Demonstrating Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program

A Report to Congress

March 2016

Executive Summary

Home visiting programs support healthy family functioning by helping expectant families and families with young children provide stimulating early learning environments and nurturing relationships for their children. These factors, in turn, have profound effects on children's physical, social-emotional, and cognitive development. The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV, hereafter referred to as the "Federal Home Visiting Program"), authorized by the Social Security Act, Title V, Section 511 (42 U.S.C. 711), as added by Section 2951 of the Patient Protection and Affordable Care Act (P.L. 111-148), is a significant expansion of federal funding for voluntary, evidence-based home visiting programs for expectant families and families with young children up to entry into kindergarten. It was reauthorized in April 2015 by the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (42 U.S.C. 1305).

The Federal Home Visiting Program is administered by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau in collaboration with the Administration for Children and Families (ACF). Since 2010, HRSA has awarded grants to 47 state agencies, the District of Columbia, 5 territories, and 3 non-profit organizations (hereafter referred to as "state grantees"). Each year, the Federal Home Visiting Program sets aside 3 percent of its funds for the Tribal Home Visiting Program, which is administered by ACF through awards to 25 tribal grantees. The Federal Home Visiting Program sets aside an additional 3 percent for research and evaluation, which funds a variety of projects including the national Mother and Infant Home Visiting Program Evaluation (MIHOPE), and is administered jointly by ACF and HRSA. The Federal Home Visiting Program funds state and tribal grantees to implement evidence-based home visiting models and promising approaches, generate additional evidence through research, and use evidence to guide improvement initiatives.

This report focuses primarily on the efforts of state grantees. A separate report provides more details on the activities of Tribal Home Visiting Program grantees, although information about tribal grantees is provided in Chapter VII of this report to present an overall picture of the results of Federal Home Visiting Program investments.

Program Growth and Expanded Reach of Home Visiting Among State Grantees

The Federal Home Visiting Program substantially expanded evidence-based home visiting services and supports to some of the nation's most vulnerable children and families.

In comparison to the first year of data collection in fiscal year (FY) 2012, in FY 2014 state grantees tripled the number of home visiting program participants (115,545 participants) and quadrupled the number of home visits provided (746,303 home visits). In 2014, the Federal Home Visiting Program's state grantees served nearly one quarter of U.S. counties (721 counties) and approximately one third of at-risk counties (274 counties). The program served high-risk families, with data from FY 2014 indicating that most families served by state grantees were economically poor (79 percent below federal poverty guidelines), young parents (55 percent under 25 years old), single (69 percent), unemployed (66 percent), and educated with a high school diploma or General Education Development (GED) certificate (35 percent) or less than a high school diploma level (34 percent). For families that face multiple demographic stressors and often lack resources and social support, research indicates that home visiting can help lay the foundation for family resilience and healthy developmental trajectories by partnering with families to establish positive parenting practices and parent–child relationships while also addressing individual family needs, such as child developmental delays and caregiver mental health or substance abuse.

Program Performance and Improvement Among State Grantees

The Federal Home Visiting Program legislation requires grantees to demonstrate measureable improvement among participating families in at least four of six benchmark areas after 3 years of program implementation. HRSA and ACF detailed each benchmark area to include multiple constructs that are specific, measureable indicators that further define each benchmark area. Grantees developed performance measurement plans detailing their approach for collecting, analyzing, and reporting performance data in the six legislatively mandated benchmark areas. Grantees selected or developed their own performance measures for each construct to ensure they were meaningful for their specific programs. As such, the performance measures are not uniform across grantees.

A majority (83 percent) of state grantees demonstrated overall improvement in four of the six benchmark areas during the 3-year period. The percentage of state grantees demonstrating improvement in each benchmark area ranged from 66 to 85 percent across benchmark areas: (1) improvements in maternal and newborn health (81 percent); (2) prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits (66 percent); (3) improvements in school readiness and achievement (85 percent); (4) reduction in crime or domestic violence (70 percent); (5) improvements in family economic self-sufficiency (85 percent); and (6) improvements in the coordination and referrals for other community resources and supports (85 percent). Grantees were challenged by the rapid scale-up of the program; those that failed to demonstrate improvement were subject to increased federal monitoring and received targeted technical assistance (TA) to improve performance in subsequent years. Program improvements in benchmark areas build a foundation for health and development for vulnerable children and families in at-risk communities.

Advancing Home Visiting Through Quality Improvement and Research

The Federal Home Visiting Program invested in quality improvement and research activities to advance home visiting. Grantee-led continuous quality improvement (CQI)

initiatives (in which grantees evaluate their own programs and identify areas for improvement) and the Home Visiting Collaborative Improvement and Innovation Network (a peer-learning network to share best practices and innovations among grantees) are intended to strengthen home visiting services. In addition, four approaches were used to learn about home visiting implementation and effectiveness: state and tribal grantee-led evaluations, MIHOPE, the Home Visiting Applied Research Collaborative, and the Tribal Early Childhood Research Center.

Technical Assistance: Building Capacity and Ensuring Quality

All Federal Home Visiting Program state and tribal grantees received comprehensive TA to support and build capacity to successfully implement home visiting programs and conduct grant-funded activities. TA efforts were strategically designed to support grantees in infrastructure development to improve service delivery, benchmark performance (including targeted TA to nine state grantees [17 percent] that did not demonstrate improvement in four of six benchmark areas), CQI, grantee-led evaluations, and data systems.

Strengthening Communities and Services for High-Risk Families

Community development and systems building are critical to ensuring an early childhood system of care that is comprehensive, coordinated, and responsive to family needs. State and tribal grantees strengthened early childhood systems of care by collaborating with community service providers to coordinate services and integrate service delivery; building and coordinating data systems; developing centralized intake systems; and providing professional development and training to home visiting staff and, in some cases, the broader early childhood workforce.

Tribal Home Visiting Program

Since 2010, ACF has used the 3 percent set-aside for the Tribal Home Visiting Program to competitively award 25 cooperative agreements to tribes, consortia of tribes, tribal organizations, and Urban Indian organizations across 14 states. In FY 2014, Tribal Home Visiting Program grantees served 870 families, 5 times the number served in FY 2012. Tribal grantees provided nearly 20,000 home visits to 3,197 adult participants and children between FY 2012 and FY 2014 and increased their ability to identify and serve American Indian and Alaska Native families and communities. After up to 3 years of implementation, a majority (77 percent) of tribal grantees demonstrated overall improvement in four of the six benchmark areas. The percentage of tribal grantees demonstrating improvement in each benchmark area ranged from 62 to 85 percent across benchmark areas: (1) improvements in maternal and newborn health (62 percent); (2) prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits (85 percent); (3) improvements in school readiness and achievement (69 percent); (4) reduction in crime or domestic violence (77 percent); (5) improvements in family economic self-sufficiency (77 percent); and (6) improvements in the coordination and referrals for other community resources and supports (69 percent). A separate report provides more details on the activities of the Tribal Home Visiting Program grantees.

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Acronym List

ACF	Administration for Children and Families
AI/AN	American Indian and Alaska Native
CQI	Continuous Quality Improvement
DOHVE	Design Options for Home Visiting Evaluation
FY	Fiscal Year
GED	General Education Development
HRSA	Health Resources and Services Administration
HV CoIIN	Home Visiting Collaborative Improvement and Innovation Network
LIA	Local Implementing Agency
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
MIHOPE	Mother and Infant Home Visiting Program Evaluation
SAIPE	Small Area Income and Poverty Estimates
TA	Technical Assistance

Demonstrating Improvement in the Maternal, Infant, and Early Childhood Home Visiting Program

A Report to Congress

I. Introduction

Home visiting programs support healthy family functioning by helping expectant families and families with young children access comprehensive services that improve outcomes for children in at-risk communities. Such services have profound effects on children's physical, social-emotional, and cognitive development. Home visiting services are provided by trained professionals, such as social workers, nurses, and parent educators. These trained professionals work with families to establish positive parenting practices and parent–child relationships while also addressing individual family needs. Evidence indicates that home visiting programs have the potential to mitigate the poor developmental outcomes associated with family poverty and provide vulnerable children and families with critical and lifelong protective factors.[1,2]

Home visiting models have been found to improve a wide range of short- and long-term child and family outcomes including child cognitive outcomes, more efficient family use of health services, positive changes in parenting attitudes and behaviors, and reduced child maltreatment and abuse.[3] Home visiting can also improve parent education and employment outcomes and increase families' economic self-sufficiency.[3]

This report is provided to Congress as required by the Social Security Act, Title V, Section 511(h)(4) (42 U.S.C. 711(h)(4)), as added by Section 2951 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148).[4] The legislation stipulates that the Maternal, Infant, and Early Childhood Home Visiting Program Report to Congress shall contain information in three areas:

1. the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the benchmark areas;
2. technical assistance provided to grantees,[a] including the type of assistance provided; and
3. recommendations for such legislative or administrative action as the Secretary of the Department of Health and Human Services determines appropriate.

The Maternal, Infant, and Early Childhood Home Visiting Program—hereafter referred to as the "Federal Home Visiting Program"—supports voluntary, evidence-based home visiting programs for expectant families and families with young children up to entry into kindergarten. The Federal Home Visiting Program has three statutory purposes:

1. strengthen and improve home visiting programs and activities carried out under Title V of the Social Security Act;
2. improve the coordination of services for at-risk communities; and
3. identify and provide comprehensive services to improve outcomes for families in at-risk communities.

The Federal Home Visiting Program is administered by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau in collaboration with the Administration for Children and Families (ACF). To date, the federal government has invested $1.85 billion in the Federal Home Visiting Program to create and expand the reach of home visiting programs to improve broader early childhood systems. Congress funded the Federal Home Visiting Program for fiscal years (FY) 2010 through 2015 and subsequently (in April 2015) authorized an additional $800 million in funding for FY 2016 and FY 2017, as follows:[b]

- FY 2010, $100 million
- FY 2011, $250 million
- FY 2012, $350 million
- FY 2013, $379.6 million
- FY 2014, $371.2 million
- FY 2015, $400 million
- FY 2016, $400 million
- FY 2017, $400 million

Since 2010, HRSA has awarded grants to 47 state agencies, the District of Columbia, 5 territories, and 3 non-profit organizations (hereafter referred to as "state grantees"). All states, territories, and the District of Columbia were eligible for formula funds, which included funding for needs assessments and start-up costs. Subsequent funding began at a base amount of $1,000,000 and included additional funding based on the state's proportion of children under age 5 in families at or below 100 percent of

[a] "Grantees" is used to refer to both grant and cooperative agreement recipients.

[b] Funding was authorized at $400 million for FY 2013 and FY 2014, but was subsequently reduced by sequestration. Under current law, the FY 2017 appropriation is subject to sequestration.

the federal poverty guidelines.[c] Recipients of formula grants were eligible to receive competitive grants either to build on existing efforts or to expand the scale or scope of evidence-based home visiting programs. During FY 2010 to FY 2015, competitive grants to states ranged from $500,000 to $22.6 million. Appendix A-1 lists each state grantee's funding amount for FY 2010 through FY 2015 from HRSA.

As an evidence-based policy initiative, the Federal Home Visiting Program prioritizes funding to implement home visiting models that have solid evidence of effectiveness.[d] The legislation requires that state grantees devote the majority of the funds to implement one or more home visiting models[e] that have been designated as evidence-based. The legislation supports innovation by allowing up to one quarter of the funds to be spent on implementing and rigorously evaluating promising approaches that do not yet qualify as evidence-based models.

In addition, each year, 3 percent of the federal funds are set aside for the Tribal Home Visiting Program and an additional 3 percent are set aside for research and evaluation. ACF oversees the Tribal Home Visiting Program, which funds 25 tribes, tribal organizations, and Urban Indian organizations (hereafter referred to as "tribal grantees"). Appendix A-2 lists each Tribal Home Visiting Program grantee's funding amount for FY 2010 through FY 2015 from ACF. ACF and HRSA collaboratively oversee the 3 percent set-aside for research and evaluation, with ACF taking the lead on the Mother and Infant Home Visiting Program Evaluation (MIHOPE, the national evaluation of the Federal Home Visiting Program); the Design Options for Home Visiting Evaluation (DOHVE) project, which provides technical assistance (TA) for grantees on evaluation, data, and continuous quality improvement (CQI); and the Home Visiting Evidence of Effectiveness Review (HomVEE).

This report focuses primarily on the efforts of state grantees. A separate report provides more details on the activities of Tribal Home Visiting Program grantees, although information about tribal grantees is provided in Chapter VII of this report to present an overall picture of the results of Federal Home Visiting Program investments.

[c] Each year, U.S. Department of Health and Human Services awards Federal Home Visiting Program formula grants to states, the District of Columbia, and five territories. The formula funding is based on the Small Area Income and Poverty Estimates (SAIPE), which are annual income and poverty estimates by the U.S. Census Bureau that help guide the allocation of federal funds to local jurisdictions. As a result, states with the highest proportion of the national estimate of children under 5 years in families at or below 100 percent of the federal poverty guidelines received the highest formula awards. The distribution was modified to ensure a floor of $1,000,000 for all grantees. For Puerto Rico, Guam, the U.S. Virgin Islands, the Northern Mariana Islands, and American Samoa, SAIPE data are not available; therefore, each was allocated a formula amount of $1,000,000.

[d] A list of evidence-based models approved for use in the Federal Home Visiting Program can be found at http://homvee.acf.hhs.gov/models.aspx.

[e] For the purposes of the Federal Home Visiting Program, home visiting models have been defined as programs or initiatives in which home visiting is a primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children from birth to entry into kindergarten.[5]

II. Program Growth and Expanded Reach of Home Visiting Among State Grantees

One goal of the Federal Home Visiting Program is to provide high-quality services to improve outcomes for vulnerable children and families in at-risk communities. State grantees completed statewide needs assessments to (1) identify at-risk communities and priority populations that would benefit most from home visiting and (2) select home visiting models best suited to address community needs. This section summarizes the successes of the Federal Home Visiting Program's state grantees in serving high-risk populations and substantially expanding home visiting services nationwide.[f]

Characteristics of Participating Families

State grantees served some of the nation's most vulnerable children and families. For example, the majority of caregivers were under 25 years old, had a high school diploma or less than a high school education, and were unemployed. Home visiting supports family resilience and healthy developmental trajectories by establishing positive parenting practices early on and promoting healthy parent–child relationships while also addressing individual family needs. This type of support is especially important for families that face multiple demographic stressors and often lack access to critical resources and valuable forms of social support. The following section presents a snapshot of the characteristics of participants served by state grantees in FY 2014.

Of all adult participants in FY 2014, 39 percent were pregnant women, 56 percent were non-pregnant female caregivers, and 5 percent were male caregivers. More than half (55 percent) of adult program participants were under 25 years old, and a significant majority (86 percent) of child participants were under 3 years of age (Figures 1 and 2).

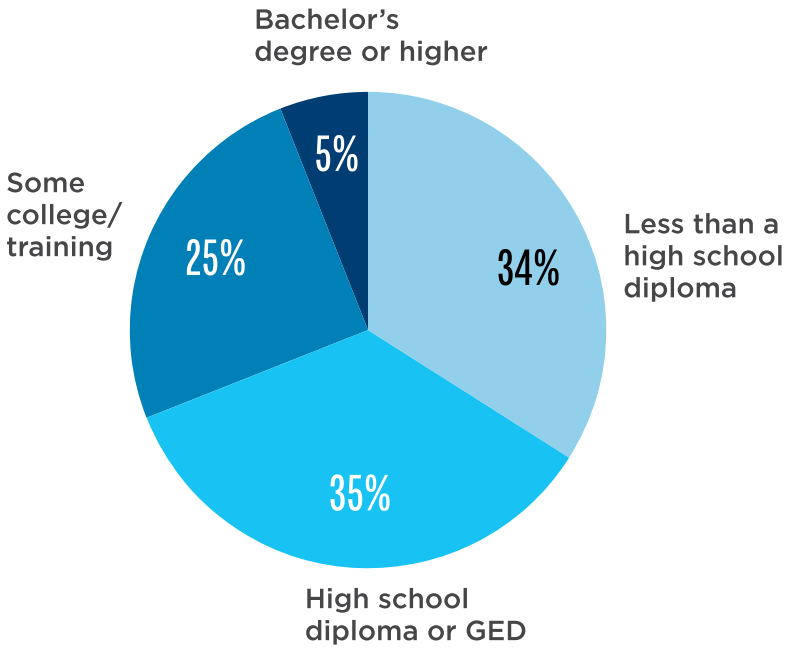
[f] Program growth for tribal grantees is described in Chapter VII: Tribal Home Visiting Program.

FIGURE 1 ADULT PARTICIPANT AGE, FY 2014[g, h]

FIGURE 2 CHILD PARTICIPANT AGE, FY 2014[i]

Adult participants were mostly single (69 percent). A majority had low educational achievement—35 percent had a high school diploma or General Education Development (GED) certificate, and 34 percent had less than a high school diploma (Figure 3). A majority (66 percent) of adults were not employed (Figure 4).

FIGURE 3 PARTICIPANT EDUCATION, FY 2014 [j]



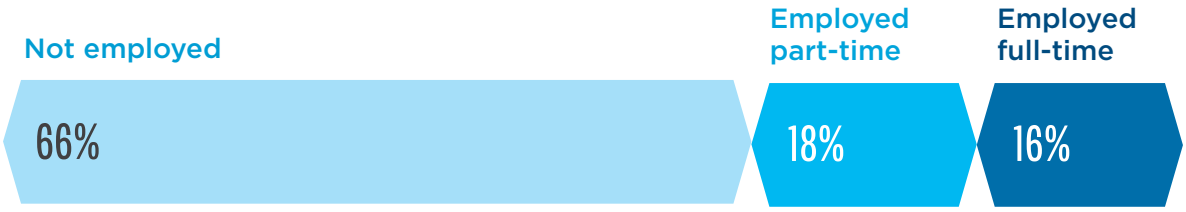
[g] N = 62,855. N excludes missing data.

[h] Data sources for Figures 1–7, 9, and 10: Discretionary Grants Information System–Home Visiting.

[i] N = 50,777. N excludes missing data.

[j] N = 59,069. N excludes "Other" and missing data.

FIGURE 4 PARTICIPANT EMPLOYMENT, FY 2014 [k]



The majority of adult and child participants were White (57 percent and 54 percent, respectively) followed by Black/African American (31 percent and 30 percent, respectively) (Figure 5). Approximately 30 percent of adults and children were Hispanic or Latino (Figure 6). Most adults and children (72 percent and 85 percent, respectively) were insured through Medicaid or the State Children's Health Insurance Program.

FIGURE 5 PARTICIPANT RACE, FY 2014 [l]

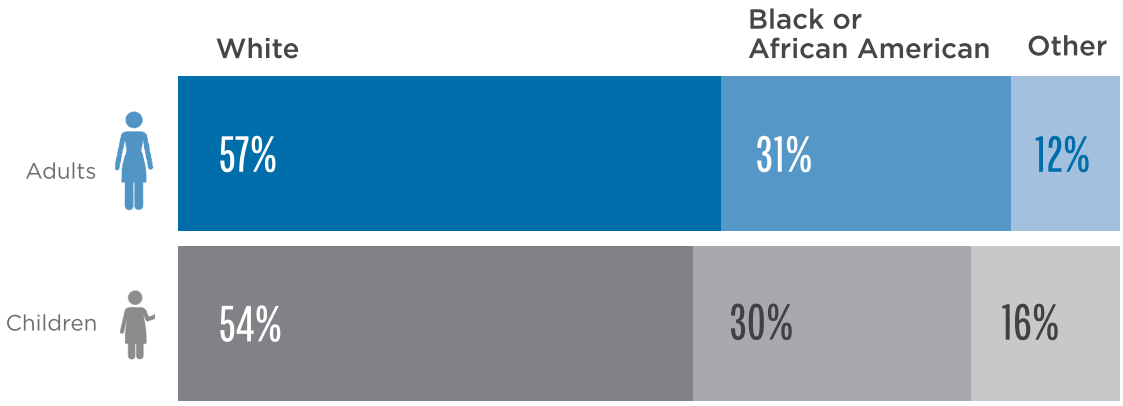
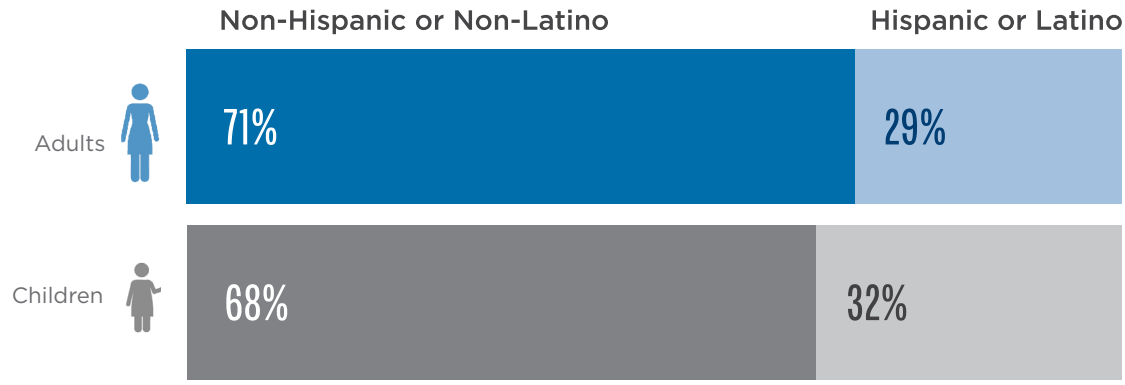


FIGURE 6 PARTICIPANT ETHNICITY, FY 2014 [m]



[k] N = 58,703. N excludes missing data.

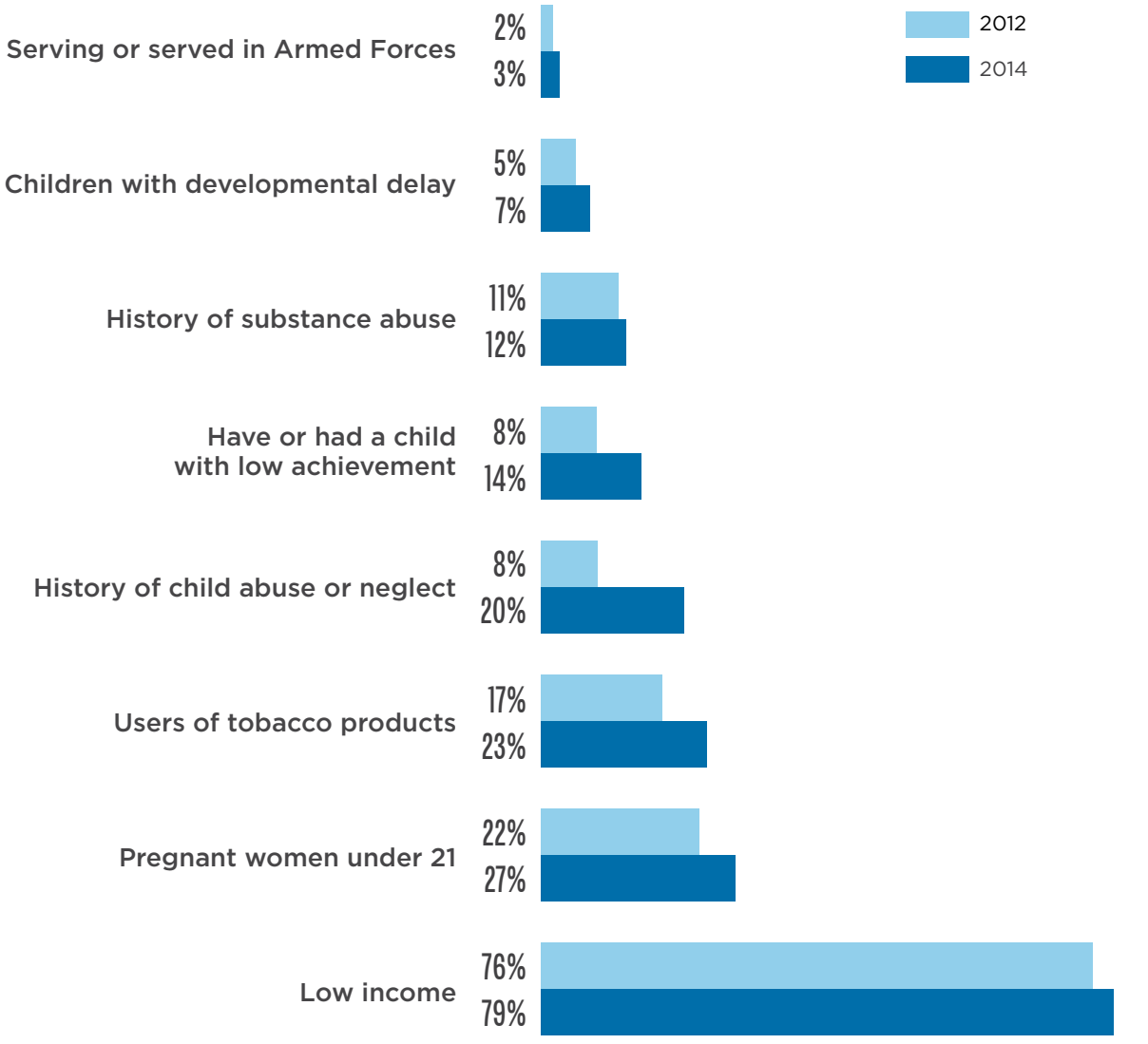
[l] Adult N = 54,687 and excludes missing data. Child N = 44,973 and excludes missing data. "Other" includes American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, and more than one race selected.

[m] Adult N = 60,238 and excludes missing data. Child N = 48,889 and excludes missing data.

Successfully Identifying and Serving Priority Populations

The Federal Home Visiting Program's state grantees identified and served priority high-risk populations as required by statute (Figure 7). In FY 2014, 79 percent of families were considered to be low income, defined as having an income at or below 100 percent of the federal poverty guidelines ($23,850 for a family of four). Further, 48 percent of these families had an income at or below 50 percent of the federal poverty guidelines. Across all priority high-risk populations, grantees saw the largest increase from FY 2012 to FY 2014 in the identification and enrollment of families with a history of child abuse or neglect.

FIGURE 7 PERCENTAGE OF FAMILIES IN PRIORITY POPULATIONS, FY 2012 AND FY 2014 [n, o]



[n] Families could belong to more than one priority population. Serving or served in Armed Forces: N = 319 in 2012, N = 1,019 in 2014. Children with developmental delay: N = 748 in 2012, N = 2,251 in 2014. History of substance abuse: N = 1,492 in 2012, N = 4,015 in 2014. Have or had a child with low achievement: N = 1,095 in 2012, N = 4,632 in 2014. History of child abuse or neglect: N = 1,152 in 2012, N = 6,544 in 2014. Users of tobacco products: N = 2,399 in 2012, N = 7,535 in 2014. Pregnant women under 21: N = 3,068 in 2012, N = 8,791 in 2014. Low income: N = 10,162 in 2012, N = 25,452 in 2014.

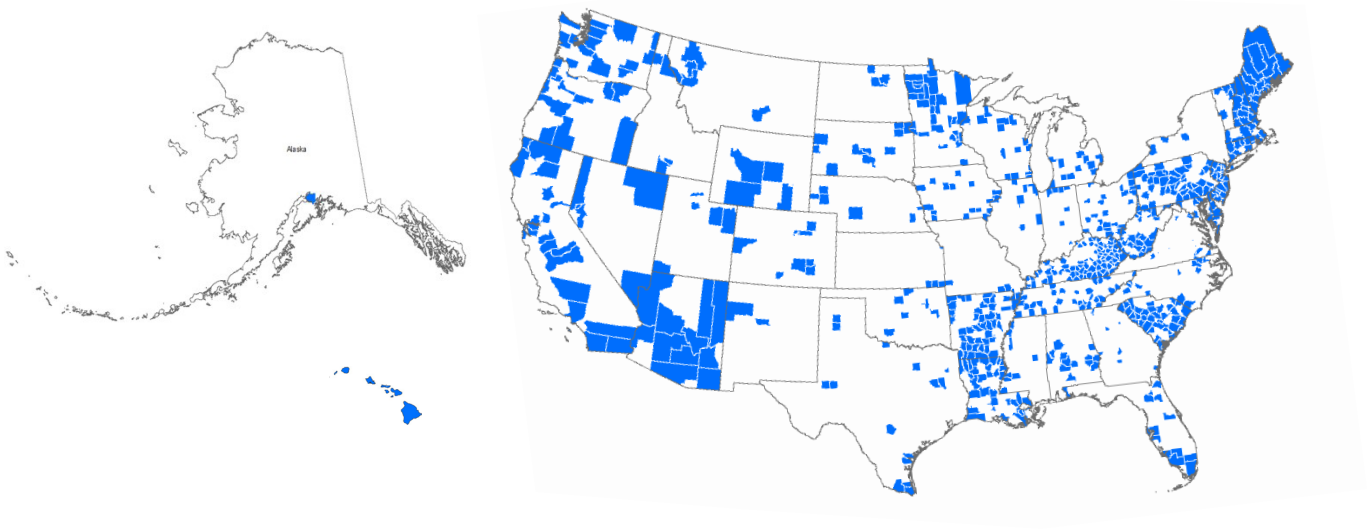
[o] Grantees applied a standardized calculation (at or below 100 percent of the federal poverty guidelines) to determine the number of "low-income" participants. For the other seven priority areas, grantees had flexibility in operationally defining criteria for inclusion.

National Expansion of Evidence-Based Home Visiting

By July 2014, the Federal Home Visiting Program's state grantees provided funding of evidence-based home visiting services to the following:[6]

- 35 percent of the nation's highest risk counties[p] (274 total);
- 22 percent of all U.S. counties (721 total) (Figure 8);
- 30 percent of the nation's urban counties (400 total); and
- 17 percent of the nation's rural counties (321 total).

FIGURE 8 COUNTIES WITH FEDERAL HOME VISITING PROGRAMS, FY 2014 [q,6]



The nearly $1.5 billion federal investment in the Federal Home Visiting Program from FY 2010 through FY 2014 provided an unprecedented expansion in the number of vulnerable families with access to evidence-based home visiting programs and the number of home visits conducted.[6] Accomplishments of the Federal Home Visiting Program's state grantees include:

- home visiting was provided to 115,545 participants in FY 2014, triple the number of participants since the first reports in FY 2012 (Figure 9); and
- over 3 years, the programs grew to provide more than 1.4 million home visits (Figure 10).

[p] Four risk indicators were used to identify at-risk communities, including low birth weight, teen births, children living in poverty, and infant mortality. Counties were determined to be at highest risk based on the average ranking of risk indicators.

[q] Territories are excluded from Figure 8.

FIGURE 9 **GROWTH IN PARTICIPANTS, FY 2012–FY 2014**

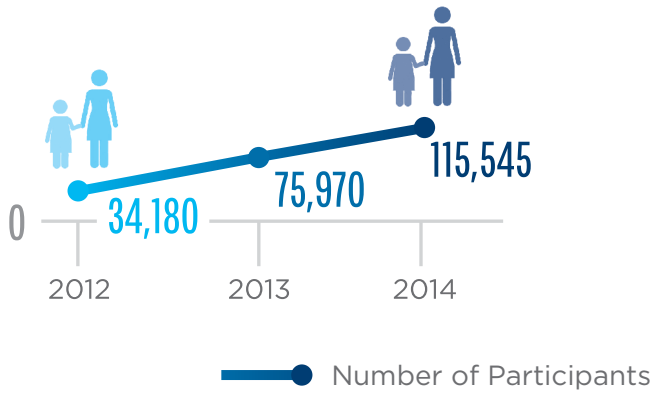
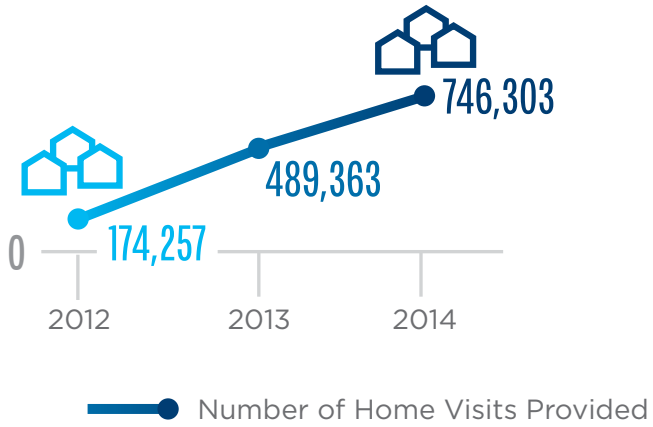


FIGURE 10 **GROWTH IN HOME VISITS, FY 2012–FY 2014**



From 2010 to 2014, the Federal Home Visiting Program **tripled** the number of home visiting program participants and **quadrupled** the number of home visits provided.

III. Federal Home Visiting Program Performance and Improvement Among State Grantees

In addition to expanding the use of evidence-based home visiting, the Federal Home Visiting Program is uniquely focused on strengthening and improving home visiting programs through performance measurement and CQI activities.[7] The Federal Home Visiting Program legislation, the Social Security Act, Title V—Section 511(d)(1) (42 U.S.C. 711(d)(1)), as added by Section 2951 of the Patient Protection and Affordable Care Act (P.L. 111-148)—required grantees to demonstrate measurable improvement among participating families in at least four of the following six benchmark areas after 3 years of implementation:

1. improvements in maternal and newborn health;
2. prevention of child injuries, child abuse, neglect, or maltreatment, and emergency department visits;
3. improvements in school readiness and achievement;
4. reduction in crime or domestic violence;
5. improvements in family economic self-sufficiency; and
6. improvements in the coordination and referrals for other community resources and supports.

HRSA and ACF detailed each benchmark area to include multiple constructs (Table 1). These constructs are specific, measureable indicators that further define each benchmark area. Grantees then developed performance measurement plans detailing their approach for collecting, analyzing, and reporting performance data in the six legislatively mandated benchmark areas. The Federal Home Visiting Program initially allowed state grantees the flexibility to establish their own performance measures for each construct, with the help of federal TA providers, to customize their performance measures according to the needs and structures of their target communities, Local Implementing Agencies (LIA), and home visiting models. As such, the performance measures are not uniform across grantees. (See Tables 2–8 for a complete list of benchmark area constructs and the percentage of state grantees demonstrating improvement by construct.[r]) HRSA and ACF have committed to a redesign of the performance measurement system for the Federal Home Visiting Program to achieve a simplified and unified performance measurement system for state grantees in the future.

[r] Program performance and improvement for tribal grantees is described in Chapter VII: Tribal Home Visiting Program.

Overall State Grantee Program Improvement

The legislation establishes expectations for grantee improvement in benchmark areas. Requiring accountability in the six benchmark areas aimed to improve family, parent, and child health and development outcomes as well as strengthen linkages between home visiting programs and early childhood systems. *Overall program improvement* is defined as improving in at least four of the six benchmark areas. Subsequent program guidance defined a grantee's *improvement within an individual benchmark area* as demonstrating improvement in at least half of its constructs. Grantees failing to demonstrate overall improvement are subject to increased federal monitoring and receive targeted TA to improve performance in subsequent years. The section below summarizes state grantee improvement in benchmark areas from FY 2012 to FY 2014.[s]

A majority (83 percent) of state grantees demonstrated overall improvement in the benchmark areas during the 3-year period. Nine of 53 (17 percent) state grantees did not demonstrate overall improvement in the benchmark areas. Within each benchmark area, the percentage of state grantees demonstrating improvement ranged from 66 to 85 percent (Table 1).

TABLE 1 STATE GRANTEE 3-YEAR IMPROVEMENT IN BENCHMARK AREAS

Benchmark Area	Number of Constructs	Grantees Showing Improvement in at Least Half of the Constructs (N = 53)	
		N	%
Improvements in Maternal and Newborn Health	8	43	**81**
Prevention of Child Injuries, Child Abuse, Neglect, or Maltreatment, and Emergency Department Visits	7	35	**66**
Improvements in School Readiness and Achievement	9	45	**85**
Reductions in Crime or Domestic Violence	5	37	**70**
Improvements in Family Economic Self-Sufficiency	3	45	**85**
Improvements in the Coordination and Referrals for Other Community Resources and Supports	5	45	**85**
Overall Program Improvement		**44**	**83**

[s] For all text and tables pertaining to grantee improvement in benchmark areas and constructs, 53 state grantees were included in the analysis unless otherwise noted. Three of the 56 state grantees began implementation in FY 2014 and will not report on demonstrated improvement until FY 2016.

Individual Benchmark Area Improvement

This section summarizes state grantee performance in each of the benchmark area constructs.

Improvements in Maternal and Newborn Health

A majority of state grantees (81 percent) improved in at least half of the performance measures for maternal and newborn health. Breastfeeding is a practice associated with positive long-term cognitive outcomes, child health, adult education, and adult incomes.[8] Moreover, identification of maternal depression through screening helps home visiting programs connect families to necessary services and contributes to efforts to mitigate the negative impact of maternal depression on child health and development.[9,10]

Overall, state grantees demonstrated improvements in prenatal and preconception care, parental substance use, inter-birth intervals, screening for maternal depressive symptoms, breastfeeding, well-child visits, and maternal and child health insurance status (Table 2).

TABLE 2 IMPROVEMENTS IN MATERNAL AND NEWBORN HEALTH

Construct	Grantees Improved (N = 53) N	%	Sample Performance Measures
Prenatal Care	33	**62**	Receipt of timely and adequate prenatal care
Parental Use of Alcohol, Tobacco, and Illicit Drugs	37	**70**	Reduced tobacco, alcohol, or illicit drug use among pregnant mothers or all enrolled mothers
Preconception Care	28	**53**	Increased postpartum checkups, routine preventative exams, or vitamin use among postpartum mothers or all enrolled mothers
Inter-Birth Intervals	32	**60**	Increased program provision of information on birth spacing, participant contraception use, or 6- to 12-month pregnancy spacing
Screening for Maternal Depressive Symptoms	36	**68**	Increased screening and referral rates among pregnant mothers, postpartum mothers, or all enrolled mothers
Breastfeeding	34	**64**	Initiation of breastfeeding or increased duration of breastfeeding
Well-Child Visits	34	**64**	Receipt of timely and adequate well-child visits
Maternal and Child Health Insurance Status	35	**66**	Increased number of children and mothers with health insurance

In FY 2014, across the 22 state grantees with similar performance measures on breastfeeding, 71 percent of participants meeting sampling criteria[t] initiated breastfeeding. In FY 2014, across the 47 state grantees with similar performance measures for maternal depression screenings, 76 percent of participants meeting sampling criteria were screened for maternal depression.

Prevention of Child Injuries, Child Abuse, Neglect, or Maltreatment, and Emergency Department Visits

Most state grantees (66 percent) improved in at least half of the performance measures for child injuries, abuse, neglect, or maltreatment, and emergency department visits. Unintentional injuries are a leading cause of death and disability among children ages 1 to 4 years.[11] Fortunately, many child injuries can be prevented by providing parents with knowledge and/or training to improve the safety of home environments for young children. Children exposed to adverse early experiences, including maltreatment, demonstrate a host of negative long-term outcomes ranging from lower incomes to poor health.[12-14]

State grantees demonstrated improvements in emergency visits for children and mothers, the provision of information or training on child injury prevention, the incidence of child injuries, reports of suspected and substantiated child maltreatment, and first-time victims of child maltreatment (Table 3). These improvements are instrumental in promoting healthy developmental trajectories among the nation's children (Table 3).

[t] Grantees defined specific sampling criteria for each performance measure. Denominators used to calculate percentages represent subsamples of total program participants according to sampling criteria. Sampling criteria might reflect specific participant characteristics (e.g., pregnant women, children under a specified age, mothers not currently receiving prenatal services) or specific timeframes (participants enrolled in the program for specific amounts of time).

The vast majority of state grantees demonstrated overall improvement in the benchmark areas during the 3-year period.

TABLE 3 PREVENTION OF CHILD INJURIES, CHILD ABUSE, NEGLECT, OR MALTREATMENT, AND EMERGENCY DEPARTMENT VISITS

Construct	Grantees Improved (N = 53) N	%	Sample Performance Measures
Visits for Children to Emergency Department From All Causes	27	**51**	Reduced child visits to emergency department or reduced number of children with visits to the emergency department
Visits for Mothers to Emergency Department From All Causes	33	**62**	Reduced mother visits to emergency department or reduced number of mothers with visits to the emergency department
Information Provided or Training on Prevention of Child Injuries	38	**72**	Increased provision of information on prevention of child injuries
Incidence of Child Injuries Requiring Medical Treatment	32	**60**	Reduced number of children with injuries or reduced number of incidents of injuries
Reported Suspected Maltreatment for Children in Program	29	**55**	Reduced number of children or families with reports of suspected maltreatment or reductions in the number of reports of suspected maltreatment
Reported Substantiated Maltreatment for Children in Program	30	**57**	Reduced number of children or families with substantiated reports of maltreatment or reductions in the number of substantiated reports of maltreatment
First-Time Victims of Maltreatment for Children in Program	31	**58**	Reduced number of children who are first-time victims of maltreatment or reductions in the number of reports of first-time victims of maltreatment

In FY 2014, across the 46 state grantees with similar performance measures for the provision of information or training on the prevention of child injuries, 70 percent of participants meeting sampling criteria received information or training on the prevention of child injuries.

Improvements in School Readiness and Achievement

A majority of state grantees (85 percent) improved in at least half of the performance measures for school readiness and achievement. Regular developmental screenings help identify delays and enable families to access early interventions to improve children's developmental trajectories. In addition, supportive parenting behaviors and quality parent–child relationships are key predictors of school readiness and achievement.[15,16]

Overall, state grantees demonstrated improvements in parent support for child's learning and development, parent knowledge of child development, parenting behaviors, parent emotional well-being, and child development (Table 4).

TABLE 4 IMPROVEMENTS IN SCHOOL READINESS AND ACHIEVEMENT

Construct	Grantees Improved (N = 53) N	%	Sample Performance Measures
Parent Support for Child's Learning and Development	43	**81**	Improved quality and quantity of parent support for child's learning and development
Parent Knowledge of Child Development and Their Child's Developmental Progress	43	**81**	Increased parent global knowledge of child development or program provision of information on child's development
Parenting Behaviors and Parent–Child Relationship	45	**85**	Improved quality of parenting behaviors or parent–child relationship
Parent Emotional Well-Being or Parenting Stress	37	**70**	Increased parent health status or reductions in parent stress level or depression
Child Communication, Language, and Emergent Literacy	38	**72**	Increased rates of completion of child screening by specified time point or receipt of necessary referral; assessment of developmentally appropriate child communication skills
Child's General Cognitive Skills	37	**70**	Increased rates of completion of child screening by specified time point or receipt of necessary referral; assessment of developmentally appropriate child problem-solving skills
Child's Positive Approaches to Learning	37	**70**	Increased rates of completion of child screening by specified time point or receipt of necessary referral
Child's Social Behavior, Emotional Regulation, and Emotional Well-Being	36	**68**	Increased rates of completion of child screening by specified time point or receipt of necessary referral; assessment of developmentally appropriate child social-emotional development
Child Physical Health and Development	40	**75**	Increased rates of completion of child screening by specified time point or receipt of necessary referral; assessment of developmentally appropriate fine and gross motor development

In FY 2014, across the 25 state grantees with similar performance measures for constructs related to developmental screening, 72 percent of children meeting sampling criteria were screened for developmental delays in communication, language, and emergent literacy. This rate is well above the 2011–2012 national average of 31 percent.[17]

Reductions in Crime or Domestic Violence

Most state grantees (70 percent) improved in at least half of the performance measures for crime or domestic violence. Given the prevalence of domestic violence, with more than a third of women in the United States reporting incidents in their lifetime, screening is an important first step in identifying families exposed to domestic violence and linking them to necessary resources and support.[18] Home visitors can also work with families to protect children from the negative outcomes associated with domestic violence. Children exposed to domestic violence may display behavioral problems and have a significantly higher risk of becoming victims of domestic violence later in life.[19,20] Research also shows that social support, similar to the support provided by home visitors, reduces the negative impact of domestic violence on the mental health of victims.[21]

For this benchmark area, grantees developed measures for domestic violence *or* crime. Of the 53 grantees, 51 measured domestic violence and 2 measured crime. Overall, state grantees demonstrated improvements in screening for domestic violence, referring families for domestic violence services, and developing safety plans for families experiencing domestic violence (Table 5).

TABLE 5 REDUCTIONS IN DOMESTIC VIOLENCE

Construct	Grantees Improved (N = 51)[u] N	%	Sample Performance Measures
Screening for Domestic Violence	39	**76**	Increased number or percent of women screened for domestic violence
Of Families Identified for Presence of Domestic Violence, Referrals Made to Relevant Services	30	**59**	Increased number of participants who receive necessary referral
Of Families Identified for Presence of Domestic Violence, Families for Which a Safety Plan Was Completed	32	**63**	Increased number or percent of families requiring a safety plan that completed safety plan

In FY 2014, across the 51 state grantees with similar performance measures related to domestic violence, 79 percent of participants meeting sampling criteria were screened for domestic violence.

One of two grantees demonstrated improvement in arrests and convictions (Table 6).

[u] For this benchmark area, grantees developed measures for domestic violence *or* crime. Of the 53 grantees, 51 measured domestic violence (Table 5) and 2 measured crime (Table 6).

TABLE 6 REDUCTIONS IN CRIME

Construct	Grantees Improved (N = 2)[v] N	%	Sample Performance Measures
Arrests	1	**50**	Reduced rate of arrests for mothers
Convictions	1	**50**	Reduced rate of convictions for mothers

Improvements in Family Economic Self-Sufficiency

Almost all state grantees (85 percent) improved in at least half of the performance measures for family economic self-sufficiency. Increased economic resources, as a result of employment, relieve some of the stresses associated with living in poverty and enable parents to dedicate more time and energy to support their children's health and early learning. Furthermore, research indicates that parents with higher educational attainment spend more time engaging in positive parenting practices to promote children's learning.[22]

Overall, state grantees demonstrated improvements in household income, employment or education of participating adults, and health insurance for participating adults and children (Table 7).

TABLE 7 IMPROVEMENTS IN FAMILY ECONOMIC SELF-SUFFICIENCY

Construct	Grantees Improved (N = 53) N	%	Sample Performance Measures
Household Income	42	**79**	Increased income among household members, family members, caregivers, or mothers
Employment or Education of Participating Adults	48	**91**	Increased participant enrollment in educational programs; educational attainment; higher rates of participant employment, paid hours worked, paid plus unpaid hours for child care, or referrals for unemployed mothers
Health Insurance Status of Participating Adults and Children	37	**70**	Increased mothers and children, households, or mothers only with health insurance

[v] For this benchmark area, grantees developed measures for domestic violence *or* crime. Of the 53 grantees, 51 measured domestic violence (Table 5) and 2 measured crime (Table 6).

Improvements in the Coordination and Referrals for Other Community Resources and Supports

Almost all state grantees (85 percent) improved in at least half of the performance measures for the coordination and referrals for other community resources and supports. Community collaborations and partnerships enhance program implementation by effectively connecting families with other community resources and supports.[23,24] Access to these other services is especially important for programs serving high-risk populations, which often require services beyond the expertise of a single program or home visitor.

Overall, state grantees demonstrated improvements in the identification of necessary services for families, referrals to community services, memoranda or formal agreements with community agencies, and establishment of a clear point of contact with other community agencies (Table 8).

TABLE 8 IMPROVEMENTS IN COORDINATION AND REFERRALS FOR OTHER COMMUNITY RESOURCES AND SUPPORTS

Construct	Grantees Improved (N = 53) N	%	Sample Performance Measures
Families Identified for Necessary Services	36	**68**	Increased completion of comprehensive screening to identify family needs
Families That Required Services and Received a Referral to Available Community Resources	34	**64**	Increased rate of referrals for families, mothers, mothers and/or children, or caregivers and/or household members
Completed Referrals	30	**57**	Increased participant self-reports of completion of referral
Memoranda of Understanding or Other Formal Agreements With Social Service Agencies in the Community	46	**87**	Increased number of memoranda of understanding with community agencies
Information Sharing: Agencies With Clear Point of Contact in Collaborating Community Agencies That Includes Regular Sharing of Information	45	**85**	Increased number of primary contacts in community agencies or amount of information sharing with community agencies

In FY 2014, across 42 state grantees with similar performance measures on referrals, 68 percent of participants meeting sampling criteria with an identified need were referred for necessary services.

IV. Advancing Home Visiting Through Quality Improvement and Research

In addition to funding the provision of home visits, the Federal Home Visiting Program invested in quality improvement and research activities to advance the home visiting field. Through quality improvement methods that identify, test, and measure changes in short intervals, home visiting systems are able to make quick course corrections and ensure effective implementation. Grantee-led CQI initiatives, whereby grantees evaluate their own programs and the areas they identified for improvement, and the Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN), a peer-learning network to share best practices and innovations among grantees, are intended to strengthen home visiting services. CQI is an effective way to improve the delivery of services and outcomes for families. Social service[25,26] and home visiting systems[27-29] have increasingly adopted CQI activities into their practices. Using CQI, providers can translate the knowledge gained from data collection into effective changes to systems and activities.

The legislation requires research and evaluation activities to build knowledge around the implementation and effectiveness of home visiting programs.[4] The Federal Home Visiting Program uses multiple approaches to understand the impact of home visiting and to contribute to generalizable knowledge about its implementation of home visiting. First, state and tribal grantees are conducting rigorous evaluations of questions of interest to their state and program. In addition, the state grantees implementing promising approaches are evaluating the effectiveness of these models. Second, MIHOPE, the legislatively mandated, large-scale evaluation of the effectiveness of the Federal Home Visiting Program, will systematically estimate the effects of home visiting programs on a wide range of outcomes and study variation in how programs are implemented. The MIHOPE Report to Congress, which presented early findings from MIHOPE, was published in January 2015.[30] Third, the Home Visiting Applied Research Collaborative has been tasked with defining a national home visiting research agenda and using innovative research methods to advance the agenda. Finally, the Tribal Early Childhood Research Center also participated in activities designed to build knowledge around the implementation and effectiveness of home visiting programs; these are discussed in more detail in the Tribal Home Visiting Program report.

V. Technical Assistance: Building Capacity and Ensuring Quality

The Federal Home Visiting Program provided comprehensive TA to support and build the capacity of all grantees to administer programs and conduct grant-funded activities. Details about the TA provided to Tribal Home Visiting Program grantees are provided in the separate tribal report. State grantees received TA from federal staff, developers of home visiting models,[w] and TA contractors from the Federal Home Visiting Program Technical Assistance Coordinating Center and the DOHVE team. TA was provided to state grantees in three forms: universal, targeted, and individualized.

TA providers worked collaboratively with HRSA and ACF to develop a TA plan to meet each state grantee's individual needs and priorities. The developers of home visiting models have also been crucial partners in providing training and TA to grantees and LIA staff on program administration, implementation, data collection, performance monitoring, and sustainability. These collective efforts strategically supported state grantees in five areas:

1. **Infrastructure development.** TA providers assisted state grantees in developing an effective infrastructure to support Federal Home Visiting Program implementation. State grantees received TA on topics including implementation science, workforce development, system integration, centralized or coordinated intake systems, leadership development, and sustainability.

2. **Benchmark performance.** In conjunction with federal staff, TA providers supported state grantees in developing benchmark performance plans and strategies for data collection, analysis, and reporting for review and approval by HRSA. TA providers and federal staff reviewed all benchmark data submissions and helped grantees identify and address issues with data quality. As state grantees implemented benchmark performance plans, TA facilitated targeted improvements in child and family outcomes. This TA focused on topics including domestic violence; family enrollment, engagement, and retention; maternal depression; and adverse childhood experiences.

3. **Continuous quality improvement.** TA providers worked with state grantees to develop CQI and data collection and analysis plans for review and approval

[w] A list of evidence-based models approved for use in the Federal Home Visiting Program can be found at http://homvee.acf.hhs.gov/models.aspx.

by HRSA. TA providers continue to help state grantees develop sustainable CQI infrastructure and implement targeted CQI projects.

4. **Grantee-led evaluation.** TA providers worked with grantees to support the development of rigorous grantee-led evaluation plans. In particular, TA providers helped state grantees identify research questions consistent with programmatic goals and select appropriate evaluation designs and rigorous methods to address those questions. TA providers also helped grantees to implement their evaluations, including giving guidance on data collection, analysis, reporting, and planning for the dissemination of findings.

5. **Data systems.** TA providers helped state grantees design or modify data systems for data collection and CQI efforts. Some state grantees developed statewide data systems to facilitate data collection and management, while others identified ways to obtain, aggregate, and report statewide data from LIAs and the data systems of model developers.

Building on the TA provided since the inception of the Federal Home Visiting Program, future TA for all state grantees will focus on program efficiency and quality, building state and LIA capacity for data-driven CQI, CQI with data-driven performance and outcomes, community systems and supports, program innovation, and collaboration among various stakeholders. In addition, the nine state grantees that did not demonstrate overall improvement will develop and implement an improvement action plan describing activities for improvement, how they will use TA in support of those activities, and measures to monitor progress. The Federal Home Visiting Program legislation requires the establishment of an Advisory Panel to make recommendations regarding TA provision to grantees that did not demonstrate overall improvement. The Panel comprises federal staff from the U.S. Department of Health and Human Services and the Department of Education. Using the Panel's recommendations regarding grantee improvement action plans, targeted TA from federal staff and TA providers will support these state grantee efforts to improve performance in subsequent years.

TA efforts were strategically designed to support grantees in infrastructure development, benchmark performance, CQI, grantee-led evaluations, and data systems.

VI. Strengthening Communities and Services for High-Risk Families

The Federal Home Visiting Program recognized that in order to improve the health, development, and well-being of young children and families, home visiting programs would have to align with other programs at the state and local levels. Since the inception of the Federal Home Visiting Program, grantees have collaborated across agencies to build service delivery systems that are comprehensive, coordinated, accessible, and responsive to participants' needs. When state and local service delivery systems are fragmented, they do not comprehensively address family needs and are not sustainable over time.[31]

State grantees made improvements across multiple systems, programs, and stakeholders at the state and local levels by collaborating to maximize resources and strengthen referrals and linkages, building and coordinating data systems, developing centralized and coordinated intake systems, and providing professional development and training opportunities. These efforts aimed to make resources more accessible to children and families at the local level and to establish home visiting as a new standard for families in those communities.

The Federal Home Visiting Program made a concerted effort to build systems of care that support early childhood development through collaboration and infrastructure development efforts.

VII. Tribal Home Visiting Program

The goals of the Tribal Home Visiting Program are to support the development of happy, healthy, and successful American Indian and Alaska Native (AI/AN) children and families; implement high-quality, culturally relevant, evidence-based home visiting programs in AI/AN communities; expand the evidence base around home visiting with AI/AN populations; and support and strengthen coordinated and comprehensive early childhood systems. To achieve these goals, Tribal Home Visiting Program grantees adhere to the same high standards and expectations of the Federal Home Visiting Program as state grantees. Though information about tribal grantees is included here, a separate report provides additional details on the activities and successes of Tribal Home Visiting Program grantees.

Diversity and Capacity of Tribal Communities

Since 2010, ACF has competitively awarded 25 Tribal Home Visiting Program cooperative agreements to tribes, consortia of tribes, tribal organizations, and Urban Indian organizations across 14 states. These cooperative agreements incorporate federal support and TA to build tribal grantee capacity in completing required program activities, while allowing for flexibility to meet unique tribal needs and contexts. Tribal grantees serve tribal communities that vary in size, culture, and locale. Fifteen tribal grantees serve rural communities, three serve diverse urban communities, and seven serve communities with a mix of rural and urban settings. Some tribal grantees serve multiple types of communities.

Most Tribal Home Visiting Program grantees had limited or no experience prior to the Federal Home Visiting Program in implementing high-quality, evidence-based home visiting programs. Federal staff and TA contractors from the Tribal Home Visiting Evaluation Institute, Programmatic Assistance for Tribal Home Visiting, and the Tribal Early Childhood Research Center provided programmatic and evaluation TA to tribal grantees to support implementation of home visiting in their communities, carry out required reporting activities, and build capacity for future home visiting service efforts. Tribal grantees designed programs to meet community needs as identified through a comprehensive needs and readiness assessment. Starting up these programs required extensive work prior to implementation to promote community awareness and support for early childhood home visiting, recruit and train program staff, build trust and rapport with families, and develop capacities for data collection and reporting. Tribal

grantees worked with home visiting model developers to adapt and tailor models to unique cultural contexts and overcame barriers such as traveling long distances to provide home visits and accommodating diversity within and across tribal service populations. After extensive planning and capacity building, tribal grantees are providing critical services to some of the most vulnerable AI/AN children in the country.

Program Successes and Improvements

Tribal Home Visiting Program grantees received approximately $56.3 million in Federal Home Visiting Program funding between FY 2010 and FY 2015. The Tribal Home Visiting Program increased program reach and service capacity each year. In FY 2014, tribal grantees served 870 families, 5 times the number served in FY 2012. Tribal grantees provided nearly 20,000 home visits to 3,197 adult participants and children between FY 2012 and FY 2014 and increased their ability to identify and serve priority high-risk populations, including families who struggle with poverty, substance abuse, or a history of child maltreatment.

Tribal grantees engaged multiple community stakeholders in all phases of program planning and implementation to best meet the needs of their unique tribal community and cultural contexts. The collaborations led to the development of early learning coalitions and initiatives to provide coordinated health, early education, and family support services to young children and their families. Tribal grantees also supported improvements in the lives of individual families, such as supporting a mother to enroll in school and find stable housing and identifying a child's learning disability early and linking the family to early intervention services.

Tribal grantees increased their ability to identify and serve American Indian and Native American families and communities.

Grantees demonstrated notable program improvements in the six legislatively mandated benchmark areas. A majority (77 percent) of the tribal grantees that reported data after up to 3 years of implementation demonstrated overall improvement in the benchmark areas. Within each benchmark area, the percentage of tribal grantees demonstrating improvement ranged from 62 to 85 percent (Table 9).

TABLE 9 TRIBAL GRANTEE 3-YEAR IMPROVEMENT IN BENCHMARK AREAS

Benchmark Area	Number of Constructs	Grantees Showing Improvement in at Least Half of the Constructs (N = 13[x])	
		N	%
Improvements in Maternal and Newborn Health	9	8	**62**
Prevention of Child Injuries, Child Abuse, Neglect, or Maltreatment, and Emergency Department Visits	7	11	**85**
Improvements in School Readiness and Achievement	9	9	**69**
Reductions in Crime or Domestic Violence	5	10	**77**
Improvements in Family Economic Self-Sufficiency	3	10	**77**
Improvements in Coordination and Referrals for Other Community Resources and Supports	5	9	**69**
Overall Program Improvement		**10**	**77**

These successes demonstrate the widespread benefits of the Tribal Home Visiting Program. While the program has substantially expanded the reach and quality of services to families in tribal communities, there is a pressing need to continue this expansion. Tribal grantees currently serve over 50 tribal communities—a small percentage of the 566 federally recognized tribal nations and the 37 Urban Indian organizations, tribal consortia, and other tribal organizations across the nation.[32]

[x] At the time of this report, 13 of 25 grantees reached 3 years of implementation and were eligible to be assessed for improvement

VIII. Future Directions

After 4 years of implementation, HRSA and ACF recognize the opportunity to strengthen the Federal Home Visiting Program and build on the solid foundation already established. Going forward, HRSA seeks to strengthen programs and policies, improve the performance measurement system, and further target TA activities to build CQI capacity and advance grantee benchmark performance among state grantees.

To further efforts to build a culture of quality, HRSA continues to refine the requirements applicable to the award of grant funding under the Federal Home Visiting Program. HRSA has developed protocols for regular communication with state grantees to promote consistency in program implementation, oversight, and management as well as performance measurement. HRSA continues to clarify its guidance and expectations to further solidify the program as the new quality standard for evidence-based home visiting programs throughout the nation.

As the Federal Home Visiting Program initially allowed state grantees flexibility to establish their own performance measures for each construct within the six benchmark areas, state grantees had the ability to customize their performance measures according to the needs and structures of their target communities, LIAs, and home visiting models. However, the resulting variation in performance measures across the state grantees made it difficult to make national comparisons. Therefore, HRSA and ACF are committed to redesigning the current performance measurement system for the Federal Home Visiting Program so it addresses legislative requirements, enables comparisons across state grantees to present a national performance profile of the program, and encourages the program's CQI efforts. The redesign will achieve a simplified and unified performance measurement system in order to fulfill the program goals of strengthening home visiting services and improving outcomes for children and families.

Utilizing specialized universal and targeted TA, the Federal Home Visiting Program will intensify its focus on measuring performance, continued development of CQI capacity, and expanded HV CoIIN efforts. This intensive TA, along with the improved performance measurement system, will facilitate the growth of the Federal Home Visiting Program and strengthen its impact on the lives of children and families.

Finally, HRSA and ACF will continue the Federal Home Visiting Program's commitment to an ongoing learning agenda that incorporates rigorous research and evaluation throughout the program. HRSA and ACF remain committed to effectively executing the legislatively-mandated national evaluation of the impact and implementation of the Federal Home Visiting Program and implementing lessons learned from the evaluation findings. Initial findings from this evaluation were reported to Congress in early 2015, meeting the statutory deadline. In addition, HRSA and ACF continue to strengthen the Federal Home Visiting Program through executing the statutory requirement of a continuous program of research and evaluation.

Appendix A-1: Federal Investment by State Grantee, FY 2010–FY 2015

Grantee	Grantee Agency	Total Award Dollars
Alabama	State of Alabama Department of Children's Affairs	$28,072,223
Alaska	Alaska Department of Health and Social Services	7,935,350
Arizona	Arizona Department of Health Services	60,715,633
Arkansas	Arkansas Department of Health	40,446,154
California	California Department of Public Health	113,590,127
Colorado	Colorado Department of Human Services	35,650,721
Connecticut	Connecticut Office of Early Childhood	41,492,829
Delaware	Executive Office of the Governor of Delaware	22,417,933
District of Columbia	Government of District of Columbia	7,864,446
Florida	Florida Association of Healthy Start Coalitions, Inc.	34,415,378
Georgia	Georgia Department of Human Resources	36,110,137
Hawaii	Hawaii Department of Health	22,525,791
Idaho	Idaho Department of Health and Welfare	8,984,503
Illinois	Illinois Department of Human Services	44,500,194
Indiana	Indiana State Department of Health	57,865,307
Iowa	Iowa Department of Public Health	25,330,469
Kansas	Kansas Department of Health and Environment	21,716,599
Kentucky	Kentucky Cabinet for Health and Family Services	32,817,653
Louisiana	Louisiana Department of Health and Hospitals	51,992,903
Maine	Maine Department of Health and Human Services	34,888,334
Maryland	Maryland Department of Health and Mental Hygiene	27,611,412
Massachusetts	Massachusetts Department of Public Health	42,930,851
Michigan	Michigan Department of Community Health	37,394,816
Minnesota	Minnesota Department of Health	42,240,776
Mississippi	Mississippi Department of Human Services	9,954,087
Missouri	Missouri Department of Health and Senior Services	12,151,802
Montana	Montana Department of Public Health and Human Services	23,145,616
Nebraska	Nebraska Department of Health and Human Services	8,215,296

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Federal Investment by State Grantee, FY 2010–FY 2015 *(continued)*

Grantee	Grantee Agency	Total Award Dollars
Nevada	Nevada Department of Health and Human Services	$9,252,327
New Hampshire	New Hampshire Department of Health and Human Services	15,122,836
New Jersey	New Jersey Department of Health and Senior Services	49,763,497
New Mexico	New Mexico Department of Children, Youth and Families	17,442,976
New York	New York Department of Health	42,088,228
North Carolina	North Carolina Department of Health and Human Services	21,588,191
North Dakota	Prevent Child Abuse North Dakota	4,589,685
Ohio	Ohio Department of Health	37,806,218
Oklahoma	Oklahoma State Health Department	45,112,107
Oregon	Oregon Department of Human Services	37,944,256
Pennsylvania	Pennsylvania Department of Public Welfare	53,812,099
Rhode Island	Rhode Island Department of Health	34,718,471
South Carolina	The Children's Trust Fund of South Carolina	33,471,372
South Dakota	South Dakota Department of Health	5,645,679
Tennessee	Tennessee Department of Health	48,373,149
Texas	Texas Health and Human Services Commission	90,956,631
Utah	Utah Department of Health	15,247,343
Vermont	Vermont Agency of Human Services	7,324,832
Virginia	Virginia Department of Health	35,378,323
Washington	Washington State Department of Early Learning	44,106,907
West Virginia	West Virginia Department of Health and Human Resources	19,499,829
Wisconsin	Wisconsin Department of Children and Families	38,303,471
Wyoming	Parents as Teachers National Center	4,567,800
American Samoa	Department of Health	5,500,000
Guam	Department of Public Health and Social Services	5,500,000
Northern Mariana Islands	Commonwealth of the Northern Mariana Islands	5,500,000
Puerto Rico	Department of Health	5,500,000
U.S. Virgin Islands	Virgin Islands Department of Health Group	5,500,000
Totals		**$1,672,593,567**

Appendix A-2: Federal Investment by Tribal Home Visiting Program Grantee, FY 2010–FY 2015

State	Awardee	Total Award Dollars
Alaska	Fairbanks Native Association	$2,790,000
Alaska	Kodiak Area Native Association	2,485,000
Alaska	Southcentral Foundation	4,020,000
Arizona	Native American Community Health Center, Inc.	2,830,000
California	Lake County Tribal Health Consortium	2,466,650
California	Native American Health Center, Inc.	2,045,000
California	Riverside-San Bernardino Indian Health, Inc.	3,107,000
Michigan	Inter-Tribal Council of Michigan	2,650,000
Minnesota	White Earth Band of Chippewa Indians	2,985,750
Montana	Confederated Salish and Kootenai Tribes	1,916,750
Nevada	Yerington Paiute Tribe	1,475,000
New Mexico	Native American Professional Parent Resources, Inc.	3,560,000
New Mexico	Pueblo of San Felipe	1,652,400
New Mexico	Taos Pueblo	1,660,000
North Carolina	Eastern Band of Cherokee Indians	1,895,000
Oklahoma	Cherokee Nation	1,882,000
Oklahoma	Choctaw Nation of Oklahoma (two grants)	4,315,750
Oregon	Confederated Tribes of Siletz Indians	1,390,000
Oregon	Yellowhawk Tribal Health Center	1,381,990
Washington	Port Gamble S'Klallam Tribe	2,305,700
Washington	South Puget Intertribal Planning Agency	2,439,000
Washington	United Indians of All Tribes Foundation	1,824,000
Wisconsin	Red Cliff Band of Lake Superior Chippewa	1,660,000
Wyoming	Northern Arapaho Tribe	1,525,000
Totals		**$56,261,990**

Appendix B: References

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