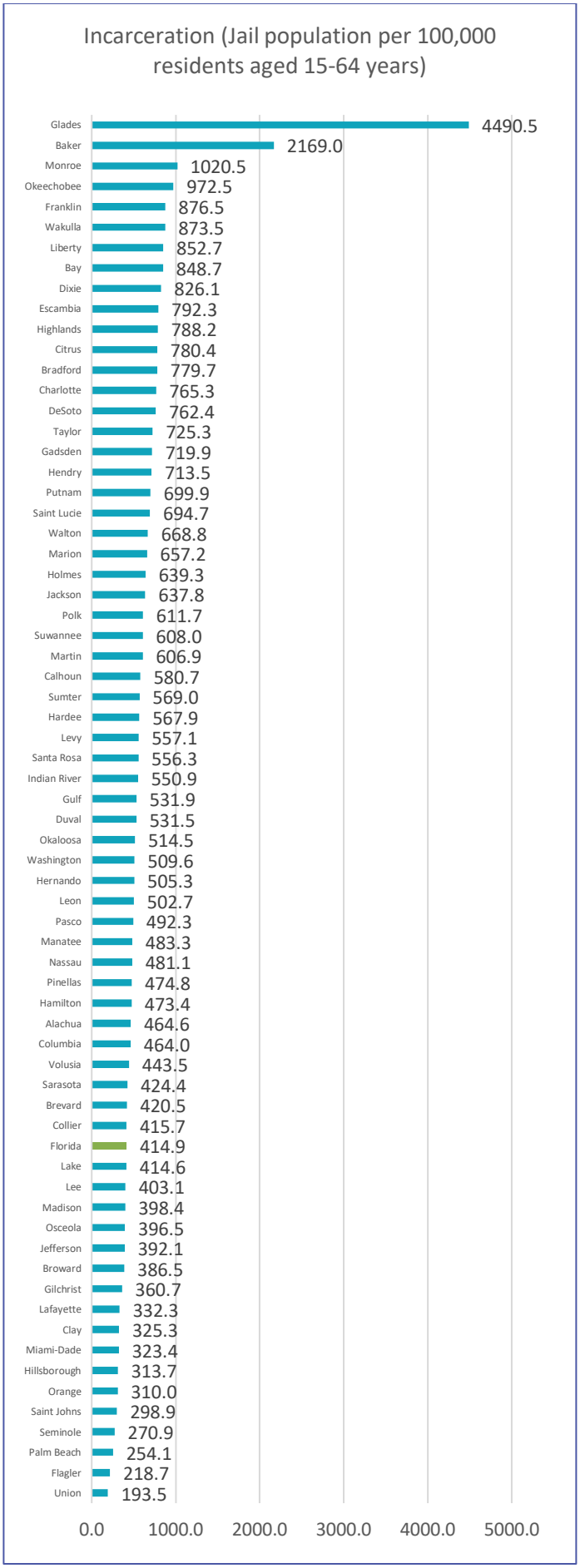


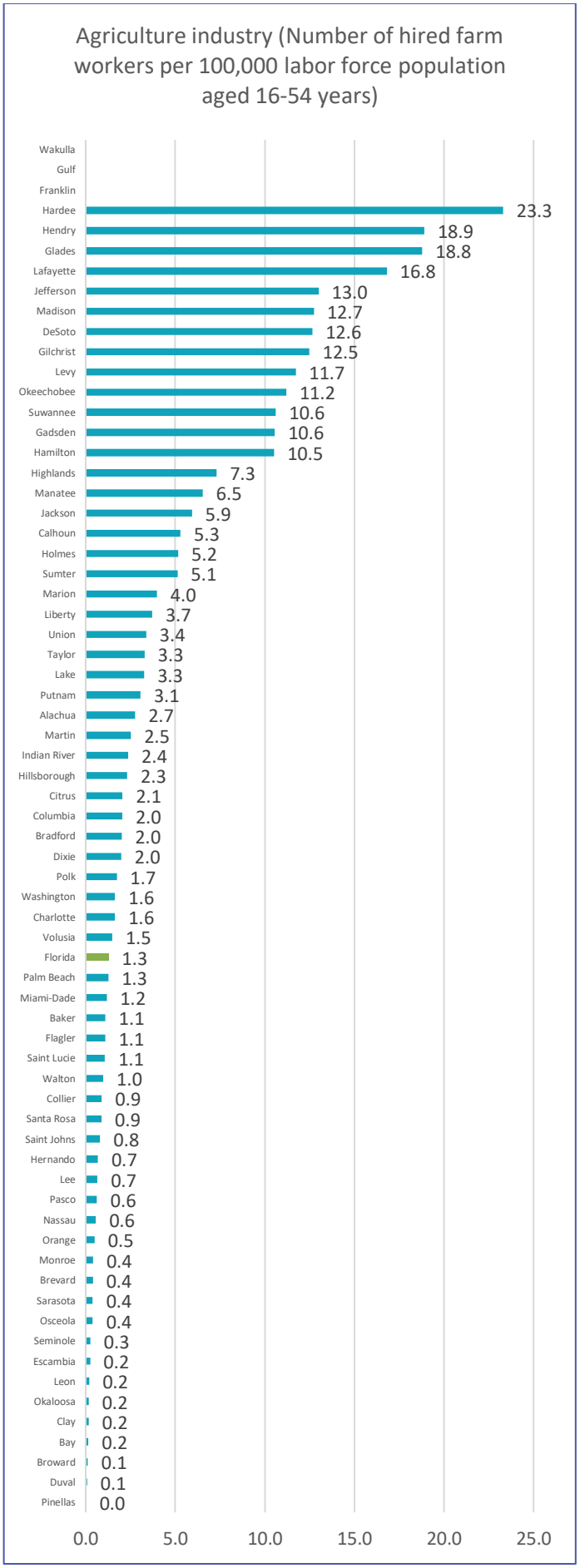

Poverty (% of families with related children of household under 5 years of age that are in poverty)
Lafayette 94.3
Madison 62.0
Dixie 50.8
Union 48.5
Franklin 47.7
Jefferson 45.5
Bradford 39.8
Holmes 38.4
Jackson 38.2
Putnam 34.7
Hamilton 32.9
Saint Lucie 29.1
Levy 26.6
Gilchrist 24.9
Okeechobee 22.5
Sumter 21.7
Gadsden 21.5
Marion 21.4
DeSoto 20.3
Charlotte 20.2
Washington 20.1
Taylor 20.1
Volusia 19.9
Osceola 19.6
Brevard 19.6
Glades 19.5
Hardee 19.3
Polk 18.4
Citrus 18.2
Baker 18.2
Martin 18.0
Leon 17.4
Columbia 17.4
Bay 17.4
Duval 17.3
Hendry 17.2
Collier 16.9
Sarasota 16.8
Gulf 16.8
Miami-Dade 16.6
Alachua 16.6
Hillsborough 16.4
Suwannee 16.2
Lee 16.1
Escambia 16.1
Wakulla 15.8
Orange 15.5
Pasco 15.2
Walton 15.0
Flagler 14.9
Hernando 14.8
Pinellas 14.1
Okaloosa 14.0
Florida 13.7
Broward 13.5
Palm Beach 13.4
Seminole 13.0
Highlands 12.8
Manatee 12.1
Lake 11.3
Indian River 11.2
Clay 10.8
Calhoun 10.8
Liberty 9.5
Santa Rosa 9.0
Monroe 9.0
Nassau 7.3
Saint Johns 6.9
0.0 20.0 40.0 60.0 80.0 100.0


Unemployed % of the civilian labor force (civilian noninstitutional population ages 16 and older)
Hamilton 14.6
Lafayette 13.5
Liberty 11.3
Highlands 10.8
Glades 10.8
Holmes 10.7
Putnam 10.5
Columbia 9.5
Marion 8.8
Jackson 8.8
Washington 8.7
Union 8.7
Citrus 8.6
Hendry 8.3
Leon 7.8
Gadsden 7.8
Franklin 7.5
Clay 7.5
Hernando 7.4
Gulf 7.4
Suwannee 7.3
Charlotte 7.3
Okeechobee 7.1
Indian River 7.1
Polk 6.9
Calhoun 6.9
Levy 6.8
Duval 6.6
Broward 6.6
Saint Lucie 6.5
Pasco 6.5
Palm Beach 6.5
Lake 6.5
Escambia 6.5
Osceola 6.3
Miami-Dade 6.3
Taylor 6.2
Brevard 6.2
Hillsborough 6.1
Gilchrist 6.1
Alachua 6.1
Orange 6.0
Hardee 6.0
Bay 6.0
Manatee 5.9
Lee 5.9
Bradford 5.9
Pinellas 5.7
Madison 5.7
Volusia 5.6
Seminole 5.6
Santa Rosa 5.6
Okaloosa 5.6
Flagler 5.5
Dixie 5.5
Baker 5.5
Martin 5.3
Walton 5.2
Wakulla 5.2
DeSoto 5.0
Saint Johns 4.9
Jefferson 4.9
Sumter 4.7
Sarasota 4.7
Nassau 4.7
Collier 4.6
Florida 3.1
Monroe 2.9
0.0 5.0 10.0 15.0 20.0

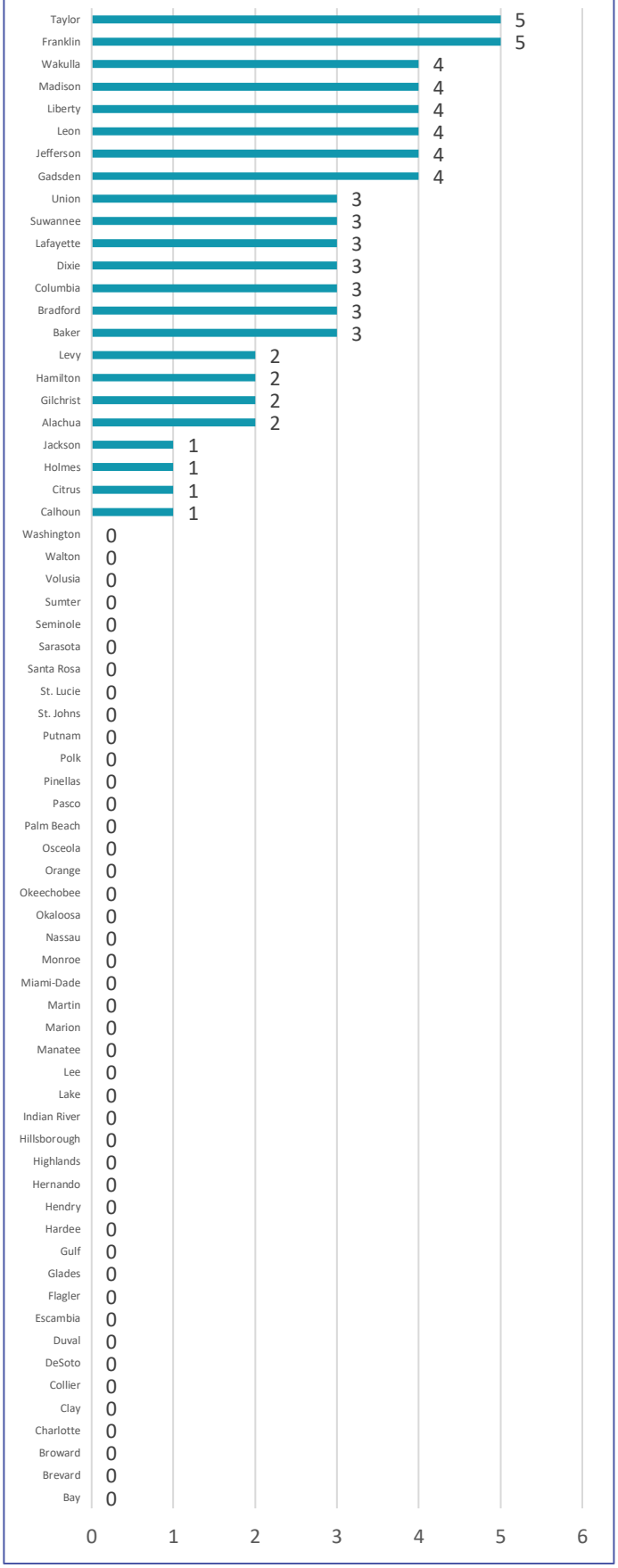

Income inequality (Gini Coefficient)
Martin 0.53
Miami-Dade 0.52
Collier 0.52
Palm Beach 0.52
Alachua 0.51
Monroe 0.51
Franklin 0.50
Madison 0.50
Walton 0.50
Florida 0.49
Leon 0.49
Orange 0.49
Broward 0.49
Pinellas 0.49
Sarasota 0.49
Hardee 0.48
Lee 0.48
Highlands 0.48
Hillsborough 0.48
Dixie 0.48
Lafayette 0.48
Union 0.47
Hendry 0.47
Duval 0.47
Suwannee 0.47
Hamilton 0.47
Columbia 0.47
Manatee 0.47
Saint Johns 0.47
Volusia 0.46
Citrus 0.46
Seminole 0.46
Putnam 0.46
Brevard 0.46
Jefferson 0.45
Nassau 0.45
Levy 0.45
Charlotte 0.45
DeSoto 0.45
Calhoun 0.45
Pasco 0.45
Bay 0.45
Marion 0.45
Saint Lucie 0.45
Holmes 0.45
Jackson 0.45
Okeechobee 0.44
Polk 0.44
Baker 0.44
Bradford 0.44
Washington 0.44
Gadsden 0.44
Escambia 0.44
Glades 0.43
Okaloosa 0.43
Liberty 0.43
Osceola 0.43
Hernando 0.43
Sumter 0.43
Lake 0.43
Flagler 0.42
Gilchrist 0.42
Santa Rosa 0.42
Clay 0.42
Taylor 0.42
Gulf 0.41
Wakulla 0.38
0.00 0.10 0.20 0.30 0.40 0.50 0.60


Number of At-Risk Indicators for the Priority Populations Domain
Okeechob... 2
2
Suwannee 1
1
Madison 1
1
Lafayette 1
1
Hendry 1
1
Hamilton 1
1
Gadsden 1
1
Baker 1
0
Walton 0
0
Volusia 0
0
Taylor 0
0
Seminole 0
0
Santa Rosa 0
0
St. Johns 0
0
Polk 0
0
Pasco 0
0
Osceola 0
0
Okaloosa 0
0
Miami-Dade 0
0
Marion 0
0
Liberty 0
0
Lee 0
0
Jackson 0
0
Holmes 0
0
Highlands 0
0
Gulf 0
0
Flagler 0
0
Duval 0
0
Columbia 0
0
Clay 0
0
Charlotte 0
0
Broward 0
0
Bradford 0
0
Alachua 0
0 1 2 3

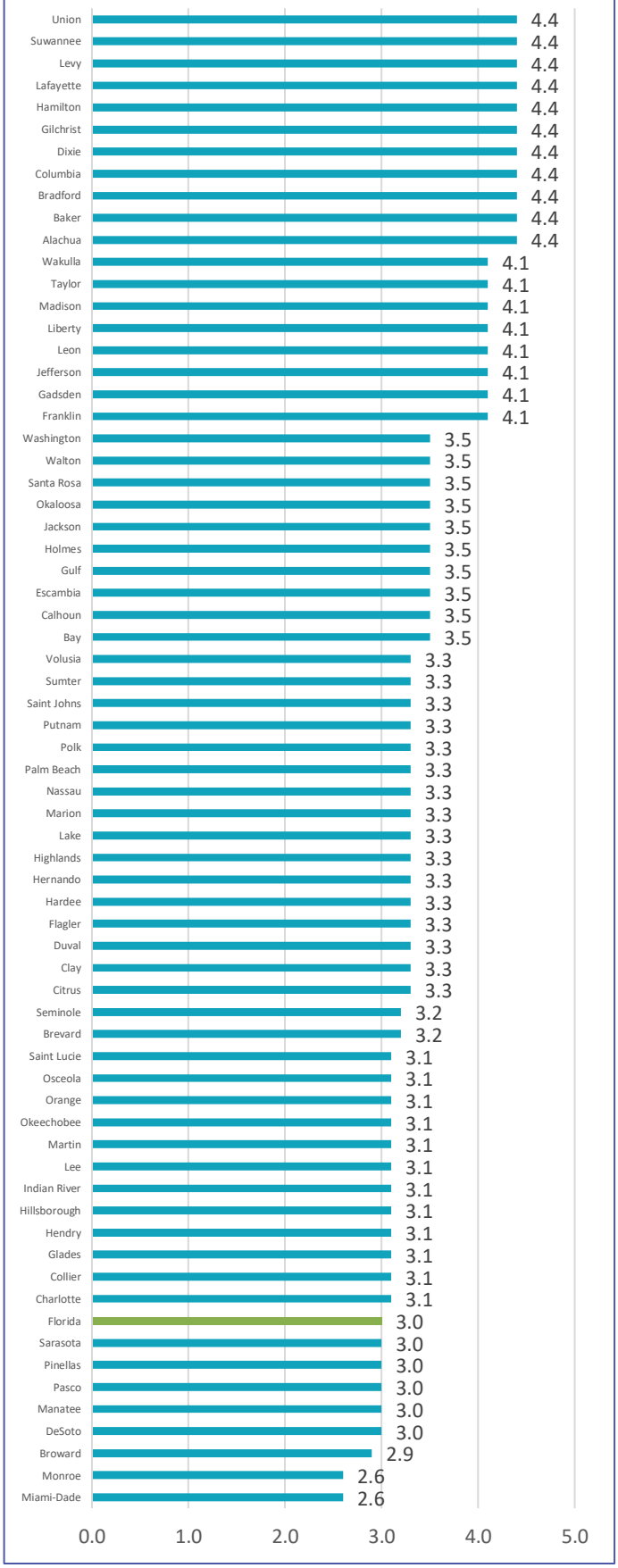

Incarceration (Jail population per 100,000 residents aged 15-64 years)
Glades 4490.5
Baker 2169.0
Monroe 1020.5
Okeechobee 972.5
Franklin 876.5
Wakulla 873.5
Liberty 852.7
Bay 848.7
Dixie 826.1
Escambia 792.3
Highlands 788.2
Citrus 780.4
Bradford 779.7
Charlotte 765.3
DeSoto 762.4
Taylor 725.3
Gadsden 719.9
Hendry 713.5
Putnam 699.9
Saint Lucie 694.7
Walton 668.8
Marion 657.2
Holmes 639.3
Jackson 637.8
Polk 611.7
Suwannee 608.0
Martin 606.9
Calhoun 580.7
Sumter 569.0
Hardee 567.9
Levy 557.1
Santa Rosa 556.3
Indian River 550.9
Gulf 531.9
Duval 531.5
Okaloosa 514.5
Washington 509.6
Hernando 505.3
Leon 502.7
Pasco 492.3
Manatee 483.3
Nassau 481.1
Pinellas 474.8
Hamilton 473.4
Alachua 464.6
Columbia 464.0
Volusia 443.5
Sarasota 424.4
Brevard 420.5
Collier 415.7
Florida 414.9
Lake 414.6
Lee 403.1
Madison 398.4
Osceola 396.5
Jefferson 392.1
Broward 386.5
Gilchrist 360.7
Lafayette 332.3
Clay 325.3
Miami-Dade 323.4
Hillsborough 313.7
Orange 310.0
Saint Johns 298.9
Seminole 270.9
Palm Beach 254.1
Flagler 218.7
Union 193.5
0.0
1000.0
2000.0
3000.0
4000.0
5000.0

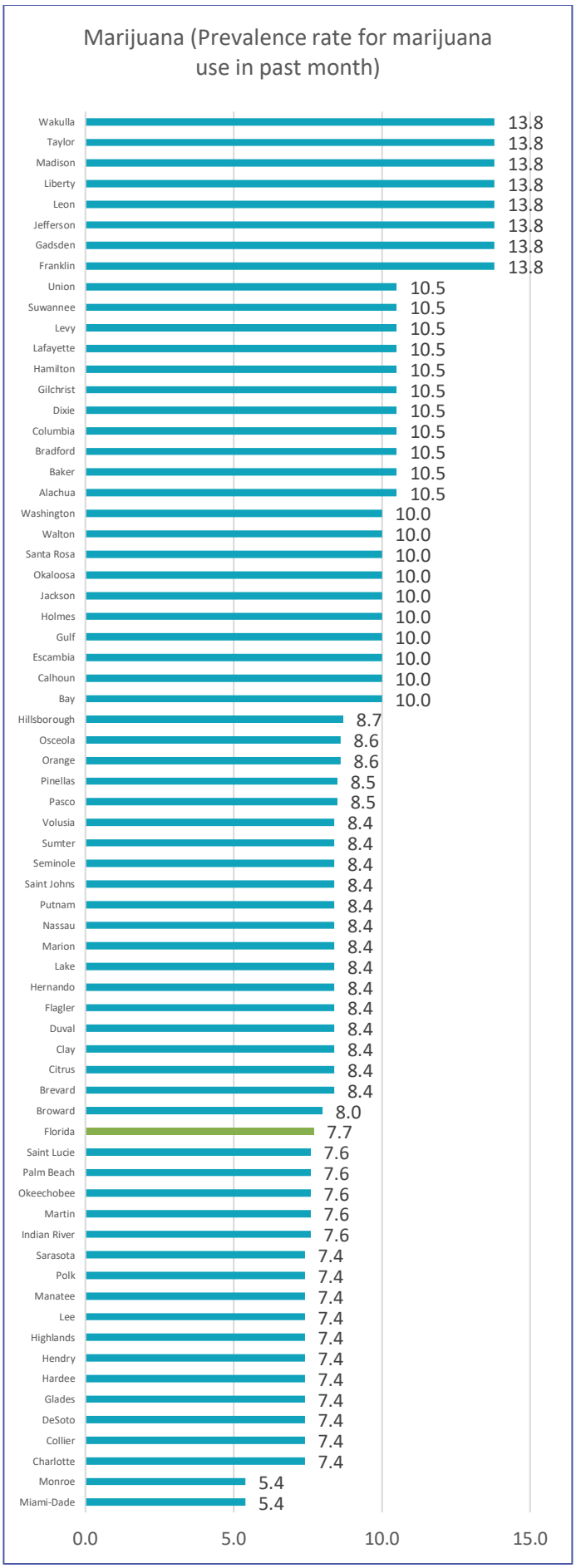

Agriculture industry (Number of hired farm workers per 100,000 labor force population aged 16-54 years)
Wakulla
Gulf
Franklin
Hardee 23.3
Hendry 18.9
Glades 18.8
Lafayette 16.8
Jefferson 13.0
Madison 12.7
DeSoto 12.6
Gilchrist 12.5
Levy 11.7
Okeechobee 11.2
Suwannee 10.6
Gadsden 10.6
Hamilton 10.5
Highlands 7.3
Manatee 6.5
Jackson 5.9
Calhoun 5.3
Holmes 5.2
Sumter 5.1
Marion 4.0
Liberty 3.7
Union 3.4
Taylor 3.3
Lake 3.3
Putnam 3.1
Alachua 2.7
Martin 2.5
Indian River 2.4
Hillsborough 2.3
Citrus 2.1
Columbia 2.0
Bradford 2.0
Dixie 2.0
Polk 1.7
Washington 1.6
Charlotte 1.6
Volusia 1.5
Florida 1.3
Palm Beach 1.3
Miami-Dade 1.2
Baker 1.1
Flagler 1.1
Saint Lucie 1.1
Walton 1.0
Collier 0.9
Santa Rosa 0.9
Saint Johns 0.8
Hernando 0.7
Lee 0.7
Pasco 0.6
Nassau 0.6
Orange 0.5
Monroe 0.4
Brevard 0.4
Sarasota 0.4
Osceola 0.4
Seminole 0.3
Escambia 0.2
Leon 0.2
Okaloosa 0.2
Clay 0.2
Bay 0.2
Broward 0.1
Duval 0.1
Pinellas 0.0
0.0
5.0
10.0
15.0
20.0
25.0

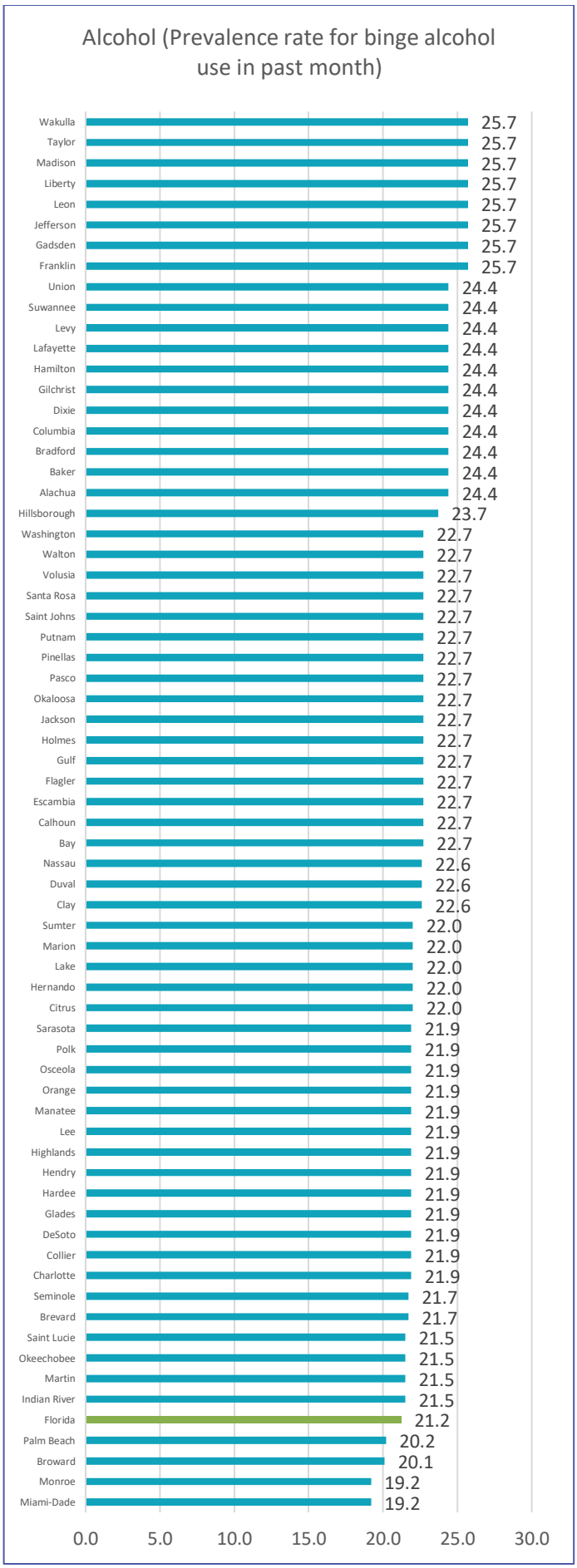
Number of At-Risk Indicators for the Substance Use Disorder Domain

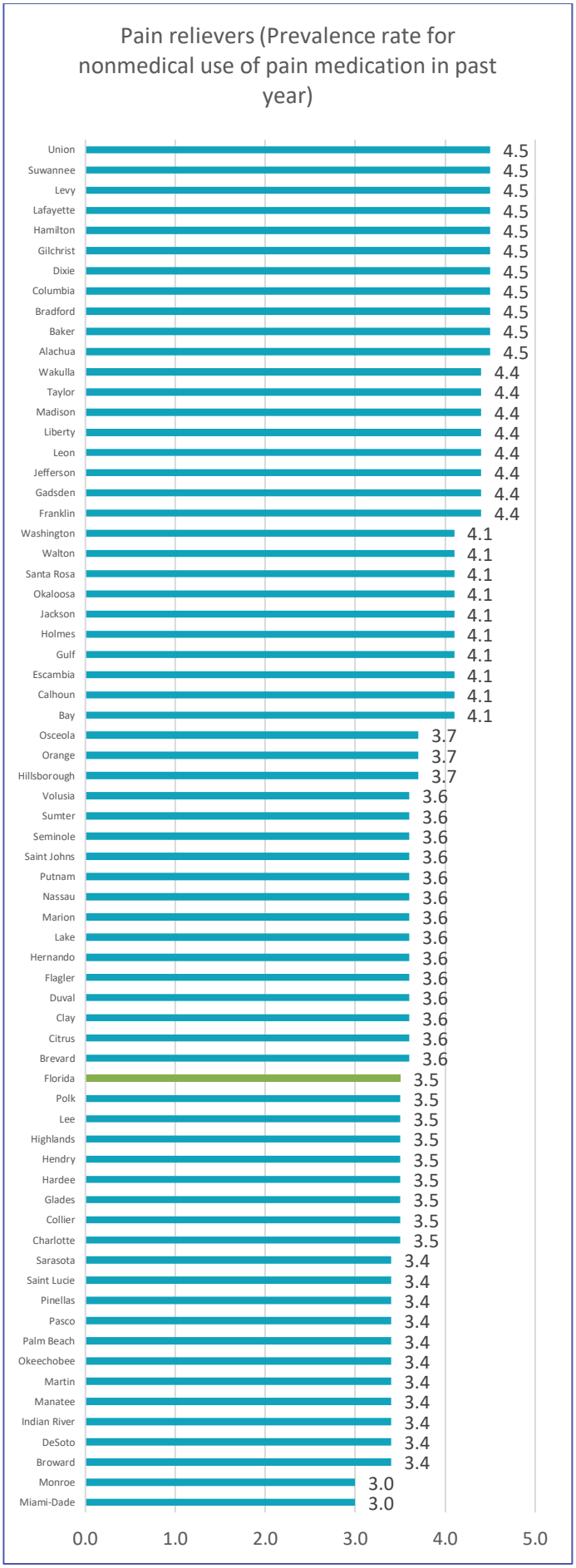


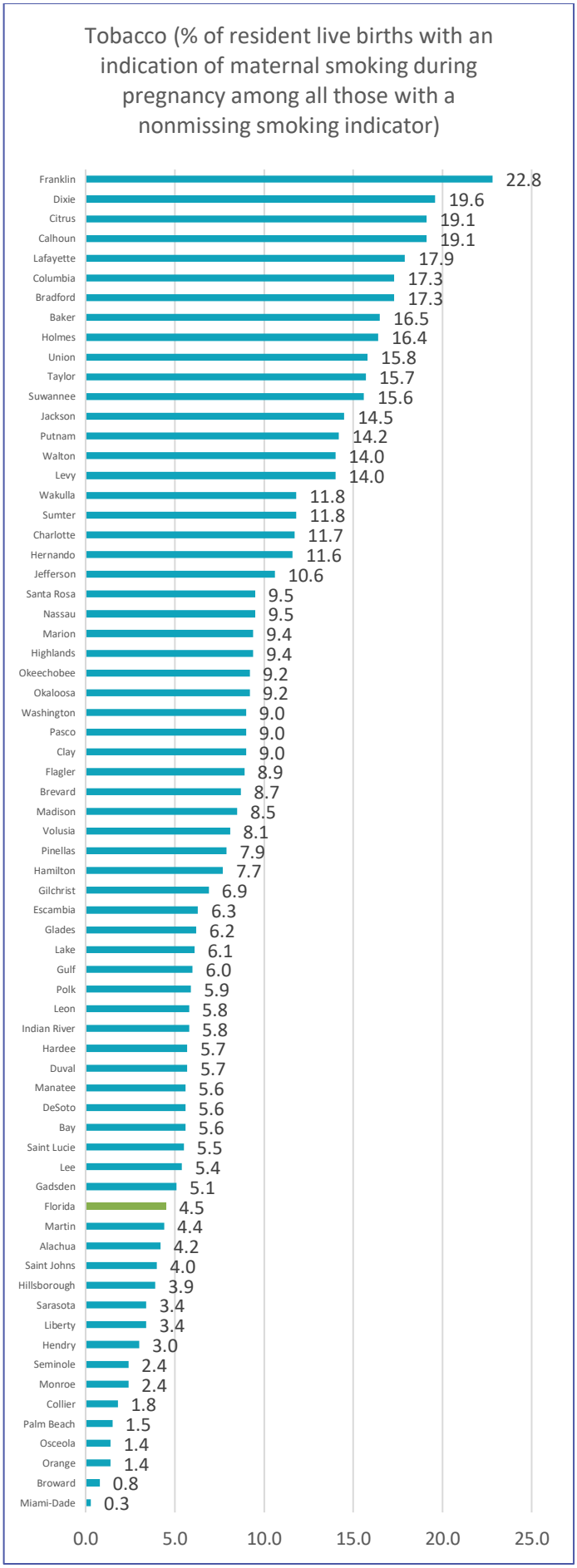
Illicit drugs (Prevalence rate for use of illicit drugs, excluding Marijuana, in past month)



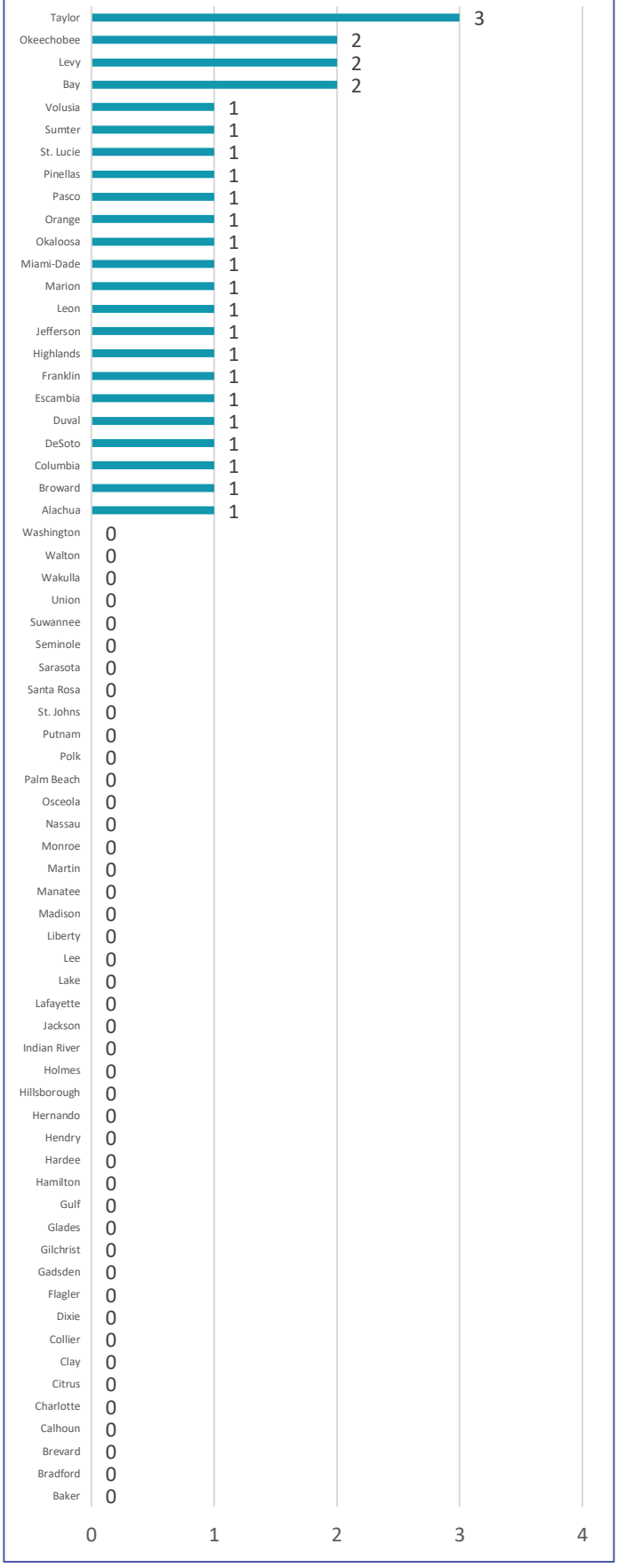

Marijuana (Prevalence rate for marijuana use in past month)
Wakulla 13.8
Taylor 13.8
Madison 13.8
Liberty 13.8
Leon 13.8
Jefferson 13.8
Gadsden 13.8
Franklin 13.8
Union 10.5
Suwannee 10.5
Levy 10.5
Lafayette 10.5
Hamilton 10.5
Gilchrist 10.5
Dixie 10.5
Columbia 10.5
Bradford 10.5
Baker 10.5
Alachua 10.5
Washington 10.0
Walton 10.0
Santa Rosa 10.0
Okaloosa 10.0
Jackson 10.0
Holmes 10.0
Gulf 10.0
Escambia 10.0
Calhoun 10.0
Bay 10.0
Hillsborough 8.7
Osceola 8.6
Orange 8.6
Pinellas 8.5
Pasco 8.5
Volusia 8.4
Sumter 8.4
Seminole 8.4
Saint Johns 8.4
Putnam 8.4
Nassau 8.4
Marion 8.4
Lake 8.4
Hernando 8.4
Flagler 8.4
Duval 8.4
Clay 8.4
Citrus 8.4
Brevard 8.4
Broward 8.0
Florida 7.7
Saint Lucie 7.6
Palm Beach 7.6
Okeechobee 7.6
Martin 7.6
Indian River 7.6
Sarasota 7.4
Polk 7.4
Manatee 7.4
Lee 7.4
Highlands 7.4
Hendry 7.4
Hardee 7.4
Glades 7.4
DeSoto 7.4
Collier 7.4
Charlotte 7.4
Monroe 5.4
Miami-Dade 5.4
0.0
5.0
10.0
15.0


Alcohol (Prevalence rate for binge alcohol use in past month)
Wakulla 25.7
Taylor 25.7
Madison 25.7
Liberty 25.7
Leon 25.7
Jefferson 25.7
Gadsden 25.7
Franklin 25.7
Union 24.4
Suwannee 24.4
Levy 24.4
Lafayette 24.4
Hamilton 24.4
Gilchrist 24.4
Dixie 24.4
Columbia 24.4
Bradford 24.4
Baker 24.4
Alachua 24.4
Hillsborough 23.7
Washington 22.7
Walton 22.7
Volusia 22.7
Santa Rosa 22.7
Saint Johns 22.7
Putnam 22.7
Pinellas 22.7
Pasco 22.7
Okaloosa 22.7
Jackson 22.7
Holmes 22.7
Gulf 22.7
Flagler 22.7
Escambia 22.7
Calhoun 22.7
Bay 22.7
Nassau 22.6
Duval 22.6
Clay 22.6
Sumter 22.0
Marion 22.0
Lake 22.0
Hernando 22.0
Citrus 22.0
Sarasota 21.9
Polk 21.9
Osceola 21.9
Orange 21.9
Manatee 21.9
Lee 21.9
Highlands 21.9
Hendry 21.9
Hardee 21.9
Glades 21.9
DeSoto 21.9
Collier 21.9
Charlotte 21.9
Seminole 21.7
Brevard 21.7
Saint Lucie 21.5
Okeechobee 21.5
Martin 21.5
Indian River 21.5
Florida 21.2
Palm Beach 20.2
Broward 20.1
Monroe 19.2
Miami-Dade 19.2
0.0
5.0
10.0
15.0
20.0
25.0
30.0

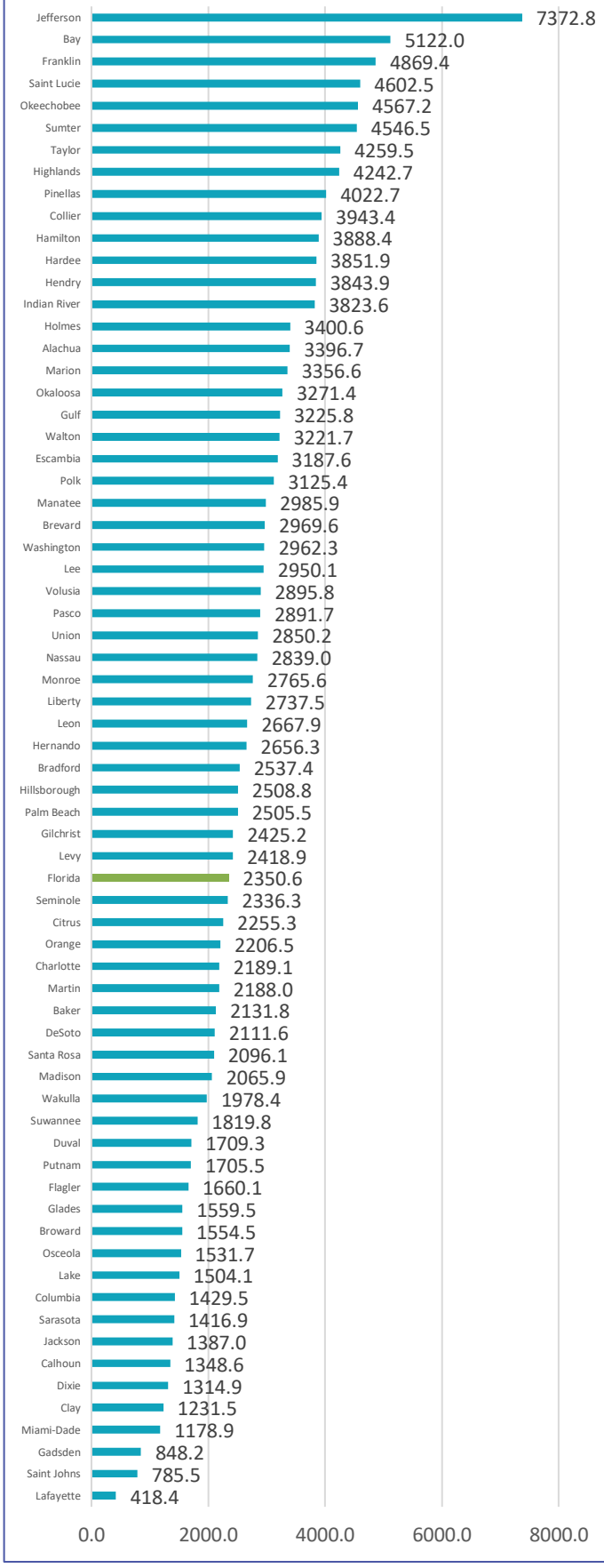

Pain relievers (Prevalence rate for nonmedical use of pain medication in past year)
Union 4.5
Suwannee 4.5
Levy 4.5
Lafayette 4.5
Hamilton 4.5
Gilchrist 4.5
Dixie 4.5
Columbia 4.5
Bradford 4.5
Baker 4.5
Alachua 4.5
Wakulla 4.4
Taylor 4.4
Madison 4.4
Liberty 4.4
Leon 4.4
Jefferson 4.4
Gadsden 4.4
Franklin 4.4
Washington 4.1
Walton 4.1
Santa Rosa 4.1
Okaloosa 4.1
Jackson 4.1
Holmes 4.1
Gulf 4.1
Escambia 4.1
Calhoun 4.1
Bay 4.1
Osceola 3.7
Orange 3.7
Hillsborough 3.7
Volusia 3.6
Sumter 3.6
Seminole 3.6
Saint Johns 3.6
Putnam 3.6
Nassau 3.6
Marion 3.6
Lake 3.6
Hernando 3.6
Flagler 3.6
Duval 3.6
Clay 3.6
Citrus 3.6
Brevard 3.6
Florida 3.5
Polk 3.5
Lee 3.5
Highlands 3.5
Hendry 3.5
Hardee 3.5
Glades 3.5
Collier 3.5
Charlotte 3.5
Sarasota 3.4
Saint Lucie 3.4
Pinellas 3.4
Pasco 3.4
Palm Beach 3.4
Okeechobee 3.4
Martin 3.4
Manatee 3.4
Indian River 3.4
DeSoto 3.4
Broward 3.4
Monroe 3.0
Miami-Dade 3.0
0.0 1.0 2.0 3.0 4.0 5.0

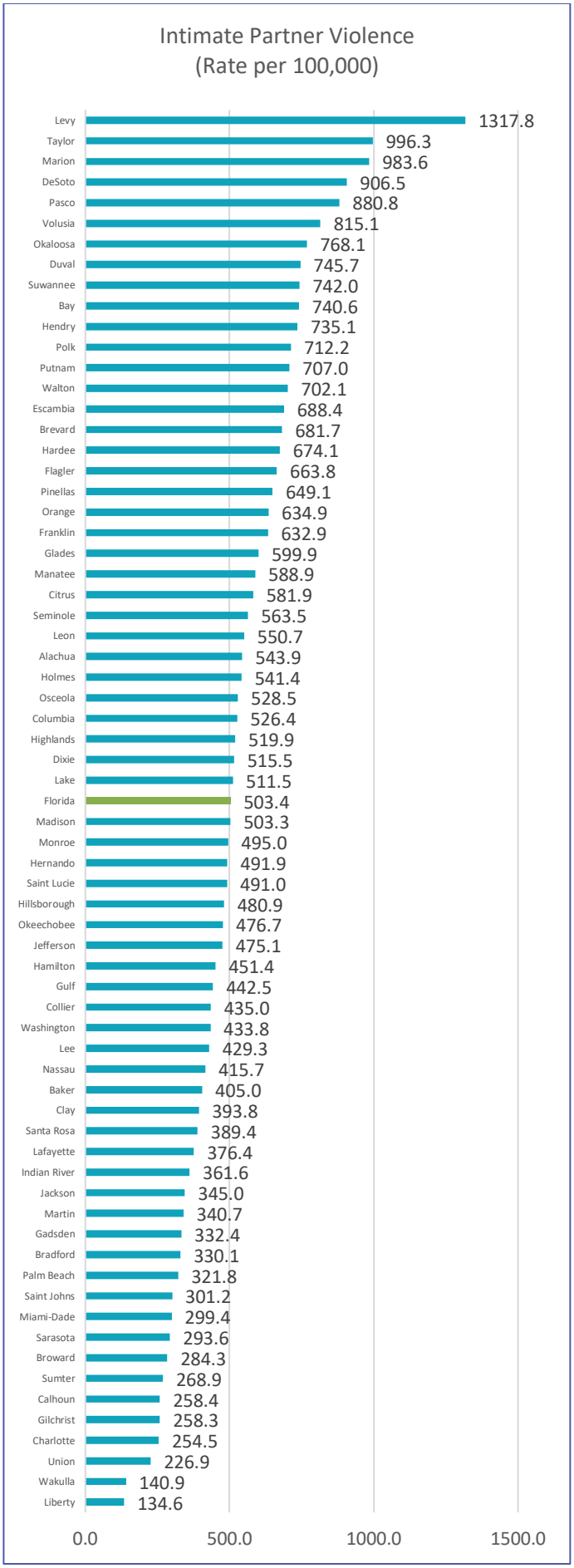

Tobacco (% of resident live births with an indication of maternal smoking during pregnancy among all those with a nonmissing smoking indicator)
Franklin 22.8
Dixie 19.6
Citrus 19.1
Calhoun 19.1
Lafayette 17.9
Columbia 17.3
Bradford 17.3
Baker 16.5
Holmes 16.4
Union 15.8
Taylor 15.7
Suwannee 15.6
Jackson 14.5
Putnam 14.2
Walton 14.0
Levy 14.0
Wakulla 11.8
Sumter 11.8
Charlotte 11.7
Hernando 11.6
Jefferson 10.6
Santa Rosa 9.5
Nassau 9.5
Marion 9.4
Highlands 9.4
Okeechobee 9.2
Okaloosa 9.2
Washington 9.0
Pasco 9.0
Clay 9.0
Flagler 8.9
Brevard 8.7
Madison 8.5
Volusia 8.1
Pinellas 7.9
Hamilton 7.7
Gilchrist 6.9
Escambia 6.3
Glades 6.2
Lake 6.1
Gulf 6.0
Polk 5.9
Leon 5.8
Indian River 5.8
Hardee 5.7
Duval 5.7
Manatee 5.6
DeSoto 5.6
Bay 5.6
Saint Lucie 5.5
Lee 5.4
Gadsden 5.1
Florida 4.5
Martin 4.4
Alachua 4.2
Saint Johns 4.0
Hillsborough 3.9
Sarasota 3.4
Liberty 3.4
Hendry 3.0
Seminole 2.4
Monroe 2.4
Collier 1.8
Palm Beach 1.5
Osceola 1.4
Orange 1.4
Broward 0.8
Miami-Dade 0.3
0.0 5.0 10.0 15.0 20.0 25.0

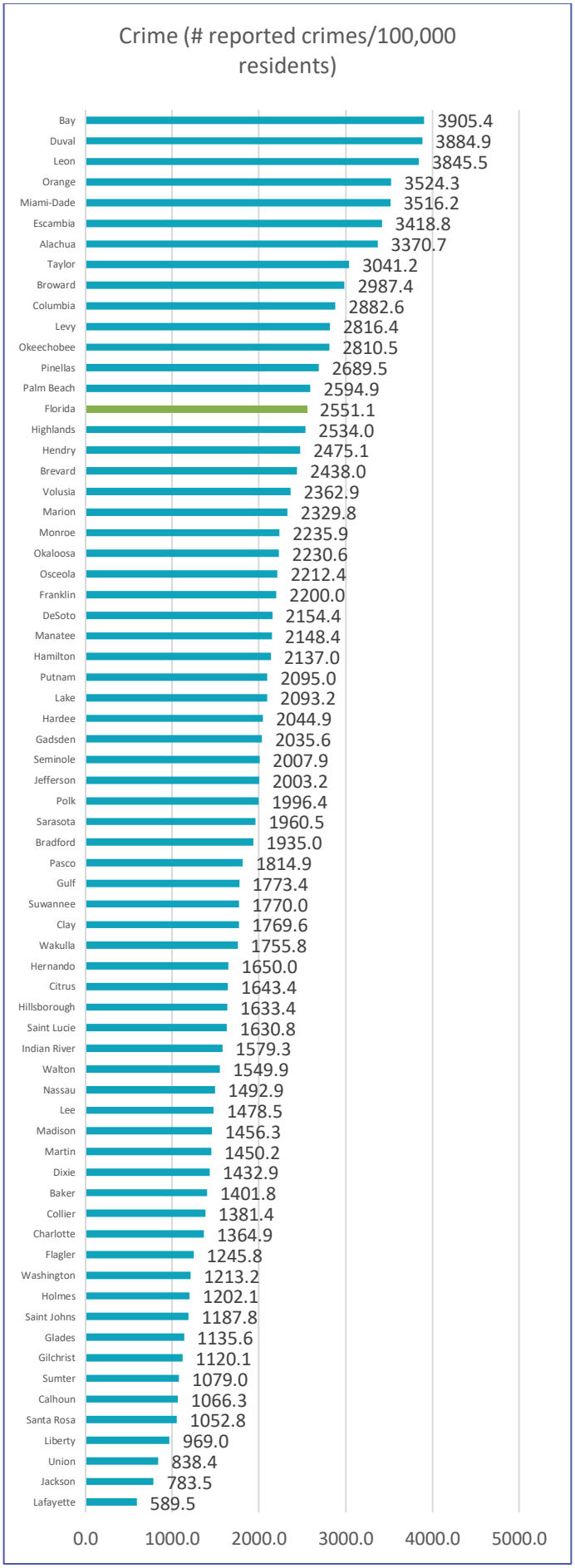
Number of At-Risk Indicators for the Family and Community Violence Domain

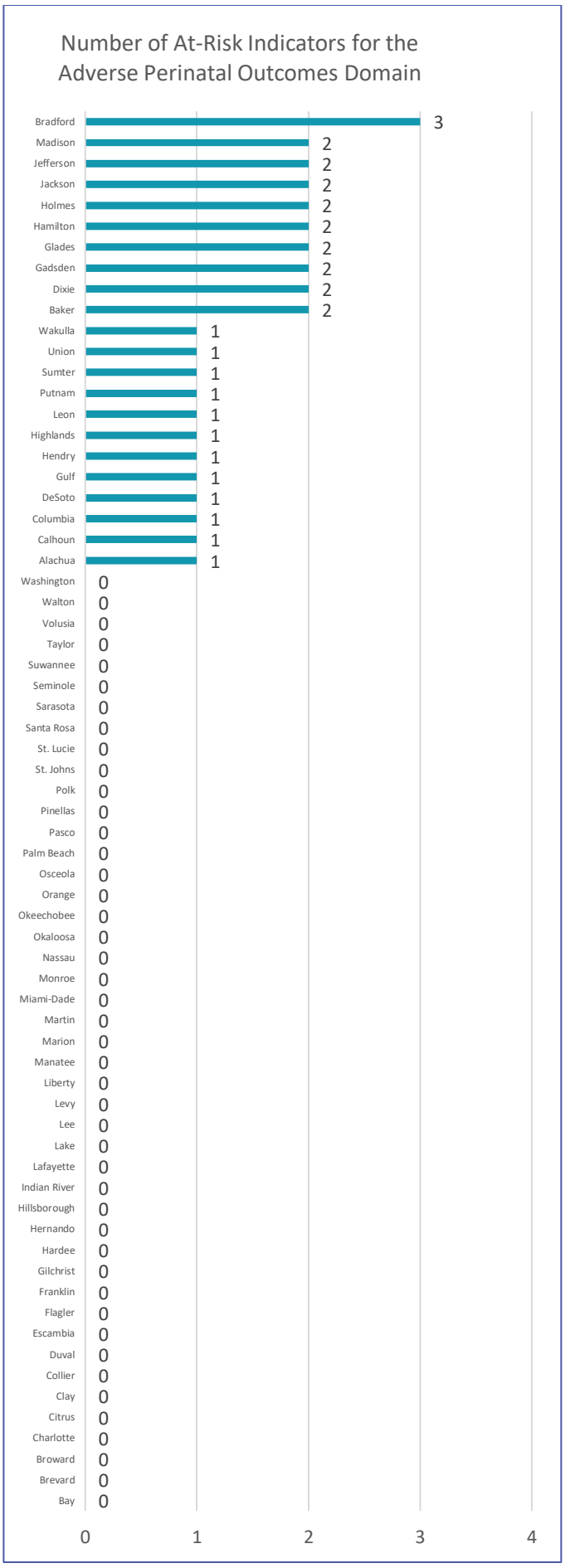


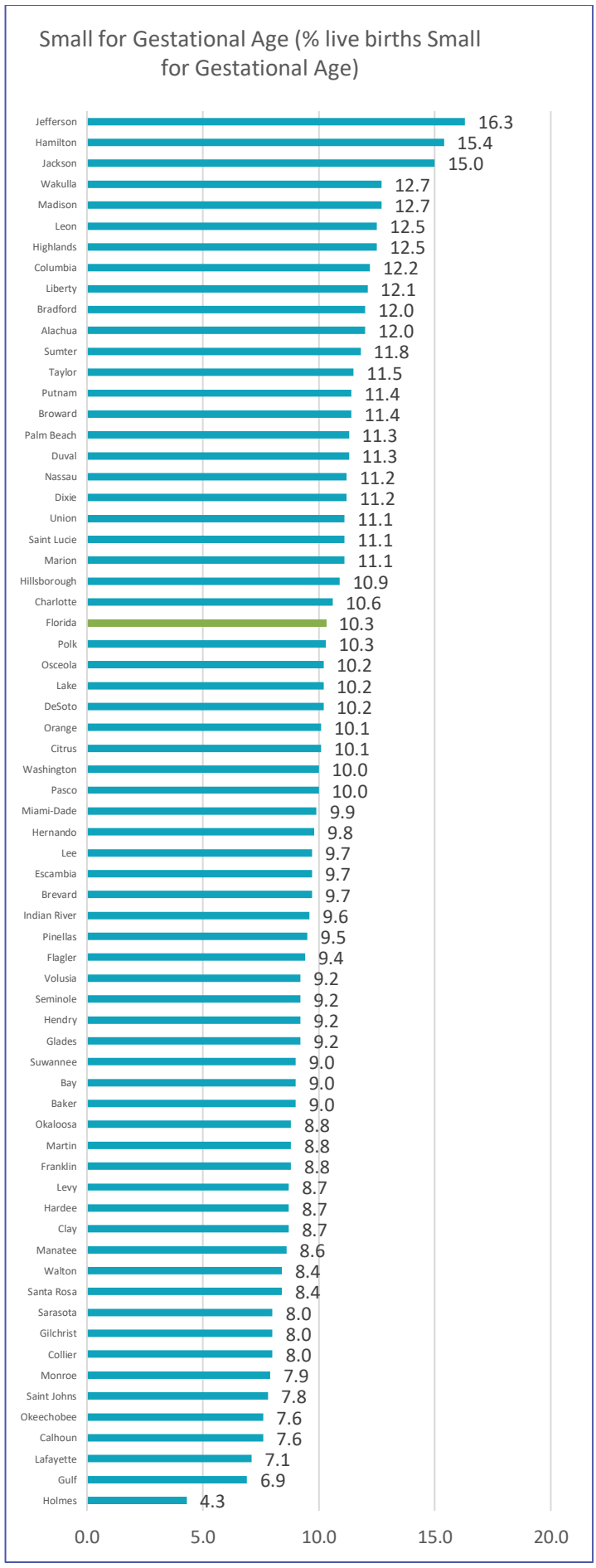
Juvenile arrests (Total juvenile arrests per 100,000 population aged 10-17 years)

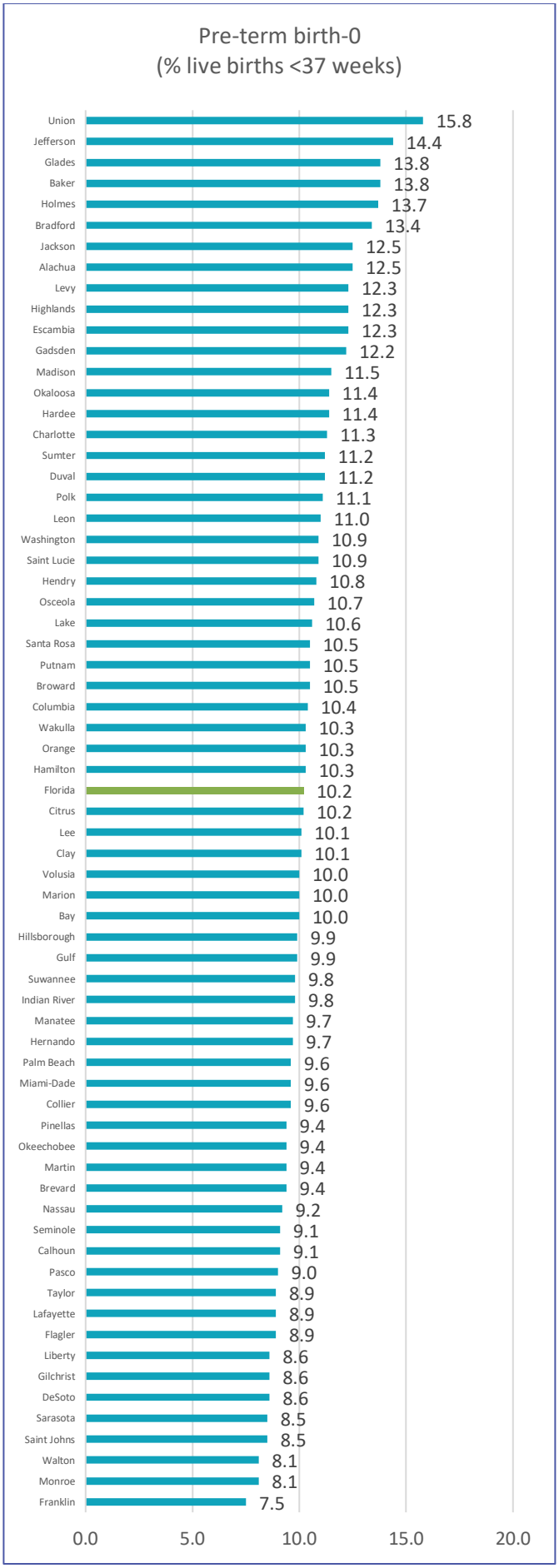


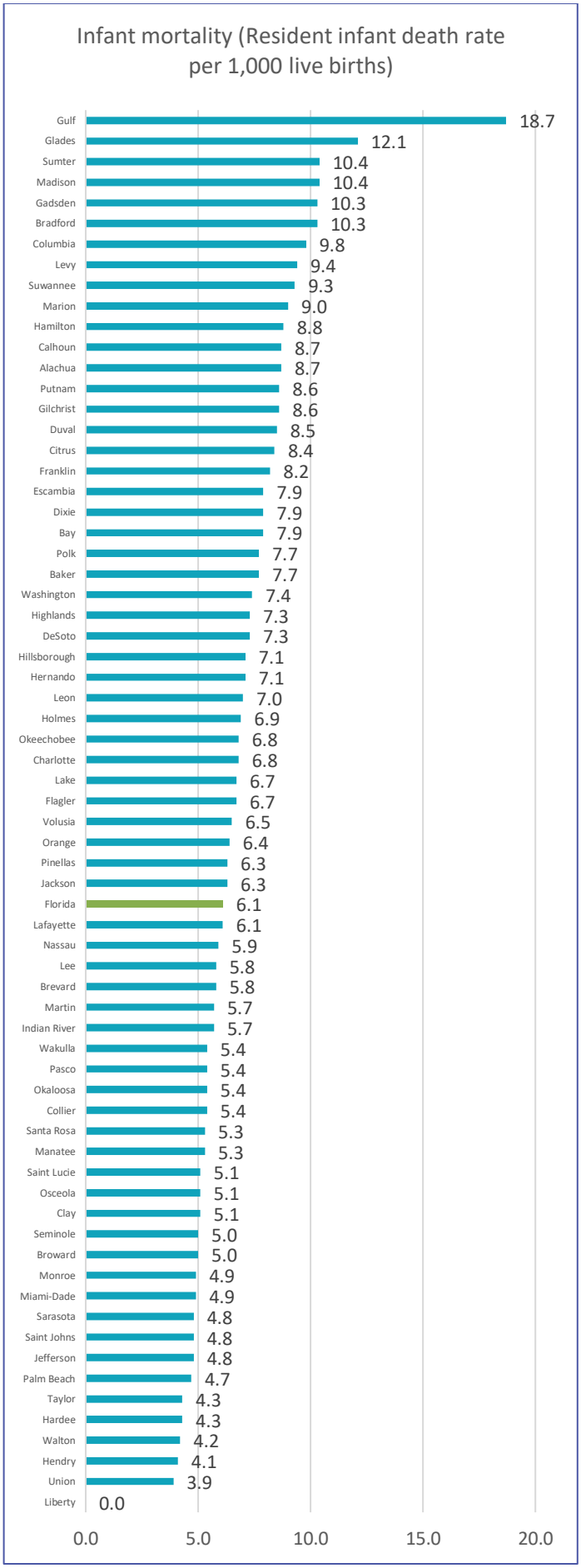

Intimate Partner Violence
(Rate per 100,000)
Levy 1317.8
Taylor 996.3
Marion 983.6
DeSoto 906.5
Pasco 880.8
Volusia 815.1
Okaloosa 768.1
Duval 745.7
Suwannee 742.0
Bay 740.6
Hendry 735.1
Polk 712.2
Putnam 707.0
Walton 702.1
Escambia 688.4
Brevard 681.7
Hardee 674.1
Flagler 663.8
Pinellas 649.1
Orange 634.9
Franklin 632.9
Glades 599.9
Manatee 588.9
Citrus 581.9
Seminole 563.5
Leon 550.7
Alachua 543.9
Holmes 541.4
Osceola 528.5
Columbia 526.4
Highlands 519.9
Dixie 515.5
Lake 511.5
Florida 503.4
Madison 503.3
Monroe 495.0
Hernando 491.9
Saint Lucie 491.0
Hillsborough 480.9
Okeechobee 476.7
Jefferson 475.1
Hamilton 451.4
Gulf 442.5
Collier 435.0
Washington 433.8
Lee 429.3
Nassau 415.7
Baker 405.0
Clay 393.8
Santa Rosa 389.4
Lafayette 376.4
Indian River 361.6
Jackson 345.0
Martin 340.7
Gadsden 332.4
Bradford 330.1
Palm Beach 321.8
Saint Johns 301.2
Miami-Dade 299.4
Sarasota 293.6
Broward 284.3
Sumter 268.9
Calhoun 258.4
Gilchrist 258.3
Charlotte 254.5
Union 226.9
Wakulla 140.9
Liberty 134.6
0.0
500.0
1000.0
1500.0

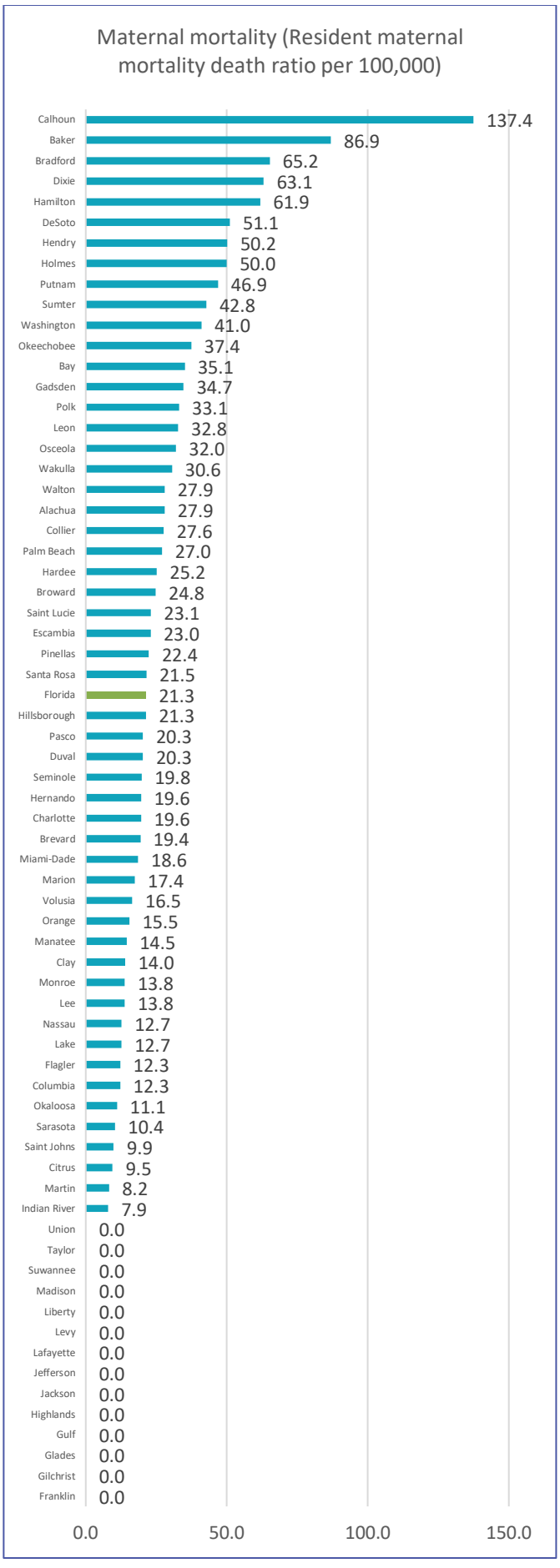

Crime (# reported crimes/100,000
residents)
Bay 3905.4
Duval 3884.9
Leon 3845.5
Orange 3524.3
Miami-Dade 3516.2
Escambia 3418.8
Alachua 3370.7
Taylor 3041.2
Broward 2987.4
Columbia 2882.6
Levy 2816.4
Okeechobee 2810.5
Pinellas 2689.5
Palm Beach 2594.9
Florida 2551.1
Highlands 2534.0
Hendry 2475.1
Brevard 2438.0
Volusia 2362.9
Marion 2329.8
Monroe 2235.9
Okaloosa 2230.6
Osceola 2212.4
Franklin 2200.0
DeSoto 2154.4
Manatee 2148.4
Hamilton 2137.0
Putnam 2095.0
Lake 2093.2
Hardee 2044.9
Gadsden 2035.6
Seminole 2007.9
Jefferson 2003.2
Polk 1996.4
Sarasota 1960.5
Bradford 1935.0
Pasco 1814.9
Gulf 1773.4
Suwannee 1770.0
Clay 1769.6
Wakulla 1755.8
Hernando 1650.0
Citrus 1643.4
Hillsborough 1633.4
Saint Lucie 1630.8
Indian River 1579.3
Walton 1549.9
Nassau 1492.9
Lee 1478.5
Madison 1456.3
Martin 1450.2
Dixie 1432.9
Baker 1401.8
Collier 1381.4
Charlotte 1364.9
Flagler 1245.8
Washington 1213.2
Holmes 1202.1
Saint Johns 1187.8
Glades 1135.6
Gilchrist 1120.1
Sumter 1079.0
Calhoun 1066.3
Santa Rosa 1052.8
Liberty 969.0
Union 838.4
Jackson 783.5
Lafayette 589.5
0.0
1000.0
2000.0
3000.0
4000.0
5000.0

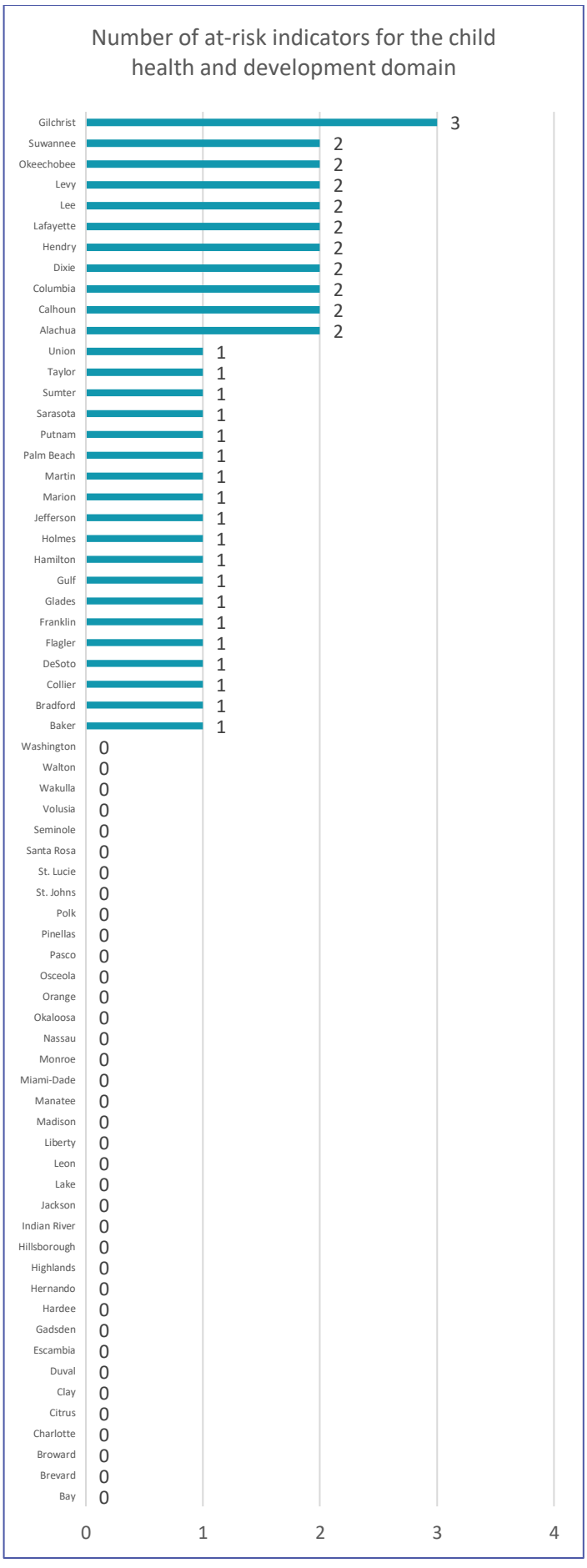

Number of At-Risk Indicators for the Adverse Perinatal Outcomes Domain
Bradford 3
Madison 2
Jefferson 2
Jackson 2
Holmes 2
Hamilton 2
Glades 2
Gadsden 2
Dixie 2
Baker 2
Wakulla 1
Union 1
Sumter 1
Putnam 1
Leon 1
Highlands 1
Hendry 1
Gulf 1
DeSoto 1
Columbia 1
Calhoun 1
Alachua 1
Washington 0
Walton 0
Volusia 0
Taylor 0
Suwannee 0
Seminole 0
Sarasota 0
Santa Rosa 0
St. Lucie 0
St. Johns 0
Polk 0
Pinellas 0
Pasco 0
Palm Beach 0
Osceola 0
Orange 0
Okeechobee 0
Okaloosa 0
Nassau 0
Monroe 0
Miami-Dade 0
Martin 0
Marion 0
Manatee 0
Liberty 0
Levy 0
Lee 0
Lake 0
Lafayette 0
Indian River 0
Hillsborough 0
Hernando 0
Hardee 0
Gilchrist 0
Franklin 0
Flagler 0
Escambia 0
Duval 0
Collier 0
Clay 0
Citrus 0
Charlotte 0
Broward 0
Brevard 0
Bay 0
0 1 2 3 4

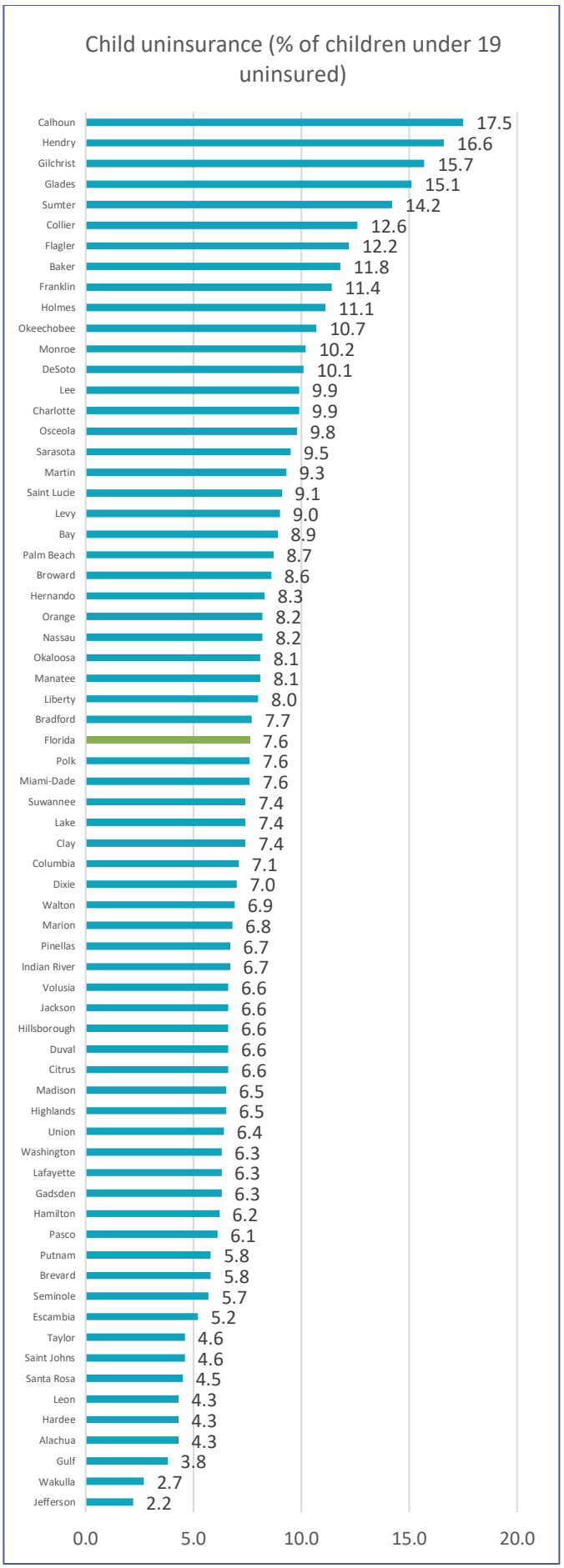

Small for Gestational Age (% live births Small for Gestational Age)
Jefferson 16.3
Hamilton 15.4
Jackson 15.0
Wakulla 12.7
Madison 12.7
Leon 12.5
Highlands 12.5
Columbia 12.2
Liberty 12.1
Bradford 12.0
Alachua 12.0
Sumter 11.8
Taylor 11.5
Putnam 11.4
Broward 11.4
Palm Beach 11.3
Duval 11.3
Nassau 11.2
Dixie 11.2
Union 11.1
Saint Lucie 11.1
Marion 11.1
Hillsborough 10.9
Charlotte 10.6
Florida 10.3
Polk 10.3
Osceola 10.2
Lake 10.2
DeSoto 10.2
Orange 10.1
Citrus 10.1
Washington 10.0
Pasco 10.0
Miami-Dade 9.9
Hernando 9.8
Lee 9.7
Escambia 9.7
Brevard 9.7
Indian River 9.6
Pinellas 9.5
Flagler 9.4
Volusia 9.2
Seminole 9.2
Hendry 9.2
Glades 9.2
Suwannee 9.0
Bay 9.0
Baker 9.0
Okaloosa 8.8
Martin 8.8
Franklin 8.8
Levy 8.7
Hardee 8.7
Clay 8.7
Manatee 8.6
Walton 8.4
Santa Rosa 8.4
Sarasota 8.0
Gilchrist 8.0
Collier 8.0
Monroe 7.9
Saint Johns 7.8
Okeechobee 7.6
Calhoun 7.6
Lafayette 7.1
Gulf 6.9
Holmes 4.3
0.0 5.0 10.0 15.0 20.0

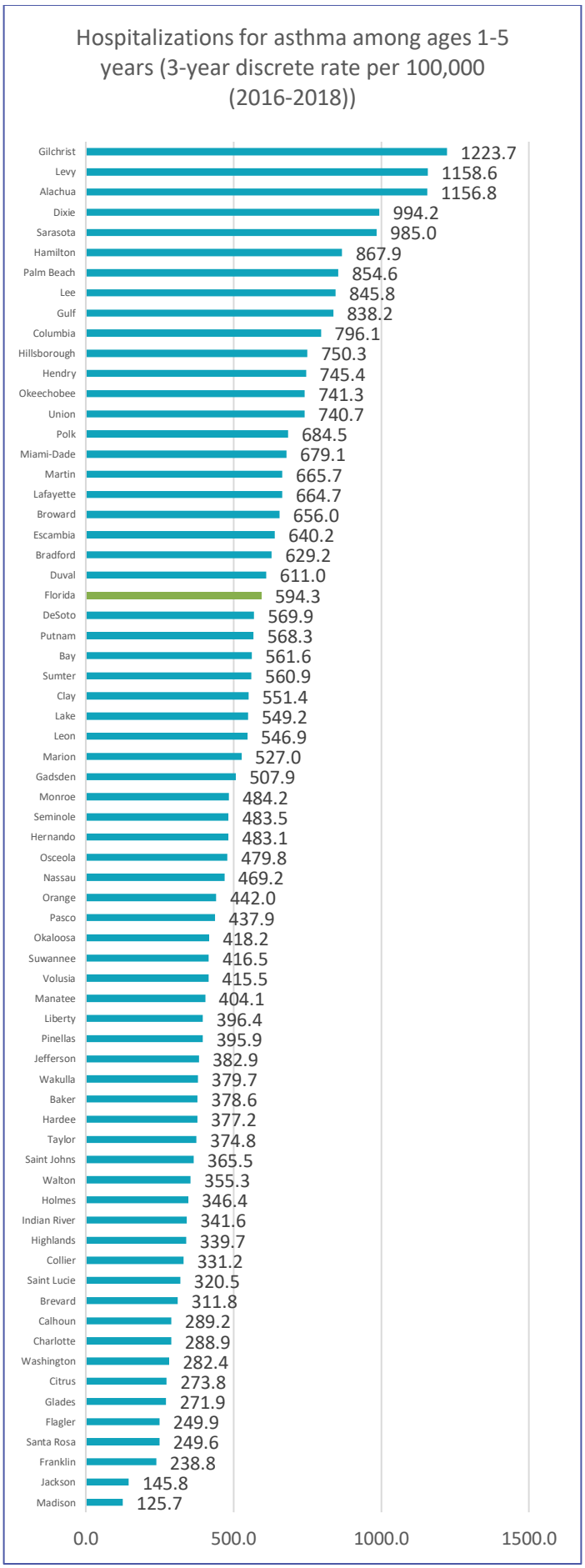

Pre-term birth-0
(% live births <37 weeks)
Union 15.8
Jefferson 14.4
Glades 13.8
Baker 13.8
Holmes 13.7
Bradford 13.4
Jackson 12.5
Alachua 12.5
Levy 12.3
Highlands 12.3
Escambia 12.3
Gadsden 12.2
Madison 11.5
Okaloosa 11.4
Hardee 11.4
Charlotte 11.3
Sumter 11.2
Duval 11.2
Polk 11.1
Leon 11.0
Washington 10.9
Saint Lucie 10.9
Hendry 10.8
Osceola 10.7
Lake 10.6
Santa Rosa 10.5
Putnam 10.5
Broward 10.5
Columbia 10.4
Wakulla 10.3
Orange 10.3
Hamilton 10.3
Florida 10.2
Citrus 10.2
Lee 10.1
Clay 10.1
Volusia 10.0
Marion 10.0
Bay 10.0
Hillsborough 9.9
Gulf 9.9
Suwannee 9.8
Indian River 9.8
Manatee 9.7
Hernando 9.7
Palm Beach 9.6
Miami-Dade 9.6
Collier 9.6
Pinellas 9.4
Okeechobee 9.4
Martin 9.4
Brevard 9.4
Nassau 9.2
Seminole 9.1
Calhoun 9.1
Pasco 9.0
Taylor 8.9
Lafayette 8.9
Flagler 8.9
Liberty 8.6
Gilchrist 8.6
DeSoto 8.6
Sarasota 8.5
Saint Johns 8.5
Walton 8.1
Monroe 8.1
Franklin 7.5
0.0
5.0
10.0
15.0
20.0


Infant mortality (Resident infant death rate
per 1,000 live births)
Gulf 18.7
Glades 12.1
Sumter 10.4
Madison 10.4
Gadsden 10.3
Bradford 10.3
Columbia 9.8
Levy 9.4
Suwannee 9.3
Marion 9.0
Hamilton 8.8
Calhoun 8.7
Alachua 8.7
Putnam 8.6
Gilchrist 8.6
Duval 8.5
Citrus 8.4
Franklin 8.2
Escambia 7.9
Dixie 7.9
Bay 7.9
Polk 7.7
Baker 7.7
Washington 7.4
Highlands 7.3
DeSoto 7.3
Hillsborough 7.1
Hernando 7.1
Leon 7.0
Holmes 6.9
Okeechobee 6.8
Charlotte 6.8
Lake 6.7
Flagler 6.7
Volusia 6.5
Orange 6.4
Pinellas 6.3
Jackson 6.3
Florida 6.1
Lafayette 6.1
Nassau 5.9
Lee 5.8
Brevard 5.8
Martin 5.7
Indian River 5.7
Wakulla 5.4
Pasco 5.4
Okaloosa 5.4
Collier 5.4
Santa Rosa 5.3
Manatee 5.3
Saint Lucie 5.1
Osceola 5.1
Clay 5.1
Seminole 5.0
Broward 5.0
Monroe 4.9
Miami-Dade 4.9
Sarasota 4.8
Saint Johns 4.8
Jefferson 4.8
Palm Beach 4.7
Taylor 4.3
Hardee 4.3
Walton 4.2
Hendry 4.1
Union 3.9
Liberty 0.0
0.0
5.0
10.0
15.0
20.0

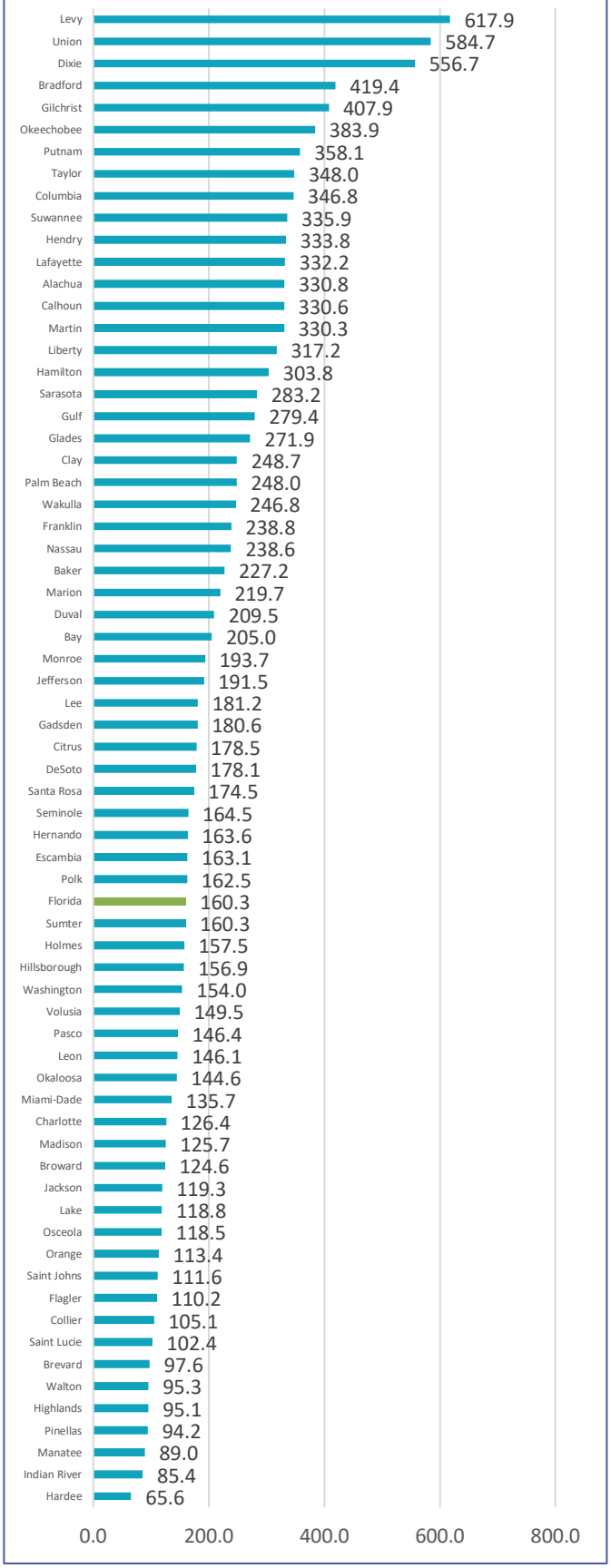

Maternal mortality (Resident maternal mortality death ratio per 100,000)
Calhoun 137.4
Baker 86.9
Bradford 65.2
Dixie 63.1
Hamilton 61.9
DeSoto 51.1
Hendry 50.2
Holmes 50.0
Putnam 46.9
Sumter 42.8
Washington 41.0
Okeechobee 37.4
Bay 35.1
Gadsden 34.7
Polk 33.1
Leon 32.8
Osceola 32.0
Wakulla 30.6
Walton 27.9
Alachua 27.9
Collier 27.6
Palm Beach 27.0
Hardee 25.2
Broward 24.8
Saint Lucie 23.1
Escambia 23.0
Pinellas 22.4
Santa Rosa 21.5
Florida 21.3
Hillsborough 21.3
Pasco 20.3
Duval 20.3
Seminole 19.8
Hernando 19.6
Charlotte 19.6
Brevard 19.4
Miami-Dade 18.6
Marion 17.4
Volusia 16.5
Orange 15.5
Manatee 14.5
Clay 14.0
Monroe 13.8
Lee 13.8
Nassau 12.7
Lake 12.7
Flagler 12.3
Columbia 12.3
Okaloosa 11.1
Sarasota 10.4
Saint Johns 9.9
Citrus 9.5
Martin 8.2
Indian River 7.9
Union 0.0
Taylor 0.0
Suwannee 0.0
Madison 0.0
Liberty 0.0
Levy 0.0
Lafayette 0.0
Jefferson 0.0
Jackson 0.0
Highlands 0.0
Gulf 0.0
Glades 0.0
Gilchrist 0.0
Franklin 0.0
0.0
50.0
100.0
150.0


Number of at-risk indicators for the child health and development domain
Gilchrist 3
Suwannee 2
Okeechobee 2
Levy 2
Lee 2
Lafayette 2
Hendry 2
Dixie 2
Columbia 2
Calhoun 2
Alachua 2
Union 1
Taylor 1
Sumter 1
Sarasota 1
Putnam 1
Palm Beach 1
Martin 1
Marion 1
Jefferson 1
Holmes 1
Hamilton 1
Gulf 1
Glades 1
Franklin 1
Flagler 1
DeSoto 1
Collier 1
Bradford 1
Baker 1
Washington 0
Walton 0
Wakulla 0
Volusia 0
Seminole 0
Santa Rosa 0
St. Lucie 0
St. Johns 0
Polk 0
Pinellas 0
Pasco 0
Osceola 0
Orange 0
Okaloosa 0
Nassau 0
Monroe 0
Miami-Dade 0
Manatee 0
Madison 0
Liberty 0
Leon 0
Lake 0
Jackson 0
Indian River 0
Hillsborough 0
Highlands 0
Hernando 0
Hardee 0
Gadsden 0
Escambia 0
Duval 0
Clay 0
Citrus 0
Charlotte 0
Broward 0
Brevard 0
Bay 0
0
1
2
3
4

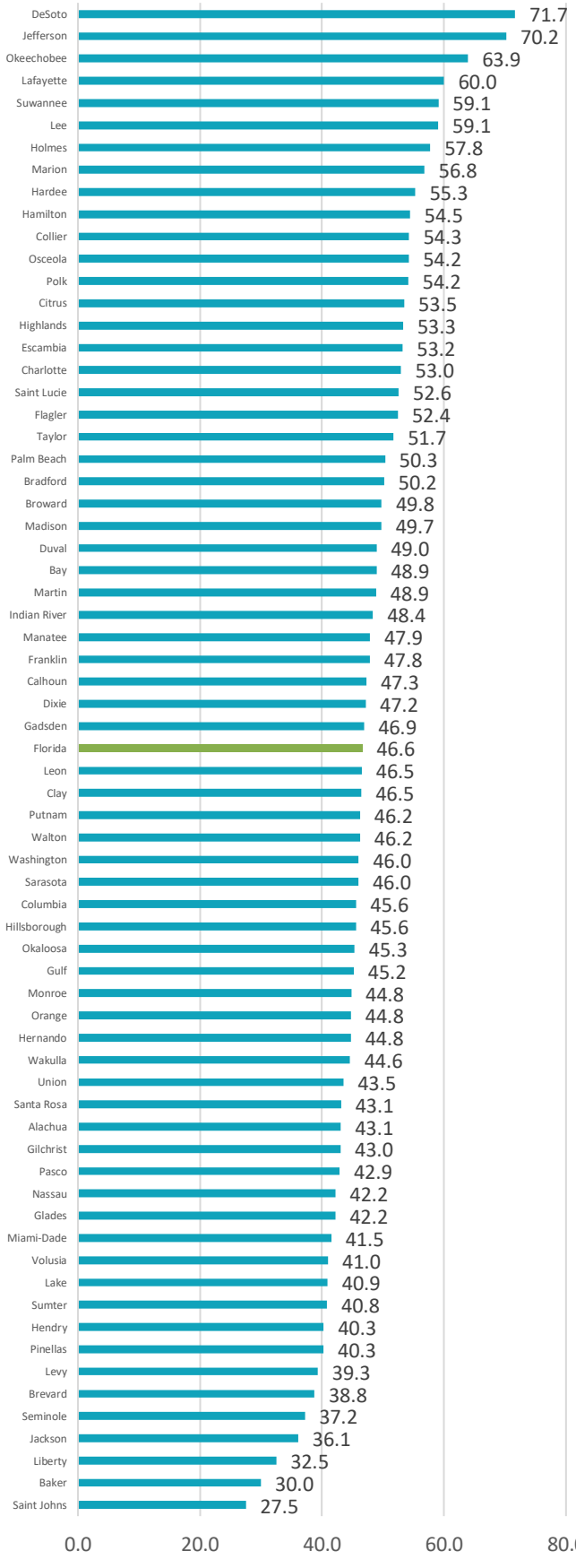

Child uninsurance (% of children under 19 uninsured)
Calhoun 17.5
Hendry 16.6
Gilchrist 15.7
Glades 15.1
Sumter 14.2
Collier 12.6
Flagler 12.2
Baker 11.8
Franklin 11.4
Holmes 11.1
Okeechobee 10.7
Monroe 10.2
DeSoto 10.1
Lee 9.9
Charlotte 9.9
Osceola 9.8
Sarasota 9.5
Martin 9.3
Saint Lucie 9.1
Levy 9.0
Bay 8.9
Palm Beach 8.7
Broward 8.6
Hernando 8.3
Orange 8.2
Nassau 8.2
Okaloosa 8.1
Manatee 8.1
Liberty 8.0
Bradford 7.7
Florida 7.6
Polk 7.6
Miami-Dade 7.6
Suwannee 7.4
Lake 7.4
Clay 7.4
Columbia 7.1
Dixie 7.0
Walton 6.9
Marion 6.8
Pinellas 6.7
Indian River 6.7
Volusia 6.6
Jackson 6.6
Hillsborough 6.6
Duval 6.6
Citrus 6.6
Madison 6.5
Highlands 6.5
Union 6.4
Washington 6.3
Lafayette 6.3
Gadsden 6.3
Hamilton 6.2
Pasco 6.1
Putnam 5.8
Brevard 5.8
Seminole 5.7
Escambia 5.2
Taylor 4.6
Saint Johns 4.6
Santa Rosa 4.5
Leon 4.3
Hardee 4.3
Alachua 4.3
Gulf 3.8
Wakulla 2.7
Jefferson 2.2
0.0
5.0
10.0
15.0
20.0

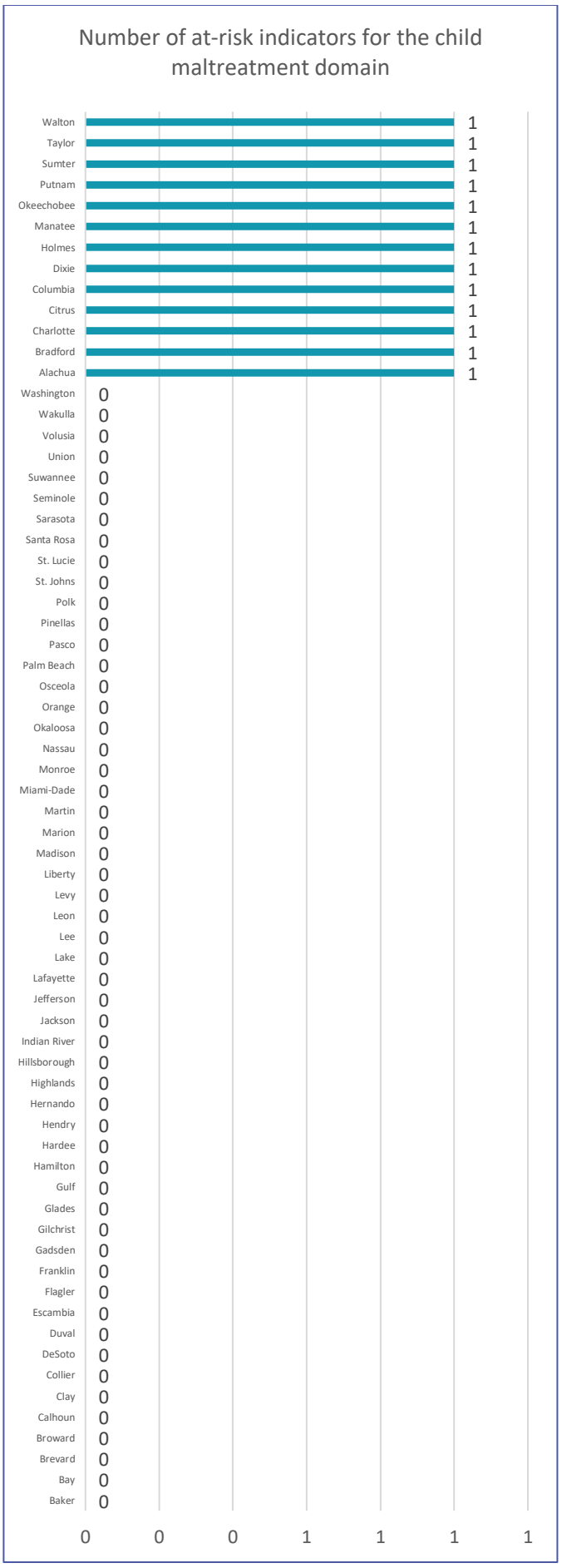

Hospitalizations for asthma among ages 1-5 years (3-year discrete rate per 100,000 (2016-2018))
Gilchrist 1223.7
Levy 1158.6
Alachua 1156.8
Dixie 994.2
Sarasota 985.0
Hamilton 867.9
Palm Beach 854.6
Lee 845.8
Gulf 838.2
Columbia 796.1
Hillsborough 750.3
Hendry 745.4
Okeechobee 741.3
Union 740.7
Polk 684.5
Miami-Dade 679.1
Martin 665.7
Lafayette 664.7
Broward 656.0
Escambia 640.2
Bradford 629.2
Duval 611.0
Florida 594.3
DeSoto 569.9
Putnam 568.3
Bay 561.6
Sumter 560.9
Clay 551.4
Lake 549.2
Leon 546.9
Marion 527.0
Gadsden 507.9
Monroe 484.2
Seminole 483.5
Hernando 483.1
Osceola 479.8
Nassau 469.2
Orange 442.0
Pasco 437.9
Okaloosa 418.2
Suwannee 416.5
Volusia 415.5
Manatee 404.1
Liberty 396.4
Pinellas 395.9
Jefferson 382.9
Wakulla 379.7
Baker 378.6
Hardee 377.2
Taylor 374.8
Saint Johns 365.5
Walton 355.3
Holmes 346.4
Indian River 341.6
Highlands 339.7
Collier 331.2
Saint Lucie 320.5
Brevard 311.8
Calhoun 289.2
Charlotte 288.9
Washington 282.4
Citrus 273.8
Glades 271.9
Flagler 249.9
Santa Rosa 249.6
Franklin 238.8
Jackson 145.8
Madison 125.7
0.0
500.0
1000.0
1500.0

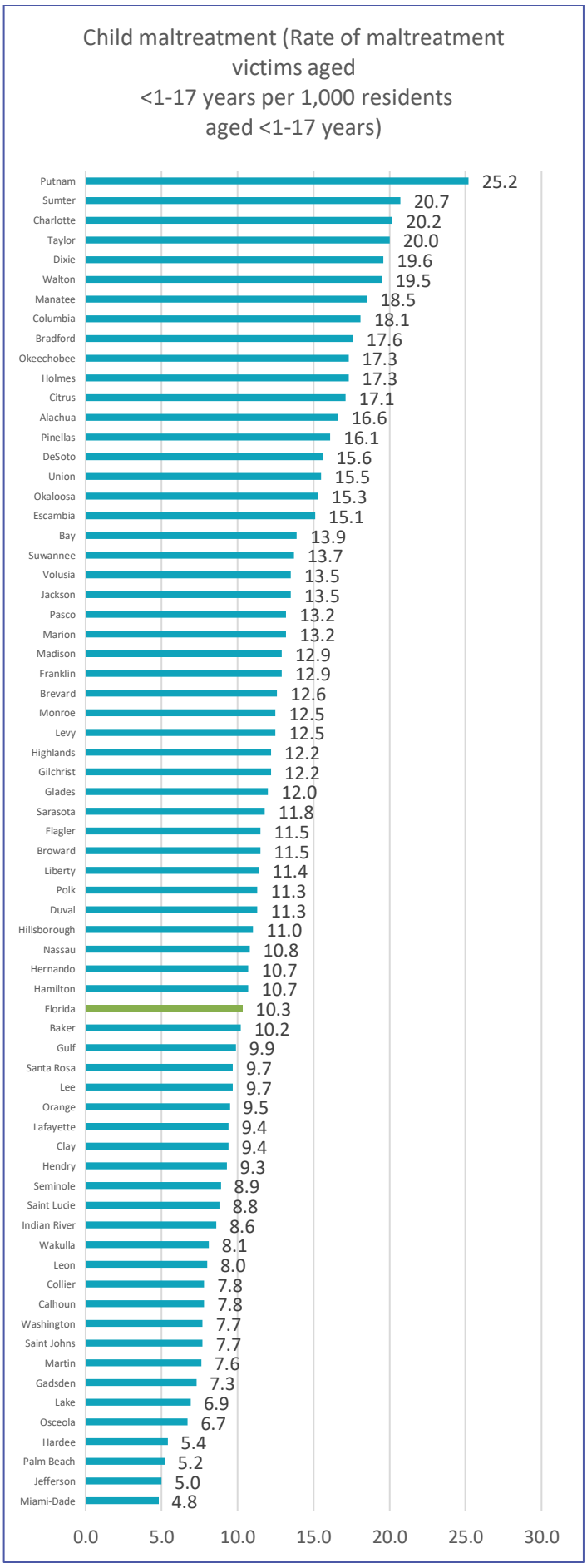
Hospitalizations for unintentional injuries among ages 1-5 years (3-year discrete rate per 100,000 (2016-2018))



Kindergarten readiness (Percentage scoring <500 on Star Early Literacy Assessment)




Number of at-risk indicators for the child maltreatment domain
Walton 1
Taylor 1
Sumter 1
Putnam 1
Okeechobee 1
Manatee 1
Holmes 1
Dixie 1
Columbia 1
Citrus 1
Charlotte 1
Bradford 1
Alachua 1
Washington 0
Wakulla 0
Volusia 0
Union 0
Suwannee 0
Seminole 0
Sarasota 0
Santa Rosa 0
St. Lucie 0
St. Johns 0
Polk 0
Pinellas 0
Pasco 0
Palm Beach 0
Osceola 0
Orange 0
Okaloosa 0
Nassau 0
Monroe 0
Miami-Dade 0
Martin 0
Marion 0
Madison 0
Liberty 0
Levy 0
Leon 0
Lee 0
Lake 0
Lafayette 0
Jefferson 0
Jackson 0
Indian River 0
Hillsborough 0
Highlands 0
Hernando 0
Hendry 0
Hardee 0
Hamilton 0
Gulf 0
Glades 0
Gilchrist 0
Gadsden 0
Franklin 0
Flagler 0
Escambia 0
Duval 0
DeSoto 0
Collier 0
Clay 0
Calhoun 0
Broward 0
Brevard 0
Bay 0
Baker 0
0 0 0 1 1 1 1


Child maltreatment (Rate of maltreatment victims aged <1-17 years per 1,000 residents aged <1-17 years)
Putnam 25.2
Sumter 20.7
Charlotte 20.2
Taylor 20.0
Dixie 19.6
Walton 19.5
Manatee 18.5
Columbia 18.1
Bradford 17.6
Okeechobee 17.3
Holmes 17.3
Citrus 17.1
Alachua 16.6
Pinellas 16.1
DeSoto 15.6
Union 15.5
Okaloosa 15.3
Escambia 15.1
Bay 13.9
Suwannee 13.7
Volusia 13.5
Jackson 13.5
Pasco 13.2
Marion 13.2
Madison 12.9
Franklin 12.9
Brevard 12.6
Monroe 12.5
Levy 12.5
Highlands 12.2
Gilchrist 12.2
Glades 12.0
Sarasota 11.8
Flagler 11.5
Broward 11.5
Liberty 11.4
Polk 11.3
Duval 11.3
Hillsborough 11.0
Nassau 10.8
Hernando 10.7
Hamilton 10.7
Florida 10.3
Baker 10.2
Gulf 9.9
Santa Rosa 9.7
Lee 9.7
Orange 9.5
Lafayette 9.4
Clay 9.4
Hendry 9.3
Seminole 8.9
Saint Lucie 8.8
Indian River 8.6
Wakulla 8.1
Leon 8.0
Collier 7.8
Calhoun 7.8
Washington 7.7
Saint Johns 7.7
Martin 7.6
Gadsden 7.3
Lake 6.9
Osceola 6.7
Hardee 5.4
Palm Beach 5.2
Jefferson 5.0
Miami-Dade 4.8
0.0 5.0 10.0 15.0 20.0 25.0 30.0

APPENDIX 5

COUNTY PROFILES

ALACHUA COUNTY

54% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPYUSA	Parents as Teachers	Early Head Start
214	50	120	22

TOTAL FUNDED SLOTS **406** # OF ESTIMATED NEED **750**

DOMAINS AT RISK

- Child Health & Development
- Special Populations
- Child Maltreatment

INDICATORS IN DOMAIN

- Hospitalizations for Asthma
- Hospitalizations for Unintentional Injury
- Incarcerations
- Child Maltreatment

OTHER INDICATORS AT RISK

- Social Economic Status
- Low Birth Weight
- Pain Relievers
- Pre-term Birth
- Illicit Drugs
- Crime Reports

A CLOSER LOOK

> We need to expand services for women who are abusing substances.
>
> – Home visiting staff survey

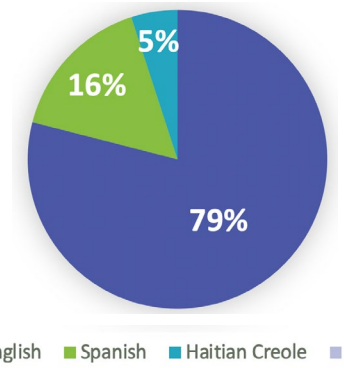
13% OF ALACHUA COUNTY'S BIRTHS ARE PRETERM AND

12% ARE SMALL FOR GESTATIONAL AGE.

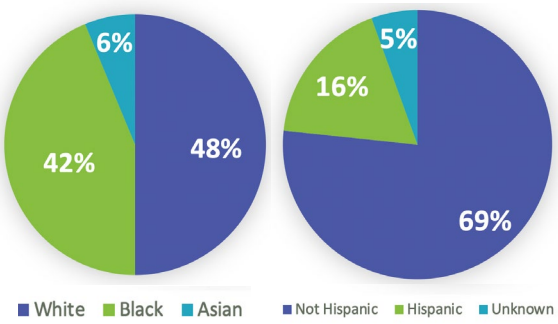
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

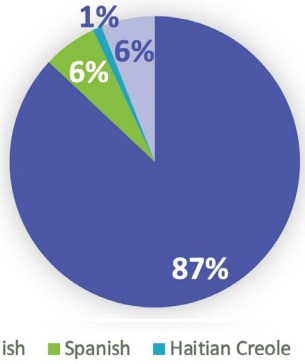
Primary Language Spoken by Staff



Race and Ethnicity of Staff



Primary Language Spoken by Participants



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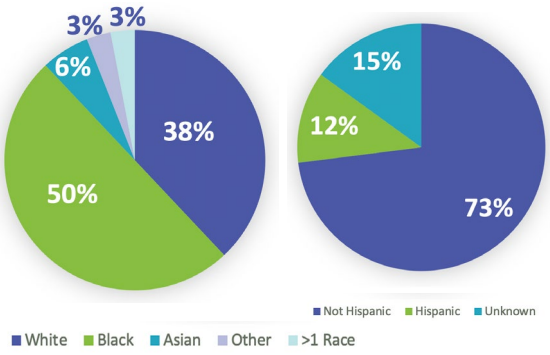


BAKER COUNTY

63%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

22	13	10
Healthy Families Florida	Nurse-Family Partnership	Early Head Start

TOTAL FUNDED SLOTS **45** # OF ESTIMATED NEED **71**

DOMAINS AT RISK

- Adverse Perinatal Outcomes
- Substance Use Disorder
- Special Populations

INDICATORS IN DOMAIN

Maternal Mortality	Low Birth Weight	Pain Relievers
Pre-term Birth	Illicit Drugs	Tobacco
	Incarcerated	

OTHER INDICATORS AT RISK

Child Un-insurance

A CLOSER LOOK

BAKER COUNTY'S RATES FOR USE OF ILLICIT DRUGS, ALCOHOL, MARIJUANA, TOBACCO, AND PAIN RELIEVERS ARE **ALL HIGHER** *THAN THE STATE AVERAGE. IT ALSO HAS THE SECOND HIGHEST RATE FOR MATERNAL MORTALITY* **(86.9%.)**

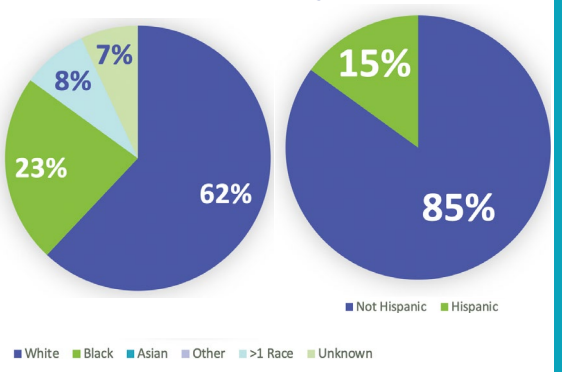
ESTIMATED MIECHV NEED MET

< 25%	25% - 50%	50% - 75%	> 75%

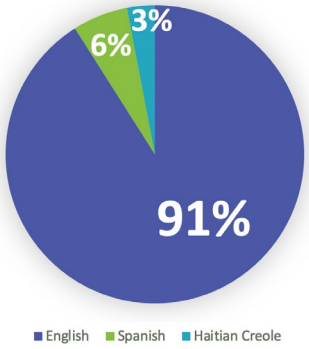
DEMOGRAPHICS

Primary Language Spoken by Staff

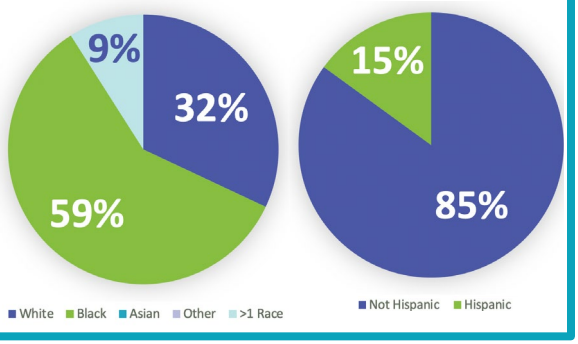
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



BAY COUNTY

10%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

122 Healthy Families Florida

50 Parents as Teachers

TOTAL FUNDED SLOTS **172** # OF ESTIMATED NEED **1650**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-Term Birth
- Unemployment
- Home Ownership
- Tobacco Use
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

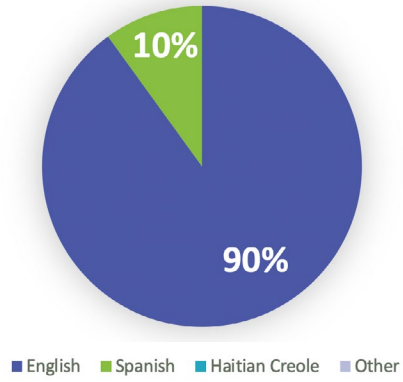
> We lack home visiting programs for ages 3-5. We find that once PAT closes the child at 3, they do not have access to home visiting services until they enter school.
>
> – Home visiting staff survey

BAY COUNTY HAS **MORE THAN TWICE** THE JUVENILE ARREST RATE THAN THE STATE AVERAGE WITH **5122** ARRESTS PER 100,000 VERSUS 2351.

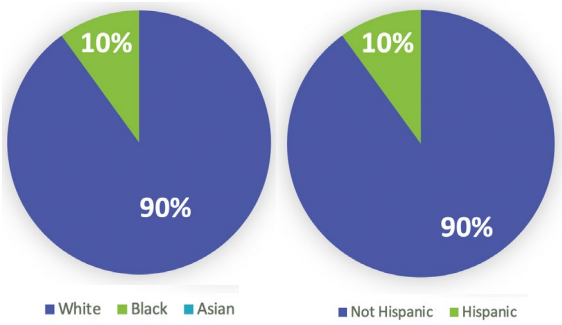
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

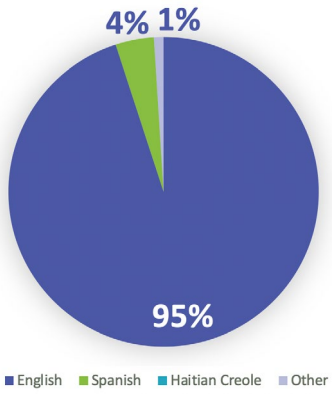
Primary Language Spoken by Staff



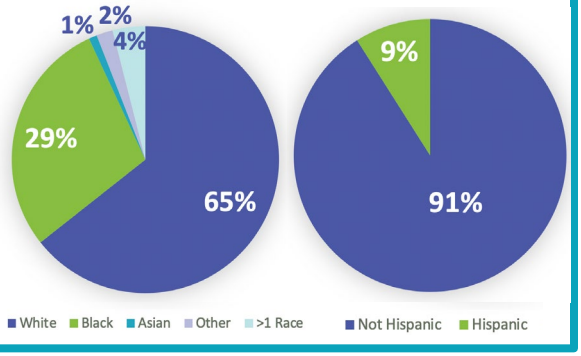
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



BRADFORD COUNTY

55%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

15	50	20	2
Healthy Families Florida	HIPPYUSA	Parents as Teachers	Early Head Start

TOTAL FUNDED SLOTS **87** # OF ESTIMATED NEED **157**

DOMAINS AT RISK

- Adverse Perinatal Outcomes
- Substance Use Disorder
- Child Maltreatment

INDICATORS IN DOMAIN

Maternal Mortality	Infant Mortality	Tobacco
Pre-term Birth	Illicit Drugs	Child Maltreatment
	Pain Relievers	

OTHER INDICATORS AT RISK

Hospitalization for Intentional Injury

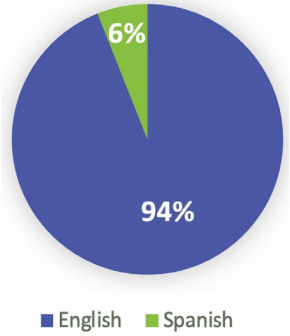
A CLOSER LOOK

BRADFORD COUNTY'S POVERTY RATE (39.8% OF FAMILIES WITH CHILDREN UNDER AGE 5) IS **3X HIGHER** *THAN THE STATE AVERAGE (13.7%.)*

ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



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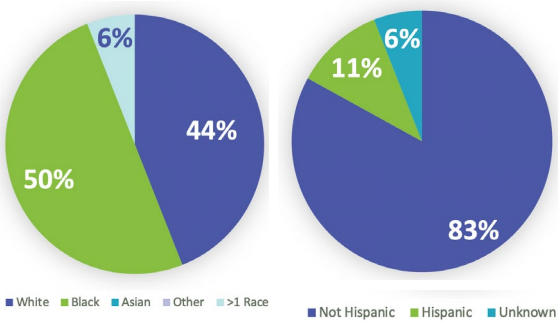

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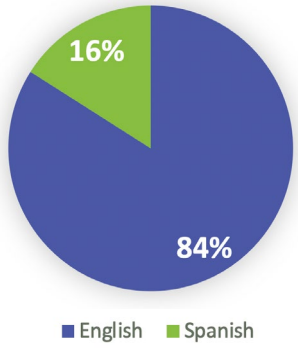

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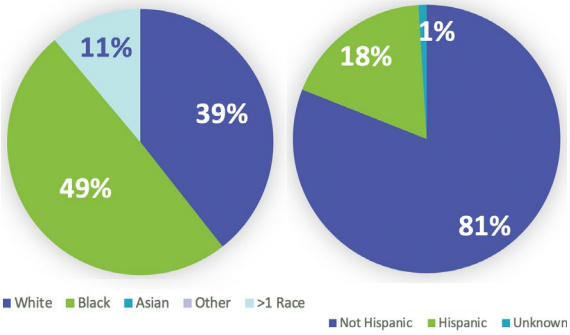


BREVARD COUNTY

28%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPY USA	Nurse-Family Partnership
271	60	50

TOTAL FUNDED SLOTS **381** # OF ESTIMATED NEED **1355**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco Use
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

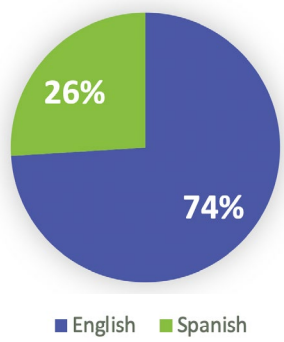
> The real question is what is available and to whom is it available to?
>
> – Parent survey regarding community services

BREVARD COUNTY'S UNEMPLOYMENT RATE (6.2% OF LABOR FORCE, AGES 16+ FOR 2014-2018) IS **TWICE** *THAT OF THE STATE (3.1%).*

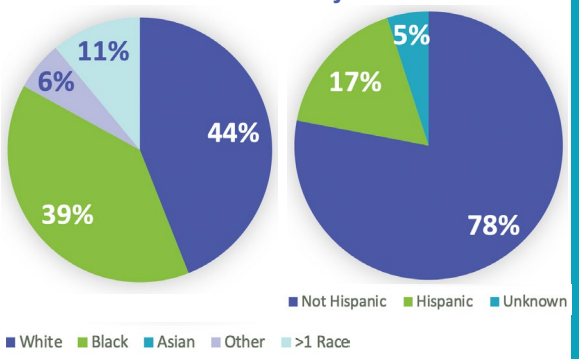
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



Race and Ethnicity of Staff



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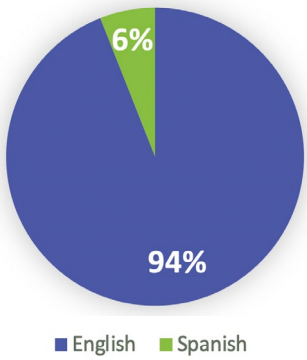

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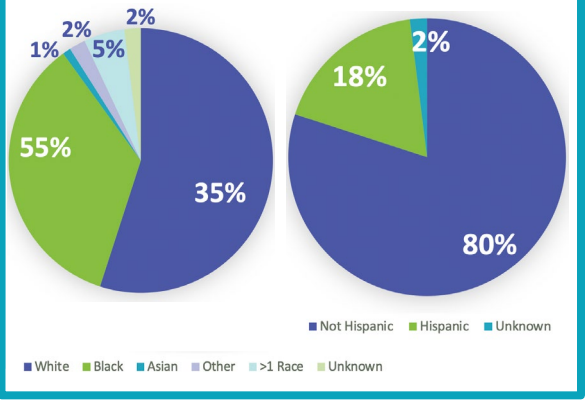


BROWARD COUNTY

12% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPY USA	Nurse-Family Partnership	Parents as Teachers
600	120	200	250

TOTAL FUNDED SLOTS **1170** # OF ESTIMATED NEED **9398**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco Use
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

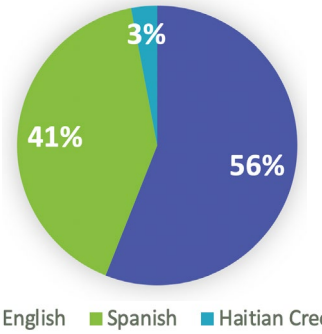
> We have a strong infrastructure and partnership with the home visiting partners along with a strong Coordinated Intake and Referral process.
>
> – Home visiting staff survey

BROWARD COUNTY'S PRE-COVID UNEMPLOYMENT RATE (6.6% OF LABOR FORCE, AGES 16+ FOR 2014-2018) IS **TWICE** *THAT OF THE STATE AVERAGE (3.1%).*

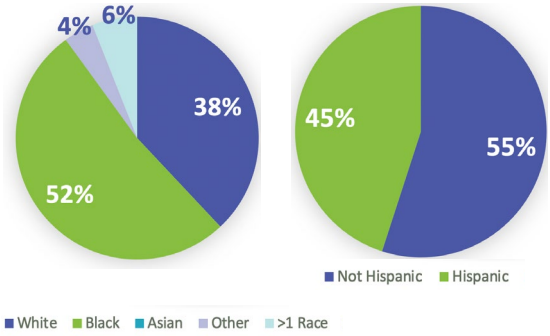
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

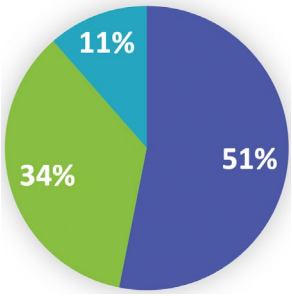
Primary Language Spoken by Staff



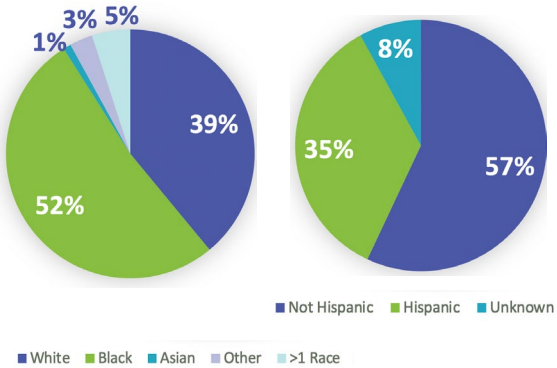
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



COLLIER COUNTY

5% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

93 — Healthy Families Florida

20 — Nurse-Family Partnership (Helping First-Time Parents Succeed®)

TOTAL FUNDED SLOTS **113** # OF ESTIMATED NEED **2718**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco Use
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

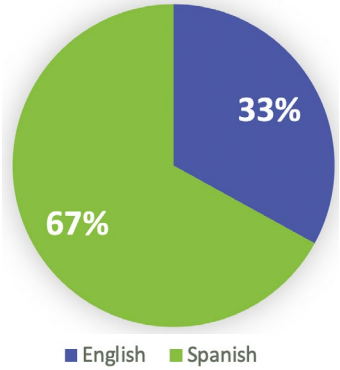
A CLOSER LOOK

12.6% *OF COLLIER COUNTY'S CHILDREN ARE UNINSURED – HIGHER THAN THE STATE AVERAGE OF 7.6%.*

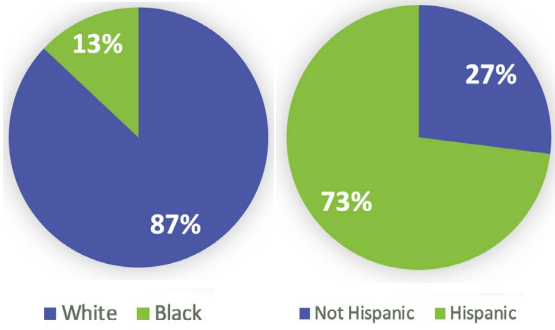
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

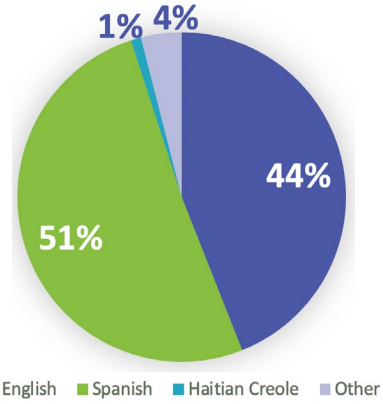
Primary Language Spoken by Staff



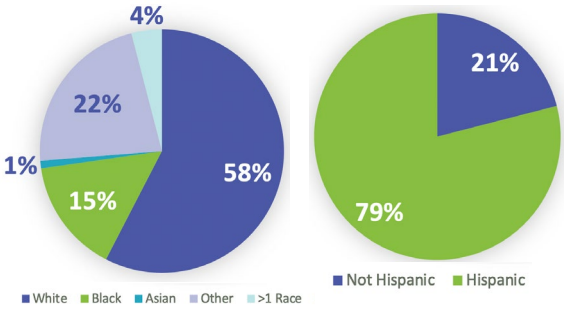
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



COLUMBIA COUNTY

12% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

30 — Healthy Families Florida

20 — Parents as Teachers

TOTAL FUNDED SLOTS **50**

OF ESTIMATED NEED **403**

INDICATORS AT RISK

Poverty	Educational Attainment	Small for Gestational Age
Unemployment	Income Equality	Tobacco Use

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

> There are online trainings, but we have access to college and university opportunities.
>
> – Home visitor survey related to community's capacity to provide ongoing professional development.

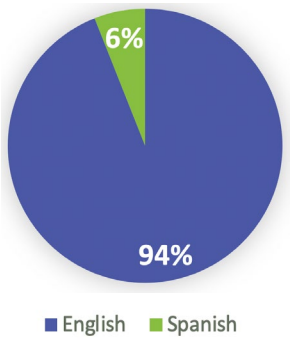
COLUMBIA COUNTY HAS THE SECOND HIGHEST HIGH SCHOOL DROPOUT RATE **(17.1%.)**

COLUMBIA COUNTY'S RATE (346.8) FOR UNINTENTIONAL INJURIES IS **MORE THAN TWICE** THAT OF THE STATE AVERAGE (160.3).

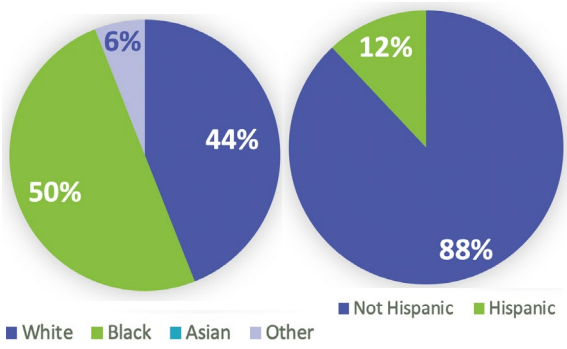
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

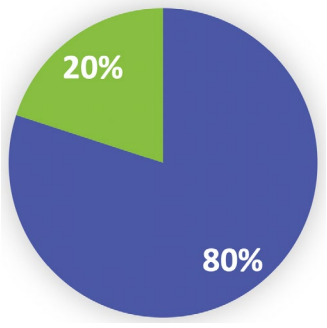
Primary Language Spoken by Staff



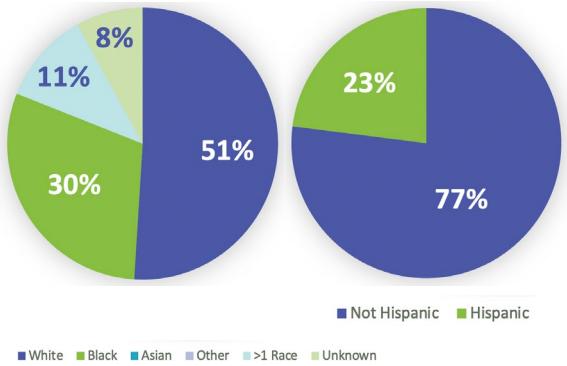
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



DESOTO COUNTY

12% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

74	40
HEALTHY FAMILIES FLORIDA	Parents as Teachers

TOTAL FUNDED SLOTS **114** # OF ESTIMATED NEED **324**

INDICATORS AT RISK

Poverty	Educational Attainment	Small for Gestational Age
Unemployment	Income Equality	Tobacco Use

Note: DeSoto County has been included with the justification that it has the highest percentage of children (71.7%) who scored less than a 500 on the Star Early Literacy assessment, meaning only 28.3% of the children in DeSoto county are considered "ready for kindergarten."

A CLOSER LOOK

"Families are in need of direct home contact as access to early learning programs is a challenge in DeSoto County due to transportation and now the pandemic."

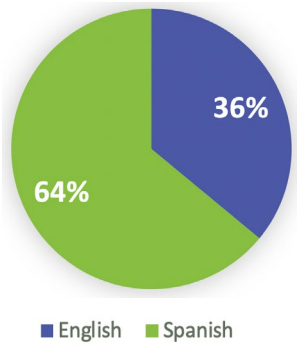
– Community stakeholder survey

DESOTO COUNTY HAS THE HIGHEST PERCENTAGE OF CHILDREN (71.7%) WHO SCORE LESS THAN 500 ON THE STAR EARLY LITERACY ASSESSMENT. THE STATE AVERAGE IS 46.6%

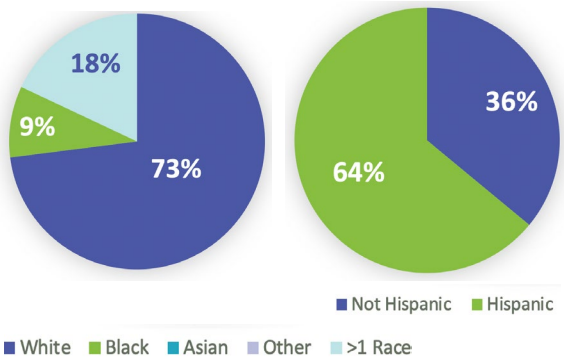
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



Race and Ethnicity of Staff



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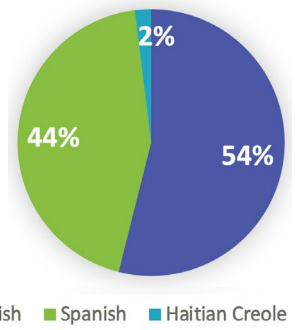

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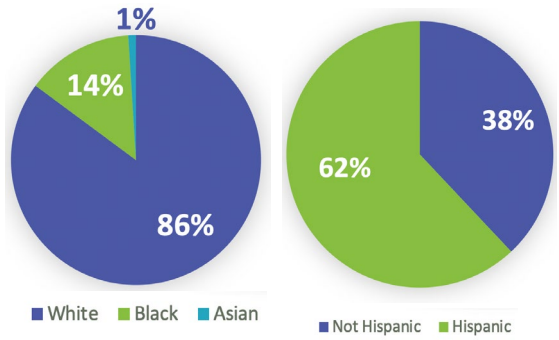


DIXIE COUNTY

24% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

12 — Healthy Families Florida

11 — Early Head Start

TOTAL FUNDED SLOTS **23**

OF ESTIMATED NEED **95**

DOMAINS AT RISK

- Adverse Perinatal Outcomes
- Substance Use Disorder
- Child Maltreatment
- Child Health & Development

INDICATORS IN DOMAIN

- Maternal Mortality
- Pre-term Birth
- Low Birth Weight
- Illicit Drugs
- Pain Relievers
- Tobacco
- Child Maltreatment
- Hospitalization for Unintentional Injury
- Hospitalization for Asthma

OTHER INDICATORS AT RISK

Poverty

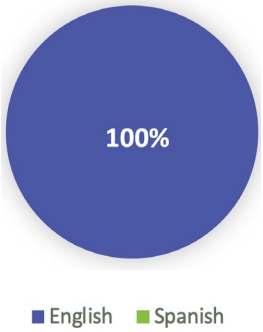
A CLOSER LOOK

JUST OVER 50% *(50.8) OF DIXIE COUNTY'S FAMILIES WITH CHILDREN UNDER AGE 5 LIVE IN POVERTY.*

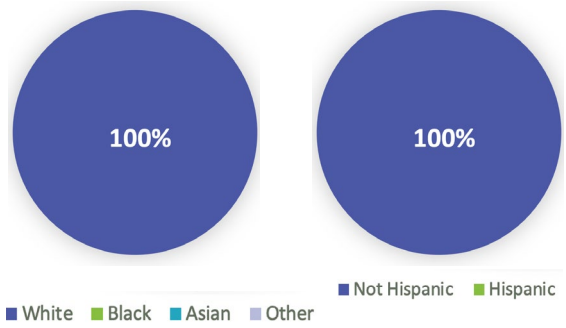
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff

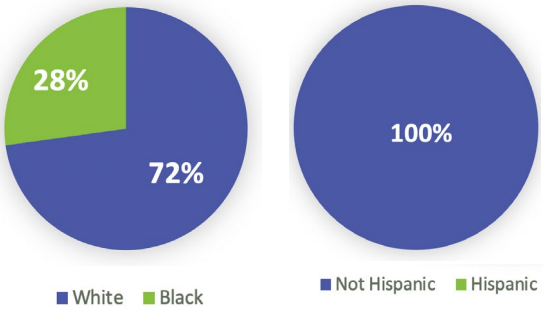


Race and Ethnicity of Staff



Primary Language Spoken by Participants

Race and Ethnicity of Participants



DUVAL COUNTY

11% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPY USA	Nurse-Family Partnership	Early Head Start
597	40*	174	171

TOTAL FUNDED SLOTS **982** # OF ESTIMATED NEED **9011**

*recently funded program, no programmatic data was provided

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco Use
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

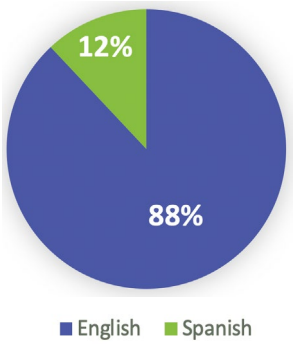
> Lack of services for undocumented clients.
>
> – Home visiting staff survey

DUVAL COUNTY'S CRIME RATE IS THE **SECOND HIGHEST** IN THE STATE. 3,885 PER 100,000 VERSUS 2,551.

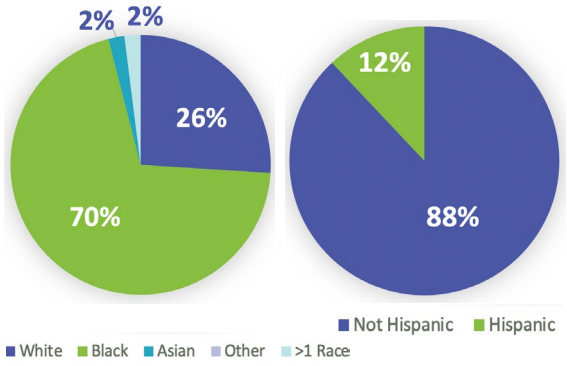
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

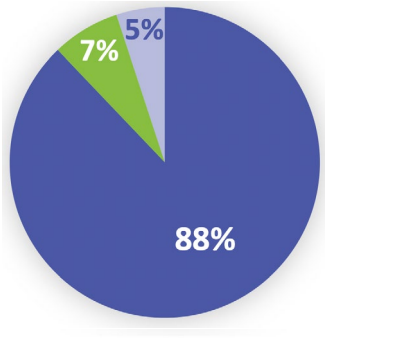
Primary Language Spoken by Staff



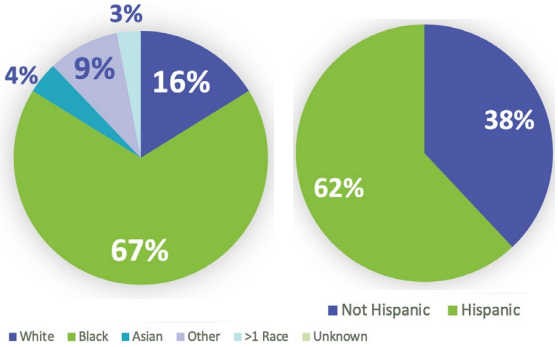
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



ESCAMBIA COUNTY

13%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

225

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **225** # OF ESTIMATED NEED **1768**

INDICATORS AT RISK

Poverty	Educational Attainment	Small for Gestational Age
Unemployment	Income Equality	Tobacco Use

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

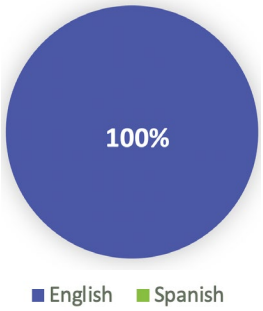
A CLOSER LOOK

IN ESCAMBIA COUNTY, RATES FOR INTIMATE PARTNER VIOLENCE (608.4 REPORTED CASES PER 100,000 RESIDENTS VS. 503.4) AND CRIME (3,419 REPORTS PER 100,000 RESIDENTS, VS. 2351) ARE **HIGHER** *THAN THE STATE AVERAGE.*

ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



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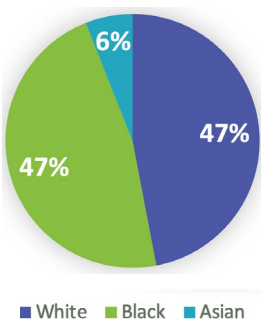

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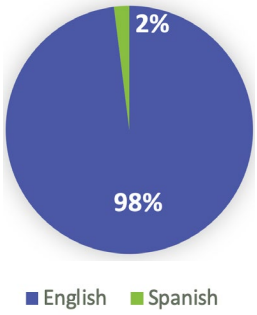
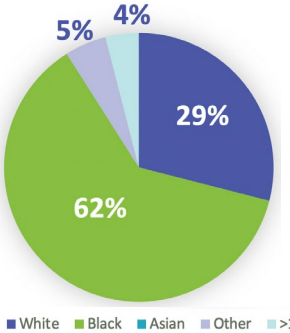
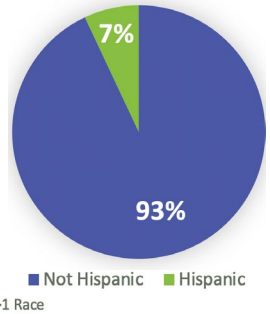


Race and Ethnicity of Participants





FRANKLIN COUNTY

100% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

49 HEALTHY FAMILIES FLORIDA

38 HIPPYUSA

TOTAL FUNDED SLOTS **87**

OF ESTIMATED NEED **83**

DOMAINS AT RISK

Socioeconomic Status

Substance Use Disorder

INDICATORS IN DOMAIN

Poverty	Alcohol	Pain Relievers
High School Dropout	Marijuana	Tobacco
Income Inequality	Illicit Drugs	

OTHER INDICATORS AT RISK

Juvenile Arrests

Child Un-insurance

A CLOSER LOOK

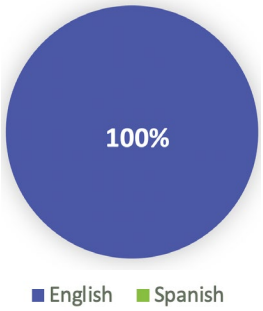
> We have recently connected with the Franklin County Sheriff's Office new substance abuse case manager to discuss possible implementation of a virtual fatherhood support group through the Franklin County jail.
>
> – Home Visiting Staff Survey

JUST UNDER HALF *(47.7%) OF FRANKLIN COUNTY'S FAMILIES WITH CHILDREN UNDER AGE 5 LIVE IN POVERTY.*

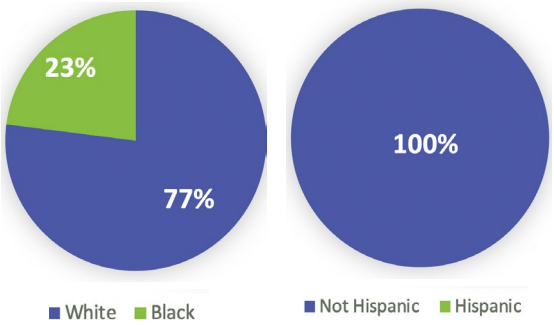
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

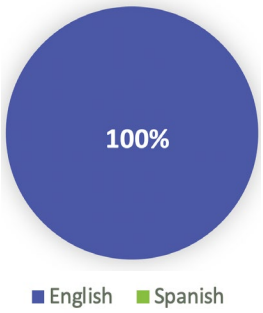
Primary Language Spoken by Staff



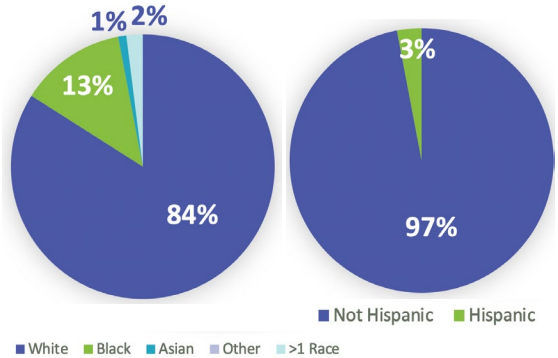
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



GADSDEN COUNTY

82%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPY USA	Early Head Start	Nurse-Family Partnership
76	80	68	40

TOTAL FUNDED SLOTS **264** # OF ESTIMATED NEED **323**

DOMAINS AT RISK

- Socioeconomic Status
- Substance Use Disorder

INDICATORS IN DOMAIN

Poverty	Alcohol	Pain Relievers
High School Dropout	Marijuana	Tobacco
Income Inequality	Illicit Drugs	

OTHER INDICATORS AT RISK

- Juvenile Arrests
- Child Un-insurance

A CLOSER LOOK

> There has always been a greater need in our rural counties for more services in general. Transportation is a major issue in rural counties.
>
> – Stakeholder survey

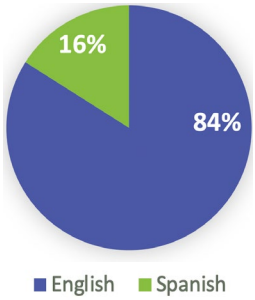
> The need is everywhere in Gadsden. The Gadsden Health Council is a great place to start as they have representatives from the community at the table who are very connected to the Gadsden communities.
>
> – Stakeholder survey

GADSDEN HAS AN AVERAGE OF 11.2% OF LIVE BIRTHS WITH LOW BIRTH WEIGHT, COMPARED TO THE STATE AVERAGE OF 8.7%.

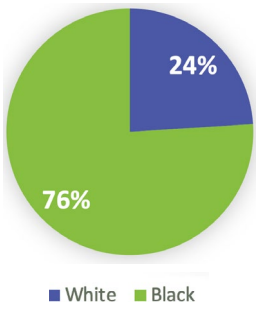
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

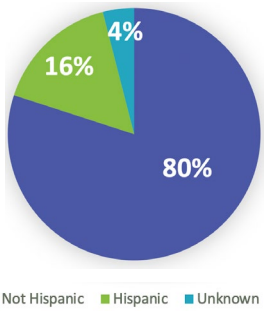
DEMOGRAPHICS

Primary Language Spoken by Staff

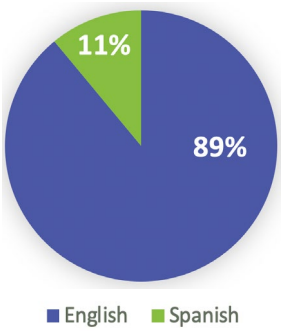


Race and Ethnicity of Staff

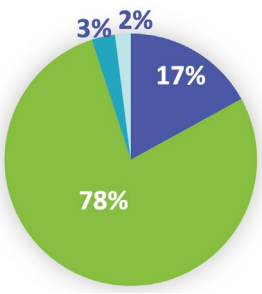


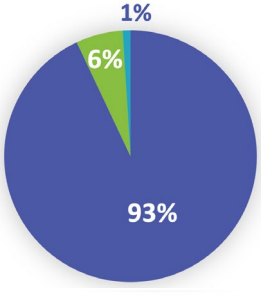


Primary Language Spoken by Participants



Race and Ethnicity of Participants





White Black Asian Other >1 Race

GILCHRIST COUNTY

25%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

14 — HEALTHY FAMILIES FLORIDA

11 — Early Head Start

TOTAL FUNDED SLOTS **25**

OF ESTIMATED NEED **100**

DOMAINS AT RISK

Special Populations

Child Health & Development

INDICATORS IN DOMAIN

Agricultural Industry

Child Un-insurance

Hospitalization for unintentional injury

Hospitalization for Asthma

OTHER INDICATORS AT RISK

High School Dropout

Illicit Drugs

Pain Relievers

A CLOSER LOOK

"There are many families that could benefit from the services in the Counties we currently serve."

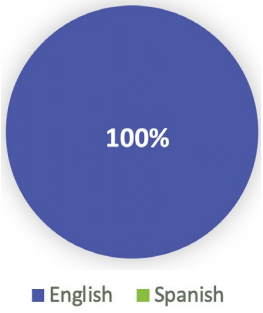
– Home visiting staff survey

GILCHRIST HAS THE **HIGHEST** RATE OF PEDIATRIC HOSPITALIZATIONS FOR ASTHMA IN THE STATE, AT **1223.7** HOSPITALIZATIONS PER 100,000 CHILDREN, COMPARED TO THE STATE AVERAGE OF 594.3 PER 100,000.

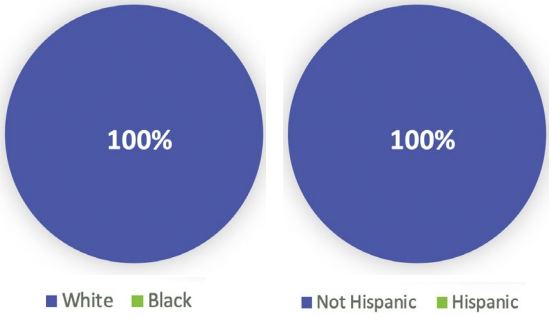
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

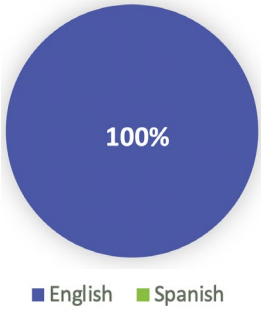
Primary Language Spoken by Staff



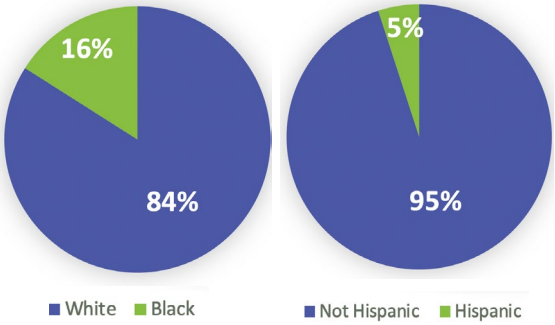
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



GLADES COUNTY

4%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

6

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **6**

OF ESTIMATED NEED **170**

DOMAINS AT RISK

- Special Populations
- Adverse Perinatal Outcomes
- Socioeconomic Status

INDICATORS IN DOMAIN

Agricultural Industry	Pre-term Births	Unemployment
Incarceration	Low Birth Weight	ALICE households
Maternal Mortality	High School Dropout	

OTHER INDICATORS AT RISK

Child Un-insurance

A CLOSER LOOK

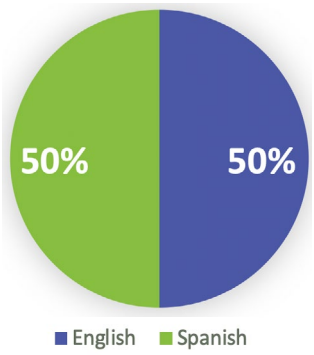
*GLADES COUNTY HAS THE **HIGHEST** JAIL POPULATION PER 100,000 RESIDENTS IN THE STATE (AGE 15-64) AT A RATE OF 4490.5, COMPARED TO THE STATE AVERAGE OF 414.9 (NEARLY 110% OF THE STATE AVERAGE).*

ESTIMATED MIECHV NEED MET

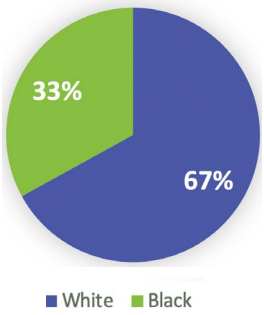
< 25%	25% - 50%	50% - 75%	> 75%

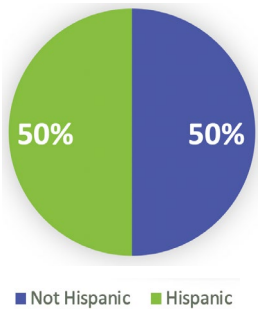
DEMOGRAPHICS

Primary Language Spoken by Staff

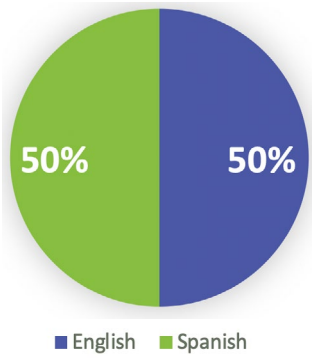


Race and Ethnicity of Staff

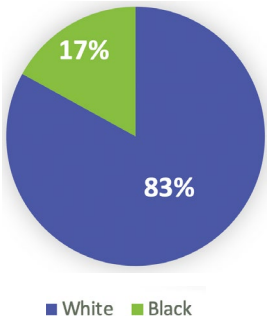


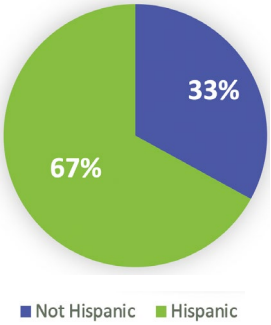


Primary Language Spoken by Participants



Race and Ethnicity of Participants





HAMILTON COUNTY

14% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

6 HEALTHY FAMILIES FLORIDA

20 Parents as Teachers

TOTAL FUNDED SLOTS **26**

OF ESTIMATED NEED **181**

DOMAINS AT RISK

Special Populations

Adverse Perinatal Outcomes

INDICATORS IN DOMAIN

- Agricultural Industry
- Maternal Mortality
- Small for Gestational Age
- Low Birth Weight

OTHER INDICATORS AT RISK

- Unemployment
- Pain Relievers
- Illicit Drugs
- Hospitalization for Asthma

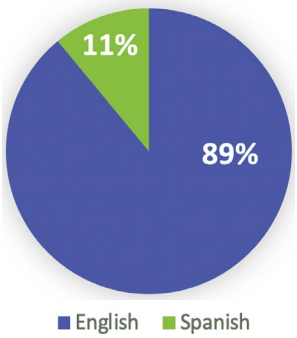
A CLOSER LOOK

HAMILTON COUNTY HAS THE **HIGHEST** UNEMPLOYMENT RATE OF ALL REPORTED COUNTIES AT **14.6%** OF THE CIVILIAN LABOR FORCE (AGES 16 AND OLDER). THE STATE AVERAGE IS 3.1%.

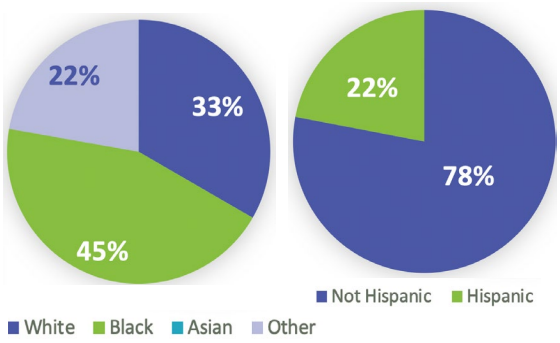
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

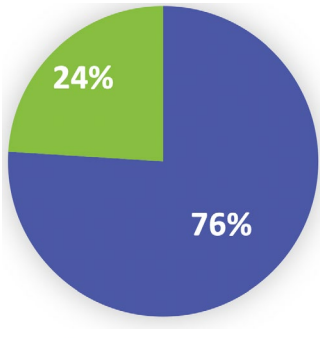
Primary Language Spoken by Staff



Race and Ethnicity of Staff



Primary Language Spoken by Participants



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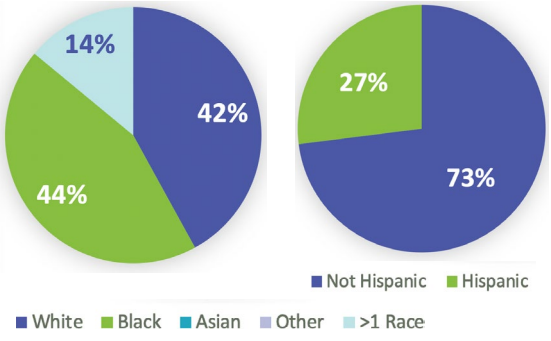


HARDEE COUNTY

66%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPYUSA	Parents as Teachers
44	60	60

TOTAL FUNDED SLOTS **164** # OF ESTIMATED NEED **248**

INDICATORS AT RISK

- Educational Attainment
- Education
- Income Equality
- Tobacco

Note: Hardee County has been included with the justification that it had the highest rate of farm workers in the state, with 23% of the county's population working in the agriculture industry.

A CLOSER LOOK

> Estoy contenta con el programa y la persona k me visita me ayudado mucho.
> Translation: I am happy with the program, and the person who visited me helped me a lot.
>
> – Parent survey

> Sometimes after getting arrangements to get to resource often times the workers are rude or untrained and uninterested in your well-being. Having a PAT worker has been a blessing because I finally feel like I have someone to advocate for me.
>
> – Home visiting staff survey

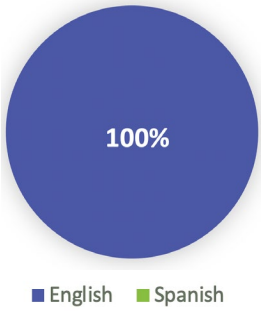
> Referral services do not exist or are not willing to work with families.
>
> – Home visiting staff survey

*HARDEE COUNTY HAS THE **HIGHEST** PROPORTION OF FARM WORKERS AMONG ALL REPORTED COUNTIES, WITH A RATE OF 23.3 HIRED FARM WORKERS PER 100,000 LABOR FORCE POPULATION AGED 16-54.*

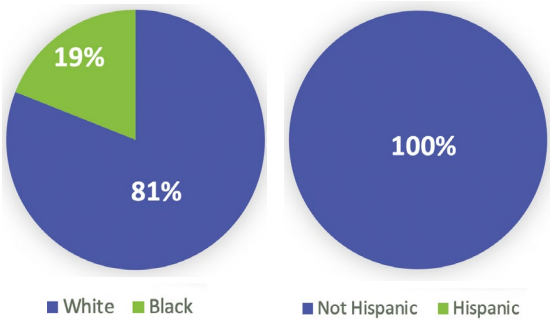
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



Race and Ethnicity of Staff



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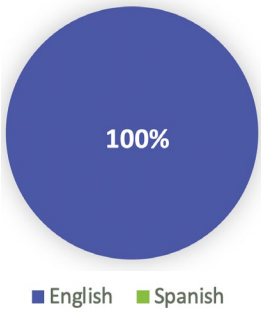
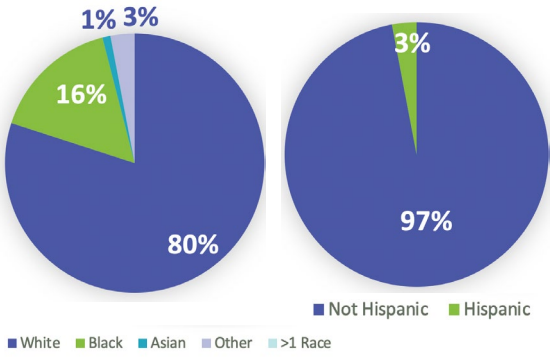


Race and Ethnicity of Participants



HENDRY COUNTY

32% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

HEALTHY FAMILIES FLORIDA	Nurse-Family Partnership
137	15

TOTAL FUNDED SLOTS **152** # OF ESTIMATED NEED **479**

DOMAINS AT RISK

- Special Populations
- Child Health & Development

INDICATORS IN DOMAIN

- Agricultural Industry
- Hospitalization for Unintentional Injury
- Child Un-insurance

OTHER INDICATORS AT RISK

- ALICE Household
- Maternal Mortality

A CLOSER LOOK

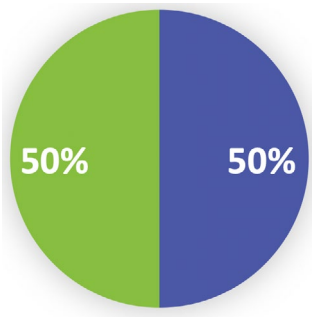
> Multiple barriers: transportation, availability of resources, etc.
>
> – Parent survey

HENDRY COUNTY'S MATERNAL MORTALITY DEATH RATIO PER 100,000 LIVE BIRTHS IS **MORE THAN TWICE** *THAT OF THE STATE, AT 50.2 DEATHS, COMPARED TO THE STATE RATIO OF 21.3 DEATHS PER 100,000.*

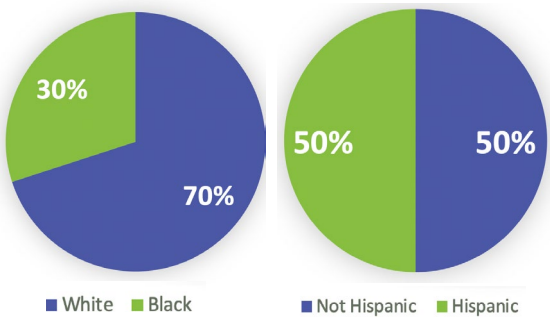
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

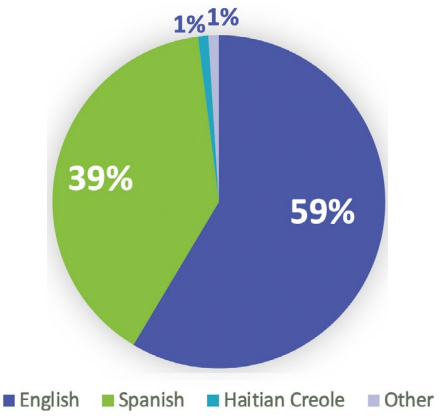
Primary Language Spoken by Staff



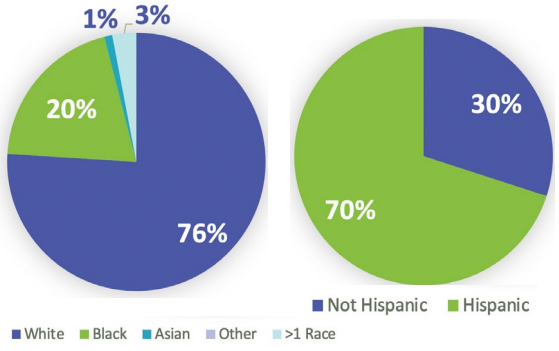
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



HERNANDO COUNTY

16% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

113

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **113** # OF ESTIMATED NEED **719**

INDICATORS AT RISK

Poverty	Income Equality	Pre-term Birth
Unemployment	Home Ownership	Tobacco Use
Educational Attainment	Small for Gestational Age	

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

"My family has really benefited from Healthy Start."
– Parent survey

"There are many families with young children who currently do not have them enrolled in Early Childhood Education. Sadly, these are generally also families where the children are at high risk in other areas and could also use other support."
– Parent survey

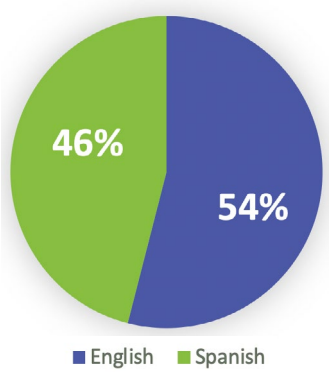
"Children need eyesight and hearing checked. Even paying for a birth certificate is very difficult."
– Stakeholder survey

HERNANDO COUNTY'S INFANT MORTALITY RATE (7.1 PER 1000 LIVE BIRTHS) IS **HIGHER** THAN THE STATE AVERAGE OF 6.1.

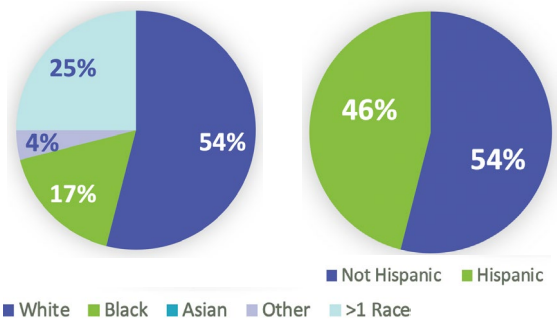
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

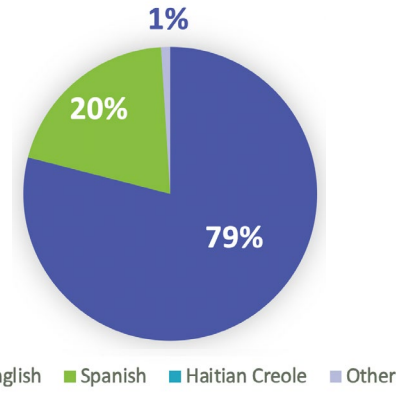
Primary Language Spoken by Staff



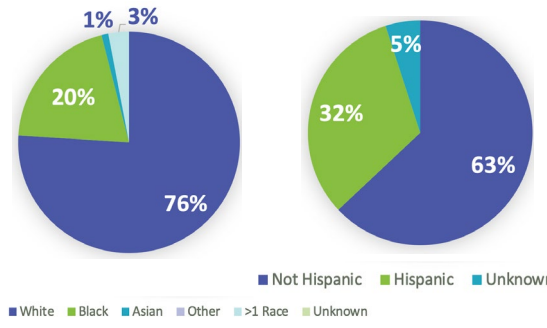
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



HIGHLANDS COUNTY

15%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

92 — Healthy Families Florida

50 — Nurse-Family Partnership (Helping First-Time Parents Succeed®)

TOTAL FUNDED SLOTS **142** # OF ESTIMATED NEED **948**

INDICATORS AT RISK

Poverty	Income Equality	Pre-term Birth
Unemployment	Home Ownership	Tobacco Use
Educational Attainment	Small for Gestational Age	

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

> Need to maximize referrals from medical providers; our program is currently limited to first time mother's, limited finding results in less productivity (for example, more time using paper charting then giving to data entry person to input into 2+ separate databases, need streamlined charting / data entry systems that flow / cross over), increased finding would also help with client engagement/retention and program quality.
>
> – Home Visiting staff survey

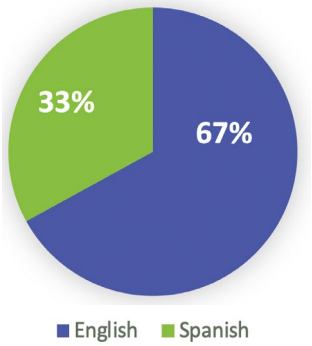
> I feel that we at NFP could reach more mothers if we could expand. Also need mental health home visiting/case management.
>
> – Home visiting staff survey

HIGHLANDS COUNTY RANKS EIGHTH OF THE REPORTED COUNTIES IN JUVENILE ARRESTS AT 4242.7 ARRESTS PER 100,000 POPULATION AGED 10-17, COMPARED TO THE STATE AVERAGE OF 2350. HIGHLANDS COUNTY ALSO RANKS EIGHTH OF THE REPORTED COUNTIES IN INCARCERATION AT A JAIL POPULATION OF 788 PER 100,0000 RESIDENTS AGED 15-64, COMPARED TO THE STATE AVERAGE OF 415.

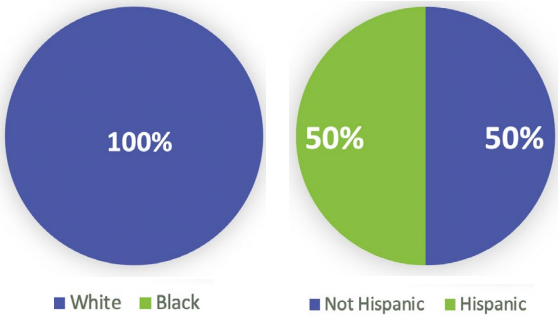
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

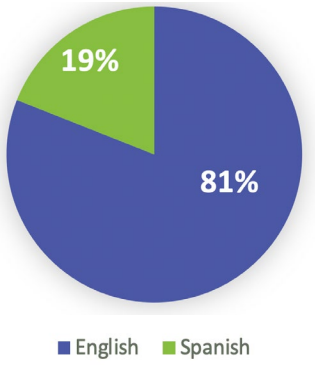
Primary Language Spoken by Staff



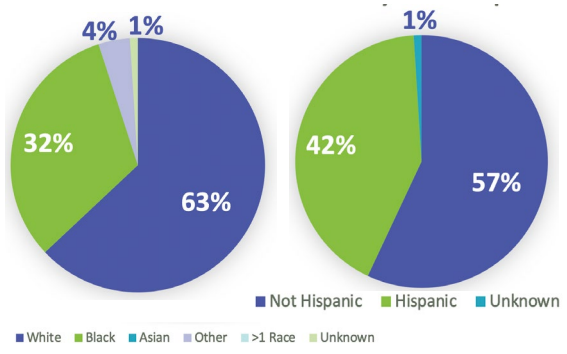
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



HILLSBOROUGH COUNTY

20%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPY USA	Nurse-Family Partnership	Parents as Teachers
636	215	156	585

TOTAL FUNDED SLOTS **1736** # OF ESTIMATED NEED **8714**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco Use
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

> We should be able to cover the entire county and not just low-income women.
>
> – Home visiting staff survey

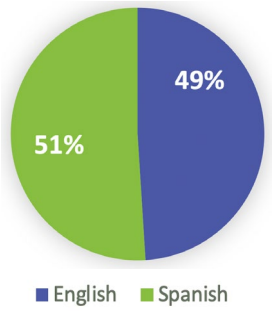
> I have been using Parents as Teachers and it is AMAZING. I feel supported and I have learned so much to help take care of my daughter.
>
> – Parent survey

HILLSBOROUGH COUNTY IS THE FOURTH MOST POPULATED COUNTY AT 1.47 MILLION RESIDENTS, FOLLOWING MIAMI-DADE, BROWARD, AND PALM BEACH COUNTIES, RESPECTIVELY. MOST COUNTY INDICATORS ARE SIMILAR TO STATE AVERAGES IN HILLSBOROUGH COUNTY. HOSPITALIZATIONS FOR CHILD ASTHMA (AGES 1-5) EXCEED THE STATE AVERAGE HOWEVER, AT 750.3 PER 100,000 COMPARED TO THE STATE AVERAGE OF 594.3 HOSPITALIZATIONS.

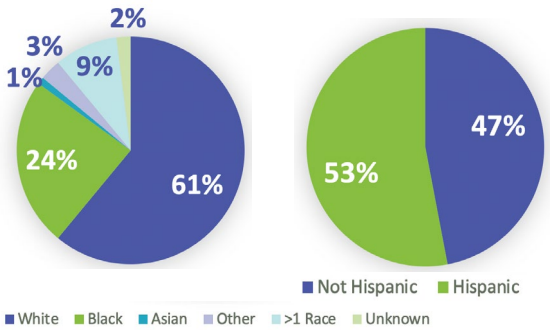
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

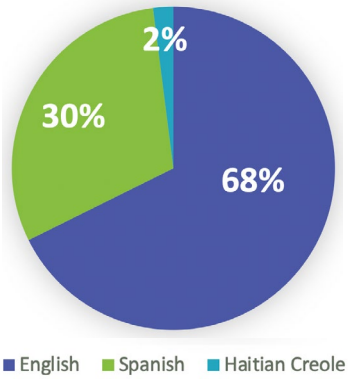
Primary Language Spoken by Staff



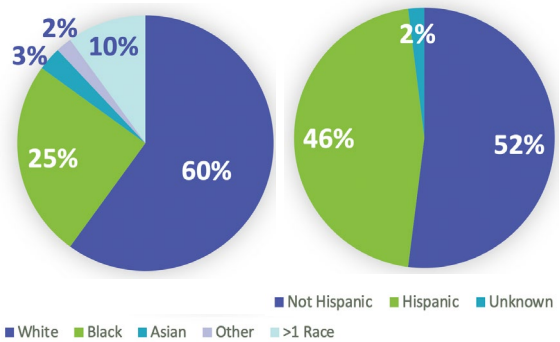
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



HOLMES COUNTY

13% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

23

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **23** # OF ESTIMATED NEED **174**

DOMAINS AT RISK

Adverse Perinatal Outcomes

Child Maltreatment

INDICATORS IN DOMAIN

Maternal Mortality

Pre-term Birth

Child Maltreatment

OTHER INDICATORS AT RISK

Unemployment

Tobacco

Kindergarten readiness

A CLOSER LOOK

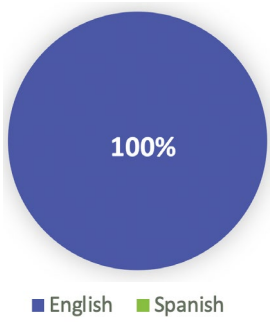
"Unable to provide Home Visiting due to COVID 19."
– Home visiting staff survey

HOLMES COUNTY'S MATERNAL MORTALITY DEATH RATIO PER 100,000 LIVE BIRTHS IS **MORE THAN TWICE** *THAT OF THE STATE DEATH RATIO, AT 50.0 DEATHS, COMPARED TO THE STATE RATIO OF 21.3 DEATHS PER 100,000.*

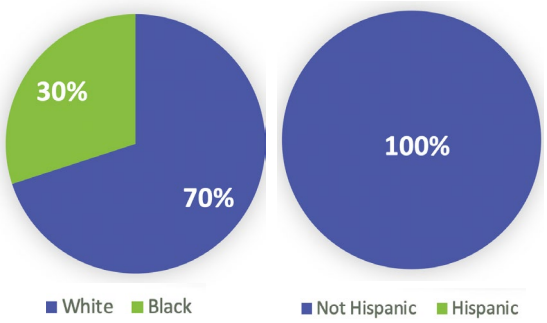
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff

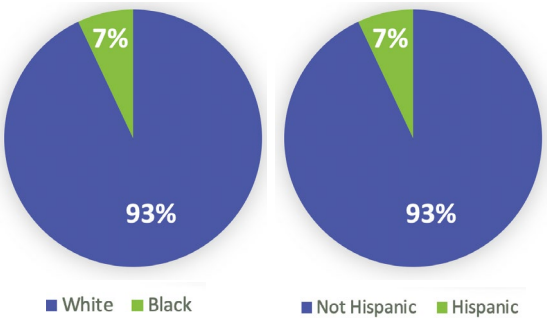


Race and Ethnicity of Staff



Primary Language Spoken by Participants

Race and Ethnicity of Participants



JACKSON COUNTY

32% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

98 Healthy Families Florida

10 Nurse-Family Partnership — Helping First-Time Parents Succeed®

TOTAL FUNDED SLOTS **108** # OF ESTIMATED NEED **339**

INDICATORS AT RISK

- Poverty
- Educational Attainment
- Pre-term Birth
- Unemployment
- Tobacco Use
- Small for Gestational Age
- Income Equality

Note: Jackson County has been included with the justification that over 30% of the births in the county are in high-risk tracts.

A CLOSER LOOK

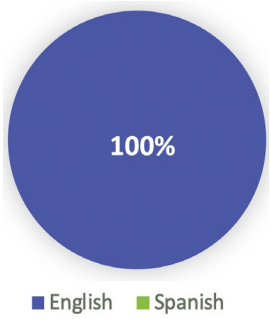
> Lack of internet in rural areas.
>
> – Home Visiting staff survey

JACKSON COUNTY HAS A **HIGH RATE OF POVERTY**, WITH 38.2% OF FAMILIES WITH RELATED CHILDREN OF HOUSEHOLD UNDER 5 YEARS OF AGE THAT ARE IN POVERTY, COMPARED TO THE STATE AVERAGE OF 13.7%.

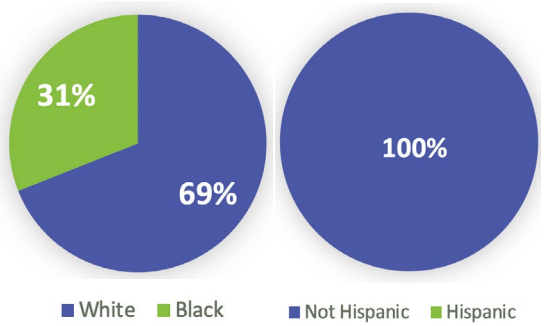
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

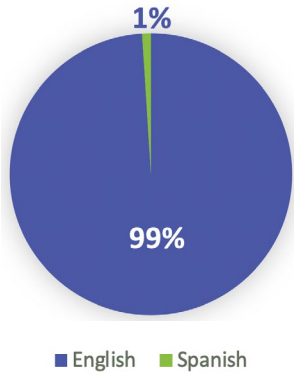
Primary Language Spoken by Staff



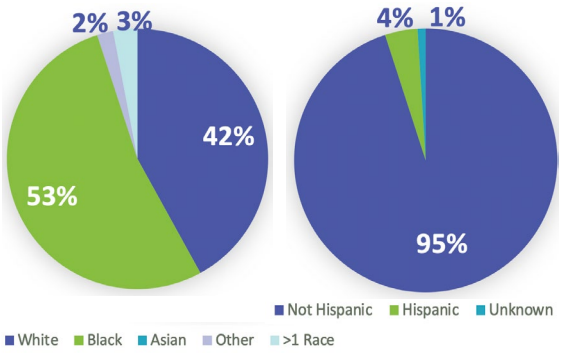
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



JEFFERSON COUNTY

7% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

7

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **7**

OF ESTIMATED NEED **98**

DOMAINS AT RISK

- Adverse Perinatal Outcomes
- Substance Use Disorder
- Special Populations

INDICATORS IN DOMAIN

- Small for Gestational Age
- Pre-term Birth
- Low Birth Weight
- Alcohol
- Marijuana
- Illicit Drugs
- Pain Relievers
- Agricultural Industry

OTHER INDICATORS AT RISK

- Kindergarten Readiness
- Juvenile Arrests

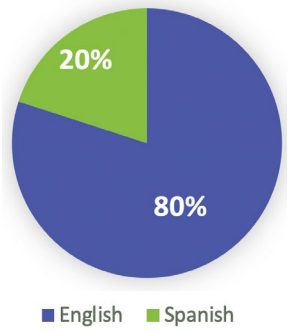
A CLOSER LOOK

JEFFERSON COUNTY HAS A **HIGH RATE OF POVERTY**, *WITH NEARLY HALF (45.5%) OF HOUSEHOLDS WITH CHILDREN UNDER AGE 5 IN POVERTY, COMPARED TO THE STATE AVERAGE OF 13.7%.*

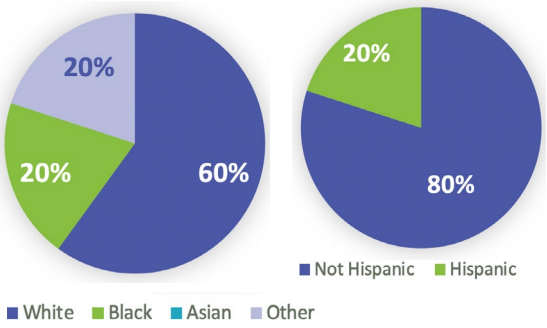
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff

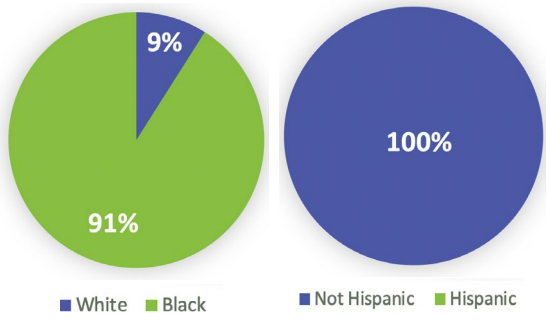


Race and Ethnicity of Staff



Primary Language Spoken by Participants

Race and Ethnicity of Participants



LAFAYETTE COUNTY

2% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

2

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **2**

OF ESTIMATED NEED **108**

INDICATORS AT RISK

Poverty

Educational Attainment

Unemployment

Tobacco

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

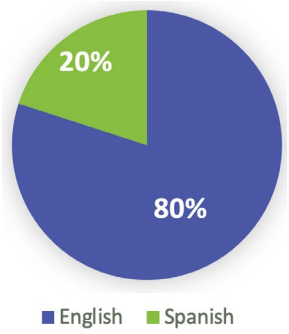
LAFAYETTE COUNTY HAS THE **HIGHEST RATE OF POVERTY** OF ALL REPORTED COUNTIES, WITH **ALMOST ALL (94.3 %)** OF HOUSEHOLDS WITH RELATED CHILDREN UNDER AGE 5 LIVING IN POVERTY, IN CONTRAST TO THE STATE AVERAGE OF 13.7%. LAFAYETTE COUNTY ALSO HAS THE 4TH HIGHEST HIRED FARMWORKER POPULATION IN THE STATE.

ESTIMATED MIECHV NEED MET

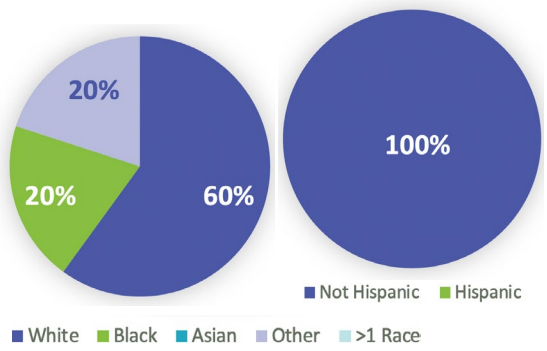
< 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

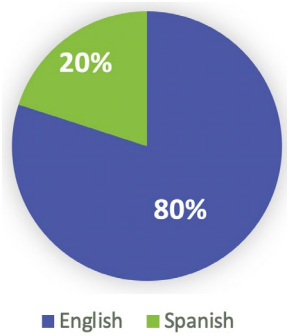
Primary Language Spoken by Staff



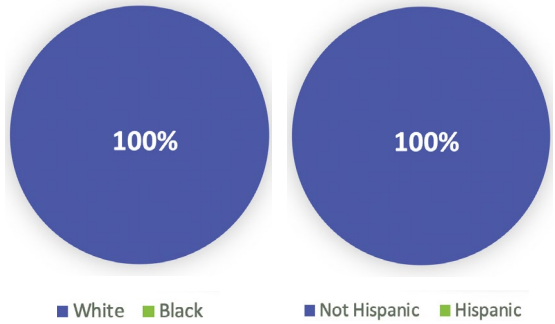
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



LAKE COUNTY

10% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

109

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **109** # OF ESTIMATED NEED **1079**

INDICATORS AT RISK

Poverty	Income Equality	Pre-term Birth
Unemployment	Home Ownership	Tobacco
Educational Attainment	Small for Gestational Age	

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

> We need funding and the ability to hire more workers to service the Lake County area. Lake County has a population of about 700,000 people and my program only has 5 workers - many people are not receiving needed services.
>
> – Stakeholder survey

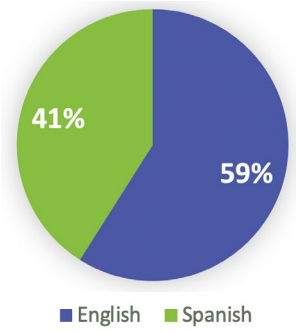
> I work with non-English speaking families and they need access and information on home visiting services in their home language.
>
> – Home visitor staff survey

ONE CENSUS TRACT IN LAKE COUNTY HAS HIGHER THAN AVERAGE RATES OF UNEMPLOYMENT, INCOME INEQUALITY, HIGH SCHOOL DROPOUT, HOME RENTAL, AND SMALL FOR GESTATIONAL AGE BIRTHS. OTHER TRACTS HAVE **2-4 TIMES** *THE AVERAGE RATES OF SMOKING DURING PREGNANCY OR BIRTHS IN POVERTY.*

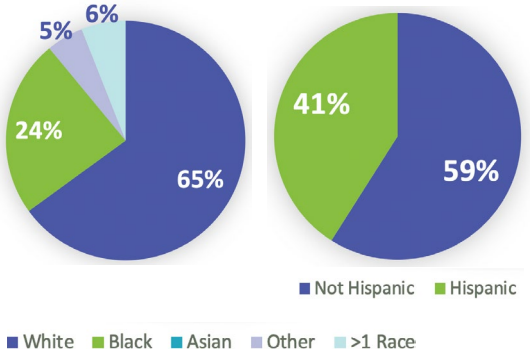
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

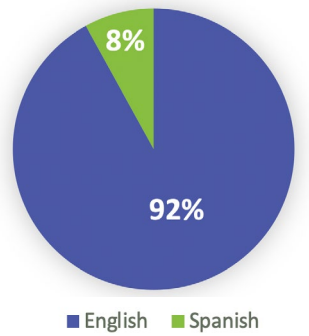
Primary Language Spoken by Staff



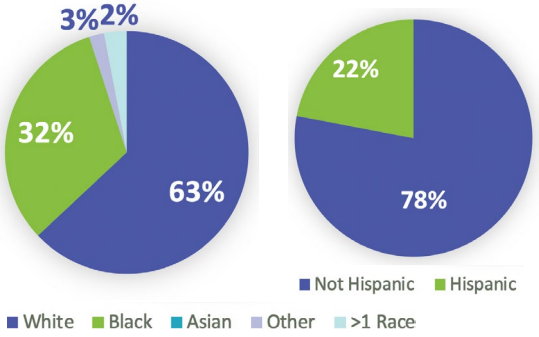
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



LEE COUNTY

5%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	Nurse-Family Partnership
125	65

TOTAL FUNDED SLOTS **190** # OF ESTIMATED NEED **3820**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

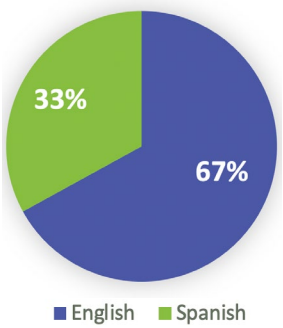
A CLOSER LOOK

LEE COUNTY HAS A **HIGHER** *PERCENTAGE OF CHILDREN "NOT READY FOR KINDERGARTEN" THAN THE STATE AVERAGE, AT 59.1% COMPARED TO THE STATE AVERAGE OF 46.6%. THIS IS THE* **FIFTH HIGHEST** *OF ALL REPORTED COUNTIES.*

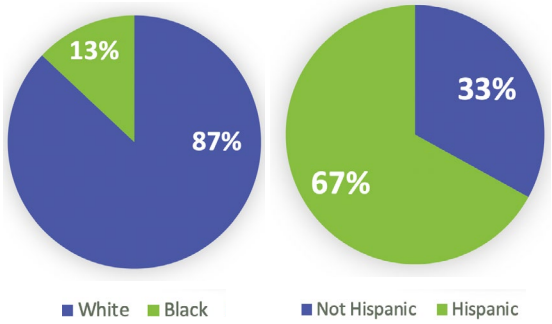
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

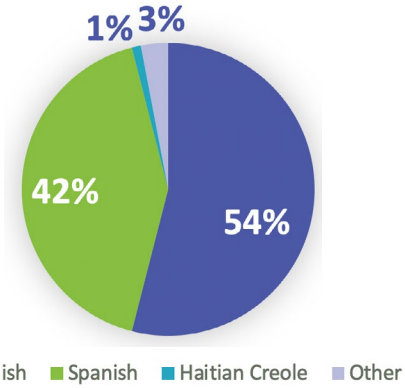
Primary Language Spoken by Staff



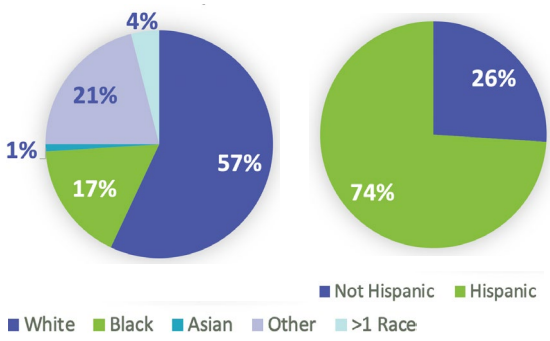
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



LEON COUNTY

12% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

107

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **107** # OF ESTIMATED NEED **884**

INDICATORS AT RISK

Poverty	Income Equality	Pre-term Birth
Unemployment	Home Ownership	Tobacco
Educational Attainment	Small for Gestational Age	

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

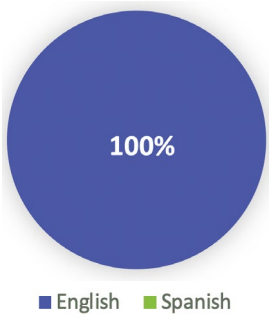
A CLOSER LOOK

LEON COUNTY HAS THE **THIRD HIGHEST** RATE OF CRIME REPORTS OF ALL COUNTIES AT 3,845 REPORTED CRIMES PER 100,000 RESIDENTS, FOLLOWING BAY COUNTY. THIS IS MUCH HIGHER THAN THE STATE AVERAGE OF 2,551 CRIMES PER 100,000 RESIDENTS.

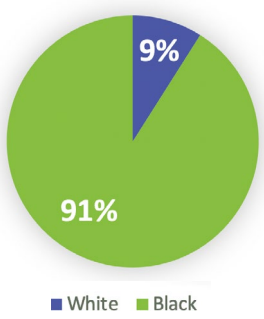
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

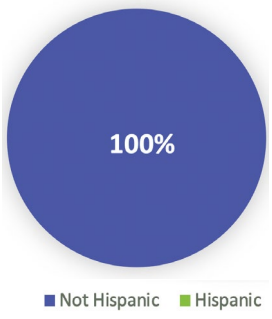
DEMOGRAPHICS

Primary Language Spoken by Staff

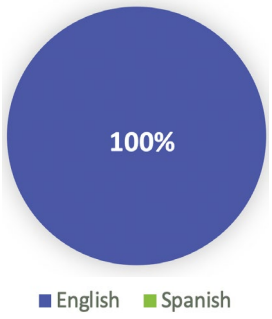


Race and Ethnicity of Staff

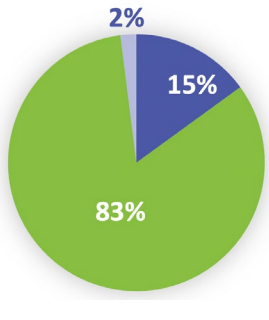


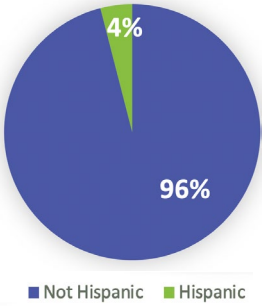


Primary Language Spoken by Participants



Race and Ethnicity of Participants





White Black Asian Other >1 Race

LEVY COUNTY

19% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

34 — Healthy Families Florida

11 — Early Head Start

TOTAL FUNDED SLOTS **45**

OF ESTIMATED NEED **232**

DOMAINS AT RISK

- Family Community Violence
- Child Health & Development
- Special Populations

INDICATORS IN DOMAIN

- Crime Reports
- Intimate Partner Violence
- Hospitalizations for Asthma
- Hospitalizations for Unintentional Injury
- Agricultural Industry

OTHER INDICATORS AT RISK

- Illicit Drugs
- Pain Relievers

A CLOSER LOOK

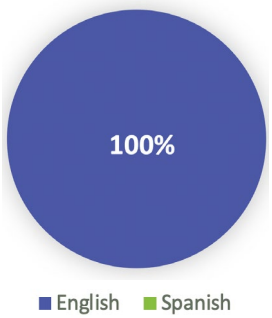
> Home visiting services are a powerful tool in breaking the cycle of generational poverty, preventing child abuse, and increasing the quality of parenting.
>
> – Stakeholder survey

*LEVY COUNTY HAS THE **HIGHEST** REPORTED INTIMATE PARTNER VIOLENCE RATE PER 100,000 RESIDENTS OF ALL REPORTED COUNTIES AT 1318/100,000, IN CONTRAST TO THE STATE AVERAGE OF 503/100,000.*

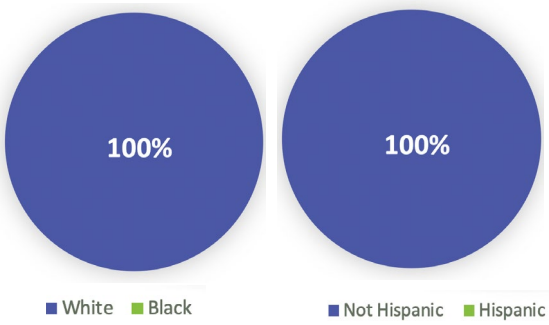
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

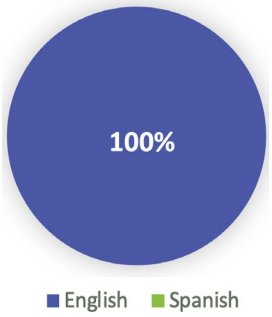
Primary Language Spoken by Staff



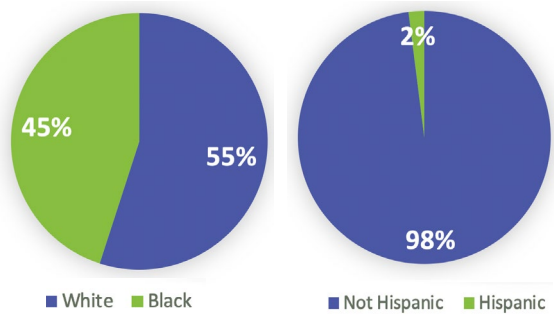
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



MADISON COUNTY

17% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

38

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **38** # OF ESTIMATED NEED **230**

DOMAINS AT RISK

- Socioeconomic Status
- Adverse Perinatal Outcomes
- Substance Use Disorder
- Special Populations

INDICATORS IN DOMAIN

High School Dropout	Infant Mortality	Illicit drugs
Income Inequality	Low Birth Weight	Pain relievers
Small for Gestational Age	Alcohol	Agricultural Industry
	Marijuana	

A CLOSER LOOK

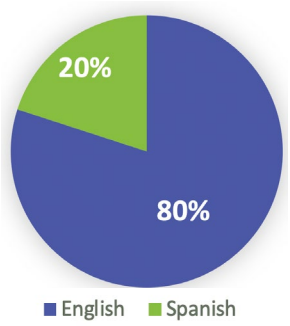
> [Additional services] allow us to be more in touch with our community's needs. Not just what is presented at an office visit.
>
> – Stakeholder survey

MADISON COUNTY'S INFANT MORTALITY RATE IS 10.4 PER 1000 COMPARED TO THE STATE AVERAGE OF 6.1 PER 1000.

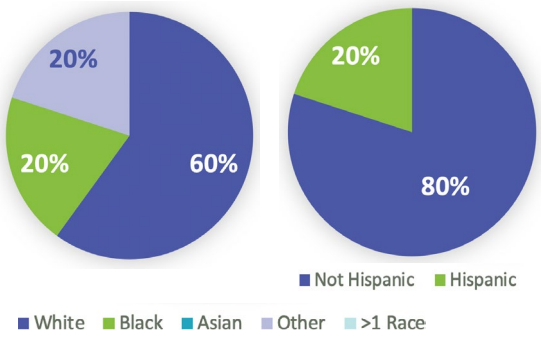
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

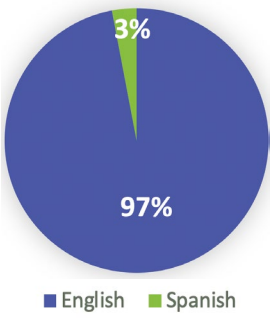
Primary Language Spoken by Staff



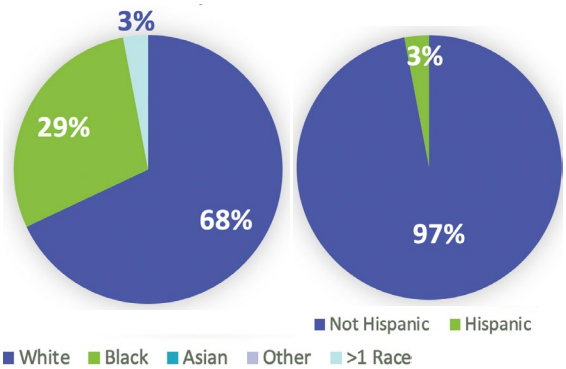
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



MANATEE COUNTY

32% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPY USA	PALS Play and Learning Strategies	Parents as Teachers
113	60	24	130

TOTAL FUNDED SLOTS **464** # OF ESTIMATED NEED **1464**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco Use
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

> I wouldn't be able to finish school like I am without the help of ELC [the Early Learning Coalition] & food stamps. I am truly grateful.
>
> – Parent survey

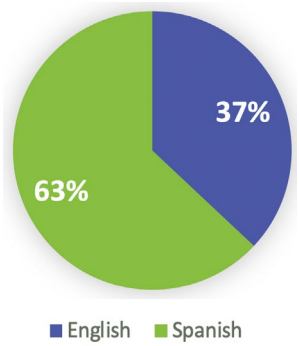
> We have an adequate amount of providers spanning various age groups with different focus areas, however program restraints make it difficult to serve all families. Local programs must have flexibility in their program design and participant requirements/expectations.
>
> – Home visiting staff survey

MANATEE COUNTY HAS THE **7TH HIGHEST** *RATE OF CHILD MALTREATMENT IN THE STATE, WITH 18.5 PER 1,000, COMPARED TO THE FLORIDA AVERAGE OF 10.3 PER 1,000.*

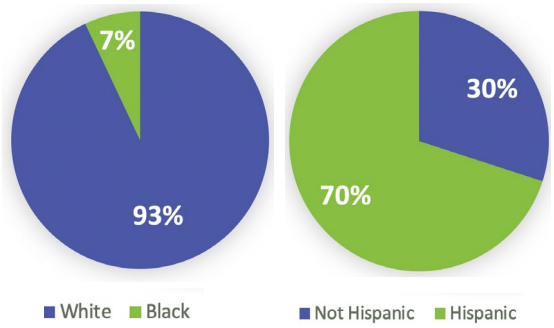
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

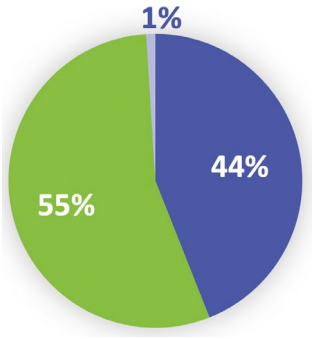
Primary Language Spoken by Staff



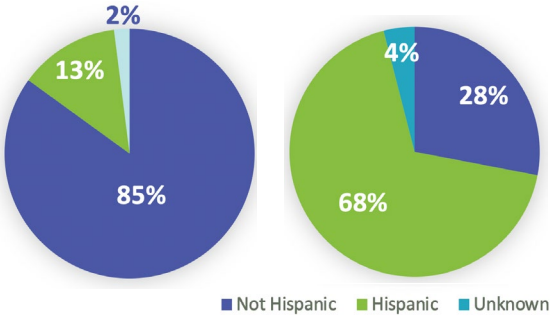
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



MARION COUNTY

16%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPY USA	Early Head Start	Parents as Teachers
159	50	22	80

TOTAL FUNDED SLOTS **311** # OF ESTIMATED NEED **1939**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco Use
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

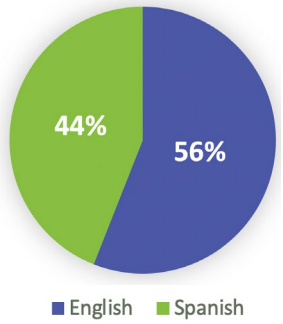
> Additional one-on-one services are always a plus.
> – Stakeholder survey

MARION COUNTY HAS THE **THIRD HIGHEST** RATE OF INTERPERSONAL VIOLENCE IN THE STATE, WITH 983.6 PER 100,000.

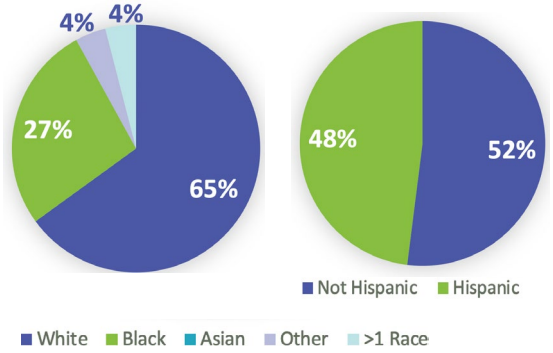
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

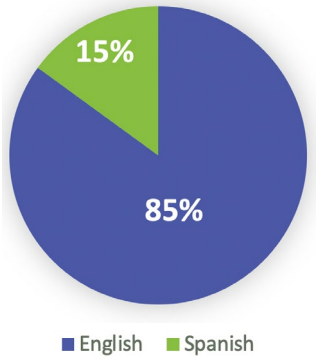
Primary Language Spoken by Staff



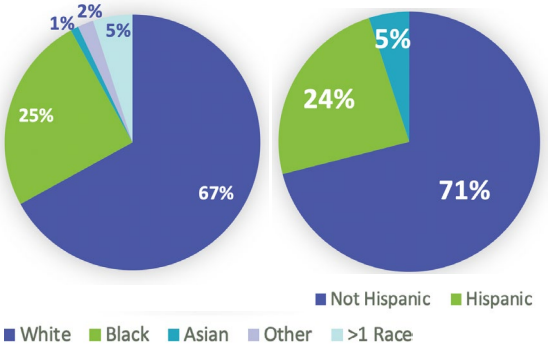
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



MARTIN COUNTY

100% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

265	12	15
HEALTHY FAMILIES FLORIDA	Nurse-Family Partnership	Parents as Teachers

TOTAL FUNDED SLOTS **292** # OF ESTIMATED NEED **22**

INDICATORS AT RISK

- Poverty
- Home Ownership
- Pre-term Birth
- Unemployment
- Educational Attainment
- Tobacco Use
- Income Equality

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

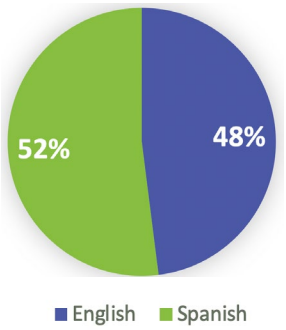
A CLOSER LOOK

MARTIN COUNTY'S INCARCERATED POPULATION IS 606.9 PER 100,000, COMPARED TO THE STATE RATE OF 414.9 PER 100,000.

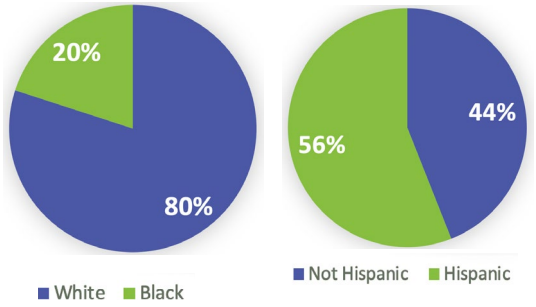
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

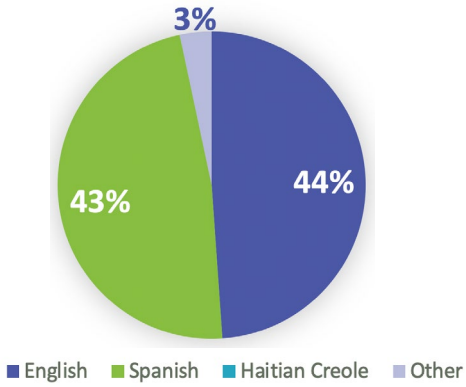
Primary Language Spoken by Staff



Race and Ethnicity of Staff



Primary Language Spoken by Participants



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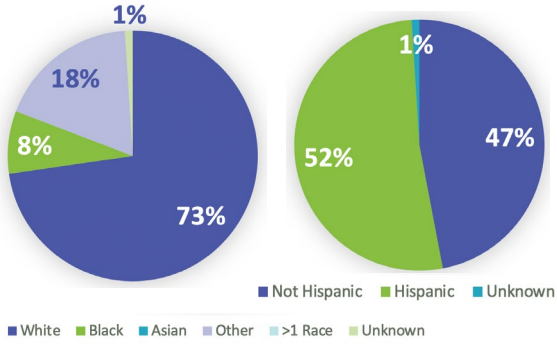


MIAMI-DADE COUNTY

7%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPY USA	Nurse-Family Partnership	Parents as Teachers
555	190	200	160

TOTAL FUNDED SLOTS **1105** # OF ESTIMATED NEED **16522**

INDICATORS AT RISK

Poverty	Home Ownership	Pre-term Birth
Unemployment	Educational Attainment	Small for Gestational Age
Income Equality		

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

> Yes, please pass legislation for grants to help with childcare.
>
> – Parent survey

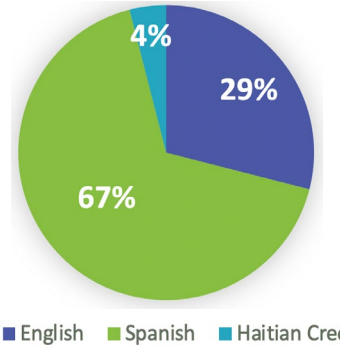
> Many children and families affected by financial feasibility to enroll their children in childcare, private institutions are no longer available and even a means of transportation becomes a roadblock to the current programs that may be provided by the state. As a result, a home visiting demand is a reality of reaching and supporting families.
>
> – Stakeholder survey

MIAMI-DADE COUNTY HAS **ONE OF THE LOWEST** *RATES OF CHILD MALTREATMENT IN THE STATE, WITH 4.8 PER 1000. HOWEVER, THE CRIME RATE IS THE* **5TH HIGHEST** *IN THE STATE, WITH 3516.2 PER 100,000 RESIDENTS.*

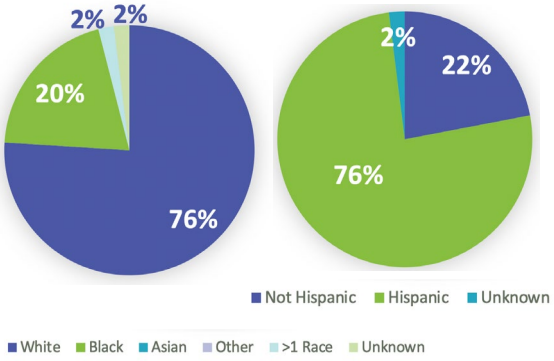
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

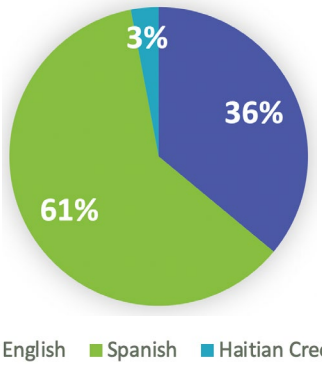
Primary Language Spoken by Staff



Race and Ethnicity of Staff



Primary Language Spoken by Participants



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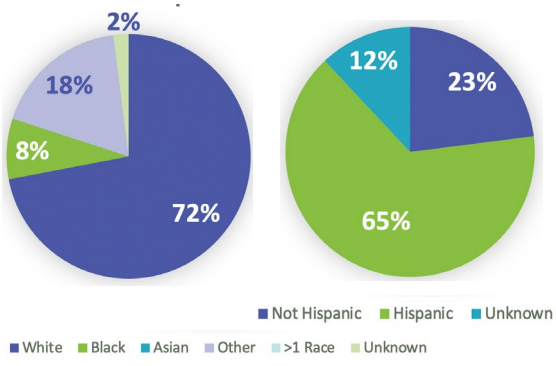


OKEECHOBEE COUNTY

7%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

110 HEALTHY FAMILIES FLORIDA

35 Parents as Teachers

TOTAL FUNDED SLOTS **145** # OF ESTIMATED NEED **491**

DOMAINS AT RISK

- Family Community Violence
- Child Maltreatment
- Child Health & Development
- Special Populations

INDICATORS IN DOMAIN

- Crime Reports
- Juvenile Arrests
- Child Maltreatment
- Kindergarten Readiness
- Hospitalization for Unintentional Injuries
- Incarceration
- Agricultural Population

OTHER INDICATORS AT RISK

High School Dropout

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

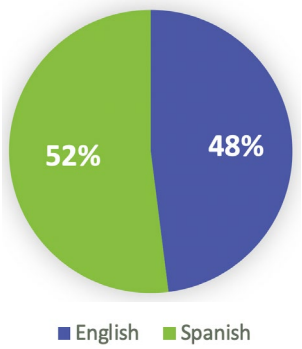
A CLOSER LOOK

OKEECHOBEE COUNTY HAS **OVER TWICE** *AS MANY UNINTENTIONAL INJURY HOSPITALIZATIONS AS THE STATE AVERAGE, WITH 383.9 PER 100,000 VS. 160.3 PER 100,000.*

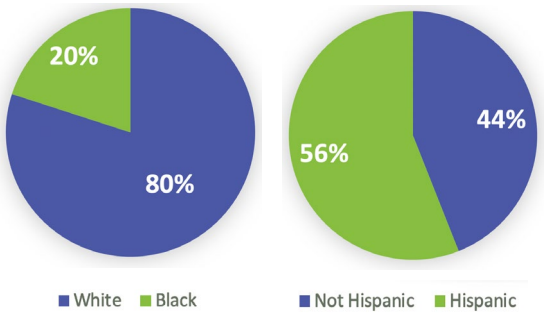
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

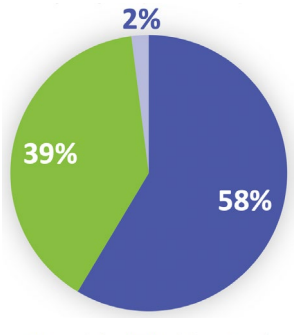
Primary Language Spoken by Staff



Race and Ethnicity of Staff



Primary Language Spoken by Participants



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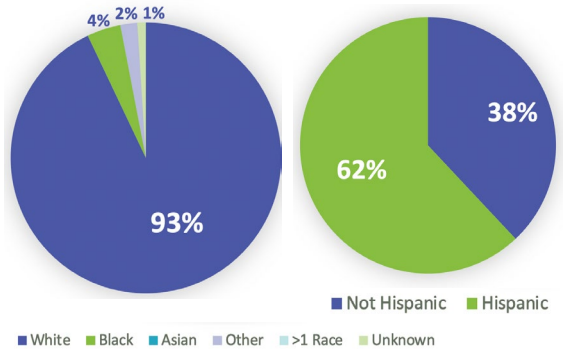


ORANGE COUNTY

7% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

594 Healthy Families Florida

87 Nurse-Family Partnership — Helping First-Time Parents Succeed®

TOTAL FUNDED SLOTS **681** # OF ESTIMATED NEED **9402**

INDICATORS AT RISK

- Poverty
- Home Ownership
- Pre-term Birth
- Unemployment
- Educational Attainment
- Small for Gestational Age
- Income Equality

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

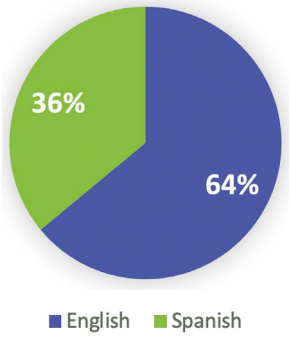
> Participate with local hospitals, child welfare agencies, and local mental health.
>
> – Stakeholder survey related to participating with community efforts to address gaps and barriers to service.

ORANGE COUNTY HAS THE **4TH HIGHEST** CRIME RATE IN THE STATE, WITH 3524.3 PER 100,000 RESIDENTS, COMPARED TO THE STATE RATE OF 2551/100,000.

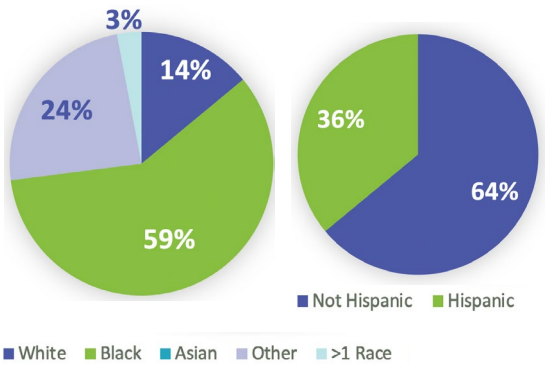
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



Race and Ethnicity of Staff



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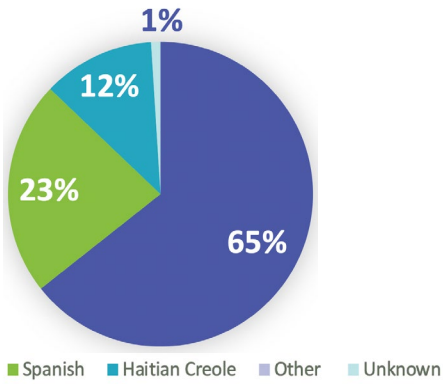

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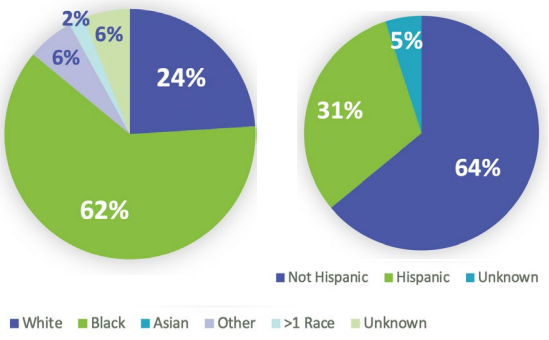


PALM BEACH COUNTY

17% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPY USA	Nurse-Family Partnership	child first
350	120	200	330

TOTAL FUNDED SLOTS **1100** # OF ESTIMATED NEED **5865**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

> When program is at capacity, clients are waitlisted or rejected. Need expanding the nurse home visiting program.
>
> – Stakeholder survey

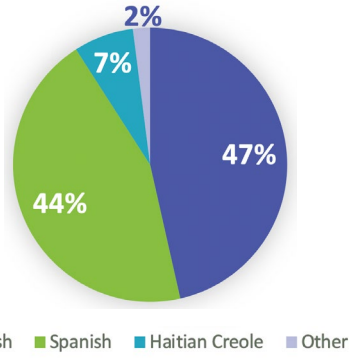
> Services are currently exceptional, there is always room for additional services.
>
> – Home visiting staff survey

PALM BEACH COUNTY'S UNEMPLOYED POPULATION IS **OVER TWICE** THE STATE AVERAGE, AT 6.5% COMPARED TO 3.1%.

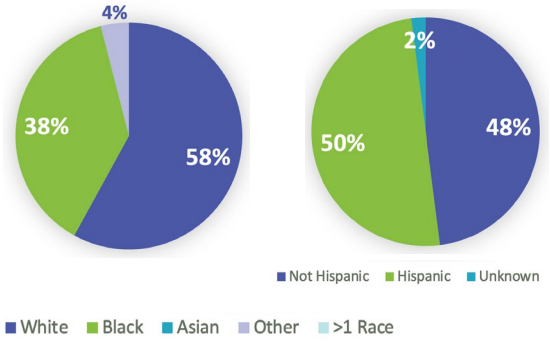
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



Race and Ethnicity of Staff



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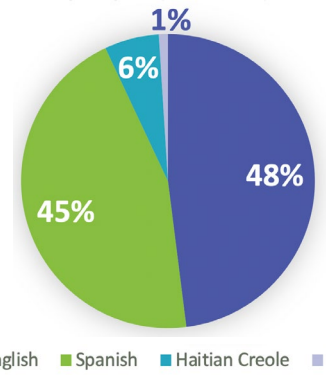

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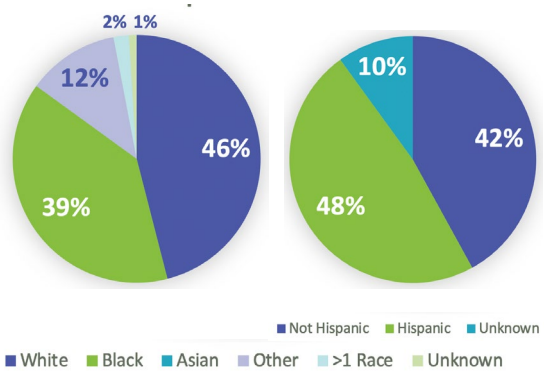


PASCO COUNTY

16%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPYUSA	Early Head Start
263	40	56

TOTAL FUNDED SLOTS **359** # OF ESTIMATED NEED **2287**

INDICATORS AT RISK

- Poverty
- Home Ownership
- Pre-term Birth
- Unemployment
- Educational Attainment
- Small for Gestational Age
- Income Equality

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

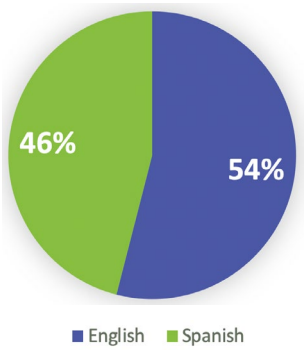
A CLOSER LOOK

TOBACCO USE AMONG PREGNANT WOMEN IN PASCO COUNTY IS **MORE THAN DOUBLE** THE STATE AVERAGE, AT 9% COMPARED TO 4.4%.

ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



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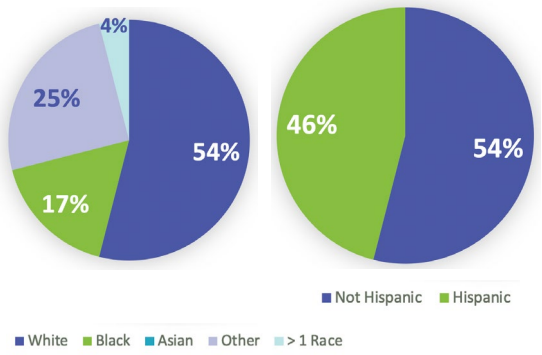
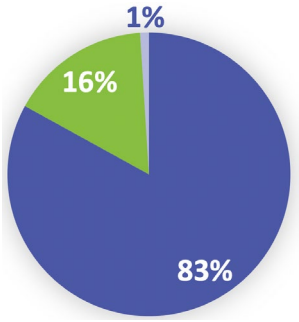
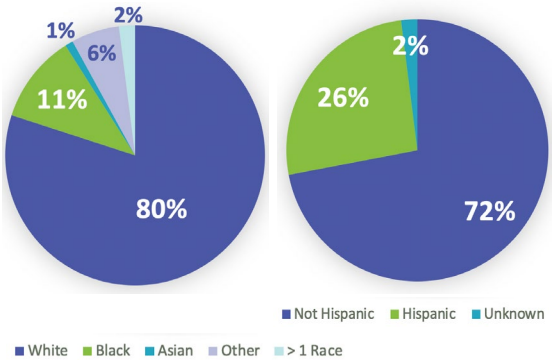


Primary Language Spoken by Participants



Race and Ethnicity of Participants



PINELLAS COUNTY

68% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

Healthy Families Florida	HIPPY USA	Nurse-Family Partnership	Parents as Teachers
1106	115	150	126

TOTAL FUNDED SLOTS **1497** # OF ESTIMATED NEED **2203**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco Use
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

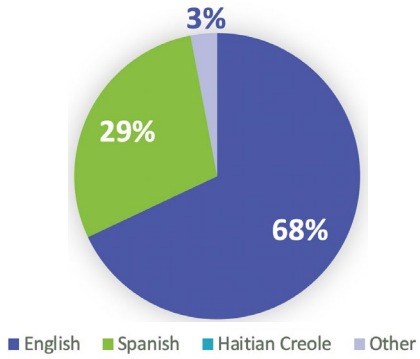
> More father involvement.
>
> – Home visitor staff survey when asked about strengths of home visiting programs in this county.

PINELLAS HAS THE **9TH HIGHEST** JUVENILE ARREST RATE IN THE STATE, AT 4022.7 PER 100,000.

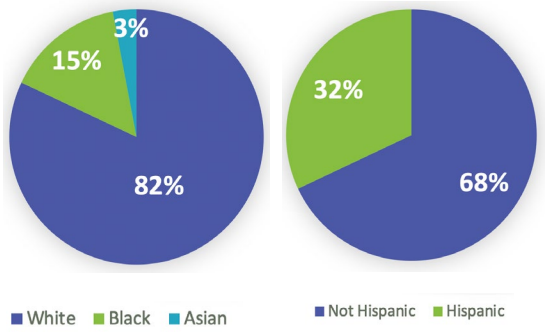
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

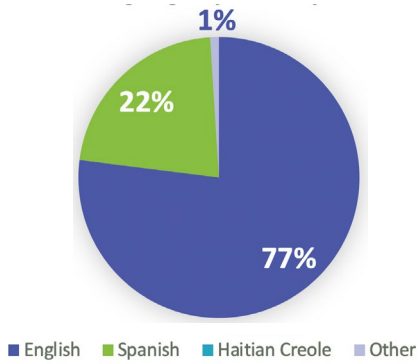
Primary Language Spoken by Staff



Race and Ethnicity of Staff



Primary Language Spoken by Participants



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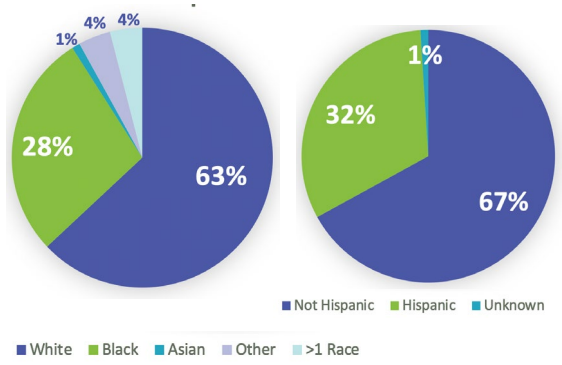


POLK COUNTY

14%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

602 — Healthy Families Florida

125 — Nurse-Family Partnership (Helping First-Time Parents Succeed®)

TOTAL FUNDED SLOTS **727** # OF ESTIMATED NEED **5179**

INDICATORS AT RISK

Poverty | Income Equality | Pre-term Birth

Unemployment | Home Ownership | Tobacco Use

Educational Attainment | Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

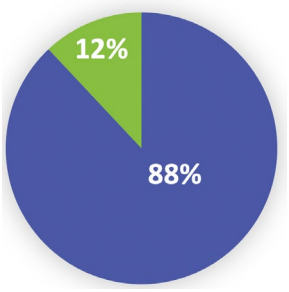
> Demand [for additional services] is high and need is higher.
>
> – Home visiting staff survey

POLK COUNTY'S UNEMPLOYED POPULATION IS **OVER TWO TIMES** THE STATE AVERAGE, AT 6.9% VERSUS 3.1%.

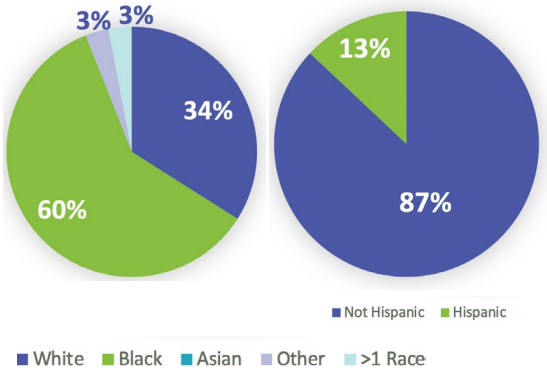
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

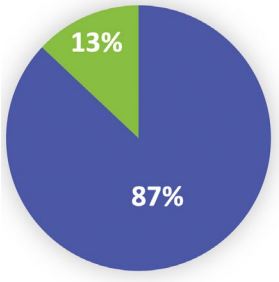
Primary Language Spoken by Staff



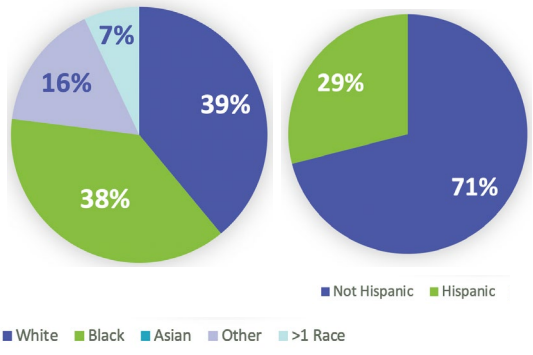
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



PUTNAM COUNTY

14%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

146 — HEALTHY FAMILIES FLORIDA

113 — Parents as Teachers

TOTAL FUNDED SLOTS **166** # OF ESTIMATED NEED **505**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco Use
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

"I participate in a monthly community safety alliance meeting in Putnam that links community resources and programs with each other."

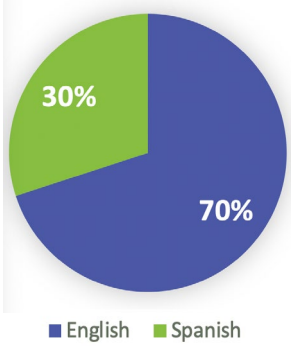
– Home visiting staff survey

PUTMAN COUNTY'S UNEMPLOYED POPULATION IS **OVER THREE TIMES** AS LARGE AS THE STATE AVERAGE, AT 10.5% VERSUS 3.1%.

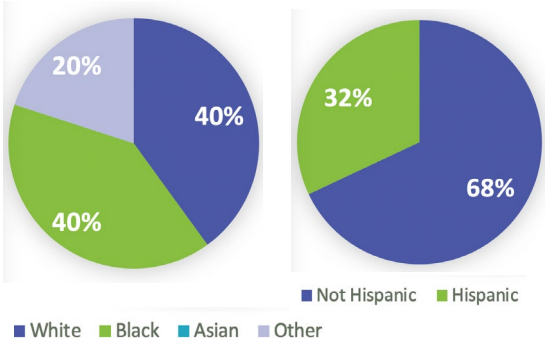
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



Race and Ethnicity of Staff



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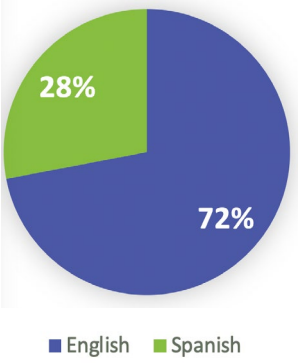
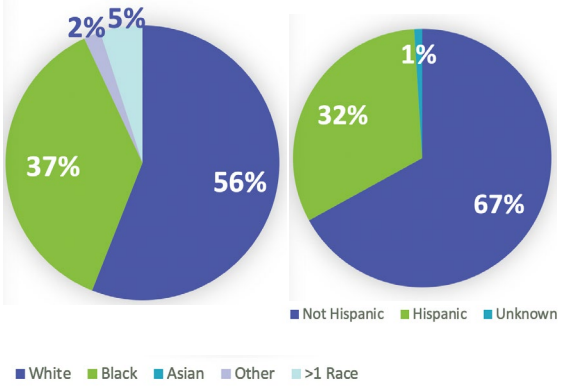


Race and Ethnicity of Participants



ST. LUCIE

13% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

176 HEALTHY FAMILIES FLORIDA

38 Nurse-Family Partnership — Helping First-Time Parents Succeed®

TOTAL FUNDED SLOTS **214** # OF ESTIMATED NEED **1692**

INDICATORS AT RISK

Poverty	Income Equality	Pre-term Birth
Unemployment	Home Ownership	Tobacco Use
Educational Attainment	Small for Gestational Age	

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

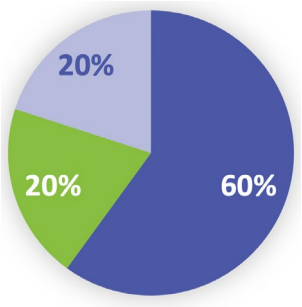
> This county has a great need with limited resources.
>
> – Home visiting staff survey

ST. LUCIE COUNTY HAS **NEARLY TWICE** THE RATE OF JUVENILE ARRESTS AS FLORIDA, WITH 4602.5 PER 100,000 VS. 2,350.6 PER 100,000.

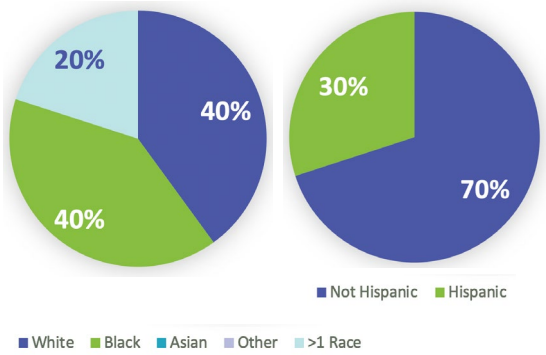
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

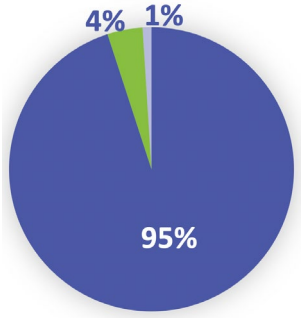
Primary Language Spoken by Staff



Race and Ethnicity of Staff



Primary Language Spoken by Participants



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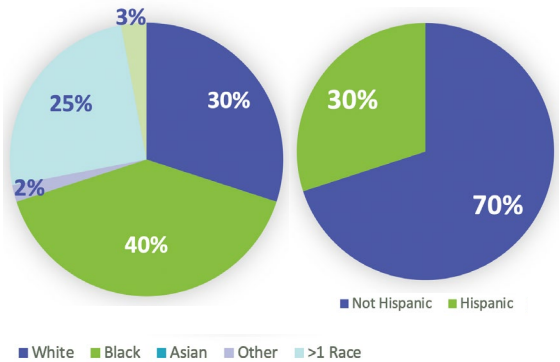


SUWANNEE COUNTY

4%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

22

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **22** # OF ESTIMATED NEED **553**

INDICATORS AT RISK

Poverty

Educational Attainment

Pre-term Birth

Unemployment

Income Equality

Tobacco

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

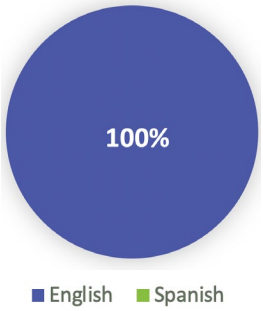
TOBACCO USE DURING PREGNANCY IN SUWANNEE COUNTY IS **OVER THREE TIMES** *AS HIGH AS THE STATE AVERAGE, AT 15.6% COMPARED TO 4.4%.*

ESTIMATED MIECHV NEED MET

< 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



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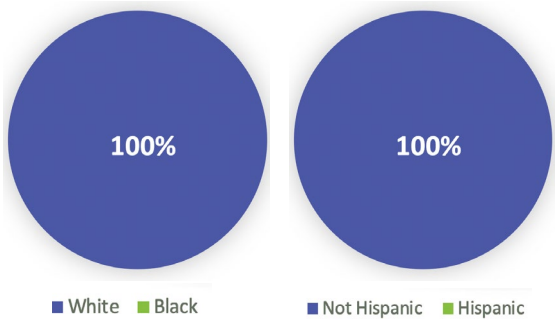

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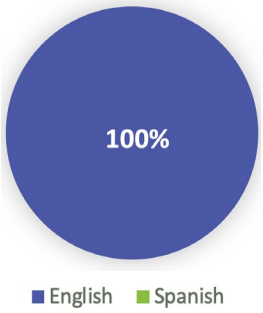

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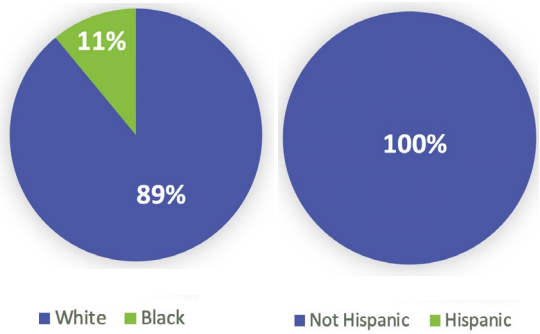


TAYLOR COUNTY

9%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

24

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **24** # OF ESTIMATED NEED **280**

DOMAINS AT RISK

- Substance Use Disorder
- Child Maltreatment
- Family Community Violence

INDICATORS IN DOMAIN

Alcohol	Pain Relievers	Crime Reports
Marijuana	Tobacco	Juvenile Arrests
Illicit Drugs	Child Maltreatment	Intimate Partner Violence

OTHER INDICATORS AT RISK

- ALICE households
- Hospitalizations for Unintentional Injuries

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

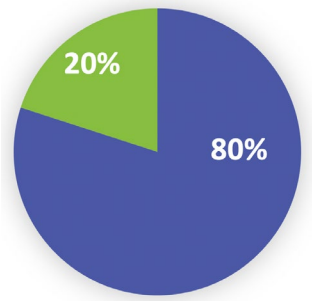
> Many in our community do not have transportation or have small children at home due to COVID-19, so it is difficult for them to get to appointments.
>
> – Stakeholder survey

TAYLOR COUNTY HAS THE **SECOND HIGHEST** RATE OF REPORTED INTIMATE PARTNER VIOLENCE IN THE STATE, WITH 996.3 PER 100,000 COMPARED TO THE STATE RATE OF 503/100,000.

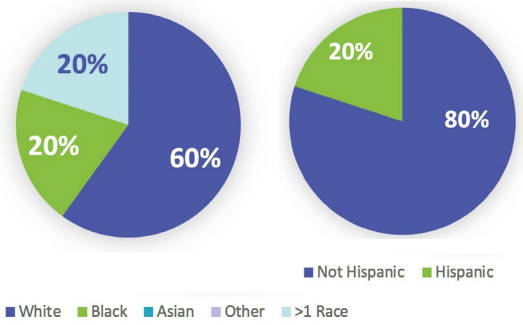
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



Race and Ethnicity of Staff



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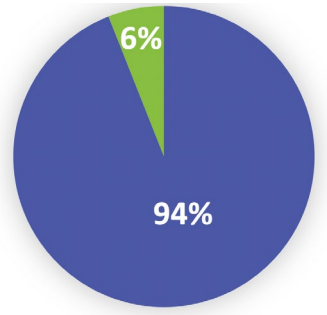

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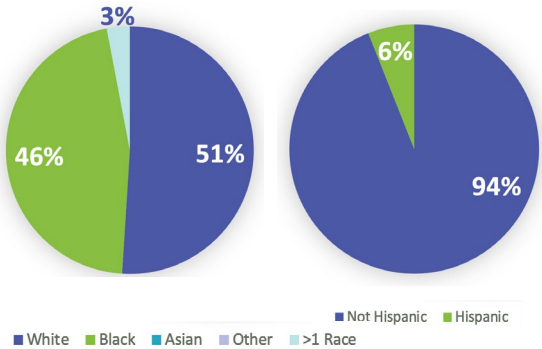


UNION COUNTY

6% ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

5

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **88** # OF ESTIMATED NEED **553**

INDICATORS AT RISK

- Poverty
- Educational Attainment
- Pre-term Birth
- Unemployment
- Income Equality
- Tobacco

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

A CLOSER LOOK

"We have the capacity to serve more families; it is difficult getting the word out to the families that these services are available to them."

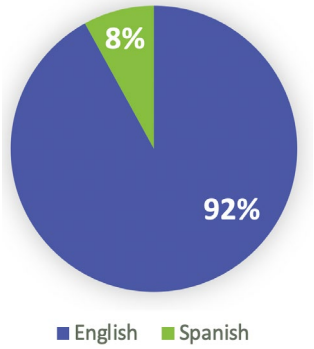
– Stakeholder survey

UNION COUNTY HAS THE **HIGHEST HIGH SCHOOL DROPOUT RATE** OF ANY COUNTY IN FLORIDA (18.2%).

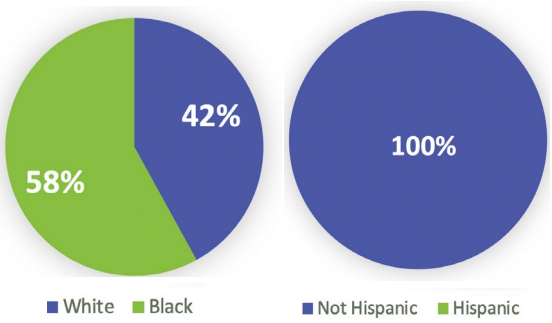
ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

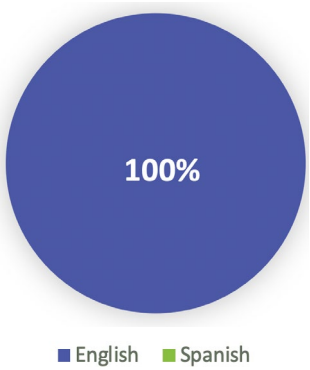
Primary Language Spoken by Staff



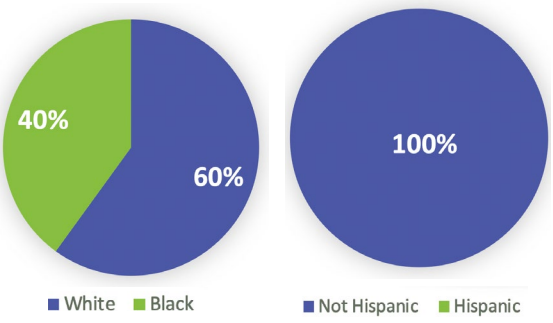
Race and Ethnicity of Staff



Primary Language Spoken by Participants



Race and Ethnicity of Participants



VOLUSIA COUNTY

4%
ESTIMATED MIECHV NEED MET

EVIDENCE-BASED HOME VISITING PROGRAMS

133

HEALTHY FAMILIES FLORIDA

TOTAL FUNDED SLOTS **133** # OF ESTIMATED NEED **3786**

INDICATORS AT RISK

- Poverty
- Income Equality
- Pre-term Birth
- Unemployment
- Home Ownership
- Tobacco
- Educational Attainment
- Small for Gestational Age

Note: A census tract was considered a high-need tract if it had 3 of the 8 indicators with a >1 z-score. A county was considered high-need if the number of births in high-need tracts was ≥150 in 2018.

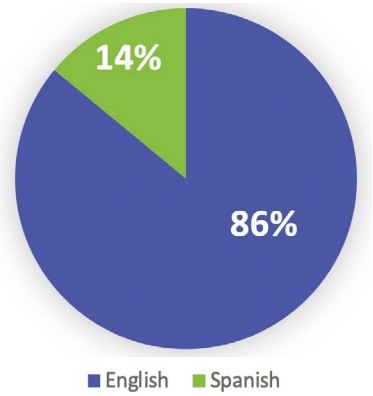
A CLOSER LOOK

VOLUSIA COUNTY HAS THE **6TH HIGHEST** INTIMATE PARTNER VIOLENCE RATE IN THE STATE, WITH 815.1 PER 100,000 COMPARED TO 503.4/100,000.

ESTIMATED MIECHV NEED MET: < 25% | 25% - 50% | 50% - 75% | > 75%

DEMOGRAPHICS

Primary Language Spoken by Staff



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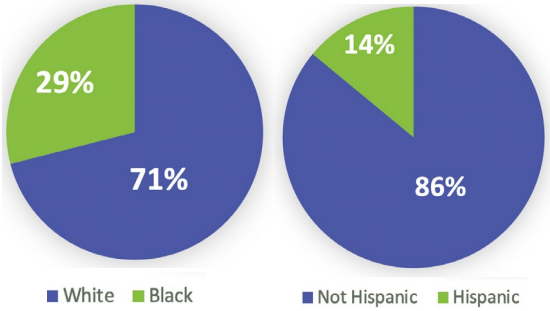
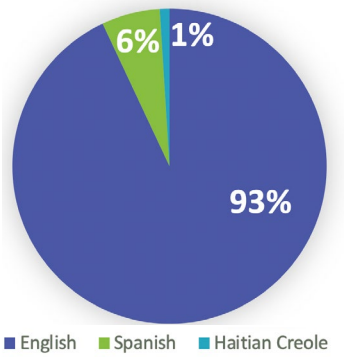
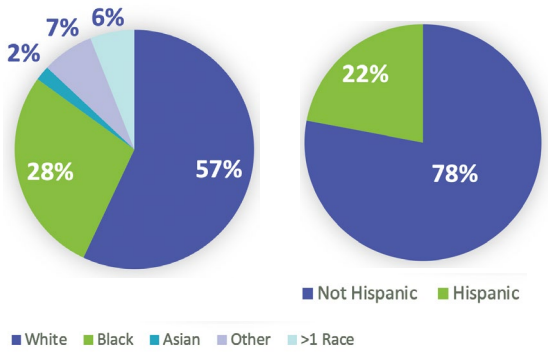


Primary Language Spoken by Participants



Race and Ethnicity of Participants



APPENDIX 6

SURVEY QUESTIONS

Home Visiting Program Survey

Name of home visiting model
County
City or community
Name of Organization
Contact person
Contact information
Role

- Administrator
- Supervisor
- Other, please specify

Community Resources

For each **high-risk** county that your program serves, please answer the following questions related **to community resources for early childhood services (**early intervention services for children under the age of 5).

1. Are there sufficient **providers** to serve your clients with early childhood services?
   Yes, *if yes skip to question 2.*
   No, *skip to question 3.*
   Don't know
   Provide detail box
2. Please select all the early childhood services **provided** in your county that could meet the needs of your families.
   - Early Head Start
   - Head start
   - Quality childcare providers
   - Part C - Early Steps
   - Part B and Transition - Local education agencies (LEA)
   - Infant and toddler mental health services
   - Mental health services for 3-5-year-old children
   - Pediatric health centers/clinics
   - Speech and language therapeutic services
   - Other, please specify
3. What programs do you think are missing or inaccessible? *Check all that apply*.
   - Early Head Start
   - Head start
   - Quality childcare providers
   - Part C - Early Steps
   - Part B and Transition - Local education agencies (LEA)
   - Infant and toddler mental health services
   - Mental health services for 3-5-year-old children
   - Pediatric health centers/clinics
   - Speech and language therapeutic services
   - Other, please specify
4. Does this county have coordinating entities or councils for local early childhood systems?
   Yes, *if yes, skip to question 5.*
   No, *skip to question 6.*

Don't know

5. What types of entities or programs coordinate or contribute to the local early childhood system? Please check all that apply.
    - Implementation site for Early Childhood Comprehensive System (ECCS) grant
    - Children's Services Council
    - Early Head Start
    - Early Steps
    - Early Learning Coalition
    - Part B and Transition - Local education agencies (LEA)
    - Child Abuse and Prevention and Permanency Advisory Council planning team
    - I don't know
    - Other

Text box for more detail

6. How do you and the local early childhood systems of care address indicators of high need (i.e., low birth weight, teen births, substance use, child maltreatment)? *Open text box.*

For each **high-risk** county that your program serves, please answer the following questions related to **home visiting services.**

7. What are the strengths of home visiting programs in your county? Check all that apply.
    - Families get services they need
    - Children have better outcomes
    - Improved family engagement
    - Reduced maltreatment (reports and/or findings)
    - Reduced child deaths
    - Children are ready for school
    - Connect families to needed services
    - Improved birth outcomes
    - Parents learn child development and positive parenting
    - Other, please specify
8. What are the weaknesses of home visiting programs in your county? Check all that apply.
    - Waiting list
    - Cannot serve all who are eligible
    - Complicated process to connect to a program
    - Families are referred to services but no follow up
    - Cannot provide families money or supplies
    - Models too complex
    - Too many visits required
    - Age eligibility limitations
9. Have there been recent or adverse events (e.g., natural or other disaster, COVID-19) that have impacted the delivery of home visiting or other services to the county?
    No, *skip to question 13*.
    If yes, *skip to questions 10, 11, and 12*
10. Yes. How have they been impacted? *Check all that apply*.

Home visitors:

- Lost homes
- Lost jobs
- Had to leave the community or county

- Had lack of access to medical care
- Had lack of access to childcare
- Experienced school closures
- Transition to virtual home visits
- Experiencing mental health issues
    - With their own children
    - Themselves or family members
- Other: *text box*

Clients:

- Lost homes
- Lost jobs
- Had to leave the community or county
- Had lack of access to medical care
- Had lack of access to childcare
- Experienced school closures
- Transition to virtual home visits
- Experiencing mental health issues
    - Children
    - Adults
- Other: *text box*

11. Please explain how the **home visiting and community services responded** to the needs of the **home visitors** affected. Open *text box.*
12. Please explain how the home visiting and community services responded to the needs of the **clients** affected. Open *text box*.
13. To what extent does your home visiting program staff reflect the community they serve? (race and ethnicity)
    - Great deal
    - Somewhat
    - Not at all
14. What are the barriers faced by your program? Drop down. Check all that apply.
    - Geographic
    - Availability of health and social services and family supports
    - Accessibility of health and social services and family supports
    - Lack of or inconsistent funding
    - Lack of funding to pay home visitors competitive salary
    - Availability of qualified staff
    - Retention of quality staff
    - Lack of community support
    - Disengaged board of directors/advisory group
    - Inactive parent groups, or no parent groups
    - Establishing partnerships with other programs
    - Changes in early intervention/healthcare providers
    - Lack of local funding
    - Community partners not understanding the program
    - Not enough eligible
    - Lack of quality referrals

- Other, please specify

For each **high-risk** county that your program serves, please answer the following questions related to **community resources available for substance abuse and mental health needs.**

15. Does your county have a system of care grant?
    Yes, *skip and go to question 16*.
    No, *skip to question 17*.
    Don't know
16. Are you participating as a stakeholder with the system of care leadership?
    Yes
    No
    Text box for detail
17. Are there sufficient **substance use treatment providers** for providing **intervention services** to meet the needs of pregnant women and families with young children who may be eligible for home visiting services?
    Yes – *if yes, skip to question 18*
    No – *if no, skip to question 19*
    Don't know
18. What types of **substance use treatment providers or interventions** are available in this county: Check all that apply.
    - Federally qualified Health Centers
    - Clubhouses
    - Mobile Crisis Units
    - Care coordination
    - Drop in centers
    - Outpatient counseling
    - Supported employment programs
    - Intensive home-based services
    - Intensive case management
    - Methadone assisted treatment clinics
    - Clinics for substance exposed newborns
    - Re-entry services
    - Vocational rehabilitation
    - Residential treatment
    - Residential treatment that allows children to stay with parent
    - Psychoeducational classes
    - Other, please specify
19. Are there sufficient substance use treatment providers for **providing treatment services** to meet the needs of pregnant women and families with young children who may be eligible for home visiting services?
    Yes – *if yes, skip to question 18*
    No – *if no, skip to question 21*
    Don't know
20. Are there sufficient substance use treatment providers for **providing recovery services** to meet the needs of pregnant women and families with young children who may be eligible for home visiting services?
    Yes – *if yes, skip to question 18*
    No – *if no, skip to question 21*

Don't know

21. What are the **barriers to receiving substance use treatment and counseling services**? Check all that apply.
    - Lack of access (wait list)
    - Transportation
    - Unaffordable
    - Limited number of providers
    - Lack of quality providers
    - No providers
    - Unaware of services
    - Not ready for treatment
    - Other please specify *text box*
22. Some communities have efforts in place to address gaps and barriers to service, focusing on pregnant women and families with young children. Often there is a partnership with local hospitals, courts, child welfare agencies and providers. Do you participate in these community efforts?
    Yes, please describe.
    No
23. Are there wrap around services to **support treatment** of substance misuse or disorders in this county?
    Yes, *if yes, skip to question 26*
    No, *skip to 25*
    Don't know
    Provide detail *text box*
24. Are there wrap around services to **prevent** substance misuse in this county?
    Yes, *if yes, skip to question 26*
    No, *skip to 27.*
    Don't know
    Provide detail *text box*
25. What are they? Check all that apply:
    - Financial assistance for treatment
    - Case management services
    - Housing assistance
    - Legal assistance
    - Childcare
    - Crisis intervention
    - School based programs like DARE
    - Mental health counseling
    - Medical care
    - HIV testing or counseling
    - Other, please specify
26. Are there wrap around services to **support outcomes** for families and individuals after they complete treatment?
    Yes, if yes, *skip to question 26.*
    No, *skip to 28*.
    Don't know
    Provide detail *text box*

27. What services are missing in this county?
    - Financial assistance for treatment
    - Case management services
    - Housing assistance
    - Legal assistance
    - Childcare
    - Crisis intervention
    - Mental health counseling
    - HIV testing or counseling
    - Domestic violence programs
    - Medical care
    - HIV testing or counseling
    - Other, please specify
28. Are there sufficient **providers** to serve your clients with **mental health challenges**?
    Yes, *if yes skip to question 30.*
    No, *if no skip to question 31.*
29. What type of **mental health treatment providers and intervention services** are available in this county: Check all that apply.
    - Outpatient counseling
    - In-home counseling (i.e. with home visiting services)
    - Residential treatment
    - Residential treatment that allows children to stay with parent
    - Psychoeducational classes
    - Other, please specify
30. What providers are missing in this county?
    - Outpatient counseling
    - Residential treatment
    - Residential treatment that allows children to stay with parent
    - Psychoeducational classes
    - Other, please specify
31. What are the **barriers** to **receiving mental health treatment and counseling services**? Check all that apply.
    - Financial assistance for treatment
    - Lack of access (wait list)
    - Unaffordable
    - No insurance coverage for mental health
    - Transportation
    - Lack of childcare
    - Treatment readiness
    - Limited number of providers
    - Lack of quality providers
    - No providers
    - Other, please specify
32. Please select all the supplementary services currently provided in this county that could meet the needs of your families. Check all that apply.
    - Circle of Parents Support Groups

- Affordable Housing
- Transitional housing
- Homelessness services
- Dental providers
- Dental home providers
- Domestic violence centers
- Public transportation
- Quality Childcare
- Educational/vocational
- Family/social
- Military family liaisons
- Food pantries
- Community health centers/clinics
- Prenatal health care
- Pediatric health care
- Local health department
- Federally Qualified Health Center
- Other, please specify

Community Readiness

For each **high-risk** county that your program serves, please answer the following questions related to **community support or community readiness** for expanding home visiting services in your county.

33. Do you think that there is a need for additional home visiting in the county?
    Yes. Please explain *text box*
    No. Please explain *text box*
    Don't know
34. Do you think your county is ready and has the capacity to expand home visiting services?
    Yes
    No
    Please explain *text box*
35. On a scale of 1 to 10, do community members think **providing services** for expectant and new parents and their young children is a priority? (1 is "not a priority" and 10 is "the highest priority")
36. On a scale of 1 to 10, how strongly would community leaders support **new or expanded efforts** in the county to address the needs of expectant and new parents and their young children (1 is "not at all" and 10 is "very strongly")?
37. Would community members and leaders **provide support** (financially, in-kind resources, training etc.) for **community resources** for home visiting services for new or expectant parents and their young children?
    Yes, please explain.
    No, please explain.
    Don't know.
38. Do community leaders and administrators **demonstrate support** for programs that meet the needs of expectant and new parents and their young children?
    Yes, *skip to question* 40.
    No, *skip to question 41.*
    Don't know.

39. How do community leaders and administrators demonstrate support for programs? Check all that apply:
    - Participate in planning, developing, or implementing efforts
    - Allocate resources to support community efforts
    - Offer grant funding
    - Provide training
    - Provide financial donations from organizations and/or businesses
    - Provide space
    - Support a children's council or similar
    - Other, please specify
40. Are you aware of any proposals or action plans that have been submitted for funding to address services to new or expectant parents and their young children?
    If yes, please explain.
    No
41. On a scale of 1 to 10, how would you rate professional development opportunities for those working with expectant or new parents and their young children (1 is "very low" and 10 is "very high")? Please explain. *Text box*
42. Does the county have the capacity to provide ongoing professional development through formal (e.g., community college, university); informal (e.g., continuing adult education); or online training opportunities?
    Yes. *Text box*
    No. *Text box*

Community Stakeholder Survey

County
City or community
Name of organization
Contact person
Contact email and phone number
Please select the type of position you currently hold in the organization identified earlier.

- Administrator
- Mental health therapist
- Evaluator/researcher
- Healthcare provider
- Health educator
- Addictions counselor
- Social worker
- Elected official
- Advocate
- Other, please specify

Please answer the following questions related to **community support or community readiness** for **expanding home visiting** services in your community.

1. Do you think that there is a need for additional home visiting in the community?
   Yes. Please explain *text box*
   No. Please explain *text box*
   Don't know
2. Do you think your community is ready and has the capacity to expand home visiting services?
   Yes, please explain.
   No, please explain.
3. On a scale of 1 to 10, do community members think **providing services** for expectant and new parents and their young children is a priority? (1 is "not a priority" and 10 is "the highest priority")
4. On a scale of 1 to 10, how strongly would **community leaders support new or expanded efforts** in the community to address the needs of expectant and new parents and their young children (1 is "not at all" and 10 is "very strongly")?
5. On a scale of 1 to 10, how would you assess the **level of potential resources** in the community to **support home visiting services** for expectant or new parents and their young children (1 is "none" and 10 is "highest level of resources")? For example: Financial donations from organizations and/or businesses? Grant funding? Space?
6. Would **community members and leaders provide support** (financially, in-kind resources, training, etc.) for **community resources for home visiting services** for new or expectant parents and their young children?
   Yes, please explain.
   No, please explain.
   Don't know.
7. Do community leaders and administrators demonstrate support for programs that meet the needs of expectant and new parents and their young children?
   Yes, *skip to question 8*.
   No. *skip to question 9.*
   Don't know.

8. How do community leaders and administrators demonstrate support for programs? Check all that apply:
    - Participate in planning, developing, or implementing efforts
    - Allocate resources to support community efforts
    - Offer grant funding
    - Provide training
    - Provide financial donations from organizations and/or businesses
    - Provide space
    - Support a children's council or similar
    - Other, please specify
9. Are you aware of any plans to start or expand programs or services that address the needs of expectant or new parents and their young children?
   Yes. *Skip to question 10.*
   No. *Skip to question 11*
10. Are they home visiting programs other than: Nurse Family Partnership, Healthy Families, Parents as Teachers, HIPPY, Early Head Start home-based option, Play and Learning Strategies, ChildFirst?
    Yes *text box*
    No. *skip to question 11*
11. What programs or services are they? *Text box*
12. What advice would you give to someone implementing home visiting services in the community? *Open text box.*

Please answer the following questions related **to community resources for early childhood services** (early intervention services for children under the age of 5) in your community.

13. Are there sufficient providers to serve your clients with early childhood services?
    Yes, *if yes skip to question 14*.
    No, *if no skip to question 15*.
    Don't know
14. Please select all the **early childhood services** provided in your community that can meet the needs of families in your community.
    - Early Head Start
    - Head start
    - Quality childcare providers
    - Early Steps
    - Local education agency (LEA)
    - Other, please specify
15. What programs do you think are missing? *Check all that apply.*
    - Early Head Start
    - Head start
    - Quality childcare providers
    - Early Steps
    - Part B and Transition - Local education agency (LEA)
    - Other. Please specify *text box*
16. What programs do you think are inaccessible to families? *Check all that apply.*
    - Early Head Start
    - Head start
    - Quality childcare providers

- Early Steps
- Part B and Transition - Local education agency (LEA)
- Other. Please specify *text box*

17. Does your community or county have a system of care grant?
    Yes, *skip to question 18*.
    No, *skip to question 19*.
    Don't know
18. Are you participating as a stakeholder with the system of care leadership?
    Yes
    No

Please answer the following questions related to **home visiting programs or initiatives to assist families** in your community.

19. On a scale of 1 to 10, how much do you know about home visiting programs or initiatives in your community (1 is "no knowledge" and 10 is "detailed knowledge")?
20. On a scale of 1 to 10, how much do you know about services in the community for new and expectant parents and their young children (1 is "no knowledge" and 10 is "detailed knowledge")?
21. Do you think that there is a need for additional home visiting services in the community?
    If yes, please explain.
    If no, please explain.
22. Which services are needed the most? Select all that apply.
    - Economic self-sufficiency
    - Mental health treatment
    - Substance use treatment
    - Employment opportunities
    - Quality childcare
    - Home visiting
    - Transportation
    - Health care
    - Other, please specify
23. Have there been recent or adverse events (e.g., natural or other disaster, COVID-19) that have impacted the **delivery of home visiting or other services** to the families in need?
    Yes – *if yes, skip to question 24.*
    No – *if no, skip to question 25.*
24. How have services been impacted? *Check all that apply*.

Home visitors:

- Lost homes
- Lost jobs
- Had to leave the community
- Lack of access to medical care
- Lack of access to childcare
- School closures
- Transition to virtual home visits
- Experiencing mental health issues
    - With their own children
    - Themselves or family members
- Other: Please explain *text box*

Clients:

- Lost homes
- Lost jobs
- Had to leave the community
- Lack of access to medical care
- Lack of access to childcare
- School closures
- Experiencing mental health issues
    - Children
    - Adults
- Other, please specify

25. *Yes.* Please explain how **the community** responded to the **home visitors** and or clients affected.
26. *Yes.* Please explain how **the community** responded to the **clients** affected.
27. *Yes*. Please explain **how** the **home visiting and community services responded to the needs of those affected.**
28. What barriers exist for expectant or new parents to access services? Select all that apply.
    - Lack of access (wait list)
    - Unaffordable
    - Transportation
    - Unaware of services
    - Limited number of providers
    - Lack of quality providers
    - No appropriate services
    - Other please specify *text box*
29. On a scale of 1 to 10, how would you rate the quality of professional development opportunities for those working with expectant or new parents and their young children (1 is "very low" and 10 is "very high")? Please explain. *Text box*
30. Does the community have capacity to provide ongoing professional development through formal (e.g., community college, university); informal (e.g., continuing adult education); or online training opportunities?
    Yes
    No
    Don't know

Please answer the following questions related to **community resources available for substance abuse and mental health needs** in your community.

31. Are there sufficient substance use providers for providing intervention, treatment, and recovery services to meet the needs of pregnant women and families with young children who may be eligible for MIECHV services?
    Yes – *if yes, skip to question 32.*
    No – *if no, skip to question 33.*
    Don't know
32. Type of treatment substance use providers or interventions available in your community: check all that apply
    - Federally Qualified Health Centers
    - Clubhouses
    - Mobile Crisis Units

- Care coordination
- Drop in centers
- Outpatient counseling
- Supported employment programs
- Intensive home-based services
- Intensive case management
- Re-entry services
- Vocational rehabilitation
- Residential treatment
- Residential treatment that allows children to stay with parent
- Psychoeducational classes
- Other, please specify

33. What are the **barriers to receiving substance use disorder treatment and counseling services**? Check all that apply:
- Lack of access (wait list)
- Transportation
- Unaffordable
- Limited number of providers
- Lack of quality providers
- No providers
- Other, please specify

34. Do you participate in any community efforts to collaborate with state or local partners, i.e., hospitals, court system, child welfare agencies, substance use treatment providers to address the gaps and barriers to care for pregnant women and families with young children impacted by **substance use issues**?
    Yes: Please describe:
    No
35. Are there wrap around services to **support treatment** of substance misuse or disorders in this community?
    Yes, *if yes, skip to question 36*
    No, *skip to 36*
    Don't know
    Provide detail *text box*
36. Are there wrap around services to **prevent** substance misuse in this community?
    Yes, *if yes, skip to question 36*
    No, *skip to 37.*
    Don't know
    Provide detail *text box*
37. What are they? *Check all that apply.*
    - Case management services
    - Housing assistance
    - Legal assistance
    - Childcare
    - Crisis intervention
    - School based programs like DARE
    - Mental health counseling
    - Medical care

- HIV testing or counseling
- Other, please specify

38. What services are missing in this community?
    - Case management services
    - Housing assistance
    - Legal assistance
    - Childcare
    - Crisis intervention
    - Mental health counseling
    - HIV testing or counseling
    - Domestic violence programs
    - Medical care
    - HIV testing or counseling
    - Other, please specify
39. Are there wrap around services to **support outcomes** for families and individuals after they complete treatment?
    Yes *If yes, skip to question 39.*
    No. *If no, skip to question 40.*
    Don't know
    Provide detail text box
40. What are these wrap around services? Check all that apply:
    - Financial assistance
    - Case management services
    - Housing assistance
    - Legal assistance
    - Childcare
    - Crisis intervention
    - Mental health counseling
    - Medical care
    - HIV testing or counseling
41. Are there sufficient providers to serve your clients with mental health challenges?
    Yes. *if yes skip to question 41.*
    No. *if no skip to question 42*.
    Provide detail box
42. What types of mental health treatment providers and intervention services are in your community? Check all that apply:
    - Outpatient counseling
    - Residential treatment
    - Residential treatment that allows children to stay with parent
    - Psychoeducational classes
    - Other, please specify *text box*
43. What are the barriers to receiving mental health treatment and counseling services? Check all that apply:
    - Lack of access (wait list)
    - Unaffordable
    - Transportation

- Limited number of providers
- Lack of quality providers
- No providers
- Other please specify *text box*

44. Are there sufficient providers to serve your clients with other supplementary service needs such as housing, transportation, basic needs?
    Yes. *if yes, skip to question 44*.
    No.
    Don't know
45. Please select all the supplementary services currently provided in this community that could meet the needs of your families. Check all that apply:
    - Florida Circle of Parents Support Groups
    - Affordable Housing
    - Transitional housing
    - Homelessness services
    - Dental providers
    - Dental home providers
    - Domestic violence agencies
    - Transportation
    - Quality Childcare
    - Educational/vocational
    - Family/social
    - Military family liaisons
    - Food pantries
    - Community health centers/clinics
    - Obstetrics and gynecological care
    - Local health department
    - Federally Qualified Health Center
    - Other, please specify

Parent Survey

Age

- 17 or younger
- 18-24
- 25-29
- 30-38
- 39 or older

To which gender identity do you most identify?

- Male
- Female
- Gender Variant/Non-Conforming
- Prefer Not to Answer

Race

- American Indian/Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- More than one race
- Other
- Prefer not to answer

Ethnicity

- Hispanic or Latino/a
- Not Hispanic or Latino/a

Marital Status

- Married
- Not married, living with partner
- Not married, not living with partner
- Divorced
- Separated
- Widowed
- Prefer not to answer

What county do you live in?

What is your zip code?

1. How many children under the age of 6 (including pregnancy) currently live in your household?
2. What are the ages of each child?
    - Currently pregnant
    - 0-11 Months
    - 1
    - 2
    - 3
    - 4
    - 5
3. Do you know what home visiting programs offer?
    Yes
    No

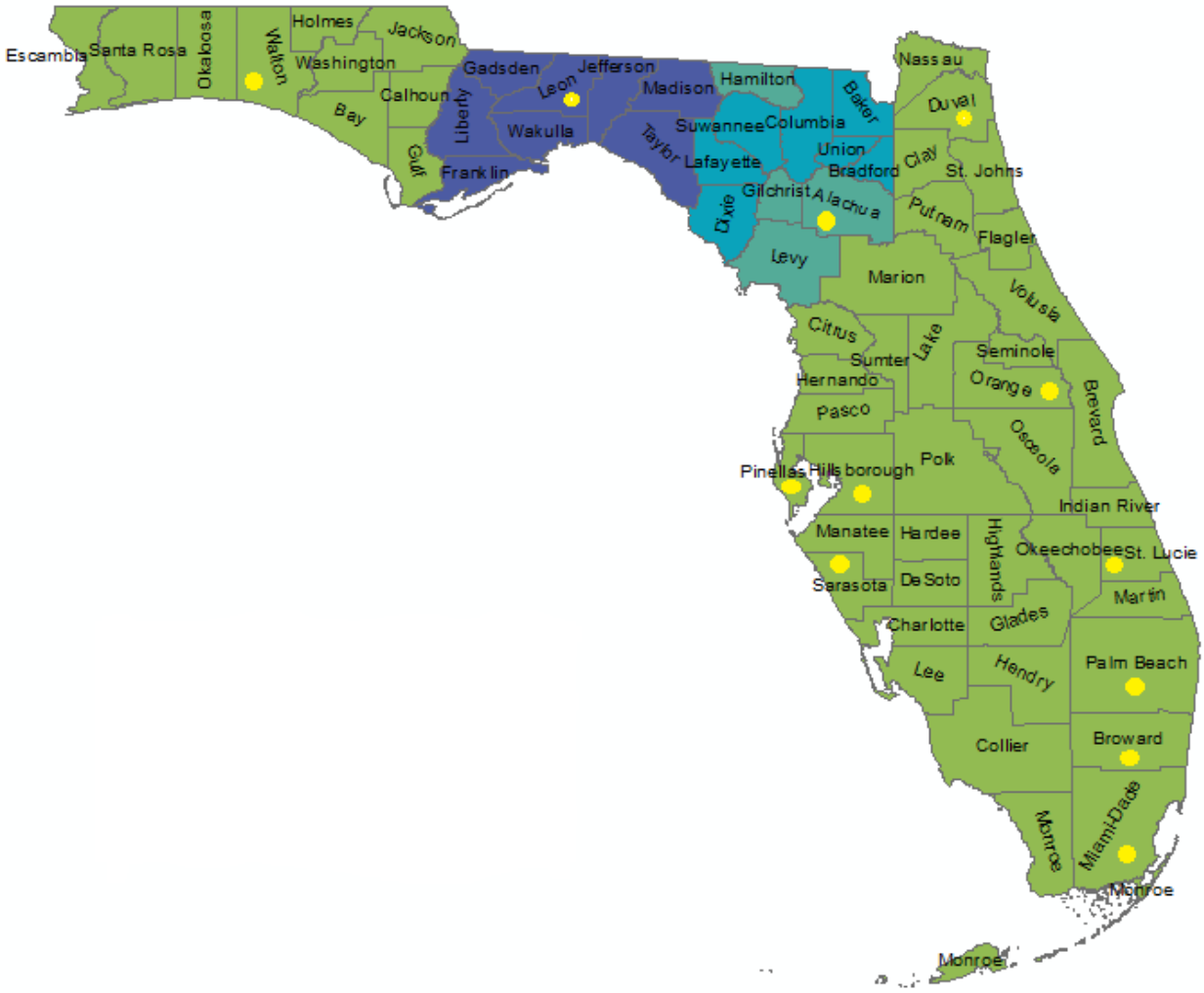
4. Do you know about home visiting services in your community?
   Yes
   No
5. Are you currently receiving services from a home visiting program?
   Yes, *skip to question 6*
   No, *skip to question 7*
6. Which home visiting program?
   - Parents as Teachers (PAT)
   - Nurse Family Partnership
   - Healthy Families
   - Healthy Start
   - ChildFirst
   - Early Head Start
   - Play and Learning Strategies
   - HIPPY
   - Other Please name *text box*
7. Have you received home visiting services in the past?
   Yes, skip to question 8
   No, skip to question 9
8. Which home visiting program?
   - Parents as Teachers (PAT)
   - Nurse Family Partnership
   - Healthy Families
   - Healthy Start
   - ChildFirst
   - Early Head Start
   - Play and Learning Strategies
   - HIPPY
   - Other, please specify
9. In your opinion, does your community have the resources you need for your family? Examples include affordable quality childcare, health care, transportation, and recreational opportunities.
10. The resources in the community are easy to access.
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree
11. If disagree or strongly disagree, what makes these resources hard to access?
    - Waiting list
    - Cost too much money
    - No transportation to get there
    - Resources not offered
    - Attitudes of workers
    - Don't qualify because of my income
    - Other (*text box*)

12. Are there additional resources for families with young children that you feel like your community could benefit from?
    - Yes
    - No
    - Not sure
13. If yes, what resources would those be? Choose all that apply.
    a. Early Head Start
    b. Head Start
    c. Quality childcare providers
    d. Early Steps/Early intervention
    e. Mental health (therapy) services
    f. Health centers/clinics for yourself
    g. Health centers/clinics for your child
    h. Pediatric Speech and language therapeutic services
    i. Assistance with utility payments
    j. Other/Additional comments *text box*
14. My community cares about families with young children.
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree
15. Any additional comments you would like to make?

APPENDIX 7

SUD AND FAMILY RESIDENTIAL TREATMENT OVERLAP MAP

Overlay of Substance Use Disorder Map and Counties with Family Residential Treatment Facility



LEGEND	# of counties
0-25% of the indicators at risk	48
26-50% of the indicators at risk	4
51-75% of the indicators at risk	7
76-100% of the indicators at risk	8