# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

**Maternal, Child and Adolescent Health Program**
**Center for Family Health**
**California Department of Public Health**

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## ACRONYMS USED IN THIS REPORT

| | |
|---|---|
| AAP | American Academy of Pediatrics |
| ABCD | Assuring Better Child Health and Development |
| ACA | Patient Protection and Affordable Care Act of 2010 |
| ACF | Administration for Children and Families |
| ACS | American Community Survey |
| AFA | Agency funding agreement |
| AFLP | Adolescent Family Life Program |
| AIIHI | American Indian Infant Health Initiative |
| AOD | Alcohol and Other Drug |
| APR | Annual Program Report |
| ARRA | American Recovery and Reinvestment Act |
| BIH | Black Infant Health |
| CA DOF | California Department of Finance |
| CA DOJ | California Department of Justice |
| CalEMA | California Emergency Management Agency |
| CalOMS | California Outcomes Measurement System |
| CalWORKs | California Work Opportunity and Responsibility to Kids |
| CA-PAMR | California Pregnancy-Related and Pregnancy-Associated Mortality Review |
| CAPIT | Child Abuse Prevention, Intervention, and Treatment Program |
| CAPTA | Child Abuse Prevention and Treatment Act |
| CAS | Cultural Access Services |
| CBC | California Breastfeeding Coalition |
| CBCAP | Community-Based Child Abuse Prevention Program |
| CCR | California Code of Regulations |
| CCS | California Children's Services |
| CDADP | California Department of Alcohol and Drug Programs |
| CDAPP | California Diabetes and Pregnancy Program |
| CDC | Centers for Disease Control and Prevention |
| CDDS | California Department of Developmental Services |
| CDE | California Department of Education |
| CDHCS | California Department of Health Care Services |
| CDPH | California Department of Public Health |
| CDSS | California Department of Social Services |
| CDSS/CFSD | California Department of Social Services/Children and Family Services Division |
| CFSD | Children and Family Services Division |
| CHDP | Child Health and Disability Prevention |
| CHIS | California Health Interview Survey |
| CHSSCO | The California Head Start State Collaboration Office |
| CLASP | The Center for Law and Social Policy |
| CMQCC | California Maternal Quality Care Collaborative |
| CMS | Children's Medical Services Branch |

## ACRONYMS USED IN THIS REPORT

| | |
|---|---|
| COSSR | Continuum of Services System Re-engineering |
| CPEDV | California Partnership to End Domestic Violence |
| CPL | CA Project LAUNCH |
| CPQCC | California Perinatal Quality Care Collaborative |
| CPS | Current Population Survey |
| CSA | County Self Assessment |
| CSSC | California Statewide Screening Collaborative |
| CTCP | California Tobacco Control Program |
| CWHS | California Women's Health Survey |
| CWS | Child Welfare Services |
| CWS/CMS | Child Welfare Services/Case Management System |
| DCR | Day Care Rehabilitative |
| DRDP | Desired Results Developmental Profile |
| EAPD | Epidemiology, Assessment, and Program Development |
| EBHV | Evidence-based Home Visiting models |
| ECCS | California's Early Childhood Comprehensive Systems |
| EHS | Early Head Start |
| ELAC | Early Learning Advisory Council |
| ELL | English Language Learner |
| EnCAL-COSSR | Evaluation Services to Enhance the Data Management System in California -Continuum of Services System Re-engineering |
| EPSDT | Early Periodic Screening, Diagnosis, and Treatment |
| ETO | Efforts to Outcomes software |
| FASD | Fetal Alcohol Spectrum Disorder |
| FDA | Federal Drug Administration |
| FFP | Federal Financial Participation |
| FFY | Federal Fiscal Year |
| FOA | Funding Opportunity Announcement |
| FPL | Federal Poverty Level |
| FTE | Full-time equivalent positions |
| FVPSA | Family Violence Prevention and Services Act |
| FY | Fiscal Year |
| HFA | Healthy Families America |
| HHS | Department of Health and Human Services |
| HIPPY | Home Instruction for Parents of Preschool Youngsters |
| HP 2010 | Healthy People 2010 Report |
| HRSA | U.S. Department of Health and Human Services, Health Resources and Services Administration |
| HRSA/MCHB | Health Resources and Services Administration Maternal and Child Health Bureau |
| HS | Head Start |
| HS/EHS | Head Start/Early Head Start |
| HV | Home Visiting |
| IDEA | Individuals with Disabilities Education Act |

## ACRONYMS USED IN THIS REPORT

| | |
|---|---|
| IPV | Intimate partner violence |
| LAUS | Local Area Unemployment Statistics |
| LBW | Low birth weight |
| LHJs | Local Health Jurisdictions |
| MCAH | Maternal, Child and Adolescent Health |
| MCAH/OFP | Maternal, Child and Adolescent Health, Office of Family Planning |
| MCH | Maternal and Child Health |
| Medicaid | Federal Title XIX |
| Medi-Cal | California Medical Assistance Program |
| MIHA | Maternal and Infant Health Assessment Survey |
| MIS | Management Information System |
| MSSAs | Medical Service Study Areas |
| NEGP | National Education Goals Panel |
| NFP | Nurse Family Partnership |
| NSDUH | National Survey on Drug Use and Health |
| NSO | National Service Office |
| NTP | Narcotic Treatment Programs |
| OCAP | Office of Child Abuse Prevention |
| PAT | Parents as Teachers |
| PCHP | Parent Child Home Program |
| PHCC | Preconception Health Council of California |
| PIR | Early Head Start State Program Information Report |
| PNC | Prenatal Care |
| PNS | Prenatal Screening Branch |
| PSSF | Promoting Safe and Stable Families |
| RPE | Rape Prevention and Education Program |
| RPPC | Regional Perinatal Programs of California |
| RSSs | Recovery Support Services |
| SAC | Safe and Active Communities |
| SAIPE | Small Area Income Poverty Estimates |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SART | Screening, Assessment, Referral and Treatment |
| SFY | State Fiscal Year |
| SGF | State General Funds |
| SHC | School Health Connections |
| SIDS | Sudden Infant Death Syndrome |
| SIR | Supplemental Information Request |
| SIT | State Interagency Team |
| TANF | Temporary Assistance to Needy Families |
| TPN | Total Parenteral Nutrition |
| UCR | Uniform Crime Reporting |
| WIC | Women, Infants and Children Program |
| WTW | Welfare-to-Work |

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# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

# Executive Summary

**Maternal, Child and Adolescent Health Program**
**Center for Family Health**
**California Department of Public Health**

# EXECUTIVE SUMMARY

## Background

The Maternal and Child Health (MCH) Services Block Grant (Title V of the Social Security Act) has operated as a Federal-State partnership to improve the health and welfare of women, children and families since 1935. On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA of 2010 amended Title V of the Social Security Act (42 U.S.C. 701 et. seq.), by adding Section 511, which establishes the Maternal, Infant and Early Childhood Home Visiting Program.

The California Department of Public Health, Maternal, Child and Adolescent Health Program (CDPH/MCAH) was designated by Governor Arnold Schwarzenegger as the single State entity authorized to apply for and administer Health Resources and Services Administration (HRSA) and Administration for Children and Families (ACF) home visiting program funds on behalf of California. The process for fulfilling requirements by HRSA includes three steps: (1) submission of an application for funding; (2) submission of a statewide needs assessment (also referred to as the first Supplemental Information Request); and (3) submission of an Updated State Plan (also referred to as the second Supplemental Information Request), that will also include an updated needs and resources assessment. Contained here is California's response to the *first* Supplemental Information Request (SIR), the submission of the statewide needs assessment to fulfill the s*econd* step required by HRSA.

## Methods

To meet the requirements for an approvable statewide needs assessment, California was required to: (1) identify communities with concentrations of at risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school drop-outs; substance abuse; unemployment; or child maltreatment; (2) identify the quality and capacity of existing early childhood home visiting programs; and, (3) discuss the State's capacity to provide substance abuse treatment and counseling services. An additional requirement was to integrate into this needs assessment the needs assessment findings from the Title V MCH Block Grant program; the community strategic planning and needs assessments conducted in accordance with section 640(g)(1)(c) of the Head Start Act; and inventory of unmet needs and programs to prevent child abuse and neglect under section 205(3) of Title II of the Child Abuse Prevention and Treatment Act.

CDPH/MCAH worked in partnership with the California Department of Social Services (CDSS), California Department of Alcohol and Drug Programs (CDADP), and the California Head Start State Collaboration Office (CHSSCO) of the California Department of Education (CDE) in order to develop California's Home Visiting Program application and needs assessment. In consultation with the California Home Visiting Collaborative Work Group, local stakeholder input from each of the 58 counties was requested through a survey to assess the quality and capacity of existing home visiting programs statewide. Local health jurisdiction MCAH Directors and their local counterparts from CDSS, Head Start, and First 5 worked together to complete this survey. Additional input for the needs assessment was obtained from the California Department of Health Care Services; the California Department of Developmental Services; the California Emergency Management Agency; the Safe and Active Communities Branch of the CDPH; the STOP Violence Against Women regional coordinator for California; the California Partnership to End Domestic Violence; the Domestic Violence Assistance Program; First 5 California; the First 5 Association of California; multiple County First 5 Commissions; and MCAH Action.

This needs assessment document is organized according to the six components required by the first SIR: (1) a statewide data report, (2) definition of "community", (3) data reports for identified "at risk" communities, (4) description of quality and capacity for existing home visitation programs, (5) description of the capacity to provide substance abuse counseling and treatment services, and (6) a narrative of needs assessment results and a discussion of how the State will address unmet needs.

The conceptual frameworks of the life course perspective, social determinants of health and socio-ecological model guided this needs assessment. These frameworks help inform the examination of maternal, infant and child health and well-being by recognizing not only genetic and behavioral influences, but also the impact of social, psychological, economic, environmental and cultural factors. These frameworks help recognize the interconnections between individuals, families, communities and the larger society while also considering the range of social, economic and environmental factors that support or threaten health and development during early childhood. These frameworks helped inform the selection of additional indicators of need beyond the minimum data elements required in the first SIR, identification of at-risk communities, and examination of home visiting models.

**Results**

For the statewide data report section, California provides data for those indicators required in the first SIR as well as additional indicators identified as critical based upon the frameworks described above and after consultation with internal and external partners. California uses County as the geographic unit for defining "community" and considered "at risk" counties to be those with a rate or percentage worse than the statewide median value for any one of the included indicators. Based on those definitions, California identified all 58 counties as "at risk" given that all counties have at least two indicators worse than the statewide median (see table at the end of the Executive Summary). In addition, 54 of 58 communities had 6 or more indicators worse than the state median. Defining and identifying at risk communities will be further refined in the Updated State Plan (step three of the process required by HRSA), as California moves forward with the continuous process of assessing needs.

This needs assessment also presents information on the quality and capacity of existing home visiting programs in California counties that was obtained via local response to a survey administered by CDPH/MCAH. The Home Visiting survey was one mechanism to gauge California's capacity to provide home visiting services. The survey showed that California has a de-centralized implementation of maternal, infant and early childhood home visiting programs. This has allowed for great local flexibility, providing a rich knowledge base for the delivery of home visiting services to diverse populations. Additionally, there exists extensive local expertise for the provision of evidence-based home visiting models, in both urban and rural settings, and in communities with very different demographics. Conversely, many counties throughout California report using locally developed programs or adaptations of national models to serve hard to reach populations. It is this tremendous experience and knowledge that will assist in informing the new state based home visiting program for California.

Lastly, this needs assessment presents information on the capacity to provide substance abuse counseling and treatment services. CDADP estimates AOD treatment capacity in California to be 110,623. This includes 38,000 pregnant and parenting women served by 300 publicly funded alcohol and drug treatment and recovery programs. Unfortunately, an estimated 3.3 million Californians need, but are not receiving AOD treatment, the highest percentage among

young adults 18-25 years of age. Considering that the majority of substance users are individuals who are not dependent on substances, there is a need to identify and address these at risk individuals with effective interventions in various settings other than AOD treatment centers. The Home Visiting Program will provide opportunities for home visitors to assist in intervention, treatment, and recovery success.

**Next Steps and Conclusion**

CDPH/MCAH continues to work closely with partners and stakeholders in this process and awaits the release of the next federal guidance document that will help inform the identification of home visiting models to meet the needs of at risk populations in California. With establishment of a State early childhood home visiting program underway, California is developing a plan to ensure adequate state-level staffing and expertise specific to home visiting. In the meantime, CDPH/MCAH, along with partners, continues to thoroughly review nationally recognized evidence based home visiting models. CDPH/MCAH will make a recommendation to select likely two to three evidence based models as well as a 'promising practice' model to fund in counties identified as high risk and with unmet needs. California will develop an application process inviting high need counties to apply for Home Visiting Program funds to be administered by CDPH/MCAH. Counties will be encouraged to incorporate information from other local needs assessments, identify gaps in service delivery, and also assess the public health system of care serving the maternal, infant and early childhood populations.

Developing a comprehensive, evidence-based Home Visiting Program in California requires a lengthy, well coordinated and collaborative effort of multiple State and local partners whereby a thorough and systematic needs assessment is completed that informs Program implementation. The information presented in this initial needs assessment is one component of this ongoing collaborative process framed by the life course perspective, social determinants of health, and the socio-ecological model. California's ongoing efforts to address identified needs will incorporate a framework for integrating local expertise to supplement results from our needs assessment process, and to inform our efforts for implementing and sustaining our Home Visiting Program.

The mission of the California Home Visiting Program is to promote and enhance the optimal development of families and young children across all domains. This will be achieved through a coordinated, comprehensive, and high quality home visiting program strategically targeting families and children facing significant barriers which place them at high risk. California's investment in high-quality services for families and children at risk will pay enormous long-term dividends for the State.

**Population Size, Number of Live Births and Frequency of Indicators Worse-Off Than the State Median, by County and Population Size**

| | COUNTY | POPULATION SIZE | NUMBER OF LIVE BIRTHS | NUMBER OF INDICATORS > MEDIAN |
|---|---|---|---|---|
| | **CALIFORNIA** | **38,648,090** | **551,567** | |
| County Population > 500,000 | LOS ANGELES | 10,441,080 | 147,684 | 8 |
| | SAN DIEGO | 3,224,432 | 46,742 | 10 |
| | ORANGE | 3,166,461 | 42,456 | 2 |
| | RIVERSIDE | 2,139,535 | 32,866 | 13 |
| | SAN BERNARDINO | 2,073,149 | 33,788 | 11 |
| | SANTA CLARA | 1,880,876 | 26,730 | 2 |
| | ALAMEDA | 1,574,857 | 20,972 | 4 |
| | SACRAMENTO | 1,445,327 | 21,389 | 14 |
| | CONTRA COSTA | 1,073,055 | 13,136 | 8 |
| | FRESNO | 953,761 | 16,760 | 12 |
| | SAN FRANCISCO | 856,095 | 9,104 | 9 |
| | VENTURA | 844,713 | 12,076 | 9 |
| | KERN | 839,587 | 15,315 | 16 |
| | SAN MATEO | 754,285 | 9,765 | 3 |
| | SAN JOAQUIN | 694,293 | 11,030 | 14 |
| | STANISLAUS | 530,584 | 8,549 | 14 |
| County Population 100,000 – 499,999 | SONOMA | 493,285 | 5,761 | 9 |
| | TULARE | 447,814 | 8,533 | 12 |
| | MONTEREY | 435,878 | 7,434 | 7 |
| | SANTA BARBARA | 434,481 | 6,319 | 9 |
| | SOLANO | 427,837 | 5,607 | 14 |
| | PLACER | 347,102 | 4,035 | 8 |
| | SAN LUIS OBISPO | 273,231 | 2,737 | 8 |
| | SANTA CRUZ | 272,201 | 3,538 | 7 |
| | MARIN | 260,651 | 2,716 | 6 |
| | MERCED | 258,495 | 4,423 | 16 |
| | BUTTE | 221,768 | 2,518 | 13 |
| | YOLO | 202,953 | 2,669 | 12 |
| | SHASTA | 184,247 | 2,186 | 16 |
| | IMPERIAL | 183,029 | 3,221 | 15 |
| | EL DORADO | 182,019 | 1,814 | 12 |
| | KINGS | 156,289 | 2,710 | 10 |
| | MADERA | 153,655 | 2,535 | 9 |
| | NAPA | 138,917 | 1,671 | 10 |
| | HUMBOLDT | 133,400 | 1,601 | 11 |
| County Population <100,000 | SUTTER | 99,154 | 1,468 | 14 |
| | NEVADA | 98,680 | 871 | 10 |
| | MENDOCINO | 90,289 | 1,168 | 14 |
| | YUBA | 73,380 | 1,264 | 16 |
| | LAKE | 64,053 | 705 | 16 |
| | TEHAMA | 63,100 | 790 | 12 |
| | SAN BENITO | 58,388 | 816 | 8 |
| | TUOLUMNE | 56,086 | 486 | 13 |
| | SISKIYOU | 46,010 | 498 | 14 |
| | CALAVERAS | 45,870 | 373 | 10 |
| | AMADOR | 38,022 | 288 | 6 |
| | LASSEN | 35,889 | 323 | 12 |
| | DEL NORTE | 29,673 | 312 | 14 |
| | GLENN | 29,434 | 472 | 12 |
| | COLUSA | 22,206 | 367 | 13 |
| | PLUMAS | 20,428 | 175 | 12 |
| | MARIPOSA | 18,192 | 147 | 8 |
| | INYO | 18,110 | 226 | 6 |
| | TRINITY | 13,898 | 126 | 13 |
| | MONO | 13,617 | 175 | 6 |
| | MODOC | 9,777 | 92 | 8 |
| | SIERRA | 3,303 | 22 | 6 |
| | ALPINE | 1,189 | 13 | 7 |

Source(s): State of California, Department of Finance, E-1 Population Estimates for Cities, Counties and the State with Annual Percent Change — January 1, 2009 and 2010. Sacramento, California, May 2010.
2008 Birth Statistical Master File.

Notes: Based on a total of 21 indicators, 14 of which were required and seven of which were included after discussion and consultation with internal and external partners.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

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# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

# Background and Methods

**Maternal, Child and Adolescent Health Program**
**Center for Family Health**
**California Department of Public Health**

# BACKGROUND AND METHODS

## Background

The Maternal and Child Health (MCH) Services Block Grant (Title V of the Social Security Act) has operated as a Federal-State partnership since 1935, when the Social Security Act was passed. The Federal Government, through Title V, pledged its support of State efforts to extend health and welfare services for mothers and children. States and jurisdictions use Title V funds to design and implement a wide range of maternal, adolescent and child health programs that meet national and State needs. In California, the Maternal Child and Adolescent Health (MCAH) Program and California Children's Medical Services (CMS) coordinate the Title V Block Grant Program.

Title V is frequently amended to reflect changing national approaches to maternal and child health and welfare issues.[1] On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010 (ACA). The ACA amended Title V of the Social Security Act (42 U.S.C. 701 et. seq.), by adding Section 511, which establishes the Maternal, Infant and Early Childhood Home Visiting Program.

The California Department of Public Health, Maternal, Child & Adolescent Health Program (CDPH/MCAH) was designated by Governor Arnold Schwarzenegger as the single State entity authorized to apply for and administer the Health Resources and Services Administration (HRSA) and Administration for Children and Families (ACF) Maternal, Infant and Early Childhood Home Visiting Program funds on behalf of California. CDPH/MCAH develops and administers programs with the goal to help protect and improve the health of California's reproductive age women, infants, children, adolescents, and their families. To accomplish this mission, CDPH/MCAH maintains partnerships, contracts, and agreements with State, federal, and local agencies in both public and private sectors. CDPH/MCAH activities are funded through the Local County Fund, the State Tobacco Tax, Federal Title XIX (Medicaid) funds, and Federal Title V MCH Block Grant funds, which CDPH/MCAH oversees to ensure that funds are expended in accordance with the grant guidelines.

CDPH/MCAH is working across systems and in partnership with the California Department of Social Services (CDSS), California Department of Alcohol and Drug Programs (CDADP), and the California Head Start State Collaboration Office (CHSSCO) of the California Department of Education (CDE) to plan, implement, and sustain home visiting programs for eligible children and families. Local partners and stakeholders also provide valuable input. A more detailed description of the collaborative efforts and partner agencies is described in the methods section.

The process for fulfilling requirements by HRSA to use Federal Fiscal Year (FFY) 2010 ACA Maternal, Infant and Early Childhood Home Visiting Program funding includes three steps: 1) submission of an application for funding; 2) submission of a statewide home visiting needs assessment (contained here); and, 3) submission of an Updated State Plan for addressing the needs identified in the assessment, including a more detailed assessment of needs and resources in the identified at risk communities.

1. Application for Home Visiting Funds (Funding Opportunity Announcement (FOA) published June 10, 2010, State response sent July 9, 2010)

The first step was the submission of an application for funding. CDPH/MCAH completed the State's application for home visiting program funds, which also included a plan for completing the home visiting needs assessment and an initial plan for developing the program in order to meet the criteria identified in the legislation. The application was submitted on July 9, 2010 and California received the approval notification on July 27, 2010. That notification served as the basis for obligating FFY 2010 funding under the ACA Maternal, Infant and Early Childhood Home Visiting Program with restrictions. Specifically, all but $500,000, which can be used for planning or implementation, are restricted until the needs assessment and Updated State Plan are submitted and approved.

2. Statewide Home Visiting Needs Assessment (Supplemental Information Request (SIR) published August 19, 2010, State response due September 20, 2010)

The second step is submission of the statewide home visiting needs assessment that is contained here. Per the ACA of 2010, all States are required to complete a needs assessment as a condition of receiving payment of FFY 2011 Title V Block Grant funds, regardless of whether the State intends to apply for a grant to provide home visiting services. As noted above, California has applied for and received the award notification for receipt of ACA Home Visiting Programs funds.

3. Updated State Plan (Supplemental Information Request (SIR) due to be published September 2010, State response due in Early Federal Fiscal Year (FFY) 2011)

The third step will be to submit an Updated State Plan. The SIR for submission of the Updated State Plan, yet to be published, will provide guidance to States for making the final designation of the targeted at risk community or communities, updating and providing a more detailed needs and resources assessment for the targeted community or communities, and submitting a specific plan tailored to address these needs. California has already begun planning for this stage of the application process by maintaining regular communications with partners and stakeholders, inviting representatives from the national home visiting models to come speak to CDPH/MCAH and its partners and stakeholders, and continuing to evaluate the needs and capacity of California's counties.

**Methods**

California's general approach to conducting the statewide home visiting needs assessment focused on extensive data collection and analysis, along with cross-agency collaboration and coordination. Several approaches have been undertaken to obtain internal and external partner and stakeholder input in this needs assessment process: detailed discussions with State partners to obtain relevant evidence, data, and reports, a Capacity Assessment Home Visiting Survey, formation of a collaborative workgroup, and solicitation of stakeholder input through the newly developed Home Visiting Program website.

Methods to Ensure Collaboration with Partner Agencies

In order to ensure that home visiting is part of a continuum of early childhood services within the State, the first SIR specified that the submission of the statewide home visiting needs assessment must contain the concurrence of the State's Title V agency, the State's agency for Title II of the Child Abuse Prevention and Treatment Act (CAPTA), the State's Single State Agency for Substance Abuse Services, and the State's Head Start State Collaboration Office.

CDPH/MCAH, the state's Title V agency, was designated by the California Governor as the lead agency for California's Home Visiting Program, in partnership with the CDSS, CDADP, and the CHSSCO of the CDE. In addition to providing letters of support (see Appendix I), these agencies have been instrumental in the home visiting needs assessment process. Specifically, CDPH/MCAH consulted with its partners to obtain relevant evidence, data, and reports to identify indicators of interest and to interpret their agencies' data. In addition, CDADP contributed to the home visiting needs assessment section on the State's capacity to provide substance abuse treatment. Moreover, communication with each of these agencies is well underway regarding the need for additional input and data for the Updated State Plan As well as identifying quantifiable, measurable benchmarks to demonstrate improvements.

The first SIR also mentioned a number of additional agencies/documents for which the application should coordinate to the extent possible. This includes the State's child care agency, education agency, agency administering Family Violence Prevention and Services Act (FVPSA) and STOP Violence Against Women funds, and the State's Individuals with Disabilities Education Act (IDEA) Part C and Part B Section 619 agencies. As described below, CDPH/MCAH has either initiated discussions with these agencies or obtained copies of relevant reports or data for this needs assessment report. CDPH/MCAH will continue to build on this information and these relationships for the updated home visiting needs assessment.

- The State's child care agency: CDPH/MCAH administers the California Early Childhood Comprehensive Systems grant, which is a federal grant provided by Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA/MCHB) to build and implement a statewide comprehensive early childhood system that supports the development of children who are healthy and ready to learn. Partially funded through this grant is the Child Care Health Linkages Project that seeks to improve the health and safety of children attending early care and education programs in 20 California counties. In addition, this program seeks to create and support the infrastructure for linkages between public health and early care and education agencies.
- The State's education agency: CDPH/MCAH worked with the CHSSCO of the CDE as well as with the California Head Start Association to obtain service and funding information on Head Start and Early Head Start. In addition to coordination around Head Start/Early Head Start (HS/EHS), the CHSSCO Director has agreed to be the point of contact regarding future discussions around school readiness as the Home Visiting Program is developed (e.g., identifying and obtaining existing school readiness data and determining benchmarks).
- The State agency administering FVPSA and STOP Against Women funds: CDPH/MCAH contacted the California Emergency Management Agency (CalEMA), the California agency that receives FVPSA funds, as well as a number of other agencies such as the Safe and Active Communities (SAC) Branch of the CDPH, the STOP Violence Against Women regional coordinator for California, and the California Partnership to End Domestic Violence (CPEDV) to obtain service statistics and other indicators of service needs.
- The State's IDEA Part C and Part B Section 619 agencies: CDPH/MCAH collaborated with the California Department of Developmental Services (CDDS) on the preschool section of IDEA 2004 (Part B, Section 619) which provides funding for special education and services to children with disabilities ages three to five. In addition, CDPH/MCAH convened the California Statewide Screening Collaborative (CSSC) in September 2007 as an activity of the California Early Childhood Comprehensive Systems (ECCS) grant. This collaborative brings together state agencies, organizations,

and special initiatives that focus on California's capacity to promote and deliver effective and well-coordinated health, developmental, and early mental health screenings for young children, birth to age five. The California Department of Education (CDE), which is California's IDEA Part C and Part B Section 619 agency, is part of that collaborative.

- The strategic plan developed by the State Advisory Council established under section 642 B(b)(1)(A)(i) of the Head Start Act: In California, the new body is the California Early Learning Advisory Council (ELAC). ELAC is co-chaired by a representative from the Secretary of Education, a State Superintendent of Public Instruction designee, and a California Children and Families Commission designee. CDPH/MCAH just recently obtained a copy of the ELAC Federal Funding Application that is essentially the strategic plan for building a comprehensive early care and education system over the next three years. Given the recent completion of and thus receipt of this report, incorporation of information into this needs assessment was not feasible. CDPH/MCAH will consult with the ELAC members to ensure that pertinent information from that document is incorporated into the updated home visiting needs assessment and that California's Home Visiting Program is coordinated with the goals of the ELAC.

Methods to Ensure Coordination with the Title V, Head Start and CAPTA Needs Assessments

In addition, the first SIR notes that the statewide home visiting needs assessment must be coordinated with and take into account the needs assessments required by: 1) the Title V MCH Block Grant program; 2) the communitywide strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act; and 3) the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect and other family resource services operating in the State required under section 205(3) of Title II of CAPTA.

CDPH/MCAH coordinated efforts to ensure that to the extent possible, existing needs assessments and inventories were incorporated into the home visiting needs assessment as required. Given CDPH/MCAH's role as lead in developing the Title V Five-Year Needs Assessments, data on key maternal, infant and child health indicators were readily available for further analysis and were integrated into the home visiting needs assessment as appropriate.

Collaboration with the California Department of Social Services, Child and Family Services Division (CDSS/CFSD) ensured that the home visiting needs assessment also considered the inventory of current unmet needs, the community-based and prevention-focused programs/activities, and other family resource services funded under Title II (also known as Community-Based Child Abuse Prevention Program, or CBCAP) of CAPTA. CDSS/CFSD just completed the CBCAP annual report for FFY 2009 and provided a written summary of the various prevention-focused programs/activities in the State from that report for inclusion in this needs assessment. In addition, the CDSS/CFSD provided CDPH/MCAH with a number of other documents including the 2007 California Child and Family Services Review, Statewide Assessment; the Title IV-B, 2010-2014 Child and Family Services Plan; and the Title IV-B Child and Family Services Plan, 2008 Annual Progress and Services Report. CDPH/MCAH reviewed these documents and incorporated pertinent information into this needs assessment where appropriate. Finally, it should be noted that while these documents provided important qualitative data on services, funding, and unmet needs, CDPH/MCAH did not use the CAPTA needs assessment as the data source for child maltreatment as indicated in the first SIR. Instead CDPH/MCAH collaborated with CDSS to identify an alternative data source for child maltreatment for inclusion in this report.

Consideration of the communitywide strategic planning and needs assessments conducted in accordance with the Head Start Act presented more of a challenge due to the number of California grantees. With over 70 Head Start grantees in the State, first obtaining and then individually reviewing each of these assessments was not feasible within the time constraints of the required home visiting needs assessment. To ensure compliance with this requirement, CDPH/MCAH worked closely with the CHSSCO on alternative strategies to incorporate information on Early Head Start. This included the use of data from the 2008-2009 Early Head Start State Program Information Report (PIR) which provides state-level aggregate data on the services, staff, children, and families served by Early Head Start in California. Similarly, alternative sources were identified and used for those indicators identified in the first SIR for which the Head Start assessments were the data source (e.g., poverty, domestic violence, unemployment, and child maltreatment). The PIR, however, did provide some state-level referral information related to child maltreatment, substance abuse, and domestic violence that was added as a supplement to the statewide data report (the "Appendix A" matrix). CDPH/MCAH is working with the CHSSCO to obtain copies of the communitywide assessments for inclusion in the updated home visiting needs assessment to be submitted as part of the Updated State Plan.

Additional Collaboration Activities

CDPH/MCAH is seeking valuable input from a number of other agencies and partners to ensure that all interested parties are working towards providing a continuum of early childhood services in California. The involvement of CDPH/MCAH branches in developing and implementing this needs assessment was facilitated through the home visiting steering committee, which met regularly throughout the process. This committee includes staff from the Home Visiting Program Section, and the Division, Branch and Section Chiefs within the CDPH/MCAH Program. Input from additional CDPH/MCAH staff was solicited during planning meetings. In drafting the Capacity Assessment Home Visiting Survey, CDPH/MCAH sought input from the home visiting steering committee, internal CDPH/MCAH staff, the Home Visiting Collaborative Workgroup (described below) and many local MCAH Directors.

The Home Visiting Collaborative Workgroup, formed by CDPH/MCAH, includes representatives from the home visiting partner agencies (CDPH/MCAH, CDSS, CDADP, CHSSCO) as well as representatives from First 5 California, the First 5 Association of California and four local MCAH Directors designated to represent and act as a conduit of information for MCAH Action (the professional organization for MCAH Directors of local health jurisdictions in California). The Workgroup addresses concerns and recommendations from local stakeholders and partners and serves as an invaluable resource for strategic planning for the Home Visiting Program.

A number of other agencies and stakeholders provided input, data, evidence or reports to assist with the preparation of this needs assessment, including the California Department of Developmental Services (CDDS), the SAC branch of the CDPH, CalEMA, the Domestic Violence Assistance Program, the CPEDV, the California Department of Health Care Services (CDHCS), First 5 California, the First 5 Association of California, a number of county First 5 Commissions, and MCAH Action.

Finally, CDPH/MCAH developed a website as another method to keep stakeholders and partner agencies informed of the application process and California's Home Visiting Program development process (http://www.cdph.ca.gov/programs/mcah/Pages/HVP-HomePage.aspx). The website also provides an opportunity for stakeholders to engage in the process through a

comments section. CDPH/MCAH received over 50 inquiries and comments from organizations and individuals about the home visiting grant application process. Most questions related to the timing of public comment, advocacy for certain home visiting approaches, and concerns about how the needs of specific communities would be addressed.

Components of the Statewide Needs Assessment

To meet the requirements for an approvable statewide home visiting needs assessment, States were required to: 1) identify communities with concentrations of at risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school drop-outs; substance abuse; unemployment; or child maltreatment; 2) identify the quality and capacity of existing early childhood home visiting programs; and, 3) discuss the State's capacity to provide substance abuse treatment and counseling services.

The first SIR provided specific instructions for responding to these requirements and for reporting the data through six separate components as described below. CDPH/MCAH organized this needs assessment document to follow these six components. While not required, in order to illustrate the complexity and diversity of California, CDPH/MCAH also included an overview of the economic climate in California and a demographic overview of California that precedes Section 1 "Complete a statewide data report." The conceptual framework for data presentation and interpretation is also provided in the overview section.

1. **Complete a statewide data report (pgs. 42-115).** This section of the report includes data for all of the select indicators in the first SIR as well as data for supplemental indicators California considered important in identifying at risk communities within the frameworks of the life course perspective, social determinants of health, and the socio-ecological model. In addition to the statewide data report (the "Appendix A" matrix), this section includes additional tables and charts that were useful in selecting California's at risk communities.

2. **Identify the unit selected as "community (pgs. 118-123)."** In this section of the report California defines "community" and identifies those communities that were considered "at risk" based on that definition. Also included is a data table that summarizes all of the indicator data presented in Section 1. This table serves as the justification for California's identification of at risk communities for this assessment.

3. **Complete a data report for each at risk community in the State (pgs 126-244).** An individual data report is included in this section, using the same data and metrics as in the statewide data report, for each of the communities identified in the State as being at risk.

4. **Provide information on the quality and capacity of existing programs/initiatives for early childhood home visitation in each of the communities identified as being at risk (pgs 246-417).** This section provides a snapshot of the quality and capacity of California's existing home visiting programs, the number and types of persons served, and identified service gaps and unmet needs. The information for this section comes primarily from the Capacity Assessment Home Visiting Survey that was developed and implemented for this needs assessment and is described in more detail in Section 4. This section is supplemented with information gathered and synthesized from several previously published reports profiling the existing early childhood home visiting programs in California as well as with information from State and local partners.

5. **Provide a narrative description of the State's capacity for providing substance abuse treatment and counseling services to individuals/families in need of these services who reside in communities identified as being at risk (pgs 420-428).** This section discusses California's current substance abuse treatment and counseling capacity, treatment needs, and gaps in services.

6. **Provide a narrative summary of needs assessment results, including a discussion of how the State will address unmet needs (pgs 430-442).** This narrative summarizes all of the information presented in the preceding sections including successes and challenges in completing this statewide home visiting needs assessment. This section also includes a preliminary discussion of California's plan for completing the Updated State Plan and for program implementation.

# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

# Economic Climate in California

**Maternal, Child and Adolescent Health Program**
**Center for Family Health**
**California Department of Public Health**

## ECONOMIC CLIMATE IN CALIFORNIA

In State Fiscal Year (SFY) 2007-08, California began experiencing an economic decline that has continued through the current fiscal year. In SFY 2008-09, California faced a $14.5 billion budget deficit for the 12-month SFY. In FY 2009-10, the budget gap had grown to $60 billion for the 18-month period between January 2009 and July 2010. The final Governor's Budget for SFY 2009-10 was $119.225 billion for all funds. Currently, the budget gap for SFY 2010-11 is $20 billion.

The largest contributor to the continuing budget gaps has been the reduction of the baseline revenue to the state as a result of the recession and related reductions in business, sales, income, use, and property tax and fee revenues. The deficit was compounded by state spending increases due to the repayment of debts incurred during the prior state budget crisis in 2003-04, and the loss of one-time budget deficit solutions adopted during the previous crisis.

The SFY 2008-09 and SFY 2009-10 18-month budget gaps were addressed as follows:

California Budget Deficit Solutions (in millions):

| | SFY 08-09 | SFY 09-10 |
|---|---|---|
| Spending Cuts | $11,343 | $31,018 |
| Taxes | $4,029 | $12,513 |
| Borrowing | $4,027 | |
| Revenue Acceleration | $3,306 | |
| Revenues (non-tax increase) | $622 | |
| Federal Stimulus | | $8,016 |
| Other | | $8,436 |
| Total | $23,327 | $59,983 |

The Governor's Proposed Budget for SFY 2010-11 (which has not yet been adopted by the Legislature) reflects a total budget of $122.619 billion and proposes to close the $20 billion budget gap as follows:

California Budget Deficit Solutions (in millions):

| | SFY 2010-11 |
|---|---|
| Spending Cuts | $12,368 |
| Federal Funds | $3,382 |
| Alternative Funding | $1,278 |
| Fund Shifts and Other Revenues | $2,114 |
| Total | $19,142 |

According to the California State Department of Finance (CA DOF), as proposed, the Governor's Budget would bring overall State General Fund (SGF) spending to a level well below what it was in SFY 1998-99, adjusted for population and inflation growth.

The budget reductions of the past two years have resulted in deep cuts to Public Health, Health Care Services, Social Services, and Education programs.

**CDPH/MCAH**

In SFY 2009-10 the elimination of all state funding for MCAH programs, including local MCAH, CDPH/MCAH support, Black Infant Health (BIH), and Adolescent Family Life Program (AFLP), reduced state and local budgets for these programs by an aggregate $21.3 million in FY 2009-10, relative to FY 2008-09. Since SGF funds spent on MCAH activities are eligible for Title XIX Federal Financial Participation (FFP) funds, which are a match of federal funds to state and local expenditures, the elimination of SGF resulted in an additional loss of approximately $12 million statewide in SFY 2009-10. In total, the elimination of SGF resulted in a loss of approximately $33.3 million in combined state and federal funding across all MCAH, BIH, and AFLP programs at the state and local levels. Statewide the funding losses resulted in the elimination of 69 full-time equivalent positions (FTE) in local MCAH agencies, 30 FTEs in local BIH programs, and 170 FTEs in AFLP agencies in SFY 2009-10.

In December 2009, CDPH/MCAH conducted a survey of California Local Health Jurisdictions (LHJs) to determine the impact of the loss of SGFs on MCAH programs. Fifty-eight of the 61 LHJs responded to the survey and reported being impacted significantly by the loss of funding, including the following:

- Home visiting programs eliminated
- Delays in access to care
- Program closures (e.g., Black Infant Health, High Risk Infant Program)
- Delays in referrals for comprehensive healthcare services
- Fewer clients receiving necessary education and support, leading to higher risk for poor public health outcomes and associated costs
- Increased numbers of potential clients on waiting lists
- Community outreach services curtailed or eliminated, affecting program ability to collaborate and coordinate with other healthcare or education services
- Infant car seat programs eliminated
- Key components of programs de-funded (e.g., obesity prevention, Sudden Infant Death Syndrome [SIDS] education, oral health, reproductive health, preconception care)
- One-to-one services replaced by telephone contacts
- Reduced mental health screening and referrals
- Fewer culturally competent services
- Elimination of fetal and infant death review programs
- Closure of some public health offices
- Staffing reductions
- Case management services reduced
- Reduced numbers of medical providers willing to participate in the Comprehensive Perinatal Services Program
- Public health nursing positions reduced or eliminated
- Reduced staff training and development funding
- Reduced oversight and coordination of services, leading to fragmentation of care
- Reduced quality assurance and program integrity services

In addition to the cuts to CDPH/MCAH programs, the 2009 Governor's Budget eliminated all state funding of Domestic Violence Shelters. However, SBX-13 provided one-time, one-year (for SFY 2009-10) special funding of $16.1 million from the Alternative and Renewable Fuel and Vehicle Technology Fund for CalEMA to fund the Domestic Violence Program formerly administered by the CDPH.

### Education

The SFY 2009-10 Governor's Budget addressed some of the deficit with cuts to per-student educational spending. The SFY 2009-10 Education budget reduced programmatic per-student funding as follows:

Programmatic Per-Student Funding by Education Area:

| | SFY 2008-09 | SFY 2009-10 | % Change |
|---|---|---|---|
| Child Care and Development | $7,312 | $7,113 | -2.70% |
| K-12 Education | $8,423 | $7,957 | -5.50% |
| California Community Colleges | $5,499 | $5,376 | -2.20% |

The SFY 2010-11Governor's Proposed Budget proposes further reductions to per-student funding by an additional 5.3% - to $6,733 - for Child Care Development, 6.8% - to $7,417 - for K-12 Education, and 1% - to $5,321- for California Community Colleges. Since multiple studies show a direct correlation between education levels and reduced teen pregnancies, domestic violence, health, and poverty, continued educational spending cuts may have an adverse impact on Health and Human Services programs in the form of increased demand for services.

### Social Services

The SFY 2009-10 Governor's Budget contained both immediate and future reductions to the State's cash assistance program (CalWORKS), Child Welfare Services and foster care programs, and community clinics. The deepest cuts, including the elimination of CalWORKS, were ultimately averted, however, with the infusion of the American Recovery and Reinvestment Act (ARRA) federal funds. Nonetheless, the Social Services budget was reduced by approximately $1 billion because of cuts in funding to counties for CalWORKS, Child Welfare Services, In-Home Health Services for all but the most severely disabled, and the elimination of statutory cost-of-living adjustments (COLAs) for CalWORKS and Supplemental Security Income/State Supplementary Payment (SSI/SSP). This puts a greater financial burden for Cal-Works and Child Welfare Services on local governments.

### Health Care Services/Medi-Cal

As with Social Services, the deepest cuts to the SFY 2009-10 Governor's Budget, including the elimination of California's FamilyPACT program, which provides health coverage at greatly reduced cost to the children of the working poor who do not otherwise qualify for Medi-Cal, were averted with the infusion of federal funding. The Medi-Cal budget assumed federal actions would reduce state Medi-Cal funding requirements by $1 billion, but still included reductions to developmental services, the Healthy Families Program, substance abuse programs, and various other gubernatorial vetoes, amounting to approximately $1.3 billion in total reductions to Health Services/Medi-Cal programs.

## Summary

The various Public Health, Social Services, Health Care Services, and Education programs that are designed to provide services, linkages, and support to the neediest populations in California have all experienced significant budget reductions as a result of California's ongoing economic difficulties. While increased federal funding has averted the deepest cuts, it is becoming increasingly difficult for the poorest Californians to find support services at a time when the economy is forcing more and more Californians into poverty.

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# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

# Overview of California's Demographics

**Maternal, Child and Adolescent Health Program**
**Center for Family Health**
**California Department of Public Health**

## OVERVIEW OF CALIFORNIA DEMOGRAPHICS

### The Conceptual Framework: Life Course, Social Determinants and the Socio-Ecological Model

CDPH/MCAH uses the life course perspective, social determinants of health, and the socio-ecological model frameworks in its efforts to protect and improve the health of mothers, infants, and children. These frameworks inform the examination of health outcomes and help target ongoing efforts to reduce health disparities by addressing their root causes. Recently, these frameworks were used in the California Title V Needs Assessment to structure the interpretation of findings, shape priorities, and develop strategies to impact health outcomes. As the statewide home visiting needs assessment has evolved out of the efforts of the Title V Needs Assessment, these frameworks have played an important role in selecting additional indicators, identifying at-risk communities, and examining home visiting models.

The Life Course Perspective is an evolving public health paradigm[2, 3] that has been applied extensively in the MCAH field in recent years. It frames health as a trajectory across the continuum of the life course, beginning with the period in utero. The life course perspective also recognizes that some evidence suggests that current health status may be influenced by the fetal experiences of previous generations.[4] This framework explains health disparities by focusing on differential exposures and opportunities during sensitive developmental periods (in utero, early childhood, adolescence, pregnancy) that may have particularly powerful influences on subsequent health trajectories.[4, 5] Further, the model incorporates the cumulative effects of chronic stress across the life span to explain declining health status. Experience of ongoing social disadvantage[4] or episodes of negative exposures[6] during these sensitive periods have been shown to result in physiologic changes, such as stress hyper-reactivity and immune dysfunction, that contribute to worsening health outcomes and chronic disease in subsequent life stages.

Implicit in the life course perspective is a consideration that health results from not only genetics and health behaviors, but from the social, psychological, economic, environmental, and cultural context in which health outcomes arise. [2-6] Collectively, these factors are referred to as the social determinants of health. In California, as in the United States, differential access to resources in these arenas has resulted in MCAH outcome disparities for certain racial and ethnic groups, the poor, non-citizens, and other population groups.[7, 8] The importance of social determinants of health in explaining health disparities in California has been recognized through its integration into the CDPH Decision Framework, the department-wide process developed to assure responsiveness to health challenges in the 21st Century.

Closely related to social determinants of health is the socio-ecological framework, which illustrates how factors at multiple levels (i.e., individual, relationship/family, community, and societal) influence health and social outcomes for women and children.[9, 10] This framework highlights the complex interplay between the individual and the environment that influences behaviors and outcomes, and has been used to develop prevention strategies that address multiple levels of the social milieu.[11]

In relation to home visiting, these frameworks emphasize the importance of health prior to and between pregnancies in the causal pathway for birth and maternal outcomes.[12] Pregnancy, though, remains an important period. For all women, it provides opportunities for positive change, but for some, pregnancy can be a period of vulnerability and worsening health.[4] Social conditions such as poverty, lack of social support, racial discrimination, and other sources of

stress also play an important role in birth outcomes.[13-17] For infants, experiences in utero relate not only to birth outcomes, but also set the stage for health status across the life span, impacting child development, chronic disease status in adulthood, and reproductive outcomes for females. Home visiting programs that address maternal health during pregnancy provide support during this vulnerable period, while a focus on maternal well-being in the postpartum period may also improve the outcomes of subsequent pregnancies.

The frameworks presented above also illustrate the life long consequences of risks and health conditions that occur during childhood, particularly during the period from birth to age five.[12,18, 19, 20] Early childhood is a critical period for a child's cognitive, emotional, and social development. Good health during this time supports children's emotional and cognitive development, which in turn contributes to academic success.[21] Nurturing environments at school, within the community, and at home also impact early childhood cognitive, emotional, and social development.[22, 23] Conversely, negative exposures such as parental mental health problems and substance use, lack of economic and social resources, and exposure to domestic violence have detrimental effects on child development and subsequent health trajectories.[18, 24-29] Early childhood home visiting programs that address these determinants of child and family well-being in the context of their larger systems not only impact important short-term outcomes for children and families but also have the potential to shape long-term outcomes for children.

CDPH/MCAH recognizes the promise that the Home Visiting Program offers to improve health and social outcomes across the life course. High quality home visiting programs should recognize the interconnections between individuals, families, communities, and the larger society while also considering range of social, economic, and environmental factors that support or threaten health and development during sensitive developmental periods. Comprehensive models that integrate these frameworks are consistent with the priorities identified through California's Title V Needs Assessment.

**Demographic Data**

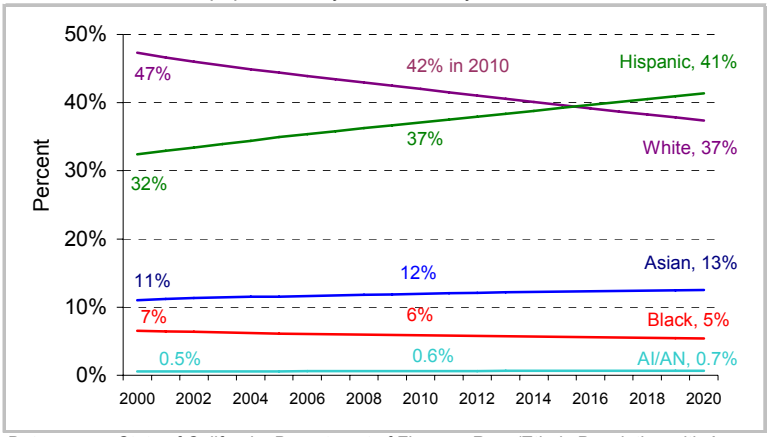
The demographic data presented in this overview include overall population projections, birth statistics, and information on immigration, languages spoken, and family structure. California's growing population and increasing diversity will continue to shape the overall need, as well as the rate and burden of maternal, infant and early childhood outcomes in the coming years.

Overall Population

An estimated 39.1 million people resided in California in 2010, an increase from 34.1 million in 2000. California's population growth is expected to continue over the next 10 years to reach 44.1 million by 2020.[30] In 2010 an estimated 42% of California's overall population is White/non-Hispanic, 37% Hispanic, 12% Asian, 6% African-American/non-Hispanic, 2% multi-race, 0.6% American Indian/Alaska Native, and 0.4% Native Hawaiian/Pacific Islander. Projections in the racial/ethnic composition of California's population through 2020 predict a continuing decline in the White population proportion and an increase in the Hispanic population proportion, which will become the largest racial/ethnic group in California. The proportions of other racial and ethnic groups in California will remain relatively stable through 2020 (Figure 1).

**Figure 1. Population Projections**

Percent of California population, by race/ethnicity, 2000-2020

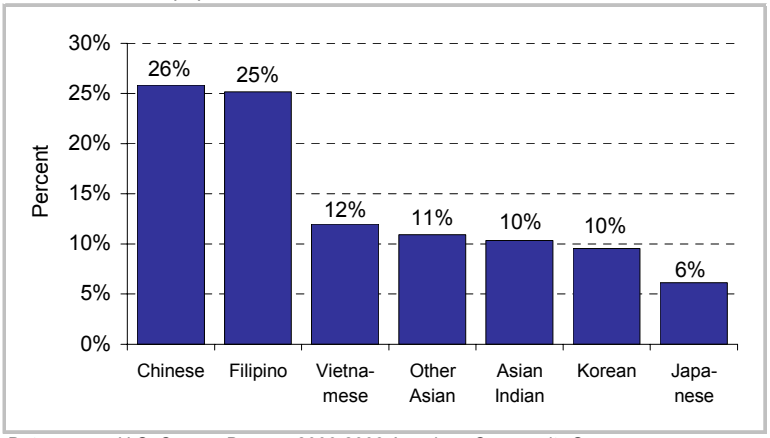



Data source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007.

Characteristics such as language and culture vary substantially both within and across racial/ethnic sub-groups in California. These factors, among others, play an important role in planning and targeting interventions for the statewide population. For example, California's Asian population, the largest in the nation, demonstrates substantial diversity (Figure 2). The largest Asian sub-groups in California are Chinese, Filipino and Vietnamese. Korean and Asian Indian sub-groups also make up at least 10% of the overall Asian population in California. While the largest numbers of Asians reside in the Southern California population centers in Los Angeles, Orange, and San Bernardino counties, the counties with the largest percentage of Asian residents are in the San Francisco Bay Area.[30]

**Figure 2. Asian Subgroups in California**

Percent of Asian population, 2006-2008

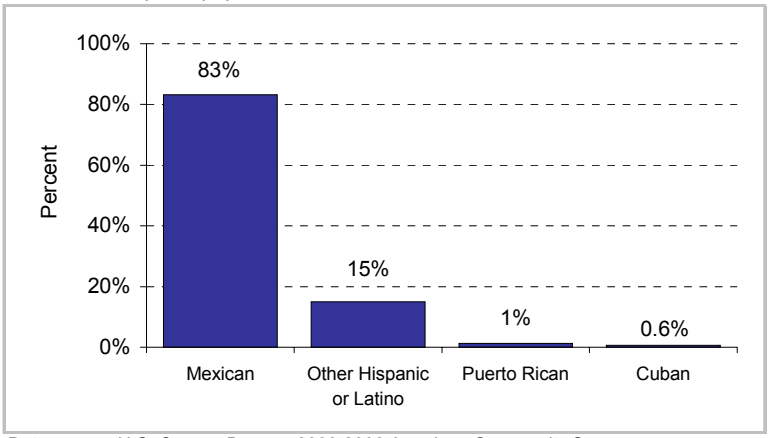



Data source: U.S. Census Bureau, 2006-2008 American Community Survey

Hispanic groups in California are predominantly of Mexican origin (83%), followed by other Hispanic or Latino groups from Central and South America (15%). Less than 2% are Puerto Rican or Cuban (Figure 3). Due to shifts in immigration patterns, an increasing number of indigenous Mexicans, who have distinct linguistic and cultural heritages, have settled in California.[31] While Southern California counties have the largest numbers of Hispanic residents, counties on the Mexican border and in Central California have the highest proportion of Hispanic residents. At 77%, Imperial County has by far the largest proportion of Hispanic

residents in California. In addition, more than 50% of the population in the agricultural counties of Central California is Hispanic.[32]

**Figure 3. Hispanic Subgroups in California**
Percent of Hispanic population, 2006-2008

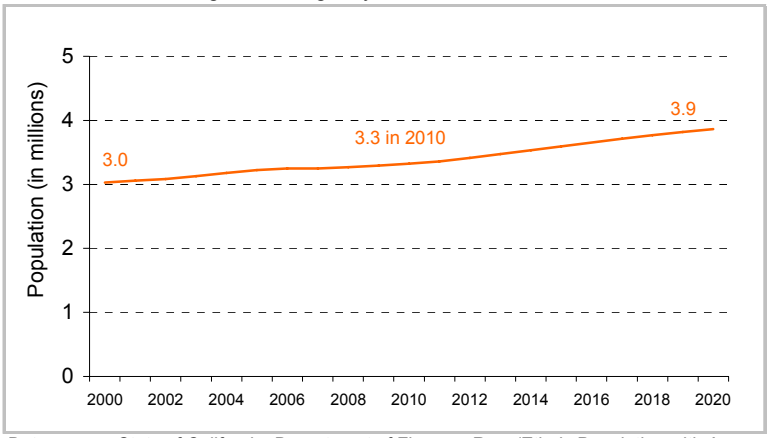



Data source: U.S. Census Bureau, 2006-2008 American Community Survey

## Young Children

As with the overall population, the number of young children ages 0 through 5 years residing in California has continued to grow at a steady pace. The population has increased from 3.0 million in 2000 to 3.3 million in 2010, and is projected to reach 3.9 million in 2020 (Figure 4).

**Figure 4. Young Child Population Projection**
Number of children ages 0 through 5 years, 2000-2020

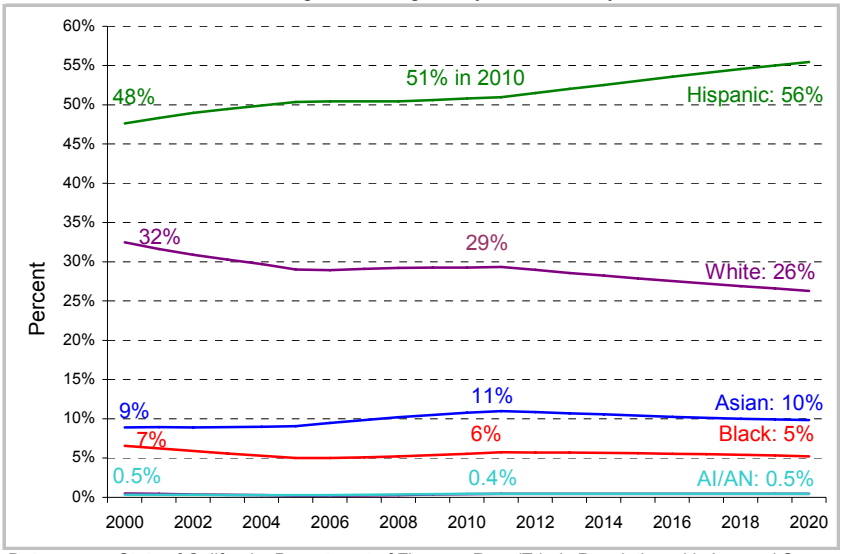



Data source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007

The racial/ethnic distribution of children ages 0 through 5 years differs from the overall population in California in that the proportion of Hispanic children is substantially larger and the proportion of White children is smaller in this age group. Over the next 10 years, the percent of Hispanic children will increase from 51% in 2010 to 56% in 2020 and the proportion of White children will decline from 29% in 2010 to 26% in 2020. Other racial/ethnic groups more closely mirror the trends of California's overall population, and are projected to remain fairly stable through 2020 (Figure 5).[30]

**Figure 5. Population Projections among Children**

Percent of California children ages 0 through 5, by race/ethnicity, 2000-2020



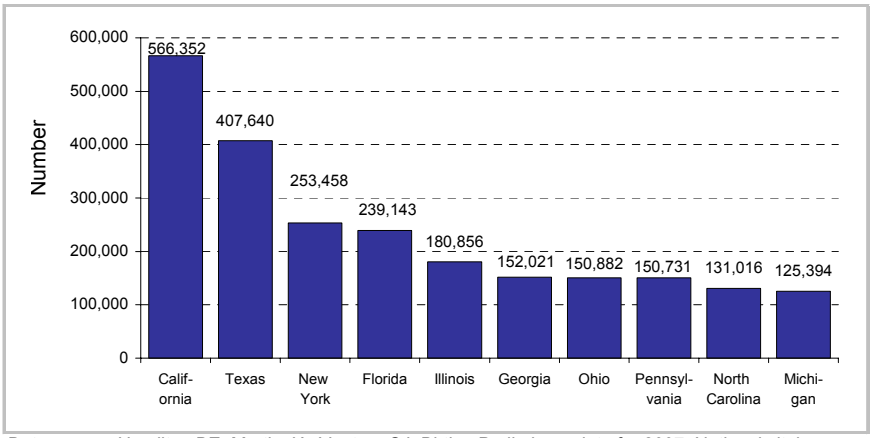

Data source: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, July 2007

## Birth Statistics

Historical trends and projections for birth statistics are essential for understanding the scope of need for maternal, infant, and early childhood home visiting services in California. In 2007, the 566,352 births in California accounted for approximately 1 in 8 of all US births, more than any other state (Figure 6).

**Figure 6. States with the Greatest Number of Births**

Number of live births, 2007



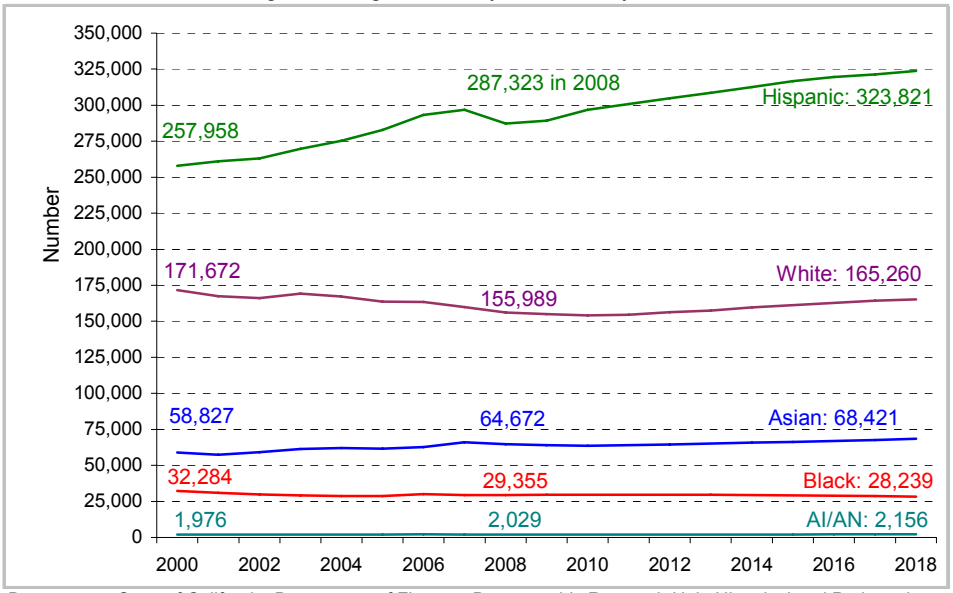

Data source: Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary data for 2007. National vital statistics reports, Web release; vol 57 no 12. Hyattsville, MD: National Center for Health Statistics. Released March 18, 2009.

During the period 2000 to 2008, the number of California births increased from 531,285 to 551,567. Through 2018, the number of births is expected to increase by about 5,590 per year, on average. The number of births in 2018 is projected to be 10.1% larger than in 2008, totaling 607,466.[33]

Births among Hispanic and Asian women showed the greatest increase from 2000 to 2008, while births to White and African-American women declined (Figure 7). Between 2008 and 2018, the number of births to women of all racial/ethnic groups will increase, with the exception of births to African-American women. In detail, births to Hispanic women will increase by 13%, births to Asian women will increase by 6% and births to American Indian/Alaska Native women will increase by 6%. Although not shown in the figure, births to multi-race women will increase by 72%, from 9,722 in 2008 to 16,703 in 2018. Births among Pacific Islander women will also increase by 16%, from 2,477 in 2008 to 2,865 in 2018.

**Figure 7. Historical and Projected Births in California**

Number of live births among women ages 15-44, by race/ethnicity, 2000-2018




Data source: State of California, Department of Finance, Demographic Research Unit, Historical and Projected State and County Births, 1980-2018, with Actual and Projected Fertility Rates by Mother's Age and Race/Ethnicity, 2000-2018. Sacramento, California: September 2009

Considerable variation in geographic size and population across California counties is reflected in the differences in the number of live births. In many counties, the number of births exceeds that seen in some states. For example, Los Angeles County makes up over one-quarter of the births in California, approaching 150,000 births in 2008. Several California counties have fewer than 400 births (Table 1).

**Table 1. Percentage of Total California Resident Live Births by County, 2008**

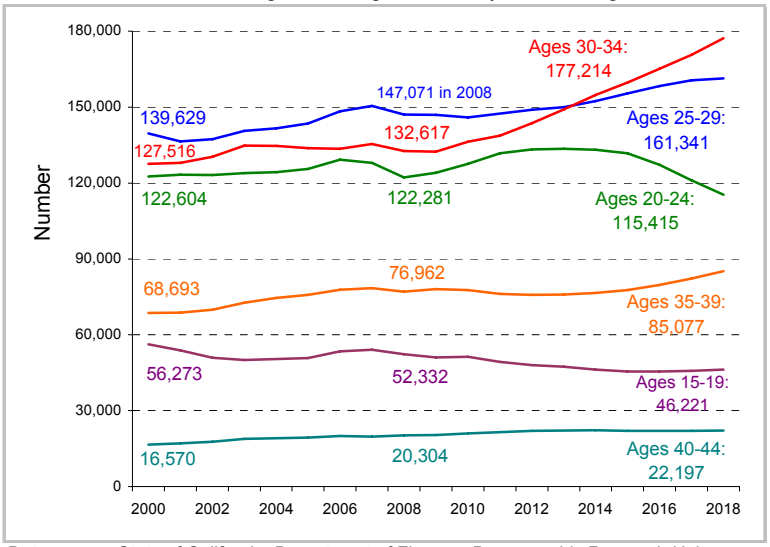
| RANK ORDER | COUNTY | NUMBER OF LIVE BIRTHS | PERCENT OF CA TOTAL |
|---|---|---|---|
| | **CALIFORNIA TOTAL** | **551,567** | **100** |
| 1 | LOS ANGELES | 147,684 | 26.8 |
| 2 | SAN DIEGO | 46,742 | 8.5 |
| 3 | ORANGE | 42,456 | 7.7 |
| 4 | SAN BERNARDINO | 33,788 | 6.1 |
| 5 | RIVERSIDE | 32,866 | 6.0 |
| 6 | SANTA CLARA | 26,730 | 4.8 |
| 7 | SACRAMENTO | 21,389 | 3.9 |
| 8 | ALAMEDA | 20,972 | 3.8 |
| 9 | FRESNO | 16,760 | 3.0 |
| 10 | KERN | 15,315 | 2.8 |
| 11 | CONTRA COSTA | 13,136 | 2.4 |
| 12 | VENTURA | 12,076 | 2.2 |
| 13 | SAN JOAQUIN | 11,030 | 2.0 |
| 14 | SAN MATEO | 9,765 | 1.8 |
| 15 | SAN FRANCISCO | 9,104 | 1.7 |
| 16 | STANISLAUS | 8,549 | 1.5 |
| 17 | TULARE | 8,533 | 1.5 |
| 18 | MONTEREY | 7,434 | 1.3 |
| 19 | SANTA BARBARA | 6,319 | 1.1 |
| 20 | SONOMA | 5,761 | 1.0 |
| 21 | SOLANO | 5,607 | 1.0 |
| 22 | MERCED | 4,423 | 0.8 |
| 23 | PLACER | 4,035 | 0.7 |
| 24 | SANTA CRUZ | 3,538 | 0.6 |
| 25 | IMPERIAL | 3,221 | 0.6 |
| 26 | SAN LUIS OBISPO | 2,737 | 0.5 |
| 27 | MARIN | 2,716 | 0.5 |
| 28 | KINGS | 2,710 | 0.5 |
| 29 | YOLO | 2,669 | 0.5 |
| 30 | MADERA | 2,535 | 0.5 |
| 31 | BUTTE | 2,518 | 0.5 |
| 32 | SHASTA | 2,186 | 0.4 |
| 33 | EL DORADO | 1,814 | 0.3 |
| 34 | NAPA | 1,671 | 0.3 |
| 35 | HUMBOLDT | 1,601 | 0.3 |
| 36 | SUTTER | 1,468 | 0.3 |
| 37 | YUBA | 1,264 | 0.2 |
| 38 | MENDOCINO | 1,168 | 0.2 |
| 39 | NEVADA | 871 | 0.2 |
| 40 | SAN BENITO | 816 | 0.1 |
| 41 | TEHAMA | 790 | 0.1 |
| 42 | LAKE | 705 | 0.1 |
| 43 | SISKIYOU | 498 | 0.1 |
| 44 | TUOLUMNE | 486 | 0.1 |
| 45 | GLENN | 472 | 0.1 |
| 46 | CALAVERAS | 373 | 0.1 |
| 47 | COLUSA | 367 | 0.1 |
| 48 | LASSEN | 323 | 0.1 |
| 49 | DEL NORTE | 312 | 0.1 |
| 50 | AMADOR | 288 | 0.1 |
| 51 | INYO | 226 | 0.0 |
| 52 | MONO | 175 | 0.0 |
| 53 | PLUMAS | 175 | 0.0 |
| 54 | MARIPOSA | 147 | 0.0 |
| 55 | TRINITY | 126 | 0.0 |
| 56 | MODOC | 92 | 0.0 |
| 57 | SIERRA | 22 | 0.0 |
| 58 | ALPINE | 13 | 0.0 |

Source: 2008 Birth Statistical Master File.
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

Maternal age at birth is related to health and social outcomes for both mother and infant. Between 2008 and 2018, the number of births to women under age 25 is projected to drop, while the number of births to women in each of the older cohorts is projected to increase. The greatest increase is expected among women ages 30-34, for whom the number of births is projected to grow by 34%, or more than 44,500 (Figure 8).

**Figure 8. Historical and Projected Births in California**

Number of live births among women ages 15-44, by maternal age, 2000-2018

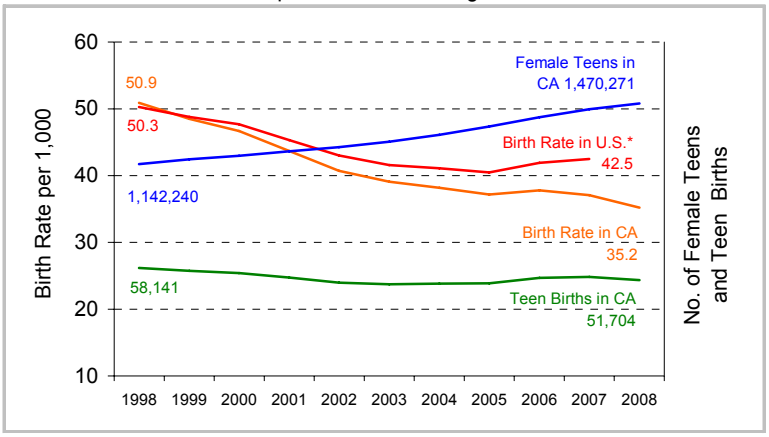



Data source: State of California, Department of Finance, Demographic Research Unit, Historical and Projected State and County Births, 1980-2018, with Actual and Projected Fertility Rates by Mother's Age and Race/Ethnicity, 2000-2018. Sacramento, California: September 2009

Young maternal age at birth is of particular interest when discussing maternal, infant and early childhood outcomes due to its association with health and social risks for both mothers and their infants.[34, 35] In California, birth rates have declined for teens ages 15-19, from 50.9 per 1,000 in 1998 to 35.2 in 2008. California's overall teen birth rate has also remained below the national rate over the past decade. The fact that there have been small decreases in the number of teen births in California marks an achievement considering there has been a steady increase in the size of the female teen population. Nevertheless, the number of teen births continues to represent a significant public health burden in California (Figure 9).

**Figure 9. Teen Births and Teen Population in California**

Teens, births, and birth rate per 1,000 females ages 15-19, 1998-2008



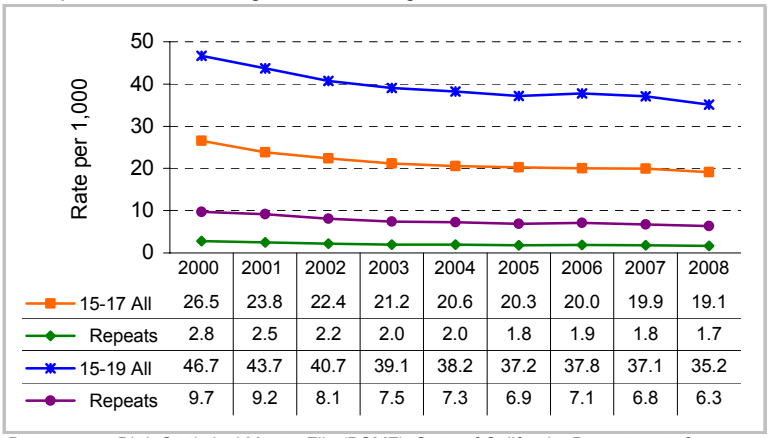

*Data for 2008 not available

Data sources: Birth Statistical Master File (BSMF); California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 1990-1999. Sacramento, CA, May 2004; California Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, CA, July 2007; National Vital Statistics Report, Vol. 57, No. 7, January 7, 2009; Births: Preliminary Data for 2007. National Vital Statistics Report, Vol. 57, No. 12, March 18, 2009

Teens who give birth at younger ages, between 15 and 17 years of age, are at greater risk of outcomes including premature labor, anemia, and high blood pressure.[34, 36] Between 2000 and 2008, the birth rate per 1,000 females ages 15-17 declined from 26.5 to 19.1 (Figure 10).

**Figure 10. Teen Births and Repeat Teen Births**

Rate per 1,000 females ages 15-17 and ages 15-19, 2000-2008



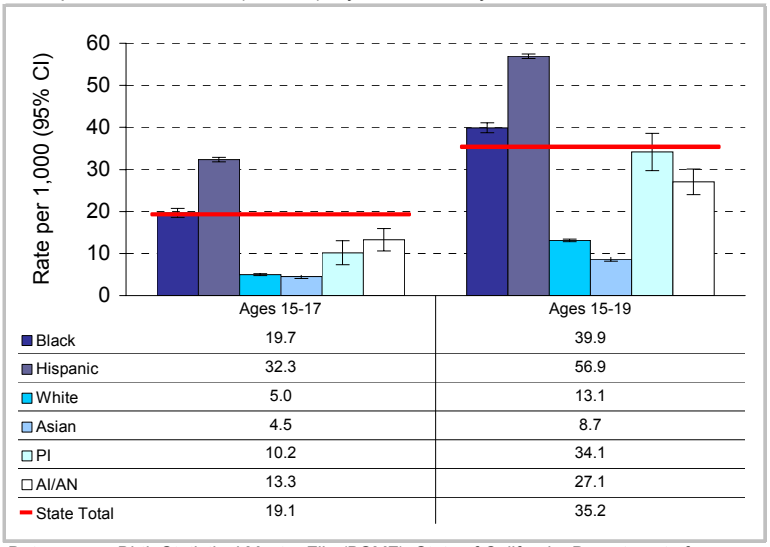

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|---|---|---|---|---|---|---|---|---|---|
| 15-17 All | 26.5 | 23.8 | 22.4 | 21.2 | 20.6 | 20.3 | 20.0 | 19.9 | 19.1 |
| Repeats | 2.8 | 2.5 | 2.2 | 2.0 | 2.0 | 1.8 | 1.9 | 1.8 | 1.7 |
| 15-19 All | 46.7 | 43.7 | 40.7 | 39.1 | 38.2 | 37.2 | 37.8 | 37.1 | 35.2 |
| Repeats | 9.7 | 9.2 | 8.1 | 7.5 | 7.3 | 6.9 | 7.1 | 6.8 | 6.3 |

Data source: Birth Statistical Master File (BSMF); State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000-2050*. Sacramento, California, July 2007

Among all teens and among younger teens, Hispanics have the highest teen birth rates, followed by African-Americans, whereas White and Asian teens have the lowest teen birth rates. In 2008, the Hispanic teen birth rate for females ages 15-17 (32.3) was over seven times higher than the rate among Asians (4.5) (Figure 11).

**Figure 11. Teen Births**

Rate per 1,000 females (95% CI), by race/ethnicity, 2008




Data source: Birth Statistical Master File (BSMF); State of California, Department of Finance, *Race/Ethnic Population with Age and Sex Detail, 2000-2050* . Sacramento, California, July 2007

Notes: PI = Pacific Islander; AI/AN = American Indian/Alaska Native

Births to teens who are already mothers, or repeat teen births, compound problems associated with teenaged childbearing.[37] For the mother, specific challenges associated with shortly spaced repeat births include difficulty finishing her education and achieving economic self-sufficiency; for the child, outcomes may include increased risk of low educational achievement and behavioral problems.[37] Factors associated with an increased risk of repeat teen birth are lower cognitive ability[38] and wanting the first birth,[39] while factors that reduce risk include delaying onset of sexual activity,[40] initiating long-acting contraception,[41] and continuing school attendance following the first birth.[42] The declining trends over time and differences by race/ethnicity described above for all teen births were also observed among repeat births (Figure 10).

## Immigration

California is home to 9.9 million foreign-born immigrants,[43] the largest number and percentage of foreign born residents in the United States.[44] International immigration has accounted for 40% of California's population growth since 2000. Furthermore, since 45% of California births are to women born outside the U.S.,[45] the well-being of this population has a strong influence on overall maternal, infant, and early childhood outcomes in California. Most of California's immigrants are from Latin America (56%) or Asia (34%). The leading countries of origin for immigrants are Mexico (4.4 million), the Philippines (750,000) and China (659,000).[46]

Immigration status is related to poverty among children in California, which in turn is a strong predictor of health outcomes. Overall, 48% of California's children have immigrant parents: 34% have at least one legal immigrant parent and an estimated 14% had at least one undocumented immigrant parent. Among these children, 24% of children with legal immigrant parents are poor and 38% of children with undocumented immigrant parents are poor.[47]

California has the largest number and proportion of undocumented immigrants of any state.[48] Many undocumented immigrants in California experience difficulty in meeting basic needs and accessing services, while facing additional health risks related to low wage jobs that lack protections and benefits. In 2008, approximately 2.7 million undocumented immigrants lived in California, an increase from 1.5 million in 1990.[48] In 2004, approximately 41% of California's undocumented immigrants resided in Los Angeles County.[47]

Languages Spoken

Limited English proficiency (being able to speak English less than 'very well') poses challenges for educational achievement, employment, and accessing services, and results in lower quality care for immigrant communities. These factors influence maternal and child health outcomes, and require special consideration when developing culturally and linguistically appropriate interventions. Among California's population over 5 years of age, 14.3 million speak a language other than English at home and 7.0 million have limited English proficiency.[49]

California's linguistic diversity requires maternal, infant, and early childhood systems to develop linguistic competence in multiple languages. Among youth in California's public schools, one in four is an English Language Learner (ELL) who is not proficient in English. These 1.5 million students speak 56 different languages, but over 1.2 million of ELL students are Spanish speakers. Other common languages are Vietnamese, Filipino, Cantonese, and Hmong. ELL students reside in every county in California; and in 14 counties located within California's Southern, Central Valley, and San Francisco Bay Area regions, ELL students comprise over 25% of the student population.[50]

Family, Household Structure, and Marital Status

Despite California's racial/ethnic diversity and large immigrant population, household structure in California is similar to the United States nationally. About 69% of children in California live in married couple households, 8% in father-only households, and 23% in mother-only households compared to 68%, 7%, and 25%, respectively, in the United States.[51] While overall 32% of children live in single-parent households, there is significant variation by racial/ethnic group: 64% of African-American children live in single-parent households compared to 43% for American Indian/Alaska Native, 26% for Hispanics, 23% for Non-Hispanic White, and 17% for Asian/Pacific Islander.[52] Patterns of household type have remained relatively stable in California during the last decade.[53]

In addition to the standard Census Bureau household types described above, in California, 8% of children live in households with cohabitating domestic partners[54] and about 5% of children under age 18 live in the care of grandparents.[55] An estimated 37,300 children live in households headed by same sex couples. Additionally, 10% of California's adopted children live in same-sex families.[54] Family-based home visiting services must be inclusive of the variation in household structure and family type in California.

Summary

California's population of mothers, infants, and children will continue to grow in number and diversity over the next five years. While the teen birth rate and numbers of teen births have declined recently, the number of women ages 15-19 continues to increase in California, indicating that attention to this vulnerable sub-population will continue to be a concern in the coming years.

Because 45% of births are to foreign-born women in California, the unique needs of the many ethnic sub-populations and immigrant communities must be included in the targeting of at risk communities, and in the selection and implementation of home visiting models. Interventions must address the needs of all targeted at risk communities, including those with limited English proficiency and non-traditional family structures.

# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

## 1. Statewide Data Report

**Maternal, Child and Adolescent Health Program**
**Center for Family Health**
**California Department of Public Health**

## COMPLETE A STATEWIDE DATA REPORT

### Introduction

The ACA Maternal, Infant and Early Childhood Home Visiting Program was created to respond to the diverse needs of children and families in communities identified as being at risk. Presenting statewide data is thus an important first step in identifying such communities and serves as the baseline in determining which communities will be designated as at risk for this needs assessment. This section presents statewide data results based on quantitative analysis conducted by the Epidemiology, Assessment, and Program Development (EAPD) Branch of the CDPH/MCAH and the compilation of secondary data from multiple datasets. This section does not identify at risk communities (the State's at risk communities are identified in the following section), rather it provides all of the data that were used to inform such an identification.

In addition to the required statewide data report (the "Appendix A" matrix) included at the end of this section, CDPH/MCAH also developed a table and a map that includes county-level data for each of the indicators.[*] The tables and maps are included to help identify areas within the State that are at highest risk for each indicator and ultimately to identify at risk communities. Specifically, for each indicator data are presented in a table sorted from worse-off to best-off counties with lines indicating the state rate or percentage and the state median.[⊥] CDPH/MCAH chose to include the State median in addition to the State rate in order to illustrate the significant influence several large counties have on the rate or percentage. For example, the statewide rate for low birth weight falls between the 14$^{th}$ and 16$^{th}$ ranked counties because several large counties including Los Angeles, San Bernardino, and Alameda rank within the top ten highest counties for low birth weight. Alternatively, the highest ranked counties for the domestic violence indicator were small rural counties, and as a result, the statewide rate drops to between the 34$^{th}$ and 35$^{th}$ ranked counties. The visual maps were created based on assigning counties to one of four quantiles based on their rate or percentage for each indicator. The resulting map identifies counties that are below the 50$^{th}$ percentile, that are between the 50$^{th}$ and 74$^{th}$ percentile and the 75$^{th}$ and the 89$^{th}$ percentile, and finally those counties that are between the 90$^{th}$ and 100$^{th}$ percentile for that indicator.

### Required Indicators

To the extent possible the data for the required indicators were drawn from the sources identified in the first SIR and were calculated using the specified metrics. In some cases the data sources used in this report differed from what was specified in the first SIR either because data from that source was not available or another source was considered preferable. An alternative data source was considered preferable if it had quantitative rather than qualitative data or because the data were available at the local level. Similarly, in some cases data could not be reported using the metrics specified in the first SIR. Whenever the data source or the metrics differed from the first SIR it was noted in the comments section of the statewide data report (the "Appendix A" matrix) and/or the narrative section for that indicator.

The *required* indicators presented in this needs assessment include:

- Premature birth
- Low birth weight infants

[*] For all county-level analyses, counties with too few events (defined as less than 20) were suppressed.

[⊥] It should be noted, however, that even if a county falls above or below the State median it does not mean that the rate is significantly different from the State median using formal hypothesis tests of statistical significance.

- Infant mortality (includes death due to neglect)
- Poverty
- Crime
- Domestic Violence
- School Drop-out rates
- Substance abuse
  - Binge alcohol use in past month
  - Marijuana use in past month
  - Nonmedical use of pain relievers in past year
  - Use of illicit drugs, excluding Marijuana, in past month
- Unemployment
- Child maltreatment
  - Substantiated maltreatment
  - Substantiated maltreatment by type

Premature Birth

*Background:* Babies who are born preterm (before 37 weeks) face increased risk of serious medical complications, hospitalization, and death compared to babies born at term.[56]In addition, preterm babies can face lifelong problems such as intellectual disabilities, respiratory problems, or cerebral palsy.[57] In California approximately 1 in 10 babies is born preterm.

*Methods:* The data source specified in the first SIR for this indicator was Title V and the metric was number of live births before 37 weeks divided by the total number of live births. For this needs assessment, CDPH/MCAH excluded births with less than 17 weeks gestation, greater than 47 weeks gestation and missing gestation. In addition, the premature birth rate was calculated using California resident births, which was not specified in the first SIR. Births prior to 17 weeks and greater than 47 weeks are excluded because they are not considered viable and are likely errors due to data entry or incorrect reporting. Excluding non-resident births is consistent with the National Center for Health Statistics and all of the other calculations presented in this report using the birth files.[58]

*Results:* The preterm birth rate increased from 10.5% in 2000 to 11.2% in 2005, and fluctuated from 2005 through 2008. In 2008 the prevalence of preterm birth remains higher than it was in 2008 at 10.7%. The Healthy People (HP) 2010 objective is to reduce the proportion of preterm births among all live births to no more than 7.6%. In 2008, African-American women had preterm birth rates (15.4%), higher than the HP 2010 objective and all other racial/ethnic groups. Preterm births were also higher among Pacific Islander (12.8%) and American Indian/Alaska Native (13.1%) women, compared with Hispanics (10.8%). At 9.7% in each group, White and Asian women had lower rates of preterm birth than women of other races/ethnicities however the rates are still above the HP 2010 goal.

In general, preterm births were most common in counties in and around the San Joaquin Valley, including, Mono (14.7%), Fresno (14.4%), Kern (13.9%), San Benito (12.5%), and Madera (11.9%). With the exception of Siskiyou County where the rate of preterm births was (11.9%), counties in the Northern Mountain region and the San Francisco Bay Area had lower rates of preterm births. While the rate in Los Angeles was a bit lower than the counties mentioned, it is important to note that there were 16,248 preterm births in Los Angeles, representing nearly one-third of the State's births born preterm (Table 2 and Figure 12).

**Table 2. Percentage of Premature Births to California Residents by County, 2008**

| RANK ORDER | COUNTY | PERCENT |
|---|---|---|
| 1 | MONO | 14.7 |
| 2 | FRESNO | 14.4 |
| 3 | KERN | 13.9 |
| 4 | SAN BENITO | 12.5 |
| 5 | SISKIYOU | 11.9 |
| 5 | MADERA | 11.9 |
| 7 | INYO | 11.7 |
| 7 | STANISLAUS | 11.7 |
| 9 | RIVERSIDE | 11.6 |
| 9 | KINGS | 11.6 |
| 11 | LOS ANGELES | 11.4 |
| 11 | SAN BERNARDINO | 11.4 |
| 11 | COLUSA | 11.4 |
| 14 | TULARE | 11.3 |
| 14 | SAN JOAQUIN | 11.3 |
| 16 | MERCED | 10.8 |
| 17 | MONTEREY | 10.7 |
| | **CALIFORNIA PERCENT** | **10.7** |
| 17 | SANTA BARBARA | 10.7 |
| 19 | IMPERIAL | 10.4 |
| 20 | SANTA CRUZ | 10.3 |
| 21 | DEL NORTE | 10.1 |
| 21 | SOLANO | 10.1 |
| 23 | CONTRA COSTA | 10.0 |
| 23 | CALAVERAS | 10.0 |
| 23 | SAN DIEGO | 10.0 |
| 26 | SACRAMENTO | 9.8 |
| 26 | BUTTE | 9.8 |
| 26 | SHASTA | 9.8 |
| 29 | YUBA | 9.7 |
| 30 | SUTTER | 9.6 |
| 30 | MENDOCINO | 9.6 |
| 30 | AMADOR | 9.6 |
| 33 | ALAMEDA | 9.5 |
| 33 | VENTURA | 9.5 |
| 33 | ORANGE | 9.5 |
| 33 | PLACER | 9.5 |
| 37 | LASSEN | 9.2 |
| 37 | SAN FRANCISCO | 9.2 |
| 39 | SANTA CLARA | 9.1 |
| 39 | MARIN | 9.1 |
| 41 | SAN MATEO | 9.0 |
| 42 | SAN LUIS OBISPO | 8.8 |
| 43 | LAKE | 8.6 |
| 44 | NAPA | 8.5 |
| 45 | NEVADA | 8.3 |
| 45 | TUOLUMNE | 8.3 |
| 47 | GLENN | 8.2 |
| 48 | SONOMA | 8.0 |
| 49 | YOLO | 7.9 |
| 49 | TEHAMA | 7.9 |
| 51 | HUMBOLDT | 7.7 |
| 52 | EL DORADO | 7.6 |
| | ALPINE | -- |
| | MARIPOSA | -- |
| | MODOC | -- |
| | PLUMAS | -- |
| | SIERRA | -- |
| | TRINITY | -- |

**State Median***

* State Median = 9.798

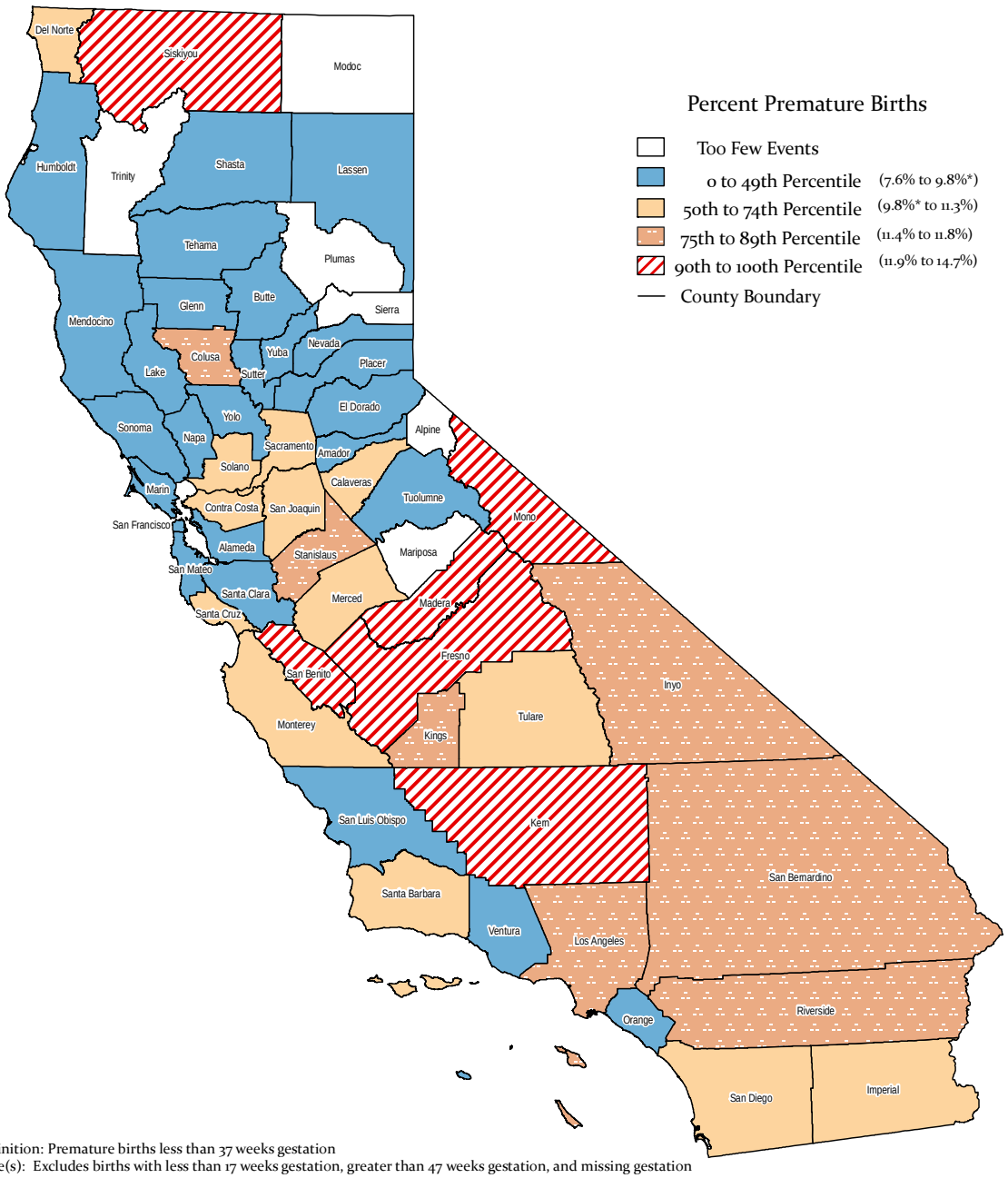
Note(s): Premature births less than 37 weeks gestation. Excludes births with less than 17 weeks gestation, greater than 47 weeks gestation, and missing gestation.

"--" denotes counties with too few events, events < 20.

Source: 2008 Birth Statistical Master File.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 12. Percentage of Premature Births to California Residents by County, 2008




Definition: Premature births less than 37 weeks gestation
Note(s): Excludes births with less than 17 weeks gestation, greater than 47 weeks gestation, and missing gestation
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): 2008 Birth Statistical Master File
*Due to rouding, categories may appear to overlap

Low Birth Weight Infants

*Background:* Low birth weight (LBW) and preterm births are strong predictors of infant mortality. Infants of LBW are at greater risk for negative physical, social, and intellectual outcomes than infants of normal weight.[59] Often these outcomes persist throughout the life course. Children who are born at a LBW are at greater risk for cognitive and school performance problems, and are more likely to be enrolled in special education classes or to repeat a grade.[60, 61] The HP 2010 objective is to reduce the proportion of LBW births to no more than 5.0%; California has not met this objective.

*Methods:* The data source specified in the first SIR for this indicator was Title V and the metric was the number of resident live births less than 2500 grams divided by the number of resident live births. While there is no exclusion criteria provided on HRSA indicator definitions for Title V, for this needs assessment CDPH/MCAH excluded infants weighing less than 227 grams or greater than 8,165 grams or births with unknown birth weight. Births outside the range are excluded because they are not considered viable and are likely an error, either due to data entry or incorrect reporting. This exclusion criterion is also consistent with the National Center for Health Statistics definition.[58]

*Results:* The percent of LBW births increased from 6.2% in 2000 to 6.9% in 2005, and remained relatively unchanged from 2005 through 2008. California reports lower rates of LBW births compared with the U.S. population (8.2% in 2007).[62] However, due to the size of the birthing population in California, the burden of LBW is still large. There were nearly 37,580 LBW births in 2008 and nearly half were among Hispanic women. The percent of LBW births among African-American women (12.4%) is over double the percent among Hispanics (6.1%). At 6.4% and 7.8%, respectively, White and Asian women also have higher rates of LBW compared with Hispanics. In addition, some counties experience higher rates of LBW. In Inyo County, for example, the rate is more than double the HP 2010 objective (11.5%). Other counties with high rates include Siskiyou (8.4%), Colusa (8.2%), Fresno (7.9%), San Francisco (7.3%), and Los Angeles (7.3%) (Table 3 and Figure 13).

**Table 3. Percentage of Low Birth Weight Infants Born to California Residents by County, 2008**

| RANK ORDER | COUNTY | PERCENT |
|---|---|---|
| 1 | INYO | 11.5 |
| 2 | SISKIYOU | 8.4 |
| 3 | COLUSA | 8.2 |
| 4 | FRESNO | 7.9 |
| 5 | SAN FRANCISCO | 7.3 |
| 5 | LOS ANGELES | 7.3 |
| 7 | SAN BENITO | 7.2 |
| 7 | MARIN | 7.2 |
| 7 | SOLANO | 7.2 |
| 10 | SAN JOAQUIN | 7.1 |
| 10 | ALAMEDA | 7.1 |
| 10 | SAN BERNARDINO | 7.1 |
| 10 | KERN | 7.1 |
| 14 | IMPERIAL | 6.8 |
| 14 | LASSEN | 6.8 |
| | **CALIFORNIA PERCENT** | **6.8** |
| 16 | YUBA | 6.7 |
| 16 | NAPA | 6.7 |
| 18 | RIVERSIDE | 6.6 |
| 18 | MERCED | 6.6 |
| 18 | SAN DIEGO | 6.6 |
| 21 | VENTURA | 6.5 |
| 21 | CONTRA COSTA | 6.5 |
| 21 | SACRAMENTO | 6.5 |
| 21 | SANTA CLARA | 6.5 |
| 21 | EL DORADO | 6.5 |
| 26 | STANISLAUS | 6.4 |
| 26 | DEL NORTE | 6.4 |
| 26 | TULARE | 6.4 |
| 26 | SAN LUIS OBISPO | 6.4 |
| 26 | KINGS | 6.4 |
| 26 | ORANGE | 6.4 |
| 32 | SUTTER | 6.3 |
| 32 | SANTA CRUZ | 6.3 |
| 32 | SAN MATEO | 6.3 |
| 35 | CALAVERAS | 6.2 |
| 35 | MENDOCINO | 6.2 |
| 37 | HUMBOLDT | 6.1 |
| 37 | MADERA | 6.1 |
| 39 | MONTEREY | 5.8 |
| 39 | SONOMA | 5.8 |
| 39 | SANTA BARBARA | 5.8 |
| 39 | PLACER | 5.8 |
| 43 | SHASTA | 5.5 |
| 43 | YOLO | 5.5 |
| 45 | LAKE | 5.4 |
| 46 | TUOLUMNE | 5.3 |
| 46 | BUTTE | 5.3 |
| 48 | TEHAMA | 5.1 |
| 49 | NEVADA | 4.9 |
| 50 | GLENN | 4.2 |
| | ALPINE | -- |
| | AMADOR | -- |
| | MARIPOSA | -- |
| | MODOC | -- |
| | MONO | -- |
| | PLUMAS | -- |
| | SIERRA | -- |
| | TRINITY | -- |

**State Median***

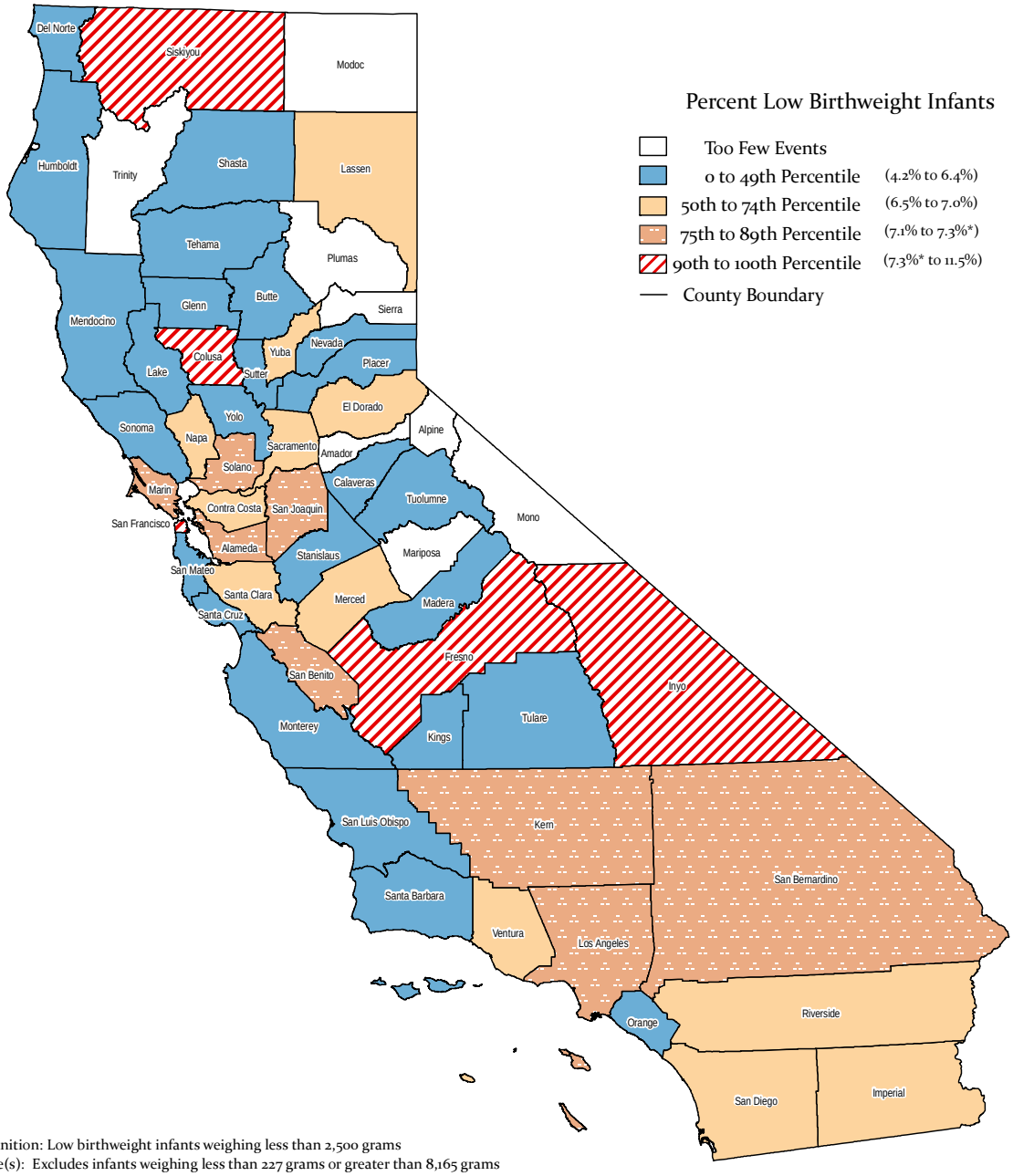
* State Median = 6.439

Note(s): Low birthweight infants weighing less than 2,500 grams. Excludes infants weighing less than 227 grams or greater than 8,165 grams.
"--" denotes counties with too few events, events < 20.

Source: 2008 Birth Statistical Master File.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 13. Percentage of Low Birth Weight Infants Born to California Residents by County, 2008




Definition: Low birthweight infants weighing less than 2,500 grams
Note(s): Excludes infants weighing less than 227 grams or greater than 8,165 grams
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): 2008 Birth Statistical Master File
*Due to rounding, categories may appear to overlap

Infant Mortality

*Background:* Infant death is a critical indicator of the health of a population. It reflects the overall state of maternal health as well as the quality and accessibility of primary health care available to pregnant women and infants.[63] The HP 2010 objective is to reduce the rate of infant deaths to 4.5 per 1,000 live births, the rate of neonatal deaths (among infants < 28 days) to 2.9, and the rate of postneonatal deaths (among infants 28 days to 1 year) to 1.2. California has not yet met these objectives.

*Methods:* The infant mortality rate came from the data source specified in the first SIR, Title V, and the calculation matched the SIR's standard metric. While the infant mortality data presented in this needs assessment represent the most recent data (2008) as specified in the first SIR, using just one year of data results in suppressed rates for several counties. CDPH/MCAH plans to aggregate data for three or more years for the updated home visiting needs assessment in order to present data for most if not all counties.

*Results:* From 2000 to 2008, the infant mortality rate decreased from 5.4 per 1,000 live births to 5.1, the neonatal mortality rate decreased from 3.7 to 3.4, and the postneonatal mortality rate remained relatively the same. Although infant mortality rates have decreased among all racial/ethnic groups over time, disparities among select populations still exist. In 2008, infant mortality rates were lowest among Asian women (3.1 per 1,000) and highest among African-American women (12.1 per 1,000). The infant mortality rate among African-American women was three times the rate among White women (4.1 per 1,000). The distribution of neonatal and postneonatal deaths also differs by race/ethnicity. A larger proportion of infant mortality among African-Americans, Pacific Islanders, and American Indian/Alaska Natives occurs in the postneonatal period. In comparison, a larger proportion of infant deaths among Hispanics, Whites, and Asians occur in the neonatal period.

Although the disparity in the infant mortality rate is pronounced for African-American women and infants, the burden in California is largely experienced by Hispanics because of the size of the Hispanic birthing population. Acknowledging disparities in both rates and frequencies is important for public health program planning in California.

While the number of deaths is too low to report rates for many of California's counties, data from some of the larger counties show that the rate of infant deaths varies depending on residence. For example, the infant mortality rate in Kern County (7.2 per 1,000) is more than double the rate in Santa Clara County (3.3 per 1,000). In fact, Santa Clara as well as Sonoma, San Mateo, and Contra Costa Counties have all met the HP 2010 goal. Fresno and San Joaquin Counties also had high rates (6.7 and 6.5 per 1,000, respectively) (Table 4 and Figure 14).

**Table 4. Infant Mortality Rate per 1,000 Live Births to California Residents by County, 2008**

| RANK ORDER | COUNTY | RATE | |
|---|---|---|---|
| 1 | KERN | 7.2 | |
| 2 | FRESNO | 6.7 | |
| 3 | SAN JOAQUIN | 6.5 | |
| 4 | MERCED | 6.3 | |
| 5 | SOLANO | 6.2 | |
| 6 | STANISLAUS | 6.1 | |
| 7 | SAN BERNARDINO | 6.0 | |
| 8 | SANTA BARBARA | 5.7 | |
| 8 | RIVERSIDE | 5.7 | |
| 10 | VENTURA | 5.6 | |
| 11 | SAN FRANCISCO | 5.3 | |
| | | | **State Median*** |
| 12 | SACRAMENTO | 5.2 | |
| 12 | TULARE | 5.2 | |
| | **CALIFORNIA RATE** | **5.1** | |
| 14 | LOS ANGELES | 5.0 | |
| 15 | SAN DIEGO | 4.9 | |
| 16 | ORANGE | 4.8 | |
| 17 | MONTEREY | 4.7 | |
| 18 | ALAMEDA | 4.2 | |
| 19 | CONTRA COSTA | 4.1 | |
| 20 | SAN MATEO | 3.8 | |
| 21 | SONOMA | 3.6 | |
| 22 | SANTA CLARA | 3.3 | |
| | ALPINE | -- | |
| | AMADOR | -- | |
| | BUTTE | -- | |
| | CALAVERAS | -- | |
| | COLUSA | -- | |
| | DEL NORTE | -- | |
| | EL DORADO | -- | |
| | GLENN | -- | |
| | HUMBOLDT | -- | |
| | IMPERIAL | -- | |
| | INYO | -- | |
| | KINGS | -- | |
| | LAKE | -- | |
| | LASSEN | -- | |
| | MADERA | -- | |
| | MARIN | -- | |
| | MARIPOSA | -- | |
| | MENDOCINO | -- | |
| | MODOC | -- | |
| | MONO | -- | |
| | NAPA | -- | |
| | NEVADA | -- | |
| | PLACER | -- | |
| | PLUMAS | -- | |
| | SAN BENITO | -- | |
| | SAN LUIS OBISPO | -- | |
| | SANTA CRUZ | -- | |
| | SHASTA | -- | |
| | SIERRA | -- | |
| | SISKIYOU | -- | |
| | SUTTER | -- | |
| | TEHAMA | -- | |
| | TRINITY | -- | |
| | TUOLUMNE | -- | |
| | YOLO | -- | |
| | YUBA | -- | |

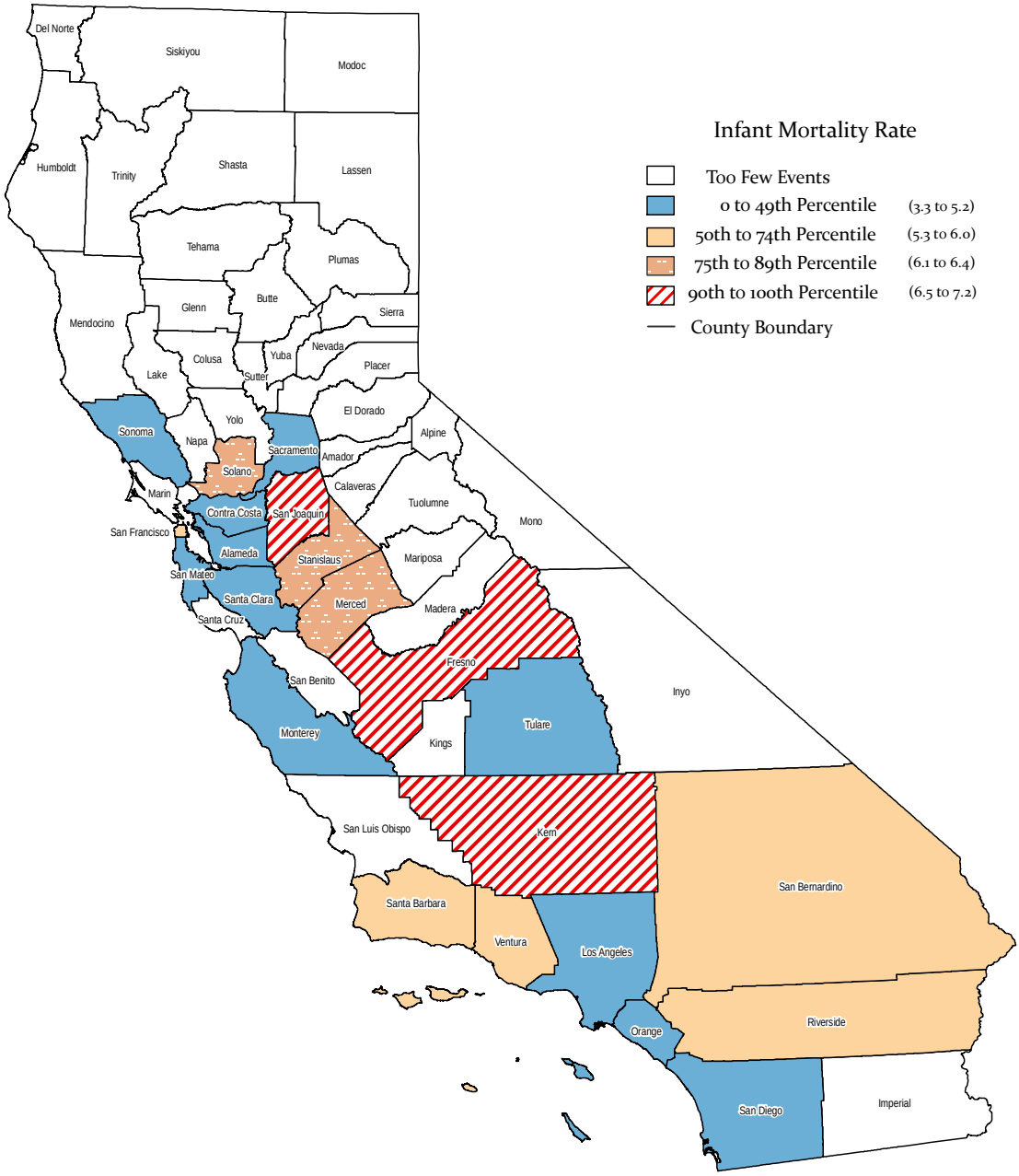
* State Median = 5.254

Note(s): Infant death occurring in the first year of life, ages 0 to <1 year
"--" denotes counties with too few events, events < 20.

Source: 2008 Birth & Death Statistical Master Files.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 14. Infant Mortality Rate per 1,000 Live Births to California Residents by County, 2008




Definition: Infant death occurring in the first year of life, ages 0 to <1 year
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): 2008 Birth & Death Statistical Master Files

## Poverty

*Background:* Poverty is concentrated in some neighborhoods where resources are scarce and social and economic distress is prevalent. Thus, a variety of pathways link neighborhood poverty to the poor health outcomes of community members.[64] Lack of economic opportunity and resources create a strain on families and can affect children's emotional, social, cognitive, and physical development and thus their readiness for school.[65-67] Poverty is associated with other stressors affecting health including inadequate nutrition and food insecurity, unsafe housing, homelessness, and lack of access to health and social services.[66, 67] It can also increase children's risk of exposure to alcohol and other drugs, abuse, neglect, and violence in the home or community.[66, 67] Children living in economically deprived communities are at greater risk for a variety of negative outcomes from low birth weight, poor nutrition, increased chance of academic failure, and emotional distress.[65] Conversely, many health outcomes, including overall health status, LBW, and preterm birth improve as income increases.

Poverty and other hardships affect many women in California. Pregnant or parenting women who are poor are likely to face multiple stressful life events such as unemployment or underemployment, low educational attainment, lack of access to health care, an unstable relationship with family or an intimate partner, a struggle to meet basic needs, and housing instability.[68]

*Methods:* According to the first SIR, the sources for poverty data (defined as number of residents below 100% Federal Poverty Level (FPL) divided by the total number of residents) are the Title V and Head Start needs assessments. Neither source of data was utilized for this needs assessment. While poverty data were included in the Title V needs assessment, they were only presented at the state-level. Similarly, CDPH/MCAH did not have access to the communitywide Head Start Needs Assessments, only the statewide PIR which did not include population-based poverty data. For this assessment, poverty data are calculated using the specified metric but the data source is the Small Area Income Poverty Estimates (SAIPE) produced by the US Census Bureau. This source was considered preferable because according the US Census, the SAIPE generally provides the best single year estimates of median household income for counties, particularly for those counties with populations below 65,000.[69] In addition, the SAIPE provides poverty data for all counties as well as school districts. A limitation to the SAIPE is that data are not available by race/ethnicity. Analysis of poverty data for the updated home visiting needs assessment by CDPH/MCAH will likely supplement the information from the SAIPE from other sources like the US Census Bureau's American Community Survey (ACS). Unfortunately, however, the ACS data are currently not available for all of California's 58 counties. Five-year ACS data to be releases in late 2010 by the Census Bureau, will provide poverty estimates for all of the counties. However it is not known if these data will be released before the updated home visiting needs assessment is due. Finally, it should be noted that while the data source used was the SAIPE, this section presents additional background data on poverty that was not required, including child poverty rates, poverty among women who recently gave birth, and income insufficiency. As a result, additional data sources were identified and are referenced when they are presented.

*Results:*
In 2008 over 4.7 million Californians, 13% of the population, have incomes below the federal poverty level (100% FPL). African-Americans, Hispanics, and American Indians have the highest rates of poverty in California.[70] Data reveal tremendous variation in rates of poverty throughout California's counties. In Del Norte County, nearly one-quarter of the population is living in poverty. This is nearly four times greater than in San Mateo County where the poverty

rate is 6.5%. Other counties with high rates of poverty include: Fresno (22.1%), Imperial, Merced and Tulare (21.5%), and Butte and Lassen (20.7%) (Table 5 and Figure 15).

Among children under age 18, the rate of poverty is even higher than the general population: 16% of the population is in poverty, or approximately 1.6 million children.[71] Projections of child poverty rates through 2012 anticipate that child poverty in California will increase as a result of the recession, peaking at 27% in 2010 before declining slightly to 24% in 2012. In Los Angeles County, home to 25% of California's children, one in three children is projected to be in poverty in 2010.[72] Similar to the general population, California child poverty varies tremendously by region. Counties with the highest child poverty rates are in the Central Valley, Northern Mountain, or border regions of California: Tulare (31%), Lake (28%), Fresno (28%), Del Norte (28%), and Imperial (27%). Counties with the lowest rates of child poverty (below 10%) are in the San Francisco Bay Area and the Lake Tahoe/mountain recreational area.[73]

Data from the California Maternal and Infant Health Assessment (MIHA) survey reveal that in 2008 over half (57.9%) of women with a live birth in California had incomes ≤ 200% of the FPL. Poverty differed widely according to race/ethnicity; 72.7% of African-American women and 81.9% of Hispanic women with a recent live birth had incomes ≤ 200% of the FPL, compared with 31.6% of White and 28.7% of Asian/Pacific Islander women. In addition, during the years 2002-2006, 43% of all California women with a live birth experienced at least one of 11 measured hardships during pregnancy, including inability to pay bills, job loss or partner's job loss, food insecurity, and lack of emotional support. Lower-income groups reported more hardships; however, even among women with incomes > 400% of the FPL, 13% experienced at least one hardship during pregnancy. Common hardships were not being able to pay bills, job loss, partner job loss, and homelessness.[74]

Only describing the population that meets the federal definition of poverty obscures the struggles faced by many families due to the high cost of living in California. An alternate measure of poverty is the self-sufficiency standard, a measure of the income required to meet basic needs (housing, child care, transportation, health care, food, applicable taxes and tax credits and other miscellaneous expenses) that accounts for family composition and regional differences in the cost of living. While 1.4 million (11.3%) of California *households* are below the FPL,[75] an additional 1.5 million households in California lack adequate income to meet basic needs. [76]

Income insufficiency is highest among households with children. Among households with children, 36% of married couple households, 47% of single father households, and 64% of single mother households have insufficient income to meet basic needs. Households headed by single mothers in some racial/ethnic groups have even higher rates of income insufficiency. Nearly 8 out of 10 Hispanic single mother households and 7 out of 10 African-American single mother households experience income insufficiency. The major financial stressors for households with children are housing and child care; many of these families cannot afford quality child care and have limited financial resources to address crises.[76]

These data demonstrate that a much larger group of Californians are unable to meet their families' financial needs than those whose incomes are below 100% FPL. Thus, the safety net programs that are designed to protect families from the worst effects of poverty, such as food insecurity, sub-standard housing, and lack of health care or early childhood development services, are not extended to many needy families in California who have incomes above the poverty line.

In the proposed FY 2009-2010 budget, some safety net programs have been identified for elimination, including Cal-WORKS (California's Temporary Assistance to Needy Families [TANF] program) or for reduction, including California Food Assistance Program (California's food stamp program). If approved, these reductions in the safety net for California's most vulnerable families will result in a greater burden on the public MCAH system, particularly at the local jurisdiction level.

**Table 5. Estimated Percentage of California Residents of All Ages Living in Poverty by County, 2008**

| RANK ORDER | COUNTY | PERCENT |
|---|---|---|
| 1 | DEL NORTE | 23.6 |
| 2 | FRESNO | 22.1 |
| 3 | IMPERIAL | 21.5 |
| 3 | MERCED | 21.5 |
| 3 | TULARE | 21.5 |
| 6 | BUTTE | 20.7 |
| 6 | LASSEN | 20.7 |
| 8 | KERN | 20.5 |
| 9 | TRINITY | 19.9 |
| 10 | HUMBOLDT | 19.8 |
| 11 | MADERA | 18.2 |
| 12 | KINGS | 17.9 |
| 12 | LAKE | 17.9 |
| 14 | MENDOCINO | 17.7 |
| 14 | SHASTA | 17.7 |
| 16 | MODOC | 17.4 |
| 17 | GLENN | 16.9 |
| 18 | YUBA | 16.6 |
| 19 | SAN JOAQUIN | 16.5 |
| 19 | TEHAMA | 16.5 |
| 21 | SISKIYOU | 16.4 |
| 22 | ALPINE | 15.7 |
| 23 | SUTTER | 15.5 |
| 24 | LOS ANGELES | 15.3 |
| 25 | SAN BERNARDINO | 14.7 |
| 26 | YOLO | 14.6 |
| 27 | STANISLAUS | 14.4 |
| 28 | COLUSA | 13.5 |
| 28 | MARIPOSA | 13.5 |
| | **CALIFORNIA PERCENT** | **13.3** |
| 30 | SACRAMENTO | 13.3 |
| 30 | SANTA CRUZ | 13.3 |
| 32 | MONTEREY | 12.7 |
| 32 | SANTA BARBARA | 12.7 |
| 32 | SIERRA | 12.7 |
| 35 | RIVERSIDE | 12.6 |
| 35 | SAN DIEGO | 12.6 |
| 37 | TUOLUMNE | 12.5 |
| 38 | SAN LUIS OBISPO | 12.1 |
| 39 | PLUMAS | 12.0 |
| 40 | INYO | 11.6 |
| 41 | CALAVERAS | 11.5 |
| 42 | SAN FRANCISCO | 11.2 |
| 43 | ALAMEDA | 10.4 |
| 43 | SAN BENITO | 10.4 |
| 43 | SONOMA | 10.4 |
| 46 | ORANGE | 9.9 |
| 47 | AMADOR | 9.8 |
| 48 | MONO | 9.6 |
| 49 | CONTRA COSTA | 9.4 |
| 50 | NEVADA | 9.2 |
| 51 | NAPA | 9.0 |
| 51 | SOLANO | 9.0 |
| 53 | VENTURA | 8.7 |
| 54 | EL DORADO | 7.8 |
| 55 | SANTA CLARA | 7.6 |
| 56 | MARIN | 7.1 |
| 57 | PLACER | 6.7 |
| 58 | SAN MATEO | 6.5 |

**State Median***

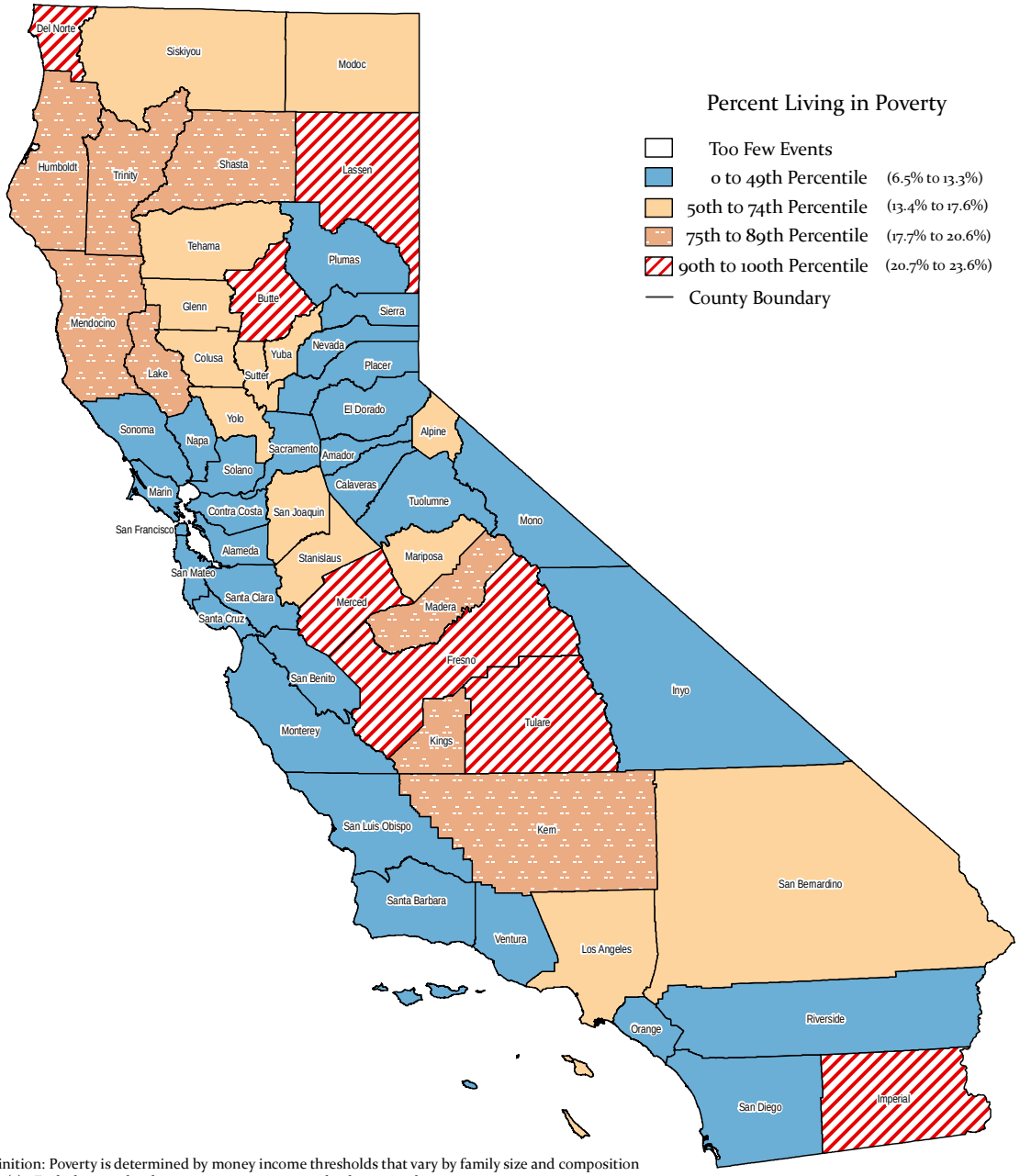
* State Median = 13.4

Note(s): Poverty is determined by money income thresholds that vary by family size and composition. Excludes people whose poverty status cannot be determined.

Source: 2008 U.S. Census Bureau, Small Area Income and Poverty Estimates, accessed at http://www.census.gov/did/www/saipe/ on August 20, 2010.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

**Figure 15. Estimated Percentage of California Residents of All Ages Living in Poverty by County, 2008**




Definition: Poverty is determined by money income thresholds that vary by family size and composition
Note(s): Excludes people whose poverty status cannot be determined
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): 2008 U.S. Census Bureau, Small Area Income and Poverty Estimates, accessed at http://www.census.gov/did/www/saipe/ on August 20, 2010

Crime

*Background:* A growing body of research establishes that neighborhood characteristics (e.g., neighborhood socioeconomic status, physical conditions, services/amenities, social capital, and social disorder) are important determinants of individual health and disease.[77] Neighborhood amenities, like parks, recreational centers, civic and cultural venues, and libraries, provide children with opportunities for activity, education, and socialization. These amenities also provide opportunities to engage parents and care providers in positive activities with children. On the other hand, neighborhood crime and violence can discourage socialization and physical activity within a community and influence the levels of stress and anxiety among residents which can lead to poor physical and emotional health. Likewise, there are few incentives to invest economically in unsafe neighborhoods, thereby leading to fewer employment opportunities, higher concentrations of poverty and higher levels of stress.[78] It is thought that repeated stress leads to wear and tear on the body's adaptive system, contributing to poorer health status over the life course.

Moreover, neighborhoods with high levels of violent crime may increase residents' risk of experiencing violence.[79] In addition to family violence, children exposed to community violence often demonstrate lower school achievement and do not adapt as well to the academic environment.[80] Community violence has also been identified as a risk factor for child maltreatment.[81] Specifically, children living in dangerous neighborhoods are at a higher risk for severe neglect and physical abuse as well as sexual victimization compared to children from safer neighborhoods.[82] In addition, child abuse and neglect have been shown to contribute to crime rates. Children who have been abused or neglected are more likely to commit a crime as a juvenile and to perpetrate aggressive behavior and violence later in life.[83] As a result, many law enforcement leaders have advocated for home visiting programs to cut abuse and neglect and reduce future crime.[84]

*Methods:* The first SIR did not specify a data source for all crime or juvenile arrests. For this report, CDPH/MCAH used the Uniform Crime Reporting (UCR) data of the California Department of Justice (CA DOJ). UCR has become a nationwide program since its inception in 1930. In California, all law enforcement agencies participate. These data are considered an extremely good indicator of crime because of the stringent rules of the system, the number of participants, and the quantity and quality of data collected.[85]

The all crime rate aggregates known incidents of homicide, forcible rape, robbery, aggravated assault, burglary, motor vehicle theft, and larceny-theft. The CA DOJ uses the California Department of Finance (CA DOF) population as denominators and rates are per 100,000. Juvenile arrests include all felony, misdemeanor and status offenses. Juvenile Arrests are aggregated for 2008 and the population age for juveniles is 10-17 years. Similar to all crime, the CA DOJ uses the CA DOF population as denominators and rates are per 100,000 CDPH/MCAH calculated rates for all counties with at least 20 events, though the CA DOJ does not typically report crime rates for counties with a total population less than 100,000. It is possible that rates for small counties are less reliable.

*Results:* In California the violent crime rate declined substantially between 1992 and 1999 (from 1103.9 to 610.7 per 100,000). Since then the decline in the rate of violent crime has been more gradual and in 2008 there were 485.6 violent crimes per 100,000 people. The property crime rate declined sharply throughout most of the 90's but then increased from 1999 to 2005. Since then the rate has been decreasing and in 2008 there were 1721.5 property crimes per 100,000 population.[86] In 2008 in California, the rate of all crime was 3319.9 per 100,000 with property

crimes accounting for the majority of crime followed by larceny and then violent crime. The counties with the most crime in California in 2008 were Alpine (7237.9 per 100,000), San Joaquin (5781.7 per 100,000), San Francisco (5210.0 per 100,000), Stanislaus (4943.9 per 100,000) and Alameda (4663.4 per 100,000) (Table 6 and Figure 16). It should be noted, however, that while Alpine has the highest crime rate, this is based on a very small population and it is possible that rates for small counties are less reliable. In fact, while CDPH/MCAH did calculate the rate for the purposes of this report, CA DOJ does not typically report crime rates for counties with a total population smaller than 100,000 persons.

In California in 2008, there were 229,104 juvenile arrests reported by law enforcement agencies. A greater percentage of Whites were arrested for a misdemeanor (62.9 percent) whereas a greater percentage of African-Americans were arrested for a felony (38.5 percent).[87] Of interest, when comparing the maps of all crime rates and juvenile arrests it is apparent that the two do not follow the same pattern. The juvenile arrest rate was particularly high in Kings County; more than double the State rate (11,045.7 versus 4,972.6 per 100,000). Other counties with high rates include Lake (9,274.2 per 100,000), Merced (9,057.5 per 100,000), Shasta (8,200.0 per 100,000), Humboldt (8,169.2 per 100,000), and Solano (8,049.1 per 100,000) (Table 7 and Figure 17).

**Table 6. All Reported Crimes Rate per 100,000 California Residents by County, 2008**

| RANK ORDER | COUNTY | RATE | |
|---|---|---|---|
| 1 | ALPINE | 7,237.9 | |
| 2 | SAN JOAQUIN | 5,781.7 | |
| 3 | SAN FRANCISCO | 5,210.0 | |
| 4 | STANISLAUS | 4,943.9 | |
| 5 | ALAMEDA | 4,663.4 | |
| 6 | KERN | 4,436.6 | |
| 7 | FRESNO | 4,433.7 | |
| 8 | TULARE | 4,368.7 | |
| 9 | SACRAMENTO | 4,285.9 | |
| 10 | MERCED | 4,124.7 | |
| 11 | SOLANO | 4,022.1 | |
| 12 | YOLO | 3,916.8 | |
| 13 | IMPERIAL | 3,769.0 | |
| 14 | CONTRA COSTA | 3,725.2 | |
| 15 | RIVERSIDE | 3,596.4 | |
| 16 | SAN BERNARDINO | 3,483.2 | |
| 17 | SANTA CRUZ | 3,412.2 | |
| 18 | BUTTE | 3,396.8 | |
| 19 | SHASTA | 3,390.7 | |
| 20 | YUBA | 3,371.1 | |
| | **CALIFORNIA RATE** | **3,319.9** | |
| 21 | MONO | 3,263.9 | |
| 22 | LAKE | 3,229.3 | |
| 23 | SUTTER | 3,197.6 | |
| 24 | MONTEREY | 3,137.9 | |
| 25 | AMADOR | 3,132.3 | |
| 26 | HUMBOLDT | 3,105.7 | |
| 27 | LOS ANGELES | 3,087.4 | |
| 28 | SAN DIEGO | 3,073.5 | |
| 29 | NAPA | 2,981.5 | **State Median*** |
| 30 | TEHAMA | 2,939.2 | |
| 31 | TUOLUMNE | 2,898.9 | |
| 32 | KINGS | 2,741.5 | |
| 33 | PLACER | 2,699.6 | |
| 34 | MADERA | 2,633.3 | |
| 35 | SANTA CLARA | 2,593.4 | |
| 36 | SAN MATEO | 2,577.8 | |
| 37 | SANTA BARBARA | 2,577.7 | |
| 38 | SAN LUIS OBISPO | 2,573.6 | |
| 39 | INYO | 2,565.1 | |
| 40 | SAN BENITO | 2,556.0 | |
| 41 | COLUSA | 2,435.0 | |
| 42 | MENDOCINO | 2,376.4 | |
| 43 | DEL NORTE | 2,360.5 | |
| 44 | ORANGE | 2,282.4 | |
| 45 | GLENN | 2,274.1 | |
| 46 | PLUMAS | 2,261.3 | |
| 47 | SONOMA | 2,214.4 | |
| 48 | MARIN | 2,207.2 | |
| 49 | VENTURA | 2,196.2 | |
| 50 | MODOC | 2,138.4 | |
| 51 | SISKIYOU | 2,068.8 | |
| 52 | CALAVERAS | 2,005.2 | |
| 53 | EL DORADO | 1,962.0 | |
| 54 | MARIPOSA | 1,776.2 | |
| 55 | NEVADA | 1,703.1 | |
| 56 | LASSEN | 1,593.8 | |
| 57 | SIERRA | 1,282.4 | |
| 58 | TRINITY | 777.1 | |

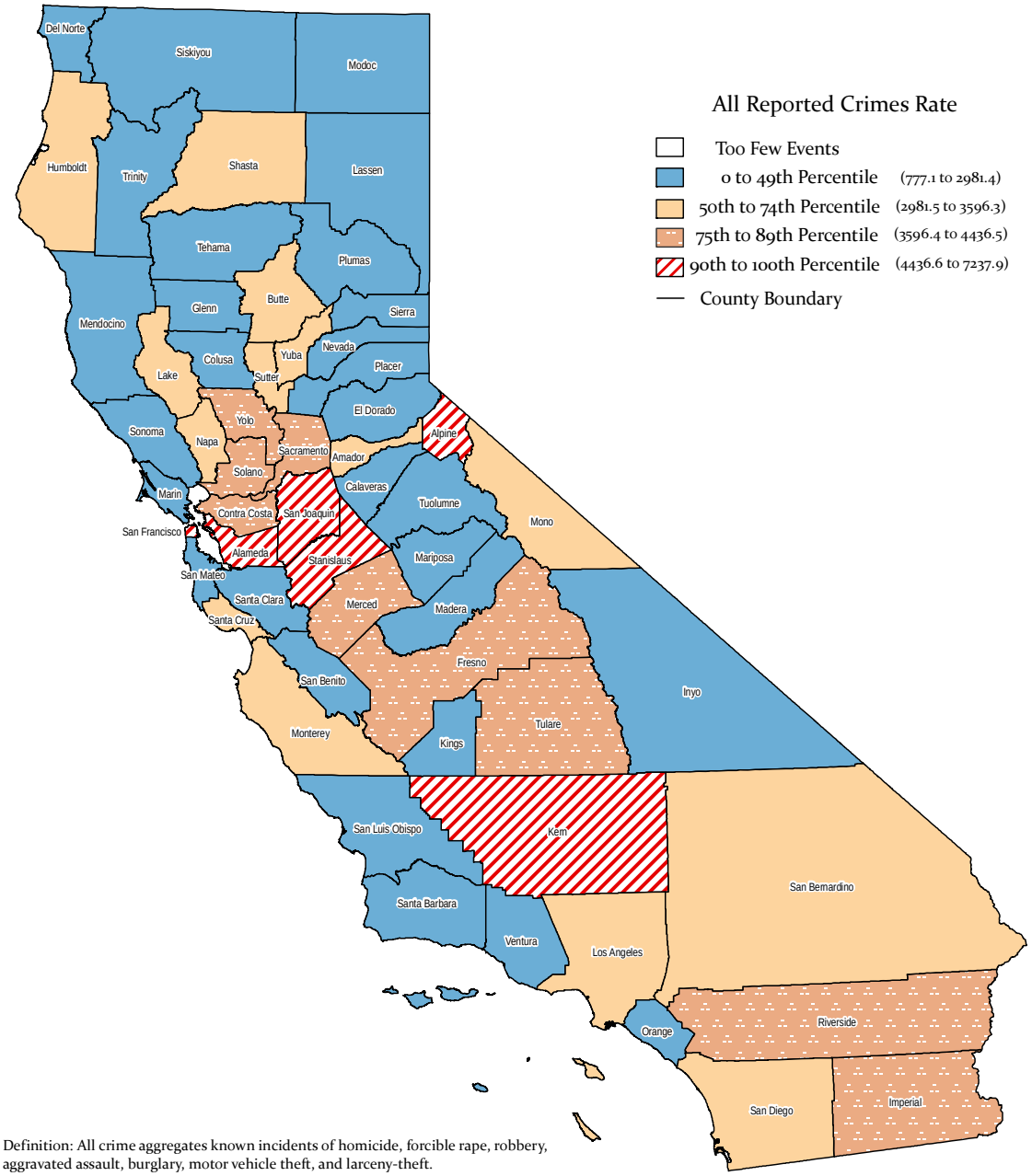
* State Median = 2960.367

Note(s): All crime aggregates known incidents of homicide, forcible rape, robbery, aggravated assault, burglary, motor vehicle theft, and larceny-theft.

CA DOJ does not typically report crime rates for counties with a total population <100,000. It is possible that rates for small counties are less reliable.

Source: 2008 CA DOJ (crime data), CA DOF (total population data by county).
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 16. All Reported Crimes Rate per 100,000 California Residents by County, 2008




Definition: All crime aggregates known incidents of homicide, forcible rape, robbery, aggravated assault, burglary, motor vehicle theft, and larceny-theft.
Note(s): CA DOJ does not typically report crime rates for counties with a total population <100,000. It is possible that rates for small counties are less reliable.
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): 2008 CA DOJ (crime data), CA DOF (total population data by county)

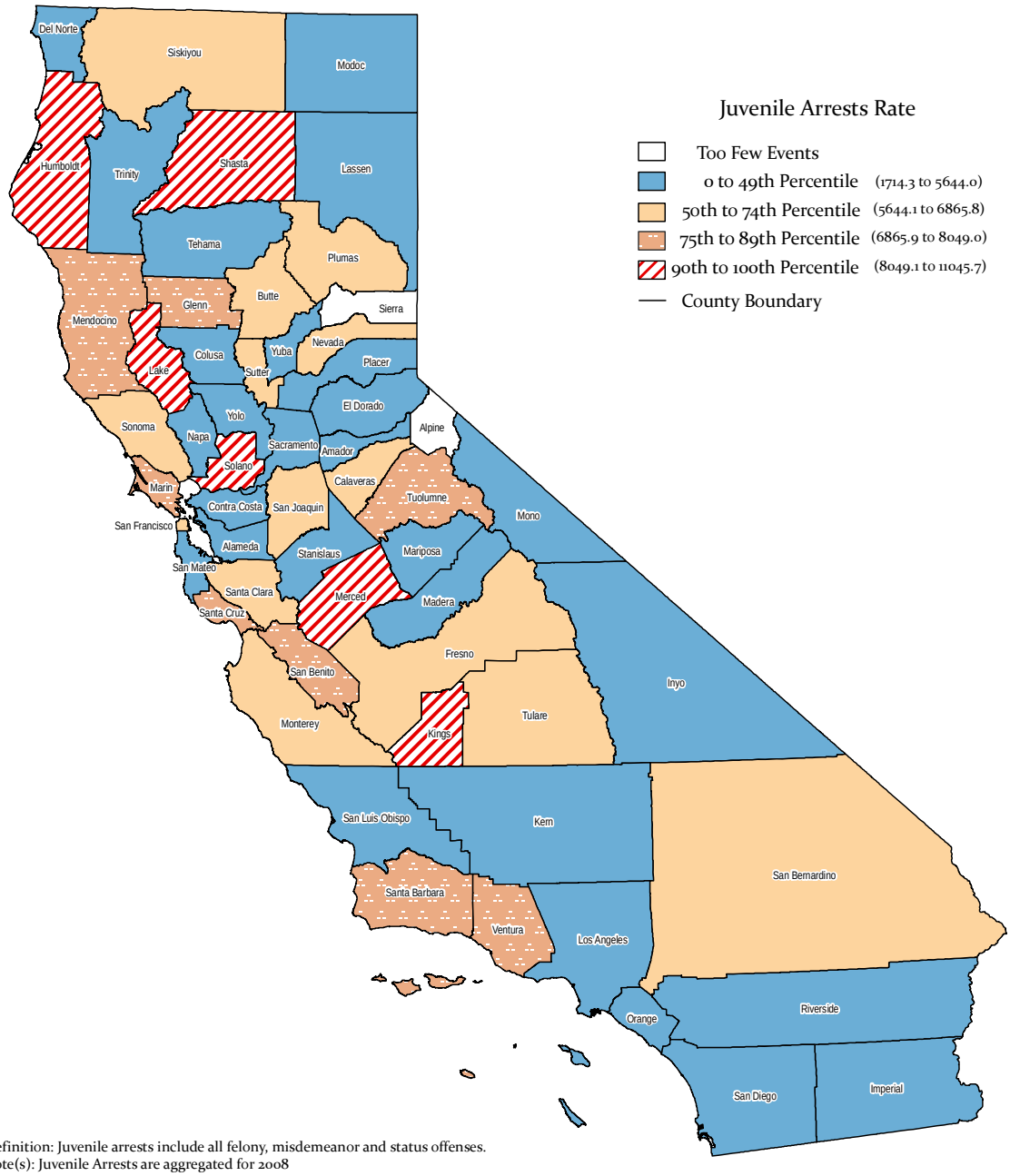
**Table 7. Juvenile Arrests for Ages 10-17, Rate per 100,000 California Residents by County, 2008**

| RANK ORDER | COUNTY | RATE | |
|---|---|---|---|
| 1 | KINGS | 11,045.7 | |
| 2 | LAKE | 9,274.2 | |
| 3 | MERCED | 9,057.5 | |
| 4 | SHASTA | 8,200.0 | |
| 5 | HUMBOLDT | 8,169.2 | |
| 6 | SOLANO | 8,049.1 | |
| 7 | TUOLUMNE | 7,775.5 | |
| 8 | SANTA CRUZ | 7,494.0 | |
| 9 | VENTURA | 7,433.1 | |
| 10 | SANTA BARBARA | 7,391.1 | |
| 11 | MENDOCINO | 6,968.1 | |
| 12 | MARIN | 6,940.7 | |
| 13 | GLENN | 6,868.4 | |
| 14 | SAN BENITO | 6,865.9 | |
| 15 | TULARE | 6,801.0 | |
| 16 | SAN JOAQUIN | 6,648.4 | |
| 17 | NEVADA | 6,621.4 | |
| 18 | SISKIYOU | 6,543.5 | |
| 19 | CALAVERAS | 6,488.9 | |
| 20 | SANTA CLARA | 6,449.7 | |
| 21 | FRESNO | 6,197.3 | |
| 22 | MONTEREY | 6,192.8 | |
| 23 | SAN BERNARDINO | 6,100.5 | |
| 24 | PLUMAS | 6,100.0 | |
| 25 | BUTTE | 5,953.4 | |
| 26 | SAN FRANCISCO | 5,901.2 | |
| 27 | SUTTER | 5,648.4 | |
| 28 | SONOMA | 5,644.1 | |
| | | | **State Median*** |
| 29 | LASSEN | 5,514.3 | |
| 30 | KERN | 5,472.8 | |
| 31 | DEL NORTE | 5,366.7 | |
| 32 | STANISLAUS | 5,341.7 | |
| 33 | YOLO | 5,217.2 | |
| 34 | SAN DIEGO | 4,981.2 | |
| | **CALIFORNIA RATE** | **4,972.6** | |
| 35 | TEHAMA | 4,397.3 | |
| 36 | IMPERIAL | 4,361.1 | |
| 37 | LOS ANGELES | 4,259.6 | |
| 38 | ORANGE | 4,124.6 | |
| 39 | SAN MATEO | 4,086.5 | |
| 40 | SAN LUIS OBISPO | 4,073.9 | |
| 41 | YUBA | 4,057.7 | |
| 42 | RIVERSIDE | 3,997.2 | |
| 43 | ALAMEDA | 3,940.7 | |
| 43 | TRINITY | 3,866.7 | |
| 45 | EL DORADO | 3,727.7 | |
| 46 | PLACER | 3,703.2 | |
| 47 | MARIPOSA | 3,529.4 | |
| 48 | MADERA | 3,352.7 | |
| 49 | CONTRA COSTA | 3,218.3 | |
| 50 | SACRAMENTO | 3,108.6 | |
| 51 | NAPA | 3,103.2 | |
| 52 | COLUSA | 2,620.7 | |
| 53 | MODOC | 2,545.5 | |
| 54 | INYO | 2,450.0 | |
| 55 | AMADOR | 2,277.8 | |
| 56 | MONO | 1,714.3 | |
| | ALPINE | -- | |
| | SIERRA | -- | |

* State Median = 5579.177

Note(s): Juvenile arrests include all felony, misdemeanor and status offenses. Juvenile Arrests are aggregated for 2008.
Source: Office of the Attorney General; Juvenile Felony and Misdemeanor Arrests by Gender, Offense and Arrest Rate file, 2008.
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

**Figure 17. Juvenile Arrests for Ages 10-17, Rate per 100,000 California Residents by County, 2008**




Definition: Juvenile arrests include all felony, misdemeanor and status offenses.
Note(s): Juvenile Arrests are aggregated for 2008
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): Office of the Attorney General; Juvenile Felony Arrests by Gender, Offense and Arrest Rate file, 2008.

Domestic Violence

*Background:* Domestic violence or Intimate partner violence (IPV) is an important health problem experienced by 25% of women in the United States at some point during their lifetime.[88] IPV not only includes physical abuse, it is characterized by a much larger pattern of efforts to exert power and control over an intimate partner, which often entails financial control, coercion, and threats.[89] Some women experience abuse by their partner during pregnancy, which is associated with delayed entry into prenatal care, miscarriage, and various pregnancy complications, including harm to the fetus from physical abuse and mental stress and depression of the mother.[90-92] The health impact of IPV extends to other family members as well. For young children, witnessing violence puts them at significant risk for developmental failures, emotional disturbance, and future victimization or perpetration of violence later in life.[67] Exposure to violence activates stress response systems in infants and children and primes the human brain to be more fearful. Stress hormones, particularly cortisol, prevent brain weight, myelination, neurogenesis and synaptic formations which later impact language, and other cognitive and behavioral function.[93, 94] Children living in a violent home may be victims of physical abuse themselves, as 30 to 60 percent of families where spouse abuse takes place, child maltreatment also occurs.[95, 96]

Based on the 2008 California Women's Health Survey (CWHS), an annual population-based survey of California women 18 years of age and older, 6.3% of women 18 or older reported experiencing physical, sexual or psychological IPV in the past 12 months.[*]

The MIHA survey provides some additional information regarding the prevalence of IPV during pregnancy. While rates of physical IPV in the 12 months before pregnancy declined from 4.9% in 2002 to 3.2% in 2008, the prevalence of physical IPV during pregnancy remained relatively unchanged from 2002 (3.8%) through 2008 (3.5%). Reported psychological abuse (with no reporting of physical abuse) was more common than physical abuse during pregnancy (6.3% vs. 3.5%, respectively, in 2008). The percentage of women reporting any IPV (physical or psychological) during pregnancy was 10% in 2008. African-American and Hispanic women reported any IPV during pregnancy more frequently (16.9% and 12.5%, respectively) than did White and Asian/Pacific Islander women (5.3% and 7.6%, respectively). Any IPV was also more common among women with lower incomes (16.3% among ≤ 100% FPL vs. 2.5% among > 400% FPL).

*Methods:* Unfortunately, prevalence at the local level is not available. The CWHS and the California Health Interview Survey (CHIS) could not be used for community or county data because there were not enough respondents to provide a reliable prevalence, even when analyzing over a two year period for the CWHS.

According to the first SIR, data for domestic violence should be coordinated with those of the Head Start communitywide needs assessments. CDPH/MCAH does not currently have access to the many Head Start communitywide assessments, and the local programs do not have a consistent reporting requirement to the State. The first SIR also stated that the metric for domestic violence should be determined by each State in conjunction with the State agencies administering FVPSA funds. CDPH/MCAH consulted with CalEMA, the entity that receives VPSA funding, on the potential domestic violence data sources available for this report. CalEMA confirmed that they collect only the numbers of clients they pay for, rather than all

[*] The CWHS is based on the national Behavioral Risk Factor Surveillance System (BRFSS) survey, sharing many of BRFSS' questions and much of its methodology.

clients served by the agencies they help fund. Therefore, the Maternal, Child and Adolescent Health Program/Office of Family Planning (MCAH/OFP) Domestic Violence Program agency data were identified as the data source for this assessment. These data represent unduplicated numbers of all clients receiving face-to-face domestic violence services, regardless of funding source, from 95% of the domestic violence agencies that received funding through either of the State Domestic Violence programs (MCAH/OFP or CalEMA) in 2008.

Calls to law enforcement, as well as calls to domestic violence hotlines, are available by county. However, they were not used here for community assessment because they do not represent unduplicated individuals (e.g., one person may make 100 calls while another makes only one call, and callers cannot regularly be identified). Since 2000, CA DOJ records reveal 160,000 to 200,000 calls for law enforcement assistance for domestic violence annually or roughly 500 calls each day.

Both counts of face-to-face services and of calls share the limitations that not all individuals experiencing IPV will seek any kind of help, whether going to a State-funded agency, a non-State-funded agency, or making a hotline call or call to law enforcement. Furthermore, there is no way of knowing whether the proportions of individuals experiencing IPV will seek help, or seek it in any particular way, similarly across counties.

*Results:* Through June 2009, CDPH/MCAH funded 94 domestic violence shelter agencies to provide emergency and non-emergency services to victims of domestic violence. Over 100,000 victims and their children received emergency shelter, legal assistance with restraining orders, transitional housing, and other support services through these agencies in 2008. Mariposa had the highest rate of domestic violence victims served through these agencies (231.7 per 10,000). In addition, there were four counties in the Northern Mountain Region that also served a high rate of domestic violence victims, including Siskiyou (158.9 per 10,000), Del Norte (155.5 per 10,000), Shasta (136.6 per 10,000) and Mendocino (129.9 per 10,000) (Table 8 and Figure 18).

**Table 8. Domestic Violence Clients Served Face-To-Face, Rate per 10,000 California Residents by County, 2008**

| RANK ORDER | COUNTY | RATE |
|---|---|---|
| 1 | MARIPOSA | 231.7 |
| 2 | SISKIYOU | 158.9 |
| 3 | DEL NORTE | 155.5 |
| 4 | SHASTA | 136.6 |
| 5 | MENDOCINO | 129.9 |
| 6 | TRINITY | 123.3 |
| 7 | INYO | 115.2 |
| 8 | SANTA CRUZ | 112.9 |
| 9 | SUTTER | 98.3 |
| 10 | CALAVERAS | 93.4 |
| 11 | EL DORADO | 82.3 |
| 12 | PLUMAS | 82.1 |
| 13 | SONOMA | 77.5 |
| 14 | MODOC | 75.7 |
| 15 | NAPA | 65.1 |
| 16 | LAKE | 64.1 |
| 17 | IMPERIAL | 63.2 |
| 18 | BUTTE | 60.7 |
| 19 | SAN LUIS OBISPO | 58.3 |
| 20 | NEVADA | 57.8 |
| 21 | TUOLUMNE | 57.3 |
| 22 | YOLO | 56.3 |
| 23 | PLACER | 54.5 |
| 24 | STANISLAUS | 52.6 |
| | | **State Median*** |
| 25 | SAN MATEO | 51.9 |
| 26 | FRESNO | 51.1 |
| 27 | MARIN | 50.4 |
| 28 | SAN DIEGO | 39.1 |
| 29 | SACRAMENTO | 38.9 |
| 30 | KERN | 36.7 |
| 31 | TULARE | 34.1 |
| 32 | LASSEN | 32.2 |
| 33 | MONTEREY | 31.0 |
| 34 | SAN FRANCISCO | 29.2 |
| | **CALIFORNIA RATE** | **26.3** |
| 35 | SANTA CLARA | 25.4 |
| 36 | MADERA | 23.6 |
| 37 | SAN JOAQUIN | 21.7 |
| 38 | ORANGE | 20.6 |
| 39 | HUMBOLDT | 20.3 |
| 40 | SOLANO | 20.2 |
| 40 | ALAMEDA | 20.2 |
| 42 | VENTURA | 17.6 |
| 43 | CONTRA COSTA | 14.5 |
| 44 | SAN BERNARDINO | 13.5 |
| 45 | KINGS | 11.3 |
| 46 | RIVERSIDE | 10.6 |
| 47 | LOS ANGELES | 10.5 |
| 48 | SANTA BARBARA | 6.3 |
| | ALPINE | -- |
| | AMADOR | -- |
| | COLUSA | -- |
| | GLENN | -- |
| | MERCED | -- |
| | MONO | -- |
| | SAN BENITO | -- |
| | SIERRA | -- |
| | TEHAMA | -- |
| | YUBA | -- |

* State Median = 52.281

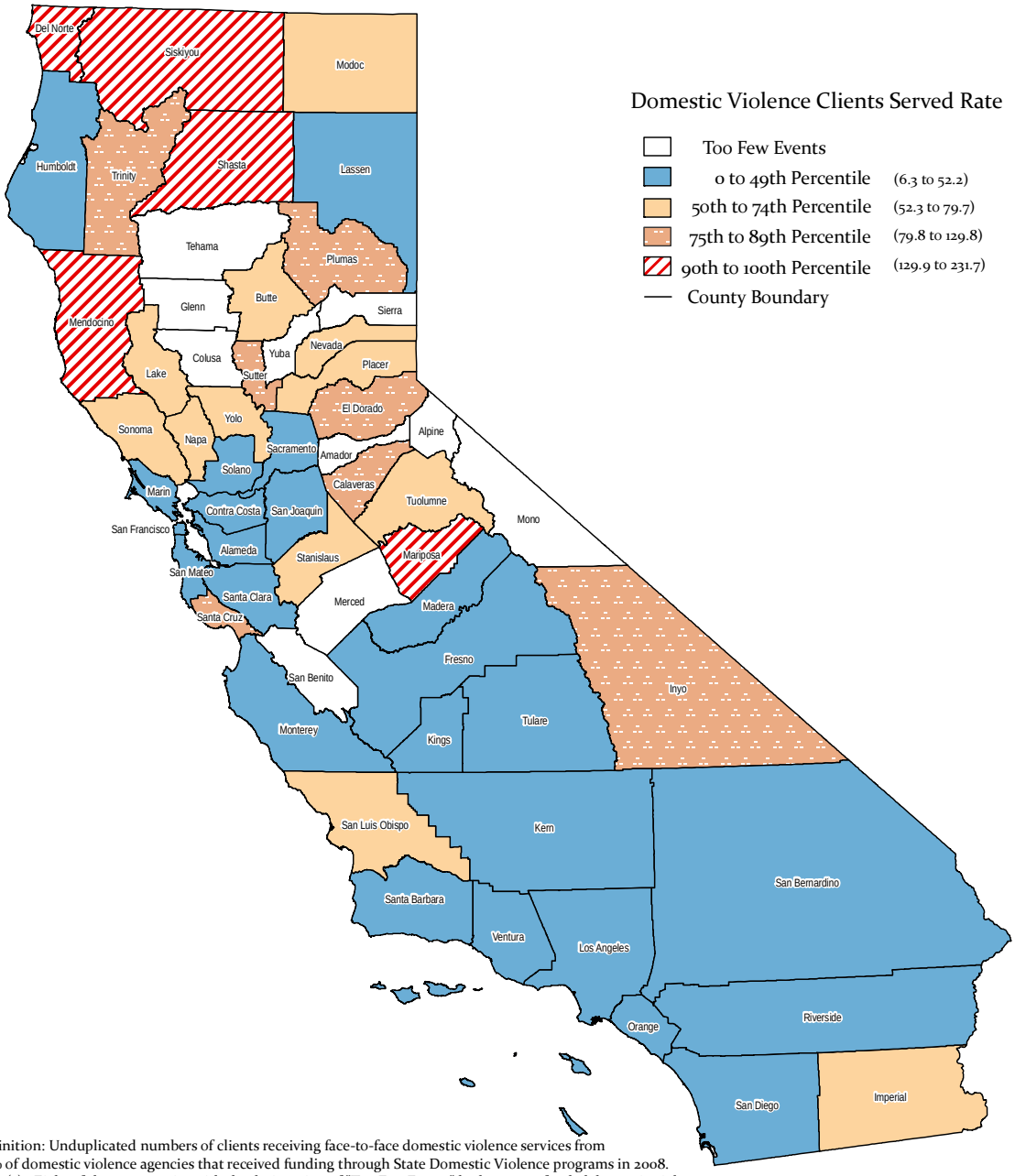
Note(s): Unduplicated numbers of clients receiving face-to-face domestic violence services from 95% of domestic violence agencies that received funding through State Domestic Violence programs in 2008.

"--" denotes counties with too few events, events < 20. Eight of the ten counties with the designation of "Too Few Events" had no state-funded domestic violence agency. The state-funded agencies in the other two counties did not report the total number of clients served.

Source: MCAH/Office of Family Planning Domestic Violence Program, 2008.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 18. Domestic Violence Clients Served Face-To-Face, Rate per 10,000 California Residents by County, 2008




Definition: Unduplicated numbers of clients receiving face-to-face domestic violence services from 95% of domestic violence agencies that received funding through State Domestic Violence programs in 2008.
Note(s): Eight of the ten counties with the designation of "Too Few Events" had no state-funded domestic violence agency. The state-funded agencies in the other two counties did not report the total number of clients served.
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): MCAH/Office of Family Planning Domestic Violence Program, 2008

School Drop-Out Rates

*Background:* Health is associated with education in multiple ways across the life course. Education influences health through its impact on employment, and thus income and insurance status. With increased education, opportunities for better paying jobs improve. Further, increased educational achievement improves MCAH outcomes through its impact on health knowledge and behaviors, as well as sense of control, social standing and social support. Early childhood health and developmental status before a child even enters kindergarten has been shown to impact measures of success in school, such as high school graduation, that subsequently impact health outcomes for mothers and their children.[64] Low educational attainment is a serious problem in the United States. According to a report published by the Robert Wood Johnson Foundation, the United States is the only industrialized nation where young people currently are less likely than members of their parents' generation to be high-school graduates.[97]

*Methods:* The first SIR suggested Title V as a data source for school drop-out rates. CDPH/MCAH used the same data source as in Title V, the California Department of Education (CDE). However CDPH/MCAH had to obtain county-level data not presented in Title V and conduct additional analyses. To obtain county level data, CDPH/MCAH accessed CDE's data system (DataQuest). The 4-year derived drop out rate is an estimate of the percent of students who would drop out in a four year period based on data collected for a single year. Rates are adjusted for re-enrollments and lost transfers.

*Results:* In California, one in five individuals over the age of 25 has not completed high school and nearly 10% have not completed 9$^{th}$ grade.[97] Measures of educational attainment show that high school graduation rates declined only slightly from 69.6% in 2000 to 68.5% in 2008, while high school drop out rates rose sharply from 10.8% in 2000 to18.9% in 2008.[98] Educational attainment varies greatly by race/ethnicity. The 2007-08 drop out rate was higher than the state average for African-Americans (32.9%), American Indian/Alaska Native (24.1%), Hispanics (23.8%), and Pacific Islander (21.3%), and was lower than the state average for Whites (11.7%), Filipinos (8.6%) and Asians (7.9%).[98] Therefore, California's high school graduation rate for African-Americans (59.4%) and Hispanics (60.3%) was substantially lower than for Whites (79.7%) and Asians (91.7%). The graduation rate for females (75.8%) is higher than for males (67.3%) overall, and within each racial/ethnic group.[99]

There is wide variation in the rate of drop outs by county, in particular in Nevada County where the drop out rate is 73.5%. However, this rate should be interpreted with caution as it is based on a small number of events and might not be as stable as those based on larger numbers. Other counties with particularly high drop out rates include: Lassen (37.5%), Yuba (32.5%), Kern (26.9%), Fresno (24.0%) and Kings (23.3) (Table 9 and Figure 19).

**Table 9. Estimated 4-Year School Dropout Rate per 100 California Residents in Grades 9-12 by County, 2007-2008**

| RANK ORDER | COUNTY | RATE |
|---|---|---|
| 1 | NEVADA | 73.5 |
| 2 | LASSEN | 37.5 |
| 3 | YUBA | 32.5 |
| 4 | KERN | 26.9 |
| 5 | FRESNO | 24.0 |
| 6 | KINGS | 23.3 |
| 7 | YOLO | 23.1 |
| 8 | STANISLAUS | 22.8 |
| 9 | SAN BERNARDINO | 22.5 |
| 10 | SOLANO | 22.4 |
| 11 | SACRAMENTO | 21.4 |
| 12 | GLENN | 21.0 |
| 12 | LOS ANGELES | 21.0 |
| 12 | TEHAMA | 21.0 |
| 15 | SAN FRANCISCO | 20.8 |
| 16 | SAN JOAQUIN | 20.4 |
| 17 | SUTTER | 20.3 |
| 18 | TULARE | 19.3 |
| | **CALIFORNIA RATE** | **18.9** |
| 19 | MENDOCINO | 18.9 |
| 20 | NAPA | 18.4 |
| 21 | MONO | 17.8 |
| 22 | VENTURA | 17.6 |
| 23 | MERCED | 17.5 |
| 23 | SHASTA | 17.5 |
| 25 | RIVERSIDE | 17.3 |
| 26 | MADERA | 17.1 |
| 26 | SAN DIEGO | 17.1 |
| 28 | HUMBOLDT | 16.9 |
| 28 | SISKIYOU | 16.9 |
| 30 | ALAMEDA | 16.7 |
| 30 | LAKE | 16.7 |
| 32 | SONOMA | 16.6 |
| 33 | DEL NORTE | 16.1 |
| 34 | CONTRA COSTA | 16.0 |
| 35 | MARIPOSA | 15.6 |
| 36 | INYO | 15.3 |
| 37 | AMADOR | 15.1 |
| 38 | BUTTE | 15.0 |
| 39 | SAN BENITO | 14.7 |
| 40 | SANTA BARBARA | 14.5 |
| 41 | SANTA CLARA | 14.4 |
| 42 | EL DORADO | 14.0 |
| 42 | SANTA CRUZ | 14.0 |
| 44 | IMPERIAL | 13.0 |
| 45 | PLUMAS | 12.8 |
| 46 | SAN MATEO | 12.3 |
| 47 | MONTEREY | 11.6 |
| 48 | SAN LUIS OBISPO | 11.1 |
| 49 | ORANGE | 10.9 |
| 50 | COLUSA | 10.3 |
| 51 | TUOLUMNE | 10.0 |
| 52 | PLACER | 8.8 |
| 53 | MARIN | 7.7 |
| 54 | CALAVERAS | 6.8 |
| | ALPINE | -- |
| | MODOC | -- |
| | SIERRA | -- |
| | TRINITY | -- |

**State Median***

* State Median = 17.0

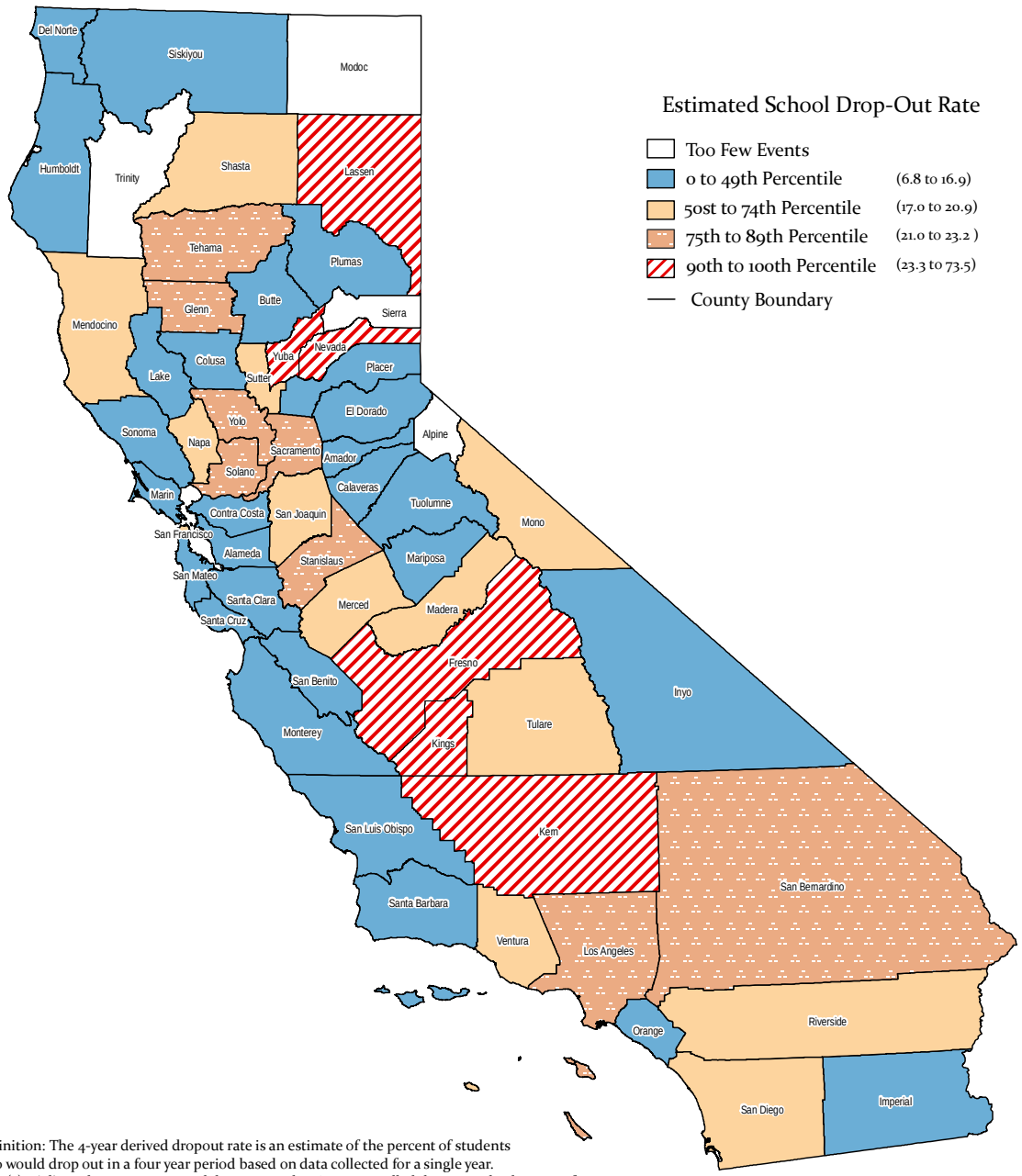
Note(s): The 4-year derived dropout rate is an estimate of the percent of students who would drop out in a four year period based on data collected for a single year. Adjusted rates are reported dropout totals minus reenrolled dropouts plus lost transfers.

"--" denotes counties with too few events, events < 20.

Source: California Department of Education, Education Demographics Office, DataQuest. Number of Dropouts in California Public Schools, Grades 9-12 by Grade Level and Ethnicity Group, 2007-08. Accessed at http://dq.cde.ca.gov/dataquest/ on August 11, 2010.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 19. Estimated 4-Year School Dropout Rate per 100 California Residents in Grades 9-12 by County, 2007-2008




Definition: The 4-year derived dropout rate is an estimate of the percent of students who would drop out in a four year period based on data collected for a single year.
Note(s): Adjusted rates are reported dropout totals minus reenrolled dropouts plus lost transfers.
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): California Department of Education, Education Demographics Office, DataQuest. Number of Dropouts in California Public Schools, Grades 9-12 by Grade Level and Ethnicity Group, 2007-08. Accessed at http://dq.cde.ca.gov/dataquest/ on August 11, 2010.

Substance Abuse

*Background:* Alcohol, tobacco and illicit drugs have an impact on health, even among individuals who do not use them. Substance abuse is a major factor in chronic disease, the spread of infectious diseases, hospital emergency room visits, newborn health problems, violence, and auto fatalities.[100] Many persons who abuse alcohol or drugs also suffer from a serious mental disorder. These individuals have a greater propensity for violence, medication noncompliance, and failure to respond to treatment compared to persons with just substance abuse or a mental illness.[101] In some cases, substance abuse may begin in childhood or the teen years. There are certain family risk factors that influence a child's early development that have been shown to increase risk of drug abuse including a chaotic home environment, ineffective parenting and a lack of nurturing and parental attachment.[102] Substance use in adolescence is associated with increased risk of a number of negative risks and outcomes such as injury, violence, and risky sexual behaviors.[103,104] Research has also linked substance abuse and child maltreatment. In fact, parental substance abuse is reported to be a contributing factor for between one- and two-thirds of maltreated children in the child welfare system.[105]

*Methods*: The SIR specified that States should use the Substance Abuse and Mental Health Services Administration (SAMHSA) Sub-State Treatment Planning Data Reports as the source for data on substance abuse. CDPH/MCAH used this report to present estimates of the prevalence of substance abuse based on data from the combined 2006-2008 National Surveys on Drug Use and Health (NSDUH).[106] However there was a difference in one the metrics specified in the SIR from what we reported in this assessment. Specifically, while the guidance specified to report the rate of nonmedical use of *prescription drugs* in the past *month*, the Sub-State Treatment Planning Data Reports only provide sub-state data on the nonmedical use of *pain relievers* in the past *year* and so this indicator was used instead.

There are some limitations to using the Sub-State Treatment Planning Data, including the fact that they are only available at the regional and not county level. In addition, the sub-state regional data from the NSDUH only provide information on the prevalence of various drug problems for California's population 12 years or older and are not specific to the home visiting population (e.g., limited to parental or family substance abuse). Thus, CDPH/MCAH included data pertaining to maternal substance abuse that is presented later in this report.

*Results:* During 2006-2008 in California, past month binge alcohol use was reported by 21.5% of persons aged 12 or older. Binge alcohol use is defined as drinking five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey. Region 9, composed of Kern and San Luis Obispo, had the highest rate at 25.3% followed by Region 15 (Imperial and San Diego) at 24.4% (Table 10 and Figure 20).

Marijuana is the most commonly used illicit drug. During the same time period the rate of past month marijuana use in California was 7.0%. The region with the highest rate of past month marijuana use was Region 10 (Santa Barbara and Ventura) at 9.7% followed by Region 7 (Monterey, San Benito, Santa Cruz) at 9.3% (Table 11 and Figure 21).

In California during 2006-2008, 5.3% of all persons aged 12 or older had used a pain reliever for non-medical use within the past year. Estimates ranged across regions from 4.5% to 7.1%. Similar to past month marijuana use, the rate was highest in Region 10 (Santa Barbara and Ventura) at 7.1% followed by Region 2 (El Dorado, Napa, Nevada, Placer, Sacramento, Sierra, Solano, Sonoma, Sutter, Yolo, Yuba) at 6.6% (Table 12 and Figure 22).

In California, 4.1% of persons aged 12 or older had used an illicit drug other than marijuana in the past month in 2006-2008. Illicit drugs other than marijuana include cocaine (and crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used non-medically. Past month use of these substances was again highest in Region 10 (Santa Barbara and Ventura) at 5.1%. Region 1, which includes several Northern California counties, (Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Plumas, Shasta, Siskiyou, Tehama, and Trinity) followed at 4.7% (Table 13 and Figure 23).

Although sub-state estimates for substance abuse indicators were only available for all persons aged 12 or older for 2006-2008, state level estimates for these indicators are available by age group (12-17, 18-25, 26-older) in the State estimates report for 2007-2008. These data are as follows:

- Prevalence rate for binge alcohol use in past month was 8.7%, 38.0% and 20.3% (for persons ages 12-17, 18-25 and 26-older, respectively).
- Prevalence rate for marijuana use in past month was 6.9%, 17.3% and 4.6% (for persons ages 12-17, 18-25 and 26-older, respectively).
- Prevalence rate for illicit drug use other than marijuana in past month was 4.8%, 8.0% and 3.1% (for persons ages 12-17, 18-25 and 26-older, respectively).
- Prevalence rate for nonmedical use of pain relievers in past year was 6.4%, 12.1% and 3.7% (for persons ages 12-17, 18-25 and 26-older, respectively).

**Table 10. Estimated Prevalence of Binge Alcohol Use in Past Month Among Persons Ages 12 or Older by California Region, 2006-2008**

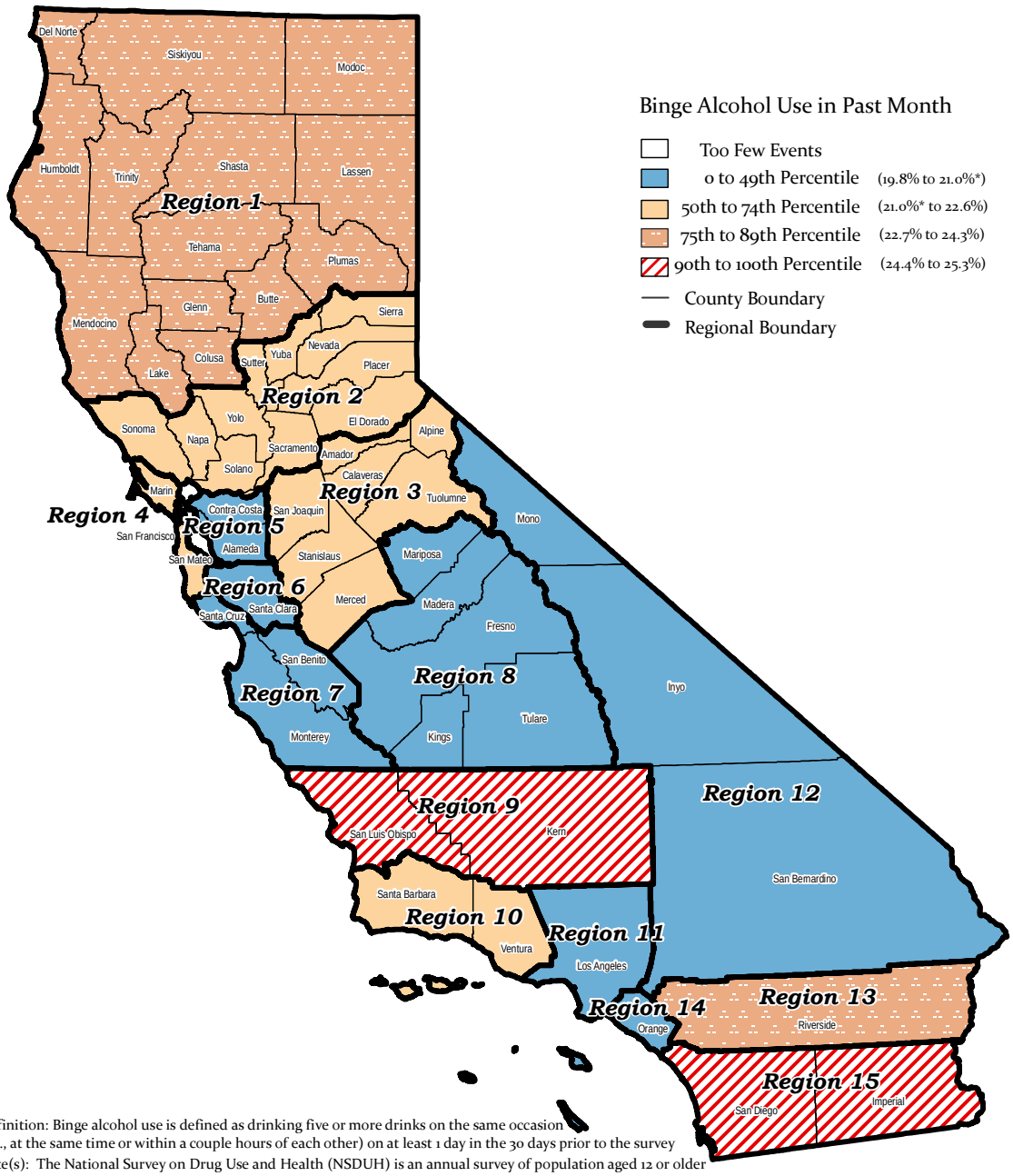
| RANK ORDER | COUNTY | RATE | |
|---|---|---|---|
| 1 | KERN<br>SAN LUIS OBISPO | 25.3 | |
| 2 | IMPERIAL<br>SAN DIEGO | 24.4 | |
| 3 | RIVERSIDE | 22.9 | |
| 4 | BUTTE<br>COLUSA<br>DEL NORTE<br>GLENN<br>HUMBOLDT<br>LAKE<br>LASSEN<br>MENDOCINO<br>MODOC<br>PLUMAS<br>SHASTA<br>SISKIYOU<br>TEHAMA<br>TRINITY | 22.7 | |
| 5 | EL DORADO<br>NAPA<br>NEVADA<br>PLACER<br>SACRAMENTO<br>SIERRA<br>SOLANO<br>SONOMA<br>SUTTER<br>YOLO<br>YUBA | 22.6 | |
| 6 | ALPINE<br>AMADOR<br>CALAVERAS<br>MERCED<br>SAN JOAQUIN<br>STANISLAUS<br>TUOLUMNE | 22.5 | |
| 7 | SANTA BARBARA<br>VENTURA | 22.3 | |
| | **CALIFORNIA RATE** | **21.5** | |
| 8 | MARIN<br>SAN FRANCISCO<br>SAN MATEO | 21.0 | **State Median*** |
| 9 | MONTEREY<br>SAN BENITO<br>SANTA CRUZ | 21.0 | |
| 10 | FRESNO<br>KINGS<br>MADERA<br>MARIPOSA<br>TULARE | 20.9 | |
| 11 | ORANGE | 20.8 | |
| 12 | INYO<br>MONO<br>SAN BERNARDINO | 20.7 | |
| 13 | LOS ANGELES | 20.4 | |
| 14 | ALAMEDA<br>CONTRA COSTA | 19.9 | |
| 15 | SANTA CLARA | 19.8 | |

* State Median = 21.03

Note(s): Binge alcohol use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple hours of each other) on at least 1 day in the 30 days prior to the survey. Data reported at regional level; 58 counties grouped into 15 regions; rank order and median based on regional value.

Source: Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD. Accessed at http://www.oas.samhsa.gov/substate2k10/toc.cfm on August 26, 2010. Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

**Figure 20. Estimated Prevalence of Binge Alcohol Use in Past Month Among Persons Ages 12 or Older by California Region, 2006-2008**




Definition: Binge alcohol use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple hours of each other) on at least 1 day in the 30 days prior to the survey
Note(s): The National Survey on Drug Use and Health (NSDUH) is an annual survey of population aged 12 or older
Prepared by: Maternal, Child and Adolescent Health Division, Center for Family Health, California Department of Public Health
SOURCE(S): Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD.
*Due to rounding, categories may appear to overlap

**Table 11. Estimated Prevalence of Marijuana Use in Past Month Among Persons Ages 12 or Older by California Region, 2006-2008**

| RANK ORDER | COUNTY | PERCENT | |
|---|---|---|---|
| 1 | SANTA BARBARA<br>VENTURA | 9.7 | |
| 2 | MONTEREY<br>SAN BENITO<br>SANTA CRUZ | 9.3 | |
| 3 | MARIN<br>SAN FRANCISCO<br>SAN MATEO | 9.3 | |
| 4 | KERN<br>SAN LUIS OBISPO | 9.0 | |
| 5 | EL DORADO<br>NAPA<br>NEVADA<br>PLACER<br>SACRAMENTO<br>SIERRA<br>SOLANO<br>SONOMA<br>SUTTER<br>YOLO<br>YUBA | 8.9 | |
| 6 | BUTTE<br>COLUSA<br>DEL NORTE<br>GLENN<br>HUMBOLDT<br>LAKE<br>LASSEN<br>MENDOCINO<br>MODOC<br>PLUMAS<br>SHASTA<br>SISKIYOU<br>TEHAMA<br>TRINITY | 8.5 | |
| 7 | ALAMEDA<br>CONTRA COSTA | 8.2 | |
| 8 | IMPERIAL<br>SAN DIEGO | 7.1 | **State Median*** |
| | **CALIFORNIA PERCENT** | **7.0** | |
| 9 | RIVERSIDE | 6.9 | |
| 10 | ALPINE<br>AMADOR<br>CALAVERAS<br>MERCED<br>SAN JOAQUIN<br>STANISLAUS<br>TUOLUMNE | 6.6 | |
| 11 | ORANGE | 6.2 | |
| 12 | SANTA CLARA | 6.1 | |
| 13 | FRESNO<br>KINGS<br>MADERA<br>MARIPOSA<br>TULARE | 6.0 | |
| 14 | INYO<br>MONO<br>SAN BERNARDINO | 5.7 | |
| 15 | LOS ANGELES | 5.4 | |

* State Median = 7.1

Note(s): Data reported at regional level; 58 counties grouped into 15 regions; rank order and median based on regional value.

Source: Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD. Accessed at http://www.oas.samhsa.gov/substate2k10/toc.cfm on August 26, 2010. Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

**Figure 21. Estimated Prevalence of Marijuana Use in Past Month Among Persons Ages 12 or Older by California Region, 2006-2008**

Note(s): Data reported at regional level; 58 counties grouped into 15 regions.
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD. Accessed at http://www.oas.samhsa.gov/substate2k10/toc.cfm on August 26, 2010.
*Due to rounding, categories may appear to overlap

**Table 12. Estimated Prevalence of Nonmedical Use of Pain Relievers in Past Year Among Persons Ages 12 or Older by California Region, 2006-2008**

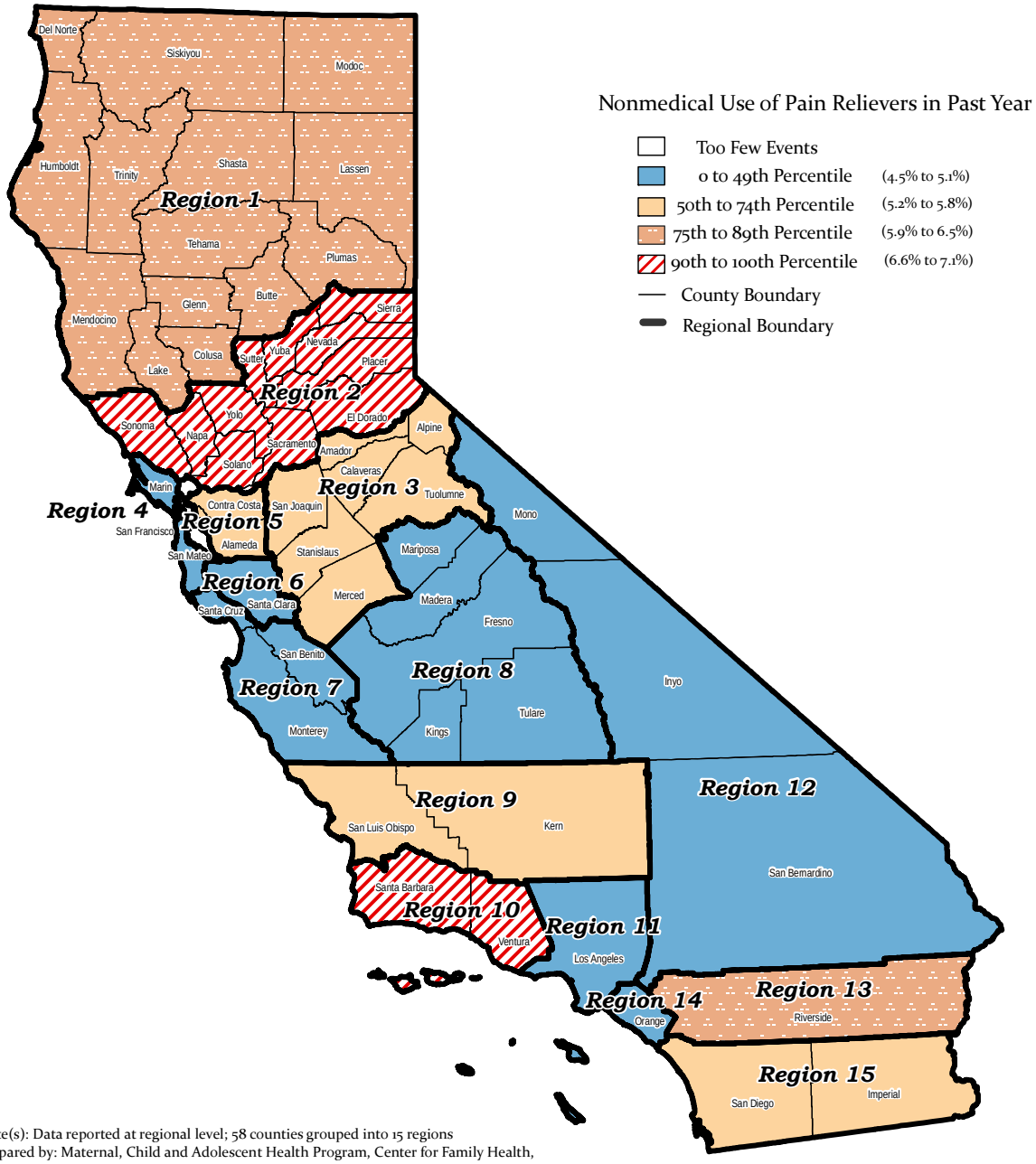
| RANK ORDER | COUNTY | PERCENT | |
|---|---|---|---|
| 1 | SANTA BARBARA<br>VENTURA | 7.1 | |
| 2 | EL DORADO<br>NAPA<br>NEVADA<br>PLACER<br>SACRAMENTO<br>SIERRA<br>SOLANO<br>SONOMA<br>SUTTER<br>YOLO<br>YUBA | 6.6 | |
| 3 | RIVERSIDE | 6.0 | |
| 4 | BUTTE<br>COLUSA<br>DEL NORTE<br>GLENN<br>HUMBOLDT<br>LAKE<br>LASSEN<br>MENDOCINO<br>MODOC<br>PLUMAS<br>SHASTA<br>SISKIYOU<br>TEHAMA<br>TRINITY | 5.9 | |
| 5 | ALPINE<br>AMADOR<br>CALAVERAS<br>MERCED<br>SAN JOAQUIN<br>STANISLAUS<br>TUOLUMNE | 5.8 | |
| 6 | IMPERIAL<br>SAN DIEGO | 5.8 | |
| 7 | KERN<br>SAN LUIS OBISPO | 5.5 | |
| | **CALIFORNIA PERCENT** | **5.3** | |
| 8 | ALAMEDA<br>CONTRA COSTA | 5.2 | **State Median*** |
| 9 | INYO<br>MONO<br>SAN BERNARDINO | 5.1 | |
| 10 | MONTEREY<br>SAN BENITO<br>SANTA CRUZ | 5.0 | |
| 11 | FRESNO<br>KINGS<br>MADERA<br>MARIPOSA<br>TULARE | 4.9 | |
| 12 | LOS ANGELES | 4.7 | |
| 13 | SANTA CLARA | 4.6 | |
| 14 | ORANGE | 4.6 | |
| 15 | MARIN<br>SAN FRANCISCO<br>SAN MATEO | 4.5 | |

*State median = 5.22

Note(s): Data reported at regional level; 58 counties grouped into 15 regions; rank order and median based on regional value.

Source: Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD. Accessed at http://www.oas.samhsa.gov/substate2k10/toc.cfm on August 26, 2010. Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

**Figure 22. Estimated Prevalence of Nonmedical Use of Pain Relievers in Past Year Among Persons Ages 12 or Older by California Region, 2006-2008**




Note(s): Data reported at regional level; 58 counties grouped into 15 regions
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD. Accessed at http://www.oas.samhsa.gov/substate2k10/toc.cfm on August 26, 2010.

**Table 13. Estimated Prevalence of Use of Illicit Drugs Other than Marijuana in Past Month Among Persons Aged 12 or Older by California Region, 2006-2008**

| RANK ORDER | COUNTY | PERCENT | |
|---|---|---|---|
| 1 | SANTA BARBARA | 5.1 | |
| | VENTURA | 5.1 | |
| 2 | BUTTE | 4.7 | |
| | COLUSA | 4.7 | |
| | DEL NORTE | 4.7 | |
| | GLENN | 4.7 | |
| | HUMBOLDT | 4.7 | |
| | LAKE | 4.7 | |
| | LASSEN | 4.7 | |
| | MENDOCINO | 4.7 | |
| | MODOC | 4.7 | |
| | PLUMAS | 4.7 | |
| | SHASTA | 4.7 | |
| | SISKIYOU | 4.7 | |
| | TEHAMA | 4.7 | |
| | TRINITY | 4.7 | |
| 3 | EL DORADO | 4.6 | |
| | NAPA | 4.6 | |
| | NEVADA | 4.6 | |
| | PLACER | 4.6 | |
| | SACRAMENTO | 4.6 | |
| | SIERRA | 4.6 | |
| | SOLANO | 4.6 | |
| | SONOMA | 4.6 | |
| | SUTTER | 4.6 | |
| | YOLO | 4.6 | |
| | YUBA | 4.6 | |
| 4 | RIVERSIDE | 4.6 | |
| 5 | IMPERIAL | 4.5 | |
| | SAN DIEGO | 4.5 | |
| 6 | MONTEREY | 4.3 | |
| | SAN BENITO | 4.3 | |
| | SANTA CRUZ | 4.3 | |
| 7 | FRESNO | 4.3 | |
| | KINGS | 4.3 | |
| | MADERA | 4.3 | |
| | MARIPOSA | 4.3 | |
| | TULARE | 4.3 | |
| 8 | KERN | 4.2 | **State Median*** |
| | SAN LUIS OBISPO | 4.2 | |
| 9 | ALPINE | 4.2 | |
| | AMADOR | 4.2 | |
| | CALAVERAS | 4.2 | |
| | MERCED | 4.2 | |
| | SAN JOAQUIN | 4.2 | |
| | STANISLAUS | 4.2 | |
| | TUOLUMNE | 4.2 | |
| 10 | ALAMEDA | 4.1 | |
| | CONTRA COSTA | 4.1 | |
| | **CALIFORNIA PERCENT** | **4.1** | |
| 11 | INYO | 3.8 | |
| | MONO | 3.8 | |
| | SAN BERNARDINO | 3.8 | |
| 12 | MARIN | 3.7 | |
| | SAN FRANCISCO | 3.7 | |
| | SAN MATEO | 3.7 | |
| 12 | SANTA CLARA | 3.7 | |
| 14 | LOS ANGELES | 3.6 | |
| 15 | ORANGE | 3.6 | |

*State median = 4.20

Note(s): Illicit drugs other than marijuana include cocaine (and crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically; Data reported at regional level; 58 counties grouped into 15 regions; rank order and median based on regional value.

Source: Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD. Accessed at http://www.oas.samhsa.gov/substate2k10/toc.cfm on August 26, 2010. Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

**Figure 23. Estimated Prevalence of Use of Illicit Drugs Other than Marijuana in Past Month Among Persons Aged 12 or Older by California Region, 2006-2008**

Definition: Illicit drugs other than marijuana include cocaine (and crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically
Note(s): The National Survey on Drug Use and Health (NSDUH) is an annual survey of population aged 12 or older
Prepared by: Maternal, Child and Adolescent Health Division, Center for Family Health, California Department of Public Health
SOURCE(S): Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD.
*Due to rounding, categories may appear to overlap

Unemployment

*Background:* Employment is associated with income, insurance status, working conditions, and stress; therefore it impacts a host of health outcomes through direct and indirect pathways. The relationship between employment and health also includes the impact of elevated rates of unemployment on community well-being by weakening social networks and neighborhood engagement, factors that have been shown to influence health outcomes.[64]

*Methods:* CDPH/MCAH used the U.S. Department of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics (LAUS) as the source for unemployment rates in this report and not the Head Start communitywide assessments as indicated in the first SIR. As noted previously, the Head Start communitywide assessments were not readily available, and even if they were, it is unknown whether such data would be included in these assessments and if the data source used would be consistent. The LAUS were considered preferable over other sources, like the US Census Bureau's American Community Survey, because unemployment rates were available for each of the State's 58 counties. In addition, the LAUS data are based on the same concepts and definitions as the Current Population Survey (CPS), the household survey that is the official measure of the labor force for the nation. CDPH/MCAH may consider using additional data sources for the Updated State Plan, like the ACS five-year aggregate data if those are ready in time. Such data may provide additional sub-county data beyond what is available through the LAUS.

*Results:* The current recession has had a major impact on the California job market. Between July 2007 and July 2009, California lost nearly one million non-farm jobs, many more than were gained in the prior 4 years. All sectors were impacted, but construction was the hardest hit. Further, Hispanics, who are most likely to work in sectors impacted by the recession, saw the greatest increase in unemployment during this period.[107] The annual unemployment rate of 2009 is more than double the level seen at the start of the recession in 2007 (11.9% versus 5.3%). Unemployment for African-Americans during the same period was 14.3% and for Hispanics was 14.7%.[108] Asians had the lowest rate of unemployment (8.9%) followed by Whites (11.3%).

Similar to other indicators, rates of unemployment also vary throughout California. The rate of unemployment in 2009 is particularly high in Imperial County where about one in every four people in the labor force is unemployed. Other counties experiencing high levels of unemployment include Colusa (18.3%), Yuba and Trinity (17.3%), Merced (17.2%), and Sutter (17.0%) (Table 14 and Figure 24).

**Table 14. Percentage of Unemployed Labor Force in California by County, 2009**

| RANK ORDER | COUNTY | PERCENT | |
|---|---|---|---|
| 1 | IMPERIAL | 28.2 | |
| 2 | COLUSA | 18.3 | |
| 3 | YUBA | 17.3 | |
| 3 | TRINITY | 17.3 | |
| 5 | MERCED | 17.2 | |
| 6 | SUTTER | 17.0 | |
| 7 | PLUMAS | 16.4 | |
| 8 | STANISLAUS | 16.0 | |
| 9 | LAKE | 15.6 | |
| 10 | SAN JOAQUIN | 15.4 | |
| 11 | TULARE | 15.3 | |
| 12 | SIERRA | 15.2 | |
| 13 | FRESNO | 15.1 | |
| 14 | SHASTA | 14.8 | |
| 14 | SISKIYOU | 14.8 | |
| 16 | KINGS | 14.6 | |
| 16 | GLENN | 14.6 | |
| 18 | KERN | 14.4 | |
| 18 | SAN BENITO | 14.4 | |
| 20 | TEHAMA | 14.1 | |
| 20 | CALAVERAS | 14.1 | |
| 22 | ALPINE | 14.0 | |
| 23 | MADERA | 13.7 | |
| 24 | RIVERSIDE | 13.6 | |
| 25 | SAN BERNARDINO | 13.0 | |
| 26 | LASSEN | 12.9 | |
| 27 | MODOC | 12.8 | |
| 28 | TUOLUMNE | 12.6 | |
| 29 | BUTTE | 12.5 | |
| 30 | DEL NORTE | 12.2 | **State Median*** |
| | **CALIFORNIA PERCENT** | **11.9** | |
| 31 | MONTEREY | 11.9 | |
| 32 | AMADOR | 11.7 | |
| 33 | LOS ANGELES | 11.6 | |
| 34 | SACRAMENTO | 11.3 | |
| 34 | EL DORADO | 11.3 | |
| 36 | YOLO | 11.2 | |
| 36 | SANTA CRUZ | 11.2 | |
| 38 | SANTA CLARA | 11.0 | |
| 38 | HUMBOLDT | 11.0 | |
| 40 | SOLANO | 10.9 | |
| 41 | NEVADA | 10.7 | |
| 41 | ALAMEDA | 10.7 | |
| 43 | MARIPOSA | 10.6 | |
| 43 | PLACER | 10.6 | |
| 45 | MENDOCINO | 10.5 | |
| 46 | CONTRA COSTA | 10.3 | |
| 47 | VENTURA | 10.0 | |
| 48 | SAN DIEGO | 9.7 | |
| 48 | SONOMA | 9.7 | |
| 50 | INYO | 9.1 | |
| 51 | MONO | 9.0 | |
| 51 | SAN FRANCISCO | 9.0 | |
| 51 | ORANGE | 9.0 | |
| 51 | SAN LUIS OBISPO | 9.0 | |
| 55 | NAPA | 8.7 | |
| 56 | SAN MATEO | 8.6 | |
| 57 | SANTA BARBARA | 8.4 | |
| 58 | MARIN | 7.8 | |

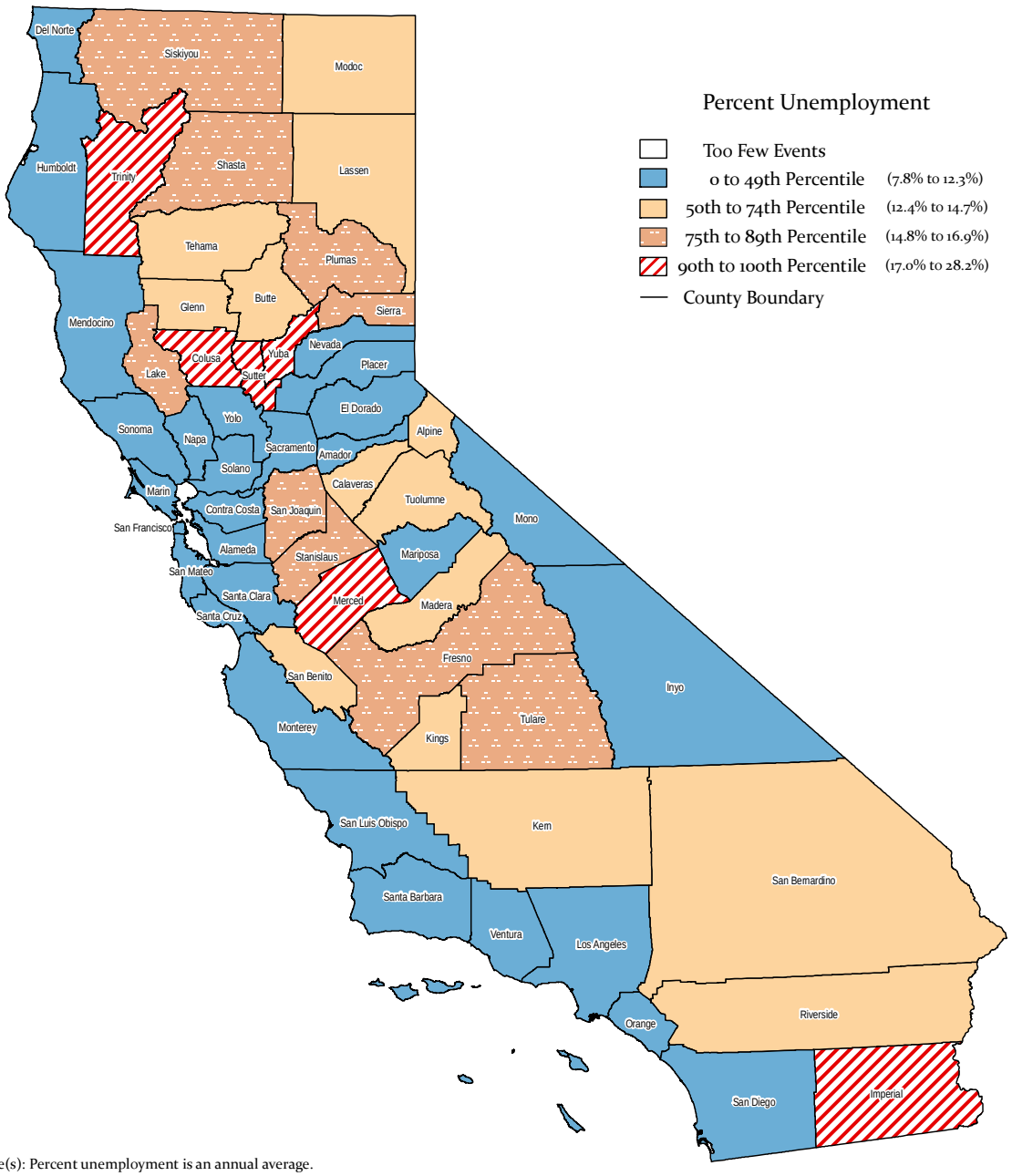
*State median = 12.357

Note(s): Percent unemployment is an annual average.

Source: U.S. Department of Labor, Bureau of Labor Statistics, Labor Force Data by County, 2009, Annual Averages. Accessed at http://www.bls.gov on August 4, 2010.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 24. Percentage of Unemployed Labor Force in California by County, 2009




Note(s): Percent unemployment is an annual average.
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): U.S. Department of Labor, Bureau of Labor Statistics, Labor Force Data by County, 2009, Annual Averages
Accessed at http://www.bls.gov on August 4, 2010.

Child Maltreatment

*Background:* Child abuse and neglect can occur in any family. However, research has recognized a number of risk factors or attributes commonly associated with maltreatment. Children within families and environments where factors such as marital conflict, domestic violence, single parenthood, unemployment, poverty, parental substance abuse, parental mental illness, poor parent-child interaction, stress, neighborhood violence and social isolation exist, have a higher probability of experiencing maltreatment.[81, 105] In addition to family and environmental factors there are some child factors including age and child disability that may put certain children at an increased risk of maltreatment.[81, 105] However, the presence of these factors does not always result in a child being abused or neglected. Likewise, child abuse and neglect can occur in families where these risk factors are absent. Child maltreatment is associated with adverse consequences that can have negative impacts across the life course including developmental failures, early pregnancy, drug abuse, violence, poor academic achievement, mental illness, and suicidal behavior.[105]

*Methods:* CDPH/MCAH worked closely with the CDSS to identify the best data source of child abuse and neglect data for California. Data were queried from the child welfare dynamic report system website. All of the data from that website come from the University of California Berkeley quarterly extracts from Child Welfare Services/Case Management System (CWS/CMS). Extracts are created approximately two months after each quarter ends, and the data are fully refreshed each quarter. Due to the time it takes to process, run, validate, and approve the data each quarter, data from the system are typically six to nine months old.

While the first SIR noted that the rate of reported *substantiated* maltreatment could also include *indicated* (referred to as “inconclusive” in California) and *alternative response* (referred to as “differential response” in California) victims, the data presented here represent rates of substantiated cases of child maltreatment only. The rate of substantiated child maltreatment in CWS/CMS is calculated by dividing the unduplicated count of children with a child maltreatment substantiation by the child population and then multiplying by 1,000. The child population data come from the CA DOF.

The CWS/CMS system does include data on inconclusive cases; however, due to time limitations these data are not included in this assessment. According to the CDSS, in California, there tends to be a large number of inconclusive cases, and because by definition these kids are at risk, CDPH/MCAH plans to include these data in the updated home visiting needs assessment. The disposition type of differential response, however, is not currently tracked in CWS/CMS so data are not available on this population.

The data on substantiated child maltreatment by type comes from the same data source. The denominator is the total number of unduplicated children with substantiated maltreatment for that county. The numerator is the number of unduplicated children, counted only once, in the category of highest severity, for that county. Percent calculations do not include "Missing" maltreatment type. The maltreatment severity hierarchy recorded on the child welfare data system, from highest to lowest severity, includes these types: Sexual Abuse, Physical Abuse, Severe Neglect, General Neglect, Exploitation, Emotional Abuse, Caretaker Absence/Incapacity, At Risk Sibling Abused and Substantial Risk.

*Results:* Substantiated child abuse cases have decreased steadily from 12.0 per 1,000 children in 1998 to 9.1 per 1,000 children in 2009 (data for 2009 in Table 15). However, in 2009, there were still 90,472 cases of substantiated abuse and another 69,740 children for which an

investigation disposition concluded that maltreatment could not be substantiated, but there was reason to suspect that the child may have been maltreated or was at risk of maltreatment. As shown in Table 16, the most common form of reported child abuse is by far general neglect, followed by physical and emotional abuse, and substantial risk (e.g. threat of harm). In 2009, African-American (23.3 per 1,000 children) and American Indian/Alaska Native children (18.7 per 1,000 children) experienced higher rates of child abuse than Hispanics (9.5 per 1,000 children), Whites (7.7 per 1,000 children), and Asian/Pacific Islanders (3.4 per 1,000 children).

The rate of child abuse varies widely among California's counties in 2009, with rates much higher in some counties than in others. For instance, Del Norte County's rate of substantiated child maltreatment (49.1 per 1,000 children) was more than 20 times the rate for San Mateo County (2.4 per 1,000 children). Other counties with particularly high rates include: Sierra (39.6 per 1,000 children), Siskiyou (31.7 per 1,000 children), Mariposa (31.1 per 1,000 children), Trinity (28.3 per 1,000 children), and Glenn (23.3 per 1,000 children) (Table 15 and Figure 25).

**Table 15. Substantiated Cases of Child Maltreatment, Rate per 1,000 Children by County, 2009**

| RANK ORDER | COUNTY | RATE | |
|---|---|---|---|
| 1 | DEL NORTE | 49.1 | |
| 2 | SIERRA | 39.6 | |
| 3 | SISKIYOU | 31.7 | |
| 4 | MARIPOSA | 31.1 | |
| 5 | TRINITY | 28.3 | |
| 6 | GLENN | 23.3 | |
| 7 | PLUMAS | 21.3 | |
| 8 | MODOC | 20.9 | |
| 9 | MENDOCINO | 20.5 | |
| 10 | TEHAMA | 19.3 | |
| 11 | SHASTA | 19.1 | |
| 12 | KERN | 18.5 | |
| 13 | BUTTE | 17.0 | |
| 14 | TUOLUMNE | 16.1 | |
| 15 | INYO | 16.0 | |
| 16 | CALAVERAS | 15.0 | |
| 17 | YUBA | 14.4 | |
| 18 | EL DORADO | 14.2 | |
| 19 | STANISLAUS | 13.5 | |
| 20 | ALPINE | 13.3 | |
| 21 | LASSEN | 12.7 | |
| 22 | MADERA | 11.8 | |
| 22 | RIVERSIDE | 11.8 | |
| 24 | MERCED | 10.9 | |
| 24 | SACRAMENTO | 10.9 | |
| 26 | AMADOR | 10.6 | |
| 26 | PLACER | 10.6 | |
| 28 | IMPERIAL | 9.9 | |
| 29 | ORANGE | 9.8 | |
| | | | **State Median*** |
| 30 | LOS ANGELES | 9.7 | |
| 31 | SAN DIEGO | 9.6 | |
| 32 | LAKE | 9.5 | |
| 33 | SAN LUIS OBISPO | 9.4 | |
| 34 | SAN FRANCISCO | 9.3 | |
| 35 | SANTA CRUZ | 9.2 | |
| | **CALIFORNIA RATE** | **9.1** | |
| 36 | YOLO | 8.8 | |
| 37 | HUMBOLDT | 8.7 | |
| 37 | MONO | 8.7 | |
| 39 | SANTA BARBARA | 8.5 | |
| 40 | TULARE | 8.2 | |
| 41 | FRESNO | 8.1 | |
| 42 | SAN JOAQUIN | 7.6 | |
| 43 | SAN BERNARDINO | 7.4 | |
| 44 | SONOMA | 6.9 | |
| 45 | KINGS | 6.5 | |
| 45 | SUTTER | 6.5 | |
| 47 | SOLANO | 6.3 | |
| 48 | NEVADA | 5.5 | |
| 49 | COLUSA | 5.3 | |
| 49 | SAN BENITO | 5.3 | |
| 51 | CONTRA COSTA | 5.2 | |
| 52 | NAPA | 4.8 | |
| 53 | MARIN | 4.7 | |
| 54 | ALAMEDA | 4.0 | |
| 54 | SANTA CLARA | 4.0 | |
| 56 | VENTURA | 3.7 | |
| 57 | MONTEREY | 3.6 | |
| 58 | SAN MATEO | 2.4 | |

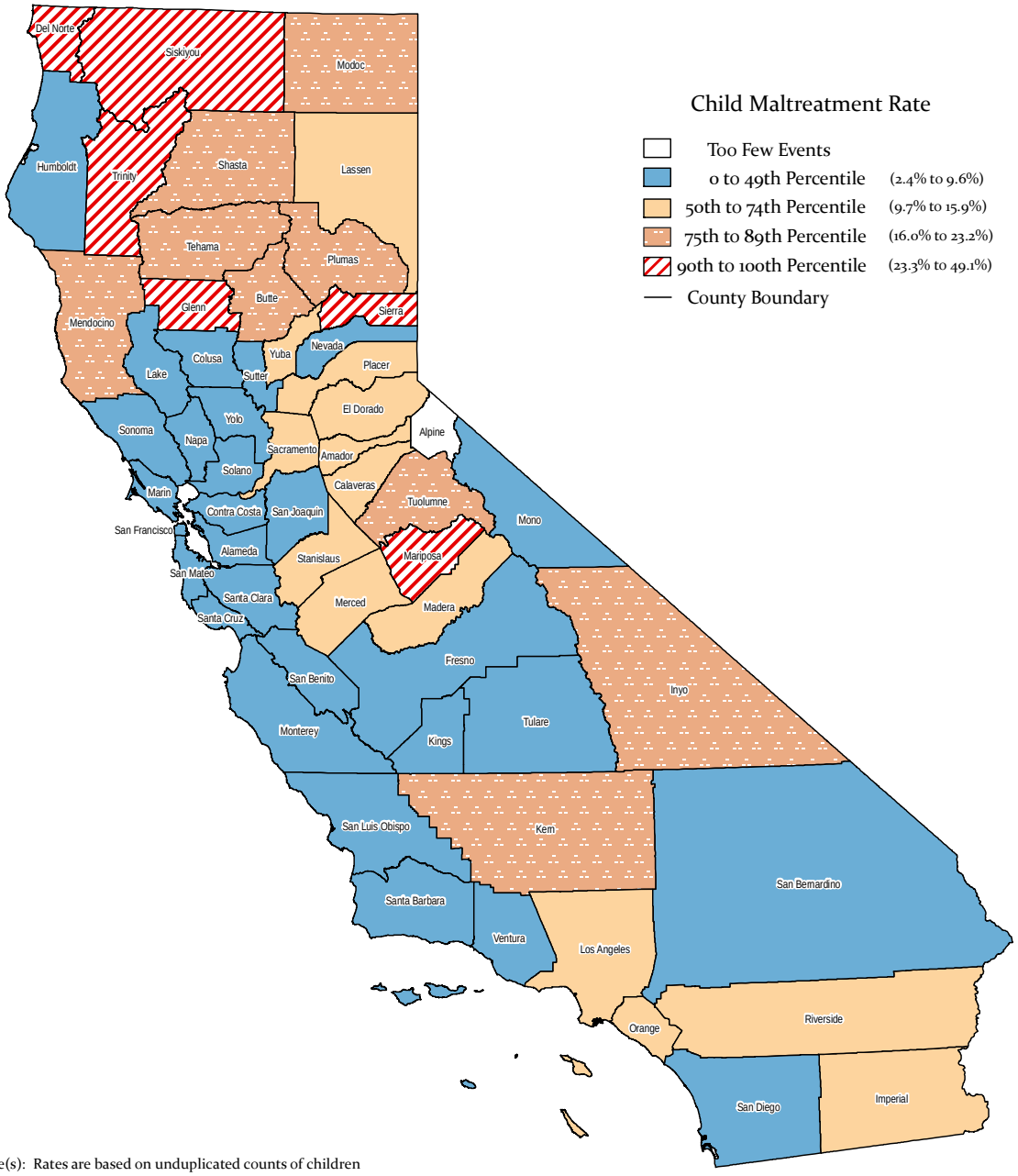
*State median = 9.75

Note(s):Rates are based on unduplicated counts of children.

Source: Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). Child Welfare Services Reports for California. Accessed on August 25, 2010, from University of California at Berkeley Center for Social Services Research. Accessed at: <http://cssr.berkeley.edu/ucb_childwelfare>

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 25. Substantiated Cases of Child Maltreatment, Rate per 1,000 Children by County, 2009




Note(s): Rates are based on unduplicated counts of children
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). Child Welfare Services Reports for California. Accessed on August 25, 2010, from University of California at Berkeley Center for Social Services Research. Accessed at: <http://cssr.berkeley.edu/ucb_childwelfare>

**Table 16. Child Maltreatment Percentage of Reported Substantiated Maltreatment by Allegation Type and County, 2009**

| | ALLEGATION TYPE | | | | | | | | | ALL |
|---|---|---|---|---|---|---|---|---|---|---|
| | SEXUAL ABUSE | PHYSICAL ABUSE | SEVERE NEGLECT | GENERAL NEGLECT | EXPLOITATION | EMOTIONAL ABUSE | CARETAKER ABUSE/ INCAPACITY | AT RISK, SIBLING ABUSE | SUBSTANTIAL RISK | |
| COUNTY | % | % | % | % | % | % | % | % | % | % |
| **CALIFORNIA** | **5.9** | **9** | **3** | **52** | **0** | **8.5** | **5.6** | **7.8** | **8.2** | **100** |
| ALAMEDA | 8.5 | 14.5 | 2.4 | 27.5 | 0.1 | 4.3 | 27.2 | 1.6 | 13.8 | 100 |
| ALPINE | 0 | 0 | 0 | 100 | 0 | 0 | 0 | 0 | 0 | 100 |
| AMADOR | 1.4 | 21.7 | 2.9 | 49.3 | 0 | 5.8 | 14.5 | 2.9 | 1.4 | 100 |
| BUTTE | 2.2 | 4.8 | 7.6 | 67.1 | 0 | 2.9 | 10.6 | 1.6 | 3.3 | 100 |
| CALAVERAS | 2.5 | 7.5 | 5.8 | 67.5 | 0 | 6.7 | 5 | 4.2 | 0.8 | 100 |
| COLUSA | 2.9 | 8.8 | 2.9 | 17.6 | 0 | 5.9 | 55.9 | . | 5.9 | 100 |
| CONTRA COSTA | 3 | 6.9 | 0.6 | 70.5 | 0.1 | 0 | 5 | 10.4 | 3.4 | 100 |
| DEL NORTE | 1.3 | 3.9 | 2.6 | 76.2 | 0 | 1 | 7.7 | 3.2 | 4.2 | 100 |
| EL DORADO | 2.5 | 5.9 | 2.8 | 75.8 | 0 | 2.3 | 5.5 | 1.2 | 3.9 | 100 |
| FRESNO | 5.7 | 7.2 | 0.8 | 65.6 | 0 | 1.9 | 0.7 | 10.5 | 7.6 | 100 |
| GLENN | 2.7 | 7.4 | 12.2 | 53.2 | 0 | 16 | 6.9 | 1.6 | 0 | 100 |
| HUMBOLDT | 0.8 | 9.6 | 2.1 | 49.2 | 0 | 5.4 | 2.5 | 4.2 | 26.3 | 100 |
| IMPERIAL | 0.6 | 2.5 | 0.2 | 84.9 | 0 | 0 | 6.2 | 1.9 | 3.6 | 100 |
| INYO | 0 | 17.7 | 0 | 53.2 | 0 | 22.6 | 0 | 6.5 | 0 | 100 |
| KERN | 1.7 | 4.8 | 1.3 | 84.3 | 0 | 0.3 | 3.1 | 3.5 | 0.9 | 100 |
| KINGS | 6.8 | 11.1 | 5.4 | 53.4 | 0 | 2.4 | 10.5 | 10.1 | 0.3 | 100 |
| LAKE | 5.7 | 4.9 | 0 | 62.3 | 0 | 0.8 | 10.7 | 0 | 15.6 | 100 |
| LASSEN | 3.5 | 10.5 | 0 | 66.3 | 0 | 2.3 | 12.8 | 4.7 | 0 | 100 |
| LOS ANGELES | 6.7 | 11.4 | 2.4 | 36.7 | 0.1 | 16.5 | 5.6 | 12.3 | 8.4 | 100 |
| MADERA | 8.7 | 6.7 | 1.2 | 62.2 | 0 | 0.2 | 6.7 | 10 | 4.3 | 100 |
| MARIN | 3.6 | 5.6 | 12.8 | 61.2 | 0 | 1.6 | 3.2 | 1.2 | 10.8 | 100 |
| MARIPOSA | 4.3 | 5.3 | 2.1 | 74.5 | 0 | 1.1 | 3.2 | 4.3 | 5.3 | 100 |
| MENDOCINO | 2.1 | 6 | 2.4 | 66.9 | 0 | 6.4 | 6 | 3.3 | 6.9 | 100 |
| MERCED | 6.1 | 7.9 | 1.3 | 59.8 | 0 | 4.5 | 8.8 | 3.4 | 8.3 | 100 |
| MODOC | 2.3 | 11.4 | 0 | 54.5 | 0 | 4.5 | 4.5 | 2.3 | 20.5 | 100 |
| MONO | 7.7 | 19.2 | 3.8 | 11.5 | 0 | 3.8 | 3.8 | 7.7 | 42.3 | 100 |
| MONTEREY | 6.7 | 8.6 | 1.6 | 50.8 | 0 | 0.9 | 10.4 | 7.4 | 13.5 | 100 |
| NAPA | 6.5 | 7.1 | 2.4 | 68.5 | 0 | 1.2 | 9.5 | 4.8 | 0 | 100 |
| NEVADA | 1 | 9 | 1 | 51 | 0 | 2 | 9 | 2 | 25 | 100 |
| ORANGE | 10.3 | 7.1 | 2.2 | 66.4 | 0 | 0.1 | 1.7 | 11.5 | 0.8 | 100 |
| PLACER | 2.8 | 7.5 | 0.9 | 40.1 | 0 | 14 | 1.9 | 3.5 | 29.5 | 100 |
| PLUMAS | 1.2 | 8.5 | 26.8 | 42.7 | 0 | 0 | 7.3 | 7.3 | 6.1 | 100 |
| RIVERSIDE | 4 | 6.1 | 3.2 | 75.5 | 0 | 0.1 | 4.3 | 2.9 | 3.9 | 100 |
| SACRAMENTO | 5.8 | 11.8 | 4.3 | 45.5 | 0 | 5.5 | 4.3 | 2.9 | 19.9 | 100 |
| SAN BENITO | 1 | 8.3 | 1 | 61.5 | 0 | 2.1 | 5.2 | 6.3 | 14.6 | 100 |
| SAN BERNARDINO | 10.7 | 9.9 | 4.8 | 52.6 | 0 | 2.9 | 10 | 5.9 | 3.1 | 100 |
| SAN DIEGO | 5 | 7.5 | 5.3 | 34.8 | 0.1 | 16.8 | 4.4 | 5.3 | 20.8 | 100 |
| SAN FRANCISCO | 3.4 | 12.2 | 1.5 | 35 | 0 | 12.8 | 10.3 | 5.1 | 19.8 | 100 |
| SAN JOAQUIN | 7 | 9.3 | 7.2 | 53.2 | 0.1 | 5.7 | 8.8 | 3.1 | 5.6 | 100 |
| SAN LUIS OBISPO | 4 | 6.4 | 1.8 | 67.5 | 0 | 8 | 2.6 | 0 | 9.8 | 100 |
| SAN MATEO | 4.1 | 15.6 | 4.1 | 47.3 | 0 | 3.8 | 9.2 | 7.4 | 8.4 | 100 |
| SANTA BARBARA | 5 | 10.8 | 5 | 50.9 | 0.1 | 7.2 | 10.6 | 1.6 | 8.7 | 100 |
| SANTA CLARA | 6 | 14.4 | 3.9 | 34.8 | 0 | 9.2 | 9.9 | 10.8 | 10.9 | 100 |
| SANTA CRUZ | 4.9 | 8.3 | 9.9 | 46.3 | 0 | 12.9 | 0.6 | 1.5 | 15.6 | 100 |
| SHASTA | 2.6 | 4.6 | 4.1 | 50.9 | 0 | 28.7 | 4.6 | 2.2 | 2.3 | 100 |
| SIERRA | 0 | 13.6 | 0 | 59.1 | 0 | 9.1 | 4.5 | 4.5 | 9.1 | 100 |
| SISKIYOU | 2 | 3.3 | 0.7 | 83.4 | 0 | 0 | 8.3 | 0 | 2.3 | 100 |
| SOLANO | 3.6 | 14.1 | 1 | 50.7 | 0 | 4.8 | 9.4 | 7.8 | 8.6 | 100 |
| SONOMA | 3.9 | 10 | 1.8 | 48 | 0.1 | 12.5 | 5.7 | 4.4 | 13.4 | 100 |
| STANISLAUS | 3.5 | 2.7 | 1 | 77.3 | 0 | 0.3 | 2.4 | 9.6 | 3 | 100 |
| SUTTER | 1 | 7.2 | 0.5 | 46.9 | 0 | 21.1 | 10.3 | 2.6 | 10.3 | 100 |
| TEHAMA | 2.8 | 10 | 6.6 | 55.5 | 0 | 4.8 | 14.1 | 4.1 | 2.1 | 100 |
| TRINITY | 2.5 | 8.9 | 1.3 | 72.2 | 0 | 3.8 | 2.5 | 0 | 8.9 | 100 |
| TULARE | 2.2 | 9.1 | 3.5 | 50.2 | 0 | 3.9 | 6 | 20.2 | 4.9 | 100 |
| TUOLUMNE | 1.3 | 7.1 | 3.9 | 79.4 | 0 | 1.9 | 1.9 | 3.9 | 0.6 | 100 |
| VENTURA | 6.2 | 7.6 | 1.4 | 64.3 | 0 | 1.9 | 11.7 | 6.6 | 0.4 | 100 |
| YOLO | 3.6 | 7.6 | 4.5 | 68.5 | 0 | 4.5 | 9.5 | 1.7 | 0.2 | 100 |
| YUBA | 3.6 | 10.2 | 5.1 | 61.1 | 0 | 3.3 | 4.2 | 6 | 6.3 | 100 |

Note(s): A child is counted only once, in category of highest severity.
Children with one or more allegations for Jan. 1, 2009 to Dec. 31, 2009.

Source: CWS/ CMS 2009 Quarter 4 Extract; Center for Social Services Research, University of California, Berkeley.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

### Supplemental Indicators

While not required, the first SIR stated that "other indicators of at risk prenatal, maternal, newborn, or child health" could be included in the statewide data report (the "Appendix A" matrix) and the home visiting needs assessment, as available. California chose to supplement the required list of indicators with some additional indicators that were considered important in identifying at risk communities. These indicators were selected for inclusion in this report based on one or more of the following criteria:

- Identified as a priority indicator based on input from the key partners involved in California's Home Visiting Program.
- Reflect conditions that can be altered through early childhood home visiting or reflect target populations for various home visiting programs, as evidenced in the literature.
- Are currently measurable at the state and county level.

In addition, these supplemental indicators were selected because in reviewing the required indicators for reporting, it became obvious that there was a need to include supplemental indicators to describe the health needs of pregnant or parenting women, infants and children. As a result, supplemental indicators are included to illuminate important factors related to observed birth outcomes in California's populations and early childhood health and development. Additional indicators reflecting the health and developmental status of infants and children were included to provide critical information not only about current well-being, but also in relation to the promotion of health and well-being into school and continuing through adulthood. As a result, a few indicators of child health are included as well as some additional indicators of newborn/infant health.

The supplemental indicators helped to frame the data according to a life course trajectory, with linkages to preceding and subsequent developmental periods such as pregnancy, infancy and early childhood and illuminates the significance of integrating home visiting as a strategy in addressing the MCAH population needs and priorities as identified in the 2011-2015 Title V Needs Assessment.

The *supplemental* indicators presented in this needs assessment include:

- Prenatal care
- Prenatal substance use
- Maternal depression
- Short birth interval
- Breastfeeding
- Children with special needs
- Foster care

Prenatal Care

*Background:* Early, comprehensive prenatal care (PNC) increases the likelihood that a child will be born healthy. Many maternal health conditions and risk factors that could threaten the birth of a healthy child are amenable to intervention during prenatal care[109] Research shows that mothers who receive adequate early prenatal care are less likely to have preterm or low birth weight infants and are more likely to obtain regular pediatric care for their young children.[61, 109]

*Methods:* Rates of first trimester prenatal care were calculated using the same metrics as Title V; the number of resident live births to pregnant women who received prenatal care beginning in first trimester divided by the total number of resident live births. Births with unknown prenatal care initiation were excluded from the analysis.

*Results:* California has seen a recent decline in first trimester PNC initiation. The percent of women with a live birth who received PNC in the first trimester increased from 85% in 2000 to 87% in 2003, but then decreased to 82% in 2008. Beginning in 2007, new variables on the California birth certificate require more precise timing of PNC initiation, which has resulted in fewer women showing PNC beginning in the first month and a rise in unknown PNC. The drastic drop seen in the birth certificate data in 2007 (first trimester PNC initiation dropped from 86% in 2006 to 83% in 2007) is explained in part by the new reporting format. Using data from MIHA, the drop in first trimester PNC in recent years does not appear to be as great. Regardless, there has been a decrease between 2003 and 2008, and the percent of California women with first trimester PNC is moving away from the HP 2010 target of 90%.

In 2008, the percent of births with first trimester PNC was highest among White and Asian groups compared to Hispanic and African-American groups. Pacific Islander and American Indian/Alaska Native women had the lowest first trimester PNC initiation. PNC initiation also varied by county with the lowest rates of first trimester prenatal care occurring in rural counties such as Del Norte and Imperial (50.2% and 59.7%, respectively) and the highest in more urban areas such as Marin and San Mateo (94.4% and 88.6%, respectively). These findings are similar to national studies which have documented that women living in non-metropolitan areas are more likely to receive inadequate prenatal care.[110] In addition to Del Norte and Imperial mentioned above, more than one-third of women did not receive prenatal care in the first trimester in the following counties: Merced (62.2%), Colusa (60.2%), Yuba (59.2%), and Sutter (57.1%). While the rates are not as low as the counties mentioned above, there is a clustering of seven counties in the Northern Mountain region with first trimester prenatal care rates between 64% and 72% (Table 17 and Figure 26).

**Table 17. First Trimester Prenatal Care Initiation as a Percentage of Live Births by County, 2008**

| RANK ORDER | COUNTY | PERCENT | |
|---|---|---|---|
| 1 | DEL NORTE | 50.2 | |
| 2 | SUTTER | 57.1 | |
| 3 | YUBA | 59.2 | |
| 4 | IMPERIAL | 59.7 | |
| 5 | COLUSA | 60.2 | |
| 6 | MERCED | 62.2 | |
| 7 | TRINITY | 63.9 | |
| 8 | GLENN | 65.3 | |
| 8 | TEHAMA | 65.3 | |
| 10 | SHASTA | 67.8 | |
| 11 | LAKE | 68.1 | |
| 12 | MENDOCINO | 69.5 | |
| 13 | BUTTE | 71.5 | |
| 14 | MADERA | 72.3 | |
| 14 | SAN JOAQUIN | 72.3 | |
| 16 | LASSEN | 72.7 | |
| 16 | MARIPOSA | 72.7 | |
| 18 | PLUMAS | 73.3 | |
| 19 | SANTA BARBARA | 73.9 | |
| 20 | KERN | 74.9 | |
| 20 | NEVADA | 74.9 | |
| 22 | MONTEREY | 75.0 | |
| 23 | TULARE | 75.1 | |
| 24 | KINGS | 75.3 | |
| 24 | YOLO | 75.3 | |
| 26 | MONO | 75.9 | |
| 27 | TUOLUMNE | 76.0 | **State Median*** |
| 28 | HUMBOLDT | 76.5 | |
| 28 | MODOC | 76.5 | |
| 30 | STANISLAUS | 76.9 | |
| 31 | SOLANO | 77.2 | |
| 32 | EL DORADO | 77.7 | |
| 32 | SAN LUIS OBISPO | 77.7 | |
| 34 | CALAVERAS | 78.6 | |
| 35 | INYO | 79.4 | |
| 36 | SANTA CRUZ | 79.9 | |
| 36 | VENTURA | 79.9 | |
| 38 | SACRAMENTO | 80.1 | |
| 39 | SAN DIEGO | 81.3 | |
| 40 | SONOMA | 81.4 | |
| 41 | NAPA | 81.6 | |
| 41 | SAN BERNARDINO | 81.6 | |
| 43 | SISKIYOU | 82.3 | |
| | **CALIFORNIA PERCENT** | **82.4** | |
| 44 | RIVERSIDE | 83.0 | |
| 45 | CONTRA COSTA | 83.3 | |
| 45 | SANTA CLARA | 83.3 | |
| 47 | PLACER | 84.4 | |
| 48 | SAN FRANCISCO | 84.7 | |
| 49 | LOS ANGELES | 85.9 | |
| 50 | ALAMEDA | 86.7 | |
| 51 | AMADOR | 87.5 | |
| 52 | FRESNO | 87.8 | |
| 53 | SAN BENITO | 87.9 | |
| 54 | ORANGE | 88.3 | |
| 55 | SAN MATEO | 88.6 | |
| 56 | MARIN | 94.4 | |
| | ALPINE | -- | |
| | SIERRA | -- | |

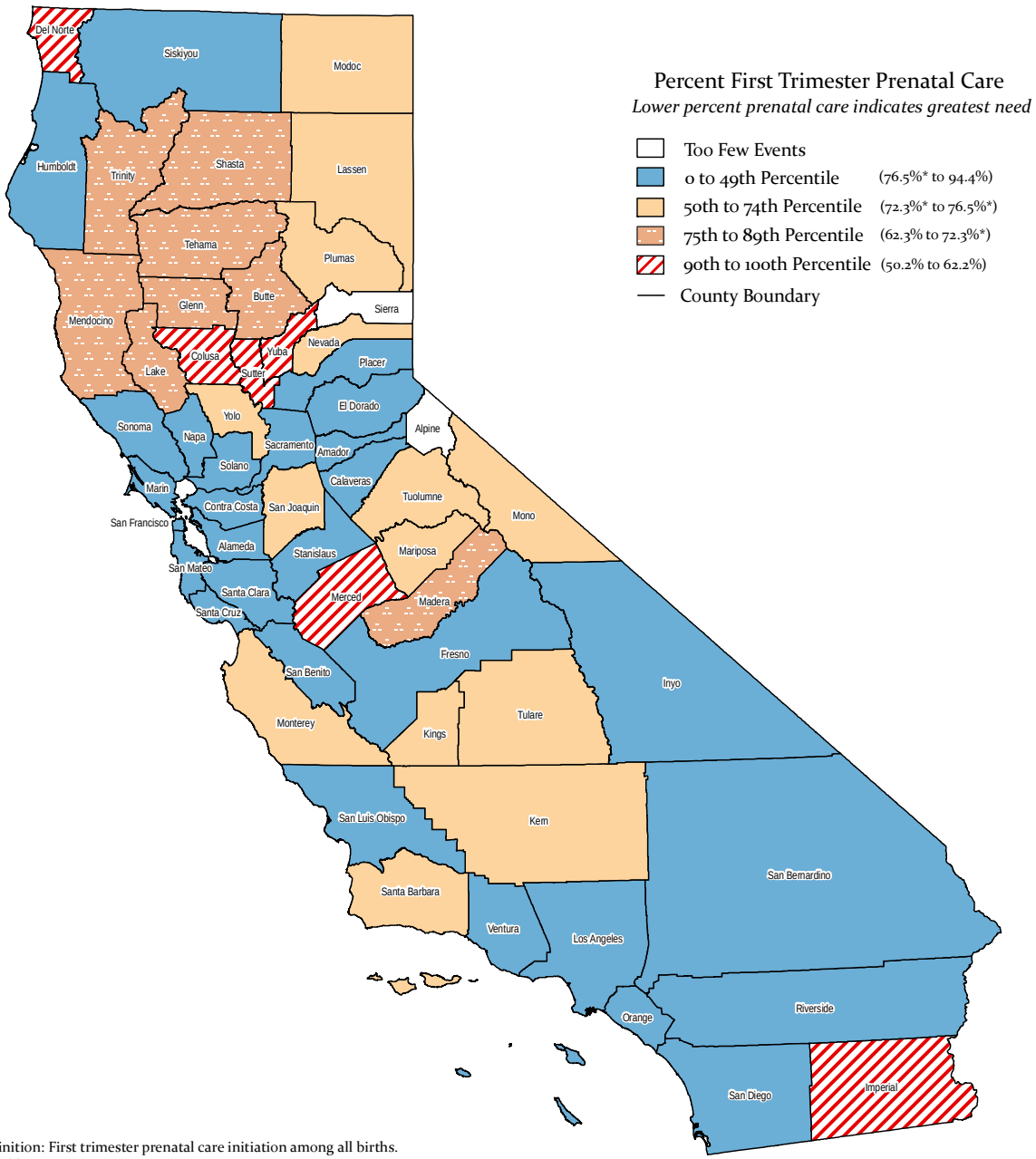
*State median = 76.472

Note(s): First trimester prenatal care initiation among all births. Excludes births with unknown prenatal care initiation. Lower percent prenatal care initiation indicates greatest need.
"--" denotes counties with too few events, events < 20.

Source: 2008 Birth Statistical Master File.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 26. First Trimester Prenatal Care Initiation as a Percentage of Live Births by County, 2008




Definition: First trimester prenatal care initiation among all births.
Note(s): Excludes births with unknown prenatal care initiation
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): 2008 Birth Statistical Master File
*Due to rounding, categories may appear to overlap

Prenatal Substance Use

*Background:* Prenatal exposure to alcohol is one of the leading preventable causes of birth defects and developmental disabilities in the U.S.[111] The use of alcohol, tobacco, and illegal substances during pregnancy is a major risk factor for LBW and other poor infant outcomes. Alcohol use is linked to fetal death, LBW, growth abnormalities, mental retardation, and fetal alcohol syndrome. While not specific to prenatal exposure, parental substance abuse in general is associated with child maltreatment.[81, 105] The U.S. Surgeon General recommends abstinence from alcohol among women who are pregnant or are planning to become pregnant and states there is no known amount or timing of alcohol that is considered safe to consume during pregnancy. Finally it should be noted that prenatal exposure accounts for only a small proportion of children negatively affected by parental substance abuse.[105]

Fetal Alcohol Spectrum Disorder (FASD) is the umbrella term used to describe the full range of effects that can occur in an individual whose mother consumed alcohol during pregnancy. These effects may include physical and mental disabilities and problems with behavior or learning.[112] While it is not known exactly how many children have an FASD, scientific study estimates indicate that approximately 1 out of every 100 people in the United States may be affected.[113] Recent evidence suggests that this prevalence could be as high as 5 percent.[114] Using the more conservative national FASD prevalence estimate and California birth data, it is estimated that about 5,550 babies are born with an FASD in California every year.[*] Using California's population in 2008, at least 33,000 children ages 0 to 5 may struggle in life because of prenatal exposure to alcohol.[30] These children may have problems with learning, memory, attention span, problem solving, speech, and hearing. When they get older, they are at very high risk for trouble in school, trouble with the law, alcohol and drug abuse, and mental health disorders.[115]

*Methods:* Prenatal substance use was calculated using hospitalizations for labor and delivery that also included a diagnosis of substance abuse (excluding tobacco). These data are likely an underestimate of actual drug or alcohol abuse during pregnancy as it represents women whose problem is severe enough that it was diagnosed by the physician and recorded on the delivery chart. However, there may be bias in who a physician suspects is abusing substances and the process for abstraction of patient diagnoses may differ across hospitals. Both of these factors will have an influence on the rates reported. The following ICD9-CM codes for substance abuse were used: 291, 303, 305.0 (Alcohol Abuse), 292, 304, 305.2-305.9, 648.3 (Drug Abuse). The denominator is women discharged with a labor/delivery code. The data source was the 2006-2008 Office of Statewide Health Planning and Development, Patient Discharge Data.

*Results:* In California, the rate of hospital discharges with a diagnosis of drug or alcohol abuse (not tobacco) was 11.9 per 1,000. There was tremendous geographic variation with rates in Trinity County (83.1 per 1,000) nearly seven times the State rate and Shasta County (54.3 per 1,000) more than four times the State rate. Other counties with high rates of hospital discharges with a diagnosis of drug or alcohol abuse include Lake (40.9 per 1,000), Humboldt (39.8 per 1,000) and Tehama (36.7 per 1,000) (Table 18 and Figure 27).

[*] These estimates were calculated using nationwide prevalence rates of FASD. Not adjusted for demographic differences between the state and the nation.

**Table 18. Prenatal Alcohol and Drug Use Rate per 1,000 Live Births by County, 2006-2008**

| RANK ORDER | COUNTY | RATE |
|---|---|---|
| 1 | TRINITY | 83.1 |
| 2 | SHASTA | 54.3 |
| 3 | LAKE | 40.9 |
| 4 | HUMBOLDT | 39.8 |
| 5 | TEHAMA | 36.7 |
| 6 | EL DORADO | 33.9 |
| 7 | TULARE | 32.4 |
| 8 | AMADOR | 30.6 |
| 9 | TUOLUMNE | 26.7 |
| 10 | SOLANO | 26.5 |
| 11 | CONTRA COSTA | 23.7 |
| 12 | NEVADA | 22.8 |
| 12 | STANISLAUS | 22.8 |
| 14 | SACRAMENTO | 22.5 |
| 15 | YUBA | 21.6 |
| 16 | MENDOCINO | 21.2 |
| 16 | DEL NORTE | 21.2 |
| 18 | YOLO | 21.1 |
| 19 | SONOMA | 19.2 |
| 20 | SAN JOAQUIN | 17.7 |
| 21 | SAN LUIS OBISPO | 17.5 |
| 22 | MERCED | 16.2 |
| 23 | SAN BERNARDINO | 14.4 |
| | | **State Median*** |
| 24 | MONTEREY | 14.1 |
| 25 | FRESNO | 13.8 |
| 25 | SUTTER | 13.8 |
| 27 | SAN FRANCISCO | 13.6 |
| 28 | ALAMEDA | 13.1 |
| 28 | BUTTE | 13.1 |
| 30 | NAPA | 13.0 |
| 31 | KERN | 12.9 |
| | **CALIFORNIA RATE** | **11.9** |
| 32 | KINGS | 11.9 |
| 33 | PLACER | 11.9 |
| 34 | SANTA CRUZ | 11.4 |
| 35 | MADERA | 11.2 |
| 36 | SAN BENITO | 10.7 |
| 37 | SANTA BARBARA | 10.5 |
| 38 | SAN DIEGO | 10.3 |
| 39 | IMPERIAL | 9.3 |
| 40 | SANTA CLARA | 8.9 |
| 41 | VENTURA | 8.5 |
| 42 | SAN MATEO | 8.4 |
| 43 | RIVERSIDE | 8.1 |
| 44 | MARIN | 7.1 |
| 45 | LOS ANGELES | 6.8 |
| 45 | ORANGE | 6.8 |
| | ALPINE | -- |
| | CALAVERAS | -- |
| | COLUSA | -- |
| | GLENN | -- |
| | INYO | -- |
| | LASSEN | -- |
| | MARIPOSA | -- |
| | MODOC | -- |
| | MONO | -- |
| | PLUMAS | -- |
| | SIERRA | -- |
| | SISKIYOU | -- |

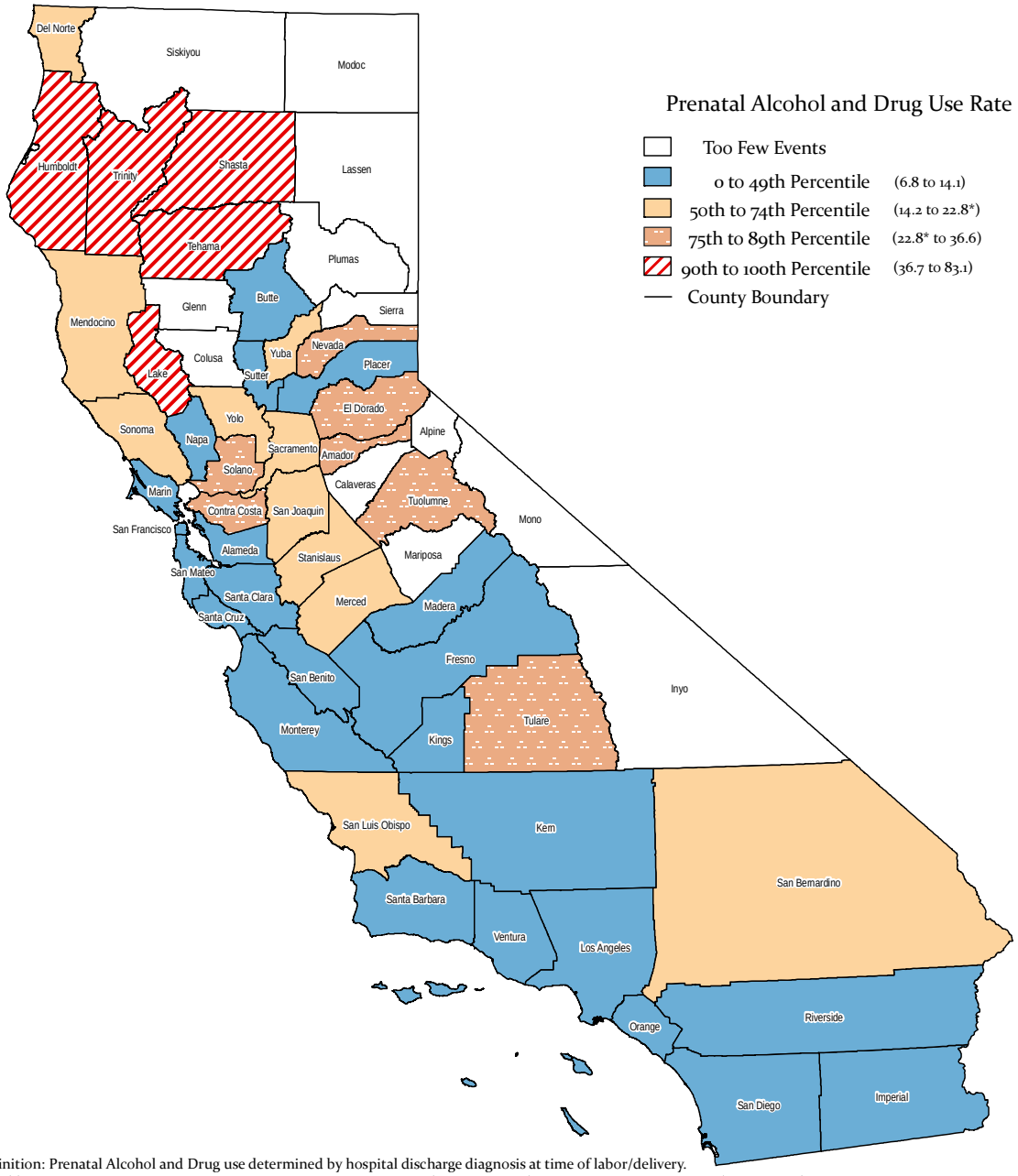
*State median = 14.248

Note(s): Prenatal Alcohol and Drug use determined by hospital discharge diagnosis at time of labor/delivery; ICD9-CM Codes used for alcohol and drug use: 291, 303, 305.0 (Alcohol Abuse), 292, 304, 305.2-305.9, 648.3 (Drug Abuse)

"--" denotes counties with too few events, events < 20.

Source: 2006-2008 Office of Statewide Health Planning and Development, Patient Discharge Data. Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 27. Prenatal Alcohol and Drug Use Rate per 1,000 Live Births by County, 2006-2008




Definition: Prenatal Alcohol and Drug use determined by hospital discharge diagnosis at time of labor/delivery.
Note(s): ICD9-CM Codes used for alcohol and drug use: 291, 303, 305.0 (Alcohol Abuse), 292, 304, 305.2-305.9, 648.3 (Drug Abuse)
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): 2006-2008 Office of Statewide Health Planning and Development, Patient Discharge Data
*Due to rounding, categories may appear to overlap

Maternal Depression

*Background:* Depression at any time in a woman's life is devastating mentally and physically.[92, 116] When it occurs before pregnancy, a woman is more likely to experience depression during and after pregnancy.[117] Untreated depression during pregnancy is associated with pregnancy complications. Maternal depression can also affect a mother's physical health, well-being, parenting behavior, employment, and social functioning. It can also lead to maladaptive social, emotional, and cognitive development in children and thus impact their readiness for school. Indeed, it has been shown that children's health improves when their mother's depression improves.[92, 118-120] Depression is commonly associated with home environments that pose a risk to child development, including marital discord, family conflict, inadequate financial resources, low social support, and poor parenting.[121] In addition, parental stress and distress, including depression or other mental health conditions are considered risk factors for child maltreatment.[81] Depression is particularly common among low-income mothers of young children.[122]

Data from the 2008 MIHA survey indicated that depression during pregnancy, as measured by having a depressed mood and markedly less interest or pleasure in nearly all activities, was prevalent among 19.2% of recent mothers and was most common among African-Americans and Hispanics (27.7% and 22.5%, respectively), compared with White and Asian/Pacific Islander women (15.2% and 12.1%, respectively). The percent reporting depression dropped in the postpartum period (15.0%). Postpartum depression was most common among African-Americans and Hispanics (18.1% and 16.4%, respectively), compared with White and Asian/Pacific Islander women (13.9% and 10.0%, respectively). Reported depression during and after pregnancy decreased as income increased.

Many women also suffer from a lack of emotional support. During the years 2002-2006, many women, particularly low-income women, reported that during pregnancy they had no one to turn to for comfort (15% among ≤ 100% FPL and 9% among 101-200% FPL). In addition to stress, a history of mental health problems, and whether a pregnancy was intended, lack of social support has been found to be a risk factor for depression in pregnant women.[123]

*Methods:* In order to conduct community level analyses, maternal depression was determined by calculating the rate of resident labor/delivery hospital discharges with a diagnosis of depression. The following ICD9-CM Codes were used for maternal depression: 296.2, 296.20-296.25, 296.3, 296.30-296.35, 296.82, 300.4, 309.0, 309.1, 309.28, 311. The denominator was women who were discharged with a labor/delivery code. The data source was the 2006-2008 Office of Statewide Health Planning and Development, Patient Discharge Data.

*Results:* In California, the rate of maternal depression at the time of delivery was 7.3 per 1,000 women discharged (Table 19). The counties with the highest rates of maternal depression at hospital discharge were located in the northern part of the State. Rates were highest in Plumas County (46.4 per 1,000) followed by Colusa (34.5 per 1,000), Yolo (33.5 per 1,000), El Dorado (25.1 per 1,000), and Napa (24.7 per 1,000) (Table 19 and Figure 28).

**Table 19. Maternal Depression Rate per 1,000 Women Discharged by County, 2006-2008**

| RANK ORDER | COUNTY | RATE | |
|---|---|---|---|
| 1 | PLUMAS | 46.4 | |
| 2 | COLUSA | 34.5 | |
| 3 | YOLO | 33.5 | |
| 4 | EL DORADO | 25.1 | |
| 5 | NAPA | 24.7 | |
| 6 | SONOMA | 22.2 | |
| 7 | HUMBOLDT | 21.9 | |
| 8 | MARIN | 20.6 | |
| 9 | NEVADA | 20.3 | |
| 10 | SACRAMENTO | 17.9 | |
| 11 | TUOLUMNE | 16.6 | |
| 12 | SHASTA | 16.1 | |
| 13 | SAN LUIS OBISPO | 15.5 | |
| 14 | PLACER | 15.1 | |
| 15 | LAKE | 14.4 | |
| 16 | CONTRA COSTA | 14.3 | |
| 17 | SOLANO | 14.2 | |
| 18 | SAN FRANCISCO | 13.5 | |
| 19 | MENDOCINO | 12.6 | |
| 20 | MONTEREY | 10.8 | |
| 21 | YUBA | 9.9 | |
| | | | **State Median*** |
| 22 | ALAMEDA | 9.3 | |
| 23 | SUTTER | 9.0 | |
| 24 | SAN DIEGO | 8.6 | |
| 25 | SANTA BARBARA | 8.4 | |
| 26 | SANTA CRUZ | 8.0 | |
| 27 | SAN BENITO | 7.9 | |
| | **CALIFORNIA RATE** | **7.3** | |
| 28 | TULARE | 7.3 | |
| 29 | SANTA CLARA | 7.2 | |
| 30 | BUTTE | 6.4 | |
| 31 | SAN JOAQUIN | 6.3 | |
| 32 | VENTURA | 6.2 | |
| 33 | ORANGE | 6.0 | |
| 34 | FRESNO | 4.9 | |
| 35 | MERCED | 4.8 | |
| 36 | RIVERSIDE | 4.7 | |
| 37 | SAN BERNARDINO | 4.6 | |
| 38 | KINGS | 4.5 | |
| 39 | STANISLAUS | 4.0 | |
| 40 | LOS ANGELES | 3.8 | |
| 41 | KERN | 3.6 | |
| 42 | MADERA | 3.1 | |
| | ALPINE | -- | |
| | AMADOR | -- | |
| | CALAVERAS | -- | |
| | DEL NORTE | -- | |
| | GLENN | -- | |
| | IMPERIAL | -- | |
| | INYO | -- | |
| | LASSEN | -- | |
| | MARIPOSA | -- | |
| | MODOC | -- | |
| | MONO | -- | |
| | SAN MATEO | -- | |
| | SIERRA | -- | |
| | SISKIYOU | -- | |
| | TEHAMA | -- | |
| | TRINITY | -- | |

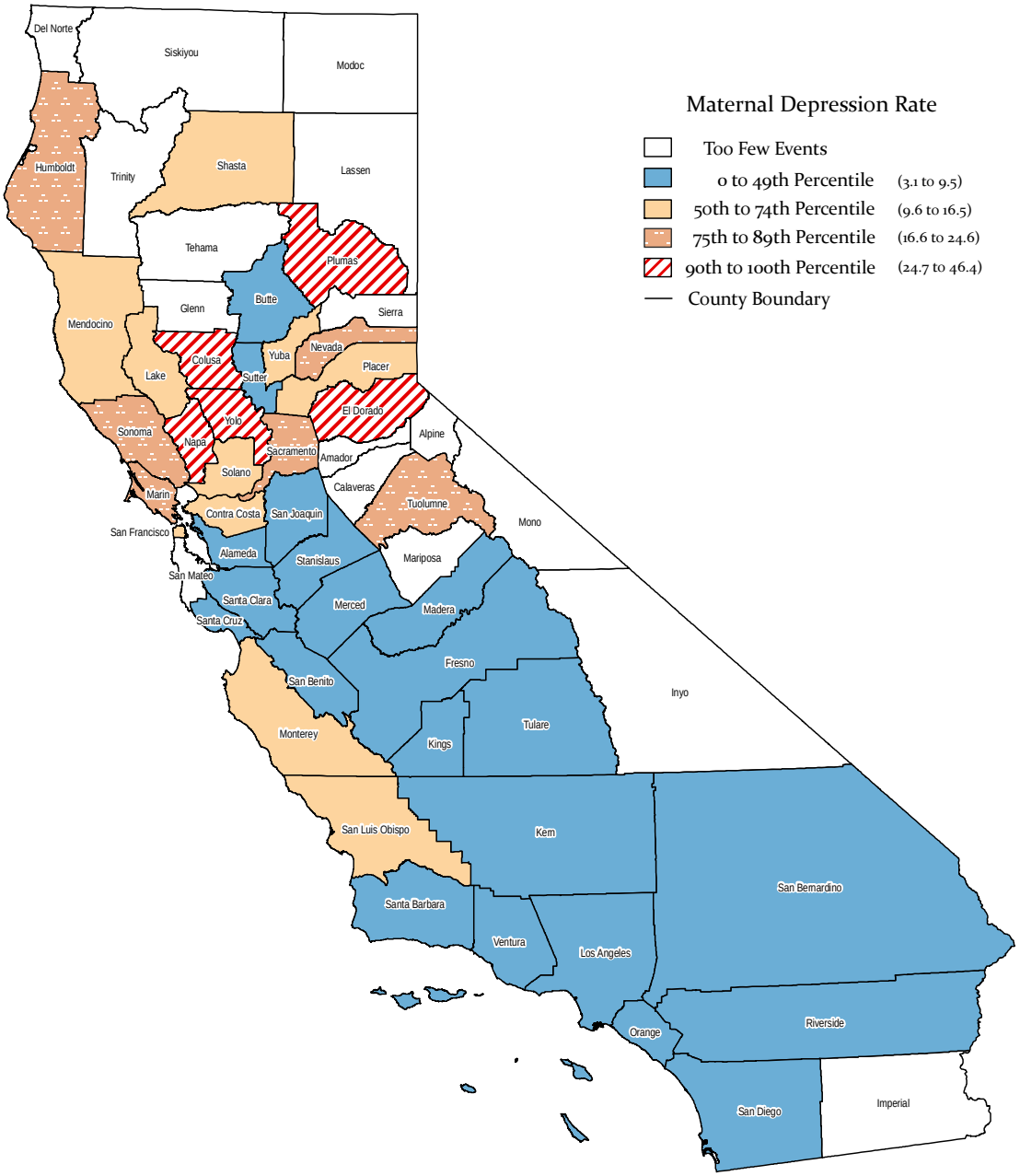
*State median = 9.608

Note(s): Depression determined by hospital discharge diagnosis at time of labor/delivery; ICD9-CM Codes used for maternal depression: 296.2, 296.20–296.25, 296.3, 296.30–296.35, 296.82, 300.4, 309.0, 309.1, 309.28, 311.

"--" denoted counties with too few events, events < 20.

Source: 2006-2008 Office of Statewide Health Planning and Development, Patient Discharge Data. Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 28. Maternal Depression Rate per 1,000 Women Discharged by County, 2006-2008




Definition: Depression determined by hospital discharge diagnosis at time of labor/delivery
Note(s): ICD9-CM Codes used for maternal depression: 296.2, 296.20–296.25, 296.3, 296.30–296.35, 296.82, 300.4, 309.0, 309.1, 309.28, 311
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): 2006-2008 Office of Statewide Health Planning and Development, Patient Discharge Data

Short Birth Interval

*Background:* Because maternal risk behaviors affect fetal development during the early weeks of pregnancy, often before a woman knows she is pregnant, pregnancy planning is important. Women who plan their pregnancies are more likely to engage in health promoting behaviors such as taking folic acid and to abstain from using tobacco and alcohol during pregnancy.[124] For these reasons, efforts aimed at promoting healthy preconception and prenatal behaviors, such as home visiting have encouraged women to establish a reproductive life plan, a set of goals about when and whether to have more children and how this fits into one's life course.[4, 125] However, some women engage in risk behaviors shortly before and during pregnancy. In California, there is a continued need for preconception efforts, as nearly half of all women with a live birth in 2007 reported their pregnancy was unintended (44.6%) (MIHA survey). Little changed since 2000 where 46.0% reported their pregnancy was unintended. Unintended pregnancy was more common among African-American and Hispanic women (64.8% and 49.4%, respectively) than among White and Asian/Pacific Islander women (37.1% and 33.0%, respectively). The prevalence of unintended pregnancy also differed widely by income level. It was most common among women with incomes ≤ 100% of the FPL (59.4%), and the prevalence decreased as income increased.

Pregnancy spacing is also important to reproductive planning; babies born to women who give birth shortly after a previous birth are at an increased risk of being delivered pre-term and being low birth weight. Short birth spacing also presents risks for the mother including possible pre-term labor, uterine rupture, and mental health issues.[126] On the other hand, if women defer the birth of a second child, particularly lower income women and women of younger age, they may be better able to leave welfare and poverty, find employment, and focus more on their child, all of which are related to better outcomes for children.[127]

*Methods:* The short birth interval rate was calculated using the following metric: the number of women ages 15-44 with birth intervals less than 24 months divided by the total number of women ages 15-44 with a live birth. This calculation excludes birth intervals less than five months. The data source was the 2008 Birth Statistical Master File.

*Results:* In California the short birth interval rate declined gradually from 12.5% in 2000 to 12% in 2002 but has been increasing steadily since, to 13.2% in 2008. A short birth interval was more common among Pacific Islander and American Indian/Alaska Native women (22.1% and 19.2%, respectively). Asian women experienced the lowest rate (11.2%). There was also geographic variation, with short birth intervals less common among the coastal counties and more common in parts of the Northern Mountain region, including Del Norte (22.8%), Trinity (19.5%), Colusa (17.3%) and Tehama (16.9%), and the San Joaquin Valley, including Fresno (16.7%) and Kings (16.6%) (Table 20 and Figure 29).

**Table 20. Birth Intervals Less Than 24 Months Among California Resident Women Ages 15-44 with a Live Birth by County, 2008**

| RANK ORDER | COUNTY | PERCENT | |
|---|---|---|---|
| 1 | DEL NORTE | 22.8 | |
| 2 | TRINITY | 19.5 | |
| 3 | COLUSA | 17.3 | |
| 4 | TEHAMA | 16.9 | |
| 5 | FRESNO | 16.7 | |
| 6 | KINGS | 16.6 | |
| 7 | MERCED | 16.5 | |
| 8 | TULARE | 16.4 | |
| 9 | SISKIYOU | 16.3 | |
| 10 | SAN BERNARDINO | 15.8 | |
| 11 | INYO | 15.7 | |
| 12 | GLENN | 15.5 | |
| 12 | PLUMAS | 15.5 | |
| 14 | MADERA | 15.3 | |
| 14 | SAN BENITO | 15.3 | |
| 16 | KERN | 15.2 | |
| 16 | SHASTA | 15.2 | |
| 18 | SAN JOAQUIN | 15.1 | |
| 19 | TUOLUMNE | 14.9 | |
| 19 | YUBA | 14.9 | |
| 21 | SUTTER | 14.8 | |
| 22 | LAKE | 14.6 | |
| 23 | EL DORADO | 14.5 | |
| 23 | RIVERSIDE | 14.5 | |
| 23 | STANISLAUS | 14.5 | |
| 26 | IMPERIAL | 14.4 | |
| 26 | MARIPOSA | 14.4 | |
| 28 | SACRAMENTO | 14.3 | **State Median*** |
| 29 | ORANGE | 13.8 | |
| 30 | BUTTE | 13.7 | |
| 31 | CALAVERAS | 13.4 | |
| 31 | VENTURA | 13.4 | |
| | **CALIFORNIA PERCENT** | **13.2** | |
| 33 | AMADOR | 13.0 | |
| 34 | MONO | 12.8 | |
| 34 | SAN DIEGO | 12.8 | |
| 36 | LOS ANGELES | 12.7 | |
| 37 | SOLANO | 12.6 | |
| 38 | LASSEN | 12.4 | |
| 39 | PLACER | 12.3 | |
| 40 | SAN LUIS OBISPO | 12.2 | |
| 40 | SANTA BARBARA | 12.2 | |
| 42 | MONTEREY | 11.8 | |
| 43 | SANTA CRUZ | 11.6 | |
| 43 | YOLO | 11.6 | |
| 45 | CONTRA COSTA | 11.4 | |
| 46 | HUMBOLDT | 11.0 | |
| 46 | NEVADA | 11.0 | |
| 46 | SANTA CLARA | 11.0 | |
| 49 | NAPA | 10.9 | |
| 50 | SAN MATEO | 10.7 | |
| 51 | ALAMEDA | 10.4 | |
| 52 | SONOMA | 10.0 | |
| 53 | MENDOCINO | 9.9 | |
| 54 | MARIN | 9.8 | |
| 55 | SAN FRANCISCO | 9.3 | |
| | ALPINE | -- | |
| | MODOC | -- | |
| | SIERRA | -- | |

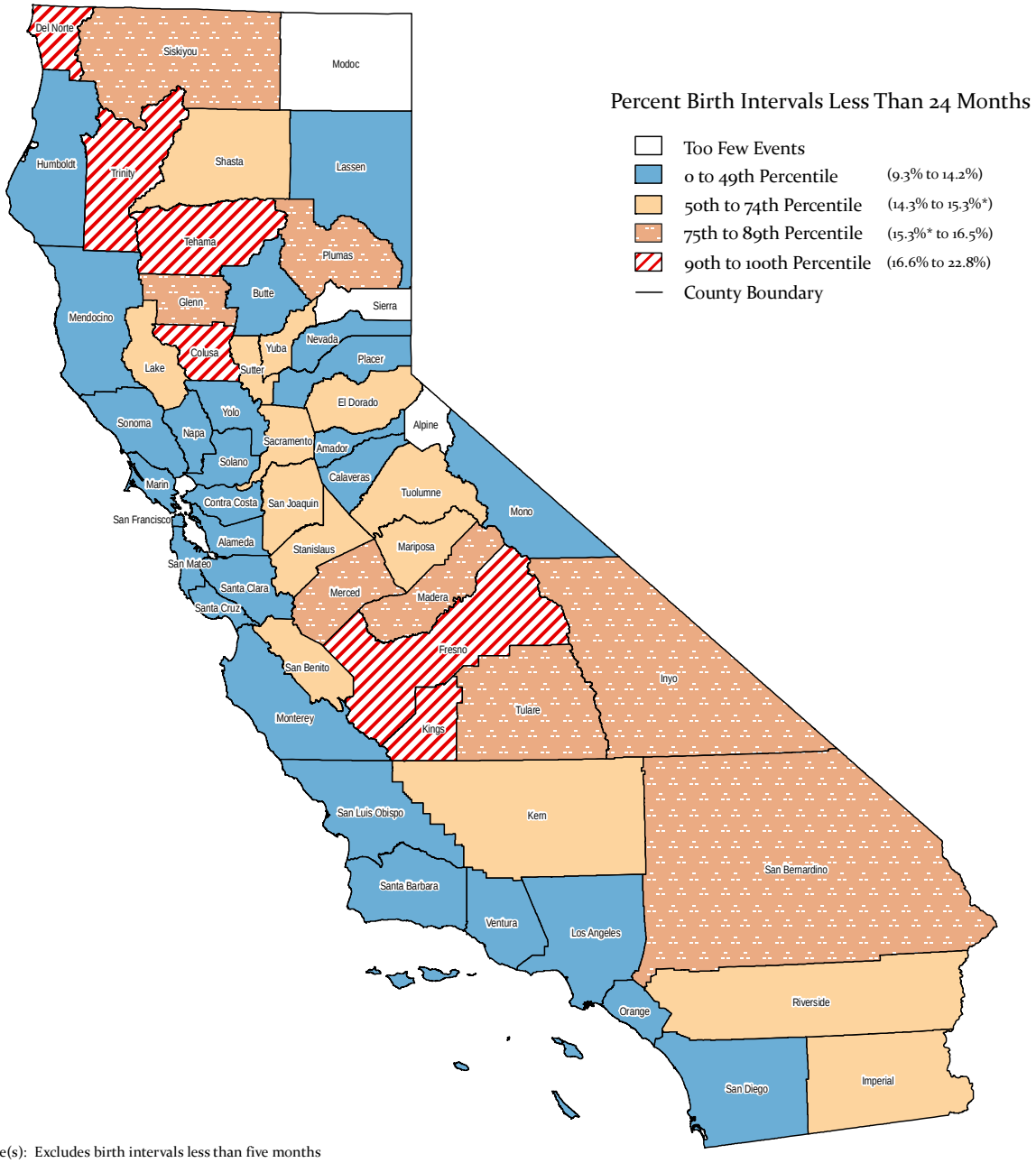
*State median = 14.316

Note(s): Excludes birth intervals less than five months.
"--" denotes counties with too few events, events < 20.

Source: 2008 Birth Statistical Master File.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

**Figure 29. Birth Intervals Less Than 24 Months Among California Resident Women Ages 15-44 with a Live Birth by County, 2008**




Note(s): Excludes birth intervals less than five months
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): 2008 Birth Statistical Master File
*Due to rounding, categories may appear to overlap

Breastfeeding

*Background:* Breastfeeding is an important contributor to overall infant health.[63] Breastfeeding provides important benefits including a stronger immune system for the infant, a reduced risk for infections and chronic diseases like diabetes, asthma and obesity, and an opportunity for bonding and attachment between the mother and baby. In addition, prolonged exclusive breastfeeding has been shown to improve children's cognitive development.[128] The American Academy of Pediatrics (AAP) recommends that infants be breastfed for approximately the first 6 months of life.[63]

The HP 2010 objective is to increase the proportion of mothers who breastfeed exclusively through 3 months to 40%. Data from the MIHA survey reveal that in California in 2008, at one month postpartum, African-American (39%) and Hispanic (39%) mothers were already not meeting the HP 2010 objective. By three months postpartum, only White mothers (46.0%) met the objective, while less than one third of Hispanic (26.1%) and African-American (19.9%) mothers breastfed exclusively. Breastfeeding at 3 months was also least common among low-income women.

*Methods:* In-hospital exclusive breastfeeding was calculated using the 2007 Newborn Screening Data from the Genetic Disease Screening Program. The metric used was: infants with feeding reported as "breastmilk" only divided by all infants with feeding reported as breastmilk or formula. Records with feeding unknown/not reported, Total Parenteral Nutrition (TPN), or Other are excluded.

*Results:* Breastfeeding initiation shortly after birth is critical to establishing feeding practices and sustaining breastfeeding after the mother and infant leave the hospital. In fact, exclusive breastfeeding in the hospital is a critical factor in how long babies are breastfed exclusively after discharge.[129-132] Although the prevalence of any in-hospital breastfeeding increased from 76.5% in 1994 to 86.6% in 2007, exclusive breastfeeding rates have remained stagnant at approximately 40%. The gap between exclusive breastfeeding and supplemented breastfeeding is wide and continues to grow. In addition, there is wide variation in rates of in-hospital exclusive breastfeeding by county. In fact, in some counties nearly two-thirds of women exclusively breastfed in the hospital whereas in others the prevalence was closer to one-quarter (e.g., Los Angeles, Kern, Tulare, Colusa, and San Benito). Breastfeeding was lowest in Imperial County, where just 12.6% of women exclusively breastfeed in the hospital. Rates were highest in the San Francisco Bay Area and the Northern Mountain region of the State (Table 21 and Figure 30).

**Table 21. In-Hospital Exclusive Breastfeeding as a Percentage of Live Births by County, 2007**

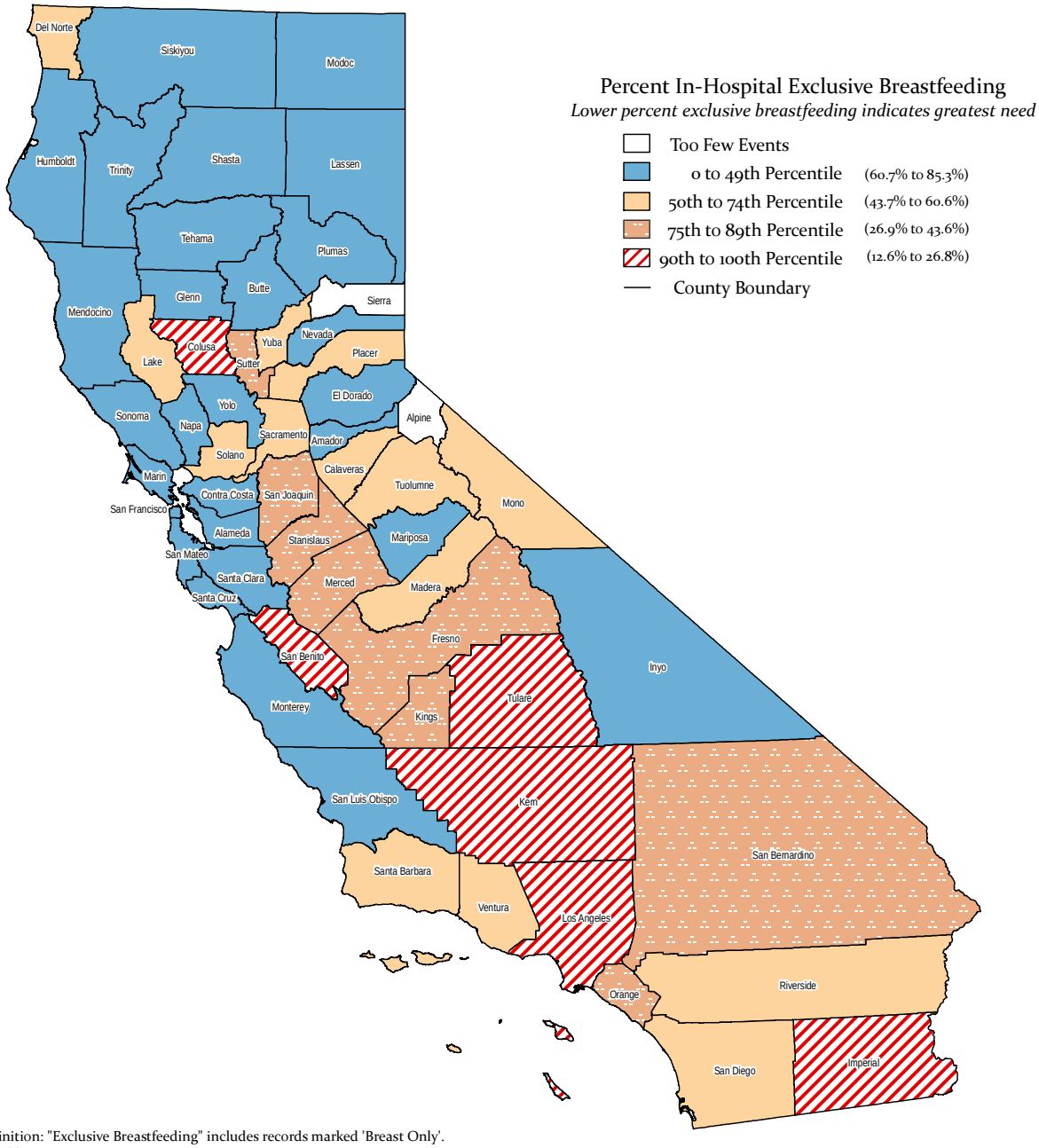
| RANK ORDER | COUNTY | PERCENT | |
|---|---|---|---|
| 1 | IMPERIAL | 12.6 | |
| 2 | TULARE | 23.3 | |
| 3 | LOS ANGELES | 24.4 | |
| 4 | COLUSA | 25.0 | |
| 5 | KERN | 25.8 | |
| 6 | SAN BENITO | 26.8 | |
| 7 | MERCED | 27.7 | |
| 8 | KINGS | 28.0 | |
| 9 | ORANGE | 29.8 | |
| 10 | SAN BERNARDINO | 34.4 | |
| 11 | SUTTER | 35.2 | |
| 12 | SAN JOAQUIN | 37.8 | |
| 13 | FRESNO | 38.9 | |
| | **CALIFORNIA PERCENT** | **42.7** | |
| 14 | STANISLAUS | 42.9 | |
| 15 | RIVERSIDE | 44.2 | |
| 16 | VENTURA | 44.4 | |
| 17 | YUBA | 46.1 | |
| 18 | LAKE | 47.5 | |
| 19 | MADERA | 49.1 | |
| 20 | MONO | 51.8 | |
| 21 | SOLANO | 53.2 | |
| 22 | SACRAMENTO | 53.3 | |
| 23 | DEL NORTE | 56.1 | |
| 24 | SANTA BARBARA | 56.9 | |
| 25 | PLACER | 58.8 | |
| 26 | SAN DIEGO | 58.9 | |
| 27 | TUOLUMNE | 59.9 | |
| 28 | CALAVERAS | 60.1 | **State Median*** |
| 29 | MARIPOSA | 61.1 | |
| 30 | SANTA CLARA | 62.1 | |
| 31 | TEHAMA | 62.6 | |
| 32 | CONTRA COSTA | 64.0 | |
| 32 | MONTEREY | 64.0 | |
| 34 | MODOC | 64.3 | |
| 35 | AMADOR | 65.1 | |
| 36 | YOLO | 66.3 | |
| 37 | HUMBOLDT | 66.7 | |
| 38 | GLENN | 67.0 | |
| 39 | NAPA | 67.2 | |
| 40 | SANTA CRUZ | 68.7 | |
| 41 | EL DORADO | 69.1 | |
| 42 | LASSEN | 70.8 | |
| 43 | BUTTE | 71.6 | |
| 44 | SAN LUIS OBISPO | 72.8 | |
| 44 | ALAMEDA | 72.8 | |
| 46 | SONOMA | 73.9 | |
| 47 | MENDOCINO | 75.5 | |
| 47 | PLUMAS | 75.5 | |
| 49 | SAN MATEO | 76.6 | |
| 50 | SAN FRANCISCO | 76.7 | |
| 51 | NEVADA | 77.1 | |
| 52 | MARIN | 77.5 | |
| 53 | SISKIYOU | 77.9 | |
| 54 | INYO | 81.7 | |
| 55 | SHASTA | 83.7 | |
| 56 | TRINITY | 85.3 | |
| | ALPINE | -- | |
| | SIERRA | -- | |

* State Median = 60.612

Note(s): "Exclusive Breastfeeding" includes records marked 'Breast Only'; records with feeding unknown/not reported, TPN, or other are excluded; lower percent exclusive breastfeeding indicates greatest need.
"--" denotes counties with too few events, events < 20.

Source: Genetic Disease Screening Program, Newborn Screening Data, 2007.
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 30. In-Hospital Exclusive Breastfeeding as a Percentage of Live Births by County, 2007




Definition: "Exclusive Breastfeeding" includes records marked 'Breast Only'.
Note(s): Records with feeding unknown/not reported, TPN, or other are excluded
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): Genetic Disease Screening Program, Newborn Screening Data, 2007

Children with Special Needs

*Background:* Children with physical, emotional, developmental and educational needs are less likely to be ready for school and are at higher risk for poor educational outcomes.[61] The specific effects of learning disabilities can be lifelong impacting a child's education, future employment, family life and daily functioning.[133] Fortunately, with appropriate early intervention services including academic and medical support, some of these impacts can be mitigated. Children with disabilities are more likely than other children to suffer from emotional health problems including depression and as noted previously, may be at greater risk of maltreatment.[81, 105] Finally, having a child with a disability can have profound impacts on the entire family including increased stress, time and financial costs, increased physical and emotional demands, interference with work, difficulty finding child care, and poor family functioning.[134]

*Methods:* The prevalence of children with disabilities was measured by the enrollment of public school students in special education. CDPH/MCAH downloaded these data from kidsdata.org on August 26, 2010. According to Kidsdata, these data were obtained as a special tabulation by the State of California, Department of Education, Special Education Division; Assessment, Evaluation and Support in June 2010.

*Results:* In 2009, 10.8% or 678,105 of California public school students were enrolled in special education. African-American, White, and Hispanic students often are over-represented in the special education system when compared to their overall enrollment figures for public schools.[135] Special education enrollment at the county level varied from 22.5% in Alpine County to 7.7% in Tulare County. In addition to Alpine, Mariposa, Humboldt, Lassen, Yuba and Colusa Counties also had high rates ranging from 19.8% to 13.6% (Table 22 and Figure 31).

**Table 22. Percentage of Public School Students Enrolled in Special Education by County, 2009**

| RANK ORDER | COUNTY | PERCENT | |
|---|---|---|---|
| 1 | ALPINE | 22.5 | |
| 2 | MARIPOSA | 19.8 | |
| 3 | HUMBOLDT | 14.8 | |
| 4 | LASSEN | 14.5 | |
| 5 | YUBA | 14.4 | |
| 6 | COLUSA | 13.6 | |
| 7 | SONOMA | 13.4 | |
| 8 | NAPA | 12.9 | |
| 9 | MARIN | 12.6 | |
| 9 | SANTA CRUZ | 12.6 | |
| 11 | BUTTE | 12.4 | |
| 11 | TUOLUMNE | 12.4 | |
| 13 | AMADOR | 12.3 | |
| 14 | MONO | 12.1 | |
| 15 | LAKE | 11.9 | |
| 15 | SAN DIEGO | 11.9 | |
| 15 | STANISLAUS | 11.9 | |
| 18 | SISKIYOU | 11.8 | |
| 18 | TRINITY | 11.8 | |
| 20 | CONTRA COSTA | 11.7 | |
| 20 | DEL NORTE | 11.7 | |
| 20 | EL DORADO | 11.7 | |
| 20 | INYO | 11.7 | |
| 20 | MENDOCINO | 11.7 | |
| 20 | SOLANO | 11.7 | |
| 26 | SAN MATEO | 11.6 | |
| 26 | SUTTER | 11.6 | |
| 28 | SAN LUIS OBISPO | 11.5 | |
| 29 | CALAVERAS | 11.2 | |
| 29 | LOS ANGELES | 11.2 | **State Median*** |
| 31 | SACRAMENTO | 11.1 | |
| 31 | SANTA BARBARA | 11.1 | |
| | **CALIFORNIA PERCENT** | **10.8** | |
| 33 | VENTURA | 10.8 | |
| 34 | SHASTA | 10.7 | |
| 35 | SAN FRANCISCO | 10.6 | |
| 36 | ALAMEDA | 10.5 | |
| 36 | PLACER | 10.5 | |
| 36 | RIVERSIDE | 10.5 | |
| 36 | SAN BERNARDINO | 10.5 | |
| 40 | GLENN | 10.4 | |
| 40 | PLUMAS | 10.4 | |
| 40 | YOLO | 10.4 | |
| 43 | KINGS | 10.2 | |
| 43 | ORANGE | 10.2 | |
| 43 | SANTA CLARA | 10.2 | |
| 46 | MADERA | 10.1 | |
| 46 | SAN JOAQUIN | 10.1 | |
| 48 | MERCED | 9.7 | |
| 49 | KERN | 9.6 | |
| 49 | SAN BENITO | 9.6 | |
| 51 | FRESNO | 9.4 | |
| 51 | MONTEREY | 9.4 | |
| 53 | SIERRA | 9.3 | |
| 53 | TEHAMA | 9.3 | |
| 55 | NEVADA | 9.1 | |
| 56 | IMPERIAL | 8.6 | |
| 57 | MODOC | 8.4 | |
| 58 | TULARE | 7.7 | |

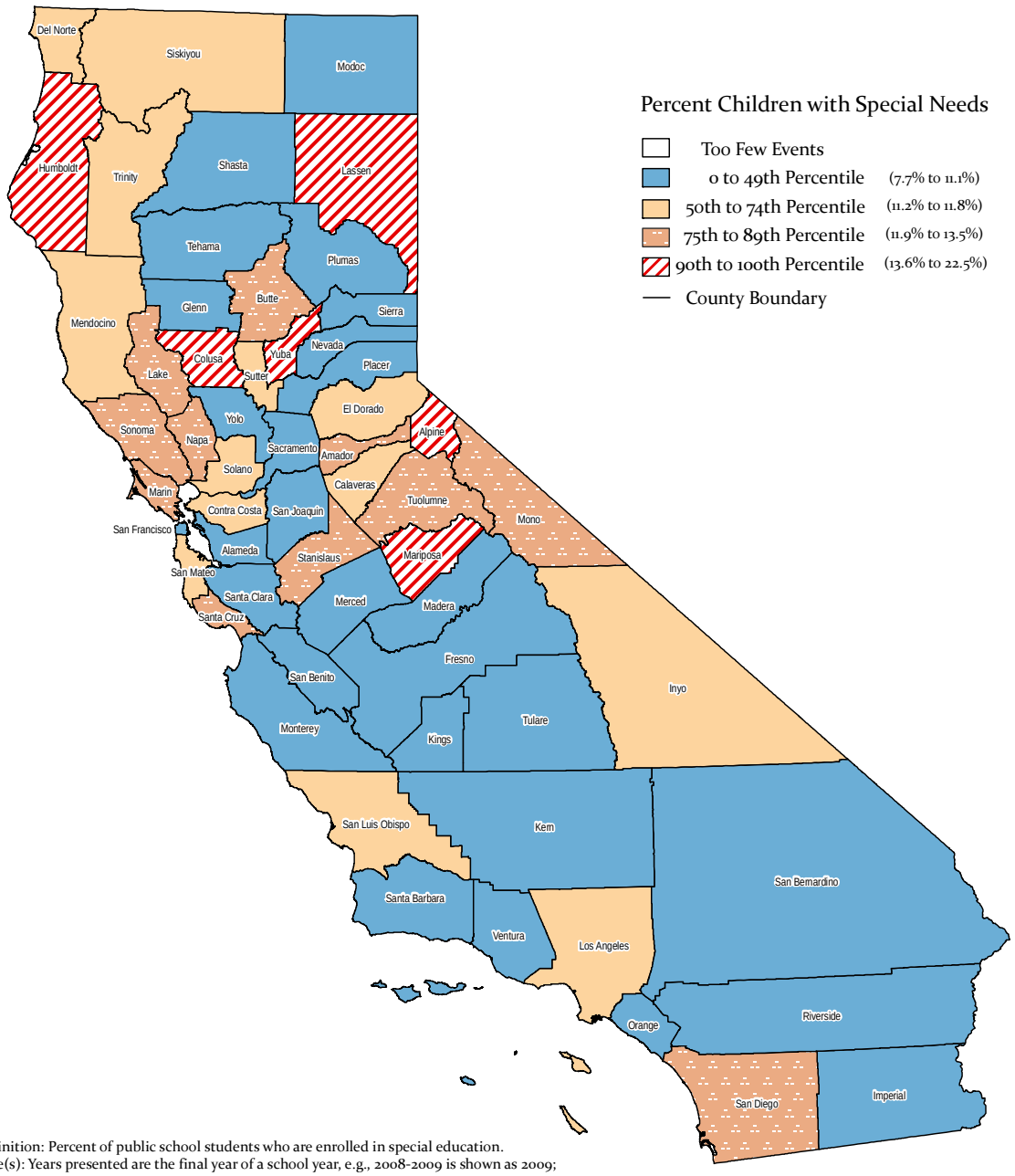
* State Median = 11.2

Note(s): Percent of public school students who are enrolled in special education; years presented are the final year of a school year, e.g., 2008-2009 is shown as 2009; data show the district of residence, but some students with disabilities attend school outside their district of residence.

Source: As cited on kidsdata.org, Special Tabulation by the State of California, Department of Education, Special Education Division; Assesement, Evaluation and Support (June 2010). Accessed at http://www.kidsdata.org/data/topic/table.aspx?f=1&dtm=244&ind=95 on August 26, 2010.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

## Figure 31. Percentage of Public School Students Enrolled in Special Education by County, 2009




Definition: Percent of public school students who are enrolled in special education.
Note(s): Years presented are the final year of a school year, e.g., 2008-2009 is shown as 2009;
data show the district of residence, but some students with disabilities attend school outside their district of residence.
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): Special Tabulation by the State of California, Department of Education, Special Education Division; Assessment, Evaluation and Support (June 2010)
Accessed at http://www.kidsdata.org/data/topic/table.aspx?f=1&dtm=244&ind=95 on August 26, 2010

## Foster Care

*Background:* Children who have been maltreated represent the majority of children in foster care. These children are among the most vulnerable in the country often arriving in foster care with medical, behavioral, developmental and/or emotional problems as a direct result of their early experiences.[136-138] These problems can be exacerbated when children have multiple foster care placements.[137] Moreover, evidence has suggested that many young children who age out of the system, usually at age 18, experience difficulties that can have negative consequences throughout the life course. Specifically, these youth are at higher risk than their peers to be homeless, involved with the legal system, unemployed, to abuse substances, to experience poverty and to have lower educational attainment.[139]

*Methods:* CDPH/MCAH worked closely with the CDSS to identify additional indicators for possible inclusion in this needs assessment. In addition to the rate of substantiated incidents of child abuse and neglect, CDSS identified children in foster care as an additional indicator. Data were queried from the same source described in the section on child maltreatment, the CWS/CMS dynamic report system. The rate is calculated by dividing the number of children placed in child welfare supervised foster care (In-Care Rate) by the child population ages 0 to 17, and then multiplying by 1,000. The child population data come from the CA DOF.

*Results:* The point in time rate of children in foster care (In-Care Rate) has declined in California by nearly half from 11.5 per 1,000 children in 1998 to 6.0 per 1,000 children in 2009. However, in 2009 there were still 59,484 children in foster care in California. The in-care rates vary substantially by race/ethnicity. African-American and American Indian/Alaska Native children had the highest in-care rates in 2009, 26.6 and 16.2 per 1,000 respectively, compared to 5.5 per 1,000 for Hispanic, 4.8 per 1,000 for White, and 1.6 per 1,000 for Asian/Pacific Islander children.

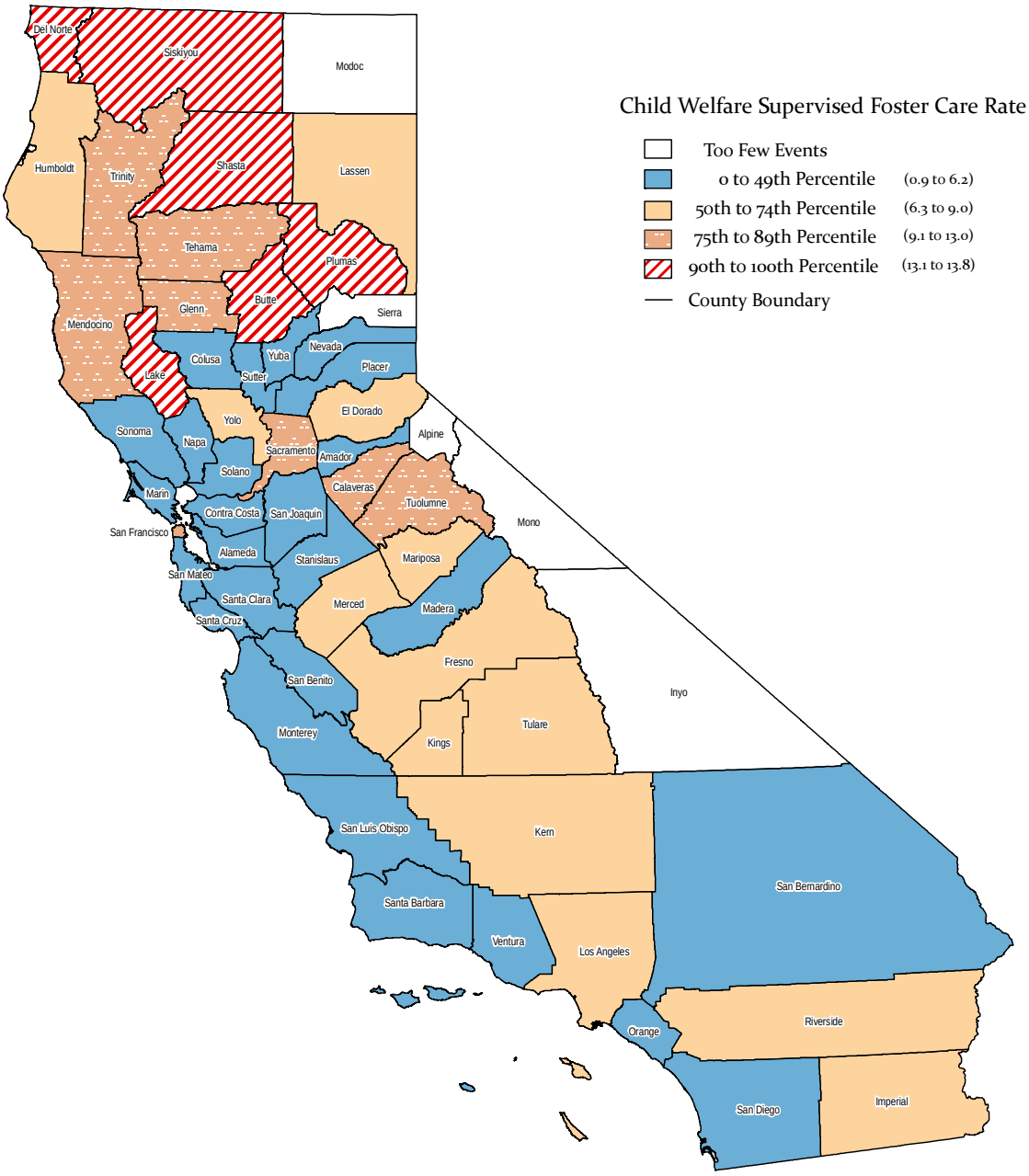
In-care rates also varied by county with the highest rate found in Lake County (13.8 per 1,000 children) and the lowest in Marin County (0.9 per 1,000). In addition to Lake County, other counties with high in-care rates were located in the northern Mountain Region including Plumas and Siskiyou (13.7 per 1,000), Del Norte and Shasta (13.6 per 1,000) and Butte (13.1 per 1,000) (Table 23 and Figure 32).

**Table 23. Children Ages 0-17 in Child Welfare Supervised Foster Care Rate per 1,000 Population by County, 2009**

| RANK ORDER | COUNTY | RATE | |
|---|---|---|---|
| 1 | LAKE | 13.8 | |
| 2 | PLUMAS | 13.7 | |
| 2 | SISKIYOU | 13.7 | |
| 4 | DEL NORTE | 13.6 | |
| 4 | SHASTA | 13.6 | |
| 4 | BUTTE | 13.1 | |
| 7 | MENDOCINO | 11.7 | |
| 8 | TRINITY | 11.1 | |
| 9 | SAN FRANCISCO | 10.8 | |
| 9 | TEHAMA | 10.8 | |
| 11 | SACRAMENTO | 10.2 | |
| 12 | TUOLUMNE | 9.8 | |
| 13 | GLENN | 9.7 | |
| 14 | CALAVERAS | 9.1 | |
| 15 | FRESNO | 8.6 | |
| 16 | KERN | 8.2 | |
| 17 | HUMBOLDT | 8.0 | |
| 17 | MERCED | 8.0 | |
| 19 | MARIPOSA | 7.6 | |
| 20 | YOLO | 7.0 | |
| 21 | EL DORADO | 6.9 | |
| 22 | IMPERIAL | 6.8 | **State Median** |
| 22 | LASSEN | 6.8 | |
| 24 | LOS ANGELES | 6.7 | |
| 25 | TULARE | 6.6 | |
| 26 | KINGS | 6.3 | |
| 26 | RIVERSIDE | 6.3 | |
| 28 | SAN BERNARDINO | 6.2 | |
| | **CALIFORNIA RATE** | **6.0** | |
| 29 | YUBA | 5.9 | |
| 30 | SANTA BARBARA | 5.7 | |
| 31 | MADERA | 5.5 | |
| 31 | SAN JOAQUIN | 5.5 | |
| 31 | SAN LUIS OBISPO | 5.5 | |
| 34 | SAN DIEGO | 5.3 | |
| 35 | ALAMEDA | 5.2 | |
| 36 | AMADOR | 5.1 | |
| 37 | SUTTER | 4.9 | |
| 38 | COLUSA | 4.8 | |
| 39 | CONTRA COSTA | 4.7 | |
| 40 | SAN BENITO | 4.6 | |
| 41 | SANTA CRUZ | 4.5 | |
| 42 | SONOMA | 4.0 | |
| 43 | NEVADA | 3.9 | |
| 44 | STANISLAUS | 3.6 | |
| 45 | SOLANO | 3.5 | |
| 46 | ORANGE | 3.3 | |
| 47 | SANTA CLARA | 3.1 | |
| 48 | NAPA | 3.0 | |
| 49 | PLACER | 2.9 | |
| 50 | MONTEREY | 2.8 | |
| 50 | VENTURA | 2.8 | |
| 52 | SAN MATEO | 1.8 | |
| 53 | MARIN | 0.9 | |
| | SIERRA | -- | |
| | MODOC | -- | |
| | INYO | -- | |
| | MONO | -- | |
| | ALPINE | -- | |

Source: Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). Child Welfare Services Reports for California. Retrieved 8/27/2010, from University of California at Berkeley Center for Social Services Research website. URL: <http://cssr.berkeley.edu/ucb_childwelfare>.
Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

**Figure 32. Children Ages 0-17 in Child Welfare Supervised Foster Care Rate per 1,000 Population by County, 2009**




Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health
SOURCE(S): Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). Child Welfare Services Reports for California. Retrieved 8/27/2010, from University of California at Berkeley Center for Social Services Research website. URL: <http://cssr.berkeley.edu/ucb_childwelfare> Accessed August 27, 2010

## Statewide Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 10.7 | Source(s): 2008 Birth Statistical Master File. Excludes births with less than 17 weeks gestation, greater than 47 weeks gestation, and missing gestation (we also used resident births which was not specified in the first SIR). |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.8 | Source(s): 2008 Birth Statistical Master File. Excludes infants weighing less than 227 grams or greater than 8,165 grams. |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 5.1 | -- | -- | -- | -- | Source(s): 2008 Birth & Death Statistical Master Files. |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 13.3 | Source(s): 2008 U.S. Census Bureau, Small Area Income and Poverty Estimates, accessed at http://www.census.gov/did/www/saipe/ on August 20, 2010.<br>Excludes people whose poverty status could not be determined. |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3319.9 | Source(s): 2008 California Department of Justice (DOJ) crime data, California Department of Finance (total population data by county).<br>CA DOJ does not typically report crime rates for counties with a total population <100,000. It is possible that rates for small counties are less reliable.<br>All crime aggregates known incidents of homicide, forcible rape, robbery, aggravated assault, burglary, motor vehicle theft, and larceny-theft. |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 4972.6 | Source(s): Office of the Attorney General; Juvenile Felony and Misdemeanor Arrests by Gender, Offense and Arrest Rate file, 2008.<br>Juvenile arrests include all felony, misdemeanor and status offenses. Juvenile Arrests are aggregated for 2008; population age for juveniles is 10-17 years; rate is per 100,000. |

## Statewide Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | 7.6% of Early Head Start families were referred to "domestic violence services" based on data from the Early Head Start 2008-09 Program Information Report. | -- | 26.3 | Source(s): MCAH/Office of Family Planning Domestic Violence Program, 2008.<br>Unduplicated numbers of clients receiving face-to-face domestic violence services from 95% of domestic violence agencies that received funding through State Domestic Violence programs in 2008/ total population per 1,000 residents. |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 18.9 | Source(s): California Department of Education, Education Demographics Office, DataQuest. Number of Dropouts in California Public Schools, Grades 9-12 by Grade Level and Ethnicity Group, 2007-08. Accessed at http://dq.cde.ca.gov/dataquest/ on August 11, 2010.<br>The 4-year derived drop out rate is an estimate of the percent of students who would drop out in a four year period based on data collected for a single year (calculated as # reported or adjusted students who dropped out/ # of students enrolled). State and county drop out rates are unadjusted for re-enrollments and transfers. |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | "Other" school drop-out rates were not obtained. |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | 5.6% of Early Head Start families were referred to "substance abuse services" (type of abuse unknown) based on data from the Early Head Start 2008-09 Program Information Report. | 21.5 | -- | Source(s): Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD. Accessed at http://www.oas.samhsa.gov/substate2k10/toc.cfm on August 26, 2010.<br>Binge alcohol use is defined as drinking five or more drinks on the same occasion.<br>(i.e., at the same time or within a couple hours of each other) on at least 1 day in the 30 days prior to the survey. |

## Statewide Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| -Prevalence rate: Marijuana use in past month | -- | -- | 5.6% of Early Head Start families were referred to "substance abuse services" (type of abuse unknown) based on data from the Early Head Start 2008-09 Program Information Report. | 7.0 | -- | Source(s): Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD. Accessed at http://www.oas.samhsa.gov/substate2k10/toc.cfm on August 26, 2010. |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | 5.6% of Early Head Start families were referred to "substance abuse services" (type of abuse unknown) based on data from the Early Head Start 2008-09 Program Information Report. | 5.3 | -- | Source(s): Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD. Accessed at http://www.oas.samhsa.gov/substate2k10/toc.cfm on August 26, 2010.<br>The Sub-State Treatment Planning Data Reports only provide sub-state data on the nonmedical use of *pain relievers* in the past *year* and so this indicator was used instead. |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | 5.6% of Early Head Start families were referred to "substance abuse services" (type of abuse unknown) based on data from the Early Head Start 2008-09 Program Information Report. | 4.1 | -- | Source(s): Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (Office of Applied Studies). Rockville, MD. Accessed at http://www.oas.samhsa.gov/substate2k10/toc.cfm on August 26, 2010.<br>Illicit drugs other than marijuana include cocaine (and crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically. |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 11.9 | Source(s): U.S. Department of Labor, Bureau of Labor Statistics, Labor Force Data by County, 2009, Annual Averages. Accessed at http://www.bls.gov on August 4, 2010. State rate was accessed at http://www.bls.gov/web/laus/haumstrk.htm. Unemployment rates are annual averages. |

## Statewide Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | 12.7% of Early Head Start families were referred to "child abuse and neglect services" based on data from the Early Head Start 2008-09 Program Information Report. | -- | 9.1 | Source(s): Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). Child Welfare Services Reports for California. Retrieved 8/25/2010, from University of California at Berkeley Center for Social Services Research website. URL: <http://cssr.berkeley.edu/ucb_childwelfare>.Calculated by dividing the unduplicated count of children with a child maltreatment substantiation by the child population and then multiplying by 1,000. Population projections are from the California Department of Finance. |
| **Child maltreatment (continued)**<br>-Rate of substantiated maltreatment by type<br>Sexual Abuse<br>Physical Abuse<br>Severe Neglect<br>General Neglect<br>Exploitation<br>Emotional Abuse<br>Caretaker Absence/Incapacity<br>At-Risk, Sibling Abused<br>Substantial Risk | -- | -- | -- | -- | 5.9<br>9.0<br>3.0<br>52.0<br>0.0<br>8.5<br>5.6<br>7.8<br>8.2 | Source(s): Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). Child Welfare Services Reports for California. Retrieved 8/25/2010, from University of California at Berkeley Center for Social Services Research website. URL: <http://cssr.berkeley.edu/ucb_childwelfare>. The denominator is the total number of unduplicated children with substantiated maltreatment for that county. The numerator is the number of unduplicated children, counted only once, in the category of highest severity, for that county. Percent calculations do not include "Missing" maltreatment type. |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care**<br>-Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 82.4 | -- | -- | -- | -- | Source(s): 2008 Birth Statistical Master File. Excludes births with unknown prenatal care initiation (we used resident births). |

## Statewide Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Prenatal substance abuse**<br>-Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco)/1,000 live births | -- | -- | -- | -- | 11.9 | Source(s): 2006-2008 Office of Statewide Health Planning and Development, Patient Discharge Data.<br>Prenatal substance abuse determined by hospital discharge diagnosis at time of labor/delivery. ICD9-CM Codes used for substance abuse: 291, 303, 305.0 (Alcohol Abuse), 292, 304, 305.2-305.9, 648.3 (Drug Abuse). Denominator is women who were discharged with labor/delivery code. |
| **Maternal depression**<br>-Rate of resident labor/delivery hospital discharges with a diagnosis of depression/1,000 women discharged | -- | -- | -- | -- | 7.3 | Source(s): 2006-2008 Office of Statewide Health Planning and Development, Patient Discharge Data.<br>Depression determined by hospital discharge diagnosis at time of labor/deliver. ICD9-CD Codes used for maternal depression: 296.2, 296.20-296.25, 296.3, 296.30-296.35, 296.82, 300.4, 309.0, 309.1, 309.28, 311. Denominator is women who were discharged with labor/delivery code. |
| **Birth interval**<br>-Percent: # women ages 15-44 with birth intervals less than 24 months/total # women ages 15-44 with a live birth | -- | -- | -- | -- | 13.2 | Source(s): 2008 Birth Statistical Master File. Excludes birth intervals less than five months. |
| **Breastfeeding**<br>-Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 42.7 | Source(s): Genetic Disease Screening Program, Newborn Screening Data, 2007.<br>Infants with feeding reported as "breastmilk" only/all infants with feeding reported as breastmilk or formula. Records with feeding unknown/not reported, TPN, or other are excluded. |
| **Children with special needs**<br>-Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.8 | Source(s): As cited on kidsdata.org, Special Tabulation by the State of California, Department of Education, Special Education Division; Assessment, Evaluation and Support (June 2010). Accessed at http://www.kidsdata.org/data/topic/table.aspx?f=1&dtm=244&ind=95 on August 26, 2010. |

## Statewide Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Foster care**<br>-Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 6.0 | Source(s): Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). Child Welfare Services Reports for California. Retrieved 8/27/2010, from University of California at Berkeley Center for Social Services Research website. URL: <http://cssr.berkeley.edu/ucb_childwelfare>. Children placed in child welfare supervised foster care, rate per 1,000 population (ages 0 to 17). |

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# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

## 2. Community Unit Selection

**Maternal, Child and Adolescent Health Program**
**Center for Family Health**
**California Department of Public Health**

## IDENTIFY THE UNIT SELECTED AS "COMMUNITY"

### Introduction

The ACA Maternal, Infant, and Early Childhood Home Visiting Program is designed to improve the coordination and provision of services to, and improve outcomes for, families who reside in at risk "communities". Describing the State's definition of "community" is an important component of this needs assessment and central to identifying initial at risk communities. This section describes how California defined community for the purposes of this needs assessment and provides a justification for each community identified as being at risk. Finally, this section describes how California will refine the definition of "community" and the designation of "at risk" communities in response to the future SIR on the Updated State Plan.

### Consideration of Several Units for Defining "Community"

The first SIR's guideline in defining "community" stated that "*Each State should describe its understanding of the term "community" in accordance with the unique structure and make-up of the State*." California's unique structure and make-up is a product of the size and diversity of the State's population and geography. California is the most populous State in the United States at an estimated 39.1 million people, and includes the nation's largest Asian population, largest number and percentage of foreign born residents, and approximately 14.3 million residents above the age of five years who speak a language other than English at home. California's population distribution is also diverse, as evidenced by having three of the ten most populous cities in the United States (Los Angeles, San Diego, and San Jose), and a county with only 1,200 residents (Alpine County).

These factors must be considered when defining "community." The first SIR provided additional context for defining "community" whereby "*Communities, furthermore, may necessarily be categorized in more than one way within a single State. For example, a community in an urban area may be described in terms of zip codes, neighborhoods, or census tracts, while in rural areas of the State, counties may be the only units for which data are available as a means of determining community needs and risks.*"

Zip codes change frequently, often cross county boundaries, and often present considerable heterogeneity with regard to population and neighborhood characteristics. Other units of analysis based on census designations address many limitations of zip codes. Census tracts are small, relatively permanent statistical subdivisions of a county. Census tracts usually have between 2,500 and 8,000 persons and, when first delineated, are designed to be homogeneous with respect to population characteristics, economic status, and living conditions. Census tracts also do not cross county boundaries. Census tract boundaries are delineated with the intention of being maintained over a long time so that statistical comparisons can be made from census to census. However, the spatial size of census tracts varies widely depending on the density of settlement. Although census tracts are designed to be homogenous, they do not necessarily represent "community". Medical Service Study Areas (MSSAs) are census tract based geographic areas developed in California for the specific purpose of conducting needs assessments to identify disparities and unmet need, and were developed with community input so the designations would reflect neighborhood characteristics. MSSAs are comprised of several U.S. census tracts. In urban areas, MSSAs tend to be comprised of a larger number of census tracts that are small in area size but high in population counts. MSSAs in rural areas are typically comprised of a smaller number of census tracts and are less densely populated.

### Defining "Community" for the Initial Needs Assessment

Census tracts and MSSAs represent the units of analysis best suited for representing the "*unique structure and make-up of the State"* particularly for the purpose of conducting a needs assessment to identify disparities and unmet need. However, there are 7,049 census tracts in California that are collapsed to form 541 MSSAs. A number of factors, particularly time constraints for responding to the current SIR and the availability of data at a sub-county level for many variables required by the current SIR, make analyses of data at the census tract and/or MSSA level not feasible in response to this SIR. Therefore, California has defined "community" as county for this needs assessment. "County", a geo-political construct, is the default unit of local government. All parts of California's land is allocated to one of its 58 counties. California may refine the definition of "community" to include census tracts and/or MSSAs in response to the future SIR on the Updated State Plan.

### Identifying At Risk Communities

The first SIR provided a definition of "at risk community" whereby "*an 'at risk community' is a community for which indicators, in comparison to statewide indicators, demonstrate that the community is at greater risk than is the State as a whole. The distinction is to be based on a comparison of statewide data and data for the community identified as being at risk.*"

Variation in the population size of California's counties typically results in a statewide rate largely influenced by a small number of highly populated counties and unstable rates in the least populated counties. For these reasons, the statewide median for each indicator is a more robust measure of comparison to identify communities at greater risk because it is less influenced by outliers. The statewide median is used in this needs assessment to identify counties at greater risk for each indicator.

The Patient Protection and Affordable Care Act of 2010 (ACA) added Section 511 to Title V of the Social Security Act requiring States to provide a statewide home visiting needs assessment that identifies:

- *communities with concentrations of –*
    - *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;*
    - *poverty;*
    - *crime;*
    - *domestic violence;*
    - *high rates of high-school drop-outs;*
    - *substance abuse;*
    - *unemployment;* ***or***
    - *child maltreatment*

Section 511 of the Social Security Act therefore designates at risk communities as those with a concentration of any one or more of these factors. For the purpose of this needs assessment, at risk communities in California are defined as those counties with a rate or percentage worse off than the statewide median for any one or more of the specified indicators as defined by Section 511 of the Social Security Act including the supplemental *indicators of at risk prenatal, maternal, newborn, or child health* that California has included in this needs assessment (i.e.,

first trimester prenatal care initiation, birth interval less than 24 months, in-hospital exclusive breastfeeding, children with special needs, children in foster care, prenatal substance use, and maternal depression).

### At Risk Communities in California

The number of indicators for which each county has an indicator worse off than the statewide median is provided in Table 24. Each of California's 58 counties has at least two indicators for which their rate or percentage is worse off than the statewide median. Based on California's definition of at risk communities for this needs assessment, all 58 counties are designated as at risk. Results from this needs assessment indicate considerable need across the state whereby 54 of 58 counties, or 93%, had rates or percentages worse off than the corresponding statewide median for six or more indicators.

**Table 24. Population Size, Number of Live Births and Frequency of Indicators Worse-Off Than the State Median, by County and Population Size**

| | COUNTY | POPULATION SIZE | NUMBER OF LIVE BIRTHS | NUMBER OF INDICATORS > MEDIAN |
|---|---|---|---|---|
| | **CALIFORNIA** | **38,648,090** | **551,567** | |
| County Population > 500,000 | LOS ANGELES | 10,441,080 | 147,684 | 8 |
| | SAN DIEGO | 3,224,432 | 46,742 | 10 |
| | ORANGE | 3,166,461 | 42,456 | 2 |
| | RIVERSIDE | 2,139,535 | 32,866 | 13 |
| | SAN BERNARDINO | 2,073,149 | 33,788 | 11 |
| | SANTA CLARA | 1,880,876 | 26,730 | 2 |
| | ALAMEDA | 1,574,857 | 20,972 | 4 |
| | SACRAMENTO | 1,445,327 | 21,389 | 14 |
| | CONTRA COSTA | 1,073,055 | 13,136 | 8 |
| | FRESNO | 953,761 | 16,760 | 12 |
| | SAN FRANCISCO | 856,095 | 9,104 | 9 |
| | VENTURA | 844,713 | 12,076 | 9 |
| | KERN | 839,587 | 15,315 | 16 |
| | SAN MATEO | 754,285 | 9,765 | 3 |
| | SAN JOAQUIN | 694,293 | 11,030 | 14 |
| | STANISLAUS | 530,584 | 8,549 | 14 |
| County Population 100,000 – 499,999 | SONOMA | 493,285 | 5,761 | 9 |
| | TULARE | 447,814 | 8,533 | 12 |
| | MONTEREY | 435,878 | 7,434 | 7 |
| | SANTA BARBARA | 434,481 | 6,319 | 9 |
| | SOLANO | 427,837 | 5,607 | 14 |
| | PLACER | 347,102 | 4,035 | 8 |
| | SAN LUIS OBISPO | 273,231 | 2,737 | 8 |
| | SANTA CRUZ | 272,201 | 3,538 | 7 |
| | MARIN | 260,651 | 2,716 | 6 |
| | MERCED | 258,495 | 4,423 | 16 |
| | BUTTE | 221,768 | 2,518 | 13 |
| | YOLO | 202,953 | 2,669 | 12 |
| | SHASTA | 184,247 | 2,186 | 16 |
| | IMPERIAL | 183,029 | 3,221 | 15 |
| | EL DORADO | 182,019 | 1,814 | 12 |
| | KINGS | 156,289 | 2,710 | 10 |
| | MADERA | 153,655 | 2,535 | 9 |
| | NAPA | 138,917 | 1,671 | 10 |
| | HUMBOLDT | 133,400 | 1,601 | 11 |
| County Population <100,000 | SUTTER | 99,154 | 1,468 | 14 |
| | NEVADA | 98,680 | 871 | 10 |
| | MENDOCINO | 90,289 | 1,168 | 14 |
| | YUBA | 73,380 | 1,264 | 16 |
| | LAKE | 64,053 | 705 | 16 |
| | TEHAMA | 63,100 | 790 | 12 |
| | SAN BENITO | 58,388 | 816 | 8 |
| | TUOLUMNE | 56,086 | 486 | 13 |
| | SISKIYOU | 46,010 | 498 | 14 |
| | CALAVERAS | 45,870 | 373 | 10 |
| | AMADOR | 38,022 | 288 | 6 |
| | LASSEN | 35,889 | 323 | 12 |
| | DEL NORTE | 29,673 | 312 | 14 |
| | GLENN | 29,434 | 472 | 12 |
| | COLUSA | 22,206 | 367 | 13 |
| | PLUMAS | 20,428 | 175 | 12 |
| | MARIPOSA | 18,192 | 147 | 8 |
| | INYO | 18,110 | 226 | 6 |
| | TRINITY | 13,898 | 126 | 13 |
| | MONO | 13,617 | 175 | 6 |
| | MODOC | 9,777 | 92 | 8 |
| | SIERRA | 3,303 | 22 | 6 |
| | ALPINE | 1,189 | 13 | 7 |

Source(s): State of California, Department of Finance, E-1 Population Estimates for Cities, Counties and the State with Annual Percent Change — January 1, 2009 and 2010. Sacramento, California, May 2010.
2008 Birth Statistical Master File.

Notes: Based on a total of 21 indicators, 14 of which were required and seven of which were included after discussion and consultation with internal and external partners.

Prepared by: Maternal, Child and Adolescent Health Program, Center for Family Health, California Department of Public Health.

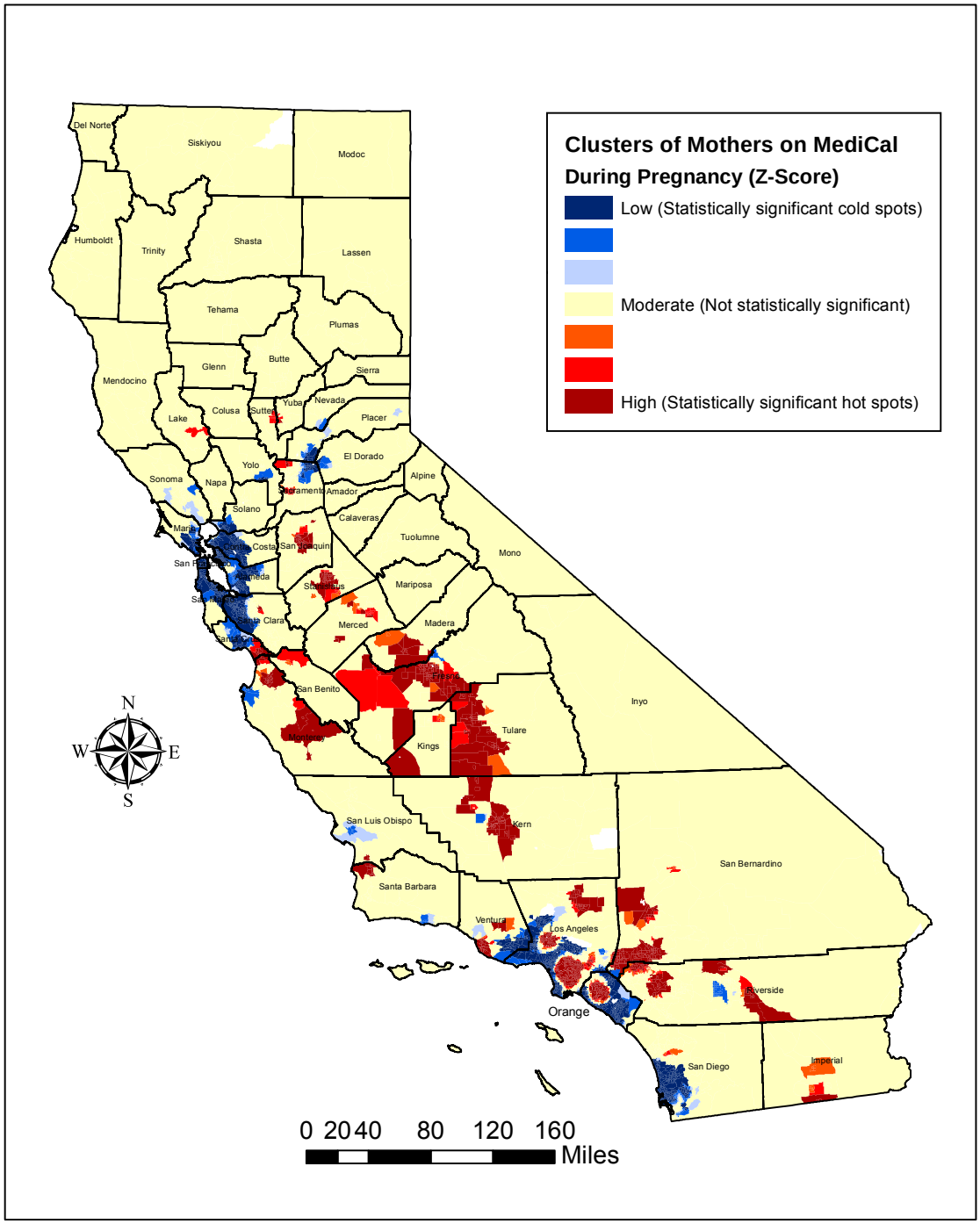
## Refining California's At Risk Communities

The first SIR states that "*there will be an opportunity for the State to refine the boundaries of a targeted community as part of the updated needs/resources assessment and Updated State Plan to be submitted in response to the Supplemental Information request on the Updated State Plan*." California may refine the definition of "community" to include census tracts and/or MSSA's in response to the future SIR on the Updated State Plan. In fact, California's partner agencies from the CDPH, CDADP, CDE and CDSS, have initiated work on the refined definition of "community", the initial step of which is to identify data sources at the sub-county level reflective of the indicators required in the current SIR. In addition, local expertise will be obtained so as to further supplement results from this needs assessment process. As an example, local partners may have access to sub-county level indicator data, service data or capacity data that could be critical to refining California's definition of at risk communities. In addition, CDPH/MCAH may utilize geospatial hot-spot analyses to further refine the boundaries of a targeted at risk community.

### Description of Geospatial Analyses

A number of spatial and statistical analyses can help better delineate and understand statistically significant clusters and patterns in data. Hot-spot analyses and corresponding hot-spot maps are one example of such analyses that use spatial autocorrelations to detect statistically significant clusters. These techniques are based on Tobler's First Law of Geography: everything is related to everything else, but things of closer proximity are more related than things separated by greater distance. Hot-spot maps allow for the locating of clusters in data and ultimately allow for 1) the determination of where indicators cluster spatially; 2) the identification of clusters that are significantly higher or lower than would be expected; 3) to calculate a standardized score (Z-score) for delineating hot and cold spots; and 4) to provide the orientation and distribution of clustering. By incorporating hot-spot analyses in response to the future SIR on the Updated State Plan, the boundaries of California's at risk communities could be refined to include statistically significant clusters of higher risk values (i.e., hot spots) within census tracts and/or MSSAs. Statistical significance for a specific cluster would be evidenced by a standardized Z-score that compares observed to expected values for specified indicators. These analyses are based on the observed and expected values for each geographic unit, and take into consideration the variability of the values across geographic units (i.e., census tract or MSSA) in the entire state. Hence, final results are not overly influenced by more populous counties which presented limitations to using statewide rates as the benchmark comparison in this needs assessment. Figure 33 provides an example hot-spot map of California Medical Assistance Program (Medi-Cal) supported births, for demonstrative purposes only, to illustrate the application of this methodology. The benefits of these hot-spot analyses in refining at risk communities are evidenced by Orange County. Orange County ranks 46$^{th}$ among all California counties for estimates of poverty (Table 5 presented previously). However, the hot-spot analysis identifies an area in Orange County with the highest level "hot spot" for Medi-Cal during pregnancy or delivery indicating an area of significantly lower income not observed when analyzing county level data alone.

**Figure 33. Hot Spot Analysis: Mothers on Medi-Cal During Pregnancy and/or Delivery California Census Tracts, 2008**



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# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

# 3. Data Report for Each At Risk Communities in California

**Maternal, Child and Adolescent Health Program**
**Center for Family Health**
**California Department of Public Health**

# COMPLETE A DATA REPORT FOR EACH AT RISK COMMUNITY IN THE STATE

## Introduction

This section includes a data report for each of California's designated at risk communities, defined previously as all 58 counties. The indicators presented in each of these data reports were calculated using the same metrics and data sources as the statewide data report (the "Appendix A" matrix presented in Section 1). In cases where the number of events was less than 20, the data were suppressed. As a result, some counties did not have data for all of the indicators. Similarly, the substance abuse data were available only at the regional level. In these cases, the regional rate was applied to each of the counties that made up that region. A technical notes table is presented on the following page that includes all of the comments from the at risk community data reports.

Finally it is important to note that while the statewide data report included some supplemental State-level data from Head Start, at this time CDPH/MCAH does not readily have access to county-level data from either the Head Start or CAPTA needs assessments. As noted previously, California is working closely with the CHSSCO to obtain copies of these communitywide assessments for the State's at risk communities. Where possible, these will be synthesized and included in the updated needs and resources assessment submitted as part of the Updated State Plan.

## Technical Notes

| Indicator | Comments |
|---|---|
| **REQUIRED INDICATORS** | |
| **Premature birth** | Source(s): 2008 Birth Statistical Master File.<br>Excludes births with less than 17 weeks gestation, greater than 47 weeks gestation, and missing gestation (we also used resident births which was not specified). |
| **Low birth weight infants** | Source(s): 2008 Birth Statistical Master File.<br>Excludes infants weighing less than 227 grams or greater than 8,165 grams. |
| **Infant mortality** | Source(s): 2008 Birth & Death Statistical Master File. |
| **Poverty** | Source(s): 2008 U.S. Census Bureau, Small Area Income and Poverty Estimates, accessed at http://www.census.gov/did/www/saipe/ on August 20, 2010.<br>Excludes people whose poverty status could not be determined. |
| **Crime**<br># reported crimes<br><br># juveniles crime arrests | Source(s): 2008 CA DOJ (crime data), CA DOF (total population data by county).<br>CA DOJ does not typically report crime rates for counties with a total population <100,000. It is possible that rates for small counties are less reliable.<br><br>Source(s): Office of the Attorney General; Juvenile Felony and Misdemeanor Arrests by Gender, Offense and Arrest Rate file, 2008. |
| **Domestic violence** | Source(s): MCAH/Office of Family Planning Domestic Violence Program, 2008.<br>Unduplicated numbers of clients receiving face-to-face domestic violence services from 95% of domestic violence agencies that received funding through State Domestic Violence programs in 2008/ total population. |
| **School Drop-out Rates** | Source(s): California Department of Education, Education Demographics Office, DataQuest. Number of Dropouts in California Public Schools, Grades 9-12 by Grade Level and Ethnicity Group, 2007-08. Accessed at http://dq.cde.ca.gov/dataquest/ on August 11, 2010.<br>The 4-year derived dropout rate is an estimate of the percent of students who would drop out in a four year period based on data collected for a single year (calculated as # reported or adjusted students who dropped out/ # of students enrolled). State and county dropout rates are adjusted for re-enrollments and lost transfers. |
| **Substance abuse**<br><br>Binge alcohol use<br><br>Marijuana use<br><br>Nonmedical use of pain relievers drugs<br><br>Use of illicit drugs, excluding Marijuana | Source(s): Substance Abuse and Mental Health Services Administration. (2010). Substate Estimates from the 2006-2008 National Surveys on Drug Use and Health (NSDUH) (Office of Applied Studies). Rockville, MD. Accessed at http://www.oas.samhsa.gov/substate2k10/toc.cfm on August 26, 2010.<br>The NSDUH is an annual survey of population aged 12 or older.<br><br>Binge alcohol use is defined as drinking five or more drinks on the same occasion. (i.e., at the same time or within a couple hours of each other) on at least 1 day in the 30 days prior to the survey.<br><br>Marijuana use in past month.<br><br>The Sub-State Treatment Planning Data Reports only provide sub-state data on the nonmedical use of *pain relievers* in the past *year* and so this indicator was used instead.<br><br>Illicit drugs other than marijuana include cocaine (and crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically in past month. |

## Technical Notes (Continued)

| Indicator | Comments |
|---|---|
| **Unemployment** | Source(s): U.S. Department of Labor, Bureau of Labor Statistics, Labor Force Data by County, 2009, Annual Averages. Accessed at http://www.bls.gov on August 4, 2010. State rate was accessed at http://www.bls.gov/web/laus/haumstrk.htm. Unemployment rates are annual averages. |
| **Child maltreatment** | Source(s): Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). Child Welfare Services Reports for California. Retrieved 8/25/2010, from University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/ucb_childwelfare .<br>Substantiated maltreatment rate per 1,000 child population. Rates are based on unduplicated counts of children. |
| **SUPPLEMENTAL INDICATORS** | |
| **Prenatal care** | Source(s): 2008 Birth Statistical Master File.<br>Excludes births with unknown prenatal care initiation (we used resident births). |
| **Prenatal substance abuse** | Source(s): 2006-2008 Office of Statewide Health Planning and Development, Patient Discharge Data.<br>Prenatal substance abuse determined by hospital discharge diagnosis at time of labor/delivery. ICD9-CM Codes used for substance abuse: 291, 303, 305.0 (Alcohol Abuse), 292, 304, 305.2-305.9, 648.3 (Drug Abuse). Denominator is women who were discharged with labor/delivery code. |
| **Maternal depression** | Source(s): 2006-2008 Office of Statewide Health Planning and Development, Patient Discharge Data.<br>Depression determined by hospital discharge diagnosis at time of labor/deliver. ICD9-CD Codes used for maternal depression: 296.2, 296.20-296.25, 296.3, 296.30-296.35, 296.82, 300.4, 309.0, 309.1, 309.28, 311. Denominator is women who were discharged with labor/delivery code. |
| **Birth interval** | Source(s): 2008 Birth Statistical Master File.<br>Excludes birth intervals less than five months. |
| **Breastfeeding** | Source(s): Genetic Disease Screening Program, Newborn Screening Data, 2007.<br>Infants with feeding reported as "breastmilk" only/all infants with feeding reported as breastmilk or formula. Records with feeding unknown/not reported, TPN, or other are excluded. |
| **Children with special needs** | Source(s): Special Tabulation by the State of California, Department of Education, Special Education Division; Assessment, Evaluation and Support (June 2010).<br>Percentage of public school students enrolled in special education. |
| **Foster care** | Source(s): Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). Child Welfare Services Reports for California. Retrieved 8/27/2010, from University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/ucb_childwelfare . Accessed August 27, 2010.<br>Children placed in child welfare supervised foster care, rate per 1,000 population (ages 0 to 17). |

## Alameda County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.5 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 7.1 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 4.2 | | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 10.4 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 4663.4 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 3940.7 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 20.2 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | -- | -- | -- | -- | 16.7 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 19.9 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.2 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.2 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.1 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 10.7 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 4.0 | See technical notes |

## Alameda County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 8.5 | |
| Physical Abuse | | | | | 14.5 | |
| Severe Neglect | | | | | 2.4 | |
| General Neglect | | | | | 27.5 | |
| Exploitation | | | | | 0.1 | |
| Emotional Abuse | | | | | 4.3 | |
| Caretaker Absence/Incapacity | | | | | 27.2 | |
| At-Risk, Sibling Abused | | | | | 1.6 | |
| Substantial Risk | -- | -- | -- | -- | 13.8 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 86.7 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 13.1 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 9.3 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 10.4 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 72.8 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.5 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 5.2 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Alpine County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | * | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | * | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 15.7 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 7237.9 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | * | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | * | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | -- | -- | -- | -- | * | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.5 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.8 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.2 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 14.0 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 13.3 | See technical notes |

## Alpine County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 0.0 | |
| Physical Abuse | | | | | 0.0 | |
| Severe Neglect | | | | | 0.0 | |
| General Neglect | | | | | 100.0 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 0.0 | |
| Caretaker Absence/Incapacity | | | | | 0.0 | |
| At-Risk, Sibling Abused | | | | | 0.0 | |
| Substantial Risk | -- | -- | -- | -- | 0.0 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | * | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | * | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | * | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 22.5 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | * | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20. The designation of "Too Few Events" for domestic violence means the county had no state-funded domestic violence agency.

## Amador County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.6 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | * | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 9.8 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3132.3 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 2277.8 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | * | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 15.1 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.5 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.8 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.2 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 11.7 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 10.6 | See technical notes |

## Amador County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 1.4 | |
| Physical Abuse | | | | | 21.7 | |
| Severe Neglect | | | | | 2.9 | |
| General Neglect | | | | | 49.3 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 5.8 | |
| Caretaker Absence/Incapacity | | | | | 14.5 | |
| At-Risk, Sibling Abused | | | | | 2.9 | |
| Substantial Risk | -- | -- | -- | -- | 1.4 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 87.5 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 30.6 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 13.0 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 65.1 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 12.3 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 5.1 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20. The designation of "Too Few Events" for domestic violence means that the state-funded agencies did not report the total number of clients served.

## Butte County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.8 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 5.3 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 20.7 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3396.8 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 5953.4 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 60.7 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | -- | -- | -- | -- | 15.0 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 12.5 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 17.0 | See technical notes |

## Butte County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.2 | |
| Physical Abuse | | | | | 4.8 | |
| Severe Neglect | | | | | 7.6 | |
| General Neglect | | | | | 67.1 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 2.9 | |
| Caretaker Absence/Incapacity | | | | | 10.6 | |
| At-Risk, Sibling Abused | | | | | 1.6 | |
| Substantial Risk | -- | -- | -- | -- | 3.3 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 71.5 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 13.1 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 6.4 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 13.7 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 71.6 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 12.4 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 13.1 | See technical notes |

*Note(s): Asterisk denotess counties with too few events, events < 20.

## Calaveras County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 10.0 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.2 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 11.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2005.2 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6488.9 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 93.4 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 6.8 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.5 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.8 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.2 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 14.1 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 15.0 | See technical notes |

## Calaveras County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.5 | |
| Physical Abuse | | | | | 7.5 | |
| Severe Neglect | | | | | 5.8 | |
| General Neglect | | | | | 67.5 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 6.7 | |
| Caretaker Absence/Incapacity | | | | | 5.0 | |
| At-Risk, Sibling Abused | | | | | 4.2 | |
| Substantial Risk | -- | -- | -- | -- | 0.8 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 78.6 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 13.4 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 60.1 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.2 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 9.1 | See technical notes |

*Note(s): Asterisk denotess counties with too few events, events < 20.

## Colusa County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 11.4 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 8.2 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 13.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2435.0 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 2620.7 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | * | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | -- | -- | -- | -- | 10.3 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 18.3 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 5.3 | See technical notes |

## Colusa County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.9 | |
| Physical Abuse | | | | | 8.8 | |
| Severe Neglect | | | | | 2.9 | |
| General Neglect | | | | | 17.6 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 5.9 | |
| Caretaker Absence/Incapacity | | | | | 55.9 | |
| At-Risk, Sibling Abused | | | | | 0.0 | |
| Substantial Risk | -- | -- | -- | -- | 5.9 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** | | | | | | |
| -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 60.2 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 34.5 | See technical notes |
| **Birth interval** | | | | | | |
| -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 17.3 | See technical notes |
| **Breastfeeding** | | | | | | |
| -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 25.0 | See technical notes |
| **Children with special needs** | | | | | | |
| -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 13.6 | See technical notes |
| **Foster care** | | | | | | |
| -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 4.8 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20. The designation of "Too Few Events" for domestic violence means the county had no state-funded domestic violence agency.

## Contra Costa Data Table: Summary of Indicators County

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 10.0 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.5 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 4.1 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | -- | -- | 9.4 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3725.2 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 3218.3 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 14.5 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 16.0 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 19.9 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.2 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.2 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.1 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 10.3 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 5.2 | See technical notes |

## Contra Costa County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 3.0 | |
| Physical Abuse | | | | | 6.9 | |
| Severe Neglect | | | | | 0.6 | |
| General Neglect | | | | | 70.5 | |
| Exploitation | | | | | 0.1 | |
| Emotional Abuse | | | | | 0.0 | |
| Caretaker Absence/Incapacity | | | | | 5.0 | |
| At-Risk, Sibling Abused | | | | | 10.4 | |
| Substantial Risk | -- | -- | -- | -- | 3.4 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 83.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 23.7 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 14.3 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 11.4 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 64.0 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.7 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 4.7 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Del Norte County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 10.1 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.4 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 23.6 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2360.5 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 5366.7 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 155.5 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | -- | -- | -- | -- | 16.1 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 12.2 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 49.1 | See technical notes |

## Del Norte County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 1.3 | |
| Physical Abuse | | | | | 3.9 | |
| Severe Neglect | | | | | 2.6 | |
| General Neglect | | | | | 76.2 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 1.0 | |
| Caretaker Absence/Incapacity | | | | | 7.7 | |
| At-Risk, Sibling Abused | | | | | 3.2 | |
| Substantial Risk | -- | -- | -- | -- | 4.2 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 50.2 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 21.2 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 22.8 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 56.1 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.7 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 13.6 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## El Dorado County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 7.6 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.5 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 7.8 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 1962.0 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 3727.7 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 82.3 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 14.0 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.6 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 11.3 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 14.2 | See technical notes |

## El Dorado County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.5 | |
| Physical Abuse | | | | | 5.9 | |
| Severe Neglect | | | | | 2.8 | |
| General Neglect | | | | | 75.8 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 2.3 | |
| Caretaker Absence/Incapacity | | | | | 5.5 | |
| At-Risk, Sibling Abused | | | | | 1.2 | |
| Substantial Risk | -- | -- | -- | -- | 3.9 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** | | | | | | |
| -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 77.7 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 33.9 | See technical notes |
| **Maternal depression** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 25.1 | See technical notes |
| **Birth interval** | | | | | | |
| -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 14.5 | See technical notes |
| **Breastfeeding** | | | | | | |
| -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 69.1 | See technical notes |
| **Children with special needs** | | | | | | |
| -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.7 | See technical notes |
| **Foster care** | | | | | | |
| -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 6.9 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Fresno County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 14.4 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 7.9 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 6.7 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 22.1 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 4433.7 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6197.3 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 51.1 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | -- | -- | -- | -- | 24.0 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 20.9 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.0 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 4.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.3 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 15.1 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 8.1 | See technical notes |

## Fresno County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 5.7 | |
| Physical Abuse | | | | | 7.2 | |
| Severe Neglect | | | | | 0.8 | |
| General Neglect | | | | | 65.6 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 1.9 | |
| Caretaker Absence/Incapacity | | | | | 0.7 | |
| At-Risk, Sibling Abused | | | | | 10.5 | |
| Substantial Risk | -- | -- | -- | -- | 7.6 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** | | | | | | |
| -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 87.8 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 13.8 | See technical notes |
| **Maternal depression** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 4.9 | See technical notes |
| **Birth interval** | | | | | | |
| -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 16.7 | See technical notes |
| **Breastfeeding** | | | | | | |
| -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 38.9 | See technical notes |
| **Children with special needs** | | | | | | |
| -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 9.4 | See technical notes |
| **Foster care** | | | | | | |
| -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 8.6 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Glenn County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 8.2 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 4.2 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 16.9 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2274.1 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6868.4 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | * | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 21.0 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 14.6 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 23.3 | See technical notes |

## Glenn County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.7 | |
| Physical Abuse | | | | | 7.4 | |
| Severe Neglect | | | | | 12.2 | |
| General Neglect | | | | | 53.2 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 16.0 | |
| Caretaker Absence/Incapacity | | | | | 6.9 | |
| At-Risk, Sibling Abused | | | | | 1.6 | |
| Substantial Risk | -- | -- | -- | -- | 0.0 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 65.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 15.5 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 67.0 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.4 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 9.7 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20. The designation of "Too Few Events" for domestic violence means the county had no state-funded domestic violence agency.

## Humboldt County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 7.7 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.1 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 19.8 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3105.7 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 8169.2 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 20.3 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | -- | -- | -- | -- | 16.9 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 11.0 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 8.7 | See technical notes |

## Humboldt County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 0.8 | |
| Physical Abuse | | | | | 9.6 | |
| Severe Neglect | | | | | 2.1 | |
| General Neglect | | | | | 49.2 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 5.4 | |
| Caretaker Absence/Incapacity | | | | | 2.5 | |
| At-Risk, Sibling Abused | | | | | 4.2 | |
| Substantial Risk | -- | -- | -- | -- | 26.3 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 76.5 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 39.8 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 21.9 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 11.0 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 66.7 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 14.8 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 8.0 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Imperial County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 10.4 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.8 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 21.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3769.0 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 4361.1 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 63.2 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | -- | -- | -- | -- | 13.0 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 24.4 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 7.1 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.8 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.5 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 28.2 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 9.9 | See technical notes |

## Imperial County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 0.6 | |
| Physical Abuse | | | | | 2.5 | |
| Severe Neglect | | | | | 0.2 | |
| General Neglect | | | | | 84.9 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 0.0 | |
| Caretaker Absence/Incapacity | | | | | 6.2 | |
| At-Risk, Sibling Abused | | | | | 1.9 | |
| Substantial Risk | -- | -- | -- | -- | 3.6 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 59.7 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 9.3 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 14.4 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 12.6 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 8.6 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 6.8 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

# Inyo County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 11.7 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 11.5 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 11.6 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2565.1 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 2450.0 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 115.2 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | -- | -- | -- | -- | 15.3 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 20.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 5.7 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.1 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 3.8 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 9.1 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 16.0 | See technical notes |

## Inyo County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 0.0 | |
| Physical Abuse | | | | | 17.7 | |
| Severe Neglect | | | | | 0.0 | |
| General Neglect | | | | | 53.2 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 22.6 | |
| Caretaker Absence/Incapacity | | | | | 0.0 | |
| At-Risk, Sibling Abused | | | | | 6.5 | |
| Substantial Risk | -- | -- | -- | -- | 0.0 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** | | | | | | |
| -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 79.4 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** | | | | | | |
| -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 15.7 | See technical notes |
| **Breastfeeding** | | | | | | |
| -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 81.7 | See technical notes |
| **Children with special needs** | | | | | | |
| -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.7 | See technical notes |
| **Foster care** | | | | | | |
| -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | * | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Kern County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 13.9 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 7.1 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 7.2 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 20.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 4436.6 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 5472.8 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 36.7 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | -- | -- | -- | -- | 26.9 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 25.3 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 9.0 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.5 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.2 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 14.4 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 18.5 | See technical notes |

## Kern County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 1.7 | |
| Physical Abuse | | | | | 4.8 | |
| Severe Neglect | | | | | 1.3 | |
| General Neglect | | | | | 84.3 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 0.3 | |
| Caretaker Absence/Incapacity | | | | | 3.1 | |
| At-Risk, Sibling Abused | | | | | 3.5 | |
| Substantial Risk | -- | -- | -- | -- | 0.9 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 74.9 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 12.9 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 3.6 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 15.2 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 25.8 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 9.6 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 8.2 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Kings County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 11.6 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.4 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | | -- | 17.9 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2741.5 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 11045.7 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | | -- | 11.3 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 23.3 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 20.9 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.0 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 4.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.3 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 14.6 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 6.5 | See technical notes |

## Kings County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 6.8 | |
| Physical Abuse | | | | | 11.1 | |
| Severe Neglect | | | | | 5.4 | |
| General Neglect | | | | | 53.4 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 2.4 | |
| Caretaker Absence/Incapacity | | | | | 10.5 | |
| At-Risk, Sibling Abused | | | | | 10.1 | |
| Substantial Risk | -- | -- | -- | -- | 0.3 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 75.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco)/1,000 live births | -- | -- | -- | -- | 11.9 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 4.5 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 16.6 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 28.0 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.2 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 6.3 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Lake County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 8.6 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 5.4 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 17.9 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3229.3 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 9274.2 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 64.1 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 16.7 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 15.6 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 9.5 | See technical notes |

## Lake County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 5.7 | |
| Physical Abuse | | | | | 4.9 | |
| Severe Neglect | | | | | 0.0 | |
| General Neglect | | | | | 62.3 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 0.8 | |
| Caretaker Absence/Incapacity | | | | | 10.7 | |
| At-Risk, Sibling Abused | | | | | 0.0 | |
| Substantial Risk | -- | -- | -- | -- | 15.6 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** | | | | | | |
| -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 68.1 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 40.9 | See technical notes |
| **Maternal depression** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 14.4 | See technical notes |
| **Birth interval** | | | | | | |
| -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 14.6 | See technical notes |
| **Breastfeeding** | | | | | | |
| -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 47.5 | See technical notes |
| **Children with special needs** | | | | | | |
| -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.9 | See technical notes |
| **Foster care** | | | | | | |
| -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 13.8 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Lassen County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.2 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.8 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 20.7 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 1593.8 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 5514.3 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 32.2 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 37.5 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 12.9 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 12.7 | See technical notes |

## Lassen County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 3.5 | |
| Physical Abuse | | | | | 10.5 | |
| Severe Neglect | | | | | 0.0 | |
| General Neglect | | | | | 66.3 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 2.3 | |
| Caretaker Absence/Incapacity | | | | | 12.8 | |
| At-Risk, Sibling Abused | | | | | 4.7 | |
| Substantial Risk | -- | -- | -- | -- | 0.0 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 72.7 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 12.4 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 70.8 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 14.5 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 6.8 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Los Angeles County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 11.4 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 7.3 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 5.0 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 15.3 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3087.4 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 4259.6 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | | -- | 10.5 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 21.0 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 20.4 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 5.4 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 4.7 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 3.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 11.6 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 9.7 | See technical notes |

## Los Angeles County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 6.7 | |
| Physical Abuse | | | | | 11.4 | |
| Severe Neglect | | | | | 2.4 | |
| General Neglect | | | | | 36.7 | |
| Exploitation | | | | | 0.1 | |
| Emotional Abuse | | | | | 16.5 | |
| Caretaker Absence/Incapacity | | | | | 5.6 | |
| At-Risk, Sibling Abused | | | | | 12.3 | |
| Substantial Risk | -- | -- | -- | -- | 8.4 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 85.9 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 6.8 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 3.8 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 12.7 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 24.4 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.2 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 6.7 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Madera County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 11.9 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.1 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 18.2 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2633.3 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 3352.7 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | | -- | 23.6 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 17.1 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 20.9 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.0 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 4.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.3 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 13.7 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 11.8 | See technical notes |

## Madera County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 8.7 | |
| Physical Abuse | | | | | 6.7 | |
| Severe Neglect | | | | | 1.2 | |
| General Neglect | | | | | 62.2 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 0.2 | |
| Caretaker Absence/Incapacity | | | | | 6.7 | |
| At-Risk, Sibling Abused | | | | | 10.0 | |
| Substantial Risk | -- | -- | -- | -- | 4.3 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** | | | | | | |
| -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 72.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 11.2 | See technical notes |
| **Maternal depression** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 3.1 | See technical notes |
| **Birth interval** | | | | | | |
| -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 15.3 | See technical notes |
| **Breastfeeding** | | | | | | |
| -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 49.1 | See technical notes |
| **Children with special needs** | | | | | | |
| -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.1 | See technical notes |
| **Foster care** | | | | | | |
| -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 5.5 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Marin County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.1 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 7.2 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 7.1 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2207.2 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6940.7 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 50.4 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 7.7 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 21.0 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 9.3 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 4.5 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 3.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 7.8 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 4.7 | See technical notes |

## Marin County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 3.6 | |
| Physical Abuse | | | | | 5.6 | |
| Severe Neglect | | | | | 12.8 | |
| General Neglect | | | | | 61.2 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 1.6 | |
| Caretaker Absence/Incapacity | | | | | 3.2 | |
| At-Risk, Sibling Abused | | | | | 1.2 | |
| Substantial Risk | -- | -- | -- | -- | 10.8 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 94.4 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 7.1 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 20.6 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 9.8 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 77.5 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 12.6 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 0.9 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Mariposa County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | * | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | * | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 13.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 1776.2 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 3529.4 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 231.7 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 15.6 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 20.9 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.0 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 4.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.3 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 10.6 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 31.1 | See technical notes |

## Mariposa County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 4.3 | |
| Physical Abuse | | | | | 5.3 | |
| Severe Neglect | | | | | 2.1 | |
| General Neglect | | | | | 74.5 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 1.1 | |
| Caretaker Absence/Incapacity | | | | | 3.2 | |
| At-Risk, Sibling Abused | | | | | 4.3 | |
| Substantial Risk | -- | -- | -- | -- | 5.3 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 72.7 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 14.4 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 61.1 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 19.8 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 7.6 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Mendocino County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.6 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.2 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 17.7 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2376.4 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6968.1 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 129.9 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 18.9 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 10.5 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 20.5 | See technical notes |

## Mendocino County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.1 | |
| Physical Abuse | | | | | 6.0 | |
| Severe Neglect | | | | | 2.4 | |
| General Neglect | | | | | 66.9 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 6.4 | |
| Caretaker Absence/Incapacity | | | | | 6.0 | |
| At-Risk, Sibling Abused | | | | | 3.3 | |
| Substantial Risk | -- | -- | -- | -- | 6.9 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 69.5 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 21.2 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 12.6 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 9.9 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 75.5 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.7 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 11.7 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Merced County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 10.8 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.6 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 6.3 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 21.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 4124.7 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 9057.5 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | * | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 17.5 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.5 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.8 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.2 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 17.2 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 10.9 | See technical notes |

## Merced County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 6.1 | |
| Physical Abuse | | | | | 7.9 | |
| Severe Neglect | | | | | 1.3 | |
| General Neglect | | | | | 59.8 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 4.5 | |
| Caretaker Absence/Incapacity | | | | | 8.8 | |
| At-Risk, Sibling Abused | | | | | 3.4 | |
| Substantial Risk | -- | -- | -- | -- | 8.3 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 62.2 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 16.2 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 4.8 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 16.5 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 27.7 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 9.7 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 8.0 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20. The designation of "Too Few Events" for domestic violence means that the state-funded agencies did not report the total number of clients served.

## Modoc County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | * | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | * | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | | -- | 17.4 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2138.4 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 2545.5 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 75.7 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | * | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 12.8 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 20.9 | See technical notes |

## Modoc County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.3 | |
| Physical Abuse | | | | | 11.4 | |
| Severe Neglect | | | | | 0.0 | |
| General Neglect | | | | | 54.5 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 4.5 | |
| Caretaker Absence/Incapacity | | | | | 4.5 | |
| At-Risk, Sibling Abused | | | | | 2.3 | |
| Substantial Risk | -- | -- | -- | -- | 20.5 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 76.5 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | * | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 64.3 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 8.4 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | * | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Mono County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 14.7 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | * | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | | -- | 9.6 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3263.9 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 1714.3 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | * | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 17.8 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 20.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 5.7 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.1 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 3.8 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 9.0 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 8.7 | See technical notes |

## Mono County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 7.7 | |
| Physical Abuse | | | | | 19.2 | |
| Severe Neglect | | | | | 3.8 | |
| General Neglect | | | | | 11.5 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 3.8 | |
| Caretaker Absence/Incapacity | | | | | 3.8 | |
| At-Risk, Sibling Abused | | | | | 7.7 | |
| Substantial Risk | -- | -- | -- | -- | 42.3 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 75.9 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 12.8 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 51.8 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 12.1 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | * | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20. The designation of "Too Few Events" for domestic violence means the county had no state-funded domestic violence agency.

## Monterey County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 10.7 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 5.8 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 4.7 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 12.7 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3137.9 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6192.8 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 31.0 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 11.6 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 21.0 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 9.3 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.0 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.3 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 11.9 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 3.6 | See technical notes |

## Monterey County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 6.7 | |
| Physical Abuse | | | | | 8.6 | |
| Severe Neglect | | | | | 1.6 | |
| General Neglect | | | | | 50.8 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 0.9 | |
| Caretaker Absence/Incapacity | | | | | 10.4 | |
| At-Risk, Sibling Abused | | | | | 7.4 | |
| Substantial Risk | -- | -- | -- | -- | 13.5 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 75.0 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 14.1 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 10.8 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 11.8 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 64.0 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 9.4 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 2.8 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Napa County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 8.5 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.7 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 9.0 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2981.5 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 3103.2 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 65.1 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 18.4 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.6 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 8.7 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 4.8 | See technical notes |

## Napa County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 6.5 | |
| Physical Abuse | | | | | 7.1 | |
| Severe Neglect | | | | | 2.4 | |
| General Neglect | | | | | 68.5 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 1.2 | |
| Caretaker Absence/Incapacity | | | | | 9.5 | |
| At-Risk, Sibling Abused | | | | | 4.8 | |
| Substantial Risk | -- | -- | -- | -- | 0.0 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 81.6 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 13.0 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 24.7 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 10.9 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 67.2 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 12.9 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 3.0 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Nevada County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 8.3 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 4.9 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | | -- | 9.2 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 1703.1 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6621.4 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 57.8 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 73.5 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.6 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 10.7 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 5.5 | See technical notes |

## Nevada County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 1.0 | |
| Physical Abuse | | | | | 9.0 | |
| Severe Neglect | | | | | 1.0 | |
| General Neglect | | | | | 51.0 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 2.0 | |
| Caretaker Absence/Incapacity | | | | | 9.0 | |
| At-Risk, Sibling Abused | | | | | 2.0 | |
| Substantial Risk | -- | -- | -- | -- | 25.0 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 74.9 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 22.8 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 20.3 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 11.0 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 77.1 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 9.1 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 3.9 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Orange County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.5 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.4 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 4.8 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 9.9 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2282.4 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 4124.6 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 20.6 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 10.9 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 20.8 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.2 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 4.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 3.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 9.0 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 9.8 | See technical notes |

## Orange County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 10.3 | |
| Physical Abuse | | | | | 7.1 | |
| Severe Neglect | | | | | 2.2 | |
| General Neglect | | | | | 66.4 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 0.1 | |
| Caretaker Absence/Incapacity | | | | | 1.7 | |
| At-Risk, Sibling Abused | | | | | 11.5 | |
| Substantial Risk | -- | -- | -- | -- | 0.8 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 88.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 6.8 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 6.0 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 13.8 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 29.8 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.2 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 3.3 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Placer County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.5 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 5.8 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | | -- | 6.7 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2699.6 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 3703.2 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 54.5 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 8.8 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.6 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 10.6 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 10.6 | See technical notes |

## Placer County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.8 | |
| Physical Abuse | | | | | 7.5 | |
| Severe Neglect | | | | | 0.9 | |
| General Neglect | | | | | 40.1 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 14.0 | |
| Caretaker Absence/Incapacity | | | | | 1.9 | |
| At-Risk, Sibling Abused | | | | | 3.5 | |
| Substantial Risk | -- | -- | -- | -- | 29.5 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 84.4 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 11.9 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 15.1 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 12.3 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 58.8 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.5 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 2.9 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Plumas County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | * | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | * | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 12.0 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2261.3 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6100.0 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | | -- | 82.1 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 12.8 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 16.4 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 21.3 | See technical notes |

## Plumas County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 1.2 | |
| Physical Abuse | | | | | 8.5 | |
| Severe Neglect | | | | | 26.8 | |
| General Neglect | | | | | 42.7 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 0.0 | |
| Caretaker Absence/Incapacity | | | | | 7.3 | |
| At-Risk, Sibling Abused | | | | | 7.3 | |
| Substantial Risk | -- | -- | -- | -- | 6.1 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 73.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 46.4 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 15.5 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 75.5 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.4 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 13.7 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Riverside County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 11.6 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.6 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 5.7 | -- | -- | -- | | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 12.6 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3596.4 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 3997.2 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | | -- | 10.6 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 17.3 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.9 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.0 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 13.6 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 11.8 | See technical notes |

## Riverside County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 4.0 | |
| Physical Abuse | | | | | 6.1 | |
| Severe Neglect | | | | | 3.2 | |
| General Neglect | | | | | 75.5 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 0.1 | |
| Caretaker Absence/Incapacity | | | | | 4.3 | |
| At-Risk, Sibling Abused | | | | | 2.9 | |
| Substantial Risk | -- | -- | -- | -- | 3.9 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 83.0 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 8.1 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 4.7 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 14.5 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 44.2 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.5 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 6.3 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Sacramento County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.8 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.5 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 5.2 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 13.3 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 4285.9 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 3108.6 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 38.9 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 21.4 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.6 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 11.3 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 10.9 | See technical notes |

## Sacramento County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 5.8 | |
| Physical Abuse | | | | | 11.8 | |
| Severe Neglect | | | | | 4.3 | |
| General Neglect | | | | | 45.5 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 5.5 | |
| Caretaker Absence/Incapacity | | | | | 4.3 | |
| At-Risk, Sibling Abused | | | | | 2.9 | |
| Substantial Risk | -- | -- | -- | -- | 19.9 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 80.1 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 22.5 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 17.9 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 14.3 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 53.3 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.1 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 10.2 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## San Benito County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 12.5 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 7.2 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 10.4 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2556.0 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6865.9 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | * | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 14.7 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 21.0 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 9.3 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.0 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.3 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 14.4 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 5.3 | See technical notes |

## San Benito County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 1.0 | |
| Physical Abuse | | | | | 8.3 | |
| Severe Neglect | | | | | 1.0 | |
| General Neglect | | | | | 61.5 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 2.1 | |
| Caretaker Absence/Incapacity | | | | | 5.2 | |
| At-Risk, Sibling Abused | | | | | 6.3 | |
| Substantial Risk | -- | -- | -- | -- | 14.6 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 87.9 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 10.7 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 7.9 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 15.3 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 26.8 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 9.6 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 4.6 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20. The designation of "Too Few Events" for domestic violence means the county had no state-funded domestic violence agency.

## San Bernardino County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 11.4 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 7.1 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 6.0 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 14.7 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3483.2 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6100.5 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 13.5 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 22.5 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 20.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 5.7 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.1 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 3.8 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 13.0 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 7.4 | See technical notes |

## San Bernardino County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 10.7 | |
| Physical Abuse | | | | | 9.9 | |
| Severe Neglect | | | | | 4.8 | |
| General Neglect | | | | | 52.6 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 2.9 | |
| Caretaker Absence/Incapacity | | | | | 10.0 | |
| At-Risk, Sibling Abused | | | | | 5.9 | |
| Substantial Risk | -- | -- | -- | -- | 3.1 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 81.6 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 14.4 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 4.6 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 15.8 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 34.4 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.5 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 6.2 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## San Diego County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 10.0 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.6 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 4.9 | -- | -- | -- | | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 12.6 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3073.5 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 4981.2 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 39.1 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 17.1 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 24.4 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 7.1 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.8 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.5 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 9.7 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 9.6 | See technical notes |

## San Diego County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 5.0 | |
| Physical Abuse | | | | | 7.5 | |
| Severe Neglect | | | | | 5.3 | |
| General Neglect | | | | | 34.8 | |
| Exploitation | | | | | 0.1 | |
| Emotional Abuse | | | | | 16.8 | |
| Caretaker Absence/Incapacity | | | | | 4.4 | |
| At-Risk, Sibling Abused | | | | | 5.3 | |
| Substantial Risk | -- | -- | -- | -- | 20.8 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 81.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 10.3 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 8.6 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 12.8 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 58.9 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.9 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 5.3 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## San Francisco County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.2 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 7.3 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 5.3 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 11.2 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 5210.0 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 5901.2 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 29.2 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 20.8 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 21.0 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 9.3 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 4.5 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 3.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 9.0 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 9.3 | See technical notes |

## San Francisco County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 3.4 | |
| Physical Abuse | | | | | 12.2 | |
| Severe Neglect | | | | | 1.5 | |
| General Neglect | | | | | 35.0 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 12.8 | |
| Caretaker Absence/Incapacity | | | | | 10.3 | |
| At-Risk, Sibling Abused | | | | | 5.1 | |
| Substantial Risk | -- | -- | -- | -- | 19.8 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 84.7 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 13.6 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 13.5 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 9.3 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 76.7 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.6 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 10.8 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## San Joaquin County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 11.3 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 7.1 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 6.5 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 16.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 5781.7 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6648.4 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 21.7 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 20.4 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.5 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.8 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.2 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 15.4 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 7.6 | See technical notes |

## San Joaquin County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 7.0 | |
| Physical Abuse | | | | | 9.3 | |
| Severe Neglect | | | | | 7.2 | |
| General Neglect | | | | | 53.2 | |
| Exploitation | | | | | 0.1 | |
| Emotional Abuse | | | | | 5.7 | |
| Caretaker Absence/Incapacity | | | | | 8.8 | |
| At-Risk, Sibling Abused | | | | | 3.1 | |
| Substantial Risk | -- | -- | -- | -- | 5.6 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** | | | | | | |
| -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 72.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 17.7 | See technical notes |
| **Maternal depression** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 6.3 | See technical notes |
| **Birth interval** | | | | | | |
| -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 15.1 | See technical notes |
| **Breastfeeding** | | | | | | |
| -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 37.8 | See technical notes |
| **Children with special needs** | | | | | | |
| -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.1 | See technical notes |
| **Foster care** | | | | | | |
| -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 5.5 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## San Luis Obispo County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 8.8 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.4 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 12.1 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2573.6 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 4073.9 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 58.3 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 11.1 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 25.3 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 9.0 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.5 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.2 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 9.0 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 9.4 | See technical notes |

## San Luis Obispo County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 4.0 | |
| Physical Abuse | | | | | 6.4 | |
| Severe Neglect | | | | | 1.8 | |
| General Neglect | | | | | 67.5 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 8.0 | |
| Caretaker Absence/Incapacity | | | | | 2.6 | |
| At-Risk, Sibling Abused | | | | | 0.0 | |
| Substantial Risk | -- | -- | -- | -- | 9.8 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 77.7 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 17.5 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 15.5 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 12.2 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 72.8 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.5 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 5.5 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## San Mateo County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.0 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.3 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 3.8 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | | -- | 6.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2577.8 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 4086.5 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 51.9 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 12.3 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 21.0 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 9.3 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 4.5 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 3.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 8.6 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 2.4 | See technical notes |

## San Mateo County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 4.1 | |
| Physical Abuse | | | | | 15.6 | |
| Severe Neglect | | | | | 4.1 | |
| General Neglect | | | | | 47.3 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 3.8 | |
| Caretaker Absence/Incapacity | | | | | 9.2 | |
| At-Risk, Sibling Abused | | | | | 7.4 | |
| Substantial Risk | -- | -- | -- | -- | 8.4 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 88.6 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 8.4 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 10.7 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 76.6 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.6 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 1.8 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Santa Barbara County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 10.7 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 5.8 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 5.7 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | | -- | 12.7 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2577.7 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 7391.1 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 6.3 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 14.5 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.3 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 9.7 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 7.1 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 5.1 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 8.4 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 8.5 | See technical notes |

## Santa Barbara County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 5.0 | |
| Physical Abuse | | | | | 10.8 | |
| Severe Neglect | | | | | 5.0 | |
| General Neglect | | | | | 50.9 | |
| Exploitation | | | | | 0.1 | |
| Emotional Abuse | | | | | 7.2 | |
| Caretaker Absence/Incapacity | | | | | 10.6 | |
| At-Risk, Sibling Abused | | | | | 1.6 | |
| Substantial Risk | -- | -- | -- | -- | 8.7 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 73.9 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 10.5 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 8.4 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 12.2 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 56.9 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.1 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 5.7 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Santa Clara County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.1 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.5 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 3.3 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | | -- | 7.6 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2593.4 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6449.7 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | | -- | 25.4 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 14.4 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 19.8 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.1 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 4.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 3.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 11.0 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 4.0 | See technical notes |

## Santa Clara County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 6.0 | |
| Physical Abuse | | | | | 14.4 | |
| Severe Neglect | | | | | 3.9 | |
| General Neglect | | | | | 34.8 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 9.2 | |
| Caretaker Absence/Incapacity | | | | | 9.9 | |
| At-Risk, Sibling Abused | | | | | 10.8 | |
| Substantial Risk | -- | -- | -- | -- | 10.9 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 83.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 8.9 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 7.2 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 11.0 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 62.1 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.2 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 3.1 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Santa Cruz County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 10.3 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.3 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 13.3 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3412.2 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 7494.0 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | | -- | 112.9 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 14.0 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 21.0 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 9.3 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.0 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.3 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 11.2 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 9.2 | See technical notes |

## Santa Cruz County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 4.9 | |
| Physical Abuse | | | | | 8.3 | |
| Severe Neglect | | | | | 9.9 | |
| General Neglect | | | | | 46.3 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 12.9 | |
| Caretaker Absence/Incapacity | | | | | 0.6 | |
| At-Risk, Sibling Abused | | | | | 1.5 | |
| Substantial Risk | -- | -- | -- | -- | 15.6 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 79.9 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 11.4 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 8.0 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 11.6 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 68.7 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 12.6 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 4.5 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Shasta County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.8 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 5.5 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 17.7 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3390.7 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 8200.0 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 136.6 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 17.5 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 14.8 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 19.1 | See technical notes |

## Shasta County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.6 | |
| Physical Abuse | | | | | 4.6 | |
| Severe Neglect | | | | | 4.1 | |
| General Neglect | | | | | 50.9 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 28.7 | |
| Caretaker Absence/Incapacity | | | | | 4.6 | |
| At-Risk, Sibling Abused | | | | | 2.2 | |
| Substantial Risk | -- | -- | -- | -- | 2.3 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 67.8 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 54.3 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 16.1 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 15.2 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 83.7 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.7 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 13.6 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Sierra County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | * | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | * | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 12.7 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 1282.4 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | * | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | * | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | * | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.6 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 15.2 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 39.6 | See technical notes |

## Sierra County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 0.0 | |
| Physical Abuse | | | | | 13.6 | |
| Severe Neglect | | | | | 0.0 | |
| General Neglect | | | | | 59.1 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 9.1 | |
| Caretaker Absence/Incapacity | | | | | 4.5 | |
| At-Risk, Sibling Abused | | | | | 4.5 | |
| Substantial Risk | -- | -- | -- | -- | 9.1 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | * | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | * | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | * | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 9.3 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | * | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20. The designation of "Too Few Events" for domestic violence means the county had no state-funded domestic violence agency.

## Siskiyou County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 11.9 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 8.4 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | -- | -- | 16.4 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2068.8 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6543.5 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 158.9 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 16.9 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 14.8 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 31.7 | See technical notes |

## Siskiyou County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.0 | |
| Physical Abuse | | | | | 3.3 | |
| Severe Neglect | | | | | 0.7 | |
| General Neglect | | | | | 83.4 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 0.0 | |
| Caretaker Absence/Incapacity | | | | | 8.3 | |
| At-Risk, Sibling Abused | | | | | 0.0 | |
| Substantial Risk | -- | -- | -- | -- | 2.3 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 82.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | * | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 16.3 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 77.9 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.8 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 13.7 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Solano County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 10.1 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 7.2 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 6.2 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 9.0 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 4022.1 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 8049.1 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 20.2 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 22.4 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.6 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 10.9 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 6.3 | See technical notes |

## Solano County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 3.6 | |
| Physical Abuse | | | | | 14.1 | |
| Severe Neglect | | | | | 1.0 | |
| General Neglect | | | | | 50.7 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 4.8 | |
| Caretaker Absence/Incapacity | | | | | 9.4 | |
| At-Risk, Sibling Abused | | | | | 7.8 | |
| Substantial Risk | -- | -- | -- | -- | 8.6 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 77.2 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 26.5 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 14.2 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 12.6 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 53.2 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.7 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 3.5 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Sonoma County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 8.0 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 5.8 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 3.6 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | | -- | 10.4 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2214.4 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 5644.1 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 77.5 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 16.6 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.6 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 9.7 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 6.9 | See technical notes |

## Sonoma County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 3.9 | |
| Physical Abuse | | | | | 10.0 | |
| Severe Neglect | | | | | 1.8 | |
| General Neglect | | | | | 48.0 | |
| Exploitation | | | | | 0.1 | |
| Emotional Abuse | | | | | 12.5 | |
| Caretaker Absence/Incapacity | | | | | 5.7 | |
| At-Risk, Sibling Abused | | | | | 4.4 | |
| Substantial Risk | -- | -- | -- | -- | 13.4 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 81.4 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 19.2 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 22.2 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 10.0 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 73.9 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 13.4 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 4.0 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Stanislaus County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 11.7 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.4 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 6.1 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 14.4 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 4943.9 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 5341.7 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | | -- | 52.6 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 22.8 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.5 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.8 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.2 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 16.0 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 13.5 | See technical notes |

## Stanislaus County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 3.5 | |
| Physical Abuse | | | | | 2.7 | |
| Severe Neglect | | | | | 1.0 | |
| General Neglect | | | | | 77.3 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 0.3 | |
| Caretaker Absence/Incapacity | | | | | 2.4 | |
| At-Risk, Sibling Abused | | | | | 9.6 | |
| Substantial Risk | -- | -- | -- | -- | 3.0 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 76.9 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 22.8 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 4.0 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 14.5 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 42.9 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.9 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 3.6 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Sutter County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.6 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.3 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 15.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3197.6 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 5648.4 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 98.3 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 20.3 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.6 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 17.0 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 6.5 | See technical notes |

## Sutter County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 1.0 | |
| Physical Abuse | | | | | 7.2 | |
| Severe Neglect | | | | | 0.5 | |
| General Neglect | | | | | 46.9 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 21.1 | |
| Caretaker Absence/Incapacity | | | | | 10.3 | |
| At-Risk, Sibling Abused | | | | | 2.6 | |
| Substantial Risk | -- | -- | -- | -- | 10.3 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 57.1 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 13.8 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 9.0 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 14.8 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 35.2 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.6 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 4.9 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Tehama County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 7.9 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 5.1 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 16.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2939.2 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 4397.3 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | * | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 21.0 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 14.1 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 19.3 | See technical notes |

## Tehama County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.8 | |
| Physical Abuse | | | | | 10.0 | |
| Severe Neglect | | | | | 6.6 | |
| General Neglect | | | | | 55.5 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 4.8 | |
| Caretaker Absence/Incapacity | | | | | 14.1 | |
| At-Risk, Sibling Abused | | | | | 4.1 | |
| Substantial Risk | -- | -- | -- | -- | 2.1 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 65.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 36.7 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 16.9 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 62.6 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 9.3 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 10.8 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20. The designation of "Too Few Events" for domestic violence means the county had no state-funded domestic violence agency.

## Trinity County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | * | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | * | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | | -- | 19.9 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 777.1 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 3866.7 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 123.3 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | * | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.7 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.5 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.7 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 17.3 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 28.3 | See technical notes |

## Trinity County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.5 | |
| Physical Abuse | | | | | 8.9 | |
| Severe Neglect | | | | | 1.3 | |
| General Neglect | | | | | 72.2 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 3.8 | |
| Caretaker Absence/Incapacity | | | | | 2.5 | |
| At-Risk, Sibling Abused | | | | | 0.0 | |
| Substantial Risk | -- | -- | -- | -- | 8.9 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** | | | | | | |
| -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 63.9 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 83.1 | See technical notes |
| **Maternal depression** | | | | | | |
| -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | * | See technical notes |
| **Birth interval** | | | | | | |
| -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 19.5 | See technical notes |
| **Breastfeeding** | | | | | | |
| -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 85.3 | See technical notes |
| **Children with special needs** | | | | | | |
| -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 11.8 | See technical notes |
| **Foster care** | | | | | | |
| -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 11.1 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Tulare County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 11.3 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.4 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 5.2 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | | -- | | -- | 21.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 4368.7 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 6801.0 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 34.1 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | -- | -- | -- | -- | 19.3 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 20.9 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.0 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 4.9 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.3 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 15.3 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 8.2 | See technical notes |

## Tulare County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 2.2 | |
| Physical Abuse | | | | | 9.1 | |
| Severe Neglect | | | | | 3.5 | |
| General Neglect | | | | | 50.2 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 3.9 | |
| Caretaker Absence/Incapacity | | | | | 6.0 | |
| At-Risk, Sibling Abused | | | | | 20.2 | |
| Substantial Risk | -- | -- | -- | -- | 4.9 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 75.1 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 32.4 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 7.3 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 16.4 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 23.3 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 7.7 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 6.6 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Tuolumne County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 8.3 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 5.3 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 12.5 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2898.9 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 7775.5 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | | -- | 57.3 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 10.0 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.5 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 5.8 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.2 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | | -- | 12.6 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 16.1 | See technical notes |

## Tuolumne County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 1.3 | |
| Physical Abuse | | | | | 7.1 | |
| Severe Neglect | | | | | 3.9 | |
| General Neglect | | | | | 79.4 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 1.9 | |
| Caretaker Absence/Incapacity | | | | | 1.9 | |
| At-Risk, Sibling Abused | | | | | 3.9 | |
| Substantial Risk | -- | -- | -- | -- | 0.6 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 76.0 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 26.7 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 16.6 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 14.9 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 59.9 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 12.4 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 9.8 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Ventura County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.5 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.5 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | 5.6 | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | -- | -- | 8.7 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 2196.2 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 7433.1 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | 17.6 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 17.6 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.3 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 9.7 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 7.1 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 5.1 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 10.0 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 3.7 | See technical notes |

## Ventura County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 6.2 | |
| Physical Abuse | | | | | 7.6 | |
| Severe Neglect | | | | | 1.4 | |
| General Neglect | | | | | 64.3 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 1.9 | |
| Caretaker Absence/Incapacity | | | | | 11.7 | |
| At-Risk, Sibling Abused | | | | | 6.6 | |
| Substantial Risk | -- | -- | -- | -- | 0.4 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 79.9 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 8.5 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 6.2 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 13.4 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 44.4 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.8 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 2.8 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Yolo County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 7.9 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 5.5 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 14.6 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3916.8 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 5217.2 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | | -- | 56.3 | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 23.1 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.6 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 11.2 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 8.8 | See technical notes |

## Yolo County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 3.6 | |
| Physical Abuse | | | | | 7.6 | |
| Severe Neglect | | | | | 4.5 | |
| General Neglect | | | | | 68.5 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 4.5 | |
| Caretaker Absence/Incapacity | | | | | 9.5 | |
| At-Risk, Sibling Abused | | | | | 1.7 | |
| Substantial Risk | -- | -- | -- | -- | 0.2 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 75.3 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 21.1 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 33.5 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 11.6 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 66.3 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 10.4 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 7.0 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20.

## Yuba County Data Table: Summary of Indicators

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Premature birth**<br>-Percent: # live births before 37 weeks/total # live births | -- | -- | -- | -- | 9.7 | See technical notes |
| **Low-birth weight infants**<br>-Percent: # resident live births less than 2500 grams/# resident live births | -- | -- | -- | -- | 6.7 | See technical notes |
| **Infant mortality** (includes death due to neglect)<br>- # infant deaths ages 0-1/1,000 live births | * | -- | -- | -- | -- | See technical notes |
| **Poverty**<br>- # residents below 100% FPL/total # residents | -- | -- | | -- | 16.6 | See technical notes |
| **Crime**<br>- # reported crimes/100,000 residents | -- | -- | -- | -- | 3371.1 | See technical notes |
| - # crime arrests ages 0-19/100,000 juveniles age 0-19 | -- | -- | -- | -- | 4057.7 | See technical notes |
| **Domestic violence**<br>-As determined by each State in conjunction with the State agencies administering the FVPSA | -- | -- | -- | -- | * | See technical notes |
| **School Drop-out Rates**<br>-Percent high school drop-outs grades 9-12 | | -- | -- | -- | 32.5 | See technical notes |
| -Other school drop-out rates as per State/local calculation method | -- | -- | -- | -- | -- | See technical notes |
| **Substance abuse**<br>-Prevalence rate: Binge alcohol use in past month | -- | -- | -- | 22.6 | -- | See technical notes |
| -Prevalence rate: Marijuana use in past month | -- | -- | -- | 8.9 | -- | See technical notes |
| -Prevalence rate: Nonmedical use of pain relievers in past year | -- | -- | -- | 6.6 | -- | See technical notes |
| -Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month | -- | -- | -- | 4.6 | -- | See technical notes |
| **Unemployment**<br>-Percent: # unemployed and seeking work/total workforce | -- | -- | -- | -- | 17.3 | See technical notes |
| **Child maltreatment**<br>-Rate of substantiated maltreatment | -- | -- | -- | -- | 14.4 | See technical notes |

## Yuba County Data Table: Summary of Indicators continued

| Indicator | Title V | CAPTA | Head Start | SAMHSA Sub-State Treatment Planning Data Reports | Other | Comments |
|---|---|---|---|---|---|---|
| **Child maltreatment (continued)** | | | | | | |
| -Rate of substantiated maltreatment by type | | | | | | |
| Sexual Abuse | | | | | 3.6 | |
| Physical Abuse | | | | | 10.2 | |
| Severe Neglect | | | | | 5.1 | |
| General Neglect | | | | | 61.1 | |
| Exploitation | | | | | 0.0 | |
| Emotional Abuse | | | | | 3.3 | |
| Caretaker Absence/Incapacity | | | | | 4.2 | |
| At-Risk, Sibling Abused | | | | | 6.0 | |
| Substantial Risk | -- | -- | -- | -- | 6.3 | See technical notes |
| **Other indicators of at risk prenatal, maternal, newborn, or child health** | | | | | | |
| **Prenatal care** -Percent: # live births to pregnant women who received prenatal care beginning in first trimester/total # live births | 59.2 | -- | -- | -- | -- | See technical notes |
| **Prenatal substance abuse** -Rate of resident labor/delivery hospital discharges with a diagnosis of substance abuse (excluding tobacco) | -- | -- | -- | -- | 21.6 | See technical notes |
| **Maternal depression** -Rate of resident labor/delivery hospital discharges with a diagnosis of depression | -- | -- | -- | -- | 9.9 | See technical notes |
| **Birth interval** -Percent: # mothers ages 15-44 with birth intervals less than 24 months/total # mothers ages 15-44 | -- | -- | -- | -- | 14.9 | See technical notes |
| **Breastfeeding** -Percent in-hospital exclusive breastfeeding | -- | -- | -- | -- | 46.1 | See technical notes |
| **Children with special needs** -Percent of public school students who are enrolled in special education | -- | -- | -- | -- | 14.4 | See technical notes |
| **Foster care** -Rate of children in child welfare supervised foster care (In Care Rate) | -- | -- | -- | -- | 5.9 | See technical notes |

*Note(s): Asterisk denotes counties with too few events, events < 20. The designation of "Too Few Events" for domestic violence means the county had no state-funded domestic violence agency.

# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

# 4. Information on the Quality and Capacity of Existing Programs/Initiatives for Early Childhood Home Visitation in At Risk California Communities

**Maternal, Child and Adolescent Health Program**
**Center for Family Health**
**California Department of Public Health**

## INFORMATION ON THE QUALITY AND CAPACITY OF EXISTING PROGRAMS/INITIATIVES FOR EARLY CHILDHOOD HOME VISITING IN EACH OF THE COMMUNITES IDENTIFIED AS BEING AT RISK

### Introduction

There are no existing statewide, state-based, evidence-based early childhood home visitation programs where home visiting is a primary intervention strategy for providing services to pregnant women and/or children birth to kindergarten entry, excluding programs with few or infrequent visits or where home visiting is supplemental to other services. There are several State agencies that provide management and oversight for a number of health and social service programs which serve as a conduit for federal funding. Though some of these health and social service programs include a home visiting component, home visiting is not the primary service delivery strategy. These State agencies are enumerated below with corresponding information.

California Department of Public Health/Maternal, Child and Adolescent Health Division (CDPH/MCAH)

The Maternal and Child Health Block Grant (Title V of the Social Security Act) is administered by the MCAH Program and the Children's Medical Services (CMS) Branch within the Center for Family Health in CDPH. The mission of the CDPH/MCAH is to develop and implement systems that protect and improve the health of California's women of reproductive age, infants, children, adolescents and their families. CDPH/MCAH promotes a comprehensive approach to perinatal and infant health. All fifty-eight counties and three local municipalities receive allocations that support local infrastructure to conduct culturally sensitive collaborative and outreach activities to improve services for women, infants, and children, to refer them to needed care, and to address state and local priorities for improving the health of the MCAH population.

The Title V Block Grant funds public health programs that seek to ensure:

- access to, and improved quality of health care, for mothers and children
- reduced infant mortality
- provision and access to comprehensive prenatal and postnatal care for women
- increased numbers of children receiving health assessments and follow-up diagnostic and treatment services
- provision and access to preventive and child care services, and rehabilitative services for certain children
- implementation of family-centered, community-based systems of coordinated care for children with special health care needs, and
- provision of toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Medicaid services

CDPH/MCAH administers many programs and initiatives, and has three programs that may have a home visiting component, the Adolescent Family Life Program, the Black Infant Health Program and the MCAH Local Health Jurisdictions:

- The **Adolescent Family Life Program (AFLP)** uses a case management model to address the social, medical, educational, and economic consequences of adolescent pregnancy and parenting on the adolescent, her child, family, and society. The AFLP program provides services to approximately 4,000 adolescents in 38 local health jurisdictions throughout the state. In FY 2009-10, total AFLP Title V funding was $8,460,418. When home visits are done, they are on a case-by-case basis, and client-specific goals and objectives are developed as part of an Individual Service Plan. Home visiting is a component, but not a primary service delivery strategy, of some AFLP programs.

- The **Black Infant Health (BIH)** program has the primary goal of reducing African American infant mortality in California. BIH uses individualized case management and group interventions to support African American women throughout their pregnancies, to improve birth outcomes. The BIH program currently serves approximately 3,000 women in 16 LHJs in the state. BIH program services are located in local health jurisdictions where over 75% of California's African American live births occur. In FY 2009-10, total BIH Title V funding was $4,315,000. Like AFLP programs, home visiting is a component, but not a primary service delivery strategy, of some BIH programs and is a supplement to other core services.

- The **MCAH Local Health Jurisdictions (LHJs)** belong to strong collaboratives, coalitions and partnerships with community groups, faith-based organizations, schools, medical communities, and policy makers. The collaboratives serve as a venue to coordinate with other agencies and increase capacity on specific issues related to women, infants, children and adolescents and their families, such as perinatal substance use, adolescent substance use, teen pregnancy, SIDS, breastfeeding, nutrition, physical activities, child safety and injury prevention, early access to prenatal care and oral health. The LHJs participate in various outreach activities to recruit and refer pregnant women and their families to public insurance and health services. In terms of service delivery, MCAH LHJs may provide one-time or episodic home visiting services to high risk individuals, such as an in-home postpartum visit requested by a local hospital or community health care provider. Further, MCAH LHJs may develop or integrate home visiting services in order to address community-specific needs. As reflected in the findings of this needs assessment, some MCAH LHJs have implemented nationally recognized home visiting programs or have made local adaptations of these home visiting models. The state's role is to monitor and encourage local MCAH efforts, and provide technical assistance through a number of health advisors. The state also maintains a comprehensive public website with information and contacts for all its programs. Most MCAH LHJs maintain their own public websites containing specific local program information.

*CDPH/MCAH Early Childhood Programs*

CDPH/MCAH has authority over HRSA funded **California's Early Childhood Comprehensive Systems (ECCS)**, a statewide effort toward comprehensive strategic planning in the areas of early childhood/school readiness. ECCS members include Medi-Cal Managed Care, American Academy of Pediatrics (AAP), Children Medical Services (Early Periodic Screening, Diagnosis, and Treatment), the Departments of Alcohol and Drugs, Developmental Services, Education, Managed Health Care Services, Mental Health, Social Services, and First 5 California. Non-state partners include First 5 County Commissions, California Association of Health Plans,

Lucile Packard Children's Hospital, University of California Davis and Los Angeles, Kaiser Permanente, WestEd Center for Prevention and Early Intervention. Much of this broad planning in ECCS has been accomplished through collaborative work between CDPH/MCAH and First 5 California.

**CA Project LAUNCH (CPL)**, a $4.2 million Substance Abuse and Mental health Administration (SAMHSA) grant awarded over 5 years to MCAH in 2009 provides a unique opportunity for the CDPH/MCAH and the County of Alameda Maternal, Paternal, Child and Adolescent Health Program (MPCAH) to leverage the broader work of the Alameda County Behavioral Health Care Services and the Alameda County Health Care Services Agency to create a continuum of age-appropriate developmental services for children from birth through 8 years of age. Through CPL, the CDPH/MCAH and the MPCAH will partner with First 5 Alameda County to demonstrate the feasibility and impact of recommended state policy changes. These policies will support counties in establishing and sustaining comprehensive developmental care continuums that enable children 0-8 years to be healthy and ready to learn.

CPL embodies the Alameda County MPCAH's diversity principle to honor and respect the diversity of Alameda County children and families in the design and delivery of all county supported programs and services. In partnership with First 5 Alameda County, training on issues of diversity is conducted for all contracted MCAH and First 5 Alameda County service providers. Linguistic, cultural and disability supports are infused at every service level to increase access to care. Cultural Access Services (CAS), a support strategy within First 5 Alameda County, works with all providers to insure each family has access to First 5 Alameda County programs and services. CAS provides outreach, interpretation, translation, training, and technical assistance to MCAH and First 5 Alameda County staff and agencies.

Under the umbrella of the ECCS grant, the CDPH/MCAH helped to establish the **California Statewide Screening Collaborative (CSSC)***,* which serves as the ECCS and the CPL Steering Committee*.* This is a collaborative statewide activity involving multiple partners, including American Academy of Pediatrics and the American Academy of Family Practice, to implement the Assuring Better Child Health and Development (ABCD) Screening Academy's Implementation Matrix. The ABCD Implementation Matrix is an outcome of a MCAH led national health initiative sponsored by the National Academy for State Health Policy (May 2007-June 2008). The ABCD Implementation Matrix is intended to enhance California's capacity to promote and deliver effective and well-coordinated health, developmental and early mental health screenings for young children ages 0-5 years. The CSSC and the ABCD Implementation Matrix are ongoing outcomes under the ECCS grant. Given CSSC's scope, this collaborative will also serve as the State Council on Young Child Wellness to maintain alignment between ECCS and CPL goals and synergy between their respective activities.

**The State Interagency Team (SIT)** provides leadership and guidance to facilitate systems improvements that benefit communities and children 0-5 years and their families. SIT members are generally at the "Deputy" level and have decision-making authority. The CSSC has adopted the goals of SIT which are to: 1) build community capacity to promote positive outcomes for vulnerable families and children; 2) maximize funds for programs and services; 3) remove systemic and regulatory barriers; 4) ensure that policies, accountability and planning are outcome-based; 5) promote practice that engages and builds on the strengths of families, youth and children; and 6) share information and data.

*Other CDPH/MCAH Programs (Without a Home Visiting Component)*

CDPH/MCAH has expertise and past experience specific to preconception health. CDPH/MCAH took the lead on preconception health in the state over four years ago through the establishment of the **Preconception Health Council of California (PHCC)** in collaboration with March of Dimes California Chapter. A community-driven, statewide forum for planning and decision-making for the integration, development and promotion of optimal health before pregnancy, the PHCC is composed of representatives from organizations and programs that are stakeholders in the development of preconception care services in California MCAH Program representatives participate in the PHCC quarterly meetings and workgroups. The PHCC achieves consensus on goals, objectives, and activities in the development of a statewide strategic plan in accordance with the Centers for Disease Control's (CDC) Select Panel Recommendations on preconception care. Each of the three workgroups—Clinical/Research, Finance/Policy, and Public Health/Consumer—has developed an action plan for its particular area of focus and workgroup members are collaborating with local partners to implement these plans. Implicit in preconception health education is a life course perspective which encourages a holistic approach to women's health that promotes care for women and girls across their lifespan, regardless of the choice to reproduce, and recognizes the impact of social and environmental factors on maternal and infant outcomes.

**The CDPH/MCAH Perinatal Substance Use Prevention Program** efforts related to perinatal substance use prevention are conducted through partnerships and collaboration. CDPH/MCAH representatives participate in the:

- California Fetal Alcohol Spectrum Disorders (FASD) Task Force, an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. Led by the Arc of California, the goal of the task force is to advance the effective prevention and treatment of FASD.

- State Interagency Team Workgroup on Alcohol and Other Drugs, composed of members from the CDPH MCAH, Social Services, Mental Health, Education, Developmental Services and Alcohol and Drug Programs (lead). The goal of the workgroup is to identify interagency and systems issues that, if addressed, could improve identification and treatment of families and children impacted by alcohol and other drugs.

The **12 Regional Perinatal Programs of California (RPPC)** provide planning and coordination to ensure that all high-risk patients are matched with the appropriate level of care. The RPPC develop communication networks, perform needs assessments, disseminate education materials, assist hospitals with data collection for quality improvement, provide hospitals with feedback on their performance (Perinatal Profiles), and provide hospital linkages to California's Perinatal Transport Systems. The RPPC have the flexibility, neutrality, and credibility to bridge public and private sectors. They offer the opportunity for multiple counties, hospitals, clinics, individual providers and health plans to work collaboratively to identify and address common perinatal concerns. RPPC works closely with other MCAH perinatal programs described below.

**California Maternal Quality Care Collaborative (CMQCC)** is a collaborative to advance California maternity care through data driven quality improvement. The CMQCC challenge is to impact 350 Hospitals with Obstetrical Services in the State of California, encompassing 550,000 annual California births. CMQCC's goal is the creation of a statewide, sustainable,

collaborative, evidence-based, and data-driven quality improvement system that will provide leadership and tools for the achievement of:

- Documentable and continuous improvements in maternity outcomes
- A reduction in disparities of care processes and outcomes
- The engagement of multiple stakeholders/groups (i.e., clinicians, women, communities, insurers, researchers, organizations and legislators) who will work together to improve maternal and newborn health outcomes in California

CMQCC has an American College of Obstetricians and Gynecologists representative on the Executive Board, working in close collaboration to develop the toolkit to reduce elective induction prior to 39 weeks.

**California Perinatal Quality Care Collaborative (CPQCC)** is a group of public and private, California leaders in healthcare, committed to improving care and outcomes for the State's pregnant mothers and newborns. The Collaborative is comprised of 127 member hospitals, representing over 90% of all neonates cared for in California Neonatal Intensive Care Units, as well as other key stakeholders, including 1) public and private, obstetric and neonatal providers, 2) health care purchasers, 3) public health professionals, and 4) private sector health industry specialists. The Collaborative's initial focus has been on the development of perinatal and neonatal outcomes and information, which allows for data driven performance improvement and benchmarking throughout California. Key CPQCC activities include:

- Developing a responsive, real-time, risk-adjusted, perinatal data system
- Implementing a comprehensive strategy for benchmarking and data driven quality improvement activities
- Providing topic-specific, quality improvement trainings and toolkits
- Researching best practices and continual reassessment of outcomes of performance improvements initiated

The **California Diabetes and Pregnancy Program (CDAPP)** which is designed for diabetic pregnant women to mitigate adverse maternal and infant morbidity and mortality. To help accomplish this, CDAPP provides comprehensive technical support and education to medical personnel and community liaisons to promote improved perinatal outcomes. Medical practices or clinics that provide direct patient care to women with diabetes while pregnant and whose medical providers undergo standardized CDAPP trainings become known as Sweet Success Affiliates.

MCAH participates in the **California Breastfeeding Coalition (CBC)** consisting of state breastfeeding advocates and community organizations. The mission of this group is to improve the health and wellbeing of Californians by working collaboratively to protect, promote, and support breastfeeding. CBC serves to galvanize new and existing collaborative relationships among state agencies and associations, hospitals, and community-based breastfeeding support organizations throughout California.

**California Pregnancy-Related and Pregnancy-Associated Mortality Review (CA-PAMR)** seeks to identify women in California whose deaths were related to pregnancy or associated

with pregnancy as defined by Center for Disease Control and Prevention and the American College of Obstetrics and Gynecology. CDPH/MCAH, together with the University of California, San Francisco and the Public Health Institute will analyze the causes of and risk factors for their deaths, including both medical and psychosocial factors. Analyses ultimately will improve public health programs and clinical practices in California to reduce maternal deaths.

**California Birth Defects Monitoring Program** - collects and analyzes data to identify opportunities for preventing birth defects and improving the health of babies**.**

*Other CDPH Programs that Address Women, Children and/or are Pregnancy*

**California Asthma Public Health Initiative** - improves the quality of life for all children and adults with asthma in California. Asthma is a public health priority for California because it continues to directly affect millions of individuals of all ages across the state. Over five million Californians have been diagnosed with asthma in their lifetime and more than half of them have an asthma attack each year. Asthma reduces the quality of life for millions of people and causes considerable economic costs for California.

**California Newborn Screening Program** - screens newborns for 76 conditions. Disorders screened for by the program have varying degrees of severity. If identified early many of these conditions can be treated before they cause serious health programs.

**California Obesity Prevention Program** - working towards the goal of increasing physical activity, improving nutrition, and preventing obesity among all Californians.
Specifically, the program addresses environmental and policy change strategies related to six CDC target areas including: increasing fruit and vegetable consumption, decreasing consumption of energy-dense foods, increasing physical activity, decreasing television viewing (screen time), increasing breastfeeding initiation, duration, and exclusivity and decreasing consumption of sugar-sweetened beverages.

**California Project LEAN (Leaders Encouraging Activity and Nutrition)** - works to advance nutrition and physical activity policy in schools and communities in order to prevent obesity and its associated chronic diseases. Specifically, it increases opportunities for healthy eating and physical activity in communities across California to reduce the prevalence of obesity and chronic diseases such as heart disease, cancer, stroke, osteoporosis, and diabetes. Services including training and technical assistance, materials development, project development and management, and conference planning.

**California Tobacco Control Program (CTCP)** - improves the health of all Californians by reducing illness and premature death attributable to the use of tobacco products. Through leadership, experience and research, CTCP empowers statewide and local health agencies to promote health and quality of life by advocating social norms that create a tobacco-free environment.

**Child Passenger Safety In California** – California's Vehicle Occupant Safety Program aims to prevent unnecessary death and disability to California's children by strengthening and expanding California's child passenger safety infrastructure.

**Childhood Lead Poisoning Prevention Branch** - a children's environmental health program offering multi-layered solutions to this complex problem. The mission of the Childhood Lead Poisoning Prevention Branch is to eliminate childhood lead poisoning by identifying and caring

for lead burdened children and preventing environmental exposures to lead.

**Drowning Prevention: Toddler Pool and Spa Safety** - provides information and a Safety Guide as an educational brochure for pool and spa safety.

**Food and Drug Branch** - charged with the implementation of Assembly Bill 121, to prevent the sale of adulterated candy to infants, young children, and pregnant women. Lead in the Candy Program is responsible for the collection and testing of candy samples. Enforcement action is taken when adulterated candies are identified and appropriate notifications are made to local environmental health directors and the public.

**Gynecologic Cancer Information Program** - increases awareness and education regarding gynecologic cancers and requires medical providers to distribute to their patients information regarding women's gynecologic cancers, including signs and symptoms, risk factors, benefits of early detection through appropriate diagnostic testing and treatment options.

**HIV Community Prevention Section** - takes a leadership role in the delivery of appropriate HIV education and prevention services through collaboration and partnership with affected and infected communities. Through the community planning process, communities are empowered to develop local prevention programs that meet the needs of the communities they serve to prevent the spread of HIV/AIDS.

**Immunization Branch** - provides leadership and support to public and private sector efforts to protect the population against vaccine-preventable diseases. The California Vaccines for Children Program helps families by providing free vaccines to doctors who serve eligible children 0 through 18 years of age.

**Infant Botulism Treatment and Prevention Program** - improves the treatment of infant botulism and prevent infant botulism and related diseases.

**FamilyPACT** - provides no-cost family planning services to low-income men and women, including teens. Many doctors and clinics all over California are part of the FamilyPACT program.

**Teen Pregnancy Prevention** - utilizes a variety of approaches and strategies to: reduce teenage and unintended pregnancy and absentee fatherhood, promote responsible parenting and assist adolescents in accessing clinical services.

**Prenatal Screening Branch (PNS)** – activities are focused on detecting birth defects during pregnancy. PNS is working to assure Prenatal screening services and follow-up services where indicated are available to all pregnant women in California. The PNS administers the Prenatal Screening Program, in the past known as the "Expanded AFP Program". Prenatal screening currently offers three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect.

**Rape Prevention and Education Program (RPE)** - prevents first-time victimization and perpetration of sexual violence, rather than helping people who have already been victimized. California's statewide survey and victim service data suggest that thousands of women are forced into unwanted sex each year. Over a million California women have suffered one or more sexual assaults, and most before age 18. All women are at some risk of sexual assault, and the RPE Program targets males and females of all ages, races, and circumstances.

**School Health Connections** - a joint program between Department of Public Health (CDPH) and the California Department of Education (CDE), SHC's goal is to ensure that children are healthy and ready to learn. SHC takes advantage of the pivotal position of schools in reaching children and families by combining health education, health promotion and disease prevention, and access to health-related services in an integrated and systematic manner.

**Vehicle Occupant Safety Program -** aims to prevent unnecessary death and disability to California's children by strengthening and expanding child passenger safety infrastructure.

**Violence Prevention Program –** a systematic primary prevention process that promotes healthy behaviors and environments, and reduces the likelihood or frequency of intimate partner violence and sexual violence. The primary focus is all forms of violence against women.

**Women, Infants and Children (WIC) Program -** is a federally-funded health and nutrition program for women, infants, and children. WIC helps families by providing checks for buying healthy supplemental foods from WIC-authorized vendors, nutrition education, and help finding healthcare and other community services. In California, 82 WIC agencies provide services locally to over 1.4 million women, infants and children each month at over 600 sites throughout the State.

Department of Health Care Services (CDHCS)

The mission of the California Department of Health Care Services is to preserve and improve the health status of all Californians by working closely with health care professionals, county governments, and health plans to provide a health care safety net for low-income individuals and persons with disabilities. CDHCS finances and administers a number of individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal), California Children's Services program, the Child Health and Disability Prevention program, and Genetically Handicapped Persons Program.

CDCHS also funds a number of health initiatives designed to deliver health care services to low income individuals and families who meet eligibility requirements. The health initiatives help with access to comprehensive health services and ensure appropriate and effective expenditure of public resources to serve those with the greatest health care needs. CDCHS provides administration and oversight of local programs that have home visiting as a service strategy, such as the American Indian Infant Health Initiative, described below.

The **American Indian Infant Health Initiative (AIIHI)** is funded by Federal Title V Maternal and Child Health (MCH) funds through the Indian Health Program, and serves over 200 families. The program receives $424,000 annually to provide extensive home visiting and case management services to high-risk Indian families in the five counties in California that experience the most severe Indian MCH disparities (Humboldt, Sacramento, San Bernardino, Riverside, and San Diego counties).

Home visitors are paraprofessionals who work under the supervision of public health nurses. Home visitors in San Bernardino train for six weeks to be community health representatives: There is no formal training process in the other five LHJs. The paraprofessional home visitors carry an average caseload of 15 families each.

Families are seen every 1-2 weeks in the home and receive services using an informal modification of the Healthy Families America (HFA) program. AIIHI home visitors provide basic health care information to high-risk or potentially at-risk families with young children under age 5. Referred families remain in the program while any child remains in the home under the age of 5, and while the families are deemed to be at-risk.

AIIHI programs adhere to the 12 critical elements of the HFA program, but the program is modified to meet community and individual needs. AIIHI does not specify how the HFA program may be modified, or state any restrictions regarding what can and cannot be done. AIIHI connects families with available resources in the American Indian communities such as the WIC health and nutrition program, parenting classes, child safety classes, and other social services. No formal quality assurance or program improvement components are in place, and this represents a difference from the way a program would operate if there were a formal Agreement Funding Application (AFA) with HFA.

CDHCS also administers the Children's Medical Services program, which consists of the California Children's Services (CCS), Child Health and Disability Prevention (CHDP), Health Care Program for Children in Foster Care, Hearing Conservation Program, High Risk Infant Follow Up, Newborn Hearing Screening Program, and Pediatric Palliative Care programs.

The CCS program provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with CCS-eligible medical conditions. Examples of CCS-eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases that produce major sequelae. CCS also provides medical therapy services that are delivered at public schools.

The CCS program is administered as a partnership between county health departments and DHCS. Currently, approximately 70% of CCS eligible children are also Medi-Cal eligible. The Medi-Cal program reimburses their care. The cost of care for the other 30% of children is split equally between CCS Only and CCS Healthy Families programs. The cost of care for CCS Only is funded equally between the State and counties. The cost of care for CCS Healthy Families is funded 65% by Federal Title XXI, 17.5% by the State, and 17.5% by county funds. Health and Safety Code, Section 123800 et seq. provides statutory authority for the CCS program.[140] The explicit legislative intent of the CCS program is to provide necessary medical services for children with CCS medically eligible conditions whose parents are unable to pay for these services, wholly or in part. The statute also requires the DHCS and the county CCS program to seek eligible children by cooperating with local public or private agencies and providers of medical care to bring potentially eligible children to sources of expert diagnosis and treatment.

The CCS program is mandated by the Welfare and Institutions Code and the California Code of Regulations (Title 22, Section 51013) to act as an "agent of Medi-Cal" for Medi-Cal beneficiaries with CCS medically eligible conditions. Medi-Cal is required to refer all CCS-eligible clients to CCS for case management services and authorization for treatment. The statute also requires all CCS applicants who may be eligible for the Medi-Cal program to apply for Medi-Cal.

In counties with populations greater than 200,000, county staff perform all case management activities for eligible children residing within the county. For counties with populations under 200,000, the Children's Medical Services (CMS) Branch provides medical case management and eligibility and benefits determination through its regional offices located in Sacramento, San Francisco, and Los Angeles.

The funding source for a county CCS program is a combination of monies appropriated by the county, State General Funds, and the federal government. AB 948, the realignment legislation passed in 1992, mandated that the State and county CCS programs share in the cost of providing specialized medical care and rehabilitation to physically handicapped children through allocations of State General Fund and county monies. The amount of State money available for the CCS program is determined annually through the Budget Act.

California Department of Developmental Services (CDDS)

Families whose infants or toddlers have developmental delay or disabilities, or are at risk for developmental delay or disabilities may qualify for developmental monitoring or early intervention services through the Birth to 36 Month program at CDDS. Regional centers operated by CDDS offer programs for families with infants and young children who qualify for prevention services, based on risk factors. For those infants and toddlers with identified developmental disorders, CDDS offers the Early Start program that provides appropriate early intervention and family support services. As of August 4, 2010, there are 3,345 children under the age of 36 months enrolled in the CDDS prevention program, and 25, 575 children under the age of 36 months enrolled in the Early Start program.

Through a regional center program, an Infant Service Coordinator performs a home visit for each Early Start enrolled child every six months to review progress, goals, and services. Home visiting is not the primary service strategy for infants and toddlers, but is a service that is integrated into CDDS programs.

California Department of Social Services (CDSS)

The California Department of Social Services/Children and Family Services Division (CDSS/CFSD), is the state agency designated by statute to promulgate regulations, policies, and procedures necessary to oversee the State's Child Welfare Services system and to ensure safety, permanency, and well-being for California's children. California's child welfare system is administered at the local level by 58 counties, each governed by a County Board of Supervisors. Federal and state funding requirements mandate spending for the prevention of child abuse and neglect, and for early intervention programs. The counties receive the majority of the funds that are allocated directly, and determine how the funds are to be spent by a local needs assessment process.

The Welfare and Institutions Code, Sections 18952-18958, gives statutory authority to the CDSS Office of Child Abuse Prevention to administer state and federal funds for child abuse prevention. CDSS administers federal funding of the **Child Abuse Prevention and Treatment Act** (CAPTA). Title II of the Federal CAPTA Amendments of 1996 (most recently reauthorized in June of 2003, P.L. 108-36) established the Community-Based Child Abuse Program (CBCAP) Program. The majority of the CAPTA/CBCAP funds are allocated directly to counties in California. The counties decide how to spend the allocations in accordance with local needs assessments and funding stream priority guidelines.

CBCAP was established to:

- support community-based efforts aimed at the prevention of child abuse and neglect
- support networks of coordinated resources and activities to strengthen and support families to reduce the incidence of child abuse and neglect, and
- foster an understanding, appreciation, and knowledge of diverse populations in order to be effective in preventing and treating child abuse and neglect

CBCAP federal funding is distributed to states and territories under a formula grant. Each state must provide a 100% cash match in non-federal funding of the total allotment. The match funds come from State or private funding. CBCAP funds may be expended for primary and secondary prevention activities. The Office of Child Abuse Prevention (OCAP) oversees grants, contracts, and projects supported by the state-funded Child Abuse Prevention, Intervention and Treatment (CAPIT) and the State Children's Trust Fund.

CAPIT is the State General Fund funding stream that acts as the cash match for the federal CBCAP that is allocated 90% to the counties for child abuse prevention and treatment efforts. The targeted priority is for high risk families being served by county child welfare departments or other children referred by other sources as high risk. Service priority is for prevention programs that identify and provide services to isolated families, particularly those with children five years of age or younger. CAPIT is one funding stream that is braided with CBCAP on the local level.

Fifty-seven counties participate in the CBCAP allocation process in California. Individual counties provide additional CAPIT-funded services, including workshops, hospital outreach, individual and group therapy, mentoring, and crisis hotlines.

Table 25 depicts the funding type, services provided, and number of counties providing various services. The OCAP survey does not collect information about home visiting, and CDSS does not have information about whether the home visiting that is funded by CBCAP or CAPIT is a primary delivery strategy or a supplemental service.

**Table 25. Funding Sources, Services, and County Participation**

| Funding Source | Number of Participating Counties |
|---|---|
| **CBCAP** | |
| • ***Home visiting*** | ***27*** |
| • Parenting class | 34 |
| • Parent mutual support | 13 |
| • Respite care | 7 |
| • Family Resource Center | 12 |
| • Family support program | 22 |
| | |
| **CAPIT** | |
| • ***Home visiting*** | ***52*** |
| • Parent education and support | 35 |
| • Psychiatric evaluations | 8 |
| • Respite care | 12 |
| • Day care/Child care | 23 |
| • Transportation to/from services | 26 |
| • Multidisciplinary team services | 14 |
| • Teaching and demonstrating homemakers | 17 |
| • Health services | 10 |

Source: CDSS Survey data, FY 2008-09

A second Federal program administered by CDSS is the Title IV **Temporary Assistance to Needy Families** (TANF) program. The TANF program is funded by a block grant administered by state, territorial, and tribal agencies. Funded activities include:

- assisting needy families so that children can be cared for in their own homes
- reducing the dependency of eligible parents by promoting job preparation, work and marriage
- preventing pregnancies in single mothers
- encouraging the formation and maintenance of two-parent families

The TANF program in California is called **California Work Opportunity and Responsibility to Kids (CalWORKs).** CalWORKs provides temporary cash assistance to meet the basic needs of families. The program funds education, employment, and training programs to assist a family's move toward self-sufficiency. CalWORKS offers assessment of eligible family needs for substance abuse intervention, disabilities assessment, vocational education training, and other welfare-to-work (WTW) interventions.

The CalWORKS program performs limited home visiting, on a case-by-case basis. For example, a county may implement a home visiting program that focuses on re-engaging recipients who are failing to meet requirements in the WTW program, and removing barriers to participation. The focus is not on the child, nor is home visiting the primary service delivery strategy.

CDSS also administers the federal **Promoting Safe and Stable Families (PSSF)** program, created by the Omnibus Budget Reconciliation Act of 1993, amending Title IV-B of the Social Security Act. PSSF is one of the sources of federal funds directed toward the prevention of problems that bring families to the attention of the child welfare system, such as child neglect, and child physical, emotional, or sexual abuse. The program offers family preservation services including family support and referrals, adoption promotion and support, and time-limited family reunification services following foster care placement.

PSSF federal funding is distributed to states under a formula grant. The State must provide a 25 percent funding match. California meets the required 25 percent federal match using funds from the State Family Preservation Program. The State Family Preservation Program serves 15 counties in California, providing a wide array of services. The priority for services is to families whose children are at risk of being placed out of the home or remaining out of the home.

No direct services are provided at the State level. All services are provided at county levels from federal and state funds administered by OCAP.

The Table 26 depicts the funding type, services provided, and number of counties providing programs under PSSF. OCAP does not collect data regarding the home visiting component of PSSF, and CDSS does not have information whether the home visiting services are a primary service delivery strategy or a supplemental service.

**Table 26. PSSF Program Services and County Participation**

| PSSF - Family Support Services | Number of Participating Counties |
|---|---|
| | |
| • ***Home visiting*** | ***39*** |
| • Drop-in Center | 12 |
| • Parent education | 39 |
| • Respite care | 6 |
| • Early development screening | 16 |
| • Transportation | 21 |
| • Information and referral | 38 |

Source: CDSS Survey data, FY 2008-09

At the local level, each County Board of Supervisors is responsible for approving services and authorizing the expenditure of the funds depending upon local priorities. Within statutory and regulatory frameworks, counties provide services necessary to meet the needs of at-risk children and families.

The service needs are identified by administering the comprehensive integrated County Self Assessment (CSA) every three years. As a result of review of a Peer Quality Case Review process and analysis of the results of the CSA, a county determines the gaps in services and makes decisions about what services are required to improve child welfare and probation outcomes. Within the context of county resources and collaborative partnerships, the county determines what programs or services need to be developed, implemented, or maintained. CDSS requires that the county prepare a three year plan based on the results of the CSA that addresses how prevention and family support activities are coordinated, how CBCAP, CAPIT, and PSSF funds will be used to fund these activities, and how services will be provided.

The CDSS Outcome and Accountability System for Child Welfare uses county data reports to track state and county performance once every three years. CDSS issues data reports about outcomes for each county. The data are used to inform and guide assessment and planning processes, and is used to analyze policies and procedures. Peer county involvement and the exchange of promising practices can help illuminate specific practice changes that may enhance future performance. The CDSS data are integrated with the CBCAP/CAPIT/ PSSF plan, so counties can maximize their resources, increase partnerships, and enhance communication between their child welfare, probation, and the local child abuse prevention networks

Counties report annually to the OCAP regarding services provided, participation rates, the role of the child abuse prevention councils, CBCAP peer reviews, client satisfaction, CBCAP outcomes, activities to promote parent leadership, outreach efforts, public awareness activities, efforts in collaboration and coordination, and interdisciplinary/innovative services. The information is aggregated and used to respond to the Annual Progress Services Report, National Child Abuse and Neglect Data System, and the CBCAP annual application and report.

*Home Visiting Programs*

CDSS provides oversight and administration for programs in which home visiting is a service strategy, however the OCAP does not capture the specific type of service delivery strategy during the annual reporting process. Forty-one of the 58 counties reported using one or more prevention funding sources to fund some kind of home visiting program during FY 2008-09. Table 27 shows the funding sources for home visiting and the unduplicated participation rates reported by counties.

**Table 27. Funding Sources for Home Visiting Services and Numbers of Participants in the State**

| Funding Source | Number of Participants Statewide |
|---|---|
| | |
| **CBCAP** | |
| • Participants | 38,251 |
| • Families | 10,938 |
| | |
| **CAPIT** | |
| • Participants | 29,541 |
| • Families | 5,446 |
| | |
| **PSSF** | |
| • Participants | 15,972 |
| • Families | 6,387 |

Source: CDSS Survey data from FY 2008-09

*CDSS Assessment of Unmet Needs*

The Federal Child and Family Services Review required California to prepare its own Assessment of Strengths and Needs in 2007, as part of a review of the state's child welfare system. The state assessment identified two outcomes in need of improvement:

- Stability of placements in foster care and foster care re-entry, and
- Safety for children who are victims of repeated maltreatment

In addition, of the 90,472 reports of abuse and neglect that were substantiated in California during 2009, 61% were for neglect. Major factors contributing to the neglect of children include parents who have mental health issues and/or alcohol and drug addictions.
Assessments also identified a greater need for family preservation and support services in rural areas where geographic isolation is a challenge to families needing preventive services. Identified gaps in rural areas include:

- the lack of readily accessible transportation to and from services, which makes it more difficult for at-risk families to access services, and for social and health service agencies to provide services
- limited adoption services
- the need for more culturally appropriate resources and services in languages other than English

California Department of Education (CDE)

The CDE oversees the state's diverse and dynamic public school system that is responsible for the education of more than six million children and young adults in more than 10,000 schools. The CDE, run by the State Superintendent of Public Instruction, is responsible for enforcing education law and regulations and for continuing to reform and improve public elementary school programs, secondary school programs, adult education, some preschool programs, and child care programs.

CDE funds a number of infant and toddler services, but does not specifically require that any of these services be home-based. Additionally, there is no federal requirement that CDE provide direct program oversight of these programs due to the federal-to-local funding model which resulted in Head Start programs often not included in policy and implementation discussions at the state level. However, the ACF recognized the important role of states in the development and implementation of policies and initiatives that affect low-income families and their children. As a result, Collaboration Office grants were developed to create a visible presence for Head Start at the state level and to assist in the development of multi-agency and public-private partnerships among Head Start and other interested stakeholders. Head Start is a direct federal-to-local program administered by over 1,600 locally based public or private organizations, called "grantees," across the country.

Head Start is a national program administered by the Office of Head Start within the Administration on Children, Youth and Families, Administration for Children and Families (ACF), Department of Health and Human Services. Head Start programs provide comprehensive developmental services for low-income children from birth to entry into elementary school.

Head Start is currently funded at over $6.8 billion and serves more than 909,000 low-income children and families nationwide. The program is child-centered, family-focused, comprehensive, and community-based. Head Start services are designed to address developmental goals for children, employment and self-sufficiency goals for adults, and support for parents in their work and child-caring roles.

**Identification of Early Childhood Home Visitation Services**

Initial Steps Taken to Assess Existing Home Visiting Programs/Initiatives

Upon the signing into law of the Patient Protection and Affordable Care Act, CDPH/MCAH convened a meeting of local MCAH Directors who were anticipating availability of federal home visiting funds. Together, CDPH/MCAH and these local MCAH leaders developed the initial strategy for California which focused on 1) establishing mechanisms of communication with stakeholders and partners, and, 2) identifying key stakeholders to engage in the process and keep informed, 3) preparing for the required needs assessment, and, 4) researching evidence-based home visiting models.

CDPH/MCAH established a Home Visiting Collaborative Workgroup to provide guidance to the state, particularly at critical junctures in the planning process. The workgroup membership evolved to consist of the following: five local MCAH Directors who were designated by their colleagues to represent local MCAH and local public health nursing directors; First 5 Association; California First 5; CDSS; CDADP; and the CDE Head Start State Collaboration Office. In order to promote communication, the CDPH/MCAH Home Visiting webpage was developed to make available all supporting documents including the ACA legislation, the ACA Home Visiting grant guidance, Frequently Asked Questions and copies of periodic stakeholder communications that were also sent to a growing e-mail distribution list. Contact was made with key state partner agencies listed above in order to gain a better understanding of their current home visiting efforts as well as availability of data and required reports that would inform the needs assessment process. Existing local home visiting capacity surveys were identified including the First 5 Association survey of local First 5 commission funded home visiting programs. Finally, critical review of evidence based home visiting models was conducted including identification of key publications as well as contacting national/state representatives of evidence based home visiting programs to supplement publicly available information and arrange for in person presentations for CDPH/MCAH and partners.

Capacity Assessment Home Visiting Survey

As previously declared, the State of California does not provide an early childhood home visitation program or initiative. In California, a variety of early childhood home visiting programs are in existence and operating at the local, county level. To learn more about these home visiting programs, CDPH/MCAH developed a Capacity Assessment Home Visiting Survey (see Appendix II). The Capacity Assessment Home Visiting Survey provides a valuable snapshot of home visiting programs throughout California, and is the basis for the information presented in this section about the quality and capacity of existing programs and initiatives for early childhood home visiting in California's at risk communities.

The Capacity Assessment Home Visiting Survey also identifies State and Federal funding use, in the most recent calendar or fiscal year, for all maternal, infant/and/or early childhood home visiting services. Through this information, CDPH/MCAH can determine which of California's at risk counties may have existing resources and infrastructure in place for home visiting programs

and initiatives. Though this information is very general, it is a starting place for the development of California's Updated State Plan.

At the time of the dissemination of the Capacity Assessment Home Visiting Survey, CDPH/MCAH was working in the absence of federal guidance prior to the release of the SIR on August 19, 2010. The compacted timeline resulted in a short turn around time for MCAH Directors to provide their respective responses to the Capacity Assessment Home Visiting Survey. To lessen the potential burden to county-level MCAH Directors, this survey focused on the eight nationally recognized models which, respectively, establish their own standard of program quality:

**Early Head Start (EHS):** In FY 1995, the EHS program was established to serve children from birth to three years of age, in recognition of mounting evidence that the earliest years matter a great deal to the growth and development of young children. In 2009, funding from the American Recovery and Reinvestment Act (ARRA) supported nationwide expansion of the EHS program. The EHS program is administered by the federal Office of Head Start, Administration for Children and Families (ACF), in the United States Department of Health and Human Services.

The mission of EHS is to promote healthy prenatal outcomes for pregnant women, enhance the development of very young children, and promote healthy family functioning. Each EHS program must provide access to a set of required services, such as comprehensive health and mental health services for children, and literacy and job training for adults in the family. The EHS program addresses the needs of low-income infants, toddlers, pregnant women and their families. EHS programs are designed to:

- enhance children's physical, social, emotional, and intellectual development
- assist pregnant women to access comprehensive prenatal and postpartum care
- support parental efforts to fulfill their roles and meet responsibilities, and
- help parents move toward self-sufficiency

In 2009, the Office of Head Start conducted an assessment related to California training and technical assistance needs. The top training priorities identified included:

- Working with dual language learners
- Determining how to expand or revise EHS programs
- Strengthening EHS services, including a home-based option

The EHS home based program option includes having an EHS educator visit a maximum of 12 families per week for a minimum of 1.5 hours per visit. Home visits are conducted by trained paraprofessionals, and the content of the visit is planned jointly by the home visitor and the parents. The purpose of the home visit is to help parents improve parenting skills and to assist in using the home as the child's primary learning environment. Home visits must, over the course of a month, contain evidence of inclusion of all Head Start performance standards.

Group socialization experiences are part of the EHS home visiting program. The purpose of the group socialization activities for the children is to emphasize peer group interaction through age-

appropriate activities in a Head Start classroom, community facility, home, or on a field trip. Parents accompany their children to group socialization activities at least twice each month to observe, participate as volunteers, or to engage in activities designed specifically for the parents.

The Center for Law and Social Policy (CLASP) compiled data from public reports regarding California HS and EHS grantees for 2008. There were 67 Early Head Start grantees, 136 Head Start grantees, and 11 migrant/seasonal grantees in California in 2008. A grantee may fund one or more than one program in a given geographical location.

In addition, CLASP reported that eight percent of California enrollees are enrolled in the home-based program option, and 2% of enrollees participate in a combination home and center-based Early Head Start program. Coordinated statewide technical assistance is provided to California entities by a coalition consisting of California First 5, WestEd, California Head Start Association, and Preschool California, which share the common goal of increasing quality services for young children.

EHS is being implemented in forty-six counties, serving approximately 14,756 families annually.

**Head Start (HS):** The HS program does not use home visiting as a primary service strategy. However, HS programs are required to make home visits to the parents, per the HS performance standards (1306.30) to "enhance the parent role in the growth and development of the child." A brief overview of HS is provided here due to its funding and relationship to the EHS program.

HS provides grants to local public and private agencies to provide comprehensive child development services to economically disadvantaged children and families, with a special focus on helping preschoolers develop the early reading and math skills they need to be successful in school. HS also promotes school readiness by enhancing the social and cognitive development of children through the provision of educational, health, nutritional, social, and other services to enrolled children and families.

**Healthy Families America (HFA):** The HFA program works with pregnant women identified as at risk and with families with preschool age children. Each agency creates its own program plan, including activities, indicators, and a quality assurance plan. Program home visitors are paraprofessionals who have received 4-5 days of primary training regarding the role of the home visitor, and 80 hours of wraparound training to cover the details of parent education and topics relevant to the needs of families in a specific community.

HFA national staff members provide training, peer review, and ongoing program support as needed. Quality controls are embedded within the HFA program's 12 critical elements. Affiliated programs must meet all model standards in order to become accredited and to maintain accreditation.

In California, a total of ten counties report using HFA, serving approximately 1,007 families annually.

**Healthy Start:** The Healthy Start program works with pregnant women and women who have just given birth, whose families have been identified as at risk for child abuse and neglect based on risk factors such as prenatal substance abuse, mental health issues, or a history of domestic abuse. Home visits are part of the services offered under this program, but home visiting is not

the primary service delivery strategy. The program is authorized under the Public Health Service Act (Section 330H, as amended by P.L. 106-310) and is administered by the Maternal and Child Health Bureau at HRSA (HRSA/MCHB). For FY 2009, Healthy Start received funding nationally of approximately $100 million.

National support for local programs includes: the HRSA/MCHB Interconceptional Learning Care Collaborative; HRSA/MCHB Technical Assistance; and National Healthy Start organization. Quality assurance and program improvement are addressed through the HRSA/MCHB National Evaluation of Annual Performance measures, indicators, and evaluation of the goals and objectives of each Healthy Start local project.

In California, a total of eight counties report using Healthy Start, serving approximately 6,779 families annually.

**Home Instruction for Parents of Preschool Youngsters (HIPPY):** HIPPY is a quasi-experimental program that promotes school readiness and early literacy through parental involvement. The model was designed to remove barriers to parental participation in school readiness and early literacy due to lack of education, poverty, social isolation, and other issues.

HIPPY is in the design stage of a new web-based management information system utilizing Efforts to Outcomes (ETO) Software. Upon implementation, this ETO system will offer a consistent electronic platform for collecting and reporting data. The current HIPPY Management Information System (MIS) records data about participating families and tracks family progress. The information derived from local implementation sites helps the local and national offices understand how to support local program management, sustainability, and expansion. The data are used at the national level for overall program evaluation and research. National trainers visit program sites annually to monitor program quality using a standardized evaluation tool. The trainers provide targeted technical assistance and guidance for program improvement.

In California, a total of five counties report using HIPPY, serving approximately 7,424 families annually.

**Nurse Family Partnership (NFP):** NFP is an evidence-based home visiting model in which ongoing services are provided by a Registered Nurse to first-time mothers during pregnancy through two years postpartum. The NFP National Service Office (NSO) supports local agencies and operating agencies, and provides training, evaluation services, and ongoing consultation for the development of NFP programs. Home visitors collect client and home visit data which is sent to the NSO national database for quality assurance and program improvement analysis. Agencies use NSO data reports to monitor, identify, and respond to variances, and to ensure fidelity to the model.

Programs affiliated with the NFP National Service Office are currently implemented by county public health departments at 12 sites in 11 LHJs.

In California, a total of fourteen counties report using NFP, serving approximately 3,096 families annually.

**Parent Child Home Program (PCHP):** PCHP works with primary caregivers to develop a child's literacy and language skills, and helps caregivers to prepare the child to enter school ready to succeed. The PCHP curriculum focuses on development of cognitive and social skills.

The program connects families with social services and early childhood and parenting education opportunities.

All partner organizations sponsoring local program sites enter into a Replication Agreement with the PCHP National Center. The agreement specifies that the program will be replicated according to the National Center's protocols, and outlines the training and technical assistance provided by the National Center.

The National Center provides annual evaluations, support, and guidance. Each site is evaluated periodically to ensure that it is operating within program guidelines and is providing quality services to families.

In California, a total of five counties report using PCHP, serving approximately 1,507 families annually.

**Parents as Teachers (PAT):** There are 73 PAT programs in California at present, primarily associated with Even Start, EHS, family literacy, or family resource centers. Program goals include improving parenting practices and child school readiness, providing early detection of developmental delays and health problems, and reducing child abuse. PAT uses home visits, group meetings, developmental and health screenings, and a resource network to accomplish program goals.

Each PAT program submits an Annual Program Report (APR) as part of the program's annual recertification process. The APR reflects data about program services provided each year. Program and state level data from the APR can be used to leverage funding and stakeholder support. The national PAT office provides technical assistance in the development and implementation of the program. Program quality visits are available at an additional cost.

In California, a total of twenty counties report using PAT, serving approximately 11,404 families annually.

**SafeCare:** SafeCare is a parent training curriculum that addresses neglectful behaviors, is appropriate for families with infants and toddlers, and has been used primarily with families referred by Child Protective Services. SafeCare uses a structured six-week curriculum focused on child abuse and maltreatment prevention. The curriculum is based upon an eco-behavioral model of child maltreatment, and focuses on social factors and parent skills training. SafeCare is generally imbedded as part of a larger social services or healthcare delivery program. The curriculum is implemented independently in different locales. Current quality assurance focus is the building of a centralized data management system. SafeCare is also in the process of developing training and coaching to ensure fidelity to the model. SafeCare offers implementation support for new programs in the form of training, coaching, and assistance with evaluation if requested. SafeCare works with all new sites for at least one year after initial training is completed. Validated measures are used to assess parent skill changes in the three areas of program focus: health, safety, and parent-child interaction. All sites conduct fidelity monitoring using observations scored on standardized fidelity scales.

In California, a total of eight counties reporting using SafeCare, serving approximately 3,337 families annually.

*Capacity Assessment Home Visiting Survey Methods*
The Capacity Assessment Home Visiting Survey was designed using Survey Monkey, a web-based survey tool. The survey contained a mix of multiple choice/multiple selection, open-ended text, and questions utilizing a 4-point Likert scale. The questionnaire totaled 114 questions with a skip logic design that allowed respondents to forego various sets of questions if the questions did not pertain to their county.

Prior to dissemination of the Capacity Assessment Home Visiting Survey, input was obtained from five county-level MCAH Directors to ensure that the survey captured the most pertinent information and there was enough time allotted for completing the survey. Once this feedback was incorporated into the survey, it was administered online to all 58 county-level MCAH Directors and their counterparts in the Department of Social Services (DSS). The three MCAH Directors from municipalities were instructed to collaborate with the county-level MCAH Directors in their respective counties, and to submit one survey response per county. The county-level MCAH Director was responsible for completing the survey in close collaboration with their counterparts in the DSS, the Department of Education, HS, and their local First 5 Director.

*Results*
On July 28, 2010, CDPH/MCAH sent an active link to Survey Monkey with a response deadline of August 10, 2010. Fifty-four of the fifty-eight county-level MCAH Directors responded to the survey. This remained constant, despite outreach to the four missing counties, and an extension of the response deadline to August 30, 2010. The missing counties include; Inyo, Mariposa, Placer, and San Benito. CDPH/MCAH is in the process of following up with these counties and information will be provided in California's Updated State Plan.

As evident in the results of the Capacity Assessment Home Visiting Survey, de-centralized implementation of maternal, infant and early childhood home visiting programs in California has allowed for great local flexibility, providing a rich knowledge base for the delivery of home visiting services to diverse populations. Extensive local expertise for the provision of evidence-based home visiting models, in both urban and rural settings, and in communities with very different demographics, will inform new state-based strategy development, and can be tapped as a resource for communities implementing new home visiting programs.

At the same time, wide-ranging experience with locally developed home visiting programs and local adaptations of national models allows for otherwise unavailable insights into the delivery of home visiting services to some of the state's most hard-to-reach target populations. For example, a 2007 First 5 California report states that there were over 334,000 linguistically isolated households in California with children under age 6 who speak one of the top 27 non-English languages identified by U.S. Census data, plus American Indians and indigenous Mexican communities who speak local dialects. CDPH/MCAH recognizes that cultural and linguistic factors are vitally important when planning for health program implementation, establishing community linkages, and providing access to care.

Based on these data, CDPH/MCAH is able to gauge the level of infrastructure in place for home visiting programs, what types of evidence based home visiting programs are currently in use, and, in many cases, what funding sources are in existences for home visiting programs. Due to the number and diversity of counties selected, further research will be needed to pinpoint the highest at risk populations.

The following tables summarize the survey data which is then followed by a specific analysis and description (narrative) of each county regarding capacity. Table 28 indicates survey responses regarding the funding source California counties use to provide maternal, infant and /or early childhood visiting services. Table 29 indicates home visiting models, by funding source, being used in each county.

***ACF Funded Home Visiting Programs in California****:* Though not specifically assessed through the home visiting survey, ACF funds two home visiting projects in California: NFP through the Solano County Department of Health and Human Services, and SafeCare at the Chadwick Center for Children and Families at Rady Children's Hospital in San Diego. These programs will receive these funds until FFY 2013 (September 30, 2013), the end of their current grant cycle. The California Home Visiting Program grant is required to sustain funding for this program for the duration of its funding cycle.

### Table 28. California Home Visiting Services Funding Source by County

| County | Title V MCH Block Grant Funds | Title II Child Abuse & Treatment Act/CBCAP/ CAPIT/PSSF | Title IV Temporary Assistance to Needy Families/ CalWORKS | Head Start Act/Early Head Start | Other Funding Source |
|---|---|---|---|---|---|
| Alameda | ✔ | | | ✔ | ✔ |
| Alpine | | ✔ | | | |
| Amador | | ✔ | | ✔ | |
| Butte | ✔ | ✔ | ✔ | ✔ | ✔ ✕ |
| Calaveras | ✔ | ✔ | | ✔ | ✔ ✕ |
| Colusa | ✔ | ✔ | | ✔ | ✔ ✕ |
| Contra Costa | ✔ | ✔ | ✔ | ✔ | ✔ |
| Del Norte | ✔ | | ✔ | ✔ | ✔ |
| El Dorado | ✔ | | | ✔ | ✔ |
| Fresno | ✔ | ✔ | ✔ | ✔ | ✔ ✕ |
| Glenn | ✔ | | | ✔ | |
| Humboldt | ✔ | ✔ | ✔ | ✔ | ✔ ✕ |
| Imperial | | | | ✔ | ✔ |
| Kern | ✔ | | | | ✔ |
| Kings | ✔ | | ✔ | ✔ | ✔ |
| Lake | ✔ | ✔ | | ✔ | ✔ ✕ |
| Lassen | ✔ | ✔ | ✔ | ✔ | ✔ ✕ |
| Los Angeles | ✔ | | | ✔ | ✔ |
| Madera | ✔ | ✔ | ✔ | ✔ | ✔ ✕ |
| Marin | | | | ✔ | |
| Mendocino | | | | ✔ | |
| Merced | ✔ | | ✔ | ✔ | ✔ |
| Modoc | ✔ | ✔ | | ✔ | ✔ |
| Mono | | | | | ✔ |
| Monterey | | ✔ | | ✔ | ✔ ✕ |
| Napa | | ✔ | ✔ | ✔ | ✔ |
| Nevada | ✔ | ✔ | ✔ | ✔ | ✔ ✕ |
| Orange | ✔ | ✔ | ✔ | ✔ | ✔ ✕ |
| Plumas | ✔ | | | ✔ | ✕ |
| Riverside | ✔ | | ✔ | ✔ | ✕ |
| Sacramento | | | | ✔ | |
| San Bernardino | ✔ | | ✔ | ✔ | ✕ |
| San Diego | | ✔ | | ✔ | ✔ |
| San Francisco | | | | | ✔ |
| San Joaquin | ✔ | | | | ✕ |
| San Luis Obispo | | | | ✔ | ✔ |
| San Mateo | ✔ | ✔ | ✔ | ✔ | ✔ |
| Santa Barbara | ✔ | ✔ | ✔ | ✔ | ✔ ✕ |
| Santa Clara | ✔ | ✔ | | | ✔ |
| Santa Cruz | | | | ✔ | |
| Shasta | | | | ✔ | |
| Sierra | | | | | ✔ |
| Siskiyou | | | | ✔ | |

| County | Title V MCH Block Grant Funds | Title II Child Abuse & Treatment Act/CBCAP/ CAPIT/PSSF | Title IV Temporary Assistance to Needy Families/ CalWORKS | Head Start Act/Early Head Start | Other Funding Source |
|---|---|---|---|---|---|
| Solano | ✔ | ✔ | | ✔ | ✔ ✕ |
| Sonoma | ✔ | ✔ | ✔ | | ✔ ✕ |
| Stanislaus | ✔ | | ✔ | ✔ | ✔ ✕ |
| Sutter | | | | ✔ | ✔ ✕ |
| Tehama | ✔ | ✔ | ✔ | ✔ | ✔ ✕ |
| Trinity | | | | ✔ | |
| Tulare | ✔ | | | ✔ | ✔ ✕ |
| Tuolumne | ✔ | ✔ | | ✔ | |
| Ventura | | ✔ | | ✔ | ✔ |
| Yolo | ✔ | ✔ | | ✔ | ✔ ✕ |
| Yuba | ✔ | ✔ | ✔ | ✔ | ✔ |

Note(s): Inyo, Mariposa, Placer and San Benito Counties did not submit a response to the Capacity Assessment Home Visiting Survey

"Other Funding Source" refers to a funding source that is currently unknown to MCAH

**"✕" indicates home visiting services are being funded by First Five funds**

Prepared by: Maternal, Child and Adolescent Health Division, Center for Family Health, California Department of Public Health

Sources: Capacity Assessment Home Visiting Survey, 2010

**Table 29. California Home Visiting Model by Funding Source and County**

| County | Title V MCH Block Grant Funds | Title II Child Abuse & Treatment Act/CBCAP/ CAPIT/PSSF | Title IV Temporary Assistance to Needy Families/ CalWORKS | Head Start Act/Early Head Start | Other Funding Source |
|---|---|---|---|---|---|
| Alameda | Unknown HV Services | | | PAT, EHS | Unknown HV Services |
| Alpine | | Unknown HV Services | | | |
| Amador | | | | EHS, Unknown HV Services | HFA |
| Butte | Unknown HV Services | Unknown HV Services | Unknown HV Services | EHS | PAT |
| Calaveras | | Unknown HV Services | | EHS | Unknown HV Services |
| Colusa | Unknown HV Services | Unknown HV Services | | EHS | Unknown HV Services |
| Contra Costa | Unknown HV Services | Unknown HV Services | Unknown HV Services | PAT, EHS | HFA, EHS |
| Del Norte | Unknown HV Services | | Unknown HV Services | EHS | Unknown HV Services |
| El Dorado | Unknown HV Services | | Unknown HV Services | Healthy Start, EHS | Unknown HV Services |
| Fresno | | SafeCare, Unknown HV Services | | EHS | NFP, PAT, Healthy Start, SafeCare, PCHP, Unknown HV Services |
| Glenn | | | | EHS | |
| Humboldt | HFA, Unknown HV Services | Unknown HV Services | Unknown HV Services | EHS | NFP, Unknown HV Services |
| Imperial | | | | EHS | HIPPY, Unknown HV Services |
| Kern | Unknown HV Services | | | | |
| Kings | Unknown HV Services | | Unknown HV Services | EHS | Unknown HV Services |
| Lake | Unknown HV Services | Unknown HV Services | | Unknown HV Services | Unknown HV Services |
| Lassen | | HFA, PAT, Unknown HV Services | | PAT, EHS | HFA, PAT, Unknown HV Services |

| County | Title V MCH Block Grant Funds | Title II Child Abuse & Treatment Act/CBCAP/ CAPIT/PSSF | Title IV Temporary Assistance to Needy Families/ CalWORKS | Head Start Act/Early Head Start | Other Funding Source |
|---|---|---|---|---|---|
| Los Angeles | Unknown HV Services | | | EHS | HFA, PAT, Healthy Start, HIPPY, Unknown HV Services |
| Madera | NFP | Unknown HV Services | | EHS | NFP, SafeCare, Unknown HV Services |
| Marin | | | | EHS | |
| Mendocino | | | | EHS | |
| Merced | | | | EHS | PAT, Unknown HV Services |
| Modoc | Unknown HV Services | Unknown HV Services | | EHS | Unknown HV Services |
| Mono | | | | | PAT |
| Monterey | | PAT, Healthy Start | | EHS, Unknown HV Services | PAT |
| Napa | Unknown HV Services | HFA | | EHS | HFA |
| Nevada | Unknown HV Services | HFA, Unknown HV Services | HFA, Unknown HV Services | EHS, Unknown HV Services | Unknown HV Services |
| Orange | Unknown HV Services | Unknown HV Services | Unknown HV Services | EHS | NFP, PAT, HIPPY, PCHP, Unknown HV Services |
| Plumas | Unknown HV Services | | | EHS | PAT, Healthy Start, Unknown HV Services |
| Riverside | PAT | | | EHS | |
| Sacramento | | | | HIPPY, EHS | NFP, Healthy Start, SafeCare, PCHP |
| San Bernardino | Healthy Start | | Healthy Start | PAT, EHS | |
| San Diego | | SafeCare | | EHS | NFP, HFA, PAT, Healthy Start, EHS |
| San Francisco | | | | | Unknown HV Services |
| San Joaquin | | | | EHS | PAT |
| San Luis Obispo | | | | | NFP |
| San Mateo | Unknown HV Services | Unknown HV Services | Unknown HV Services | PAT, EHS | PAT, Unknown HV Services |

| County | Title V MCH Block Grant Funds | Title II Child Abuse & Treatment Act/CBCAP/ CAPIT/PSSF | Title IV Temporary Assistance to Needy Families/ CalWORKS | Head Start Act/Early Head Start | Other Funding Source |
|---|---|---|---|---|---|
| Santa Barbara | Unknown HV Services | Unknown HV Services | Unknown HV Services | HIPPY, EHS | HFA, SafeCare, HIPPY, Unknown HV Services |
| Santa Clara | Unknown HV Services | Unknown HV Services | | EHS | NFP |
| Santa Cruz | | | | EHS | Unknown HV Services |
| Shasta | | | | PAT, EHS, Unknown HV Services | |
| Sierra | Unknown HV Services | Unknown HV Services | Unknown HV Services | Unknown HV Services | Unknown HV Services |
| Siskiyou | | | | EHS | |
| Solano | Unknown HV Services | | | EHS | NFP |
| Sonoma | | | | | NFP, PAT, Unknown HV Services |
| Stanislaus | Unknown HV Services | Unknown HV Services | | EHS | PAT, PCHP |
| Sutter | | | Unknown HV Services | EHS | Unknown HV Services |
| Tehama | Unknown HV Services | PAT | Unknown HV Services | PAT, EHS | PAT |
| Trinity | | | | PAT, EHS | Unknown HV Services |
| Tulare | NFP | | | EHS | SafeCare |
| Tuolumne | Unknown HV Services | Unknown HV Services | | Unknown HV Services | Unknown HV Services |
| Ventura | | | | EHS | |
| Yolo | | | | EHS | HFA, Unknown HV Services |
| Yuba | | | | EHS | |

Note(s): Inyo, Mariposa, Placer and San Benito Counties did not submit a response to the Capacity Assessment Home Visiting Survey

"Unknown HV Services" refers to either locally developed home visiting programs or adaptations of national models.

Prepared by: Maternal, Child and Adolescent Health Division, Center for Family Health, California Department of Public Health

Source: Capacity Assessment Home Visiting Survey, 2010

## Individual Tables and Narratives for California's Identified At Risk Counties

Tables and narratives for fifty-four of California's identified at risk counties are included in pages 274-417. Tables are not provided for four counties because they did not provide a response. These narratives and tables identify the following:

- the home visiting model or approach in use,
- the intended recipient(s) of the service,
- the number of families served,
- the geographic area served, and
- identification of gaps in home visiting services

Because the survey was developed and disseminated prior to the release of the first SIR, CDPH/MCAH does not have available data on the following:

- the name of the program,
- the specific service(s) provided,
- the targeted goals/outcomes of the intervention,
- the demographic characteristics of families served, and
- the extent to which such programs/initiatives are meeting the needs of eligible families

The Key below is applicable for all of the tables presented in pages 274-417.

**Key**

Geographic location is referred to with * symbol

All models are in an Agency Funding Agreement (AFA) agreement with a national office unless stated, "with no AFA".

-- indicates data is not currently available

'Other' funding source refers to a funding source currently unknown to CDPH/MCAH

Evidence-Based Home Visiting (EBHV) Model Abbreviations

| | |
|---|---|
| **NFP** | Nurse Family Partnership |
| **HS** | Head Start |
| **HFA** | Healthy Families America |
| **PAT** | Parents as Teachers |
| **HS** | Healthy Start |
| **EHS** | Early Head Start |
| **PCHP** | Parent-Child Home Program |
| **HIPPY** | Home Instruction for Parents of Preschool Youngsters |

## Alameda County Survey Results

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | PAT | -- | Low income, Pregnant Women, Teens | -- | -- | 36 | ✓ | HS/EHS |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Parents with Disabilities, and New Immigrant Families | -- | -- | 538 | ✓ | HS/EHS |

Home Visiting Model(s)

Alameda County is using the following two national evidence-based home visiting (EBHV) models: Parents as Teachers (PAT) and Early Head Start (EHS).

Number of Families Served and Funding Sources

Alameda County reports that in the most recent calendar or fiscal year:

- approximately 574 families received home visiting services through the two national EBHV models cited above.
- Title V MCH Block Grant Funds and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 843 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Alameda County services provided:

- **EHS (AFA)** Comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PAT (AFA)** Paraprofessionals may provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Alameda County. A more targeted description will be presented in the second SIR.

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

Alameda County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs; **(moderately significant)**
- families with a history of child abuse or neglect
- families with a history of domestic violence; **(moderately significant)**
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Alameda County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health; **(moderately significant)**
- Infant health and development
- Child health and development; **(moderately significant)**
- Parenting skills
- Child abuse and injury prevention;**(moderately significant)**
- School readiness; **(moderately significant)**
- Domestic violence prevention; **(moderately significant)**
- Mental health; **(moderately significant)**
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**

- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Alameda County.

Alameda County reports gaps of service identified in all domains. In addition, there are waiting lists that exist for PAT and EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Alpine County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | Other | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | Unknown | Unknown | Title II Child Abuse & Treatment Act/CBCAP/ CAPIT/PSSF |

HV Model(s)

Alpine County is not using an EBHV model to serve families

Number of Families Served and Funding Sources

Alpine County reports that in the most recent calendar or fiscal year:

- Approximately 460 families received non-EBHV services through Title II Child Abuse & Treatment Act/CBCAP/CAPIT/PSSF funds.

Services Provided

Information is not currently available on the services Alpine County is providing to families using a non-EBHV model

Targeted Goals/Outcomes of the Intervention

Information is not currently available on the targeted goals/outcomes of the intervention Alpine County is using a non-EBHV model

Gaps/Unmet Needs

Alpine County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age; **(not significant)**
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities; **(somewhat significant)**
- Families with children with low student achievement/drop-outs
- Families with a history of child abuse or neglect;
- Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families

- Non-English speaking families

Benchmarks

In addition, Alpine County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health; **(somewhat significant)**
- Infant health and development; **(moderately significant)**
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health; (moderately significant)
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, it is not clear if there is an existing infrastructure in place (funding and an AFA agreement) to build EBHV models in Alpine County.

Alpine County reports gaps of service that are identified in all domains. Data on duplications of service are not readily available.

**Amador County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women | -- | -- | 35 | ✓ | HS/EHS |

Home Visiting Model(s)

Amador County is using one national evidence-based home visiting (EBHV) model: Early Head Start (EHS).

Number of Families Served and Funding Sources

Amador County reports that in the most recent calendar or fiscal year:

- Approximately 35 families received home visiting services through EHS.
- Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 48 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Amador County services provided:

- **EHS (AFA)** comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Amador County. A more targeted description will be presented in the second SIR.

- **EHS –** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Amador County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities; **(moderately significant)**
- families with children with low student achievement/drop-outs

- families with a history of child abuse or neglect; **(moderately significant)**
- families with a history of domestic violence; **(moderately significant)**
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Amador County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health; **(moderately significant)**
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention; **(moderately significant)**
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to build on and expand an established EBHV model in Amador County.

Amador County reports gaps of service that are identified in all domains. There is a waiting list for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

## Butte County Survey Results

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/ outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | PAT | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Families that live in the neighborhood are not turned away; Hispanic and Hmong families with English as a second language | -- | -- | 108 | ✓ | Other |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Families with multiple risk factors such as homeless, public assistance | -- | -- | 400 | ✓ | HS/EHS |
| -- | HFA | -- | Mothers under the age of 25, living in southern Butte County who deliver at Oroville Hospital and/or are receiving prenatal care from OB/GYN providers in Oroville and Gridley. This geographic area is low income area and has relatively high rates of substance abuse and domestic violence, so some of the items in question #3 are embedded in this target population definition. | -- | -- | 80 | | Unknown |
| -- | Other | -- | Unknown | -- | -- | 55 | Unknown | Title V MCH Block Grant Funds |
| -- | Other | -- | Unknown | -- | -- | 35 | Unknown | Title II Child Abuse & Treatment Act/CBCAP/CAPIT/PSSF |
| -- | Other | -- | Unknown | -- | -- | 40 | Unknown | Title IV Temporary Assistance to Needy Families/ CalWORKS |

Home Visiting Model(s)

Butte County is using the following three national evidence-based home visiting (EBHV) models: Healthy Families America (HFA), Parents as Teachers (PAT), and Early Head Start (EHS).

Number of Families Served and Funding Sources

Butte County reports that in the most recent calendar or fiscal year:

- approximately 588 families received home visiting services through the three national EBHV models cited above.
- Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 688 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Butte County services provided:

- **HFA (AFA)** programs typically include an initial assessment of new parents; ensure families to have a medical home; link families with other resources in the community; and help families feel empowered
- **EHS (AFA)** comprehensive child development services provided in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PAT (AFA)** Paraprofessionals may provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Butte County. A more targeted description will be presented in the second SIR.

- **HFA –** To promote positive parenting skills; prevent child abuse and neglect; and support optimal prenatal care and child health and development.
- **EHS –** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PAT** – To empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

Butte County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age;
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families; and
- non-English speaking families

Benchmarks

In addition, Butte County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Butte County.

Butte County reports gaps of service that are identified in all domains. Waiting lists exist for PAT and EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Calaveras County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse | -- | -- | 114 | ✓ | HS/EHS |

Home Visiting Model(s)

Calaveras County is using one national evidence-based home visiting (EBHV) model: Early Head Start (EHS).

Number of Families Served and Funding Sources

Calaveras County reports that in the most recent calendar or fiscal year:

- Approximately 114 families received home visiting services through EHS.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 151 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Calaveras County services provided:

- **EHS (AFA)** comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Calaveras County. A more targeted description will be presented in the second SIR.

- **EHS –** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Calaveras County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age

- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities; **(moderately significant)**
- families with children with low student achievement/drop-outs; **(moderately significant)**
- families with a history of child abuse or neglect; **(moderately significant)**
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families; and
- non-English speaking families

Benchmarks

In addition, Calaveras County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills; **(moderately significant)**
- Child abuse and injury prevention; **(moderately significant)**
- School readiness
- Domestic violence prevention
- Mental health; **(moderately significant)**
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to build on and expand an established EBHV model in Calaveras County.

Calaveras County reports gaps of service that are identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Colusa County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse | -- | -- | 60 | ✓ | HS/EHS |

Home Visiting Model(s)

Colusa County is using only EHS as a national EBHV model.

Number of Families Served and Funding Sources

Colusa County reports that in the most recent calendar or fiscal year:

- Approximately 60 families received HV services through the EHS model
- Title V MCH Block Grant, Title II Child Abuse & Treatment Act/CBCAP/CAPIT/PSSF, and HS/EHS funds may support both EBHV and non-EBHV services for 240 families

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model description for EHS, we can make the following general statement regarding Colusa County services provided:

- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of EHS, the national model used by Colusa County. A more targeted description will be presented in the second SIR.

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Colusa County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- Pregnant females under 21 years of age
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8

- Families with children with developmental delays or disabilities
- Families with children with low student achievement/drop-outs
- Families with a history of child abuse or neglect
- Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Colusa County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is a basic infrastructure in place (funding and an AFA agreement) to build on and expand established EBHV models in Colusa County.

Colusa County reports gaps of service that are identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Contra Costa County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | HFA | -- | Low income, Pregnant Women, Teens, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 150 | ✓ | Other |
| -- | PAT | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 84 | ✓ | HS/EHS |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Any High Risk Needs | -- | -- | 150 | ✓ | HS/EHS, Other |

Home Visiting Model(s)

Contra Costa County is using the following three national evidence-based home visiting (EBHV) models: Healthy Families America (HFA), Parents as Teachers (PAT), and Early Head Start (EHS).

Number of Families Served and Funding Sources

Contra Costa County reports that in the most recent calendar or fiscal year:

- approximately 384 families received home visiting services through the three national EBHV models cited above.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; Title IV Temporary Assistance to Needy Families/CalWORKS; and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 1030 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Contra Costa County services provided:

- **HFA (non-AFA)** programs typically include an initial assessment of new parents; ensure families to have a medical home; link families with other resources in the community; and help families feel empowered
- **EHS (AFA)** Comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PAT (non-AFA)** Paraprofessionals may provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Contra Costa County. A more targeted description will be presented in the second SIR.

- **HFA –** Promote positive parenting skills; prevent child abuse and neglect; and support optimal prenatal care and child health and development.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

Contra Costa County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs; **(somewhat significant)**
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Contra Costa County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health

- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is substantial infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Contra Costa County.

Contra Costa County reports gaps of service identified in all domains. In addition, there are waiting lists that exist for all Contra Costa County EBHV models which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Del Norte County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse Newborn to 5yrs | -- | -- | 109 | ✓ | HS/EHS |

Home Visiting Model(s)

Del Norte County is using only EHS as a national EBHV model.

Number of Families Served and Funding Sources

Del Norte County reports that in the most recent calendar or fiscal year:

- Approximately 150 families received HV services through the EHS model
- Title V MCH Block Grant, Title IV Temporary Assistance to Needy Families/CalWORKS, HS/EHS, and other unidentified funds may fund both EBHV and non-EBHV services for 739 families

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model description for EHS, we can make the following general statement regarding Del Norte County services provided:

- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of EHS, the national model used by Del Norte County. A more targeted description will be presented in the second SIR.

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Del Norte County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- Pregnant females under 21 years of age

- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities
- Families with children with low student achievement/drop-outs
- Families with a history of child abuse or neglect
- Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Del Norte County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is a basic infrastructure in place (funding and an AFA agreement) to build on and expand established EBHV models in Del Norte County.

Del Norte County reports gaps of service that are identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**El Dorado County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | Healthy Start with no AFA | -- | Pregnant Women, Teens, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 90 | | HS/EHS |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Foster Children, Children with Open CPS Cases, Parents with Limited Parenting Capacities | -- | -- | 150 | ✓ | HS/EHS |

Home Visiting Model(s)

El Dorado County is using two EBHV models: Healthy Start and EHS.

Number of Families Served and Funding Sources

El Dorado County reports that in the most recent calendar or fiscal year:

- Approximately 240 families received HV services through the two national EBHV models cited above
- Title V MCH Block Grant, Title IV Temporary Assistance to Needy Families/CalWORKS, HS/EHS, and other unidentified funds may fund both EBHV and non-EBHV services for 500 families

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding El Dorado County services provided:

- **Healthy Start (non-AFA)** has core service components including outreach, case management, health education, interconceptional care, and screening and referral.
- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by El Dorado County. A more targeted description will be presented in the second SIR.

- **Healthy Start** – Reduce infant mortality, birth weight and racial disparities in prenatal outcomes.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

El Dorado County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities; **(not significant)**
- Families with children with low student achievement/drop-outs Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, El Dorado County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency; **(unknown)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in El Dorado County.

El Dorado County reports gaps of service identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

## Fresno County Survey Results

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/ outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low Income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Foster children and homeless given priority | -- | -- | 500 | | HS/EHS |
| -- | NFP | -- | Low Income, Pregnant Women, Teens, History of Domestic Violence, History of Substance Abuse, Census tract areas with higher Infant Mortality Rates (IMR) | -- | -- | 175 | ??? | Other |
| -- | PAT | -- | Low Income, Pregnant Women, Teens, Pregnant Women, Children with Developmental Disabilities, All Families | -- | -- | 50 | ??? | Other |
| -- | Healthy Start | -- | Low Income, Teens, History of Domestic Violence, History of Substance Abuse, Pregnant women residing in census tracts with high IMR | -- | -- | 200 | ??? | Other |
| -- | SafeCare | -- | Pregnant Women, teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Teen parents; CWS referred families with no court action, | -- | -- | 70 | program just started | Title II Child Abuse & Treatment Act/CBCAP/CAPIT/PSSF |
| -- | PCHP | -- | Low Income | -- | -- | 30 | ✓ | Other |
| -- | Other | -- | Low Income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse CWS families and voluntary family maintenance | -- | -- | 277 | | Other |

Home Visiting Model(s)

Fresno County is using the following six national evidence-based home visiting (EBHV) models: the Nurse Family Partnership (NFP), Parents as Teachers (PAT), Healthy Start, SafeCare, Early Head Start (EHS), and Parent-Child Home Program (PCHP).

Number of Families Served and Funding Sources

Fresno County reported that in the most recent calendar or fiscal year:

- approximately 1025 families received home visiting services by the six national EBHV models cited above.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; Title IV Temporary Assistance to Needy Families/CalWORKS; and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 2913 families.

Survey responders reported that SafeCare and EHS are the only two EBHV programs funded by Title II Child Abuse and Treatment Act/CBCPA/CAPIT/PSSF and Head Start/Early Head Start, respectively.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Fresno County services provided:

- **NFP (AFA)** uses public health nurses to provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.
- **Healthy Start (AFA)** has core service components including outreach, case management, health education, interconceptional care, and screening and referral.
- **SafeCare (AFA)** consists of a parent-training curriculum which includes three modules: Health; Home Safety; and Parent-Infant.
- **EHS (AFA )** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PCHP (AFA)** works with primary caregivers to develop their children's literacy and language skills and prepares them to enter school. Also serves as a referral to link families with social services or early childhood and parenting education opportunities.
- **PAT (Non-AFA)** provides weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Fresno County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.
- **Healthy Start** – Reduce infant mortality, birth weight and racial disparities in perinatal outcomes.
- **SafeCare –** Teach parents in child behavior management and home safety training, child health care skills to prevent child maltreatment.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PCHP –** Develop children's language and literacy skills; empower parents to be teachers; prepare children for life long academic success; enhance parenting skills
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

Fresno County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Fresno County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills

- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is substantial infrastructure in place (funding and AFA agreements) to expand established EBHV models.

Fresno County reports significant gaps of service identified in all domains. In addition, there are waiting lists that exist for all six EBHV models cited, which reinforce the need for more HV services. Data on duplications of service are not readily available.

**Glenn County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 63 | ✓ | HS/EHS |

Home Visiting Model(s)

Glenn County is using only EHS as a national EBHV model.

Number of Families Served and Funding Sources

Glenn County reports that in the most recent calendar or fiscal year:

- Approximately 63 families received HV services through EHS
- Title V MCH Block Grant and HS/EHS funds may fund both EBHV and non-EBHV services for 150 families

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model description for EHS, we can make the following general statement regarding Glenn County services provided:

- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of EHS, the national models used by –Glenn County. A more targeted description will be presented in the second SIR.

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Glenn County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age

- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities; **(somewhat significant)**
- Families with children with low student achievement/drop-outs; **(moderately significant)**
- Families with a history of child abuse or neglect
- Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Glenn County indicated that new home visiting funding would **significantly** or **moderately** address the following services:

- Prenatal/maternal health; **(moderately significant)**
- Infant health and development**; (moderately significant)**
- Child health and development; **(moderately significant)**
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health; **(moderately significant)**
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports; **(moderately significant)**

Summary

On the basis of this information, there is a basic infrastructure in place (funding and an AFA agreement) to build on and expand established EBHV models in Glenn County.

Glenn County reports gaps of service that are identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Humboldt County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | NFP | -- | Low income, Pregnant Women, Teens, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, First Time Mothers | -- | -- | 73 | | Other |
| -- | HFA | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Mental Illness, Single, Separated or Divorced Parents, Children in Foster Care/CWS System | -- | -- | 25-30 | ✓ | Title V MCH Block Grant Funds |
| -- | EHS | -- | Low income, Pregnant Women, Children with Developmental Delays/Disabilities, Homelessness | -- | -- | 167 | ✓ | HS/EHS |

Home Visiting Model(s)

Humboldt County is using three EBHV models: NFP, HFA, and EHS.

Number of Families Served and Funding Sources

Humboldt County reports that in the most recent calendar or fiscal year:

- Approximately 270 families received HV services through the three national EBHV models cited above
- Title V MCH Block Grant, Title II Child Abuse & Treatment Act/CBCAP/CAPIT/PSSF, Title IV Temporary Assistance to Needy Families/CalWORKS, HS/EHS, and other unidentified funds may support both EBHV and non-EBHV services for 1004 families

Services Provided

Some national EBHV programs have an AFA with their national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Humboldt County services provided:

- **NFP (AFA)** uses public health nurses to provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.

- **HFA (AFA)** programs typically include an initial assessment of new parents; ensure families to have a medical home; link families with other resources in the community; and help families feel empowered
- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Humboldt County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.
- **HFA –** Promote positive parenting skills; prevent child abuse and neglect; and support optimal prenatal care and child health and development.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Humboldt County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- Pregnant females under 21 years of age
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities
- Families with children with low student achievement/drop-outs
- Families with a history of child abuse or neglect
- Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Humboldt County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills

- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is significant infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Humboldt County.

Humboldt County reports gaps of service identified in all domains. Waiting lists exists for HFA and EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Imperial County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | HIPPY with no AFA | -- | Low Student Achievement/Dropouts, Children from low academic school districts, exempt care providers | -- | -- | 74 | ✓ | Other |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 70 | | HS/EHS |

Home Visiting Model(s)

Imperial County is using two EBHV models: EHS and HIPPY.

Number of Families Served and Funding Sources

Imperial County reports that in the most recent calendar or fiscal year:

- Approximately 144 families received HV services through EHS and HIPPY using HS/EHS and other unidentified funds

Services Provided

Some national EBHV programs have an AFA with their national office. An AFA increases the likelihood that HV programs follow standards of care and maintain model fidelity than EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Imperial County services provided:

- **HIPPY (non-AFA)** is a school readiness program that helps parents prepare their three to five year old children for success in school and life. Parents are provided with books and materials to help strengthen their child's cognitive and literacy skills.
- **EHS (AFA )** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Imperial County. A more targeted description will be presented in the second SIR.

- **HIPPY** – Empower parents as primary educators of their children; promote school readiness and early literacy through parental
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Imperial County reported that new home visiting funding would **significantly** address gaps in serving the following population unless otherwise noted:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Imperial County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention; **(moderately significant)**
- School readiness; **(moderately significant)**
- Domestic violence prevention; **(moderately significant)**
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, an infrastructure is in place (funding and an AFA agreement) to build on and/or expand established EBHV models in Imperial County.

Imperial County reports gaps of service identified in all domains. A waiting list exists for HIPPY which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Kern County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | NFP | -- | Low Income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 399 | ✓ | Title V MCH Block Grant Funds |

Home Visiting Model(s)

Kern County is using one national evidence-based home visiting (EBHV) model: the Nurse Family Partnership (NFP).

Number of Families Served and Funding Sources

Kern County reports that in the most recent calendar or fiscal year:

- Approximately 399 families received home visiting services through the NFP.
- Title V MCH Block Grant Funds may fund other non-EBHV home visiting services for 300 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Kern County services provided:

- **NFP (AFA)** provides home visits by public health nurses to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Kern County. A more targeted description will be presented in the second SIR.

- **NFP** improve pregnancy outcomes; child health and development and families economic self-sufficiency.

Gaps/Unmet Needs

Kern County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age

- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Kern County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness **(moderately significant)**
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency **(moderately significant)**
- Coordination of referrals to community resources and supports**(moderately significant)**

Summary

On the basis of this information, there is basic infrastructure in place to support and expand the current NFP program. Title V MCH Block Grant Funds supports additional non-EBHV programs in Kern County.

Kern County reports gaps of service that are identified in all domains. A waiting list for NFP exists which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Kings County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, History of Domestic Violence, History of Substance Abuse | -- | -- | 50 | ✓ | HS/EHS |

Home Visiting Model(s)

Kings County is using only EHS as a national EBHV model.

Number of Families Served and Funding Sources

Kings County reports that in the most recent calendar or fiscal year:

- Approximately 50 families received HV services through the EHS
- Title V MCH Block Grant, Title IV Temporary Assistance to Needy Families/CalWORKS, HS/EHS, and other unidentified funds may fund both EBHV and non-EBHV services for 975 families

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model description for EHS, we can make the following general statement regarding Kings County services provided:

- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of EHS, the national models used by Kings County. A more targeted description will be presented in the second SIR.

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Kings County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8

- Families with children with developmental delays or disabilities; **(somewhat significant)**
- Families with children with low student achievement/drop-outs
- Families with a history of child abuse or neglect
- Families with a history of domestic violence; **(somewhat significant)**
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Kings County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness; **(somewhat significant)**
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is a basic infrastructure in place (funding and an AFA agreement) to build on and expand established EBHV models in Kings County.

Kings County reports gaps of service identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Lake County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Foster Children and Homeless | -- | -- | 52 | ✓ | HS/EHS |

Home Visiting Model(s)

Lake County is using one national evidence-based home visiting (EBHV) model: Early Head Start (EHS).

Number of Families Served and Funding Sources

Lake County reports that in the most recent calendar or fiscal year:

- approximately 50 families received home visiting services through EHS.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 207families

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Lake County services provided:

- **EHS (AFA)** comprehensive child development services provided in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Lake County. A more targeted description will be presented in the second SIR.

- **EHS –** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Lake County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8 **(moderate)**
- families with children with developmental delays or disabilities; **(moderately significant)**
- families with children with low student achievement/drop-outs; **(moderately significant)**
- families with a history of child abuse or neglect; **(moderately significant)**
- families with a history of domestic violence; **(moderately significant)**
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Lake County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health; **(moderately significant)**
- Infant health and development**; (moderately significant)**
- Child health and development; **(moderately significant)**
- Parenting skills; **(moderately significant)**
- Child abuse and injury prevention; **(moderately significant)**
- School readiness; **(somewhat significant)**
- Domestic violence prevention; **(moderately significant)**
- Mental health; **(moderately significant)**
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to build on and expand established the EBHV model in Lake County.

Lake County reports gaps of service that are identified in all domains. There is a waiting list for the EHS service which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Lassen County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | HFA with no AFA | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 184 | ✓ | Title II Child Abuse & Treatment Act/CBCAP/ CAPIT/PSSF, Other |
| -- | PAT | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Homeless, Single Parents, CPS Involved families, Court ordered and Probation cases through Lassen County | -- | -- | 208 | ✓ | Title II Child Abuse & Treatment Act/CBCAP/ CAPIT/PSSF, Other |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Single Parents | -- | -- | 24 | | HS/EHS |

Home Visiting Model(s)

Lassen County is using the following three national evidence-based home visiting (EBHV) models: Healthy Families America (HFA), Parents as Teachers (PAT), and Early Head Start (EHS),

Number of Families Served and Funding Sources

Lassen County reports that in the most recent calendar or fiscal year:

- approximately 416 families received home visiting services through the three national EBHV models cited above.
- Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; Title IV Temporary Assistance to Needy Families/CalWORKS and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 339 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Lassen County services provided:

- **HFA (non-AFA)** programs typically include an initial assessment of new parents; ensure families to have a medical home; link families with other resources in the community; and help families feel empowered
- **EHS (AFA)** Comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PAT (AFA)** Paraprofessionals may provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Lassen County. A more targeted description will be presented in the second SIR.

- **HFA –** Promote positive parenting skills; prevent child abuse and neglect; and support optimal prenatal care and child health and development.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

Lassen County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age;
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Lassen County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills; **(moderately significant)**
- Child abuse and injury prevention
- School readiness; **(moderately significant)**
- Domestic violence prevention; **(moderately significant)**
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Lassen County.

Lassen County reports gaps of service that are identified in all domains. Waiting lists exist for HFA and PAT which reinforces the need for more HV services. Data on duplications of service are not readily available.

## Los Angeles County Survey Results

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Homeless/Foster Children | -- | -- | 2953 | ✓ | HS/EHS |
| -- | HFA | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Mental Health Issues | -- | -- | 98 | | Other |
| -- | PAT | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Mono-lingual Spanish Speaking & Immigrant | -- | -- | 900 | ✓ | Other |
| -- | Healthy Start | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Mental Health Issues | -- | -- | 200 | | Other |
| -- | HIPPY | -- | Low income, Teens, History of Domestic Violence, History of Substance Abuse, Pregnant women, Children with Developmental Delays/ Disabilities, Low Student Achievement/Dropout, Mental health issues | -- | -- | 129 | ✓ | Other |
| -- | NFP | -- | Low Income, Pregnant Women | -- | -- | 350 | ✓ | Title V MCH Block Grant Funds |

Home Visiting Model(s)

Los Angeles County is using the following seven national evidence-based home visiting (EBHV) models: the Nurse Family Partnership (NFP), Healthy Families America (HFA), Parents as

Teachers (PAT), Healthy Start, Early Head Start (EHS), Parent-Child Home Program (PCHP) and Home Instruction for Parents of Preschool Youngsters (HIPPY).

Number of Families Served and Funding Sources

Los Angeles County reports that in the most recent calendar or fiscal year:

- Approximately 4652 families received home visiting services through the seven national EBHV models cited above.
- Title V MCH Block Grant Funds and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 4314 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Los Angeles County services provided:

- **NFP (AFA)** Public health nurses provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.
- **HFA (AFA)** programs typically include an initial assessment of new parents; ensure families to have a medical home; link families with other resources in the community; and help families feel empowered
- **Healthy Start (AFA)** Core service components including outreach, case management, health education, interconceptional care, and screening and referral.
- **EHS (AFA)** Comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PCHP (AFA)** Works with primary caregivers to develop their children's literacy and language skills and prepares them to enter school. Also serves as a referral to link families with social services or early childhood and parenting education opportunities.
- **PAT (AFA)** Paraprofessionals may provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.
- **HIPPY (AFA)** is a school readiness program that helps parents prepare their three to five year old children for success in school and life. Parents are provided with books and materials to help strengthen their child's cognitive and literacy skills.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Los Angeles County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families' economic self-sufficiency.

- **Healthy Start** – Reduce infant mortality, birth weight and racial disparities in perinatal outcomes.
- **HFA –** Promote positive parenting skills; prevent child abuse and neglect; and support optimal prenatal care and child health and development.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PCHP –** Develop children's language and literacy skills; empower parents to be teachers; prepare children for life long academic success; enhance parenting skills
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.
- **HIPPY** – Empower parents as primary educators of their children; promote school readiness and early literacy through parental involvement.

Gaps/Unmet Needs

Los Angeles County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Los Angeles County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention

- Mental health
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is substantial infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Los Angeles County.

Los Angeles County reports gaps of service that are identified in all domains. Waiting lists exist for NFP, PAT, EHS, and HIPPY which strongly reinforces the need for more HV services. Data on duplications of service are not readily available.

**Madera County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | NFP with no AFA | -- | Low income, Pregnant Women, Teens, First Time Parents | -- | -- | 638 | ✓ | Other |
| -- | SafeCare | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 10 | | Other |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 15 | ✓ | HS/EHS |

Home Visiting Model(s)

Madera County is using the following EBHV models: NFP, SafeCare, and EHS.

Number of Families Served and Funding Sources

Madera County reports that in the most recent calendar or fiscal year:

- Approximately 663 families received HV services through the three national EBHV models cited above
- Title V MCH Block Grant Funds, Title II Child Abuse & Treatment Act/CBCAP</CAPIT/PSSF, Title IV Temporary Assistance to Needy Families/CalWORKS, HS/EHS and other unidentified funds may fund both EBHV and non-EBHV services for 1188 families

Services Provided

Some national EBHV programs have an AFA with their national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Madera County services provided:

- **NFP (non-AFA)** uses public health nurses to provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.

- **SafeCare (non-AFA)** consists of a parent-training curriculum which includes three modules: Health; Home Safety; and Parent-Infant.
- **EHS (AFA )** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Madera County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.
- **SafeCare –** Teach parents in child behavior management and home safety training, child health care skills to prevent child maltreatment.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Madera County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8; **(moderately significant)**
- Families with children with developmental delays or disabilities; **(moderately significant)**
- Families with children with low student achievement/drop-outs
- Families with a history of child abuse or neglect; **(somewhat significant)**
- Families with a history of domestic violence; **(moderately significant)**
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Madera County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills

- Child abuse and injury prevention
- School readiness; **(moderately significant)**
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports ; **(moderately significant)**

Summary

On the basis of this information, there is substantial infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Madera County.

Madera County reports gaps of service identified in all domains. Waiting lists exist for NFP and EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

## Marin County Survey Results

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse | -- | -- | 80 | ✓ | HS/EHS |

Home Visiting Model(s)

Marin County is using only the national evidence-based home visiting (EBHV) model Early Head Start (EHS).

Number of Families Served and Funding Sources

Marin County reports that in the most recent calendar or fiscal year:

- Approximately 80 families received home visiting services through EHS.
- Head Start Act/Early Head Start is the only reported funding source in Marin County. .

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Marin County services provided:

- **EHS (AFA)** Comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national model used by Marin County. A more targeted description will be presented in the second SIR.

- **EHS -** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Marin County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8; **(moderately significant)**

- families with children with developmental delays or disabilities; **(moderately significant)**
- families with children with low student achievement/drop-outs;**(moderately significant)**
- families with a history of child abuse or neglect;
- families with a history of domestic violence; **(moderately significant)**
- families with a history of substance abuse
- current or former military families; and
- non-English speaking families

Benchmarks

In addition, Marin County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health; **(moderately significant)**
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention; **(moderately significant)**
- School readiness; **(moderately significant)**
- Domestic violence prevention; **(moderately significant)**
- Mental health
- Substance abuse
- Economic self-sufficiency; **(somewhat significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreement) to build on and expand the established EBHV model in Marin County.

Marin County reports gaps of service identified in all domains. A waiting list exists for the EHS model which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Mendocino County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, History of Domestic Violence, History of Substance Abuse | -- | -- | 16 | ✓ | HS/EHS |

Home Visiting Model(s)

Mendocino County is using only EHS as a national EBHV model. They do have an AFA with the national EHS office.

Number of Families Served and Funding Sources

Mendocino County reports that in the most recent calendar or fiscal year:

- Approximately 16 families received HV services through the EHS model using HS/EHS funds

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model description for EHS, we can make the following general statement regarding Mendocino County services provided:

- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of EHS, the national model used by Mendocino County. A more targeted description will be presented in the second SIR.

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Mendocino County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8

- Families with children with developmental delays or disabilities; **(moderately significant)**
- Families with children with low student achievement/drop-outs; **(somewhat significant)**
- Families with a history of child abuse or neglect
- Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Mendocino County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention; **(moderately significant)**
- Mental health; **(moderately significant)**
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is a basic infrastructure in place (funding and an AFA agreement) to build on and expand established EBHV models in Mendocino County.

Mendocino County reports gaps of service identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Merced County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | PAT | -- | Pregnant Women, Isolated Families, First Time Parents, Families with Children 0-3, not receiving other services | -- | -- | 170 | ✓ | Other |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities | -- | -- | 197 | ✓ | HS/EHS |

Home Visiting Model(s)

Merced County is using the following two national evidence-based home visiting (EBHV) models: Parents as Teachers (PAT) and Early Head Start (EHS).

Number of Families Served and Funding Sources

Merced County reports that in the most recent calendar or fiscal year:

- Approximately 367 families received home visiting services through the two national EBHV models cited above.
- Title V MCH Block Grant Funds; Title IV Temporary Assistance to Needy Families/CalWORKS and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 424 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Merced County services provided:

- **EHS (AFA)** Comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PAT (non-AFA)** Paraprofessionals may provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Merced County. A more targeted description will be presented in the second SIR.

- **EHS -** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PAT -** To empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

Merced County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age;
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8;
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect;
- families with a history of domestic violence; **(moderately significant)**
- families with a history of substance abuse; **(moderately significant)**
- current or former military families; and
- non-English speaking families

Benchmarks

In addition, Merced County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development; **(moderately significant)**
- Child health and development; **(moderately significant)**
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is some basic infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Merced County.

Merced County reports gaps of service identified in all domains. In addition, waiting lists exist for PAT and EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Modoc County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Children with Developmental Delays/Disabilities | -- | -- | 129 | ✓ | HS/EHS |

Home Visiting Model(s)

Modoc County is using only EHS as a national EBHV model.

Number of Families Served and Funding Sources

Modoc County reports that in the most recent calendar or fiscal year:

- Approximately 129 families received HV services through EHS services
- Title V MCH Block Grant, Title II Child Abuse & Treatment Act/CBCAP/CAPIT/PSSF, HS/EHS, and other unidentified funds may fund both EBHV and non-EBHV services for 247 families

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model description for EHS, we can make the following general statement regarding Modoc County services provided:

- **EHS (AFA )** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of EHS, the national model used by –Modoc County. A more targeted description will be presented in the second SIR.

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Modoc County reported that new home visiting funding would **moderately** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities

- Families with children with low student achievement/drop-outs
- Families with a history of child abuse or neglect
- Families with a history of domestic violence
- Families with a history of substance abuse; **(significant)**
- Current or former military families; **(significant)**
- Non-English speaking families; **(significant)**

Benchmarks

In addition, Modoc County indicated that new home visiting funding would **moderately** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports; **(significant)**

Summary

On the basis of this information, there is a basic infrastructure in place (funding and an AFA agreement) to build on and expand established EBHV models in Modoc County.

Modoc County reports gaps of service that are identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Mono County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | PAT | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Universal Home Visiting Program- all families welcome | -- | -- | 74 | | Other |

Home Visiting Model(s)

Mono County is using only PAT as a national EBHV model.

Number of Families Served and Funding Sources

Mono County reports that in the most recent calendar or fiscal year:

- Approximately 74 families received HV services through PAT using other unidentified funds

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model description for PAT, we can make the following general statement regarding Mono County services provided:

- **PAT (AFA)** provides weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of PAT, the national models used by –Mono County. A more targeted description will be presented in the second SIR.

- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

Mono County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age

- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities; **(somewhat significant)**
- Families with children with low student achievement/drop-outs; **(moderately significant)**
- Families with a history of child abuse or neglect; **(somewhat significant)**
- Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Mono County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health; (moderately significant)
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is a basic infrastructure in place (funding and an AFA agreement) to build on and expand established EBHV models in Mono County.
Mono County reports gaps of service that are identified in all domains.. Data on duplications of service are not readily available.

**Monterey County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | PAT | -- | Low Income, Pregnant Women, Teens, Children with Developmental Delays/ Disabilities, History of Domestic Violence, History of Substance Abuse, At Risk for Neglect or Abuse | -- | -- | 500 | ✓ | Title II Child Abuse & Treatment Act/CBCAP/CAPIT/PSSF, Other |
| -- | Healthy Start with no AFA | | Low Income, Pregnant Women, Teens, Children with Developmental Delays/ Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Low Income, Teens, Pregnant Women, Children with Developmental Delays/ Disabilities, History of Domestic Violence, History of Substance Abuse, Undocumented and Immigrant Population | -- | -- | 200 | ✓ | Title II Child Abuse & Treatment Act/CBCAP/CAPIT/PSSF |
| -- | EHS | -- | Low Income, Pregnant Women, Teens, History of Domestic Violence, History of Substance Abuse | -- | -- | 100 | ✓ | HS/EHS |

Home Visiting Model(s)

Monterey County is using the following three national evidence-based home visiting (EBHV) models: Parents as Teachers (PAT); Healthy Start and Early Head Start (EHS).

Number of Families Served and Funding Sources

Monterey County reports that in the most recent calendar or fiscal year:

- approximately 800 families received home visiting services through the three national EBHV models cited above.
- Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 300 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model

fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Monterey County services provided:

- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PAT (AFA)** uses paraprofessionals to provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.
- **Healthy Start (Non-AFA)** has core service components including outreach, case management, health education, interconceptional care, and screening and referral.

Targeted Goals/Outcomes of the Intervention

In general, the following describe some of the goals and outcomes of the national models used by Monterey County. A more targeted description will be presented in the second SIR:

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.
- **Healthy Start** – Reduce infant mortality, birth weight and racial disparities in perinatal outcomes.

Gaps/Unmet Needs

Monterey County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age;
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8;
- Families with children with low student achievement/drop-outs; **(moderately significant)**
- families with children with developmental delays or disabilities
- families with a history of substance abuse
- families with a history of child abuse or neglect
- families with a history of domestic violence
- current or former military families
- non-English speaking families

Benchmarks

In addition, Monterey County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is substantial infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Monterey County.

Monterey County reports gaps of service that are identified in all domains. Waiting lists exist for PAT, Healthy Start and EHS, which reinforces the need for more HV services. Data on duplications of service are not readily available

**Napa County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | HFA | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, At Risk for Child Abuse, Neglect, and Homelessness | -- | -- | 277 | ✓ | Title II Child Abuse & treatment Act/CBCAP/CAPIT/PSSF, Other |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Hispanic | -- | -- | 116 | ✓ | HS/EHS |

Home Visiting Model(s)

Napa County is using two EBHV models: HFA and EHS.

Number of Families Served and Funding Sources

Napa County reports that in the most recent calendar or fiscal year:

- Approximately 393 families received HV services through the two national EBHV models cited above
- Title II Child Abuse & Treatment Act/CBCAP/CAPIT/PSSF, Title IV Temporary Assistance to Needy Families/CalWORKS, HS/EHS, and other unidentified funds may fund both EBHV and non-EBHV services for 548 families

Services Provided

Some national EBHV programs have an AFA with their national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Napa County services provided:

- **HFA (non-AFA)** programs typically include an initial assessment of new parents; ensure families to have a medical home; link families with other resources in the community; and help families feel empowered
- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Napa County. A more targeted description will be presented in the second SIR.

- **HFA –** Promote positive parenting skills; prevent child abuse and neglect; and support optimal prenatal care and child health and development.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Napa County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities
- Families with children with low student achievement/drop-outs; **(moderately significant)**
- Families with a history of child abuse or neglect
- Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Napa County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Napa County.

Napa County reports gaps of service identified in all domains. Waiting list exists for HFA and EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Nevada County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | HFA | -- | Low income, Pregnant Women, History of Domestic Violence, History of Substance Abuse, At Risk for Child Abuse Per Screening Tool | -- | -- | 184/10 | ✓ | Title II Child Abuse & Treatment Act/CBCAP/ CAPIT/PSSF, Title IV Temporary Assistance to Needy Families/ CalWORKS |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, | -- | -- | 92 | ✓ | HS/EHS |

Home Visiting Model(s)

Nevada County is using two EBHV models: HFA and EHS.

Number of Families Served and Funding Sources

Nevada County reports that in the most recent calendar or fiscal year:

- Approximately 144 families received HV services through HFA and EHS
- Title II Child Abuse & Treatment Act/CBCAP/CAPIT/PSSF and Title IV Temporary Assistance to Needy Families/CalWORKS funds may fund both EBHV and non-EBHV services for 379 families

Services Provided

Some national EBHV programs have an AFA with their national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Nevada County services provided:

- **HFA (AFA)** programs typically include an initial assessment of new parents; ensure families to have a medical home; link families with other resources in the community; and help families feel empowered
- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Nevada County. A more targeted description will be presented in the second SIR.

- **HFA –** Promote positive parenting skills; prevent child abuse and neglect; and support optimal prenatal care and child health and development.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Nevada County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities
- Families with children with low student achievement/drop-outs; **(moderately significant)**
- Families with a history of child abuse or neglect
- Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Nevada County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development
- Child health and development; **(somewhat significant)**
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention; **(moderately significant)**
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Nevada County.

Nevada County reports gaps of service identified in all domains. Waiting list exists for HFA and EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

## Orange County Survey Results

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | NFP | -- | Low income, Pregnant Women, Under 24 yrs and less than 28 weeks gestation, first time pregnant and parenting | -- | -- | 255 | ✓ | Other |
| -- | PAT | -- | Low income, Educationally and Economically Disadvantaged | -- | -- | 200 | | Other |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse | -- | -- | 164 | ✓ | HS/EHS |
| -- | PCHP | -- | Low income, Educationally and economically disadvantaged Latino children is Santa Ana, Anaheim and parts of Tustin. Mean family income is $19,000 mean parental education is 9 years. | -- | -- | 525 | ✓ | Other |
| -- | Other | -- | Low income, Pregnant Women, Teens | -- | -- | 2733 | ✓ | Other |

Home Visiting Model(s)

Orange County is using the following four national evidence-based home visiting (EBHV) models: the Nurse Family Partnership (NFP), Parents as Teachers (PAT), Early Head Start (EHS) and Parent-Child Home Program (PCHP).

Number of Families Served and Funding Sources

Orange County reported that in the most recent calendar or fiscal year:

- approximately 3847 families received home visiting services by the four national EBHV models cited above.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; Title IV Temporary Assistance to Needy Families/CalWORKS; and Head Start Act/Early Head Start fund both EBHV and non-EBHV home visiting services for 4112 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Orange County services provided:

- **NFP (AFA)** Public health nurses provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.
- **PAT (AFA)** provides weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.
- **EHS (AFA )** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PCHP (AFA)** works with primary caregivers to develop their children's literacy and language skills and prepares them to enter school. Also serves as a referral to link families with social services or early childhood and parenting education opportunities.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Orange County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PCHP –** Develop children's language and literacy skills; empower parents to be teachers; prepare children for life long academic success; enhance parenting skills

Gaps/Unmet Needs

Orange County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities; **(moderately significant)**
- families with children with low student achievement/drop-outs; **(moderately significant)**
- families with a history of child abuse or neglect; **(moderately significant)**

- families with a history of domestic violence; **(moderately significant)**
- families with a history of substance abuse; **(moderately significant)**
- current or former military families
- non-English speaking families

Benchmarks

In addition, Orange County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills **(moderately significant)**
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is substantial infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Orange County.

Orange County reports significant gaps of service identified in all domain. Waiting lists exist for NFP, EHS, PCHP, and an unidentified service which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Plumas County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | PAT | -- | Low income, Pregnant Women, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse | -- | -- | 300 | | Other |
| -- | Healthy Start with no AFA | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 106 | | Other |
| -- | EHS | -- | Low income, Pregnant Women, Children with Developmental Delays/Disabilities, | -- | -- | 25 | | HS/EHS |

Home Visiting Model(s)

Plumas County is using three national EBHV models; PAT, Healthy Start, and EHS.

Number of Families Served and Funding Sources

Plumas County reports that in the most recent calendar or fiscal year:

- Approximately 431 families received HV services through the EHS models listed using Title V MCH Block Grant, HS/EHS, and other unidentified funds

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statement regarding Plumas County services provided:

- **Healthy Start (non-AFA)** has core service components including outreach, case management, health education, interconceptional care, and screening and referral.
- **PAT (AFA)** provides weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.
- **EHS (AFA )** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Plumas County. A more targeted description will be presented in the second SIR.

- **Healthy Start** – Reduce infant mortality, birth weight and racial disparities in prenatal outcomes.
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Plumas County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities
- Families with children with low student achievement/drop-outs
- Families with a history of child abuse or neglect
- Families with a history of domestic violence; **(moderately significant)**
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Plumas County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness; **(moderately significant)**
- Domestic violence prevention
- Mental health; **(moderately significant)**
- Substance abuse

- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is significant infrastructure in place (funding and an AFA agreement) to build on and expand established EBHV models in Plumas County.

Plumas County reports gaps of service that are identified in all domains. Data on duplications of service are not readily available.

**Riverside County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | PAT | -- | Low income, Pregnant Women, Teens, Large Families | -- | -- | 600 | ✓ | Title V MCH Block Grant Funds |
| -- | EHS | -- | Children with Developmental Delays/Disabilities, Infants and Toddlers | -- | -- | 2000 | ✓ | HS/EHS |
| -- | NFP | -- | Low income, Pregnant Women, Teens, First Time Parents | -- | -- | 80 | ✓ | Unknown |

Home Visiting Model(s)

Riverside County is using the following three national evidence-based home visiting (EBHV) models: the Nurse Family Partnership (NFP), Parents as Teachers (PAT), and Early Head Start (EHS).

Number of Families Served and Funding Sources

Riverside County reported that in the most recent calendar or fiscal year:

- approximately 35,170 families received home visiting services from the three national EBHV models cited above.
- Title V MCH Block Grant Funds; Title IV Temporary Assistance to Needy Families/CalWORKS; and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 2680 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Riverside County services provided:

- **NFP (AFA)** uses public health nurses to provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.
- **PAT (AFA)** provides weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.
- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also

includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Riverside County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Riverside County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Riverside County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention

- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Riverside County.

Riverside County reports significant gaps of service identified in all domains. Waiting lists exist for all three EBHV models cited which reinforces the need for more HV services. Data on duplications of service are not readily available.

## Sacramento County Survey Results

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/ outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | NFP | -- | Low income, Pregnant Women, Teens, Clients in the primary target population listed above may also have domestic violence and substance abuse issues, but this is not known until the Public Health Nurse visits the client and establishes a trusting relationship. | -- | -- | 372 | | Other |
| -- | Healthy Start | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, children 0-5, differential response families referred by CPS | -- | -- | 1200 | ✓ | Other |
| -- | SafeCare | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Special assessments-health and CHDP, preschool and elementary | -- | -- | 2700 | ✓ | Other |
| -- | HIPPY with no AFA | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse | -- | -- | 7000 | ✓ | HS/EHS |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Homeless | -- | -- | 3585 | ✓ | HS/EHS |
| -- | PCHP with no AFA | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 900 | ✓ | Other |

Home Visiting Model(s)

Sacramento County is using the following six national evidence-based home visiting (EBHV) models: the Nurse Family Partnership (NFP), Healthy Start, SafeCare, Early Head Start (EHS), Parent-Child Home Program (PCHP) and Home Instruction for Parents of Preschool Youngsters (HIPPY).

Number of Families Served and Funding Sources

Sacramento County reported that in the most recent calendar or fiscal year:

- Approximately 15,757 families received home visiting services from the six national EBHV models cited above.
- Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 10,585 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Sacramento County services provided:

- **NFP (AFA)** Public health nurses provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.
- **Healthy Start (AFA)** Core service components including outreach, case management, health education, interconceptional care, and screening and referral.
- **SafeCare (non-AFA)** consists of a parent-training curriculum which includes three modules: Health; Home Safety; and Parent-Infant.
- **EHS (AFA)** Comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PCHP (non-AFA)** Works with primary caregivers to develop their children's literacy and language skills and prepares them to enter school. Also serves as a referral to link families with social services or early childhood and parenting education opportunities.
- **HIPPY (non-AFA)** is a school readiness program that helps parents prepare their three to five year old children for success in school and life. Parents are provided with books and materials to help strengthen their child's cognitive and literacy skills.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Sacramento County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.
- **Healthy Start** – Reduce infant mortality, birth weight and racial disparities in perinatal outcomes.

- **SafeCare –** Teach parents in child behavior management and home safety training, child health care skills to prevent child maltreatment
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PCHP –** Develop children's language and literacy skills; empower parents to be teachers; prepare children for life long academic success; enhance parenting skills
- **HIPPY** – Empower parents as primary educators of their children; promote school readiness and early literacy through parental involvement

Gaps/Unmet Needs

Sacramento County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs; **(moderately significant)**
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Sacramento County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is substantial infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Sacramento County.

Sacramento County reports significant gaps of service identified in all domains. Waiting lists exist for Healthy Start, SafeCare, EHS, PCHP and HIPPY services which reinforces the need for more HV services. Data on duplications of service are not readily available.

**San Bernardino County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | Healthy Start | -- | Low income, Pregnant Women, Teens | -- | -- | 901 | | Title IV Temporary Assistance to Needy Families/CalWORKS, Title V MCH Block Grant Funds |
| -- | PAT | -- | Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Homeless and Foster Children | -- | -- | 334 | ✓ | HS/EHS |
| -- | HIPPY | -- | Low income, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Homeless and Foster Care Children | -- | -- | 108 | | Unknown |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Homeless and Foster Children | -- | -- | 354 | | HS/EHS |

Home Visiting Model(s)

San Bernardino County is using the following four national evidence-based home visiting (EBHV) models: Parents as Teachers (PAT), Healthy Start, Early Head Start (EHS) and Home Instruction for Parents of Preschool Youngsters (HIPPY).

Number of Families Served and Funding Sources

San Bernardino County reports that in the most recent calendar or fiscal year:

- approximately 1697 families received home visiting services through the four national EBHV models cited above.

- Title V MCH Block Grant Funds; Title IV Temporary Assistance to Needy Families/CalWORKS and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 3255 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding San Bernardino County services provided:

- **PAT (AFA)** Paraprofessionals may provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network
- **Healthy Start (non-AFA)** Core service components including outreach, case management, health education, interconceptional care, and screening and referral.
- **EHS (AFA)** Comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **HIPPY (AFA)** is a school readiness program that helps parents prepare their three to five year old children for success in school and life. Parents are provided with books and materials to help strengthen their child's cognitive and literacy skills.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by San Bernardino County. A more targeted description will be presented in the second SIR.

- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.
- **Healthy Start** – Reduce infant mortality, birth weight and racial disparities in perinatal outcomes.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **HIPPY** – Empower parents as primary educators of their children; promote school readiness and early literacy through parental involvement.

Gaps/Unmet Needs

San Bernardino County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8

- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, San Bernardino County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in San Bernardino County.

San Bernardino County reports gaps of service that are identified in all domains. Waiting lists exist for PAT and HIPPY which reinforces the need for more HV services. Data on duplications of service are not readily available.

## San Diego County Survey Results

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | NFP | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Pregnant Teens in Foster Care or Kinship | -- | -- | 443 | | Other |
| -- | HFA | -- | Low income, Pregnant Women, East African Families | -- | -- | 40 | | Other |
| -- | PAT | -- | Military Families | -- | -- | 1900 | ✓ | Other |
| -- | Healthy Start | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, High Medical Risk & Residents in Target Zip Codes | -- | -- | 318 | ✓ | Other |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, First Time Parents | -- | -- | 355 | ✓ | EHS |
| -- | SafeCare | -- | Families Involved With Child Welfare Services With an Allegation of Neglect | -- | -- | 299 | ✓ | Title II Child Abuse & Treatment Act/CBCAP/CAPIT/PSSF |

Home Visiting Model(s)

San Diego County is using the following six national evidence-based home visiting (EBHV) models: the Nurse Family Partnership (NFP), Healthy Families America (HFA), Parents as Teachers (PAT), Healthy Start, Early Head Start (EHS), and SafeCare.

Number of Families Served and Funding Sources

San Diego County reports that in the most recent calendar or fiscal year:

- approximately 3355 families received home visiting services through the six national EBHV models cited above.

- Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 3024 families

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding San Diego County services provided:

- **NFP (AFA)** Public health nurses provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.
- **HFA (non-AFA)** programs typically include an initial assessment of new parents; ensure families to have a medical home; link families with other resources in the community; and help families feel empowered
- **Healthy Start (AFA)** Core service components including outreach, case management, health education, interconceptional care, and screening and referral.
- **EHS (AFA)** Comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **SafeCare (AFA)** consists of a parent-training curriculum which includes three modules: Health; Home Safety; and Parent-Infant.
- **PAT (AFA)** Paraprofessionals may provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by San Diego County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.
- **Healthy Start** – Reduce infant mortality, birth weight and racial disparities in perinatal outcomes.
- **HFA –** Promote positive parenting skills; prevent child abuse and neglect; and support optimal prenatal care and child health and development.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **SafeCare –** Teach parents in child behavior management and home safety training, child health care skills to prevent child maltreatment.

- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

San Diego County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities; **(somewhat significant)**
- families with children with low student achievement/drop-outs; **(moderately significant)**
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, San Diego County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in San Diego County.

San Diego County reports gaps of service that are identified in all domains. Waiting lists exist for the four of the six existing EBHV models which reinforces the need for more HV services. Data on duplications of service are not readily available.

**San Francisco County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | Other | -- | Low Income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Newborns and Infants | -- | -- | 1000 | ✓ | Other |

Home Visiting Model(s)

San Francisco (SF) County reported that they are not using the any of the national evidence-based home visiting (EBHV) models.

Number of Families Served and Funding Sources

In the most recent calendar or fiscal year:

- approximately 1000 families received non-EBHV home visiting services in SF County.
- SF County reported they do use the following funding sources: Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; Title IV Temporary Assistance to Needy Families/CalWORKS; and Head Start Act/Early Head Start

Services Provided

Information regarding SF County services was not provided in the survey.

Targeted Goals/Outcomes of the Intervention

Information was not available for the goals and outcomes of the other HV program used in SF County.

Gaps/Unmet Needs

SF County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect

- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, SF County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is limited infrastructure in place to support EBHV models in SF County. Their response to the survey appears to be incomplete.

SF County reports gaps of service that are identified in all domains. A waiting list for an unidentified HV service is mentioned which shows a need for additional services. Data on duplications of service are not readily available.

**San Joaquin County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Pregnant Women, Children ages 0-3 | -- | -- | Unknown | ✓ | HS/EHS |
| -- | PAT | -- | Pregnant Women, Children ages 0-3 | -- | -- | 300 | ✓ | Other |

Home Visiting Model(s)

San Joaquin County is using the following two national evidence-based home visiting (EBHV) models: Parents as Teachers (PAT) and Early Head Start (EHS).

Number of Families Served and Funding Sources

San Joaquin County reports that in the most recent calendar or fiscal year:

- approximately 300 families received home visiting services through the PAT model. EHS did not identify the number of families served in the survey.
- Title V MCH Block Grant Funds and Head Start Act/Early Head Start may fund EBHV and non-EBHV home visiting services for 800 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and more likely follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding San Joaquin County services provided:

- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PAT (AFA)** uses paraprofessionals to provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, the following describe some of the goals and outcomes of the national models used by San Joaquin County. A more targeted description will be presented in the second SIR:

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

San Joaquin County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs; **(moderately significant)**
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families; **(moderately significant)**
- non-English speaking families

Benchmarks

In addition, San Joaquin County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills; **(moderately significant)**
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in San Joaquin County.

San Joaquin County reports gaps of service that are identified in all domains. Waiting lists exist for the both PAT and EHS, which reinforces the need for more HV services. Data on duplications of service are not readily available.

## San Luis Obispo County Survey Results

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | NFP | -- | Low Income, Pregnant Women, Teens, Families in the Foster Care System | -- | -- | 46 | | Other |
| -- | EHS | -- | Low Income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Families in the Foster Care System | -- | -- | 125 | ✓ | HS/EHS |

Home Visiting Model(s)

San Luis Obispo County is using the following two national evidence-based home visiting (EBHV) models: the Nurse Family Partnership (NFP), and Early Head Start (EHS).

Number of Families Served and Funding Sources

San Luis Obispo County reported that in the most recent calendar or fiscal year:

- approximately 245 families received home visiting services by the two EBHV models cited above.
- Head Start Act/Early Head Start may fund 125 of the EBHV and non-EBHV services.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding San Luis Obispo County services provided:

- **NFP (AFA)** uses public health nurses to provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.
- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by San Luis Obispo County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

San Luis Obispo County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age; **(moderately significant)**
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8; **(moderately significant)**
- families with children with developmental delays or disabilities**; (moderately significant)**
- families with children with low student achievement/drop-outs**; (somewhat significant)**
- families with a history of child abuse or neglect; **(moderately significant)**
- families with a history of domestic violence; **(moderately significant)**
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, San Luis Obispo County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development **(moderately significant)**
- Parenting skills
- Child abuse and injury prevention
- School readiness **(moderately significant)**
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is basic infrastructure to expand established home visiting services in San Luis Obispo County.

San Luis Obispo County reports significant gaps of service identified in all domains. A waiting list exist for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**San Mateo County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | PAT with AFA | -- | Low Income, Pregnant Women, Children with Developmental Delays/ Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement | -- | -- | 137 | ✓ | HS/EHS |
| -- | EHS | | Low Income, Pregnant Women, Children with Developmental Delays/ Disabilities, History of Domestic Violence, Spanish-speaking; Father/Male; San Mateo County Coast | -- | -- | 88 | ✓ | HS/EHS |
| -- | PAT with no AFA | -- | Low Income, Teens, Pregnant Women, Children with Developmental Delays/ Disabilities, History of Domestic Violence, Spanish-speaking; Father/Male; San Mateo County Coast | -- | -- | 88 | | Other |

Home Visiting Model(s)

San Mateo County is using the following two national evidence-based home visiting (EBHV) models: Parents as Teachers (PAT) and Early Head Start (EHS). PAT exists in two different EBHV models, one operates independently with a national agency funding agreement (AFA). The other PAT is embedded in the EHS which does not have an AFA.

Number of Families Served and Funding Sources

San Mateo County reports that in the most recent calendar or fiscal year:

- approximately 225 families received home visiting services through the two national EBHV models cited above.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; Title IV Temporary Assistance to Needy Families/CalWORKS; and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 731 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and more likely follow model fidelity than those EBHV programs without AFAs. Based on the national model

descriptions, we can make the following general statements regarding San Mateo County services provided:

- **EHS (Non-AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services. PAT is embedded in their program (separate from below).
- **PAT (AFA)** uses paraprofessionals to provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, the following describe some of the goals and outcomes of the national models used by San Mateo County. A more targeted description will be presented in the second SIR:

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

San Mateo County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with a history of child abuse or neglect
- families with a history of domestic violence
- current or former military families
- non-English speaking families

New HV funding would **somewhat significantly** address gaps in these populations:

- families with children with developmental delays or disabilities
- families with a history of substance abuse

Families with children with low student achievement/drop-outs would not be significantly addressed by new home visiting funding.

Benchmarks

In addition, San Mateo County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health

- Infant health and development
- Child health and development **(moderately significant)**
- Parenting skills
- Child abuse and injury prevention
- Domestic violence prevention
- Mental health
- Substance abuse **(moderately significant)**
- Economic self-sufficiency **(moderately significant)**

New HV funding would **somewhat significantly address these services:**

- Coordination of referrals to community resources and supports
- School readiness

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to expand established EBHV models in San Mateo County.

San Mateo County reports gaps of service that are identified in all domains. Waiting lists exist for PAT and EHS, which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Santa Barbara County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | HFA with no AFA | -- | Low Income, Pregnant Women, Teens | -- | -- | 50 | | Other |
| -- | SafeCare | -- | History of Substance Abuse, Families reported for Child Abuse & Neglect or at High Risk | -- | -- | Implemented in 2/10: Currently serving 24 Families | | Other |
| -- | HIPPY | -- | Low Income, Low Student Achievement/Dropouts, Parents with Low Education Levels | -- | -- | 113 | ✓ | HS/EHS, Other |
| | EHS | -- | Pregnant Women, Children with Developmental Delays/ Disabilities, | -- | -- | 20 | ✓ | HS/EHS |
| | Other | | Low Income, Pregnant Women, Teens, Children with Developmental Delays/ Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, English Language Learners | -- | -- | Implementation Date of 10/1/10: No families Currently Served | | Unknown |

Home Visiting Model(s)

Santa Barbara County is using the following four national evidence-based home visiting (EBHV) models: Healthy Families America (HFA), SafeCare, Healthy Start, Early Head Start (EHS), and Home Instruction for Parents of Preschool Youngsters (HIPPY).

Number of Families Served and Funding Sources

Santa Barbara County reports that in the most recent calendar or fiscal year:

- Approximately 207 families received home visiting services through the four national EBHV models cited above
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; Title IV Temporary Assistance to Needy Families/CalWORKS and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 2414 families

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model

fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Santa Barbara County services provided:

- **HFA (non-AFA)** programs typically include an initial assessment of new parents; ensure families to have a medical home; link families with other resources in the community; and help families feel empowered
- **EHS (AFA)** Comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **HIPPY (AFA)** is a school readiness program that helps parents prepare their three to five year old children for success in school and life. Parents are provided with books and materials to help strengthen their child's cognitive and literacy skills.
- **SafeCare (AFA)** consists of a parent-training curriculum which includes three modules: Health; Home Safety; and Parent-Infant.

Targeted Goals/Outcomes of the Intervention

In general, the following describe some of the goals and outcomes of the national models used by Santa Barbara County. A more targeted description will be presented in the second SIR:

- **HFA –** Promote positive parenting skills; prevent child abuse and neglect; and support optimal prenatal care and child health and development.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **HIPPY** – Empower parents as primary educators of their children; promote school readiness and early literacy through parental involvement.
- **SafeCare** - Teaches parents in child behavior management and home safety training, child health care skills to prevent child maltreatment.

Gaps/Unmet Needs

Santa Barbara County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with low student achievement/drop-outs
- families with children with developmental delays or disabilities; **(moderately significant)**
- families with a history of substance abuse;
- families with a history of child abuse or neglect;
- families with a history of domestic violence;
- current or former military families; and
- non-English speaking families

Benchmarks

In addition, Santa Barbara County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Santa Barbara County.

Santa Barbara County reports gaps of service that are identified in all domains. Waiting lists exist for EHS and HIPPY which reinforces the need for expansion of HV services. Data on duplications of service are not readily available.

**Santa Clara County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | NFP | -- | Low income, Pregnant Women, Teens, Involved in the Juvenile Justice System and Child Protective Services | -- | -- | Program begins 10/01/10 | ✓ | Other |
| -- | EHS | -- | Unknown | -- | -- | Unknown | Unknown | HS/EHS |

Home Visiting Model(s)

Santa Clara County is using the following two national evidence-based home visiting (EBHV) models: the Nurse Family Partnership (NFP), and Early Head Start (EHS). The NFP model will begin service on 10/1/10, therefore data is "unknown" at this time. EHS did not provide data on their program.

Number of Families Served and Funding Sources

Santa Clara County reported that in the most recent calendar or fiscal year:

- The number of families receiving home visiting services by the two national EBHV models cited above is unknown at this time.
- Title V MCH Block Grant Funds; Title IV Temporary Assistance to Needy Families/CalWORKS; and Head Start Act/Early Head Start *may* fund both EBHV and non-EBHV home visiting services for 1297 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Santa Clara County services provided:

- **NFP (AFA)** uses public health nurses to provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.
- **EHS (AFA ?)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Santa Clara County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Santa Clara County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs; **(moderately significant)**
- families with a history of child abuse or neglect; families with a history of domestic violence; **(moderately significant)**
- families with a history of substance abuse; **(somewhat significant)**
- current or former military families; and
- non-English speaking families

Benchmarks

In addition, Santa Clara County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention; **(moderately significant)**
- Mental health
- Substance abuse; **(somewhat significant)**
- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of limited information, it appears there is limited infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Santa Clara County. The establishment of a new NFP model has potential.

Santa Clara County reports significant gaps of service identified in all domains. Data on duplications of service are not readily available.

**Santa Cruz County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Substance Abuse, Foster Children | -- | -- | 174 | ✓ | HS/EHS |

Home Visiting Model(s)

Santa Cruz County is using one national evidence-based home visiting (EBHV) model: Early Head Start (EHS).

Number of Families Served and Funding Sources

Santa Cruz County reports that in the most recent calendar or fiscal year:

- approximately 174 families received home visiting services through EHS.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; Title IV Temporary Assistance to Needy Families/CalWORKS; and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 750 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Santa Cruz County services provided:

- **EHS (AFA)** comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Santa Cruz County. A more targeted description will be presented in the second SIR.

- **EHS –** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Santa Cruz County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age;

- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8;
- families with children with developmental delays or disabilities;
- families with children with low student achievement/drop-outs;
- families with a history of child abuse or neglect;
- families with a history of domestic violence; **(moderately significant)**
- families with a history of substance abuse
- current or former military families; and
- non-English speaking families

Benchmarks

In addition, Santa Cruz County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to build on and expand the established EBHV model in Santa Cruz County.

Santa Cruz County reports gaps of service that are identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Shasta County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | PAT with EHS | -- | Low Income | -- | -- | 206 | ✓ | HS/EHS |

Home Visiting Model(s)

Shasta County is using the following two national evidence-based home visiting (EBHV) models: Parents as Teachers (PAT) and Early Head Start (EHS).

Number of Families Served and Funding Sources

Shasta County reports that in the most recent calendar or fiscal year:

- approximately 206 families received home visiting services through the two national EBHV models cited above.
- Head Start Act/Early Head Start funds both home visiting models.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Shasta County services provided:

- **EHS (AFA)** Comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PAT (non-AFA)** Paraprofessionals may provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Shasta County. A more targeted description will be presented in the second SIR.

- **EHS -** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PAT -** To empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

Shasta County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities; **(somewhat significant)**
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Shasta County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development **(moderately significant)**
- Parenting skills
- Child abuse and injury prevention
- School readiness **(somewhat significant)**
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports **(somewhat significant)**

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Shasta County.

Shasta County reports gaps of service identified in all domains. Waiting lists that exist for the two Shasta County EBHV models reinforces the need for more HV services. Data on duplications of service are not readily available

**Sierra County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | Other | -- | Unknown | -- | -- | Unknown | Unknown | Title II Child Abuse & Treatment Act/CBCAP/ CAPIT/PSSF, Title IV Temporary Assistance to Needy Families/ CalWORKS, Title V MCH Block Grant Funds, and Other |

Home Visiting Model(s)

Sierra County is not using either EBHV or non-EBHV models to serve families

Number of Families Served and Funding Sources

Sierra County is not serving any families

Services Provided

Sierra County has no available services

Targeted Goals/Outcomes of the Intervention

There are no interventions in Sierra County

Gaps/Unmet Needs

Sierra County reported that new home visiting funding would **either somewhat or moderately** address the following services. Only three services would be **significantly** affected by new home visiting services:

- Pregnant females under 21 years of age; **(not significant)**
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8; **(moderately significant)**
- Families with children with developmental delays or disabilities; **(somewhat significant)**
- Families with children with low student achievement/drop-outs; **(somewhat significant)**
- Families with a history of child abuse or neglect; **(moderately significant)**
- Families with a history of domestic violence; **(moderately significant)**
- Families with a history of substance abuse; **(significant)**
- Current or former military families; **(significant)**

- Non-English speaking families; **(significant)**

Benchmarks

In addition, Sierra County indicated that new home visiting funding would **either somewhat or moderately** address the following services. Only one service would be **significantly** affected by new home visiting services:

- Prenatal/maternal health; **(somewhat significant)**
- Infant health and development; **(moderately significant)**
- Child health and development; **(moderately significant)**
- Parenting skills; **(moderately significant)**
- Child abuse and injury prevention; **(somewhat significant)**
- School readiness; **(moderately significant)**
- Domestic violence prevention; **(moderately significant)**
- Mental health; **(unknown)**
- Substance abuse: **(significant)**
- Economic self-sufficiency ; **(moderately significant)**
- Coordination of referrals to community resources and supports; **(somewhat significant)**

Summary

On the basis of this information there is no existing infrastructure in place (funding and an AFA agreement) to build EBHV models in Sierra County.

Sierra County reports gaps of service that are identified, to various degrees, in all domains. Data on duplications of service are not readily available.

**Siskiyou County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 136 | ✓ | HS/EHS |

Home Visiting Model(s)

Siskiyou County is using one national evidence-based home visiting (EBHV) model: Early Head Start (EHS).

Number of Families Served and Funding Sources

Siskiyou County reports that in the most recent calendar or fiscal year:

- Approximately 136 families received home visiting services through EHS.
- Head Start Act/Early Head Start is the only funding source identified in the survey.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Siskiyou County services provided:

- **EHS (AFA)** comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Siskiyou County. A more targeted description will be presented in the second SIR.

- **EHS –** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Siskiyou County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age

- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities; **(moderately significant)**
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Siskiyou County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness; **(moderately significant)**
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to build on and expand an established EBHV model in Siskiyou County.

Siskiyou County reports gaps of service that are identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Solano County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| | NFP | -- | Low Income, Pregnant Women, Teens, Parents in Foster Care System | -- | -- | 46 | | Other |
| -- | EHS | -- | Low Income, Pregnant Women, Children with Developmental Delays/ Disabilities, History of Domestic Violence, History of Substance Abuse | -- | -- | 66 | ✓ | HS/EHS |
| | SafeCare | -- | Low Income | -- | -- | 100 | | Other |
| -- | Other | -- | Low Income, Pregnant Women, Children with Developmental Delays/ Disabilities, Isolated Monolingual Spanish Families | -- | -- | 80 | ✓ | Title V MCH Block Grant Funds |

Home Visiting Model(s)

Solano County is using the following three national evidence-based home visiting (EBHV) models: the Nurse Family Partnership (NFP), SafeCare, and Early Head Start (EHS).

Number of Families Served and Funding Sources

Solano County reported that in the most recent calendar or fiscal year:

- approximately 292 families received home visiting services by the three EBHV models cited above.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 449 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Solano County services provided:

- **NFP (AFA)** uses public health nurses to provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.

- **SafeCare (non-AFA)** consists of a parent-training curriculum which includes three modules: Health; Home Safety; and Parent-Infant.
- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Solano County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.
- **SafeCare –** Teach parents in child behavior management and home safety training, child health care skills to prevent child maltreatment.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Solano County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age;
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Solano County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention

- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports; **(moderately significant)**

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Solano County.

Solano County reports significant gaps of service identified in all domains. Waiting lists that exist for two of the four EBHV models cited (this includes the unnamed service) which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Sonoma County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| | NFP | -- | Low Income, Pregnant Women, Teens, Parents in Foster Care System | -- | -- | 46 | ✓ | Other |
| -- | EHS | -- | Parents with low education levels and children ages 0-3 | -- | -- | 66 | ✓ | HS/EHS |
| -- | Other | -- | Low Income, Pregnant Women, Children with Developmental Delays/ Disabilities, Isolated Monolingual Spanish Families | -- | -- | 80 | ✓ | Title V MCH Block Grant Funds |

Home Visiting Model(s)

Sonoma County is using the following two national evidence-based home visiting (EBHV) models: Nursing Family Partnership (NFP), and Parents as Teachers (PAT). PAT operates in two different EBHV models, one has a national agency funding agreement (AFA) and the other does not have an AFA.

Number of Families Served and Funding Sources

Sonoma County reports that in the most recent calendar or fiscal year:

- approximately 228 families received home visiting services through the two national EBHV models cited above.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; and Title IV Temporary Assistance to Needy Families/CalWORKS may fund both EBHV and non-EBHV home visiting services for 566 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Sonoma County services provided:

- **NFP (AFA)** uses public health nurses to provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.
- **PAT (AFA)** uses paraprofessionals to provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group

meetings, developmental screenings, and linkage to a resource network. *Another PAT (non-AFA) exists as previously noted.*

Targeted Goals/Outcomes of the Intervention

In general, the following describe some of the goals and outcomes of the national models used by Sonoma County. A more targeted description will be presented in the second SIR:

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

Sonoma County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with low student achievement/drop-outs
- families with children with developmental delays or disabilities
- families with a history of substance abuse
- families with a history of child abuse or neglect
- families with a history of domestic violence
- current or former military families
- non-English speaking families

Benchmarks

In addition, Sonoma County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse

- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Sonoma County.

Sonoma County reports gaps of service that are identified in all domains. Data on duplications of service are not readily available.

**Stanislaus County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low Income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities | -- | -- | 204 | ✓ | HS/EHS |
| -- | PAT | -- | Low Income, Teens | -- | -- | 50 | ✓ | Other |
| -- | PCHP | -- | Low Income | -- | -- | 30 | | Other |

Home Visiting Model(s)

Stanislaus County is using the following three national evidence-based home visiting (EBHV) models: Parents as Teachers (PAT), Healthy Start, Early Head Start (EHS), and Parent-Child Home Program (PCHP).

Number of Families Served and Funding Sources

Stanislaus County reports that in the most recent calendar or fiscal year:

- approximately 284 families received home visiting services through the three national EBHV models cited above.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; Title IV Temporary Assistance to Needy Families/CalWORKS; and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 2110 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Stanislaus County services provided:

- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PCHP (AFA)** works with primary caregivers to develop their children's literacy and language skills and prepares them to enter school. They also serve as a referral to link families with social services or early childhood and parenting education opportunities.
- **PAT (Non-AFA)** uses paraprofessionals to provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, the following describe some of the goals and outcomes of the national models used by Stanislaus County. A more targeted description will be presented in the second SIR:

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PCHP –** Develop children's language and literacy skills; enhance parenting skills and empower parents to be teachers; and prepare children for life long academic success;
- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

Stanislaus County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age;
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8;
- families with children with developmental delays or disabilities; **(moderately significant)**
- families with children with low student achievement/drop-outs
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Stanislaus County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse

- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Stanislaus County.

Stanislaus County reports gaps of service that are identified in all domains. Waiting lists exist for the two of the three EBHV models, PAT and EHS, which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Sutter County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts, Those who qualify for EHS | -- | -- | 50 | ✓ | HS/EHS |

Home Visiting Model(s)

Sutter County is using only EHS as a national EBHV model.

Number of Families Served and Funding Sources

Sutter County reports that in the most recent calendar or fiscal year:

- Approximately 50 families received HV services through the EHS model
- Title IV Temporary Assistance to Needy Families/CalWORKS, HS/EHS, and other unidentified funds may fund both EBHV and non-EBHV services for 89 families

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model description for EHS, we can make the following general statement regarding Sutter County services provided:

- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of EHS, the national model used by Sutter County. A more targeted description will be presented in the second SIR.

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Sutter County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age

- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities
- Families with children with low student achievement/drop-outs
- Families with a history of child abuse or neglect
- Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Sutter County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness; **(moderately significant)**
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is a basic infrastructure in place (funding and an AFA agreement) to build on and expand established EBHV models in Sutter County.

Sutter County reports gaps of service identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

## Tehama County Survey Results

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | PAT with no AFA | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, No previous early learning education (pre-K)/Parents working with CPS | -- | -- | 130 | ✓ | Title II Child Abuse & Treatment Act/CBCAP/ CAPIT/PSSF, Other |
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 30 | ✓ | HS/EHS |

Home Visiting Model(s)

Tehama County is using the following two national evidence-based home visiting (EBHV) models: Parents as Teachers (PAT) and Early Head Start (EHS).

Number of Families Served and Funding Sources

Tehama County reports that in the most recent calendar or fiscal year:

- approximately 160 families received home visiting services through the three national EBHV models cited above.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; Title IV Temporary Assistance to Needy Families/CalWORKS; and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 156 families

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Tehama County services provided:

- **EHS (AFA)** comprehensive child development services provided in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **PAT (non-AFA)** Paraprofessionals may provide weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Tehama County. A more targeted description will be presented in the second SIR.

- **EHS –** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **PAT** – To empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.

Gaps/Unmet Needs

Tehama County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age;
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8;
- families with children with developmental delays or disabilities; **(moderately significant)**
- families with children with low student achievement/drop-outs; **(somewhat significant)**
- families with a history of child abuse or neglect;
- families with a history of domestic violence;
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Tehama County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**

- Coordination of referrals to community resources and supports; **(moderately significant)**

Summary

On the basis of this information, there is infrastructure in place (funding and AFA agreements) to build on and expand established the EBHV model in Tehama County.

Tehama County reports gaps of service that are identified in all domains. Waiting lists exist for EHS and PAT which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Trinity County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 25 | ✓ | HS/EHS |
| -- | PAT | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Low Student Achievement/Dropouts | -- | -- | 25 | ✓ | HS/EHS |

Home Visiting Model(s)

Trinity County is using two national EBHV models; PAT and EHS.

Number of Families Served and Funding Sources

Trinity County reports that in the most recent calendar or fiscal year:

- Approximately 25 families received HV services through PAT and EHS models using HS/EHS funds

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model description for PAT and EHS, we can make the following general statement regarding Trinity County services provided:

- **PAT (AFA)** provides weekly to monthly home visits during pregnancy through enrollment in kindergarten. Service components also include group meetings, developmental screenings, and linkage to a resource network.
- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of PAT and EHS, the national model used by - Trinity County. A more targeted description will be presented in the second SIR.

- **PAT** – Empower parents to give children a solid foundation in life and school readiness; prevent and reduce child abuse/neglect; improve parenting practices/skills; detect developmental delays and health issues early.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Trinity County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age
- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities
- Families with children with low student achievement/drop-outs
- Families with a history of child abuse or neglect
- Families with a history of domestic violence; **(moderately significant)**
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition, Trinity County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness; **(moderately significant)**
- Domestic violence prevention
- Mental health; **(moderately significant)**
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**

- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is a basic infrastructure in place (funding and an AFA agreements) to build on and expand established EBHV models in Trinity County.

Trinity County reports gaps of service that are identified in all domains. Waiting lists exist for EHS and PATwhich reinforces the need for more HV services. Data on duplications of service are not readily available.

**Tulare County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | NFP | -- | Low Income, Teens, Pregnant Women, History of Domestic Violence, History of Substance Abuse | -- | -- | 50 | | Title V MCH Block Grant Funds |
| -- | SafeCare with no AFA | -- | Low Income, History of Substance Abuse, Families with Children 0-5 Years with Substantiated General Neglect Referrals | -- | -- | Implemented on 7/1/10; Currently serving 55 | ✓ | Other |
| -- | EHS | -- | Low Income, Pregnant Women | -- | -- | 79 | | HS/EHS |
| -- | Other | -- | Low Income, Pregnant Women, Teens, Families in Rural Communities | -- | -- | 250 | ✓ | Unknown |
| -- | Other | -- | Low Income, History of Domestic Violence, History of Substance Abuse, Child Welfare Services Families Working Towards Reunification or Recently Reunified | -- | -- | 40 | | Unknown |

Home Visiting Model(s)

Tulare County is using the three national evidence-based home visiting (EBHV) models: the Nurse Family Partnership (NFP), SafeCare, and Early Head Start (EHS).

Number of Families Served and Funding Sources

Tulare County reported that in the most recent calendar or fiscal year:

- approximately 184 families received home visiting services by the three EBHV models cited above.
- Title V MCH Block Grant Funds and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 96 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model

fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Tulare County services provided:

- **NFP (AFA)** uses public health nurses to provide home visits to promote positive health and development behaviors to first time mothers beginning prenatally through their child's 2nd birthday.
- **SafeCare (non-AFA)** consists of a parent-training curriculum which includes three modules: Health; Home Safety; and Parent-Infant.
- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Tulare County. A more targeted description will be presented in the second SIR.

- **NFP** – Improve pregnancy outcomes; child health and development and families economic self-sufficiency.
- **SafeCare –** Teach parents in child behavior management and home safety training, child health care skills to prevent child maltreatment.
- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Tulare County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age;
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8;
- families with children with developmental delays or disabilities; **(moderately significant)**
- families with children with low student achievement/drop-outs; **(moderately significant)**
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Tulare County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health

- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to expand established EBHV models in Tulare County.

Tulare County reports significant gaps of service identified in all domains. Waiting lists exist for SafeCare, EHS and an unidentified service which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Tuolumne County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, and English Language Learners | -- | -- | 15 | ✓ | Unknown |

Home Visiting Model(s)

Tuolumne County is using one national evidence-based home visiting (EBHV) model: Early Head Start (EHS).

Number of Families Served and Funding Sources

Tuolumne County reports that in the most recent calendar or fiscal year:

- Approximately 15 families received home visiting services through EHS.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 532 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Tuolumne County services provided:

- **EHS (AFA)** comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Tuolumne County. A more targeted description will be presented in the second SIR.

- **EHS –** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Tuolumne County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities
- families with children with low student achievement/drop-outs; **(moderately significant)**
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Tuolumne County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports; **(moderately significant)**

Summary

On the basis of this information, there is some infrastructure in place (funding and AFA agreements) to build on and expand an established EBHV model in Tuolumne County.

Tuolumne County reports gaps of service that are identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

## Ventura County Survey Results

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low Income, Pregnant Women, Children ages 0-3 | -- | -- | 465 | ✓ | HS/EHS |

Home Visiting Model(s)

Ventura County is using the following two national evidence-based home visiting (EBHV) models: SafeCare and Early Head Start (EHS).

Number of Families Served and Funding Sources

Ventura County reports that in the most recent calendar or fiscal year:

- approximately 544 families received home visiting services through the two national EBHV models cited above.
- Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 767 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Ventura County services provided:

- **EHS (AFA)** is a comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.
- **SafeCare (Non-AFA)** consists of a parent-training curriculum which includes three modules: Health; Home Safety; and Parent-Infant.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of the national models used by Ventura County. A more targeted description will be presented in the second SIR.

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.
- **SafeCare (Non-AFA)** - Teaches parents in child behavior management and home safety training, child health care skills to prevent child maltreatment.

Gaps/Unmet Needs

Ventura County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with developmental delays or disabilities; **(somewhat significant)**
- families with children with low student achievement/drop-outs; **(somewhat significant)**
- families with a history of child abuse or neglect
- families with a history of domestic violence
- families with a history of substance abuse
- current or former military families
- non-English speaking families

Benchmarks

In addition, Ventura County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness **(somewhat significant)**
- Domestic violence prevention
- Mental health **(moderately significant)**
- Substance abuse
- Economic self-sufficiency **(moderately significant)**
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Ventura County.

Ventura County reports significant gaps of service identified in all domains. A waiting list exists for EHS services which reinforces the need for more HV services. Data on duplications of service are not readily available.

**Yolo County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | HFA with no AFA | -- | Low income, Pregnant Women, History of Depression | -- | -- | 46 | | Other |
| -- | EHS with no AFA | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse | -- | -- | 60 | ✓ | HS/EHS |

Home Visiting Model(s)

Yolo County is using the following two national evidence-based home visiting (EBHV) models: Healthy Families America (HFA) and Early Head Start (EHS).

Number of Families Served and Funding Sources

Yolo County reports that in the most recent calendar or fiscal year:

- Approximately 106 families received home visiting services through the two national EBHV models cited above.
- Title V MCH Block Grant Funds; Title II Child Abuse and Treatment Act/CBCAP/CAPIT/PSSF; and Families/CalWORKS and Head Start Act/Early Head Start may fund both EBHV and non-EBHV home visiting services for 407 families.

Services Provided

Some national EBHV programs have an Agency Funding Agreement (AFA) with their national office. An AFA increases the likelihood that they follow standards of care and follow model fidelity than those EBHV programs without AFAs. Based on the national model descriptions, we can make the following general statements regarding Yolo County services provided:

- **HFA (non-AFA)** programs typically include an initial assessment of new parents; ensure families to have a medical home; link families with other resources in the community; and help families feel empowered
- **EHS (non-AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, the following describe some of the goals and outcomes of the national models used by Yolo County. A more targeted description will be presented in the second SIR:

- **HFA –** To promote positive parenting skills; prevent child abuse and neglect; and support optimal prenatal care and child health and development.
- **EHS –** To promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Yolo County reported that new home visiting funding would **significantly** address gaps in serving the following populations:

- pregnant females under 21 years of age
- low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- families with children with low student achievement/drop-outs; **(somewhat significant)**
- families with children with developmental delays or disabilities; **(somewhat significant)**
- families with a history of substance abuse
- families with a history of child abuse or neglect; **(moderately significant)**
- families with a history of domestic violence; **(moderately significant)**
- current or former military families
- non-English speaking families

Benchmarks

In addition, Yolo County indicated that new home visiting funding would **significantly** address the following services:

- Prenatal/maternal health
- Infant health and development
- Child health and development
- Parenting skills
- Child abuse and injury prevention
- School readiness
- Domestic violence prevention
- Mental health; **(moderately significant)**
- Substance abuse
- Economic self-sufficiency; **(moderately significant)**
- Coordination of referrals to community resources and supports; **(moderately significant)**

Summary

On the basis of this information, there is basic infrastructure in place (funding and AFA agreements) to build on and expand established EBHV models in Yolo County.

Yolo County reports gaps of service identified in all domains. A waiting list exists for EHS which may reinforce the need for more HV services. Data on duplications of service are not readily available.

**Yuba County Survey Results**

| Name of the Program | Model or approach in use | Specific service provided | Intended recipients/targeted population | Targeted goals/outcomes of interventions | Demographic characteristics of families served | Number of families served | Waiting list for services | Funding Source |
|---|---|---|---|---|---|---|---|---|
| -- | EHS | -- | Low income, Pregnant Women, Teens, Children with Developmental Delays/Disabilities, History of Domestic Violence, History of Substance Abuse, Families with Multiple Risk-Factors, Homeless, and Receiving Public Assistance | -- | -- | 400 | ✓ | HS/EHS |

Home Visiting Model(s)

Yuba County is using only EHS as a national EBHV model.

Number of Families Served and Funding Sources

Yuba County reports that in the most recent calendar or fiscal year:

- Approximately 400 families received HV services through the EHS model
- HS/EHS funds are used for EHS services

Services Provided

Some national EBHV programs have an AFA with the national office. An AFA increases the likelihood that programs follow standards of care and model fidelity than EBHV programs without AFAs. Based on the national model description for EHS, we can make the following general statement regarding Yuba County services provided:

- **EHS (AFA)** provides comprehensive child development services in a center-based setting, supplemented with home visits by the child's teacher and other EHS staff. Also includes early education, parenting education, comprehensive health and mental health services for mother and children, nutrition education and family support services.

Targeted Goals/Outcomes of the Intervention

In general, these are the goals and outcomes of EHS, the national model used by Yuba County. A more targeted description will be presented in the second SIR.

- **EHS –** Promote healthy prenatal outcomes for pregnant women; enhance the development of very young children; and promote healthy family functioning.

Gaps/Unmet Needs

Yuba County reported that new home visiting funding would **significantly** address gaps in serving the following populations unless otherwise noted:

- Pregnant females under 21 years of age

- Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8
- Families with children with developmental delays or disabilities; **(moderately significant)**
- Families with children with low student achievement/drop-outs; **(moderately significant)**
- Families with a history of child abuse or neglect; **(somewhat significant)**
- Families with a history of domestic violence
- Families with a history of substance abuse
- Current or former military families
- Non-English speaking families

Benchmarks

In addition Yuba County indicated that new home visiting funding would **significantly** address the following services unless otherwise noted:

- Prenatal/maternal health
- Infant health and development; **(moderately significant)**
- Child health and development; **(moderately significant)**
- Parenting skills
- Child abuse and injury prevention; **(somewhat significant)**
- School readiness; **(moderately significant)**
- Domestic violence prevention; **(moderately significant)**
- Mental health; **(moderately significant)**
- Substance abuse
- Economic self-sufficiency
- Coordination of referrals to community resources and supports

Summary

On the basis of this information, there is a basic infrastructure in place (funding and an AFA agreement) to build on and expand established EBHV models in Yuba County.

Yuba County reports gaps of service identified in all domains. A waiting list exists for EHS which reinforces the need for more HV services. Data on duplications of service are not readily available.

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# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

# 5. Narrative Description of California's Capacity for Providing Substance Abuse Treatment and Counseling Services to Individuals/families in Need of These Services in Those that Reside in At Risk Communities

**Maternal, Child and Adolescent Health Program**
**Center for Family Health**
**California Department of Public Health**

## NARRATIVE DESCTIPTION OF THE STATE'S CAPACITY FOR PROVIDING SUBSTANCE ABUSE TREATMENT AND COUNSELING SERVICES TO INDIVIDUALS/FAMILIES IN NEED OF THESE SERVICES WHO RESIDE IN COMMUNITIES IDENTIFIED AS BEING AT RISK

### Introduction

Numerous studies have shown that alcohol exposure during pregnancy can result in unfavorable birth outcomes including preterm labor, low birth weight, prematurity, congenital anomalies, stillbirths and mental retardation. Fetal Alcohol Syndrome, characterized by facial dysmorphology, growth retardation, and central nervous system impairment, represents the severe end of a spectrum of effects that can occur in an individual whose mother consumed alcohol during pregnancy. Since 2004, the umbrella term, Fetal Alcohol Spectrum Disorders (FASD), has been used to describe this range of physical and nuerodevelopmental effects. FASD is the leading known cause of mental retardation and birth defects, with brain damage being the most harmful effect. Approximately 1 of 100 people in the United States may have FASD.[113] Recent evidence suggests that rate could be as high as 5%.[114]

### Maternal, Child and Adolescent Health Program Efforts

The CDPH/MCAH uses data sources such as the California Women's Health Survey (CWHS) and the California Maternal Infant Health Assessment (MIHA) survey to estimate the prevalence of alcohol consumption among women of reproductive age. MIHA data for 2008 showed that 13% of pregnant women reported drinking during the first or third trimester. CWHS 2008 data showed that almost 45% of women aged 18-44 reported having had at least one alcoholic drink in the past month and 13% reported drinking 4 or more drinks on at least one occasion. Among women trying to get pregnant, CWHS 2006-07 data showed that 50% reported drinking in the past month.

In April to July 2006, CDPH/MCAH conducted a survey of local MCAH Directors to assess the availability and format of local MCAH data on prenatal substance use screening.[141] The survey also inquired about local use of prenatal substance use screening tools, resources and public health activities. Findings from this survey showed that 46% of Local Health Jurisdictions (LHJs) used the *4P's Plus© Screen for Substance Use in Pregnancy*, while 26% used the Comprehensive Perinatal Services Program tool solely or in conjunction with other available prenatal screening tools. These other prenatal screening tools or questionnaires used by LHJ providers are those that were locally developed or provided by the BIH program, the American College of Obstetricians and Gynecologists, or Kaiser Permanente. Thirty-seven percent reported that they do not promote a specific tool.

As stated in the October 2008 report commissioned by CDPH/MCAH, 20 California MCAH LHJs in 19 counties are actively utilizing the community-based system of Screening, Assessment, Referral and Treatment (SART) and screening pregnant women for substance use with the *4P's Plus.©* [142] SART is the "core intervention" of the overall community plan to achieve universal screening and intervention for substance use in pregnancy. Each of the counties engaged in systems preparation through county participation in the Leadership Institute, a 3½-day learning and planning initiative under the direction of Drs. Chasnoff and McGourty. The Leadership Institute focuses on preventing and reducing the impact of prenatal substance exposure by working with perinatal health care personnel in the community to eliminate substance use among pregnant women. The community plan then guides the county's efforts in this arena. The

key members of the community team include representatives from the MCAH Agency; public and private prenatal care providers, Public Health, Child Protective Services, Mental Health, Substance Abuse Treatment, and the court system.

In addition to LHJ activities, CDPH/MCAH efforts related to perinatal substance use prevention are conducted through partnerships and collaboration. CDPH/MCAH representatives participate in the following projects:

- California Fetal Alcohol Spectrum Disorders (FASD) Task Force: an independent, public-private partnership of parents and professionals from various disciplines committed to improving the lives of Californians affected by FASD and eliminating alcohol use during pregnancy. With the Arc of California as lead, the goal of the task force is to advance the effective prevention and treatment of FASD.
- State Interagency Team Workgroup on Alcohol and Other Drugs: led by CDADP and includes members from the departments of Public Health, Social Services, Mental Health, Education, Developmental Services, Corrections and Rehabilitation, and the Administrative Office of the Courts. The goal of the workgroup is to identify interagency and systems issues that, if addressed, could improve identification and treatment of families and children impacted by alcohol and other drugs.

**Substance Abuse Services in California**

The California Department of Alcohol and Drug Programs (CDADP) is responsible for the management and oversight of alcohol and other drug services that are implemented at the county level. When an individual seeks treatment or a referral is made to the county Alcohol and Other Drug (AOD) Department, an assessment is preformed to determine the appropriate level of care.

California's substance abuse treatment services include intervention, client-centered, culturally appropriate treatment, and recovery services. Treatment and recovery approaches are based on the individual's needs, preferences, experiences, and cultural backgrounds. Clients' rights include choosing from a range of options and participating in decisions that will affect their lives.

The following is a description of the continuum of substance abuse treatment services that will continue to be available in California:

- **Assessment, Referrals, and Intake**: Assessment of a client's needs regarding treatment to ensure the most appropriate treatment and referral to such treatment are important components of the continuum of services.

- **Case Management**: Case Management services are activities involved in the integration and coordination of all necessary services to ensure successful treatment and recovery. Services may include outreach, intake, assessment, individual service plans, monitoring and evaluation of progress, and community resource referrals.

- **Nonresidential Treatment**: Nonresidential treatment services are provided by program-designated personnel and include the following elements: personal recovery/treatment planning, educational sessions, social/recreational activities, individual and group sessions, and information about, and may include assistance in obtaining, health, social, vocational, and other community services. These services are available to youth, ages 12 to 17, and adults. In addition, perinatal providers must provide gender specific services tailored to meet the treatment, therapeutic, and recovery needs of women and

their children. Perinatal providers must also make primary medical care available to the women and their children.

- **Rehabilitative Ambulatory Intensive Outpatient (Day Care Rehabilitative)**: Day Care Rehabilitative (DCR) services are intensive outpatient counseling and rehabilitative services that typically last a minimum of 3 hours but are less than 24 hours per day for three or more days per week. DCR differs from non-intensive Rehabilitative/Ambulatory Outpatient services, in which clients participate according to a minimum attendance schedule and have regularly assigned treatment activities.
- **Rehabilitative/Ambulatory Outpatient or Outpatient Drug Free – Group**: Treatment/recovery or rehabilitation services are provided to a client who does not reside in a treatment facility. The client receives substance abuse treatment services with or without medication, including counseling and/or supportive services.
- **Rehabilitative/Ambulatory Outpatient or Outpatient Drug Free – Individual**: Treatment/recovery or rehabilitation services are provided to a client who does not reside in a treatment facility. The client receives substance abuse treatment services with or without medication, including counseling and/or supportive services.
- **Outpatient Methadone Detoxification**: This service is comprised of the provision of narcotic withdrawal treatment pursuant to California Code of Regulations (CCR) Title 9, beginning with Section 10000, to clients who, with the aid of medication, are undergoing a period of planned withdrawal from narcotic drug dependence. Withdrawal without medication is not considered detoxification treatment for reporting purposes.
- **Inpatient Methadone Detoxification**: In a controlled, 24-hour hospital setting, this service element is comprised of the provision of narcotic withdrawal treatment pursuant to CCR Title 9, beginning with Section 10000, to clients who, with the aid of medication, are undergoing a period of planned withdrawal from narcotic drug dependence. Withdrawal without medication is not considered detoxification for reporting purposes.
- **Rehabilitative Ambulatory Detoxification (Other than Methadone)**: Rehabilitative ambulatory detoxification is an outpatient treatment service rendered in less than 24 hours; it provides for safe withdrawal in an ambulatory setting.
- **Narcotic Replacement Therapy**: Narcotic Treatment Programs (NTPs) provide narcotic replacement therapy using methadone, buprenorphine and any other Federal Drug Administration-approved medications for the treatment of opiate addiction. Currently, California regulates the use of methadone. Buprenorphine may be prescribed by a physician who has obtained a Drug Addiction Treatment Act of 2000 waiver and is affiliated or associated with an NTP; however, California does not regulate the use of this medication and refers to the federal Center for Substance Abuse Treatment guidelines. Narcotic replacement therapy also includes assessment, treatment planning, urinalysis drug testing, group and individual counseling, and educational sessions.
- **Residential Treatment**: CDADP must license all non-medical adult residential facilities that provide alcohol and drug treatment services on-site. Residential Adolescent Group Homes are licensed by the CDSS. Residential services are provided by program-designated personnel and include the following elements: personal recovery/treatment planning, educational sessions, social/recreational activities, individual and group sessions, detoxification services, and information about, and may include assistance in obtaining, health, social, vocational, and other community services. These services are

available to youth, ages 12 to 17, and adults. In addition, perinatal providers must provide gender specific services tailored to meet the treatment, therapeutic, and recovery needs of women and their children. Perinatal providers must also make primary medical care available to the women and their children.

- **Free-Standing Residential Detoxification**: Free-standing residential detoxification provides detoxification services in a non-hospital setting, which is designed to provide for safe withdrawal and transition to ongoing treatment.
- **Residential/Recovery Long Term (over 30 days)**: Long-term residential care is typically more than 30 days of nonacute care in a setting with recovery/treatment services for alcohol and other drug use and dependency.
- **Residential/Recovery Short Term (up to 30 days)**: Short-term residential care is typically 30 days or less of nonacute care in a setting with recovery/treatment services for alcohol and other drug abuse and dependency.

Other Services:

The following services are part of the outreach, engagement, and treatment support services. They are an important part of the treatment continuum, and therefore are included here.

- **Early Intervention/Brief Intervention and Referral to Treatment**: This service is designed to come between a substance user and his or her actions in order to modify behavior. It includes a wide spectrum of activities ranging from user education to formal intervention and referral to appropriate treatment/recovery services.
- **Outreach -** Outreach activities are designed to encourage those individuals in need of treatment to undergo such treatment, including outreach to intravenous drug users. Outreach may be used to identify and encourage eligible pregnant and parenting women in need of treatment services to take advantage of these services. Outreach may also be used to educate the professional community on perinatal services so that they become referral sources for potential clients.
- **Aftercare and Recovery Support Services** Recovery support (aftercare) services that may begin during or following treatment services and utilize services coordination, relapse prevention, continuing comprehensive assessments, motivational counseling, recovery maintenance planning, and exit planning; and referrals to services such as family preservation and reunification, child care, housing (sober living, safe housing, permanent housing), drop-in services, transportation, peer support and mentoring, and education/life skills training.

**Treatment Capacity**

To calculate capacity, CDADP generates a report using the California Outcomes Measurement System (CalOMS), which measures the number of people served at a given time. According to a CalOMS report dated September 1, 2010, AOD treatment capacity in California is 110,623. The AOD treatment capacity in California continually changes. Licensing and certification applications for new programs are processed on an ongoing basis. In addition, programs can shut down and capacity is affected.

## Service Gaps

CDADP and its stakeholders have identified gaps in systemic, intervention, treatment, and recovery approaches.

### Systemic Gaps

CDADP and its stakeholders have identified gaps in service to at risk communities which are compounded by the acute model of care provided by the systems in place. Currently, the system addresses AOD problems as acute issues. This model for serving individuals with AOD problems limits the potential for successful treatment outcomes because the acute care model inhibits holistic treatment and continuous care. Indeed, AOD use and dependency have been likened to chronic conditions such as diabetes, asthma and heart disease. As health experts assert and current research demonstrates, all chronic conditions share the similar need for the prevention, treatment, and recovery maintenance of that condition.[143]

### Intervention Gaps

The current focus of many substance use programs is the treatment of individuals who are dependent on alcohol and/or other drugs. Although treatment for seriously addicted individuals is an important public health priority, these individuals represent a small percentage of those afflicted with substance use disorders. It is estimated that the great majority of substance users are individuals who are not dependent on substances yet misuse drugs and/or alcohol on a regular basis. Proper and timely interventions have been shown to reduce this problem drug use, thus potentially preventing these individuals from increasing their use of substances and developing dependency on alcohol and other drugs.

To effectively address these at risk, problem substance users, identification and the delivery of effective interventions by trained professionals in various settings is required. This approach is based on the premise that there are “teachable moments” that can positively influence an individual’s behavior with regard to substance use. Thus, identifying persons at risk of substance-use dependence involves the application of effective screening and brief intervention methods in settings where these individuals receive services, including home visiting support programs, primary health care clinics, emergency rooms, trauma centers, psychological counseling centers, and detention centers. Individuals at risk of substance use disorders continually interface with such settings, and so they present potentially important opportunities to address problem drug and alcohol use.

Research has shown that there are missed opportunities for identifying and assisting at risk individuals when they interface with various services. A 2003 study of adult-dependent and problem drinkers in the general population[144] indicated that approximately two thirds had a medical visit and one third had a psychiatric visit within 1 year of follow-up, yet most did not have their drinking problems addressed during their visit.

### Treatment Gaps

In the National Survey on Drug Use and Health (NSDUH) by the Substance Abuse and Mental Health Services Administration (SAMHSA), all persons meeting criteria for alcohol and/or illicit drug dependence/abuse are counted as needing treatment. All those meeting these criteria who are not in treatment are then counted as needing but not receiving treatment. The majority

(95.2%) of persons who meet the criteria for needing treatment do not receive it because they do not feel they need treatment.

**Table 30. Population Needing But Not Receiving Treatment By Age**

| Age Group | 2009 CA Population | Percentage Needing Treatment For Illicit Drug Use | Percentage Needing Treatment For Alcohol Use | Percentage Needing Treatment For Either Illicit Drug Or Alcohol Use† | Number Needing But Not Receiving Treatment For Illicit Drug Or Alcohol Use |
|---|---|---|---|---|---|
| **Age 12+** | 32,193,265 | 2.57 | 7.8 | 10.37 | 3,338,000 |
| **Age 12 - 17** | 3,497,305 | 4.19 | 5.55 | 9.74 | 341,000 |
| **Age 18 - 25** | 4,598,102 | 7.07 | 16.8 | 23.87 | 1,098,000 |
| **Age 26+** | 24,097,858 | 1.48 | 6.43 | 7.91 | 1,906,000 |

Note: Number Needing but Not Receiving Treatment is rounded to the nearest 1,000.

†This percentage is derived by adding the percentage needing but not receiving alcohol treatment to the percentage needing but not receiving illicit drug treatment. This sum overestimates the percentage needing alcohol or other illicit drug treatment because it doe not account for persons that meet both alcohol and drug abuse/dependence criteria. California specific estimates that account for this overlap are not available.

Source: National Survey on Drug Use and Health (NSDUH) with California estimates provided by the California Department of Alcohol and Drug Programs (CDADP).

*Highlights from Table 30:*

- Over 3.3 million Californians are estimated to need, but are not receiving AOD treatment.
- Young adults 18-25 years of age have the highest, and youth age 12-17 have the lowest percentage needing but not receiving treatment for alcohol use.
- Young adults 18-25 years of age have the highest, and adults age 26 and over have the lowest percentage needing but not receiving treatment for illicit drug use.
- Overall young adults 18-25 years of age have the highest percentage needing but not receiving AOD treatment. They account for over one million people in need of treatment.
- Although the 26+ group has the lowest overall percentage needing treatment, it has the largest overall population. Therefore, this age group accounts for nearly two million people in need of treatment.

**Table 31. Population of Age 12+ Needing But Not Receiving Treatment By Gender**

| Gender | 2009 CA Population | Percentage Needing But Not Receiving Treatment for Illicit Drug or Alcohol | Number Needing But Not Receiving Treatment for Illicit Drug or Alcohol† |
|---|---|---|---|
| **Male** | 15,991,019 | 10.7 | 1,711,000 |
| **Female** | 16,202,246 | 6.1 | 988,000 |

Note: Number Needing but Not Receiving Treatment is rounded to the nearest 1,000.

†These estimates of need are based on national estimates which account for the overlap in populations using both alcohol and illicit drugs. Additionally the percentage needing treatment for alcohol use is slightly lower for the nation than for California. Therefore the total number needing but not receiving treatment is lower than the number presented using California estimates.

Source: National Survey on Drug Use and Health (NSDUH) with California estimates provided by the California Department of Alcohol and Drug Programs (CDADP).

National estimates are used to determine the gender breakout of individuals in need but not receiving treatment (Table 31). Percentages from the 2008 NSDUH were multiplied by the California population by gender.

**Table 32. Population of Age 12+ Needing But Not Receiving Treatment By Race/ Ethnicity**

| Race/Ethnicity | 2009 CA Population | Percentage Needing But Not Receiving Treatment for Illicit Drug or Alcohol | Number Needing But Not Receiving Treatment for Illicit Drug or Alcohol† |
|---|---|---|---|
| **Hispanic** | 10,934,876 | 9.2 | 1,006,000 |
| **White** | 14,503,410 | 8.4 | 1,218,000 |
| **Black** | 1,927,834 | 8.2 | 158,000 |
| **American Indian** | 211,174 | 10.2 | 22,000 |
| **Pacific Islander** | 122,184 | * | ** |
| **Asian** | 3,952,810 | 3.8 | 150,000 |
| **Multirace** | 540,977 | 9.1 | 49,000 |

Note: Number Needing but Not Receiving Treatment is rounded to the nearest 1,000.
†These estimates of need are based on national estimates which account for the overlap in populations using both alcohol and illicit drugs. Additionally the percentage needing treatment for alcohol use is slightly lower for the nation than for California. Therefore the total number needing but not receiving treatment is lower than the number presented using California estimates.
*Low precision; no estimate reported.
**Unable to calculate.
Source: National Survey on Drug Use and Health (NSDUH) with California estimates provided by the California Department of Alcohol and Drug Programs (CDADP).

National estimates are used to determine the race/ethnic breakout of individuals in need but not receiving treatment (Table 32). Percentages from the 2008 NSDUH were multiplied by the California population by race/ethnicity. Although American Indians have the fewest numbers in need but not receiving treatment, they have the highest combined percentage needing and not receiving treatment for alcohol or illicit drugs. While not shown in the table above, American Indians have the highest percentages of any race/ethnicity needing but not receiving treatment for both alcohol problems and for illicit drug problems. Hispanics have the second highest combined percentage needing but not receiving AOD treatment. Problems with alcohol use contribute the most to the high combined percentage of Hispanics who need but did not receive treatment.

*Highlights from Table 32:*

- Although American Indians have the fewest numbers in need but not receiving treatment, they have the highest combined percentage needing and not receiving treatment for alcohol or illicit drugs. While not shown in the table above, American Indians have the highest percentages of any race/ethnicity needing but not receiving treatment for both alcohol problems and for illicit drug problems.
- Hispanics have the next highest percentage of needing but not receiving treatment for illicit drug or alcohol use.
- Given their respective large percentages of the overall population, both Hispanics and Whites account for the largest proportions in need of treatment. Each group contributes over one million people to the estimate.

Summary of Population-Based Estimates of Treatment Need

The information presented in the preceding sections estimates the number of individuals in need but not receiving AOD treatment by demographic characteristics. The NSDUH survey found only a small proportion of these individuals who need treatment actually sought treatment. Of the over three million Californians over 12 years of age estimated to need but not receive treatment, about 4.8% or 160,000 felt they needed treatment, thus are more likely to seek treatment. The top three reasons for not seeking treatment are:

1. No Health Coverage/Could Not Afford Cost
2. Not Ready to Stop Using
3. Able to Handle Problem without Treatment

Survey respondents were allowed to list multiple reasons for not seeking treatment but these three reasons made up about 80% of them. Some of the other reasons mentioned include:

- No transportation/inconvenient
- No program having type of treatment
- Did not feel need for treatment at the time
- Did not know where to go for treatment
- Might cause neighbors/community to have negative opinion
- Might have negative effect on job.

Recovery Gaps

CDADP has identified seven areas of recovery support in the Evaluation Services to Enhance the Data Management System in California - Continuum of Services System Re-engineering (EnCAL-COSSR) project. Recovery support includes but is not limited to, the following types of services:

- Assertive continuing care;
- Continuous telephone recovery monitoring;
- Home visits;
- Medication;
- Recovery management;
- Recovery centers; and
- Traditional counseling and self/mutual-help programs.

Three recovery support services were studied within four California counties. Several barriers were identified and lessons were learned that will require further research and pilot testing in order to achieve the overall mission of COSSR. The barriers include:

- Significant lack of funding for Recovery Support Services (RSSs) in California may limit the ability of counties to provide and measure the efficacy of RSSs.
- The definition of recovery continues to be unclear across counties.
- Collecting and using data within RSSs appears to be challenging.
- There are no clear guidelines on RSS measurements and there are few standardized performance/outcome measures to test the efficacy of RSSs.
- Lessons learned from existing RSS models implemented in other states will be crucial guidelines to plan next steps for recovery services and measurement in California.

### Overlap in Services

There is no overlap in services. The communities are underserved. The relapse and recidivism rates in at risk communities demonstrate there is room for improvement in how we serve these communities. The Home Visiting Program will provide opportunities for providers to assist in intervention, treatment, and recovery success.

# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

# 6. Narrative Summary of Needs Assessment Results

## Maternal, Child and Adolescent Health Program
## Center for Family Health
## California Department of Public Health

## PROVIDE A NARRATIVE SUMMARY OF NEEDS ASSESSMENT RESULTS, INCLUDING A DISCUSSION OF HOW THE STATE WILL ADDRESS UNMET NEEDS

### Introduction

The Framework: Life Course, Social Determinants and the Socio-Ecological Model

CDPH/MCAH uses the Life Course Perspective, social determinants of health, and the socio-ecological model frameworks in its efforts to protect and improve the health of mothers, infants, and children. The Life Course Perspective frames health as a trajectory across the continuum of the life course, beginning with the period in utero, and explains health disparities by focusing on differential exposures and opportunities during sensitive developmental periods (in utero, early childhood, adolescence, pregnancy) that may impact health status over time.[4, 5] One component of the model is recognition of the cumulative effects of chronic stress across the life span. Experience of ongoing social disadvantage[4] or episodes of negative exposures[6] during these sensitive periods have been shown to result in physiologic changes, such as stress hyper-reactivity and immune dysfunction, that contribute to worsening health outcomes and chronic disease in subsequent life stages. Implicit in the life course perspective is a consideration that health results from not only genetics and health behaviors, but from the social, psychological, economic, environmental, and cultural context in which health outcomes arise.[2-5, 12] Collectively, these factors are referred to as the social determinants of health. In California, as in the United States, differential access to resources in these arenas has contributed to health status differences across racial and ethnic groups, the poor, non-citizens, and other population groups.[7, 8] These social determinants of health and their differential impact on certain populations signify the opportunities for Home Visiting to positively impact early childhood development and subsequently health over the life course. Closely related to social determinants of health is the socio-ecological framework, which illustrates how factors at multiple levels (i.e., individual, relationship/family, community, and societal) influence health and social outcomes for women and children.[9, 10] Together, the life course perspective, social determinants of health, and the socio-ecological framework provide the overarching theoretical frameworks through which California conceptualized its' methods for completing a Home Visiting Needs Assessment.

Preliminary Groundwork on the "Universe" of Home Visiting Indicators

Prior to the release of the first SIR, CDPH/MCAH undertook an extensive and collaborative effort to define a potential "universe" of home visiting indicators based on the Life Course Perspective, social determinants of health, and the socio-ecologic framework. Variables were included in this universe if they related to a topic specifically mentioned in the ACA Legislation, the indicator had an established connection with home visiting in published peer reviewed literature, or the indicator could potentially serve as a benchmark for measuring Home Visiting Program success. From this "universe", CDPH/MCAH selected a core set of variables in consultation with key partners and then organized these under topic domains specifically mentioned in the ACA. Key to the inclusion of an indicator among this core set was the availability of data at the sub-county level, the validity of information collected, and the usefulness of the indicator in representing California's diversity and complexity when identifying at risk communities. These efforts to identify a core set of variables were intended to serve as the basis for California's efforts to identify at risk communities where geospatial hotspot analyses would identify sub-county geographic areas at significantly higher risk for each indicator. California's planned approach for completing the needs assessment would provide the evidence base for developing and implementing a Home Visiting Program that achieves the

overall goal of the ACA Maternal, Infant and Early Childhood Home Visiting Program to provide, promote, and facilitate interventions that address the diverse needs of children and families at risk.

Step-Wise Needs Assessment Process

The process for fulfilling requirements by HRSA to use FY 2010 ACA Maternal, Infant and Early Childhood Home Visiting Program funding provides States the basis for this systematic approach via a three step process: 1) submission of an application for funding; 2) submission of a statewide needs assessment (contained here); and, 3) submission of an Updated State Plan for addressing the needs in identified at risk communities, including an opportunity to refine the needs assessment. The process required by HRSA reflects the fact that this needs assessment is one-step of a longer process to develop and implement a Home Visiting Program. Given the size, diversity, and complexity of California's geography and population, this process requires a comprehensive approach. The first SIR limited California from incorporating all aspects of our planned approach due to time constraints and limitations in the required data indicators. As California moves forward in this continuous process, input will be sought from State and local partners and stakeholders to refine the needs assessment and facilitate implementation of the Home Visiting Program.

Coordination and Collaboration

The goal of developing a comprehensive, evidence-based service delivery system in California will require a well-coordinated partnership among several State agencies and with local programs. One of the core values of the CDPH is collaboration that has also been reinforced by the State Administration. CDPH fosters collaboration both internally to empower and engage staff and externally by reaching out to diverse groups and external stakeholders. Echoing our Department's values, CDPH/MCAH has been committed to engaging stakeholders in administering programs under the Title V Block Grant. No single agency has the resources, access and relationships to address the multiple needs of at risk families. Because of this, CDPH/MCAH views the involvement of partners as essential to addressing the complex needs of California's population.

Local Input and Involvement

Central to CDPH/MCAH's philosophy of involving external stakeholders has been our ability to leverage the local relationships and systems expertise of LHJs in order to ensure broad and diverse stakeholder input, particularly in our Title V 5-Year Needs Assessment. CDPH/MCAH's model for incorporating local expertise is to have LHJs obtain input from other local public agencies, service providers, non-profit organizations, and families or clients in order to shape local assessment of health status and capacity, and to identify local priority health needs. This extensive local input gets communicated to the CDPH/MCAH which in turn informs the selection of statewide priorities. California recognizes that local input is also crucial to the success of the Home Visiting Program; therefore, local level input was obtained to assess the quality and capacity of existing programs for early childhood home visitation. As California moves forward with its Home Visiting Program efforts, a more involved, comprehensive framework for leveraging local expertise will be refined so as to further supplement results from this needs assessment process and to inform efforts for implementing and sustaining the Home Visiting Program.

**Summary of Findings Provided In Response to Sections One Through Five, Including Challenges**

This section provides a summary of findings for the six components described in the first SIR under *Instructions for reporting data* and includes a description of challenges encountered in identifying and compiling data.

Complete a Statewide Data Report, Section #1

The first SIR provided a list of indicators that States were required to include in the assessment. The first SIR required States to complete a statewide data report using the most recent and/or relevant data available; to define these data using standardized metrics defined in the SIR; and to report these statewide data using a standardized table referred to in the SIR as Appendix A. For each of the indicators, the first SIR also indicated areas in which the response(s) must be coordinated, to the extent possible, with the Title V, CAPTA and Head Start Needs Assessments.

The required indicators included fourteen variables representing ten topic areas. California obtained these data from the sources identified in the first SIR, where these sources were available, and calculated the statewide value using those metrics specified in the first SIR. California also calculated a value for each county in California and presented this information together with the statewide value in a table separate from what the first SIR required. In some cases data from the specified source was not available or another source was considered preferable. An alternative data source was considered preferable if it had quantitative rather than qualitative data or because the data were available at the sub-county level. For example, CDPH/MCAH worked with the CDSS to identify the best data source possible for data on child maltreatment. This data source was the Child Welfare Services/Case Management System (CWS/CMS) which provides quantitative data at the county level on a number of child welfare indicators including child maltreatment. Thus, this source was utilized instead of the CAPTA or Head Start Needs Assessments. Similarly, in some cases data could not be reported using the metrics specified in the legislation or the metric specified in the legislation differed slightly from common practices in California. These practices were developed by extensive collaborative processes with State Agencies, academic partners, and local programs so that the metric reflects best available science and California's unique characteristics. For example, whereas the metrics specified in the SIR for premature births did not mention any exclusion criteria, CDPH/MCAH excluded births prior to 17 weeks and greater than 47 weeks because these are likely data entry or reporting errors, as well as non-resident births to be consistent with Title V reporting and the Center for Health Statistics.

California took advantage of the opportunity to build on information from the required indicators by providing *other indicators of at risk prenatal, maternal, newborn, or child health*. The indicators California included were drawn from the "universe" of indicators developed in consultation with key partners and based on the Life Course Perspective, social determinants of health, and the socio-ecologic framework. Upon release of the first SIR, California recognized that although those variables required in the SIR covered many domains, they did not cover maternal health as well as some important indicators of infant and child health that had been identified as important to key partners. Thus the following indicators were also included in this needs assessment: prenatal care initiation, prenatal substance use, maternal depression, short birth interval, breastfeeding, children with special needs and foster care. A statewide value was calculated for each of these *other indicators* and included in the statewide data report, and a value was calculated for each county in California.

In addition to providing the statewide data report (the "Appendix A" matrix), for each indicator included in this needs assessment a separate table was developed and presented. This separate table provides the county level values sorted from worse-off to best-off, as well as the statewide rate or percentage and the statewide median. California also developed chloropleth maps for each indicator where the rate for each county was categorized into one of four quantiles and then thematically represented on the map. The four quantiles were 0 to 49$^{th}$ percentile, 50$^{th}$ to 74$^{th}$ percentile, 75$^{th}$ to 89$^{th}$ percentile, and 90$^{th}$ to 100$^{th}$ percentile. Consultation with key partners indicated the usefulness of these maps in providing a "snapshot" of California, and while not required, the maps were therefore also included in the needs assessment.

Analyses of these indicators revealed several key findings instrumental to our identifying at risk communities in this needs assessment. First, variation in the population size of California's counties resulted in statewide rates largely influenced by a small number of highly populated counties. The influence of more populous counties on statewide rates and percentages is illustrated by the findings for first trimester initiation of prenatal care. The higher rates of first trimester prenatal care initiation in more populous areas like Los Angeles, San Francisco, Orange, Alameda, Contra Costa, and Santa Clara counties resulted in a statewide rate where thirteen counties were above and forty-three counties were below the statewide rate. For these reasons, the statewide median for each indicator was a more stable measure of comparison to identify communities at greater risk. The statewide median was therefore used in this needs assessment to identify counties at greater risk for each indicator. A second key finding was that although rates identified disparities with regard to need, these did not fully account for population size and the burden of need in certain areas. For example, Los Angeles was below the statewide rate and the statewide median for infant mortality, despite accounting for more than 25% of California's infant deaths. California's plan for refining this needs assessment will incorporate a framework for leveraging local expertise, input from partner agencies and additional analyses (e.g., hot-spot analyses) that identify clusters of at risk communities accounting for the burden of need.

*Challenges:*
The greatest challenges to our data collection efforts included the short timeline for completing this needs assessment, the broad nature of required data elements, and the limitations of some required data elements. As a parallel example, the Title V Needs Assessment takes more than two years to complete. Time constraints to gather a broad array of data elements presented the most critical challenge. The first SIR was released on August 19, 2010 and required States to submit their response by September 20, 2010. The one-month afforded for completion of the needs assessment was further reduced in California by mandated furloughs implemented in response to California's budget deficit and delays enacting a budget. As a result, there existed just sixteen work days to complete this needs assessment. Coordination of data collection efforts across multiple state branches and agencies is time-consuming and complex, as data definitions, formats and interpretations must be clarified and verified. The short turnaround for this needs assessment also limited the State's capacity to undertake the sub-county analyses intended to further inform the identification of at risk communities.

Limitations of required data represented the next biggest challenge in completing the specified data reports. While California has rich data in most of the required health, social service, and demographic areas, some data were not readily available to the State or available at the local level. Some examples of data gaps or challenges include:

- Substance Abuse Data: While the State has access to several datasets that are available at the sub-county level (e.g., vital statistics, hospital discharge data), the SIR specified a data source for which data were only available at the State and regional level.

- Statewide School Readiness Data: California intended to include indicators that measure children's readiness for school in the five dimensions identified by the National Education Goals Panel (NEGP) as important for school success (Physical Well-Being and Motor Development; Social and Emotional Development; Approaches to Learning; Communication and Language; and Cognition and General Knowledge). However, currently in California there are no readily available statewide school readiness data at the pre-kindergarten level. The Child Development Division of the CDE, however, has had a requirement that all children in their funded programs be assessed using the Desired Results Developmental Profile (DRDP) since the 2007-08 program year. The DRDP is an assessment instrument based on teacher observation that measures a child's developmental progress across the five NEGP dimensions of school readiness. Unfortunately these data are not currently accessible for statewide use. CDPH/MCAH and CDE are discussing possible data sources to include in the Updated State Plan and for benchmark purposes.

Identify the Unit Selected as "Community", Section #2

The first SIR required States to define which geographic units were selected as "communities" for determining "at risk communities". The SIR also required States to provide justification for each community identified as being at risk. *For the purposes of this needs assessment,* ***California defined community as the County, and identified all 58 counties as at risk communities.***

California considered several units for defining "community" including census tracts, Medical Service Study Areas (MSSA's), zip codes, and County. Census tracts and MSSA's represent the units of analysis best suited for representing the "*unique structure and make-up of the State"* particularly for the purpose of conducting a needs assessment to identify disparities and unmet need. However, there are 7,049 census tracts in California that are collapsed to form 541 MSSA's. A number of factors make analyses of data at the census tract and/or MSSA level not feasible in response to this SIR, mainly time constraints for responding to the current SIR and the non-availability of sub-county data for many variables required by the current SIR. As the needs assessment findings are refined in response to the future SIR on the Updated State Plan, California may refine the definition of "community" to include census tracts and/or MSSA's data where possible.

The ACA designates at risk communities as those with a concentration of any one or more of a series of specific factors. For the purpose of this needs assessment, at risk communities in California are defined as those counties with a rate or percentage worse off than the statewide median for any one or more of the specified indicators including our "*other indicators of at risk prenatal, maternal, newborn, or child health*". Results from our analyses identified all counties in California as being worse off than the statewide median for at least two indicators. A finding of considerable importance is that 54 of the 58 counties, or 93%, were worse off than the statewide median for six or more indicators. The large number of counties with need in multiple topic areas illustrates the importance and potentially sizeable impact of Home Visiting in California. This large number of high need areas also indicates the importance of a comprehensive approach to completing a needs assessment where information is obtained via

a coordinated effort with multiple State and local agencies, and where the methods are developed to reflect California's unique characteristics using indicators available at sub-county levels. California's overall planned approach, beyond what is provided in this needs assessment, is this exact type effort.

*Challenges:*
The population size of some California counties resulted in statewide rates largely influenced by a small number of highly populated counties, and unstable rates in the least populated counties. The influence of more populous counties on the statewide rate was increased for some required indicators because these indicators did not always have data for the less populous areas of the State. A unit of analysis such as census tracts or MSSA's would lessen the impact of population size, but analyses of 7,049 census tracts or 541 MSSAs were not feasible in the short time period provided by the SIR. As the needs assessment findings are refined, California will develop a framework that incorporates analysis of indicators with data available at the sub-county level (e.g., census tracts and/or MSSA's) and will incorporate methods for statistical comparison of geographic areas to a robust estimate of the statewide rate.

Complete a Data Report for Each At Risk Community in the State, Section #3

Given that all 58 of California's counties were determined to be at risk for the purposes of this needs assessment, a data report was completed for each county. The data report is provided in the Appendix A template as required in the first SIR.

Provide Information on the Quality and Capacity of Existing Programs/Initiatives for Early Childhood Home Visitation in Each of the Communities Identified as Being At Risk, Section #4

*Initial Steps Taken to Assess Existing Home Visiting Programs/Initiatives*
Upon the signing into law of the Patient Protection and Affordable Care Act, CDPH/MCAH convened a meeting of local MCAH Directors who were anticipating availability of federal home visiting funds. Together, CDPH/MCAH and these local MCAH leaders developed the initial strategy for California which focused on 1) establishing mechanisms of communication with stakeholders and partners, and, 2) identifying key stakeholders to engage in the process and keep informed, 3) preparing for the required needs assessment, and, 4) researching evidence-based home visiting models.

CDPH/MCAH established the Home Visiting Collaborative Workgroup to provide guidance to the state, particularly at critical junctures in the planning process. The Workgroup membership evolved to consist of the following: five local MCAH Directors who were designated by their colleagues to represent local MCAH and local public health nursing directors; First 5 Association; California First 5; CDSS; CDADP; and the CDE Head Start State Collaboration Office. In order to promote communication, the CDPH/MCAH Home Visiting Program webpage was developed to make available all supporting documents including the ACA legislation, the ACA home visiting grant guidance, Frequently Asked Questions and copies of periodic stakeholder communications that were also sent to a growing e-mail distribution list. Contact was made with key state partner agencies listed above in order to gain a better understanding of their current home visiting efforts as well as availability of data and required reports that would inform the needs assessment process. Existing local home visiting capacity surveys were identified including the First 5 Association survey of local First 5 Commission funded home visiting programs. Finally, critical review of evidence based home visiting models was conducted including identification of key publications as well as contacting national/state

representatives of evidence based home visiting programs to supplement publicly available information and arrange for in person presentations for CDPH/MCAH and partners.

*The Capacity Assessment Home Visiting Survey*

The CDPH/MCAH disseminated a Capacity Assessment Home Visiting survey to all 58 counties with the sole purpose of gleaning information regarding what programs each county was implementing and how each county administered, targeted, and staffed their respective home visiting programs. Additionally, information was ascertained regarding funding streams. The instructions for survey completion were intended to facilitate local communication and coordination by requiring that only one survey be completed per county in a coordinated effort led by the local MCAH Director and involving the Public Health Department, County Child Welfare Director, CalWORKS, Family Resource Centers, First Five Commission representatives, Head Start and Early Head Start Programs, and other school readiness partners. The survey revealed that the majority of counties have multiple home visiting programs currently underway. These programs include nationally recognized models as well as local adaptations and locally developed home visiting programs developed to address community need.

The survey further demonstrated that California has multiple gaps in services with significant unmet needs in targeted populations. In a state the size of California with all of its overwhelming needs, it is difficult to quantify “gaps” in services. Large counties, such as Los Angeles report ‘gaps’ in all services and frontier counties report few ‘gaps’ in services. Though a crude measure of unmet need, most counties report having waiting lists for services. Counties report use of a variety and, often, multiple funding streams, yet still report inadequate funding and resources to serve all identified vulnerable families.

**Early Head Start (EHS):** In California, a total of forty-six counties report using EHS and serve approximately 14,756 families annually. Forty-three counties have a current AFA in place with the EHS National Program office and serve approximately 14,572 families annually. Three counties are using EHS without any AFA in place and serve approximately 184 families annually. Of forty-six counties using EHS, forty-five report having a waiting list for services.

The Center for Law and Social Policy (CLASP) compiled data from public reports regarding California EHS grantees for 2008. There were 67 EHS grantees in California in 2008. A grantee may fund one or more than one program in a given geographical location. In addition, CLASP reported that 8% of California enrollees are enrolled in the home-based program option, and 2% of enrollees participate in a combination home and center-based EHS program.

**Healthy Families America (HFA):** In California, a total of ten counties report using HFA and serve approximately 1,007 families annually. Four counties have a current AFA in place with the HFA National Program office and serve approximately 260 families annually. Six counties are using HFA without any AFA in place and serve approximately 747 families annually. Of ten counties using HFA, five report having a waiting list for services.

**Healthy Start:** In California, a total of eight counties report using Healthy Start and serve approximately 6,779 families annually. Five counties have a current AFA in place with the Healthy Start National Program office and serve approximately 2,819 families annually. Three counties are using Healthy Start without any Agency Funding Agreement in place and serve approximately 3960 families annually. Of eight counties using Healthy Start, four report having a waiting list for services.

**Home Instruction for Parents of Preschool Youngsters (HIPPY):** In California, a total of five counties report using HIPPY and serve approximately 7,424 families annually. Three counties have a current AFA in place with the HIPPY National Program office and serve approximately 350 families annually. Two counties are using HIPPY without any AFA in place and serve approximately 7,074 families annually. All five counties using HIPPY report having a waiting list for services.

**Nurse Family Partnership (NFP):** In California, a total of fourteen counties report using NFP and serve approximately 3,096 families annually. Thirteen counties have a current Agency Funding Agreement (AFA) in place with the NFP National Service office and serve approximately 2,458 families annually. One county is using NFP without any AFA in place and serve approximately 638 families annually. All fourteen counties using NFP report having a waiting list for services.

**Parent Child Home Program (PCHP):** In California, a total of five counties report using PCHP and serve approximately 1,507 families annually. Four counties have a current AFA in place with the PCHP National Program office and serve approximately 607 families annually. One county is using PCHP without any AFA in place and serve approximately 900 families annually. Of five counties using PCHP, three report having a waiting list for services.

**Parents as Teachers (PAT):** In California, a total of twenty counties report using PAT and serve approximately 11,404 families annually. Fourteen counties have a current AFA in place with the PAT National Program office and serve approximately 5,337 families annually. Three counties are using PAT without any AFA in place and serve approximately 690 families annually. Of twenty counties using PAT, sixteen report having a waiting list for services.

**SafeCare:** In California, a total of eight counties report using SafeCare and serve approximately 3,337 families annually. Six counties have a current AFA in place with the Safecare National Program office and serve approximately 627 families annually. Two counties are using SafeCare without any AFA in place and serve approximately 2,710 families annually. Of eight counties using SafeCare, three report having a waiting list for services.

*Challenges:*
The greatest challenge experienced by CDPH/MCAH was being able to provide information on the quality of all of the home visitation services being used in at risk counties in California. Although CDPH/MCAH compiled data from other sources, the Capacity Assessment Home Visiting Survey is our main source for assessing quality and capacity of existing home visiting programs in California's at risk communities. Because the Capacity Assessment Home Visiting Survey was developed and disseminated prior to the release of the first SIR on August 19, 2010, the survey did not identify targeted goals/outcomes of interventions, the name of programs, or demographic characteristics of families served.

In fact, the findings from the Capacity Assessment Home Visiting Survey were surprising to CDPH/MCAH in that there are many more locally developed home visiting programs in use by at risk counties than the eight nationally recognized, evidence-based home visiting models mentioned above. Prior to the analysis of the Capacity Assessment Home Visiting Survey, we were aware that at risk counties in California were struggling to serve as many families with home visiting services as possible with limited resources. The short turnaround for this needs assessment did not allow the analyses required to understand how at risk communities are evaluating the quality and effectiveness of these home visiting programs. CDPH/MCAH is currently planning how we will assess this as we develop the Updated State Plan.

Provide a Narrative Description of the State's Capacity for Providing Substance Abuse Treatment and Counseling Services to Individuals/Families in Need of These Services Who reside in Communities Identified as Being at Risk, Section #5

The California Department of Alcohol and Drug Programs (CDADP) is responsible for the management and oversight of alcohol and other drug services that are implemented at the county level. California's substance abuse treatment services include intervention, client-centered, culturally appropriate treatment, and recovery services. Treatment and recovery approaches are based on the individual's needs, preferences, experiences, and cultural backgrounds. CDADP resources available for prevention programs are very limited.

The AOD treatment capacity in California continually changes. Licensing and certification applications for new programs are processed on an ongoing basis. In addition, programs can shut down and capacity is affected. On September 1, 2010, CDADP estimated AOD treatment capacity in California to be 110,623. Pregnant and parenting women are a priority population served by this system. There are over 300 publicly-funded perinatal alcohol and drug treatment and recovery programs which serve the needs of over 38,000 pregnant and parenting women annually.[145]

Unfortunately, over 3.3 million Californians are estimated to need, but are not receiving AOD treatment. Young adults 18-25 years of age have the highest percentage needing but not receiving treatment for alcohol use. They account for over one million people in need of treatment. Therefore, young families may be among those most in need. Although the 26+ years age group has the lowest overall percentage needing treatment, it has the largest overall population. Therefore, this age group accounts for nearly two million people in need of treatment.

The current focus of many substance use programs is the treatment of individuals who are dependent on alcohol and/or other drugs. Although treatment for seriously addicted individuals is an important public health priority, these individuals represent a small percentage of those afflicted with substance use disorders. It is estimated that the great majority of substance users are individuals who are not dependent on substances yet misuse drugs and/or alcohol on a regular basis. To effectively address these at risk, problem substance users, identification and the delivery of effective interventions by trained professionals in various settings is required. The Home Visiting Program will provide opportunities for home visitors to assist in intervention, treatment, and recovery success.

*Challenges:*
The greatest challenge for CDPH/MCAH is the quantification of substance abuse treatment and counseling capacity for families in need in California. At the time of this report, capturing AOD service delivery data that meaningfully reflects how well California families in need are served is not possible.

**State Plans For Identifying Communities In Need, Addressing Gaps In Services, And Addressing Identified Needs, Especially Among High Risk Communities**

Which communities or sub-communities have been identified by the State as particularly at risk and in particular need of improved/expanded home visiting services including a discussion of the basis on which decisions were made to prioritize at risk communities

The SIR for the Submission of the Updated State Plan provides an opportunity for States to refine the boundaries of targeted communities as part of the updated needs/resources assessment and Updated State Plan. Prior to the release of the first SIR, CDPH/MCAH undertook an extensive and collaborative effort to develop a comprehensive approach for completing the needs assessment. Part of this comprehensive approach was the selection of core indicators based on the Life Course Perspective, social determinants of health, and the socio-ecologic framework. Key to the inclusion of an indicator was the availability of data at the sub-county level, the validity of information collected, and the usefulness of the indicator in representing California's diversity and complexity when identifying at risk communities. California's partner Agencies from the CDPH, CDADP, CDE, and CDSS will collaboratively refine the definition of "community" and identify variables from our core set that are reflective of the indicators required in the current SIR. The plan for refining this needs assessment will incorporate a framework for conducting additional analyses (e.g., hot-spot analyses and creation of geospatial hot spot maps) that identify clusters of at risk communities.

California's children face a myriad of challenges including poverty which compels us to act to improve the services provided them and their families. It is the goal of CDPH/MCAH to design a home visiting program focused on high-quality home visiting programs that will improve California's long-term educational, health, and economic outcomes.

Address gaps in services to individuals and families residing in communities at risk

In California, with its state fiscal crisis, no one program will be sufficient to meet all the needs of individuals and families residing in communities at risk. This is a powerful message which was confirmed while reviewing the results of the Capacity Assessment Home Visiting Survey completed by 54 of California's 58 counties. All 54 counties responded "yes" when asked whether there were unmet needs in their county that could be addressed through new home visiting services. Counties were asked to rank the extent that the gaps in services of nine high-risk priority populations (e.g., pregnant teens, low income pregnant women or poor families with young children, etc) could be addressed through a home visiting program. Further, counties were asked to rank the extent that specific services could be addressed through home visiting, including, services that support prenatal health, maternal health, infant health and development, child health and development, parenting skills, child abuse and injury prevention, school readiness, domestic violence prevention, mental health, substance use, economic self-sufficiency, and coordination of community referrals. Though detailed analysis is pending, the majority of counties indicated that it was significantly likely that these specific service needs could be met for the high risk priority populations using a home visiting program. Further assessment of gaps in services to individuals and families will require local identification of specific high-risk priority populations and the capacity of the local public health system to effectively meet their service delivery needs. As gaps in services are identified, the next challenge will be to determine whether home visiting services can meet the needs, and, specifically which home visiting model or models(s) is most likely to help achieve the ultimate goal of improving immediate health outcomes as well as health and well-being over the life course.

How the State will Address these Needs, especially with respect to high-risk communities, which may include applying for a grant to conduct an early childhood home visiting program

It is recognized that the best way to align and coordinate multiple home visiting programs and to maximize available resources, both human and fiscal, is to create a coordinated state-level home visiting program. CDPH/MCAH, with its partners and stakeholders, will provide the necessary leadership to improve the quality and capacity of home visiting services throughout the state. This can be done by providing a state based home visiting program which includes policies to promote optimal early childhood health and development, coordination of existing home visiting programs, linkages that support a seamless continuum of services, and state based data collection for enhanced evaluation and continuous quality improvement.

*Home Visiting Programs are Currently Being Implemented but are Insufficient to Meet the Needs*

This needs assessment highlights the fact that at risk populations reside in all counties in California, with the vast majority of counties housing populations with multiple needs and risks (as evidenced by the fact that 54 of 58 counties had rates worse off than the corresponding statewide median for six or more indicators). Further, as evident in the results of the Capacity Assessment Home Visiting Survey, counties are actively implementing home visiting programs to meet community needs, but capacity within existing programs is universally inadequate. Therefore, in order to take steps to address these unmet needs, CDHP/MCAH fully intends to complete the application process for the ACA Maternal, Infant and Early Childhood Home Visiting Program funds.

*Local Infrastructure and Expertise are Available*

Based on data generated for this report, CDPH/MCAH is able to gauge the level of infrastructure in place for home visiting programs, what types of evidence based home visiting programs are currently in use, and, in many cases, what funding sources are in existence for home visiting programs. The de-centralized implementation of maternal, infant and early childhood home visiting programs in California has allowed for great local flexibility, providing a rich knowledge base for the delivery of home visiting services to diverse populations. Extensive local expertise for the provision of evidence based home visiting models, in both urban and rural settings, and in communities with very different demographics, will inform new state-based strategy development, and can be tapped as a resource for communities implementing new home visiting programs. At the same time, wide-ranging experience with locally developed home visiting programs and local adaptations of national models allows for otherwise unavailable insights into the delivery of home visiting services to some of the state's most hard-to-reach target populations.

*Home Visiting Program Coordination and Systems Development Requires Broad Collaboration*

Recognizing that the goal of the Home Visiting Program is beyond the scope of any single Agency, CDPH/MCAH views the involvement of partners as essential to the success of California's Home Visiting Program as well. CDPH/MCAH has worked across systems and in partnership with the CDSS, CDADP, and the CHSSCO of the CDE in developing California's Home Visiting Program application and in completing this needs assessment. California will continue these partnerships as the needs assessment is further refined and as California's Home Visiting Program is developed, implemented and sustained.

*Addressing Substance Use with Early Intervention, Treatment and Counseling through the California Home Visiting Program*
One of the key strategic goals of the California Department of Alcohol and Drug Programs (CDADP) is to develop and maintain a comprehensive, integrated statewide prevention, treatment and recovery system. ADP is responsible for the management and oversight of services that are implemented on the county level. Recognizing the opportunity for alcohol and other drug (AOD) early identification and intervention through home visiting services, CDPH/MCAH will reach out to CDADP in order to foster this systems integration and collaboration. Efforts at CDADP to provide a quality and effective system of AOD services include: 1) a systems change efforts to evolve public alcohol AOD services from an acute care system to a chronic disease model to address the chronic nature of substance use and abuse; 2) performance management efforts for on-going improvement of the quality of client-based data collection and measurement of performance and outcomes; and 3) statewide needs assessment and planning which informs departmental goals related to diversity and cultural competency, including the needs of women.

*Targeting County or Sub-county Needs and Gaps in Services Through an Application Process*
Due to the number and diversity of counties selected, further research will be needed to pinpoint the highest at risk populations in communities with unmet need or gaps in services. Additional sub-county analyses, such as geospatial hot spot analyses, will help to refine the boundaries of targeted communities and will serve as the basis of California's initial implementation plan. Upon completion of these additional analyses, California will develop an application process inviting high need counties to apply for Home Visiting Program funds to be administered by CDPH/MCAH. County responses to the application process should address those indicators within their County boundaries that were identified as a cluster significantly higher than the State's overall mean value. Counties will have the opportunity to incorporate local information and knowledge by introducing additional statistical evidence, where such evidence exists, to support the need for Home Visiting to address other population needs or geographic areas within their County boundaries. Counties will be encouraged to incorporate information from other needs assessments, particularly those that are only available at the local level such as Head Start needs assessments. Further, counties will be asked to assess the public health system of care serving the maternal, infant and early childhood population in order to clearly identify the gaps in service delivery and opportunities for local program coordination.

*Establishing the CDPH/MCAH Home Visiting Program Infrastructure*
With establishment of a State early childhood home visiting program underway, California is developing a plan to ensure adequate state-level staffing and expertise specific to home visiting. Activities include conducting extensive critical review of the various home visiting models; evaluating program outcomes; addressing administrative and oversight issues; performing fiscal analyses; and developing additional State infrastructure to support the training, technical assistance, data analysis, and reporting needs of new and/or expanded home visiting programs.

CDPH/MCAH awaits the release of the next federal guidance document that will help inform the identification of home visiting models to meet the needs of at risk populations in California. In the meantime, CDPH/MCAH, in partnership with it's partners and stakeholders, has thoroughly reviewed the following evidence based models: Head Start/Early Head Start, Healthy Families America, Healthy Start, Home Instruction for Parents of Preschool Youngsters, Nurse Family Partnership, Parent Child Home Program, Parents as Teachers and SafeCare. CDPH/MCAH will appropriately select likely two to three evidence based models as well as a 'promising practice' model to fund in counties identified as high risk and with unmet needs.

## Conclusion

Developing a comprehensive, evidence-based Home Visiting Program in California requires a well coordinated and collaborative effort of multiple State and local partners whereby a thorough and systematic needs assessment is completed that informs program implementation. The information presented in this initial needs assessment is one component of this ongoing collaborative process framed by the Life Course Perspective, social determinants of health, and the socio-ecological model. As California moves forward in this continuous process, indicators from our overall planned approach developed with key partners will provide further opportunity to refine this needs assessment and facilitate implementation of the Home Visiting Program. California's ongoing efforts to address identified needs will also incorporate a framework for leveraging local expertise so as to further supplement results from this needs assessment process, and to inform efforts for implementing and sustaining the Home Visiting Program.

The mission of the California Home Visiting Program is to promote and enhance the optimal development of families and young children across all domains. This will be achieved through a coordinated, comprehensive, and high quality home visiting program strategically targeting families and children facing significant barriers which place them at high risk. California's investment in high-quality services for families and children at risk will pay enormous long-term dividends for the State.

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# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

# Appendix I

## Maternal, Child and Adolescent Health Program
## Center for Family Health
## California Department of Public Health

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State of California—Health and Human Services Agency
California Department of Public Health

MARK B HORTON, MD, MSPH
*Director*

ARNOLD SCHWARZENEGGER
*Governor*

September 9, 2010

Audrey M. Yowell, Ph.D., MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
8A-39
Rockville, MD 20857

Dear Dr. Yowell:

I am pleased to support the California Department of Public Health's (CDPH) Statewide Needs Assessment application for the Maternal, Infant and Early Childhood Home Visiting Program.

At the federal level, the Health Resources and Services Administration and the Administration for Children and Families have jointly made policy decisions regarding the home visiting program. CDPH will mirror the model set forth by the federal agencies.

CDPH has a history of addressing the needs of the "at risk communities" identified by the federal Supplemental Information Request guidance. CDPH looks forward to building a coordinated system of early childhood home visiting, using high-quality, evidence-based practices throughout California.

If you have questions, please contact Shabbir Ahmad, DVM, MS, PhD, CDPH Maternal, Child and Adolescent Health Division at (916) 650-0300.

Sincerely,

Mark B Horton, MD, MSPH
Director

Director's Office, MS 0500, P.O. Box 997377, Sacramento, CA 95899-7377
(916) 558-1700
Internet Address: www.cdph.ca.gov

CDSS
JOHN A. WAGNER
DIRECTOR

STATE OF CALIFORNIA—HEALTH AND HUMAN SERVICES AGENCY
**DEPARTMENT OF SOCIAL SERVICES**
744 P Street • Sacramento, CA 95814 • *www.cdss.ca.gov*

ARNOLD SCHWARZENEGGER
GOVERNOR

September 8, 2010

Dr. Audrey M. Yowell, Ph.D., MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 18A-39
Rockville, MD 20857

Dear Dr. Yowell:

As the Director of the California Department of Social Services (CDSS), which is designated by the Governor as the single state agency responsible to administer the funding received through Title II of the Child Abuse Prevention and Treatment Act, as well as the Community-Based Child Abuse Prevention funds, I am writing this letter of support for the second phase of the grant application submitted by the California Department of Public Health for the Affordable Care Act Maternal Infant and Early Childhood Home Visiting Program (CDFA #93.505).

Our departments have a history of addressing the needs of the "at risk communities" as described in the federal Supplemental Information Request guidance. We look forward to building a coordinated system of early childhood home visiting utilizing high quality, evidence-based practice models throughout California.

At the federal level, home visiting policy and program decisions have been made jointly between the Health Resources and Services Administration (HRSA) and the Administration for Children and Families. It is the goal of the CDSS and the California Department of Public Health's Maternal, Child and Adolescent Health Division to mirror the relationship demonstrated by the federal agencies through our collaboration in sharing information and data necessary for the completion of the Statewide Needs Assessment application to HRSA. We look forward to our continued partnership.

If you have any questions, please contact me at (916) 657-2598 or Gregory E. Rose, Deputy Director of the Children and Family Services Division, at (916) 657-2614.

Sincerely,

PC, for

JOHN A. WAGNER
Director

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

ARNOLD SCHWARZENEGGER, *Governor*

**DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS**
1700 K STREET
SACRAMENTO, CA 95811-4037
TTY/TDD (800) 735-2929
(916) 322-0495

September 9, 2010

Audrey M. Yowell, Ph.D.
MSSS Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane 18A-39
Rockville, Maryland 20857

Dear Dr. Yowell:

The California Department of Alcohol and Drug Programs (ADP) supports the California Department of Public Health/Maternal, Child and Adolescent Health (CDPH/MCAH) Division in making the Health Resources and Services Administration's (HRSA) Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program a success for California families.

At the federal level, home visiting policy and program decisions have been made jointly between HRSA and Administration for Children and Families (ACF). It is the goal of CDPH/MCAH to mirror the relationship set by the federal agency cooperation model by their collaboration of sharing information and data necessary for the submission of the Statewide Needs Assessment application to HRSA.

Our departments have a history of addressing the needs of the "At Risk Communities" identified by the federal Supplemental Information Request guidance. ADP looks forward to building a coordinated system of early childhood home visiting utilizing high quality, evidence based practices throughout California.

If you have any questions, please contact Tara Murphy, Manager, Office of Women's and Perinatal Services at (916) 322-0495, or by email at tmurphy@adp.ca.gov.

Sincerely,

RENÉE ZITO, LMSW, CASAC
Director

Flex your POWER

DO YOUR PART TO HELP CALIFORNIA SAVE ENERGY
For energy saving tips, visit the Flex Your Power website at
http://www.fypower.org

CALIFORNIA
DEPARTMENT OF
EDUCATION

**JACK O'CONNELL**
STATE SUPERINTENDENT OF PUBLIC INSTRUCTION

September 2, 2010

Audrey M. Yowell, Ph.D.
MSSS Health Resources and Services Administration
Maternal and Child Health Bureau
Rockville, MD 20857

Dear Dr. Yowell:

Subject: Maternal, Infant, and Early Childhood Home Visiting Program

The California Department of Education supports the California Department of Public Health/Maternal, Child and Adolescent Health (CDPH/MCAH) Division in making the Health Resources and Services Administration's (HRSA) Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Program a success for California families.

At the federal level, home visiting policy and program decisions have been made jointly between HRSA and Administration for Children and Families (ACF). It is the goal of CDPH/MCAH to mirror the relationship set by the federal agency cooperation model by their collaboration of sharing information and data necessary for the submission of the Statewide Needs Assessment application to HRSA.

Our departments have a history of addressing the needs of the "At Risk Communities" identified by the federal Supplemental Information Request guidance. The California Department of Education looks forward to building a coordinated system of early childhood home visiting utilizing high quality, evidence-based practices throughout California.

If you have any questions, please contact Michael Zito by phone at 916-323-9727 or by e-mail at mzito@cde.ca.gov.

Sincerely,

Nancy Remley, Director
CA Head Start-State Collaboration Office

NR:al

# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

# Supplemental Information Request for the Submission of the Statewide Needs Assessment

# Appendix II

## Maternal, Child and Adolescent Health Program
## Center for Family Health
## California Department of Public Health

# California Maternal, Infant & Early Childhood Home Visiting Program

## 1. Introduction

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (ACA) of 2010. This historic legislation is designed to make quality, affordable health care available to all Americans, to reduce costs, improve health care quality, enhance disease prevention, and strengthen the health care workforce. Through a provision authorizing the creation of the ACA Maternal, Infant, and Early Childhood Home Visiting Program, the Act provides an unprecedented opportunity for collaboration and partnership at the Federal, State, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.

The California Department of Public Health, Maternal, Child & Adolescent Health Division (CDPH/MCAH) has been designated by Governor Arnold Schwarzenegger as the single State entity authorized to apply for and administer home visiting program funds for the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF) on behalf of California. CDPH/MCAH will work across systems and in partnership with diverse stakeholders to plan, implement, and sustain home visiting programs for eligible children and families.

Section 511(b) of Title V, as amended by ACA, requires that a statewide needs assessment be conducted that is separate from the needs assessment required under section 505(a) of the Title V for the Maternal Child Health (MCH) Services Block Grant. As part of this statewide needs assessment, CDPH/MCAH requests your cooperation and assistance in identifying home visiting programs in your local health jurisdiction and learning more about their functions and services. Your response to this survey is critical, and will assist CDPH/MCAH in selecting home visiting models for state-based implementation.

Please complete this survey and submit it by 8:00 p.m. on August 10, 2010.

If you have any questions, please direct them to Laurel Cima:
Email: laurel.cima@cdph.ca.gov
Phone: (916) 650-0314

Home Visiting Definition:
An evidence-based program implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to pregnant women or children birth to age 5 targeting the participant outcomes in the legislation which include improved maternal and child health, prevention of child

injuries, child abuse, or maltreatment, and reduction of emergency department visits, improvement in school readiness and achievement, reduction in crime or domestic violence, improvements in family economic self-sufficiency, and improvements in the coordination and referrals for other community resources and supports.

For a summary of the law pertaining to home visiting and updates on CDPH/MCAH's funding application process, please visit CDPH/MCAH's home visiting website:

http://cdph.ca.gov/CA-MCAH-HomeVisitation

## 2. Respondent Information

* 1. Your name and contact information:

Name:

Title & Organization

Address Line 1:

Address Line 2:

City/Town:

State:

ZIP:

County:

Email Address:

Phone Number:

* 2. Please list any agencies/programs you coordinated with to answer questions in this survey.

State/County Maternal, Child, & Adolescent Health

State/County Social Services

State/County Department of Education

State/County Alcohol & Drug

Other 1

Other 2

Other 3

## 3. Home Visiting Services by Funding Source

* 1. What funding sources does your county use to provide maternal, infant and/or early childhood home visiting services (select all that apply)?

- ☐ Title V MCH Block Grant Funds
- ☐ Title II Child Abuse & Treatment Act/CBCAP/CAPIT
- ☐ Title IV Temporary Assistance to Needy Families/CalWORKS
- ☐ Head Start Act/Early Head Start
- ☐ Other

* 2. By funding source, about how many families in your county received maternal, infant and/or early childhood home visiting services in the most recent calendar or fiscal year?

| | |
|---|---|
| Title V MCH Block Grant Funds | |
| Title II Child Abuse & Treatment Act/CBCAP/CAPIT | |
| Title IV Temporary Assistance to Needy Families/CalWORKS | |
| Head Start Act/Early Head Start | |

* 3. By funding source, please identify all home visiting models being used in your county in the most recent calendar or fiscal year:

| | Nurse Family Partnership (NFP) | Healthy Families America (HFA) | Parents as Teachers (PAT) | Healthy Start | SafeCare | Home Instruction Program for Preschool Youngsters (HIPPY) | Early Head Start | Parent-Child Home Program (PCHP) | Other |
|---|---|---|---|---|---|---|---|---|---|
| Title V MCH Block Grant Funds | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Title II Child Abuse & Treatment Act/CBCAP/CAPIT | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Title IV Temporary Assistance to Needy Families/CalWORKS | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Head Start Act/Early Head Start | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

## 4. Nurse Family Partnership (NFP)

Nurse Family Partnership – an evidence based home visiting program employing nurses as case managers. Clients are low income, unmarried and teenagers who are first time mothers and are followed during pregnancy (no later than the 28th week) through the child's second birthday. The nurse visits once per month during pregnancy and through the child's second birthday. The nurses teach positive health related behaviors, competent care of children, and maternal personal development (family planning, educational achievement, and participation in the workforce). Evaluation is through national performance objectives based on outcomes from research trial, site performance in replication and measures set forth in Healthy People 2010. To monitor program quality NFP sites have real time access to their own program data, including client enrollment rates and number of completed visits; client demographics; and risk and outcome indicators related to pregnancy, birth outcomes, child health and development; and maternal life course development.

* 1. Are you using the Nurse Family Partnership (NFP) home visiting model in your county?

- ◯ Yes
- ◯ No

## 5. Nurse Family Partnership (NFP) continued...

* 1. Do you have a current contract or Agency Funding Agreement (AFA) with the national NFP office?

- ◯ Yes, we have a current contract or AFA
- ◯ No, but we are using the model

* 2. For how many years has this model been implemented in your county?

- ◯ 0-2+ years
- ◯ 3-5 years
- ◯ 5+ years

* 3. Please identify the primary target population(s) this home visiting model serves (select all that apply):

- ☐ Low Income
- ☐ Pregnant Women
- ☐ Teens
- ☐ Children with Developmental Delays/Disabilities
- ☐ History of Domestic Violence
- ☐ History of Substance Abuse
- ☐ Low Student Achievement/Dropouts
- ☐ Other

4. If you selected "Other" in the previous question, please identify this population below:

* 5. Approximately how many families were served by this model in the most recent calendar or fiscal year?

* 6. Please identify staff who are conducting home visits:

- ☐ Professionals (PHN, RN, Social Worker, Teacher, etc.)
- ☐ Paraprofessionals (community health workers, trained parents, former program participants)

* 7. Do home visiting staff receive initial standardized training specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with initial standardized training specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with initial standardized training specifically related to their home visiting roles and responsibilities.

* 8. Do home visiting staff receive standardized continuing education specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with standardized continuing education specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with standardized continuing education specifically related to their home visiting roles and responsibilities

* 9. Is there a waiting list for NFP home visiting services?

◯ Yes

◯ No

## 6. Healthy Families America (HFA)

Healthy Families America (HFA) – a paraprofessional home visiting program model that targets at-risk pregnant women and families with school age children. The program serves pregnant women and children within 2 weeks of birth through entry into preschool or kindergarten. Home visitors visit families at least weekly and follow a well defined criteria for increasing or decreasing frequency of home visiting over the long term. Each agency creates its own program plan and evaluation which is guided by the 12 critical elements central to all HFA programs. The program goals are to promote positive parenting skills, prevent child abuse and neglect, support optimal prenatal care, child health and development and improve parents' self sufficiency.

* 1. Are you using the Healthy Families America (HFA) home visiting model in your county?

- ◯ Yes
- ◯ No

## 7. Healthy Familes America (HFA) continued...

* 1. Do you have a current contract or Agency Funding Agreement (AFA) with the national HFA office?

- ◯ Yes, we have a current contract or AFA
- ◯ No, but we are using the model

* 2. For how many years has this model been implemented in your county?

- ◯ 0-2+ years
- ◯ 3-5 years
- ◯ 5+ years

* 3. Please identify the primary target population(s) this home visiting model serves (select all that apply):

- ☐ Low Income
- ☐ Pregnant Women
- ☐ Teens
- ☐ Children with Developmental Delays/Disabilities
- ☐ History of Domestic Violence
- ☐ History of Substance Abuse
- ☐ Low Student Achievement/Dropouts
- ☐ Other

4. If you selected "Other" in the previous question, please identify this population below:

[ ]

* 5. Approximately how many families were served by this model in the most recent calendar or fiscal year?

[ ]

* 6. Please identify staff who are conducting home visits:

- ☐ Professionals (PHN, RN, Social Worker, Teacher, etc.)
- ☐ Paraprofessionals (community health workers, trained parents, former program participants)

* 7. Do home visiting staff receive initial standardized training specifically related to their home visiting roles and responsibilities?

- ◯ Yes, home visiting staff are provided with initial standardized training specifically related to their home visiting roles and responsibilities.
- ◯ No, home visiting staff are not provided with initial standardized training specifically related to their home visiting roles and responsibilities.

* 8. Do home visiting staff receive standardized continuing education specifically related to their home visiting roles and responsibilities?

- ◯ Yes, home visiting staff are provided with standardized continuing education specifically related to their home visiting roles and responsibilities.
- ◯ No, home visiting staff are not provided with standardized continuing education specifically related to their home visiting roles and responsibilities

* 9. Is there a waiting list for HFA home visiting services?

- ◯ Yes
- ◯ No

## 8. Parents as Teachers (PAT)

Parents as Teachers (PAT) – a paraprofessional home visiting program model serving pregnant women and families with young children through kindergarten entry. Home visits can be monthly, biweekly or weekly and include group meetings. “Born to Learn”, a curriculum model that uses home visits and group meetings is the curriculum for all sites. Program quality is evaluated using the PAT Standards and Self-Assessment Process and reported through the PAT Annual Program Report submitted with recertification materials. The program goals are to increase parent knowledge of early childhood development, improve parenting skills, detect developmental delays, prevent child maltreatment, and increase school readiness.

* 1. Are you using the Parents as Teachers (PAT) home visiting model in your county?

- ◯ Yes
- ◯ No

## 9. Parents as Teachers (PAT) continued...

* 1. Do you have a current contract or Agency Funding Agreement (AFA) with the national PAT office?

- ◯ Yes, we have a current contract or AFA
- ◯ No, but we are using the model

* 2. For how many years has this model been implemented in your county?

- ◯ 0-2+ years
- ◯ 3-5 years
- ◯ 5+ years

* 3. Please identify the primary target population(s) this home visiting model serves (select all that apply):

- ☐ Low Income
- ☐ Pregnant Women
- ☐ Teens
- ☐ Children with Developmental Delays/Disabilities
- ☐ History of Domestic Violence
- ☐ History of Substance Abuse
- ☐ Low Student Achievement/Dropouts
- ☐ Other

4. If you selected "Other" in the previous question, please identify this population below:

* 5. Approximately how many families were served by this model in the most recent calendar or fiscal year?

* 6. Please identify staff who are conducting home visits:

- ☐ Professionals (PHN, RN, Social Worker, Teacher, etc.)
- ☐ Paraprofessionals (community health workers, trained parents, former program participants)

* 7. Do home visiting staff receive initial standardized training specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with initial standardized training specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with initial standardized training specifically related to their home visiting roles and responsibilities.

* 8. Do home visiting staff receive standardized continuing education specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with standardized continuing education specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with standardized continuing education specifically related to their home visiting roles and responsibilities

* 9. Is there a waiting list for PAT home visiting services?

◯ Yes

◯ No

## 10. Healthy Start

Healthy Start (HS) - a paraprofessional home visiting program model serving pregnant women, women who have just given birth and newborns and toddlers through 3 years of age whose family has been identified as at-risk of child maltreatment. There is no set or prescribed curriculum. Each site develops its own program and staff training needs based on the needs and services that will be provided to the identified target population. There are two major components: early identification of eligible families and home visiting to families to foster family functioning, promote child growth/development, and enhance positive parenting skills to reduce the risk of child maltreatment. The program goals are to reduce infant mortality, low birthweight births and racial disparities in perinatal outcomes.

* 1. Are you using the Healthy Start (HS) home visiting model in your county?

- ◯ Yes
- ◯ No

## 11. Healthy Start (HS) continued...

* 1. Do you have a current contract or Agency Funding Agreement (AFA) with the national HS office?

- ◯ Yes, we have a current contract or AFA
- ◯ No, but we are using the model

* 2. For how many years has this model been implemented in your county?

- ◯ 0-2+ years
- ◯ 3-5 years
- ◯ 5+ years

* 3. Please identify the primary target population(s) this home visiting model serves (select all that apply):

- ☐ Low Income
- ☐ Pregnant Women
- ☐ Teens
- ☐ Children with Developmental Delays/Disabilities
- ☐ History of Domestic Violence
- ☐ History of Substance Abuse
- ☐ Low Student Achievement/Dropouts
- ☐ Other

4. If you selected "Other" in the previous question, please identify this population below:

[ ]

* 5. Approximately how many families were served by this model in the most recent calendar or fiscal year?

[ ]

* 6. Please identify staff who are conducting home visits:

- ☐ Professionals (PHN, RN, Social Worker, Teacher, etc.)
- ☐ Paraprofessionals (community health workers, trained parents, former program participants)

* 7. Do home visiting staff receive initial standardized training specifically related to their home visiting roles and responsibilities?

- ◯ Yes, home visiting staff are provided with initial standardized training specifically related to their home visiting roles and responsibilities.
- ◯ No, home visiting staff are not provided with initial standardized training specifically related to their home visiting roles and responsibilities.

* 8. Do home visiting staff receive standardized continuing education specifically related to their home visiting roles and responsibilities?

- ◯ Yes, home visiting staff are provided with standardized continuing education specifically related to their home visiting roles and responsibilities.
- ◯ No, home visiting staff are not provided with standardized continuing education specifically related to their home visiting roles and responsibilities

* 9. Is there a waiting list for HS home visiting services?

- ◯ Yes
- ◯ No

## 12. SafeCare

SafeCare – a paraprofessional home visiting program where trained professionals work with at-risk families in their home environments to improve parents' skills. Services are provided for infants and children from newborn to 5 years old. Home visitors use three modules, Health, Home Safety and the Parent-Child/Parent-Infant Interactions Modules, to teach parents how to provide their children with engaging and stimulating activities and structured problem solving skills. Parents are taught, for example, how to plan and implement activities with their children, respond appropriately to child behaviors, improve home safety, and address health and safety issues. SafeCare is generally provided in weekly home visits lasting from 1-2 hours. The program typically lasts 18-20 weeks for each family. Evaluation is through observational assessment tools which are built into each module to evaluate whether parents are progressing as expected in targeted skills.

* 1. Are you using the SafeCare home visiting model in your county?

- ◯ Yes
- ◯ No

## 13. SafeCare continued...

* 1. Do you have a current contract or Agency Funding Agreement (AFA) with the national SafeCare office?

- ◯ Yes, we have a current contract or AFA
- ◯ No, but we are using the model

* 2. For how many years has this model been implemented in your county?

- ◯ 0-2+ years
- ◯ 3-5 years
- ◯ 5+ years

* 3. Please identify the primary target population(s) this home visiting model serves (select all that apply):

- ☐ Low Income
- ☐ Pregnant Women
- ☐ Teens
- ☐ Children with Developmental Delays/Disabilities
- ☐ History of Domestic Violence
- ☐ History of Substance Abuse
- ☐ Low Student Achievement/Dropouts
- ☐ Other

4. If you selected "Other" in the previous question, please identify this population below:

* 5. Approximately how many families were served by this model in the most recent calendar or fiscal year?

* 6. Please identify staff who are conducting home visits:

- ☐ Professionals (PHN, RN, Social Worker, Teacher, etc.)
- ☐ Paraprofessionals (community health workers, trained parents, former program participants)

* 7. Do home visiting staff receive initial standardized training specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with initial standardized training specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with initial standardized training specifically related to their home visiting roles and responsibilities.

* 8. Do home visiting staff receive standardized continuing education specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with standardized continuing education specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with standardized continuing education specifically related to their home visiting roles and responsibilities

* 9. Is there a waiting list for SafeCare home visiting services?

◯ Yes

◯ No

## 14. Home Instruction Program for Preschool Youngsters (HIPPY)

Home Instruction for Parents of Preschool Youngsters (HIPPY) – a paraprofessional home visiting program model serving parents with children ages 3-5, especially low-income families with little education. Program services include a blend of 30 minutes of home visiting biweekly and two hour biweekly group meetings over 3 years. Evaluation is through data entry into the HIPPY Management Information System (MIS) that tracks families' progress. Local programs are responsible for producing end of year reports. The model is primarily cognitive-based and program goals are to promote school readiness and early literacy through parental involvement.

* 1. Are you using the Home Instruction Program for Preschool Youngsters (HIPPY) home visiting model in your county?

- ◯ Yes
- ◯ No

## 15. Home Instruction Program for Preschool Youngsters (HIPPY) continued...

* 1. Do you have a current contract or Agency Funding Agreement (AFA) with the national HIPPY office?

- ◯ Yes, we have a current contract or AFA
- ◯ No, but we are using the model

* 2. For how many years has this model been implemented in your county?

- ◯ 0-2+ years
- ◯ 3-5 years
- ◯ 5+ years

* 3. Please identify the primary target population(s) this home visiting model serves (select all that apply):

- ☐ Low Income
- ☐ Pregnant Women
- ☐ Teens
- ☐ Children with Developmental Delays/Disabilities
- ☐ History of Domestic Violence
- ☐ History of Substance Abuse
- ☐ Low Student Achievement/Dropouts
- ☐ Other

4. If you selected "Other" in the previous question, please identify this population below:

[ ]

* 5. Approximately how many families were served by this model in the most recent calendar or fiscal year?

[ ]

* 6. Please identify staff who are conducting home visits:

- ☐ Professionals (PHN, RN, Social Worker, Teacher, etc.)
- ☐ Paraprofessionals (community health workers, trained parents, former program participants)

* 7. Do home visiting staff receive initial standardized training specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with initial standardized training specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with initial standardized training specifically related to their home visiting roles and responsibilities.

* 8. Do home visiting staff receive standardized continuing education specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with standardized continuing education specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with standardized continuing education specifically related to their home visiting roles and responsibilities

* 9. Is there a waiting list for HIPPY home visiting services?

◯ Yes

◯ No

## 16. Early Head Start

Early Head Start - a paraprofessional home visiting program model serving pregnant women and families with infants and toddlers to 3 years old. Eligible families must be at or below federal poverty level to qualify for EHS services. Home visitors provide comprehensive child development services through three program options; Center-based, Home-based and a combination of both home visiting and center experiences.. Home visiting services are provided weekly for 90 minutes. Evaluation includes selected measures from the Head Start framework. The program goals are to promote healthy prenatal outcomes for pregnant women, enhance the development of very young children and promote healthy family functioning.

* 1. Are you using the Early Head Start home visiting model in your county?

- ◯ Yes
- ◯ No

17. Early Head Start continued...

* 1. Do you have a current contract or Agency Funding Agreement (AFA) with the national Early Head Start office?

- ◯ Yes, we have a current contract or AFA
- ◯ No, but we are using the model

* 2. For how many years has this model been implemented in your county?

- ◯ 0-2+ years
- ◯ 3-5 years
- ◯ 5+ years

* 3. Please identify the primary target population(s) this home visiting model serves (select all that apply):

- ☐ Low Income
- ☐ Pregnant Women
- ☐ Teens
- ☐ Children with Developmental Delays/Disabilities
- ☐ History of Domestic Violence
- ☐ History of Substance Abuse
- ☐ Low Student Achievement/Dropouts
- ☐ Other

4. If you selected "Other" in the previous question, please identify this population below:

* 5. Approximately how many families were served by this model in the most recent calendar or fiscal year?

* 6. Please identify staff who are conducting home visits:

- ☐ Professionals (PHN, RN, Social Worker, Teacher, etc.)
- ☐ Paraprofessionals (community health workers, trained parents, former program participants)

* 7. Do home visiting staff receive initial standardized training specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with initial standardized training specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with initial standardized training specifically related to their home visiting roles and responsibilities.

* 8. Do home visiting staff receive standardized continuing education specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with standardized continuing education specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with standardized continuing education specifically related to their home visiting roles and responsibilities

* 9. Is there a waiting list for Early Head Start home visiting services?

◯ Yes

◯ No

## 18. Parent-Child Home Program (PCHP)

Parent-Child Home Program (PCHP) - a paraprofessional home visiting program model serving low-income families with low levels of education and multiple risk factors. Families participate in the two-year program when their child is 2- 3 years old. A child can enter the Program as young as 16 months. Some sites serve families with children up to 4 years old. A Home Visitor is matched with the family and visits them for half-an-hour, twice-a-week on a schedule that is convenient for the family. A Program Year consists of a minimum of 23 weeks of home visits (or 46 home visits). Evaluation is through annual reporting to the National Center and in accordance with the PCHP guidelines. The National Center provides local programs with informational materials, follow-up training, administrative written materials, and training videos and manuals. The program goals are to prepare young children for school success, enhance social-emotional development and strengthen the parent-child relationship.

* 1. Are you using the Parent-Child Home Program (PCHP) home visiting model in your county?

- ◯ Yes
- ◯ No

## 19. Parent-Child Home Program (PCHP) continued...

* 1. Do you have a current contract or Agency Funding Agreement (AFA) with the national PCHP office?

- ◯ Yes, we have a current contract or AFA
- ◯ No, but we are using the model

* 2. For how many years has this model been implemented in your county?

- ◯ 0-2+ years
- ◯ 3-5 years
- ◯ 5+ years

* 3. Please identify the primary target population(s) this home visiting model serves (select all that apply):

- ☐ Low Income
- ☐ Pregnant Women
- ☐ Teens
- ☐ Children with Developmental Delays/Disabilities
- ☐ History of Domestic Violence
- ☐ History of Substance Abuse
- ☐ Low Student Achievement/Dropouts
- ☐ Other

4. If you selected "Other" in the previous question, please identify this population below:

[ ]

* 5. Approximately how many families were served by this model in the most recent calendar or fiscal year?

[ ]

* 6. Please identify staff who are conducting home visits:

- ☐ Professionals (PHN, RN, Social Worker, Teacher, etc.)
- ☐ Paraprofessionals (community health workers, trained parents, former program participants)

* 7. Do home visiting staff receive initial standardized training specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with initial standardized training specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with initial standardized training specifically related to their home visiting roles and responsibilities.

* 8. Do home visiting staff receive standardized continuing education specifically related to their home visiting roles and responsibilities?

◯ Yes, home visiting staff are provided with standardized continuing education specifically related to their home visiting roles and responsibilities.

◯ No, home visiting staff are not provided with standardized continuing education specifically related to their home visiting roles and responsibilities

* 9. Is there a waiting list for PCHP home visiting services?

◯ Yes

◯ No

## 20. Other #1

CDPH/MCAH is using the following definition for home visiting:

An evidence-based program implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to pregnant women or children birth to age 5 targeting the participant outcomes in the legislation which include improved maternal and child health, prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits, improvement in school readiness and achievement, reduction in crime or domestic violence, improvements in family economic self-sufficiency, and improvements in the coordination and referrals for other community resources and supports.

* 1. Are there any programs in your county using a home visiting model not already specified in this survey?

- ◯ Yes
- ◯ No

## 21. Other #1 continued...

* 1. For how many years has this service been implemented in your county?

- ◯ 0-2+ years
- ◯ 3-5 years
- ◯ 5+ years

* 2. Who implements this home visiting service in your county (select all that apply)?

- ☐ State Government Staff
- ☐ County Staff
- ☐ Schools/School Districts
- ☐ Community-Based Organizations
- ☐ Other Non-Profit Agency
- ☐ Private Agency

* 3. Please identify the primary target population(s) this home visiting program serves (select all that apply):

- ☐ Low Income
- ☐ Pregnant Women
- ☐ Teens
- ☐ Children with Developmental Delays/Disabilities
- ☐ History of Domestic Violence
- ☐ History of Substance Abuse
- ☐ Low Student Achievement/Dropouts
- ☐ Other

4. If you selected "Other" in the previous question, please identify this population below:

* 5. What is the primary focus(es) of this home visiting service in your county (select all that apply)?

- [ ] Child Development/School Readiness
- [ ] Child Abuse and Neglect
- [ ] Prenatal Care/Pregnancy Outcomes
- [ ] Infant/Child Health
- [ ] Maternal Health
- [ ] Domestic Violence
- [ ] Substance Abuse
- [ ] Parenting Skills
- [ ] Family Economic Self-Sufficiency
- [ ] Linkage to Community Services

* 6. How long does a family receive this home visiting service?

- ( ) 1-time only
- ( ) 0-3 months
- ( ) 4-6 months
- ( ) 7-12 months
- ( ) More than 1 year

* 7. What is the approximate frequency of these home visits?

- ( ) 1-time visit only
- ( ) Weekly
- ( ) Bi-weekly
- ( ) Monthly
- ( ) Quarterly

* 8. Please identify staff who are conducting home visits?

- [ ] Public Health Nurses
- [ ] Other Registered Nurses
- [ ] Social Workers
- [ ] Licensed Mental Health Professionals (LCSWs, MFT, Psychologists)
- [ ] Teachers/Educators
- [ ] Child Development Specialists
- [ ] Auxilary Specialists (speech, occupational, or physical therapists)
- [ ] Paraprofessionals (community health workers, trained parents, former program participants)

Other (please specify)

* 9. Approximately how many families were served by this home visiting service in the most recent calendar or fiscal year?

* 10. Is there a waiting list for this home visiting service?

- ◯ Yes
- ◯ No

* 11. Are resources allocated for independent evaluation efforts of this home visiting service?

- ◯ Yes
- ◯ No

* 12. Is there another home visiting service being used in your county not already specified in this survey?

- ◯ Yes
- ◯ No

## 22. Other #2

CDPH/MCAH is using the following definition for home visiting:

An evidence-based program implemented in response to findings from a needs assessment, that includes home visiting as a primary service delivery strategy (excluding programs with infrequent or supplemental home visiting), and is offered on a voluntary basis to pregnant women or children birth to age 5 targeting the participant outcomes in the legislation which include improved maternal and child health, prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits, improvement in school readiness and achievement, reduction in crime or domestic violence, improvements in family economic self-sufficiency, and improvements in the coordination and referrals for other community resources and supports.

* 1. For how many years has this model been implemented in your county?

- ◯ 0-2+ years
- ◯ 3-5 years
- ◯ 5+ years

* 2. Who implements this home visiting program in your county (select all that apply)?

- ☐ State Government Staff
- ☐ County Staff
- ☐ Schools/School Districts
- ☐ Community-Based Organizations
- ☐ Other Non-Profit Agency
- ☐ Private Agency

* 3. Please identify the primary target population(s) this home visiting program serves (select all that apply):

- ☐ Low Income
- ☐ Pregnant Women
- ☐ Teens
- ☐ Children with Developmental Delays/Disabilities
- ☐ History of Domestic Violence
- ☐ History of Substance Abuse
- ☐ Low Student Achievement/Dropouts
- ☐ Other

4. If you selected "Other" in the previous question, please identify this population below:

* 5. What is the primary focus(es) of this home visiting program in your county (select all that apply)?

- ☐ Child Development/School Readiness
- ☐ Child Abuse and Neglect
- ☐ Prenatal Care/Pregnancy Outcomes
- ☐ Infant/Child Health
- ☐ Maternal Health
- ☐ Domestic Violence
- ☐ Substance Abuse
- ☐ Parenting Skills
- ☐ Family Economic Self-Sufficiency
- ☐ Linkage to Community Services

* 6. How long does a family receive this home visiting service?

- ◯ 1-time only
- ◯ 0-3 months
- ◯ 4-6 months
- ◯ 7-12 months
- ◯ More than 1 year

* 7. What is the approximate frequency of these home visits?

- ◯ 1-time visit only
- ◯ Weekly
- ◯ Bi-weekly
- ◯ Monthly
- ◯ Quarterly

* 8. Please identify staff who are conducting home visits?

- ☐ Public Health Nurses
- ☐ Other Registered Nurses
- ☐ Social Workers
- ☐ Licensed Mental Health Professionals (LCSWs, MFT, Psychologists)
- ☐ Teachers/Educators
- ☐ Child Development Specialists
- ☐ Auxilary Specialists (speech, occupational, or physical therapists)
- ☐ Paraprofessionals (community health workers, trained parents, former program participants)

Other (please specify)

* 9. Approximately how many families were served by this home visiting service in the most recent calendar or fiscal year?

* 10. Is there a waiting list for these home visiting services?

- ◯ Yes
- ◯ No

* 11. Are resources allocated for independent evaluation efforts of these home visiting services?

- ◯ Yes
- ◯ No

## 23. Unmet Needs/Gaps in Service

* 1. Are there unmet needs in your county that could be addressed through home visiting services?

- ◯ Yes
- ◯ No

## 24. Unmet Needs/Gaps in Service continued...

1. To what extent could new home visiting funding address gaps in serving the following populations in your county?

Please select the most appropriate answer for each row:

| | Significant | Moderately Significant | Somewhat Significant | Not Significant |
|---|---|---|---|---|
| Pregnant females under 21 years of age | ○ | ○ | ○ | ○ |
| Low income pregnant women and/or low income families with newborns, infants, or children between the ages of 1-8 | ○ | ○ | ○ | ○ |
| Families with children with developmental delays or disabilities | ○ | ○ | ○ | ○ |
| Families with children with low student achievement/drop-outs | ○ | ○ | ○ | ○ |
| Families with a history of child abuse or neglect | ○ | ○ | ○ | ○ |
| Families with a history of domestic violence | ○ | ○ | ○ | ○ |
| Families with a history of substance abuse | ○ | ○ | ○ | ○ |
| Current or former military families | ○ | ○ | ○ | ○ |
| Non-English speaking families | ○ | ○ | ○ | ○ |
| Other | ○ | ○ | ○ | ○ |

2. If you selected "Other" in the previous question, please identify this population below:

* 3. To what extent could the following services be addressed by new home visiting funding?

Please select the most appropriate answer for each row:

| | Significant | Moderately Significant | Somewhat Significant | Not Significant |
|---|---|---|---|---|
| Prenatal Health | ○ | ○ | ○ | ○ |
| Maternal Health | ○ | ○ | ○ | ○ |
| Infant Health & Development | ○ | ○ | ○ | ○ |
| Child Health & Development | ○ | ○ | ○ | ○ |
| Parenting Skills | ○ | ○ | ○ | ○ |
| Child Abuse & Injury Prevention | ○ | ○ | ○ | ○ |
| School Readiness | ○ | ○ | ○ | ○ |
| Domestic Violence Prevention | ○ | ○ | ○ | ○ |
| Mental Health | ○ | ○ | ○ | ○ |
| Substance Abuse | ○ | ○ | ○ | ○ |
| Economic Self-Sufficiency | ○ | ○ | ○ | ○ |
| Coordination of Referrals to Community Resources & Supports | ○ | ○ | ○ | ○ |
| Other | ○ | ○ | ○ | ○ |

4. If you selected "Other" in the previous question, please identify this service below:

## 25. End of Survey

Thank you for completing this survey!