Home Visiting in Connecticut: Current Status, Future Directions

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OEC-21-CT Home Visiting System

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I think they need to have people explain it [home visiting] though. Cause I think a lot of these programs you just hear it and you…I think sometimes parents can feel like if I engage in these programs that means I'm saying that I'm lacking something as a parent. And that's a difficult thing to acknowledge or to admit and so having somebody come out and explain the benefits of the program and that you engaging in a program is more a reflection of you as a positive parent versus being negative would entice people more to get engaged.

-Family Focus Group Parent

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INTRODUCTION

This report is to provide applicants to the OEC-RFP with relevant information for their applications. The information was collected during a year-long needs assessment of home visiting in Connecticut. The process was initiated to comply with a federal requirement to assess the needs for the Maternal Infant Early-Childhood Home Visiting (MIECHV) program in Connecticut. Home visiting can be a broad term; in this report, we focused on the need for programs that are approved by the Health Resources & Services Administration (HRSA) or similar types of programs that focus on families with young children. Other programs that provide home-based services for specific needs, such as the Birth to Three System or Family Based Recovery, were included in the survey and are certainly an important type of service delivered to Connecticut families in their home. However, they were not the focus of this report.

Information was collected through focus groups with families, focus groups with providers other professionals who serve children and community members, a survey of home visiting providers, different administrative data sources, and from a state-wide advisory board. Each of these sources provided different information and a unique perspective on what home visiting looks like currently and what is needed to best serve families in the future. Another aspect of the main needs assessment was to identify communities with high concentrations of risk. To do that, we used administrative data from many agencies and sources to identify the extent of different types of factors that can make it difficult for families to care for their children. This was done at the town-level for all towns in Connecticut. Maps were generated from this data that visually display the differences across towns. The administrative data was then used to identify communities that had higher than average risk across multiple factors.

ACKNOWLEDGEMENTS

We would like to thank everyone who contributed their time, attention, and perspectives to this project. Hundreds of people across the state participated in the focus groups and community listening sessions. We appreciate that you gave of your time to help improve home visiting in Connecticut. Thank you to the Advisory Board for lending us your time and expertise. We would also like to thank all of the agencies that shared their data with us so we could develop a profile of the state and identify where there were many families who needed support. Your contribution was essential to an accurate picture of the state. We would also like to thank the Office of Early Childhood for the opportunity to conduct this important needs assessment. Finally, we would like to thank the staff of the UConn School of Social Work Research Unit who worked tirelessly on all aspects of this project.

EXECUTIVE SUMMARY

The report provides an overview of the current home visiting landscape and what we learned about how the program could better meet the needs of families. The information is organized into sections that describe the findings related to:

- Recruiting families
- Enrolling families in home visiting
- Improving services to families
- Topics that may be useful future training topics
- Distribution of risk factors across towns

KEY FINDINGS

CURRENT LANDSCAPE:

- Services are inconsistently available, some towns have many families served by home visiting programs, while other towns have few if any families served.
- There are many different populations that programs consider one of their top priorities.
- Targeted outcomes also vary widely.
- The workforce does not represent the current client population. A higher percentage of staff are white and female and fewer speak Spanish than the clients.

RECRUITING FAMILIES

- Parents want more direct marketing to them so they could "self-refer".
- Preferably this direct marketing would be done in a strengths-based way through non-stigmatizing locations and referrals.
- Home visiting is stigmatized, and parents assume that if they are being referred then someone has determined that they are not parenting well.
- Agencies use a variety of recruitment strategies but recruitment efforts tend to focus on referral sources.
- Parents recommend a variety of ways to make more parents aware of home visiting.
- The difference between OEC-affiliated home visiting and DCF programs is unclear to families and some providers, and this increases fear and stigma around home visiting.

ENROLLING FAMILIES

- A more centralized intake system would reduce barriers to accessing home visiting, including helping families connect to the appropriate program that is available and best fits their family's needs.

- Eligibility criteria that is related to income excludes families, who may be just over the income thresholds, from many programs and services.
- 211 has possibilities for facilitating the enrollment process but has limitations, such as having updated information, that need to be addressed.

SERVING FAMILIES

- Families value the relationship they formed with the home visitor.
- An important function home visiting has been serving is to connect families to the larger community along with referring them to specific services, such as the Birth to Three System.
- Families want voluntary services that promote family function and are available before a crisis.
- Families want family-centered, family-directed plans that included parents' goals.
- Providers and families want family perspectives and opinions incorporated at all levels of planning.
- Cultural adaptation of curricula and cultural humility training could improve families' engagement in home visiting.
- Families with severe needs, such as homelessness, may not be ready for another service and can be logistically difficult for home visiting programs to serve.

TRAINING TOPICS

- Nonjudgmental services delivery
- The difference between child maltreatment and minimally sufficient care
- Screening and training on adult mental health problems
- The purpose of data collection and data entry

DISTRIBUTION OF RISK FACTORS

- The categories that are included in the assessment of risk are four measures of socio-economic factors, prenatal and perinatal outcomes, child maltreatment, domestic violence, use of substance use disorder and mental health services, and crime and arrests.
- Some towns are high risk in one or two areas but a number of towns emerge as having much higher than average risk on many factors.
- There are towns in all areas of the state that have a high level of the risk factors that can make it challenging for parents to raise their children.

METHODS

To understand the current landscape of home visiting, we collected data in multiple ways. These are the different types of data we collected and some important strengths and limitations of each data source.

PROVIDER SURVEY: Surveys were sent to agencies that provided home visiting and/or home-based services. Some of the information is at the agency level and some is at the program level. This report only includes agencies and programs that received funding from the Office of Early Childhood. One limitation of the survey is that not all agencies that were sent the survey responded so this information only reflects the agencies who replied.

FAMILY FOCUS GROUPS: Twelve focus groups of families were held throughout the state in the summer of 2019. The communities represented were Bridgeport, Danbury, Derby/Ansonia, Hartford, Killingly, New Britain, New London, Stamford, Torrington, and Waterbury. Additionally a focus group was held at an inpatient substance use disorder treatment facility for women with young children and a focus group was held in New Haven that was specifically for fathers. We intentionally recruited families with and without home visiting experience. Spanish translation was available at all groups, with some of the focus groups being solely conducted in Spanish. Many of the participants were mothers but there were fathers in many groups along with other caretakers, such as grandparents. The results presented here apply to home visiting programs as much as we could determine. In some cases, it was unclear if the person was referring to a home visiting program, a home-based service, or some form of case management. When it was ambiguous, we did not use that information for these findings.

COMMUNITY FOCUS GROUPS, CALLED COMMUNITY LISTENING SESSIONS (CLS): We held meetings in ten communities and on two webinars. We called these "Community Listening Sessions" but they were structured more like focus groups with consistent questions, note takers, and recordings. These were attended by home visiting providers, providers of other types of child- and family-serving programs, and other community stakeholders. Because of the format of the sessions, it was not always evident what type of provider was making the statement. Again, where possible we have excluded comments that were related to other types of programs.

ADMINISTRATIVE DATA: Data was gathered from multiple state agencies and other organizations including the Department of Children and Families (DCF), the Connecticut Coalition Against Domestic Violence (CCADV), Department of Mental Health and Addictions Services (DMHAS), and Department of Public Health (DPH) among others. Much of this information reflects the people who sought services or were in other ways identified by the agencies and even the type of information we have presented is limited by the information that is collected. It is the most accurate information available on these different issues, but no dataset will reflect all of the

people who may experience a problem or the complex nature of many challenges people experience. Some of this data is highly sensitive so we have presented what we can while still protecting the anonymity of the residents of Connecticut. We selected what we thought were the most relevant maps and data for the RFP to include in this report. A complete collection of the maps are included in a separate Map Appendix.

ADVISORY BOARD: The Advisory Board of approximately 30 members met four times throughout the process of the needs assessment. The board represented experts from home visiting and other agencies that serve a similar population and/or may refer to home visiting programs. They provided invaluable institutional knowledge and perspectives, subject matter expertise, and a different viewpoint on the direct service process.

SECTION 1: THE CURRENT HOME VISITING LANDSCAPE

CURRENTLY, MANY PROGRAMS EXIST TO SERVE FAMILIES ACROSS THE STATE BUT THE COVERAGE IS INCONSISTENT BASED ON LOCATION. There are six home visiting programs being administered in Connecticut that are approved by HRSA. These are Minding the Baby, Child First, Nurse Family Partnership, Parents as Teachers, Family Check-up, and Early Head Start-Home Based Option. The map on page 38 at the end of this report provides a snapshot of one quarter (3 months) of the families served by an OEC-funded home visiting program by town and which programs are serving the towns. While the home visiting contracts provide coverage for the entire state, the majority of families served are in a smaller number of towns, with some towns only having one or two families enrolled in services and many towns having no families enrolled. Having multiple programs with different areas of focus creates an uneven patchwork of home visiting services. This is reflective of the development of home visiting services over time through two separate major funding streams. The current landscape is confusing for families, as well as for providers who may want to refer families to services.

THERE IS MINIMAL AGREEMENT ACROSS PROGRAMS ON FOCAL POPULATIONS AND OUTCOMES. Even within the same models of OEC-funded home visiting programs, the focal populations are not consistent across agencies. For example, across Parents as Teachers agencies identified 13 different populations as priorities for eligibility criteria. Similarly, the outcomes that different agencies and models focus on also varies. Figure 1 in the Appendix identifies the top three priority populations across the survey respondents, regardless of model. The most common priority population (75% of agencies selected as one of their top 3) was *Families with prior/current interactions with child welfare services.* There are also many different outcomes that programs are working toward, as shown in Figure 2 in the Appendix. The most common outcome was *Nurturing parenting/improved parent-child interactions* (62%) but *Child maltreatment prevention* (50%), *Healthy births and immediate post-natal care* (37%) and *Improvements for children with behavioral or social-emotional issues* (37%) were also

common. This range of focal populations and targeted outcomes prevents a clear message of who home visiting serves and what it aims to accomplish.

THERE IS NOT THE SAME LEVEL OF DIVERSITY IN THE HOME VISITING WORKFORCE THAT IS CURRENTLY REFLECTED WITHIN THE FAMILIES THEY SERVE.

The home visiting workforce is less diverse than the families who are enrolled in services, with fewer Black, Latinx and other home visitors who are people of color and a low percentage of male staff (3.1%) despite men comprising about 20% of agency clients. There is also a gap between the number of families for whom Spanish is their primary language (22%) and the number of home visitors who speak Spanish (15%). About 2.5% of home visitors and families speak languages other than Spanish and English. Having these additional languages is something that surfaced in the Community Focus Groups as something providers recognized as important for making home visiting more accessible to more families and that they would like to increase.

HOME VISITING WORKFORCE. Almost a third of home visiting staff are part-time. Of these workers, there is a range of the type of benefits offered with the majority (70-80%) having paid vacation and other personal time, medical and dental benefits but only 55% offering Employee Assistance Programs for mental and behavioral health. These are also the percentage who are offered benefits rather than uptake among employees (e.g. health insurance may be offered but the premiums may be unaffordable for many employees). Some agencies provide no benefits to their part-time employees (18%).

The need for more cultural awareness or cultural humility[1] was identified in the Family Focus Groups (FFG) and to a lesser

RECRUITING FAMILIES

I really don't know what programs there are, or if I do know it's a week before the program starts.... So I don't think the information is being well-distributed to organizations or families. ***It's almost like you have to know about the program in order to access the outreach materials.*** - New Haven Community Focus Group

"Whenever I've been in a program, you'll hear about certain things like Early Head Start or you know Nurturing Families, diaper bank, ***things that I had no idea of until you hear about them and sometimes you have to like ask questions to get it*** *but, yeah I definitely didn't know on my own, I found out as I went along."* - Parent

[1] Cultural humility is an important but complex concept and process and a discussion is beyond the scope of this report. Key aspects of cultural humility that are particularly relevant for home visiting are developing an understanding of one's own cultural perspective and an openness to learning about an individual's culture as they understand it and recognizing that cultural humility is an on-going practice that includes self-reflection/evaluation and being aware of and addressing power imbalances.

extent in the Community Listening Sessions (CLS) as needed areas of improvement in the current system. However, few programs identified cultural awareness/humility as a barrier to service completion. That does not mean programs are not aware of the need, but that it is not perceived as one of the more important needs for retaining families.

SECTION 2: RECRUITING FAMILIES

Recruiting families to home visiting is an important function of home visiting agencies. The goal is to have families who could benefit from programs be aware of the opportunity to enroll at the time that they need the program and to understand the enrollment process. Parents from the FFG and providers from the CLS both discussed the challenges of connecting to home visiting programs.

Families generally connect to home visiting through one of two primary paths: they are referred by the provider of another service, or parents find out about the program on their own through different types of advertising or outreach. Currently, many programs rely on established referral relationships or informal networks for the majority of their referrals and there is less focus on direct outreach to families. Referral networks are important, however, some referral sources are perceived as more stigmatizing than others. Shifting efforts to less-stigmatized referral sources and increasing direct outreach is an important focus of the new direction for home visiting.

AGENCIES ENGAGED IN DIFFERENT MODES OF RECRUITMENT AND OUTREACH FOR REFERRALS: Figure 3 in the Appendix illustrates the outreach strategies that agencies are currently engaging in. The strategy used by the largest number of agencies (76%) was posting flyers or placing brochures in community locations and the fewest number of agencies (17.6%) did outreach to Federally Qualified Health Centers. Overall, most of the efforts were directed toward other organizations and professionals. There was no outreach strategy that was used universally among all agencies.

Outreach to community groups and coordinating councils was used by about two-thirds of agencies; however, agencies had very different levels of involvement in these groups. A third of agencies were not involved in any councils or collaborative groups while about 24% were involved in four or more. There were not any obvious regional or geographic trends of which the agencies involved in collaborative groups or multiple groups. Collaborative groups are one way for other types of providers to learn about home visiting. Survey respondents' estimates of

how aware other professionals were of home visiting professionals ranged from a low of 33% to a high of 95% of professionals being aware of home visiting services.

MANY REGIONAL NETWORKS CREATES CONFUSION: Each service department in the state has divided the state into a different set of regions. This creates a much more complicated and challenging service referral environment than most states grapple with and creates barriers to cross-system referrals. According to the CLS, referring professionals may refer families to programs that are not available in the family's town or may refer families to a program with a long waiting list. They also simply do not refer because they do not know where to send families or what types of services are available.

REFERRAL NETWORKS ARE USEFUL BUT THEY HAVE LIMITATIONS: Professionals talked about confusion over the focus of different home visiting programs, a lack of awareness of what was available in particular towns, and long waiting lists that resulted in them ceasing to refer to programs because the program was effectively not available.

REFERRALS CAN FEEL LIKE A SECRET DOOR: Parents want to see home visiting advertised directly to them. Families are often referred to home visiting through another professional service provider. While identifying families who have already engaged with another type of support service can be an effective strategy, there are some disadvantages with this approach as well. First, a parent has to connect to one service before being referred. This makes the services feel like a secret door; once you find one door a whole new set of possibilities opens up to you, but it can be hard to find the door. The second issue is that when they are referred by other types of services, parents often feel that their parenting and/or their children are being judged and negatively assessed. This can feel very stigmatizing and is not an encouraging way to begin a new program. Parents would like to see home visiting advertised more widely as a positive

RECRUITING FAMILIES

I think the language in our current one pager is geared more towards providers and community partners. ***I'd love to have a one pager that's for parents and families.*** *What would be nice is if we could make the tri-fold and put it in a pediatrician's office, and…parents can grab a one pager.* – Norwalk Community Focus Group

They [home vistor] came when we started going I think for the checkups for the baby and stuff, you got to catch people kind of like right when people have, you know out of necessity or something like that. ***You gotta catch people when they need something*** *or else they don't always-you know. Even if you might need it a few days later, you are not thinking about it right then and you might pass it up.* – Parent

program. This way parents can learn about it and it feels like a more general program for families rather than a program for families with problems.

THE BENEFITS OF HOME VISITING NEED TO BE EXPLAINED IN POSITIVE AND FAMILY FRIENDLY TERMS. Parents talked about how at the beginning of the program they often did not understand what home visiting was and what the benefits could be for them as a family. Providers mentioned that many of the materials seemed to be designed to inform other service providers about home visiting, rather than being designed to explain home visiting to parents. Parents wanted brief flyers and pamphlets that explained in simple language why they might want to enroll in a home visiting program and what the benefits are for them, their child, and their family.

PARENTS RECOMMENDED USING A RANGE OF PLACES FOR RECRUITMENT MATERIALS AND DIFFERENT TYPES OF MATERIALS. Many of the parents' suggestions for recruitment were more traditional types of advertising such as flyers, pamphlets, direct mail and advertisements or announcements in town newspapers. Parents suggested having flyers and pamphlets that they could pick up in places they commonly go such as the WIC office, the pediatricians, libraries, schools, daycares and laundromats. Having a booth or outreach worker at community fairs was suggested by parents and at the CLS as well. Some parents in the focus groups had been recruited at the hospital and felt this was a non-stigmatizing way of receiving information about home visiting. Some parents found the hospital experience overwhelming but suggested sending materials home with families so they can read about the program when they are ready. Parents were moderately enthusiastic about social media and suggested outlets such as their town Facebook pages or organizations that parents might already be connected to through social media. Social networks, where parents told other parents about home visiting, was not a common way for the parents in the focus groups to find out about home visiting and it did not surface as one of the recommendations for recruitment.

NEED TO REDUCE THE STIGMA. Unfortunately, for many families home visiting is a stigmatized program and many parents perceive that if they "need" home visiting it is because they are doing something wrong or something is wrong with them or their child. While home visiting can help families and children who are experiencing challenges or struggles, all families can benefit

from the support and information from many home visiting programs. Home visiting does not have to be only for families with "problems" or who are perceived to need help because they are low-income. Providers suggested reframing the eligibility as a benefit they were eligible for, based on income or other characteristics, rather than something they needed because of those same characteristics.

SOME REFERRALS ARE MORE STIGMATIZED THAN OTHERS.

As we noted in the referral section above, many referrals are made to the home visiting agency by another professional and then the home visiting agency calls the family. Additionally, many referrals come from service provider networks. This can result in the family receiving a call for a program that they did not necessarily ask for or know that they were referred for. Parents and providers wanted more referrals from universal providers such as birthing hospitals, pediatricians, obstetricians, and day care centers. This has two key advantages. First, it lessens the stigma. From these sources, being referred to a program that can support a family feels very natural. Second, these providers see a wide swath of families and may be able to identify which families need additional support before the situation is more serious.

Providers did raise concerns about the challenges of informing and engaging doctors. More focused efforts through health clinics or pamphlets in doctors' offices may be a way to increase awareness without needing to engage medical doctors. The doctors' offices are important opportunities for recruiting families and raising awareness of home visiting.

THE LINE BETWEEN DCF SERVICES AND OEC-FUNDED HOME VISITING IS CONFUSING TO FAMILIES AND PROVIDERS.

Families and providers both talked about the confusion between OEC home visiting services and services with some DCF affiliation. Providers and families were often not clear about what programs were voluntary and separate from DCF and/or how programs were affiliated with DCF services. This is a complicated relationship for a number of reasons.

BARRIERS TO ENGAGEMENT

What needs to be improved is that general feeling that families have that you're just here to find out what's wrong with us, you're here to take away my kids. You're not here to support me. There is a mistrust because they hear horror stories. It's a shame because ***there's a communication barrier that gets in the way of going further with a family****.* – Killingly Community Focus Group

Many families have denied access to home visiting because it may be connected with DCF*, which makes them uneasy and worry they being 'watched' rather than helped.* – Webinar Community Focus Group

CONFUSION IS UNDERSTANDABLE. Currently there is overlap between these funding streams with DCF and OEC funding some of the same programs at the same agencies. Additionally, while none of the OEC-funded home visiting programs exclude non-DCF-involved families, as noted in earlier sections, many programs prioritize families referred by or with some DCF involvement. This limits the number of non-DCF-involved families and may create the impression that services are only available to families with DCF involvement. One provider pointed out that staff at different agencies may not even be clear about the distinction between programs.

VOLUNTARY MAY NOT MEAN THE SAME THING TO FAMILIES AS IT DOES TO PROVIDERS. Providers spoke about the challenges with engaging families referred from DCF. Families need to be invested in the program in order to be successful. If they feel coerced into participating, their investment is conditional on their DCF involvement. Even though the DCF involvement has officially ended or will end soon, and the families are told by DCF and the home visiting program that the services are voluntary, families often do not believe that to be true. Therefore, when the DCF involvement ends, or they perceive that the DCF surveillance has ended, they end their participation in the home visiting program.

THE CLOSE ASSOCIATION BETWEEN DCF AND OEC HOME VISITING INCREASES FEARS OF SURVEILLANCE AND REPORTING FOR MINOR ISSUES. The perception of a close relationship affects families who do not have any DCF involvement because they see home visiting as a potential surveilling entity and are fearful it will lead to a DCF report for a minor issue.

This perceived and actual blurring of the lines between OEC home visiting and DCF services creates a barrier to engaging families who want to protect themselves from any program they see affiliated with DCF.

We use the term "DCF-involved" broadly to encompass families who have had different types and intensities of involvement with DCF. This involvement could range from a family with an accepted report of maltreatment that is sent to

REFERRAL PROCESS

Services are word of mouth or families find out about things depending on where they go. ***There's not one place to go.***
-Danbury Community Focus Group

Well I think the big thing is the referral source. *You know, because a lot of programs, like I know nurturing families, they don't even want to collaborate with DCF and have referrals from DCF. Because their model is, you know, to provide services voluntarily for people who want them then it becomes a different dynamic.* –Parent

211 maybe isn't the most up-to-date place for families to go to find services. Sometimes there's a long wait time before they pick up…some of the information that they're given is outdated, and the information is only as good as the providers who update it all the time. – Danbury Community Focus Group

the differential response program (Family Assessment Response) through families where one or more children may have been removed from the home either currently or in the past.

SECTION 3: ENROLLING FAMILIES

CURRENT REFERRALS PROCESSES. The referral process that was used by the majority of agencies (77%) was for a referring provider to telephone or fax a referral to the home visiting agency they were referring to and then for that home visiting agency to contact the family. Less than a third of agencies (29%) received referrals through a warm hand-off, which is the most recommended referral process, such as a joint call between the referring provider and the parent. Providers at the CLS told us that often the first time a family hears about home visiting is when the agency calls. This may increase families' feelings of stigma or being judged when they have not been included in the decision to refer.

A MORE CENTRALIZED INTAKE WOULD MAKE IT EASIER TO REFER AND RECRUIT FAMILIES. Families and providers wanted a more coordinated and accessible system. Families wanted to be able to call one number to find out more about possible programs and services. Providers wanted families to be referred to home visiting in general and for it to be easier to refer families to the appropriate program.

WHAT DOES "CENTRALIZED INTAKE" MEAN? Providers described a range of services under the term "centralized intake". Their ideas ranged from a contact point that would simply connect families to programs in their town, to a system that would actually conduct an intake with a family. The latter might also identify the most appropriate program, and, if there were multiple program options, establish the family's eligibility for the different programs and then send that information to the program. This would mean families were connected to an appropriate program they were eligible for as well as prevent the family from having to repeat their information multiple times.

Providers were also interested in streamlining the process, including having a system that would list the existing availability of different programs, developing commonly accepted measures to collect from all families to reduce duplication of data collection and data entry, and to share information across multiple service types (e.g. home visiting and Birth23).

ELIGIBILITY WAS ANOTHER AREA OF CONFUSION. Providers suggested that a more centralized process could facilitate eligible referrals. Referring providers did not always know which families were eligible for different programs. This confusion is understandable given the range of priority populations that providers serve.. A centralized system would remove the burden from providers of assessing the needs of families and the eligibility of programs.

While the RFP requires a regionalized intake process, this process could look different in different places. Regardless of the specific format, a centralized intake would increase equity by raising awareness of programs and making them more accessible. It would reduce the amount of information needed to find a program and/or to refer a family to one.

211 POSSIBILITIES AND CHALLENGES. 211 was raised as a possibility for this type of centralized intake, but there remain some logistical challenges due to the high demand for 211 services and the difficulty in keeping program information current. Additionally, long wait times for phone calls act as a deterrent to using the system. Workers are trained to provide information on the programs that a caller requests, but they are not trained to identify possible programs that could be useful and are not allotted the time to conduct a thorough family assessment. Also, the burden of updating programs and services is the responsibility of busy agencies, so new programs are not always listed and listed programs may no longer be available.

INCOME ELIGIBILITY AND BENEFIT CLIFFS. The federal poverty line has become a standard proxy for financial need. Many public benefit programs are linked to some multiple of the line (e.g. 150% of the federal poverty line). However, for families just over the income thresholds benefits are entirely unavailable or can abruptly cut as income rises.

This can result in substantially more resources available to families making just below the income threshold than for families just above. While OEC-home visiting has not required programs to use the federal poverty line to determine eligibility, according to the survey, many programs use that to identify one of their priority populations. Families talked about the frustration with being just over the benefit cliff and perceiving that when programs were making enrollment selections, the overall financial picture of a family was not taken into account. Having a more flexible or comprehensive assessment of financial need would improve the perceptions

BENEFIT CLIFFS

I feel that we should be able to-not have to struggle - to buy food for our kids. Not everybody gets food stamps and not everybody gets WIC. So I feel like why can she or he get the thousand dollars or $600 a month for food but because…I make an extra hundred dollars or more a month than what the guideline is-I can't get anything at all. ***It's not fair to the people that need a little bit of a jump but not too much****.* – Parent, Derby/Ansonia

*Yeah, I'm ecstatic [about losing a bad job] but my reasoning behind the excitement is the fact that I can feed my children and that's sad. That's the saddest story ever…Just for the time being so I can get some food in there…I got a month worth of food…****But she's right we have to dig for these resources.*** **–** Parent, New Britain

of fairness and allow more access for families who were above the poverty line but still experiencing financial hardship.

SECTION 4: SERVING FAMILIES

FAMILIES LIKED THEIR HOME VISITING PROGRAM AND VALUED THE RELATIONSHIP WITH THEIR HOME VISITOR. In the family focus groups, parents generally liked the home visiting program they had participated in. They particularly enjoyed learning about their child's development and how to do new activities with their child to continue to promote the child's development. They also talked about the ways that home visitors connected them to their larger community and to specific resources. For many parents, their relationship with the home visitor was an important aspect of their home visiting experience. Often, the home visitor was someone they trusted and felt comfortable with. Having the home visiting come to their house reduced the isolation many new parents tend to experience and they described the home visitor as a therapeutic relationship for them.

HOME VISITING CONNECTS FAMILIES TO SERVICES AND THE LARGER COMMUNITY. Learning about events and services in the community was another important aspect of home visiting that parents mentioned frequently. They valued receiving information about different psychosocial or developmental services the child or family could benefit from as well as information about programs or services that addressed material needs, such as food pantries. Parents also relied on their home visitor to learn about activities in the community that the family could participate in, such as town-sponsored holiday celebrations.

All of these aspects of home visiting were identified by parents as important and positive aspects of being in a home visiting program.

Providing this information accurately can be a challenge for programs that serve multiple towns, particularly when the home visiting service area extends across the regional borders of other types of services. For example, a home visiting

[SIDEBAR TITLE]

*…**My daughter was able to do way more than what the school expected her for kindergarten, before kindergarten, because of them**.* – Parent, Torrington

At the time, I had gotten really comfortable with them coming to my house, talking to me helping me, emotionally and stuff like that. And at the time it was just me and the baby at home, my husband would go to work. ***This was a support system and I looked forward to it every week.*** – Parent, Bridgeport

program could serve families in multiple DMHAS regions so home visitors would need very specific information to refer parents to mental health or substance use disorder programs. Similarly, each town has their own events, but parents may also be able to attend events in nearby towns.

FAMILIES WANTED FAMILY-CENTERED, FAMILY-DIRECTED PLANS WITH A BROAD FOCUS. When asked about what they would like from a home visiting program, many families said they wanted exactly what they had been receiving and wanted it to continue for older aged children. One other common suggestion was to have more expansive plans that went beyond child development or other home visiting curriculum, that included all adults in the household, and that incorporated parents' own family-related goals. Their goals included things like education or training for the parent or finding a job. Parents saw these goals as important for the family overall and therefore thought this type of support should also be included in their family's plan.

Providers talked about using family-directed plans, but the way they spoke about family-directed plans was more of letting the parents determine the focus of their home visiting within the standard curriculum options. This is also critical and an important part of a family feeling engaged and committed, but it is somewhat narrower than what parents described.

FAMILIES WANT VOLUNTARY SERVICES THAT PROMOTE POSITIVE FAMILY FUNCTIONING AND ARE PREVENTATIVE. Parents wanted to be able to make a choice to engage in home visiting. Most parents saw home visiting as something that helped them become better and more confident parents and they appreciated this approach. Parents were frustrated when they felt like they could not access services until something had gone wrong in their family. This suggests increasing service availability for families as they become parents or expand their families. Providers expressed similar sentiments when they talked about wanting more "lighter touch" programs that would allow them to serve more

CONNECTION TO THE LARGER COMMUNITY

Literally there is something every single day of the week that I had no idea about until I got into the program. – Parent, Killingly/Plainfield

Right a focus on the parents, the family overall, the children, as well as mom, dad.

- Bridgeport Family Focus Group

What works? ***Parents set the goals. That really works. Their treatment plan is goal-based, it's for them, and it's what works for them.*** *We start with what they want to work on. They feel in charge and respected. What works too is always building the partnership with the family by letting them know that they are the expert with their child and starting from there.*

-Killingly Community Focus

families and to provide more services before families were experiencing a crisis or trauma.

PARENTS AND PROVIDERS WANT THE FAMILY VOICE TO HAVE INFLUENCE, BUT MORE INPUT REQUIRES ON-GOING COMMUNICATION. Parents and providers both wanted more input from families, and providers in particular thought that parents should be included at all levels of decision-making. Providers wanted family voice to be included from the highest levels of policy decisions, through identifying priority outcomes for programs, to how individual programs should operate.

Families wanted the agencies to ask them how to improve the program. Many programs may have some kind of parent-advisory committee or board but no parents mentioned this type of parent involvement. This suggests that while some parents may have been providing input into the program's operation, more work may be needed to communicate to parents and staff how input from parents is used in practice. The need for communication and input extends to providers. Providers talked about their frustrations with giving feedback, both in the community listening sessions and at other times, and then not seeing how their input was listened to or applied.

ADAPTION OF PROGRAMS AND CULTURAL HUMILITY TRAINING MAY IMPROVE SERVICE DELIVERY. Some CLS participants noted that programs needed to move beyond the goal of just speaking the same language as families. They emphasized that talking to people about how they are caring for their children is one of the most sensitive topics to discuss and is even more complicated to talk about with people from different cultures.

Families brought up the lack of understanding of cultural traditions of interaction and relationships and wanted more understanding of their cultures. For example, in a focus group that was conducted in Spanish in Danbury, parents brought up the issue that the home visiting programs' policies prevent home visitors from engaging with families and that this is inconsistent with their cultural traditions. The parents described how they felt close to the home visitor but could not include the home visitor in important events or even share food. Additionally, families identified that a barrier to home visiting is that corporal punishment is a accepted parenting practice for many families but it is perceived as not allowed or even abusive by home visiting programs. In both of these cases, some kind of adaptation may be appropriate so that the home visiting can be delivered in a way that is comfortable for the home visitors and the family.

HOME VISITING MAY NOT BE THE BEST OPTION FOR ALL FAMILIES AT ALL TIMES: CONSIDERATIONS FOR FAMILIES WITH SEVERE NEEDS. Appropriately sequencing services to support, but not overwhelm parents is a key factor in considering services of all kinds but particularly non-essential programs such as home visiting. Providers spoke about the

challenges that occurred when families needed to address critical issues first before they were really ready for home visiting. Families experiencing homelessness, intimate partner violence, substance use disorder, and severe mental health problems all present potential logistical problems for home visiting programs. For instance, families might be in a temporary housing situation that is in a different town or even a different part of the state than they had been living in. Or there may be safety concerns for the family or the home visitor.

Working to resolve or recover from each of these problems takes a significant amount of time and parental capacity. Parents' needs may include intensive substance use treatment or mental health services, looking for employment, seeking permanent housing and other essential tasks. Parents in recovery may also experience cycles of recovery and relapse that are common and expected in substance use disorder recovery but are very disruptive in people's lives. If families experiencing these challenges have an existing relationship with a home visitor, that person may continue to be a support and constant presence for the parent and children. However, engaging families in home visiting in the midst of a critical life situation may be overwhelming for the family. It may also present the home visitor with situations well beyond their training. Providers spoke with frustration about their inability to deliver the curriculum to families in crisis because of the urgency of the situation which took precedence. They were empathetic to these families, but they were still unable to help the family in the way that the family needed.

SECTION 5: TRAINING TOPICS

Some topics emerged as areas where it could benefit families if home visitors had additional training.

NON-JUDGMENTAL SERVICE DELIVERY. Some parents described feeling judged by their home visitor. This seemed to span a range of issues from the cleanliness or tidiness of the

CULTURAL SENSITIVITY

So I think that so much of the outreach - and the solution with multicultural communities - has been focused on language, and the aspect of cultural sensitivity, and how do you deal with that…clearly lacks as a second thought because ***they thought that language was going to solve everything.***
-Danbury Community Focus Group

home, to their approach to parenting, or just feeling judged overall. They expressed that there should be more training for the home visitors around being non-judgmental regardless of the situation. In some cases, the parents requested a different home visitor or they just discontinued services. In other cases they continued with the home visitor but the perceived judgment created a barrier to full engagement and trust.

THE DIFFERENCES BETWEEN CHILD ABUSE AND NEGLECT AND CORPORAL PUNISHMENT, AND MINIMALLY SUFFICIENT CARE. Parents explained that they felt they could be reported to DCF for minor issues with their home or parenting approaches the home visitor did not approve of. Parents are told at the initiation of all services that the home visitor is a mandated reporter but it seems to be a very general statement to parents and often said in a way that suggests the home visitor will err on the side of reporting any situation that they suspect could be maltreatment. More training around what constitutes a dangerous situation or a safety risk for children could help home visitors feel more informed. They could have a better understanding of the distinction between what is minimally sufficient care and what situations need to be reported because the child is experiencing or is likely to experience harm. If home visitors had a clearer idea of what they need to report they could explain mandated reporting more specifically to parents.

SCREENING AND TRAINING ON MENTAL HEALTH ISSUES TO BETTER SERVE FAMILIES. Many parents talked about feelings of depression, particularly post-partum, and how the home visitor helped them. Sometimes it was clear that this help took the form of connecting parents to mental health services. In other situations, it seemed that the home visitor became the de facto mental health provider. It can be a complicated balance between being a supportive listener and allowing a parent's mental health problem to go without professional treatment. It seems clear from the data that more comprehensive training on different aspects of working with families with mental health problems is necessary. This could include identifying the ongoing need to screen for new or more severe mental health problems and when and where to refer parents. It could also cover how to broach the idea to parents and what to do when the parents' mental health problems continue without improvement making it impossible for the home visitor to deliver their service. While home visitors were an important emotional support for parents, it is unfair to the home visitors and to parents to place the burden of significant mental health care on the home visitors.

THE PURPOSE OF DATA COLLECTION AND DATA ENTRY. Providers expressed frustration over the amount of information that had to be gathered from parents. They described the number of assessments they had to get from parents and the number of, sometimes only slightly different, pieces of data they needed to collect. They discussed double- and triple-entry of data

and feeling like they spent a lot of their time collecting information, such that it took away from delivering services, but that they did not see how all of the information was needed or used.

Some of these issues are broader systemic problems, such as the program models, state funders, and federal funders requiring similar but slightly different data points or assessments. However, some additional training on what the data are used for and educating home visitors on using the data and assessments in their work could reduce this frustration by making the information-gathering feel more purposeful.

WORKING TOWARD FAMILY ECONOMIC STABILITY WITH EMPATHY AND INFORMATION. Many of the parents who participated in the focus groups talked about receiving a benefit program such as SNAP or Husky. They told us about running out of food or being unable to afford rent and childcare. They talked about the trade-offs they made such as having to have one parent stay at home with their child or children because the second paycheck would only cover childcare and/or they could lose the eligibility for Husky. They were acutely aware of the balance between these means-tested benefit programs and other ways to take care of their family such as employment for one or both parents. It is important to the families that their financial hardships be recognized and that the issues of benefit cliffs and insufficient benefits be considered when setting goals. They want to have economic stability, but immediate employment or training may not be the best plan for every family. In addition to understanding their situation, it was very helpful for families when home visitors knew about different resources or programs that provided material goods (food, children's clothing, etc…) or different types of financial support or benefit programs. Providers added that more financial literacy and skills like budgeting could be helpful for families.

DATA COLLECTION

When you're asking a home visitor to do a quality visit…drive to and from a visit, do the visit, come back, document everything in one system, get all the data in. Then open another system, do it in another system, then open it and do another system. They only work 35 or 40 hours a week. ***It's impossible.***
-Waterbury Community Focus Group

"Oh, I got another thing of paperwork. I got it filled out." And you just do it because you've got to get it in. ***What does it really mean? Where's it going?***
-Norwalk Community Focus Group

SUMMARY OF FOCUS GROUPS AND PROVIDER SURVEY

Currently, home visiting in Connecticut serves many different populations and performs a variety of functions. This fragmentation leads to a number of distinct perspectives on what home visiting should do and who it should serve. Ultimately, the confusion over the purpose of the program leads to disappointment because with a limited budget home visiting cannot meet all of the needs that families and providers would like it to fill. The confusion can also create unnecessary barriers to families connecting to and engaging with home visiting. Parents generally liked the home visiting program they received, but they also described how services could better meet the needs of families and communities.

DISTRIBUTION OF RISK FACTORS

The Federal MIECHV Needs Assessment of Connecticut identified 22 towns as high risk. These towns include major urban hubs as well as three rural towns (see Figure 5 below). The at-risk towns span the six regions and including areas in the northwest and northeast in addition to the major urban areas. Overall, the high-risk communities had 40.4% Hispanic Ethnicity and 28.1% of minority race. In these communities, 51.9% were female and 6.1% were aged 4 or younger.

High-risk towns are outliers in two of five domains prescribed by the Federal needs assessment. Those domains are socioeconomic status, adverse perinatal outcomes, substance use disorder (SUD), crime, and child maltreatment. These domains represent social risk factors for parent and child well-being as defined by the MIECHV Home Visiting Program.[2] Home visiting has been shown to prevent child abuse and neglect, and supports positive parenting.[3] It is anticipated that the identification of these towns will help providers focus their outreach and networking activities.

METHOD

This analysis follows the method outlined by the Federal MIECHV Needs Assessment. This approach examines indicators for five different domains (see Figure 4 below). Within each domain are a series of indicators. The average and variance for each indicator is calculated across all towns to calculate the state average and variance. The variance tells us how spread out the 169 towns' scores are – that is whether most scores tend to be around the average or whether there are lots of scores well above and below the average. The variance is then used to determine the standard deviations for each indicator. Individual towns are then compared to the state norms. If the difference between the town's average and the state's average is greater than one standard deviation (z-score), then the town is considered an outlier for that indicator. If a town is an outlier for at least half of the indicators in a domain, it is considered an at-risk town in that domain. If a town is considered at-risk in at least two of the five prescribed domains, then the town is designated a high-risk town.

[2] Social Security Act, Title V, § 511(b)(1)(A)
[3] http://homvee.acf.hhs.gov/

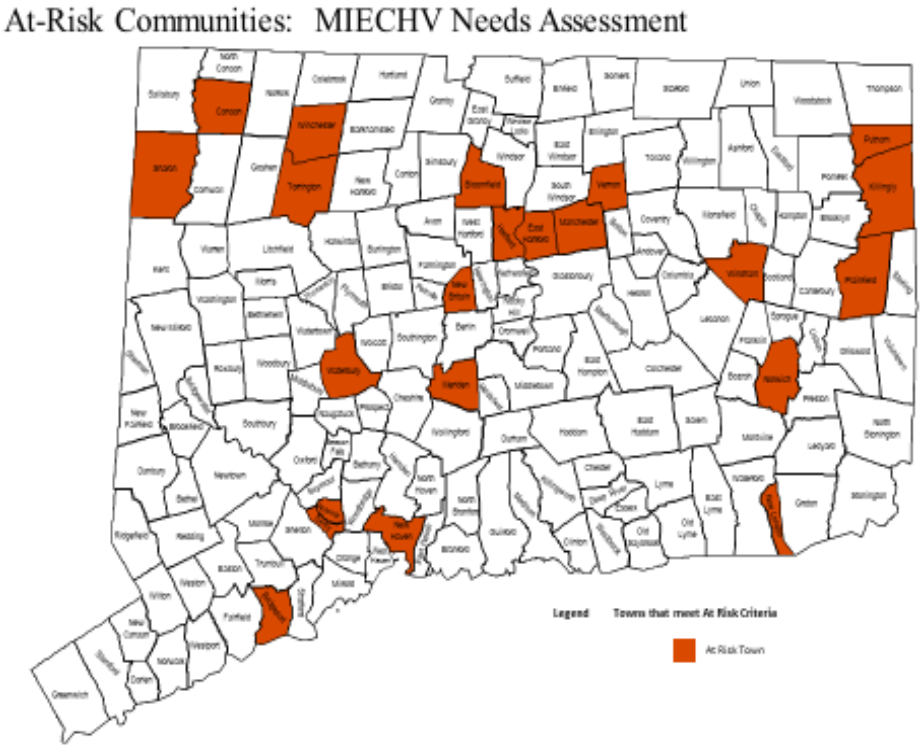
Figure 4: Risk Indicators and Domains

Domain	Indicator	Year	Source	Source Link
Socioeconomic Status (SES)	Population in Poverty	2014-2018	ACS	http://data.ctdata.org/dataset/poverty-status-by-town
	Unemployment	2018	CT DOL	https://www1.ctdol.state.ct.us/lmi/digest/pdfs/cedjun19.pdf
	Disengaged Youth	2014-2018	ACS	http://data.ctdata.org/dataset/disengaged-youth
	Income Inequality	2014-2018	ACS	http://data.ctdata.org/dataset/gini-ratio
Adverse Perinatal Outcomes	Preterm Birth	2014-2018	CT DPH	File received by OEC
	Low Birth Weight	2014-2018	CT DPH	File received by OEC
	Teen Pregnancy	2014-2018	CT DPH	https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports
	Infant Mortality	2018	CT DPH	https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports
Substance Use Disorder	Binge Alcohol Use	2012-2014	SAMSHA	https://www.samhsa.gov/data/sites/default/files/NSDUHsubstateExcelTabs2014/NSDUHsubstateExcelTabs-2014.xlsx
	Non-medical Use Pain Relievers	2012-2014	SAMSHA	https://www.samhsa.gov/data/sites/default/files/NSDUHsubstateExcelTabs2014/NSDUHsubstateExcelTabs-2014.xlsx
	Drug Arrests	2018	CT DESPP	https://portal.ct.gov/-/media/DESPP/Division-of-Crimes-Analysis/2018_Crime_in_CT_Final.pdf?la=en
	SUD Treatment	2019	CT DMHAS	https://portal.ct.gov/-/media/DMHAS/EQMI/Annual-Report-SFY2019.pdf
	Mental Health Treatment	2019	CT DMHAS	https://portal.ct.gov/-/media/DMHAS/EQMI/Annual-Report-SFY2019.pdf
Crime	Crime Reports	2018	CT DESPP	https://portal.ct.gov/-/media/DESPP/Division-of-Crimes-Analysis/2018_Crime_in_CT_Final.pdf?la=en
	Juvenile Arrests	2018	CT DESPP	https://portal.ct.gov/-/media/DESPP/Division-of-Crimes-Analysis/2018_Crime_in_CT_Final.pdf?la=en
Child Maltreatment	Child Maltreatment	2018	CT DCF	https://catalog.data.gov/dataset/ct-dcf-abuse-neglect-reports-and-allegations-by-town-and-state-fiscal-year-56a71
	Domestic Violence	2017-2019	CTCADV	File received by OEC

FINDINGS

OVERALL HIGH-RISK TOWNS The Federal MIECHV risk assessment identified 22 towns as high risk (see Figure 5). These towns represent a total population of 508,468.[4] The average town population is 23,112 with a minimum of 2,703 people in Sharon and a maximum of 122,587 in Hartford. These high-risk towns include 3 rural towns.

Figure 5: 22 High-risk communities across all domains



The high-risk towns were 51.9% female with a high of 54.3% female in Putnam and a low of 47.7% in Winchester. About 6.1% of the population or 61,753 are less than 5 years old. The racial and ethnic composition varies across the different high-risk communities but are generally different than the average distribution across the state. In the high-risk communities, 21.1% of residents were Black or African American compared to the state average of 9.8%.[5] Putnam had the lowest percent of Black or African American (0.3%) and Bloomfield had the highest percent with 57.0% of the population Black/African American. People with Hispanic ethnicity comprise 30.4% of the people in the high-risk communities. This percent is higher than the state average of 15.7%. Canaan has the lowest percent of people who identify as

[4] http://data.ctdata.org/visualization/census-annual-population-estimates-by-town
[5] http://data.ctdata.org/dataset/population-by-race-by-town

Hispanic (0.8%) and Hartford has the highest percent of people with Hispanic Ethnicity (44.5%). The high-risk communities were less likely to have people who identified as white non-Hispanic. Only 41.5% of the residents in the high-risk communities were white compared to the state as a whole, 67.5%. The percent of white residents from a low in Hartford of 14.8% to a high of 93.4% in Putnam. Other race proportions were similar to state averages with 3.8% Asian, 0.2% American Indian or Alaskan Native, 2.6% of two or more races, and 0.4% other races. The percent of Native Hawaiian or Pacific Islander in the high-risk communities was less than 0.1%.

The average number of at-risk domains for the high-risk towns was 3. Hartford and New Britain were at-risk in all five domains. Vernon, Winchester, Bloomfield, and Canaan were at-risk in just two domains. Among the high-risk towns, the most frequently observed at-risk domain was child maltreatment with all but one town at-risk in this domain. The SUD domain was the least likely to be identified with just 10 towns at-risk in that domain. Thirteen towns were at-risk in the adverse perinatal outcomes domain (see Figure 6 below).

Figure 6: High-risk towns by at-risk domains

		At Risk Domains				
Town	Population	Socioeconomic	Perinatal	MH & SUD	Crime	Maltreatment
Ansonia	18,721	X			X	X
Bloomfield	2,131		X		X	
Bridgeport	1,449	X	X			X
Canaan	155				X	X
Derby	12,515	X	X		X	X
East Hartford	49,998	X	X			X
Hartford	122,587	X	X	X	X	X
Killingly	17,287			X	X	X
Manchester	57,699		X		X	X
Meriden	5,954		X		X	X
New Britain	72,453	X	X	X	X	X
New Haven	13,418	X	X		X	X
New London	26,939	X	X	X		X
Norwich	39,136	X		X	X	X
Plainfield	15,173		X	X		X
Putnam	9,395		X	X	X	X
Sharon	273	X			X	X
Torrington	34,228			X	X	X
Vernon	2,933				X	X
Waterbury	1,893	X	X	X	X	X
Winchester	1,655	X				X
Windham	2,476	X		X	X	X

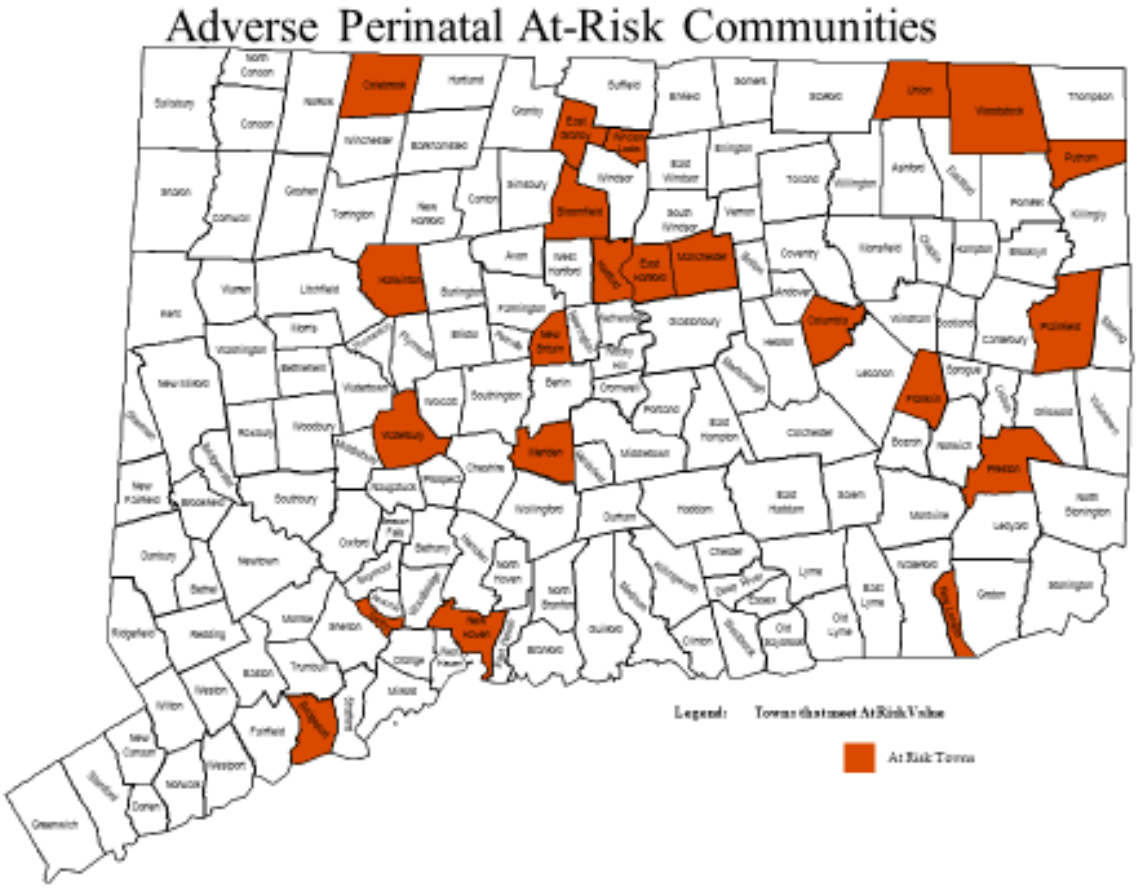
*Population from Census 2018, http://data.ctdata.org/dataset/census-annual-population-estimates-by-town

ADVERSE PERINATAL RISK: The OEC has identified healthy starts for families and children as a priority outcome. Nationally, Black mothers die at a rate that is 3.3 times greater than white mothers in the first year after childbirth.[6] The majority of these deaths are preventable. In Connecticut, Black mothers are half as likely to get timely prenatal care, twice as likely to have low birth weight babies, and have three times the rate of infant mortality.[7] These changes persist even after controlling for differences in the social determinants of health.

Adverse perinatal risk is one of the risk domains the federal needs assessment prescribes to identify at-risk communities. The federal needs assessment identifies two important birth outcomes as risk factors: (1) rate of live births at less than 37 weeks gestational age, and (2) low-birth weight births of less than 2500 g. Through consultation with the OEC, two additional risk factors were add to the calculation of this domain. The first one was teen births (15-19 years). Teen births was defined as the number of births by 15-19 year olds per 1000 15-19 year old females. The second one was infant mortality. This is defined as the number of infant deaths within the first year of life per 1000 live births. Figure 7 below shows the towns identified as having outlier status on 2 or more of these indicators.

[6] https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w
[7] https://portal.ct.gov/-/media/DPH/Office-of-Health-Equity/Health-Disparities/Briefs-and-Fact-Sheets/FactsMinorityHealthCT2013pdf.pdf?la=en

Figure 7: At-risk towns for adverse perinatal outcomes



At-Risk Adverse Perinatal Outcomes: *Bloomfield, Bridgeport, Colebrook, Columbia, Derby, East Granby, East Hartford, Franklin, Hartford, Harwinton, Manchester, Meriden, New Britain, New Haven, New London, Plainfield, Preston, Putnam, Union, Waterbury, Windsor Locks, Woodstock*

There are 22 outlier towns based on the four perinatal indicators described above. Most of these towns were outliers in two of four indicators. Hartford, East Hartford, Colebrook were outliers in three indicators. Being an outlier implies that the difference between the town average and the state average is greater than one standard deviation. In this sense, these towns face 'excess risk'.

There were 34,506 live births in Connecticut in 2018 based on the most recent available data, CT DPH provisional data.[8] Of these, an estimated 152 resulted in infant death, giving Connecticut a state average infant mortality rate of 4.4 per 1000 live births.[9] The remaining indicators were estimated using 2014-2018 data because they are relatively rare events at the town level. Low Gestational Age (17-36 weeks at birth) occurred an estimated 93.7 times per 1000 live births across the state.[10] Low Birthweight (<2500 g) occurred an average of 58.4 times per 1000 live births.[11] Live births to teen mothers aged 15-19 occurred 9.6 times per 1000 females 15-19 years old.[12] In each case, a town would have to be at least one standard deviation above these state averages to be considered a town at risk. Figure 8 below provides town level data on these indicators for use in responding to the RFP.

Figure 8: Town-Level Rates for Adverse Perinatal Outcomes

	Live Births	Low Birth Weight (<2500 g) per 1000 Live Births	Pre-term Birth (17-26 weeks Gest age) per 1000 Live Births	Infant Mortality	Teen Birth Rate per 1000 Teen Females (15-19)	Adverse Perinatal At-Risk Indicator
Andover	21	*	64.8	0	0.0	0
Ansonia	197	63.23	96.0	3	10.4	0
Ashford	41	56.70	102.9	0	5.7	0
Avon	138	46.06	68.7	0	0.3	0
Barkhamsted	23	*	58.4	0	1.4	0
Beacon Falls	48	51.16	62.2	0	4.3	0
Berlin	131	47.20	87.3	1	1.4	0
Bethany	37	*	76.9	0	2.1	0
Bethel	195	38.37	75.5	0	2.9	0
Bethlehem	21	*	56.5	0	0.0	0
Bloomfield	176	91.67	119.5	2	7.4	1
Bolton	37	43.72	94.2	0	3.9	0
Bozrah	19	*	72.2	0	9.4	0
Branford	213	45.41	56.6	0	4.4	0
Bridgeport	1,843	74.24	106.5	14	22.7	1
Bridgewater	6	*	119.0	0	0.0	0

[8] https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports
[9] https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports
[10] Special Request CT DPH, 2014-18.
[11] Special Request CT DPH, 2014-18.
[12] https://portal.ct.gov/DPH/Health-Information-Systems--Reporting/Hisrhome/Vital-Statistics-Registration-Reports

	Live Births	Low Birth Weight (<2500 g) per 1000 Live Births	Pre-term Birth (17-26 weeks Gest age) per 1000 Live Births	Infant Mortality	Teen Birth Rate per 1000 Teen Females (15-19)	Adverse Perinatal At-Risk Indicator
Bristol	612	61.37	94.3	7	10.6	0
Brookfield	156	35.31	88.1	0	1.4	0
Brooklyn	84	61.05	111.7	0	6.0	0
Burlington	66	39.66	75.6	0	1.3	0
Canaan	7	*	*	0	0.0	0
Canterbury	44	30.46	88.7	0	3.4	0
Canton	78	44.64	76.3	0	0.7	0
Chaplin	23	*	134.1	0	3.1	0
Cheshire	209	31.42	83.0	0	1.2	0
Chester	19	62.50	65.6	0	1.9	0
Clinton	92	40.54	60.9	0	1.6	0
Colchester	133	37.37	75.1	0	4.2	0
Colebrook	7	*	*	1	14.0	1
Columbia	32	85.11	126.3	0	2.9	1
Cornwall	9	*	*	0	0.0	0
Coventry	105	42.80	93.9	2	3.2	0
Cromwell	109	39.74	67.5	0	4.0	0
Danbury	974	54.38	83.5	6	14.3	0
Darien	177	20.83	57.3	0	0.0	0
Deep River	28	*	52.3	0	3.4	0
Derby	140	67.11	98.2	1	12.6	1
Durham	56	46.22	77.9	0	3.7	0
East Granby	55	76.58	160.3	0	1.4	1
East Haddam	83	28.57	77.3	1	2.2	0
East Hampton	97	30.99	87.1	0	4.1	0
East Hartford	624	80.97	118.2	0	19.2	1
East Haven	267	55.28	91.3	1	12.5	0
East Lyme	119	53.63	120.3	0	2.2	0
East Windsor	102	59.96	93.2	0	4.6	0
Eastford	17	*	79.4	0	0.0	0
Easton	49	45.83	82.4	0	0.7	0
Ellington	147	38.30	78.8	1	3.5	0
Enfield	366	52.24	80.6	1	9.3	0

	Live Births	Low Birth Weight (<2500 g) per 1000 Live Births	Pre-term Birth (17-26 weeks Gest age) per 1000 Live Births	Infant Mortality	Teen Birth Rate per 1000 Teen Females (15-19)	Adverse Perinatal At-Risk Indicator
Essex	36	*	85.5	0	2.7	0
Fairfield	481	35.55	78.0	1	0.6	0
Farmington	201	53.01	105.3	0	1.1	0
Franklin	14	73.53	138.9	0	0.0	1
Glastonbury	270	45.76	100.2	0	0.4	0
Goshen	17	*	*	0	2.4	0
Granby	86	54.12	70.0	0	1.1	0
Greenwich	501	35.98	73.5	2	1.7	0
Griswold	104	68.23	87.6	0	9.9	0
Groton	438	45.64	75.1	1	14.0	0
Guilford	137	36.98	69.3	0	2.3	0
Haddam	59	40.37	81.8	0	0.9	0
Hamden	540	57.22	88.7	4	3.4	0
Hampton	16	*	104.5	0	7.8	0
Hartford	1,704	89.45	120.2	21	25.5	1
Hartland	12	*	140.6	0	0.0	0
Harwinton	31	67.57	114.6	0	2.3	1
Hebron	65	49.02	73.6	0	1.2	0
Kent	22	*	53.8	0	4.7	0
Killingly	151	56.09	105.3	1	9.8	0
Killingworth	38	26.04	104.8	0	0.0	0
Lebanon	60	51.66	82.4	0	6.5	0
Ledyard	163	46.13	67.0	0	3.6	0
Lisbon	29	31.65	74.1	0	3.7	0
Litchfield	42	50.42	52.4	0	2.1	0
Lyme	13	*	107.7	0	0.0	0
Madison	116	27.84	70.9	0	0.9	0
Manchester	733	70.46	106.3	1	14.2	1
Mansfield	76	30.93	84.2	0	0.5	0
Marlborough	49	59.57	91.3	1	0.0	0
Meriden	673	67.02	93.0	3	20.5	1
Middlebury	47	32.52	96.9	0	3.4	0
Middlefield	21	61.54	95.6	0	1.7	0

	Live Births	Low Birth Weight (<2500 g) per 1000 Live Births	Pre-term Birth (17-26 weeks Gest age) per 1000 Live Births	Infant Mortality	Teen Birth Rate per 1000 Teen Females (15-19)	Adverse Perinatal At-Risk Indicator
Middletown	443	60.67	88.6	3	7.5	0
Milford	438	43.58	89.4	1	3.7	0
Monroe	173	50.63	101.6	0	2.0	0
Montville	168	55.22	71.3	2	8.6	0
Morris	13	*	61.7	0	7.9	0
Naugatuck	288	74.76	96.1	1	8.2	0
New Britain	958	80.73	113.9	6	26.3	1
New Canaan	129	30.44	66.1	1	0.5	0
New Fairfield	107	34.86	48.0	0	0.4	0
New Hartford	53	39.13	54.9	0	3.5	0
New Haven	1,676	69.58	98.6	15	17.9	1
New London	313	73.26	103.3	1	13.9	1
New Milford	233	48.82	92.0	0	6.5	0
Newington	262	49.33	81.2	2	4.7	0
Newtown	217	42.90	74.1	0	1.9	0
Norfolk	4	*	176.5	0	8.5	0
North Branford	122	25.84	80.4	2	1.8	0
North Canaan	28	*	63.0	1	4.3	0
North Haven	182	34.01	75.6	1	1.7	0
North Stonington	45	36.46	55.0	0	4.6	0
Norwalk	1,127	52.20	88.5	3	12.5	0
Norwich	428	62.17	90.4	3	21.0	0
Old Lyme	52	49.18	89.6	0	0.0	0
Old Saybrook	52	34.33	53.9	0	3.5	0
Orange	113	44.81	72.5	0	1.4	0
Oxford	86	42.06	74.2	0	3.4	0
Plainfield	165	72.85	122.6	1	10.4	1
Plainville	143	54.70	84.2	0	3.8	0
Plymouth	95	74.16	102.0	0	5.9	0
Pomfret	36	75.76	100.0	0	6.5	0
Portland	84	38.17	95.9	0	5.3	0
Preston	33	69.36	132.6	0	7.7	1
Prospect	68	25.94	77.6	0	1.3	0

	Live Births	Low Birth Weight (<2500 g) per 1000 Live Births	Pre-term Birth (17-26 weeks Gest age) per 1000 Live Births	Infant Mortality	Teen Birth Rate per 1000 Teen Females (15-19)	Adverse Perinatal At-Risk Indicator
Putnam	88	80.58	85.4	0	23.1	1
Redding	52	40.65	106.6	0	2.1	0
Ridgefield	152	30.83	71.5	0	0.9	0
Rocky Hill	197	47.72	100.6	0	1.7	0
Roxbury	10	*	*	0	0.0	0
Salem	40	56.41	64.7	0	6.9	0
Salisbury	21	*	61.4	0	2.2	0
Scotland	5	*	*	0	4.4	0
Seymour	150	55.19	98.0	0	1.9	0
Sharon	9	60.00	153.8	0	0.0	0
Shelton	317	54.35	109.5	1	5.6	0
Sherman	19	*	78.9	0	0.0	0
Simsbury	230	32.64	69.1	0	1.2	0
Somers	64	41.24	84.7	0	1.3	0
South Windsor	247	41.59	78.2	1	2.8	0
Southbury	97	31.98	89.6	0	1.4	0
Southington	383	44.17	81.6	1	2.5	0
Sprague	26	78.95	68.8	0	5.4	0
Stafford	97	48.42	106.2	1	6.7	0
Stamford	1,698	56.12	99.4	5	12.5	0
Sterling	34	62.50	94.1	0	12.5	0
Stonington	100	41.88	70.1	0	3.8	0
Stratford	507	65.39	106.2	1	6.9	0
Suffield	94	42.74	69.1	0	2.4	0
Thomaston	51	56.18	90.9	0	1.5	0
Thompson	75	62.13	99.4	0	9.9	0
Tolland	109	26.22	87.0	0	1.8	0
Torrington	334	48.66	76.9	0	11.6	0
Trumbull	321	44.85	89.1	2	1.1	0
Union	4	*	*	0	0.0	1
Vernon	323	60.87	93.0	2	11.3	0
Voluntown	11	60.24	58.8	0	2.5	0
Wallingford	390	39.70	87.4	1	2.7	0

	Live Births	Low Birth Weight (<2500 g) per 1000 Live Births	Pre-term Birth (17-26 weeks Gest age) per 1000 Live Births	Infant Mortality	Teen Birth Rate per 1000 Teen Females (15-19)	Adverse Perinatal At-Risk Indicator
Warren	9	*	186.0	0	0.0	0
Washington	9	*	*	0	2.2	0
Waterbury	1,531	81.98	113.7	6	27.8	1
Waterford	147	43.48	91.2	0	3.5	0
Watertown	174	52.00	82.6	0	3.1	0
West Hartford	599	48.32	77.5	0	3.5	0
West Haven	556	65.20	90.1	4	9.4	0
Westbrook	30	39.55	82.4	0	3.2	0
Weston	54	25.55	64.2	0	0.0	0
Westport	151	25.03	76.1	1	0.6	0
Wethersfield	295	53.45	86.9	0	4.8	0
Willington	34	32.43	72.5	1	4.5	0
Wilton	133	50.34	73.0	0	0.0	0
Winchester	78	51.04	87.6	2	9.5	0
Windham	227	64.94	97.9	2	12.3	0
Windsor	288	62.55	111.7	0	6.3	0
Windsor Locks	130	67.14	105.5	1	15.0	1
Wolcott	121	38.02	104.1	0	2.0	0
Woodbridge	60	40.13	54.3	0	0.6	0
Woodbury	57	49.81	92.3	0	2.1	0
Woodstock	57	86.81	150.3	0	2.9	1
Connecticut	34,506	58.38	93.7	152	9.6	

* Indicates value redacted because of low reliability

Table Highlighting indicates at-risk values more than one standard deviation above the state average.

CONCLUSION: PART II

This section reports the key findings associated with the Federal MIECHV Needs Assessment requirement. In addition, the detailed data related to adverse perinatal outcomes is reported to support providers in their response to the RFP. Data on the additional four domains can be found in the Map Appendix available as an accompaniment to this report.

MAPS INCLUDED IN THE MAP APPENDIX (SEPARATE DOCUMENT)

- Final Risk Communities

SOCIO-ECONOMIC INDICATORS

- Poverty by Federal Poverty Level
- Unemployment
- Disengaged Youth
- Income Inequality by Gini Coefficient (closer to 1 is less equal)
- High-risk by socio-economic status

ADVERSE PERINATAL OUTCOMES

- Low birthweight
- Preterm Births
- Infant Mortality
- Teen Birth Rate
- High-risk by adverse perinatal outcomes

SUBSTANCE USE DISORDER AND MENTAL HEALTH

- Binge alcohol use (by DMHAS region)
- Nonmedical use of pain relievers (by DMHAS region)
- Drug arrests (by DMHAS region)
- SUD treatment service use
- Mental health service use
- High-risk by SUD/MH

CRIME

- Crime rate
- Juvenile arrests
- High-risk by crime

CHILD MALTREATMENT AND DOMESTIC/INTIMATE PARTNER VIOLENCE

- Child maltreatment allegation rates
- Unique individuals contacting domestic violence services
- High-risk by maltreatment

NOTE: All maps use a rate of the indicator unless noted on the map.

Figure 1. Respondents Who Selected Each of These Priority Populations as One of the Top 3 Eligibility Criteria

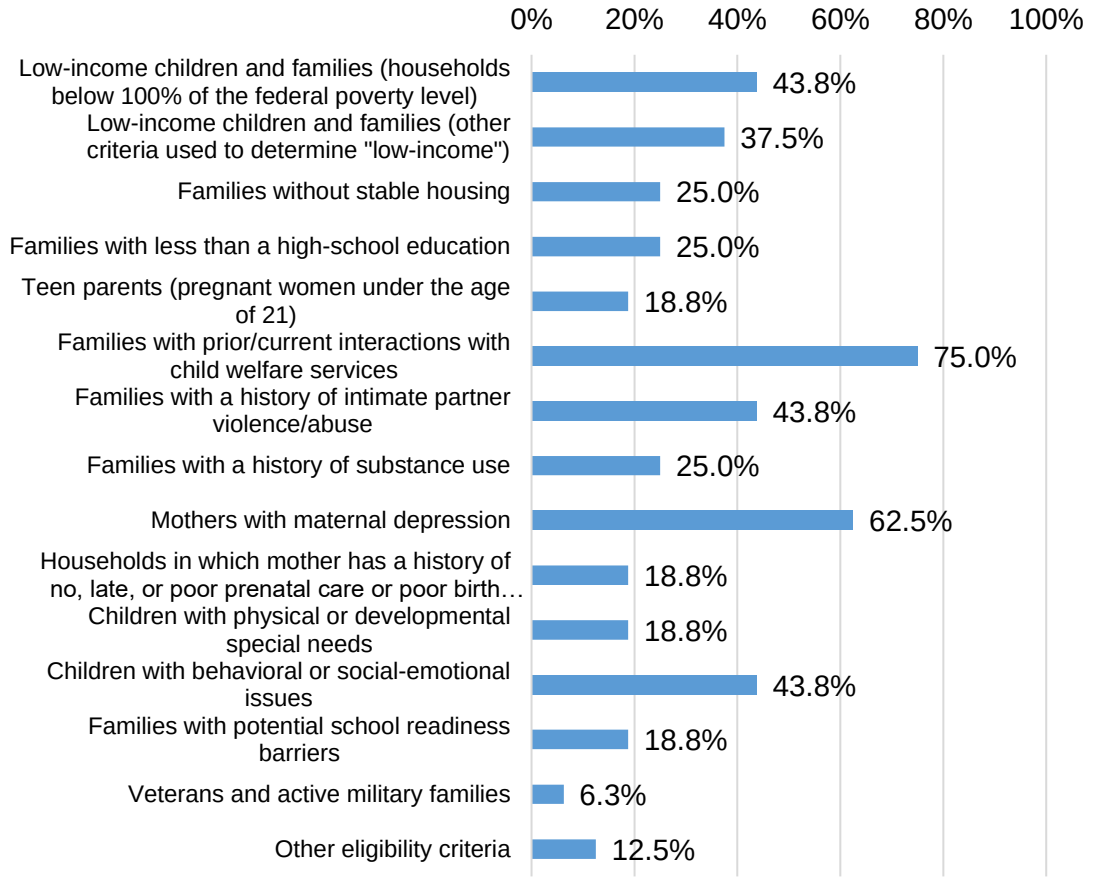


Figure 2: Respondents Across All Home-Visiting Models Who Selected Each of These Target Outcomes as One of the Top 3

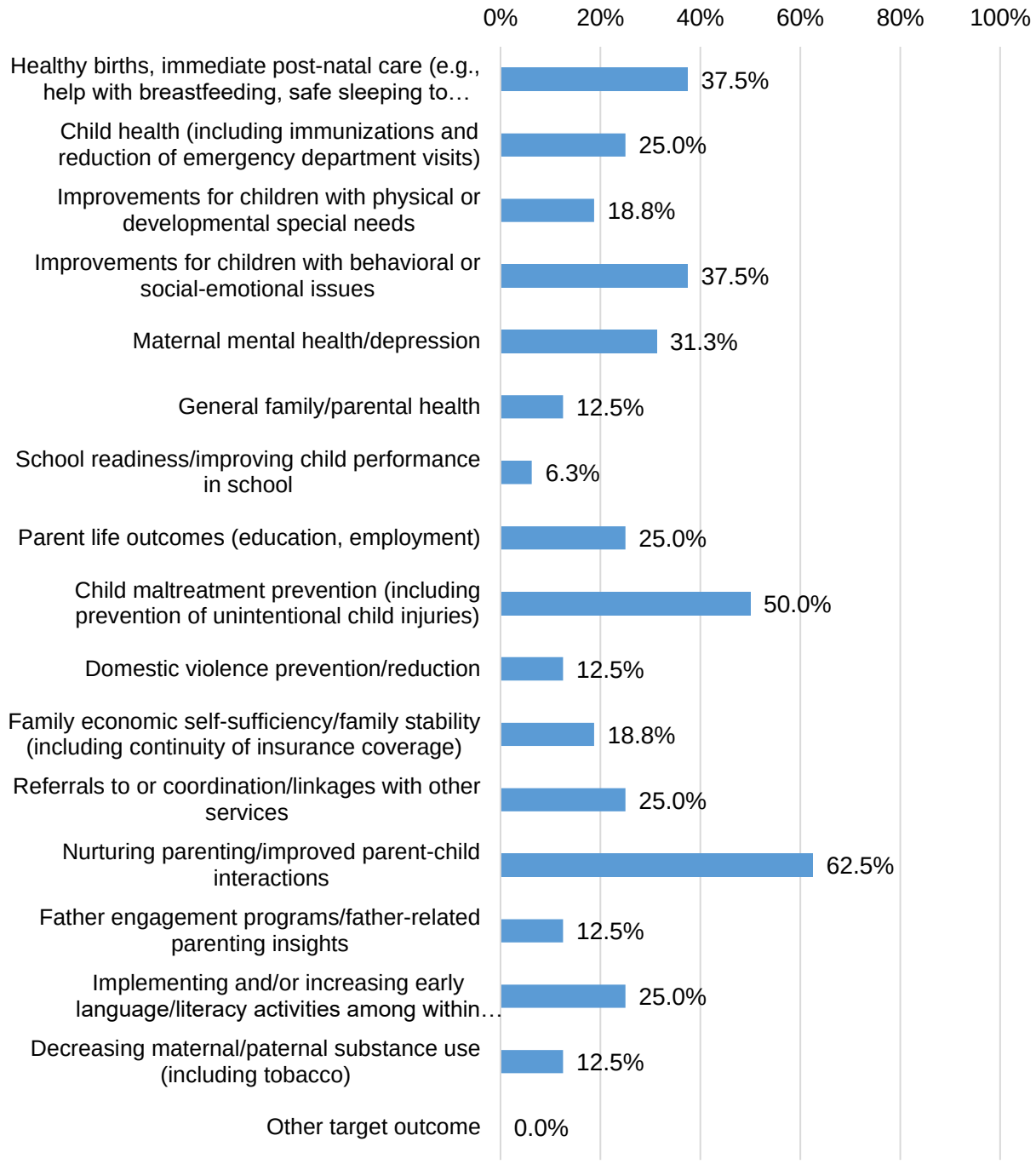
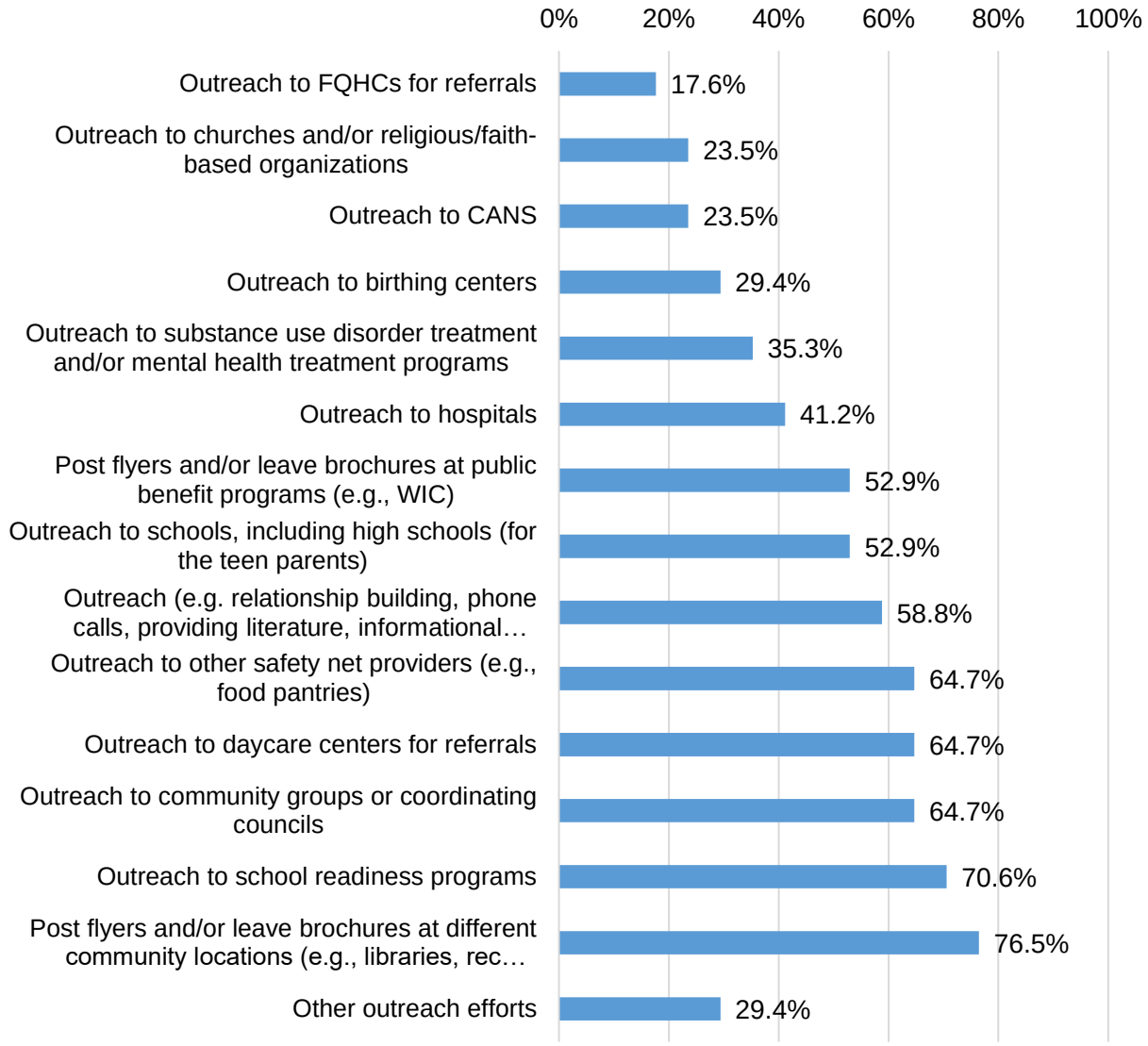
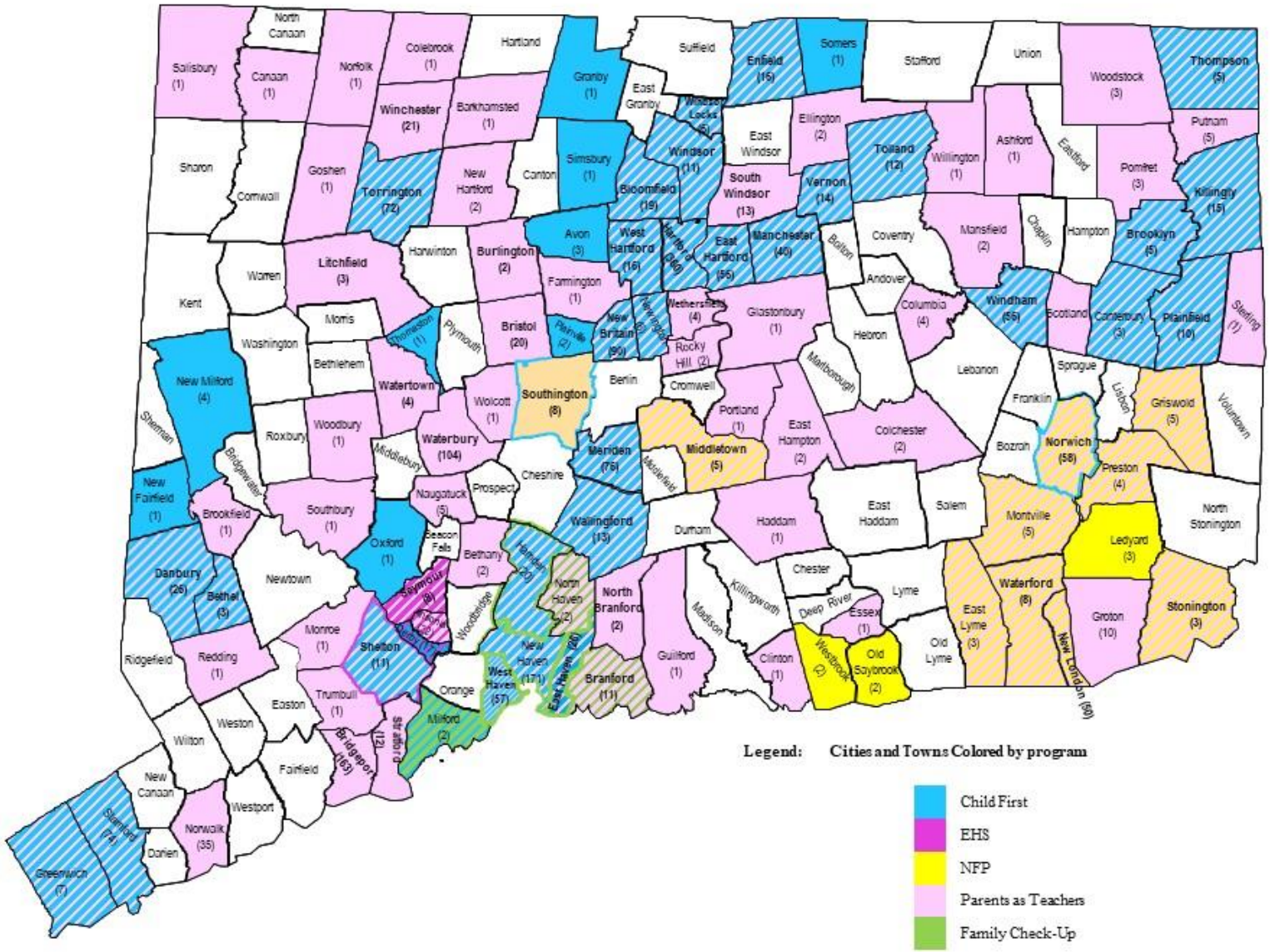


Figure 3: Percent of Respondents who Selected Each Outreach Strategy For Their Organization/Agency



MIECHV & State Funded HV Programs: # of Households Served by Town Oct-Dec 2019



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