VDH VIRGINIA DEPARTMENT OF HEALTH

To protect the health and promote the well-being of all people in Virginia.

EARLY IMPACT VIRGINIA

ALLIANCE FOR EARLY CHILDHOOD HOME VISITING

Needs Assessment for the Virginia Maternal, Infant, and Early Childhood Home Visiting Program

Revised January 2021

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1. Introduction

Virginia is a large and diverse state with a population of more than 8.5 million including more than 700,000 children age 0-6, including an estimated 208,000 in low-income households (with income under 200% of poverty). These children and their families reside in Virginia's 133 cities and counties, all of which have some level of need for home visiting.

The Virginia Department of Health (VDH) administers the state Maternal Infant and Early Childhood Home Visiting (MIECHV) program. MIECHV is a critical resource for improving the health and well-being of women, infants and children across the Commonwealth of Virginia. The program supports pregnant women, families and at risk parents of children (birth to age 5) to access resources and develop the skills needed to raise children who are physically, socially and emotionally healthy and ready to learn. The MIECHV program supports and implements voluntary evidence-based home visiting programs using models that are proven to improve child health and be cost effective.

A. Virginia Department of Health and the MIECHV Team

The MIECHV leadership team at VDH includes: Project Director, Andelicia Neville, MS; Program Coordinator, Trinita Wright, MPH; Home Visiting Specialist; Pamela Hanks, MA; Evaluator, Staysi Blunt, MPH; Epidemiologist, Arami Anwell, MA, NCC; Program Support Technician Sr., Jessica Fallen. MIECHV currently funds 18 Local Implementing Agencies that provide direct home visiting services, and two centralized intake sites that disseminate referrals. In addition, there are two state contracts: (1) James Madison University supports the development of professional development opportunities, including online training modules for the Institute for the Advancement of Family Support Professionals and (2) Early Impact Virginia supports system building efforts including convening the Alliance for Early Childhood Home Visiting **(Box 1.1)** which serves as the MIECHV Advisory Council, providing statewide professional development, continuous quality improvement and statewide data reporting. The Virginia Department of Health contracted with Early Impact Virginia to complete the MIECHV Needs Assessment.

Box 1.1
Alliance for Early Childhood Home Visiting

Home Visiting Models

- ☐ CHIP of Virginia
- ☐ Early Head Start
- ☐ Family Spirit
- ☐ Healthy Families
- ☐ Healthy Start/Loving Steps
- ☐ Nurse Family Partnership
- ☐ Parents as Teachers
- ☐ Resource Mothers

Early Childhood Partners

- ☐ Early Childhood Mental Health Virginia
- ☐ Early Childhood Special Education @ Virginia Department of Education
- ☐ Early Intervention/Part C @ Virginia Department of Behavioral Health and Development Services
- ☐ Head Start Collaboration Office
- ☐ Health Education and Design Group @ James Madison University
- ☐ Project Link @ Virginia Department of Behavioral Health and Development Services
- ☐ Reach Out and Read Carolinas
- ☐ Virginia Commonwealth University
- ☐ Virginia Department of Health
- ☐ Virginia Department of Medical Assistance Services
- ☐ Virginia Department of Social Services

This **MIECHV Needs Assessment** is the product of a statewide collaborative effort to identify strengths and needs in Virginia's system of home visiting programs. The effort to produce this needs assessment was led by Early Impact Virginia, and informed by dozens of organizations and hundreds of individuals from across Virginia. These stakeholders shared their insights, ideas, and critiques of Virginia's home visiting system from a wide range of perspectives. This guidance is invaluable for understanding the needs, challenges, and opportunities for optimizing home visiting in Virginia.

The results of this needs assessment are intended to inform the work of multiple audiences, including public agencies, home visiting programs, and advocacy groups. In the following subsections we describe the Early Impact Virginia mission, members, and partners, along with the state and federal directives that guided the needs assessment.

Early Impact Virginia advances the delivery of high quality, efficient services that improve the health, social, and educational outcomes for new and expecting parents, young children, and their families within safe homes and connected communities so that children grow up healthy and ready to learn.

Early Impact Virginia convenes the Alliance for Early Childhood Home Visiting, which also serves as the advisory council for MIECHV. The Alliance includes members that represent eight home visiting models and eleven early childhood partners as shown in **Box 1.1**. These organizations work individually and collaboratively to strengthen home visiting services across Virginia.

B. Purpose of the Needs Assessment

This report is intended to inform the work of multiple audiences concerned with home visiting in Virginia. At the federal level, the U.S. Health Resources and Services Administration (HRSA) requires a statewide needs assessment as a requirement of its Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants to states. The MIECHV needs assessment will inform the systemic and statewide needs assessment for Virginia's home visiting programs that occur once every three years and is mandated by the Governor and General Assembly, which will be conducted by Early Impact Virginia.

In the local setting, the needs assessment can inform the work of home visiting programs, other community organizations, advocates, other state-level federal programs implemented by local health districts, and local government.

MIECHV Program. The MIECHV Program is authorized by Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c)) to support voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry. The MIECHV Program is administered by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF). Program awardees receive funding through the MIECHV Program to implement evidence-based home visiting programs and promising approaches.

Awardees have the flexibility to tailor their program to serve the specific needs of their communities. Through a statewide needs assessment, awardees identify target populations and select home visiting service delivery models that best meet state and local needs. By law, a needs assessment update must identify communities with concentrations of defined risk factors, assess the quality and capacity of home visiting services in the state, and assess the state's capacity for providing substance abuse treatment and counseling services. HRSA encourages states to use their needs assessment updates to:

- ☐ Understand the current needs of families and children, and at-risk communities.
- ☐ Target home visiting services to at-risk communities with evidence-based and promising approach home visiting models that meet community needs.
- ☐ Support statewide planning to develop and implement a continuum of home visiting services for eligible families and children prenatally through kindergarten entry.

- ☐ Inform public and private stakeholders about the unmet need for home visiting and other services in the state.
- ☐ Identify opportunities for collaboration with state and local partners to establish appropriate linkages and referral networks to other community resources and supports and strengthen strong early childhood systems.
- ☐ Direct technical assistance resources to enhance home visiting service delivery and improve coordination of services in at-risk communities.

State Partners. Multiple agencies are involved in supporting home visiting at the state level, including:

- Virginia Department of Social Services
- Virginia Department of Education
- Virginia Department of Behavioral Health and Developmental Services
- Virginia Department of Medical Assistance Services
- Virginia Department of Health

Local Partners. Home visiting programs operate within a broader array of services and supports for children and families at the local level, including:

- Local social service agencies
- Community services boards
- Public health agencies
- School districts
- Health care providers
- Local government officials
- Advocacy groups

C. Research Methods

This needs assessment was produced using multiple methods. Multiple sources of community data were used to generate community profiles of need and risk. Data on service utilization and workforce were obtained from program records. Insights from community stakeholders were generated through surveys and interviews. These sources are cited more specifically throughout the report and appendixes.

D. Organization of the Report

The main sections of the report are outlined in **Box 1.2**. Section 2 is focused on identifying communities with concentrations of risk so that Virginia can target resources toward communities with greatest need. Sections 3.1 and 3.2 describe the quality and capacity of existing programs at the state and community level. Section 4 examines Virginia's capacity for providing maternal treatment and counseling for substance use disorders. Section 5 describes how this needs assessment is coordinated with other needs assessments focused on maternal, infant, and early childhood issues. Finally, Section 6 summarizes major findings, and outlines strategy for disseminating this needs assessment report.

Box 1.2
Report Outline

- 1. Introduction
- 2. Identifying Communities with Concentrations of Risk
- 3.1 Quality and Capacity of Existing Programs (System Level)
- 3.2 Quality and Capacity of Existing Programs (Community Level)
- 4. Capacity for Providing Treatment and Counseling for Substance Use Disorders
- 5. Coordination with Other Needs Assessments
- 6. Conclusion

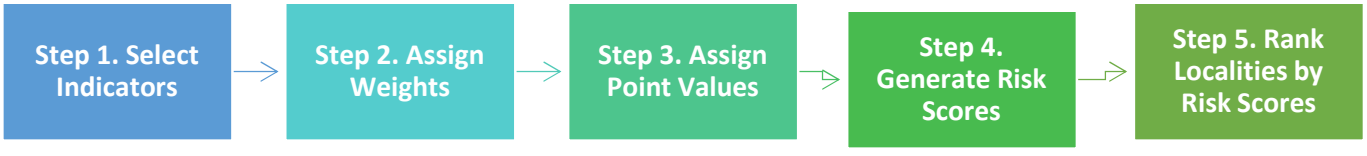
2. Virginia Communities with Concentrations of Risk

One of HRSA's requirements for the MIECHV program's needs assessment is to identify communities with concentrations of risk. This analysis applied the Independent Method option, outlined in the Supplemental Information Request for Submission of the MIECHV Statewide Needs Assessment Update, to analyze concentrations of risk in 133 localities (cities and counties) in Virginia. This section describes:

A. Methods for Assessing Concentrations of Risk
B. Indicators of Risk Across Virginia Localities
C. Concentrations of Risk in Virginia Localities

A. Methods for Assessing Concentrations of Risk

Virginia is a large and diverse state with wide variations in community need and community capacity for home visiting. Using the Independent Method option for identifying communities with concentrations of risk is designed to acknowledge this diversity. A five-step method outlined below was used to produce the assessment of risk. Steps 1 through 3 were completed collaboratively with the Early Impact Virginia Data Action Team. The Data Action Team includes representatives from multiple home visiting models at both the state and local program level.



Step 1. Select Indicators. Virginia selected sixteen Maternal and Child Health (MCH) indicators that were identified as key proxy measures of maternal, infant, and early childhood development and health. The resulting list of indicators is shown in **Exhibit 2.1**.

Exhibit 2.1 Selected Indicators and Assigned Weights		
Weight = 0-2 Points	*Weight = 0-1 Points*	*Weight = 0-0.5 Points*
1. Children Age 0-6 in Low-Income Households 2. Low Birth Weight Rate 3. Late/No Prenatal Care Rate 4. Teen Pregnancy Rate 5. Preterm Birth Rate 6. Child Maltreatment Rate 7. Children in Food-Insecure Homes	8. Live Births 9. Unemployment Rate 10. Pain Reliever Abuse Prevalence Rate 11. Illicit Drug Use Prevalence Rate	12. Marijuana Abuse Prevalence Rate 13. Alcohol Abuse Prevalence Rate 14. High School Dropout Rate 15. Crime Rate 16. Juvenile Arrest Rate

Step 2. Assign Weights. As also shown in the exhibit, each of the indicators was assigned a weighting value to reflect the potential impact on infant and early childhood development and health. The seven indicators assigned a weight of 0-2 points are considered to have the greatest direct impact on infant and early childhood development and health. The nine additional indicators were assigned a weight of 0-1.0 or 0-0.5, based on assumptions about their relative influence on maternal, infant, and early child health.

Step 3. Assign Point Values. Points were assigned based on which quartile, or 25% section of data, each county's value fell in within each indicator. The specific method for assigning point values to each locality is described in **the needs assessment data summary tables (excel workbook).**

Step 4. Generate Concentration-of-Risk Scores. A concentration-of-risk score was calculated for each locality by summing the point values (assigned in Step 3) across all 16 indicators. The resulting risk score was used to produce the locality rankings as shown in **the needs assessment data summary tables (excel workbook).**

Step 5. Rank Localities by Concentration of Risk Score. The localities were then ranked according to their concentration-of-risk score. The resulting list of at-risk counties is provided in **Section C** and again in **the needs assessment data summary tables (excel workbook).**

B. Indicators of Risk across Virginia Localities

The maps in **Appendix B, Figures 1 – 16,** illustrate the variation in indicators of risk (described in **Exhibit 2.2**) across Virginia localities. The results indicate that all geographic regions in Virginia have a relatively high score on one or more of the risk indicators.[1] This includes the larger urban and suburban corridors in northern, central, and eastern Virginia, as well as the rural communities and smaller cities and towns across southern, southwest, and western Virginia. T**he needs assessment data summary tables** show the number of points assigned to each locality based on their quartile ranking on each indicator. **Section C** shows the overall concentration-of-risk scores for each locality.

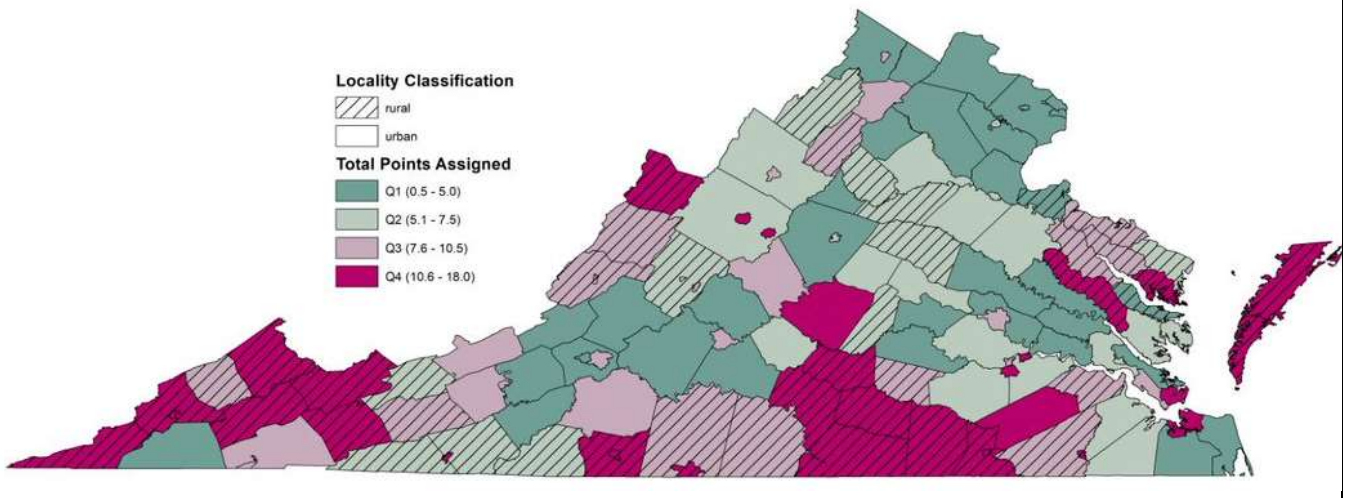
[1] Juvenile arrests could not be mapped due to missing data at the locality level.

Exhibit 2.2 Indicators of Risk	
Data Point	**Description**
# of Live Births	# of live births
Teen Pregnancy Rate	Pregnancy rate = (number pregnancies to females ages 15-19) / number of females in a specific age group) x 1,000
Preterm Birth Rate	% preterm births = (number of births to less than 37 weeks gestation / number of live births) x 100
% Low Birth Weight	% low weight births = (number of births less than 2,500 grams / number of live births) x 100
% Late/No Prenatal Care	% late or no prenatal care = (number of births to moms who had late or no prenatal care / number of live births) x 100
Unemployment Rate	Unemployed percent of the civilian labor force
High School Dropout Rate	% of 16-19 year olds not enrolled in school with no high school diploma – (5 year estimate)
Alcohol Abuse Prev. Rate	Prevalence rate: Binge alcohol use in past month
Marijuana Abuse Prev. Rate	Prevalence rate: Marijuana use in past month
Illicit Drug Use Prev. Rate	Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month
Pain Relievers Abuse Prev. Rate	Prevalence rate: Nonmedical use of pain medication in past year
Crime Reports	# reported crimes/1000 residents
Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17
Child Maltreatment Rate	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents
Children in Poverty	% children, ages 0-6, living below 200% FPL
Children in Food Insecure Homes	% of children identified as food insecure of the total child population

C. Concentrations of Risk in Virginia Localities

A concentration-of-risk score was calculated for each locality by summing the point values displayed in the maps above across all 16 indicators. The resulting concentration-of-risk scores for each locality were then ranked into quartiles from highest (4th quartile) to lowest (1st quartile). The results are illustrated in **Exhibit 2.3,** and high risk counties are listed in **Exhibit 2.4**.

Exhibit 2.3
Community Concentrations of Risk: Statewide View



Source: EIV analysis of risk indicators and concentration-of-risk scores.

As shown:

- Localities in quartile four (Q4) have the highest concentration of risk scores. The Q4 localities include rural counties and some urban pockets in the western, southwestern, southern, and eastern parts of Virginia.
- Localities in quartile 3 (Q3) are also spread across the state, including rural counties and some additional urban localities in central, eastern, and Northern Virginia.
- The table below lists each locality in Q4 and Q3 in descending order from highest to lowest risk score within that quartile.

As an additional factor for **setting priorities**, localities were categorized as urban or rural based on classifications assigned by the Virginia Department of Health. These designations are illustrated on the map with cross-hatching of rural localities and were examined when forming the final list of at-risk communities. There are a total of 40 rural localities above the median number of points, and 28 urban localities.

The needs assessment data summary tables (excel workbook) includes data tables for raw indicators, weighting, estimated numbers of families and children served, and estimated need[2], for the **74 at-risk localities** to be given priority attention by the MIECHV program for resources and support. The list includes localities that rank above the median concentration-of-risk score, which was 7.5 points.

Exhibit 2.4
Community Concentrations of Risk in Quartiles 3-4: 2020 At-Risk County Ranking

Localities With Risk Scores in Q4 (11.0-18.0 pts.)		**Localities With Risk Scores in Q3** (7.5-10.5 pts.)	
Locality	**Total Points**	**Locality**	**Total Points**
Hopewell City	18	Franklin County	10.5
Danville City	16.5	Nottoway County	10.5
Petersburg City	16	Pulaski County	10.5
Accomack County	15.5	Covington City	10.5
Lee County	15.5	Roanoke City	10.5
Wise County	15.5	Winchester City	10.5
Norfolk City	15.5	Nelson County	10
Portsmouth City	15.5	Page County	10
Lunenburg County	15	Wythe County	10
Galax City	15	Radford City	10
Norton City	15	Surry County	9.5
Northampton County	14.5	Colonial Heights City	9.5
Martinsville City	14	Bath County	9
Staunton City	14	Dickenson County	9
Charlotte County	13.5	Essex County	9
Franklin City	13.5	Washington County	9
Brunswick County	13	Bristol City	9
Buchanan County	13	Halifax County	8.5
Highland County	13	Southampton County	8.5
Prince Edward County	13	Westmoreland County	8.5
Russell County	13	Harrisonburg City	8.5

[2] Virginia has defined need for home visiting as number of children age 0-6 living under 200% of the Federal Poverty Level.

Sussex County	13	Lynchburg City	8.5
Waynesboro City	13	Alleghany County	8
Tazewell County	12.5	Giles County	8
Henry County	12	Pittsylvania County	8
Lancaster County	12	Richmond County	8
Greensville County	11.5	Warren County	8
King and Queen County	11.5	Buena Vista City	8
Mecklenburg Count	11.5	Caroline County	7.5
Hampton City	11.5	Carroll County	7.5
Richmond City	11.5	Prince George County	7.5
Buckingham County	11	Spotsylvania County	7.5
Smyth County	11	Suffolk City	7.5
Emporia City	11		
Newport News City	11		

In the 2020 needs assessment:

- There are 16 new localities on the list of at-risk communities that were not identified in the prior needs assessment. Those localities are: Alleghany, Bath, Buena Vista, Caroline, Colonial Heights, Covington, Essex, Highland, King and Queen, Nelson, Page, Prince George, Spotsylvania, Staunton, Surry and Westmoreland.
- Six (6) localities that were on the prior list of at-risk communities, and are currently funded by MIECHV in Virginia, did not make the 2020 list. They are: Campbell, Fairfax, Frederick, Fredericksburg, Montgomery, and Williamsburg.

While the six (6) localities that came off the list did not rank in the top two quartiles of concentration of risk, each locality still demonstrates need in one or more indicators of risk. For example, Campbell was in Q3 for number of live births, percent of low-birth-weight, and percent of women with late entry into prenatal care. Fairfax was in Q3 for number of live births and teen pregnancy rate. Frederick was in Q3 for number of live births, preterm birth rate, and illicit drug use and pain reliever abuse prevalence rates. Montgomery was in Q4 for child maltreatment, as well as Q3 for number of live births. And lastly, Williamsburg was in Q4 – the highest category of risk – for percent of women with late entry into prenatal care, and Q3 for number of children 0-6 living in poverty and child maltreatment.

While their overall concentration of risk score did not rank in the highest quartiles, these six (6) localities continue to demonstrate need. In addition, they are currently serving families. The table below shows each locality's concentration of risk score, as well as the average number of families served each quarter between October 2019 and September 2020.

Locality	Total Points	Average Number of Families/Quarter
Campbell	**4.0**	**12**
Fairfax	**1.5**	**113**
Frederick	**4.5**	**28**
Fredericksburg	**6.5**	**29**
Montgomery	**4.0**	**54**
Williamsburg	**7.0**	**22**

Because of these risk indicators, and the fact that families are currently being served in these localities, Virginia has added these six (6) localities to the 2020 list of at-risk communities. MIECHV will work with local programs in these localities to develop strategies so that no families currently receiving home visiting will experience an interruption in services. Virginia MIECHV will also work with its advisory council to integrate the new list of 74 at-risk localities into the upcoming renewal process (Spring 2021).

Additionally, MIECHV leadership in Virginia recognizes the critical importance of sustainable, reliable funding to ensure high-quality program delivery and cultivate long-term success of local home visiting programs. Because of this, MIECHV will work in partnership with Early Impact Virginia, local programs, and model offices in Virginia to determine that best way to sustain gains made by prior MIECHV investment in at-risk localities.

MIECHV, in partnership with Early Impact Virginia, will participate in updating a comprehensive strategic financing plan for home visiting in Virginia. Determining how to braid myriad public funding streams to ensure stability, and foster nimble and adaptable approaches to emerging demographic trends and service needs will be a priority for Virginia in 2021.

3.1 Quality and Capacity of Existing Programs – System Level

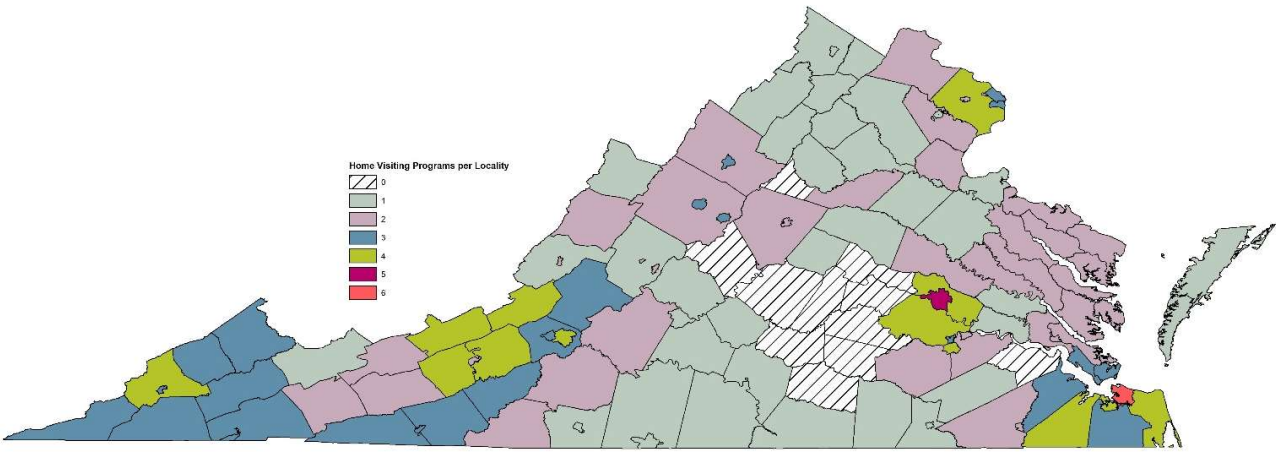
In this section we assess the quality and capacity of existing home visiting programs from a system-level perspective (see Section 3.2 for a community-level assessment). The following sections describe:

A. Virginia's Eight Unique Home Visiting Models
B. System-Level Strengths, Gaps, and Challenges
C. Virginia's Plan for Home Visiting
D. Additional System-Level Initiatives

A. Virginia's Eight Unique Home Visiting Models

Virginia has eight unique, early childhood home visiting models. As shown in **Exhibit 3.1**, as of 2020 one or more of these models were implemented in 121 Virginia localities. The localities with the highest number of programs are Norfolk (6) and Richmond (5); 119 localities have 1 to 4 programs, and 12 localities have no home visiting program in operation.

Exhibit 3.1
Virginia Home Visiting Programs by Locality (2020)



Source: EIV analysis of home visiting program data.

asterisk are promising practice or evidence-informed.

- **CHIP of Virginia***. CHIP of Virginia changes lives two generations at a time by working with families caught in the cycle of poverty. Using proven best practices to intervene early, CHIP prepares parents to be their child's first and most important teacher.

- **Early Head Start**. Head Start is a national child development program for children from birth to age 5, which provides services to promote academic, social, and emotional development for income-eligible families. Many Head Start programs also offer home-based services to families and childcare for infants and toddlers through Early Head Start.

- **Family Spirit (new in 2020).** Family Spirit® is an evidence-based, culturally tailored home-visiting program of the Johns Hopkins Center for American Indian Health to promote optimal health and wellbeing for parents and their children. The program combines the use of paraprofessionals from the community as home visitors and a culturally focused, strengths-based curriculum as a core strategy to support young families.

- **Healthy Families Virginia**. Healthy Families Virginia is the nationally recognized home visiting model developed by Prevent Child Abuse America. The program is designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment.

- **Healthy Start/Loving Steps***. Healthy Start/Loving Steps works to eliminate disparities in perinatal health experienced by African-American women and their families to prevent infant mortality and low weight births.

- **Nurse-Family Partnership**. Nurse-Family Partnership is a maternal and early childhood health program that introduces vulnerable first-time parents to caring maternal and child health nurses.

Nurses support first-time moms to have a healthy pregnancy, develop parenting skills, and provide their babies with the best possible start in life.

- **Parents as Teachers.** Parents as Teachers promotes optimal early development, learning, and health of young children by supporting and engaging their parents and caregivers. Parents as Teachers supports parents in being their child's first and most influential teachers.

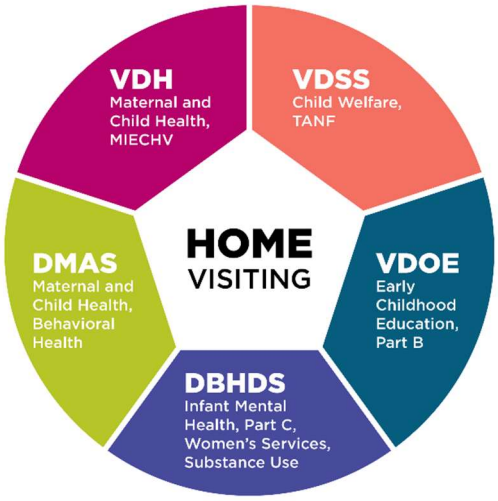
- **Resource Mothers***. Resource Mothers is designed to decrease infant mortality and low birth weight rates among Virginia's teen mothers. The program was created to improve birth outcomes for the teen and the baby.

Virginia's MIECHV program is committed to implementing evidence-based home visiting models. Virginia selected Healthy Families Virginia, Parents as Teachers, and Nurse-Family Partnership as the evidence-based models to be funded by the MIECHV program.

B. System-Level Strengths, Gaps, and Challenges

At the system level, home visiting lives at the intersection of five agencies serving Virginia children and families (**Box 3.1**). Each agency plays a significant role in all or some part of the administration, funding, and delivery of home visiting services. While this offers certain advantages for collaboration, it also creates inherent fragmentation and adds to the complexity of an already disparate system.

Box 3.1
Virginia State Agencies Involved in Home Visiting



The opportunity to strengthen the statewide home visiting system has been clearly identified by state and local leaders. In 2017 the Virginia General Assembly's Joint Legislative Audit and Review Commission (JLARC) conducted a comprehensive, statewide evaluation of Virginia's early childhood development programs. In its resulting report, JLARC noted a series of system strengths:

> *Virginia's voluntary home visiting programs demonstrate effective performance, are generally well designed, and have strong quality assurance mechanisms to ensure they are implemented as intended. Participants often have better outcomes than those who do not participate, both nationwide and in Virginia. For example, participants in Virginia's home visiting programs for pregnant women are more likely than nonparticipants to carry their pregnancies to full term, which is associated with positive developmental outcomes. Virginia's voluntary home visiting programs also feature the key components that experts generally agree are necessary to be effective.*

JLARC also identified gaps and challenges in administrative infrastructure to ensure effective coordination, evaluation, and planning across programs, stating:

> *However, these programs lack adequate administrative infrastructure to ensure effective coordination, evaluation, and planning across programs. The funding for voluntary home*

visiting programs in Virginia is unstable and difficult to predict each year, and this instability hinders the ability of these programs to operate in a consistent, strategic manner over time.

To address these concerns, JLARC recommended that the state "take action to solidify and strengthen Early Impact Virginia as the lead entity for the state's voluntary home visiting programs."

Virginia leaders acted swiftly during the following legislative session to address these recommendations by including legislation to support this work. The 2018-2019 budget signed into law by Governor Northam grants Early Impact Virginia "*the authority and responsibility to determine, systematically track and report annually on the key activities and outcomes of Virginia's home visiting programs; conduct systematic and statewide needs assessments for Virginia's home visiting programs at least once every three years; and to support continuous quality improvement, training, and coordination across Virginia's home visiting programs on an ongoing basis."*

As further demonstration of the state's commitment to streamlining administration across the home visiting system, VDH entered into a unique partnership with Early Impact Virginia to support the broader system goals of the MIECHV program. Since 2012, the Alliance for Early Childhood Home Visiting has served as the Advisory Board for MIECHV. In a clear display of public-private collaboration, VDH redesigned its approach to MIECHV administration to align with the Early Impact Virginia legislative mandate. This approach creates the opportunity for full statewide alignment of legislative priorities for home visiting, including standardized workforce development, continuous quality improvement, accountability, needs assessment and strategic planning.

MIECHV funding currently supports three evidence-based models serving 1,300 families (2019) through 18 local programs. This represents a fraction of the overall services delivered in the state. Aligning MIECHV funding with state administered funding demonstrates a fundamental commitment to strategically addressing system-level gaps and challenges by reinforcing the existing strengths inherent in Virginia's system.

C. Virginia's Plan for Home Visiting

Early Impact Virginia also partnered with the Governor's office to convene a Leadership Council charged with developing the plan to guide the state's investment in home visiting that is driven by a clearly articulated vision for the Commonwealth's families with young children. Virginia's first Lady Pamela Northam convened and chaired the inaugural Leadership Council meeting in November 2018. The resulting planning framework was drafted in partnership with Leadership Council and informed by the Alliance for Early Childhood Home Visiting, which includes home visiting leaders and state funding partners, including MIECHV.

Virginia's Plan for Home Visiting: The Framework was endorsed by the Virginia Children's Cabinet in May of 2019. The framework is intended to guide the development of a comprehensive plan for coordination of home visiting program services within the early childhood system to ensure quality service delivery and sustainable growth. See **Appendix A** for more details on the framework.

D. Additional System-Level Initiatives

MIECHV funding supports a broad range of systems-level initiatives to strengthen the home visiting workforce, enhance state-level coordination, and advance quality improvement projects and other data-driven efforts. Specific examples of initiatives led by VDH to improve the health of prenatal women and their families include: supporting online training modules at no-cost to home visitors through The Institute for Family Support Professionals; assuring home visiting program staff are represented on the Title V-funded state Maternal Mortality Review Committee; supporting state and regional coordination of developmental screening; collaborative efforts around breastfeeding with statewide Women Infant and Children (WIC) programs; continuing efforts with the Office of Family Health Services on ensuring equity in all service programs; agency representation on the Sister Agency Workgroup to form collaborative efforts around maternal infant health initiatives with various state agencies; agency representation on Family First Prevention Services Act Workgroup; collaborative efforts to promote smoking cessation through the use of the VDH "Quit Now" line; and promotion and education on safe sleep measures using the VDH Safe Sleep Virginia webpage.

Maternal and Infant Health Initiatives. Gov. Ralph Northam's budget proposal for FY 2021 and FY 2022 included a package of directives and funding to boost health care access and support for new moms and babies, as well as reduce the racial disparity in the state's maternal mortality rate. The Virginia General Assembly approved many elements of this package, including the milestone achievement of expanding access to home visiting services by making them eligible for Medicaid reimbursement.

This phenomenal "win" for home visiting in Virginia can be traced back to 5-years goals established as a part of MIECHV program sustainability planning. The budget approved in March 2020 included $12M in state funding to establish home visiting as a Medicaid funded services, with a projected federal match rate of at least $30M.

Other efforts to support maternal and child health, and the elimination of racial disparities in health and maternal mortality, that were approved in the budget included:

- Budget language and funding to:
    - Support efforts by the Virginia Neonatal Perinatal Collaborative (VNPC) to decrease maternal mortality and morbidity and to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes.
    - Create a Perinatal Quality Collaborative to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes.
    - Expand Medicaid offerings for uninsured pregnant women, including extended coverage and reimbursement for support services like educational home visits.
    - Extend the length of time an uninsured expectant or new mother can be covered under the state's Medicaid program for uninsured mothers, known as FAMIS MOMS.
    - Extend Medicaid coverage from pregnancy to up to one year after delivery, including coverage for medically necessary addiction and substance abuse treatment.

- Budget language authorizing the Department of Medical Assistance Services to require contracted Medicaid managed care organizations to:
    - Identify and address racial disparities in maternal, reproductive and child health.
    - Provide additional care coordinators for the early intervention population.

- Develop advisory groups for member feedback and engagement surrounding maternal, child, and women's health.
- Develop strategies to keep mom and baby together during residential SUD treatment.
- Improve care coordination of the high-risk maternity program.

However, due to COVID-19, funding for all new initiatives was frozen until the overall impact of the pandemic can be assessed. In the meantime, state and local leaders continue to work to advance critical policy elements that must be in place for successful future implementation.

Family First Prevention Services Act. The Family First Prevention Services Act aims to keep children safe, strengthen families and reduce the need for foster care whenever it is safe to do so. Within Virginia, Family First services are coordinated by the Virginia Department of Social Services, and operated collaboratively with other state and local agencies. Funding is available for trauma informed, evidence-based, foster care prevention services within the following categories:

- Mental Health Prevention and Treatment Services
- Substance Use Disorder Prevention and Treatment Services
- In-Home Parent Skill-Based Programs

The implementation of Family First has been extended to January 30, 2021. Virginia Department of Social Services had several major Family First implementation activities scheduled for Spring 2020 that unfortunately have been cancelled and/or postponed due to COVID-19. These activities include training for specified providers in evidence based practices and assisting localities in determining the needs of their communities which are critical to support the implementation of Family First. Implementing Family First remains a high priority for the Division of Family Services and implementation activities will continue with our state and community partners.

Behavioral Health Redesign. Virginia is engaged in a multi-year effort to redesign behavioral health services including services for mental health, substance disorder, and intellectual disability. Significant elements of this redesign are designed to improve prevention and treatment services for children and families. See **Section 4** for additional detail.

The Children's Cabinet. In 2018 Governor Ralph Northam issued Executive Order No. 11 reestablishing the Children's Cabinet. Experiences during the early years of a child's life have a tremendous impact on development and life outcomes. This Children's Cabinet will develop solutions to address challenges that exist for children across the Commonwealth and will focus its efforts on several key priorities. Among these priorities are early childhood development and school readiness, nutrition and food security, systems of care and safety for school-aged youth. In addressing these priorities, the Children's Cabinet will work to develop goals, identify strategies, and measure impact and outcomes.

3.2 Quality and Capacity of Existing Programs – Community Level

The system-level dynamics described in Section 3.1 influence the community context for home visiting programs. The following sections describe:

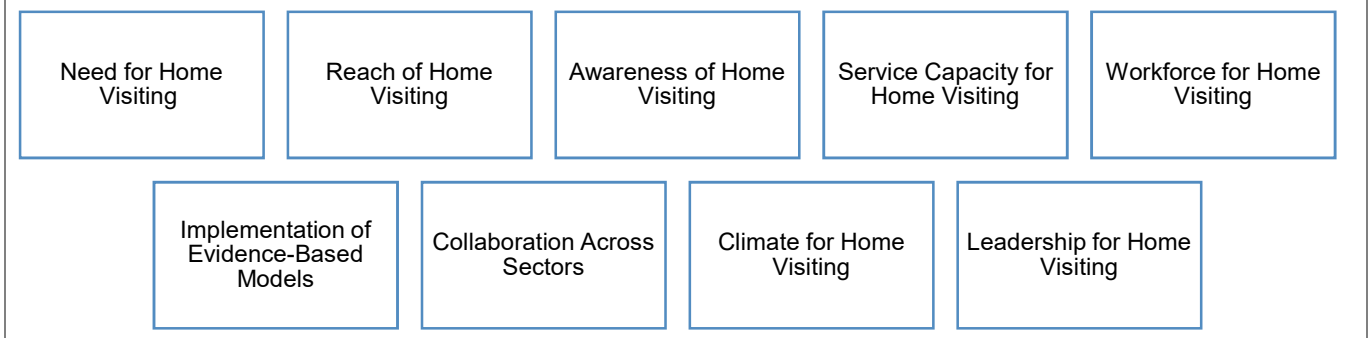
A. A Framework for Community Readiness
B. The Need for Home Visiting

C. The Reach of Home Visiting Programs
D. Awareness of Home Visiting Programs
E. Service Capacity for Home Visiting
F. Workforce for Home Visiting
G. Implementation of Evidence-Based Models for Home Visiting
H. Collaboration, Climate, and Leadership for Home Visiting

A. A Framework for Community Readiness

Community readiness can be defined as the extent to which a community is ready, willing, and able to meet the home visiting needs of young children and their families. As shown in **Exhibit 3.2**, the framework for community readiness includes nine core elements that influence a community's ability to meet local needs. The following sections apply this framework to assess the quality and capacity of existing programs at the community level.

Exhibit 3.2
A Framework for Community Readiness



To add richer detail and community-level context to the quantitative data analyzed for this needs assessment, the following qualitative research was also conducted: Home Visiting Workforce Focus Groups, key informant interviews, and the Virginia Home Visiting Needs Assessment survey.

Home Visiting Workforce Focus Groups were conducted from January – June 2020. These focus groups began in a face-to-face format, but with the emergence of COVID-19, shifted to virtual in April 2020. A total of 54 home visiting staff and 17 supervisors participated in focus groups, totaling 71 participants. All regions of the state were represented in the focus groups, as were eight home visiting models. Comprehensive detail about the focus groups is available in the full Qualitative Summary Report for the Virginia Home Visiting Needs Assessment, included as **Appendix C.**
The Virginia Home Visiting Needs Assessment Survey was conducted in summer 2020 and targeted four distinct stakeholder groups: home visiting directors, community service providers, community leaders, and other stakeholders. Key informant interviews were identified via the survey and volunteers represented all four stakeholder groups.

Through collaboration with other state level needs assessments, it was decided not to include parents in the Virginia Home Visiting Needs Assessment Survey as many families served by home visiting had been

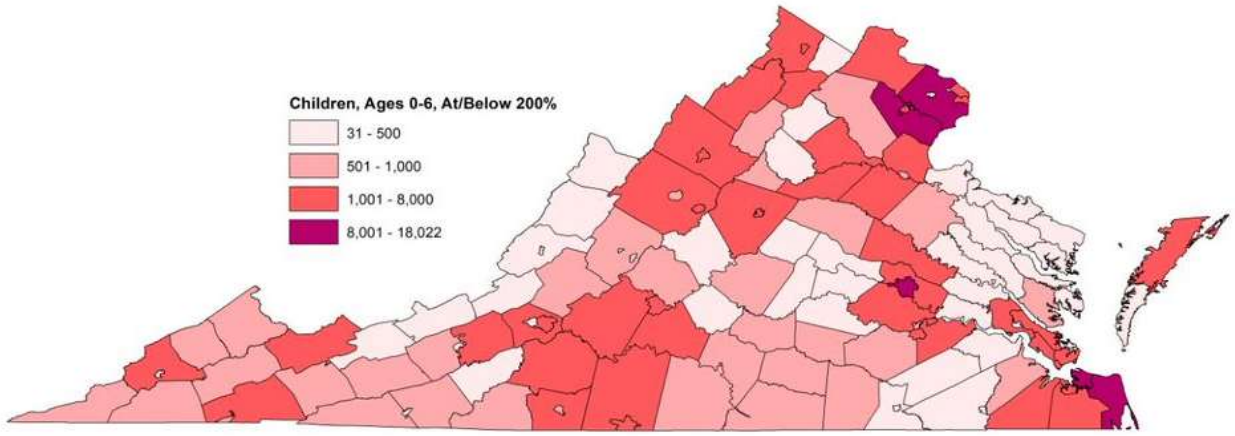
targeted for interviews, surveys and focus groups by both Preschool Development Grant and Title V needs assessment efforts in 2018 and 2019. Honoring and acknowledging the demand that participation in these efforts place on families was tantamount. The MIECHV needs assessment will pull on parent and family voice from other concurrent needs assessments.

B. The Need for Home Visiting

This assessment defines potential community need in terms of the number of children age 0-6 with income below 200% of the federal poverty level. Although this is not the only possible indicator of need, low-income is a prominent factor in most models that predict need for home visiting services. Applying this measure for Virginia, as of 2018 there were an estimated 208,000. Virginia children age 0-6 with income below 200% of poverty. This estimate represents roughly one out of three children age 0-6 statewide.

Exhibit 3.3 provides a map of this population by city and county. Focusing on population counts, the *largest numbers* of low-income children reside in the most populous cities and counties (Fairfax County, Prince William County, and the cities of Norfolk, Virginia Beach, and Richmond). However, many rural localities have a comparatively high *percentage* of children age 0-6 with income below 200% of poverty. See **the needs assessment data summary tables (excel workbook)** for an estimate of potential need by locality.

Exhibit 3.3
Estimate of Children with Potential Need for Home Visiting in Virginia (2018)



Source: EIV analysis of data from the United States Census Bureau American Community Survey.

Insight from Community Stakeholders. Community stakeholders contacted for the needs assessment provided additional insight on community need. As shown in **Exhibit 3.4**, home visiting directors reported via the Virginia Home Visiting Needs Assessment Survey that they use a variety of indicators to assess community needs and target community populations, with the five most frequently identified being live births, teen pregnancy, child abuse and neglect, the poverty rate, and low weight births. These survey results further validate the indicators of risk selected by the Data Action Team to determine Concentration of Risk scores for the needs assessment.

Exhibit 3.4
Community Need: Insights from Community Stakeholders

Use of Community Indicators

Which indicators does your program use to assess community needs and identify target populations?

Five most frequently identified:	*Home Visiting Directors (n=41)*
Number of live births	63%
Teen pregnancy rate	49%
Child abuse and neglect rate	46%
Percent of population in poverty	46%
Low birth weight rate	39%

Observed Extent of Need

Please indicate the extent to which each of the following services is needed by most expectant parents and/or families with young children in your community.

Mean rating for each service on a scale from 1 (not needed) to 5 (very needed):	*Community Service Providers (n=55)*	*Community Leaders (n=30)*	*Other Stakeholders (n=20)*
Home Visiting	4.6	4.6	4.9
Mental Health	4.4	4.7	4.9
Substance Use	4.5	4.5	4.6
Maternal Health	4.3	4.5	4.8
Public Transportation	4.0	4.5	4.6
Unemployment Assistance	4.3	4.4	4.5
Employment Opportunities	4.8	4.6	4.5
Child Care	3.9	4.8	4.9
Government Assistance	4.4	4.1	4.3
Affordable Healthcare	4.0	4.5	4.8
Healthcare for Undocumented Residents	4.0	3.9	4.5
Food Assistance	4.2	4.4	4.6
Culturally & Linguistically Appropriate Services	4.2	4.1	4.6

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey.

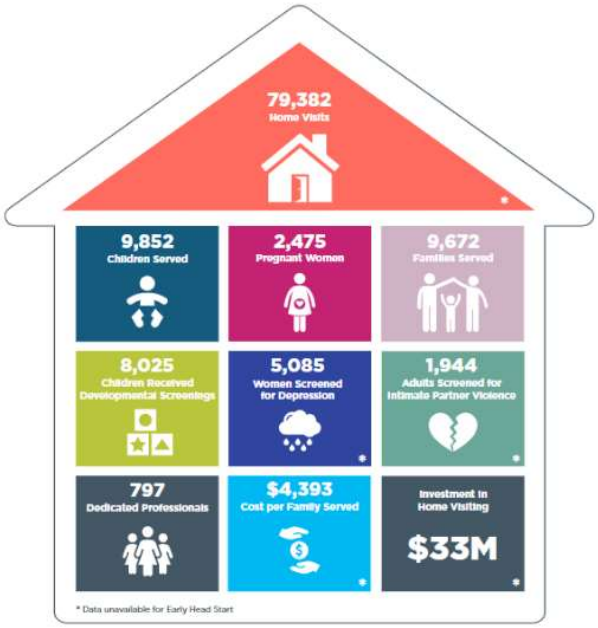
Respondents to the Virginia Home Visiting Needs Assessment Survey were asked to rate the extent of need they have observed for various community services. Home visiting was rated as needed to very-needed by all three groups The need for services is further supported by parent and family voice findings in the Title V qualitative data collection, specifically for women of reproductive age and pregnant women and mothers of young children.

Themes from women of reproductive age stated that "[m]ental health is a primary need, and common complaints relate to finding a mental health provider, long wait times to schedule an appointment, large gaps between appointments, and long-distance travel to see providers or access services." Additionally, pregnant women and mothers of young children findings indicated that "[s]upport system and service needs include financial stress and issues, access to and navigation within housing and transportation, lack of community, essential supplies for infants like diapers, breastfeeding, and mental health counseling. The high ratings of need across the board for multiple community services quantified in the survey and underscored by insight from parents and family illustrates the diverse and substantial needs of families with young children.

C. The Reach of Home Visiting Programs

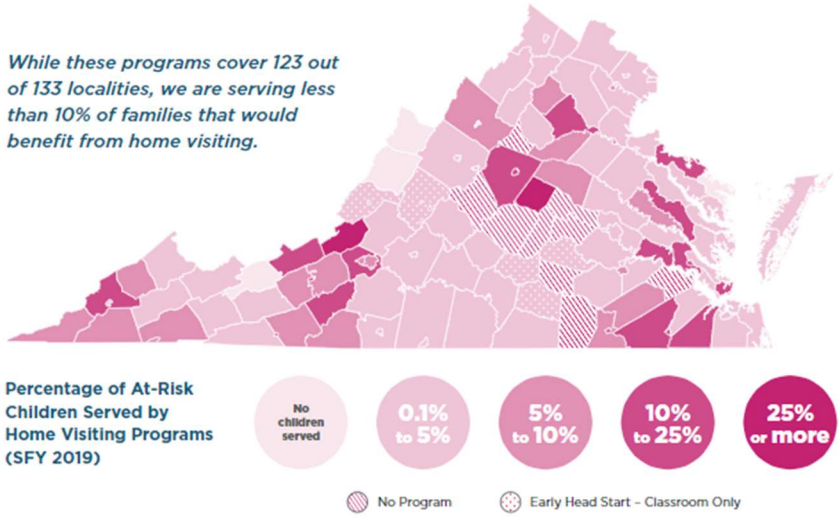
Community reach of home visiting is defined as the percent of children in need served by voluntary home visiting programs. As shown in **Exhibit 3.5a-b**, in 2019 an estimated 797 professionals from **seven home visiting programs** provided **over** 79,000 home visits to more than 9,600 families. The estimated percent of children in need who were served by these programs reached 25% or more in only two localities. Although home visiting programs have expanded since 2018, there are still large pockets of unmet need in most localities.

Exhibit 3.5a
Selected Home Visiting Indicators for Virginia in 2019



Source: Home Visiting in Virginia, State Fiscal Year 2019, Early Imapct Virginia

Exhibit 3.5b
Selected Home Visiting Indicators for Virginia in 2019



Source: Home Visiting in Virginia, State Fiscal Year 2019, Early Imapct Virginia

Insight from Community Stakeholders. Community stakeholders contacted for the needs assessment provide additional insights about community reach. As shown in **Exhibit 3.6,** more than 40% of community service providers and community leaders surveyed reported they have observed barriers to accessing home visiting services for expectant parents or families with children. Also, between 39% and 54% of Home Visiting Directors surveyed identified one or more barriers to access.

Exhibit 3.6
Community Reach: Insights from Community Stakeholders

Observed Barriers to Accessing Home Visiting Services

Have you observed any barriers for expectant parents or families with children to accessing home visiting services?

Response:	*Community Service Providers (n=56)*	*Community Leaders (n=31)*
Yes	48%	42%
No	52%	58%

What barriers do home visiting programs face in providing services in your community?

Response:	*Home Visiting Directors (n=41)*
Engaging working families	54%
Presence of multiple, additional high-risk factor among families	49%
Developing and maintaining referral relationships	46%
Access to technology and/or reliable phone/internet services	41%
Language needs	39%
Enrolling new families	39%
Retaining families	39%

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey.

The observed barriers identified in the survey results are further illuminated by insights shared in the Home Visiting Workforce Focus Groups, as shown in **Box 3.2**.

Box 3.2
Home Visitor Insights on Helping Families Address Barriers to Accessing Services

One of the primary ways home visiting serves families is by connecting them to resources in the community; however, programs vary widely in the ways in which they help bridge the structural gaps, especially in regards to transportation and providing tangible goods to families. Because they are often the service providers most familiar with a family and use a trauma-informed approach, home visitors often serve as a "lifeline" for families, aiding families beyond the scope of their job. The supportive relationships between home visitors and the family are of utmost importance, often determining whether families stick with the program. When families do disengage with home visiting, it is typically because of staff turnover, families moving to a different service area, or other significant families issue arise.

Source: Qualitative Summary Report for Virginia Home Visiting Needs Assessment.

Health Disparities and Health Equity. Health disparities and health equity are critical considerations for assessing and meeting the needs of families served by home visiting programs. A recent analysis conducted by the Virginia Hospital & Healthcare Association (VHHA) indicates disparate rates of maternal morbidity, as summarized in **Box 3.3**.

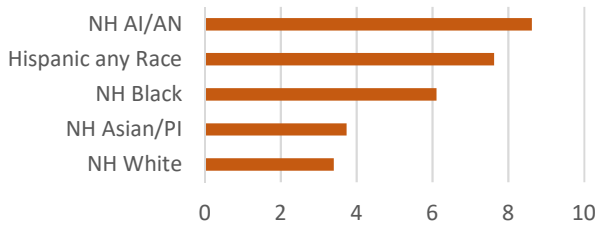
Box 3.3
Selected Indicators of Maternal Morbidity

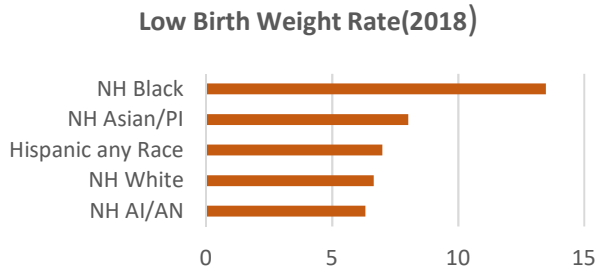
The VHHA Data Analytics team examined the records of 226,403 deliveries from 2017 through the second quarter of 2019. The analysis indicates **40 percent** of mothers in this group (n=89,562) gave birth with a chronic condition diagnosis or risk factor, with the most common conditions being anemia, obesity, asthma, tobacco use, anxiety disorders, acquired hypothyroidism, depression, drug use, and diabetes. The analysis also shows noticeable differences in prevalence when the data is stratified by race and payer class.

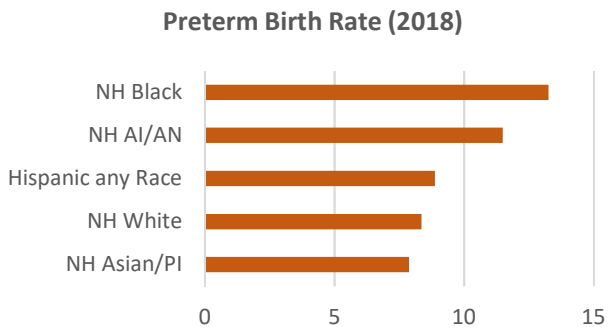
Source: Virginia Hospital & Healthcare Association. (https://www.vhha.com/research/2020/03/06/health-factors-linked-to-maternal-morbidity-and-mortality/)

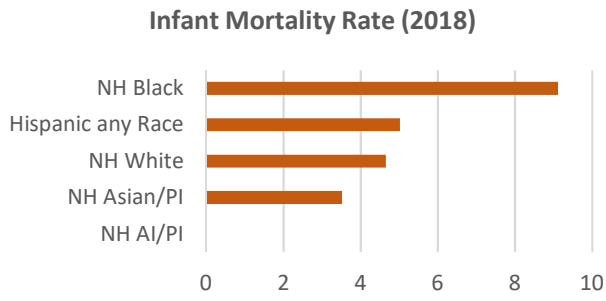
In addition, as shown in **Exhibit 3.7**, within Virginia there are racial/ethnic disparities in rates of obtaining early prenatal care, low birth weight, preterm births, infant mortality, and maternal mortality.

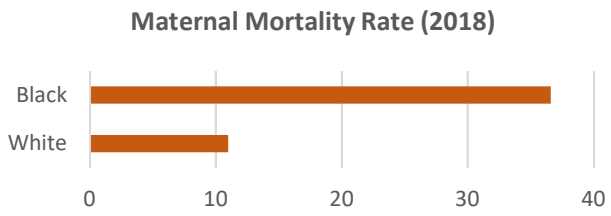
Exhibit 3.7
Selected Indicators of Disparities in Maternal and Infant Health in Virginia











Source: EIV analysis of data from the Virginia Department of Health. Additional information on maternal and infant morbidity and mortality is available from the Virginia Department of Health at https://insight-editor.livestories.com/s/v2/pregnant-women-and-infants---morbidity-and-mortality/dbcdd202-7b14-4143-af2c-bdafdef945d3

The disparities outlined above are shaped by multiple factors including inequities in access to health care, as well as various social determinants of health. The scope and complexity of these factor are reflected in **Box 3.4** summarizing insights from home visiting professionals.

Box 3.4
Home Visitor Insights on Factors in Health Disparities and Equity

The families served are diverse. There are many races and ethnicities represented; many do not speak English as a first language; refugee and immigrant families have concerns about documentation status.

While a minority of organizations have an adequate proportion of bilingual staff, overall, there is a severe shortage across the state—both in terms of home visiting staff and health providers in the community. These clients also have notable difficulties navigating the U.S. healthcare and related systems.

In addition, although differences may be magnified in rural areas, all regions highlighted the structural barriers that impact their clients, including lack of affordable housing and childcare, lack of accessible public transportation, and few employment opportunities or workforce development resources.

Source: Qualitative Summary Report for Virginia Home Visiting Needs Assessment.

Similar insight was gathered from maternal and child health providers through the Title V needs assessment, which found that "providers demonstrate implicit bias in their practice and systems of healthcare have chronically oppressed and disenfranchised people of color, immigrants and non-native English speakers, persons of low socioeconomic status, incarcerated persons, people with disabilities, and those who identify as LGBTQ+."

The implication for community readiness is that home visiting programs should directly identify and address health disparities in program planning, service delivery, and program evaluation.

D. Awareness of Home Visiting Needs and Programs

Community awareness is defined as the community knowledge of family needs and home visiting efforts. Community stakeholders shared their insights about community awareness as outlined in **Exhibit 3.8**. Home visiting directors rated parental knowledge about home visiting at an average of 4.1 on a scale of 1 (no knowledge) to 10 (detailed knowledge). Focusing on information sharing for parents, home visiting directors identified brochures, program websites, and special/community events as the most common communication channels.

Exhibit 3.8
Community Awareness: Insights from Community Stakeholders

Parent Awareness

How much do you think parents know about home visiting?

Mean rating on a scale of 1 (no knowledge) to 10 (detailed knowledge)	Home Visiting Directors (n=31)
	4.1

Information Sharing for Parents

How is information about home visiting made available in the community?

Methods:	*Home Visiting Directors (n=41)*
Brochures	84%
Program websites	76%
Special/community events	61%
Social media	58%
Posters	39%
Branded giveaways from programs	24%
Printed newsletters	17%
E-newsletters	14%
Rack cards	8%
Other	24%

Exhibit 3.8
Community Awareness: Insights from Community Stakeholders

Professional Awareness

How would you rate your knowledge of home visiting programs in your community?

Mean rating on a scale of 1 (no knowledge) to 10 (detailed knowledge)	*Community Leaders (n=31)*	*Other Stakeholders (n=19)*
	7.1	7.7

How would you rate your knowledge of other services in the community for expectant parents and/or families with young children?

Mean rating on a scale of 1 (no knowledge) to 10 (detailed knowledge)	*Community Leaders (n=33)*
	6.9

Information Sharing for Professionals

How does your agency or program learn or obtain information about current home visiting programs and services in the community?

Method:	*Community Service Providers (n=57)*
Community coalitions/alliances	74%
Community meetings	67%
Communication from leadership	63%
Word of mouth	56%
Newsletters/email distributions	49%
Other	6%

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey.

Community leaders and other stakeholders were asked to rate their own knowledge of home visiting programs and other community services. The survey respondents rated their own knowledge in the range 6.9 to 7.7 on a scale of 1 (no knowledge) to 10 (detailed knowledge). When asked how their program or agency receives information about home visiting programs and services in their community, community coalitions/alliances, community meetings, and communication from leadership were identified as the most common information sources.

E. Service Capacity for Home Visiting

Community capacity for home visiting is defined as the availability of services to help meet the home visiting needs of at-risk families. Community stakeholders shared their insights about community capacity as outlined in **Exhibit 3.9.** As shown, 47% of home visiting directors surveyed reported the need for home visiting services in their community exceeds program capacity, and 39% reported they were unable to enroll new families due to capacity issues at some point in the past year. The management challenges most frequently identified by home visiting directors and community leaders included identifying/recruiting families, funding, and retention of families.

Exhibit 3.9
Service Capacity: Insights from Community Stakeholders

Concerns about Service Capacity

Does the need for home visiting services in your community exceed your program's capacity?

Response:	*Home Visiting Directors (n=36)*
Yes	47%
No	31%
Not sure	22%

At any point in the last year, were you unable to enroll new families because you didn't have the staffing or capacity to provide services?

Response:	*Home Visiting Directors (n=39)*
Yes	39%
No	61%

Management Challenges

In your opinion, what are the most challenging aspects of managing a home visiting program?

Concerns:	*Home Visiting Directors (n=41)*	*Community Leaders (n=42)*
Administrative/operational capacity	17%	24%
Data collection	24%	17%
Training/professional development	2%	19%
Model-specific technical assistance/quality assurance	10%	5%
Maintaining model fidelity	15%	7%
Identifying/recruiting families	63%	45%
Retention of families	49%	36%
Integrating into existing early childhood systems	12%	19%
Access to additional community services	32%	21%
Funding	54%	57%
Public/political will	12%	31%
Other	14%	5%

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey.

F. Workforce for Home Visiting

The community workforce for home visiting is defined as the supply and skill level of professionals available to meet home visiting staffing needs. In exploring challenges and opportunities for workforce development, it is important to understand the work environment for home visiting professionals. As reflected in **Box 3.5**, having a "heart" for the job, plus the ability to create and sustain positive relationships are essential. In addition, home visitors must be able to manage effectively in a complex environment that is not always structured to support delivery of what families really need.

Box 3.5
Insights from Home Visitor on their Professional Practice

Having a "heart" for the job was described as the most important qualification for home visiting. Staff are generally satisfied with the onboarding process at the local level and very satisfied with the trainings from EIV.

Many reported high job satisfaction from relationships with clients, seeing their families accomplish goals, and their work environment and colleagues. While many participants appreciated the autonomy of their jobs, others felt that their positions were more rigid and that detracted from their job satisfaction. Several participants felt the caseload expectations were not aligned with the realities of doing the job on the ground.

Similarly, participants expressed a desire for a greater understanding from supervisors of the context of their clients' lives and how those challenges impact home visiting. The low pay, lack of professional growth, and lack of appreciation for staff were the most commons reasons for staff turnover.

Source: Qualitative Summary Report for Virginia Home Visiting Needs Assessment.

Exhibit 3.10 shows additional insights about community workforce from the perspective **home visiting directors**. To summarize:

- Successful home visitors should ideally have good communication and personal skills, reflect the community/families they serve, have an appropriate educational level/degree, and demonstrate interest in home visiting.

- The most frequently identified hiring challenges include inability to offer a competitive salary, lack of candidates with necessary skills, and lack of candidates with bilingual skills.

- Professional development and training opportunities are generally available, although it is important to assure that these opportunities are responsive to needs and realities of home visiting practice.

- In addition, home visiting directors were asked to rate the extent to which home visiting staff and leadership reflect the community they serve in relation to race, gender, and language. On a scale of 1 (does not reflect) to 10 (is highly reflective), the average ratings were 6.7 for staff and 6.0 for leadership

Exhibit 3.10
Community Workforce: Insights from Home Visiting Directors

Most Important Qualities in a Successful Home Visitor	
What are the most important qualities in a successful home visitor?	
Response:	*Home Visiting Directors (n=41)*
Communication and personal skills	71%
Education level/degree	46%
Reflect the community/families served	46%
Interest in home visiting	44%
Bilingual/language fluency	15%
Relevant experience and expertise	15%

Challenges in Hiring New Home Visitors	
What challenges have you experienced in hiring new home visitors for your program?	
Response:	*Home Visiting Directors (n=41)*
Unable to offer competitive salary	56%
Lack of candidates with necessary education, skills, and experience	39%
Lack of bilingual candidates	34%
Lack of interest	2%
Other	15%

Training and Professional Development Opportunities for Home Visitors

How would you describe the training and professional development opportunities for home visiting in the following areas?

Extent accessible at the:	*Home Visiting Directors (n=30)*		
	Not accessible	*Moderately Accessible*	*Very Accessible*
Community Level	13%	60%	27%
Regional Level	3%	61%	35%
State Level	3%	42%	55%
National Level	3%	70%	27%

Home Visiting Workforce as a Reflection of Communities Served	
To what extent do you believe home visiting STAFF reflect the community they serve in relation to race, gender, and language?	
Mean score on scale of 1 (does not reflect at all) to 10 (is highly reflective)	*Home Visiting Directors (n=31)*
	6.7
To what extent do you believe home visiting LEADERSHIP reflect the community they serve in relation to race, gender, and language?	
Mean score on scale of 1 (does not reflect at all) to 10 (is highly reflective)	*Home Visiting Directors (n=26)*
	6.0

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey.

Shifting the focus to **professional development**, home visitors need to possess a complex array of knowledge and skills, as well as a unique temperament and a willingness to work in challenging environments. To support the comprehensive training needs of all home visitors, Virginia provides extensive professional development opportunities for all local providers. Access to free competency-based e-learning training is provided through the **Institute for the Advancement of Family Support Professionals**. Additionally, Early Impact Virginia provides regional classroom training to meet the advanced training and development needs of all home visiting staff members, as shown in **Box 3.6.**

All training is developed collaboratively with state and local home visiting and early childhood professionals, and designed to meet the needs of staff. In addition to required evidence based program training to ensure model fidelity and foundational relational skills, Early Impact Virginia works together with model trainers to support the multidisciplinary knowledge and skills necessary for effective service delivery.

Box 3.6
Virginia Home Visiting MIECHV-Supported Workforce Development Activities (SFY'20)

66	On-line training modules on **The Institute**
7	Classroom based trainings
1615	Virginia Home Visitors and Early Childhood Professionals participated in EIV trainings
197	Hours of classroom training provided*
23	Classroom trainings provided
4,138	On-line trainings completed by Virginia professionals
28	Supervisors participating in Early Impact Virginia 2-year Reflective Practice Learning Community
10	Scholarships for Virginia Infant Mental Health Endorsement
146	Home Visiting professionals join their program supervisors to Kick-off their reflective supervision learning journey
28	Local Home Visiting programs trained to implement *Mothers & Babies* curriculum

** 6 hours delivered virtually in May 2020*

G. Implementation of Evidence-Based Models for Home Visiting

Virginia's home visiting programs are committed to implementing evidence-based or informed service models. These models are backed by research indicating home visiting programs can positively affect the health and well-being of children parents. The Virginia MIECHV program currently supports three evidenced based program models, Healthy Families America, Nurse Family Partnership and Parents as Teachers. All local service providers receive extensive training and support prior to engaging in service delivery with families. Virginia is fortunate to have a strong infrastructure of support for these three evidence based models. The MIECHV program partners with the program model offices to support all model related technical assistance, quality assurance and training needs of local providers.

The Research Evidence. One resource for documenting the evidence for home visiting is the Home Visiting Evidence of Effectiveness (HomVEE) initiative operated by the Administration for Children and Families in the US Department of Health and Human Services. [3] HomVEE was launched in 2009 to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting program models that serve families with pregnant women and children from birth to age 5.

In its most recent review from 2019, HomVEE published a systematic review of research on 21 different home visiting models nationally. The home visiting models vary in focus and scope of services, so it is not expected that every model should improve every relevant outcome. The results of the HomVEE

[3] https://homvee.acf.hhs.gov/

review indicate that one or more of the 21 programs studied had evidence of a positive primary or secondary impact on one or more of eight defined outcome domains, as listed in **Box 3.7**.

The HomVEE research is just one of multiple published reviews that indicate home visiting can contribute to positive outcomes for children and parents. Achieving these outcomes in Virginia will require effective design and delivery of home visiting programs that are evidence-based and targeted toward families in need. The positive impact will be elevated to the extent that programs are adequately resourced and effectively coordinated with children and families at the center. Virginia's MIECHV program will continue to support these objectives in collaboration with its members and partners.

MIECHV Grant Requirements. There are additional criteria identified in statute for evidence-based models eligible for implementation under the MIECHV grant. Legislative requirements for an evidence-based model to be implemented under MIECHV are that it: "conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement," among other requirements.

When selecting a model or models for a state or territory, MIECHV grantees must ensure the selection can:

- Meet the needs of the identified at-risk communities and/or any specific target populations in statute;
- Provide the best opportunity to achieve meaningful outcomes in benchmark areas and measures; and
- Be implemented effectively with fidelity to the model in the state or territory based on available resources and support from the national model developer.

The model(s) selected should also be well-matched to the needs of the state's or territory's early childhood system. States or territories may select multiple models for different communities and use a combination of models with a family, avoiding concurrent dual enrollment, to support a continuum of home visiting services that meets families' specific needs.

Implementation Challenges and Opportunities. Virginia's MIECHV program is committed to implementing evidence-based home visiting models. Virginia's MIECHV program selected Healthy Families America, Parents as Teachers, and Nurse-Family Partnership as the evidence-based models eligible for funding.

Research and experience show that evidence-based practice requires strong capacity in terms of funding, staffing, training, and management. In this context, the challenges outlined in Section E on **service capacity** and

Box 3.7
Outcomes that Can Be Affected by Home Visiting

1. Child health
2. Child development and school readiness
3. Family economic self-sufficiency
4. Linkages and referrals
5. Maternal health
6. Positive parenting practices
7. Reductions in child maltreatment
8. Reductions in juvenile delinquency, family violence, and crime.

Source: HomVEE initiative

Section F on **workforce development** can directly impact the ability of home visiting programs to deliver evidence-based service models. Building on the recent momentum for supporting home visiting services, Virginia has an opportunity to resource and manage programs in ways that are demonstrated to best support evidence-based practice.

At the ground level, matching families' needs to home visiting programs is crucial to developing relationships. Pulling from Title V insight gathered from pregnant women and mothers with young children, families shared that "parenting [support] needs include affirmation and reassurance that they are doing the right thing." This strengths-based approach is embedded in all of the home visiting models in Virginia, and enabling them to first build trust with families creates additional opportunities to identify and address each family's specific needs.

The subsequent Community Readiness Framework and Toolkit that will be released by Early Impact Virginia after the needs assessment will provide an additional tool to enable local communities to determine the best home visiting programs for their community based on data, as well as readiness of factors that are essential to implementing a successful home visiting program – such as availability of other community services, presence of referral partners, awareness of home visiting, and supportive community leadership.

H. Collaboration, Climate, and Leadership for Home Visiting

Box 3.8
Home Visitor Insights on Community Coordination

There are some community coalitions related to early childhood and/or child and maternal health, but they vary widely in their organization and efficacy. In general, there is low reported community understanding of what home visiting is and how it can serve the community. This is compounded by the confusion of multiple home visiting programs in an area (which may or may not work together with a centralized intake coordinator). Most organizations expressed a desire for greater community collaboration and coordination, both within and outside of home visiting programs.

Source: Qualitative Summary Report for Virginia Home Visiting Needs Assessment.

While home visiting can create positive impact for children and families on its own, the impact is strongest when home visiting is delivered as part of a coordinated set of services tailored to meet the needs of families. The ideal approach is for service providers to work across sectors and agencies to coordinate services, with parents as partners. This requires effective collaboration, a positive community climate, and committed community leadership.

The Importance of Community Collaboration. Community collaboration is essential for delivering effective child and family serves, including home visiting services. As reflected in **Box 3.8**, coordination across agencies is essential for helping families understand and navigate available services. Coordination works best in a climate where home visiting is perceived as important, and community leaders are committed to coordinating services for children and families.

Perceived Importance of Home Visiting. One element of a positive community climate is community members who see home visiting as important. As shown in **Exhibit 3.11**, the stakeholders surveyed reported their communities generally see home visiting as important, with ratings from 6.4 to 8.0 on a scale from 1 (not important) to 10 (very important).

Exhibit 3.11
Importance of Home Visiting Services: Insights from Community Stakeholders

How does your community rate the importance of home visiting services?				
	Home Visiting Directors (n=33)	*Community Service Providers (n=50)*	*Community Leaders (n=28)*	*Other Stakeholders (n=21)*
Mean score on scale of 1 (not important) to 10 (very important)	6.4	7.4	7.6	8.0

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey.

Leadership Support for Home Visiting. Another important indicator of community climate and readiness to collaborate is community leadership support. As shown in **Exhibit 3.12**:

- The stakeholders surveyed generally view community leaders as sometimes or always ready to participate in planning, partnering to deliver necessary services, and communicating the importance of home visiting to the public/community, and facilitating development of new referral relationships.
- Home visiting directors reported generally positive, but lower levels of support for allocating resources to support home visiting and engaging in volunteer activities to support home visiting efforts.
- Community service providers and community leaders reported generally positive but lower levels of support for generating new revenue/resources for home visiting.

Exhibit 3.12
Support from Community Leaders: Insights from Community Stakeholders

How often do community leaders demonstrate support for home visiting programs in the following ways?

Type of Support:	*Home Visiting Directors (n=31)*			*Community Service Providers (n=53)*			*Community Leaders (n=29)*		
	Never	*Some-times*	*Always*	*Never*	*Some-times*	*Always*	*Never*	*Some-times*	*Always*
Participating in planning and developing home visiting efforts	9%	76%	15%	7%	76%	17%	3%	79%	17%
Partnering to provide necessary services (healthcare, early intervention)	0%	45%	55%	4%	67%	30%	0%	55%	45%
Allocating resources (funding, staffing, training) to support home visiting efforts	29%	61%	10%	9%	72%	19%	4%	71%	25%
Communicating importance of home visiting to the public/community	9%	81%	9%	11%	70%	19%	14%	71%	14%
Engaging in volunteer activities to support home visiting efforts	23%	71%	6%						
Facilitate development of new referral relationships				11%	74%	15%	3%	79%	17%
Generate new revenue/resources for home visiting				22%	71%	8%	21%	79%	0%

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey.

Plans for Expanding Home Visiting. A positive community climate and committed community leadership are fundamental for program development. **Exhibit 3.13** shows insights from community stakeholders about local support for starting or expanding home visiting services.

Exhibit 3.13
Support for Program Development

How strongly would community leaders support new or expanded home visiting efforts in your community?		
Mean score on scale of 1 (not at all) to 10 (very strongly)	*Community Service Providers (n=46)*	*Other Stakeholders (n=19)*
	6.5	8.0

Does your community have a coalition or an advisory board (other than your own) that addresses topics relevant to early childhood development, child health, trauma-informed practices, substance abuse, or other issues relevant to home visiting?	
Response:	*Community Leaders (n=29)*
Yes	17%
No	69%
Not sure	24%

Are there community members who would oppose implementing or expanding home visiting services in your community?		
Response:	*Community Leaders (n=31)*	*Other Stakeholders (n=19)*
Yes	16%	21%
No	84%	79%

Are you aware of any proposals that have been submitted for funding for home visiting or other early childhood services in your community?		
Response:	*Community Leaders (n=29)*	*Other Stakeholders (n=21)*
Yes	7%	24%
No	34%	43%
Not sure	41%	33%

Are you aware of any plans to start or expand home visiting programs in your community?	
Response:	*Community Leaders (n=42)*
Aware of plans to start new home visiting services	2%
Aware of plans to expand home visiting services	5%

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey.

As shown in the exhibit:

- Community service providers and other stakeholders surveyed believe (on average) that community leaders would be supportive of expanding home visiting services, (although this type of support is not perceived in every locality).

- Also, 16% of community leaders and 21% of other stakeholders believe there are community members who would oppose expansion of home visiting. Only 2%-5% of community leaders reported they are aware of plans to start new programs or expand home visiting.

- Sixty-nine percent (69%) of community leaders reported there was no community coalition or advisory board (other than their own) working on issues relevant to early childhood and related services, and 24% said they were not sure.

4. Capacity for Providing Substance Use Disorder Treatment and Counseling Services

In Virginia as in the nation, substance use disorder has been a growing concern for pregnant women, parents, and the children in their care. In this section we describe:

A. The consequences of parental substance use
B. Indicators of parental substance use in Virginia
C. Insights from community stakeholders
D. Virginia strategies for strengthening services
E. Opportunities and challenges for effective implementation

A. Consequences of Parental Substance Use

Prenatal and Infant Development. Research indicates parental substance use can have profound negative consequences for children, beginning before the child is born. For example:

- Maternal drug and alcohol use during pregnancy have been associated with premature birth, low birth weight, slowed growth, and a variety of physical, emotional, behavioral, and cognitive problems. (National Institute on Drug Abuse)[4]
- Research suggests powerful effects of legal drugs, such as tobacco, as well as illegal drugs on prenatal and early childhood development. (ACOG)[5]
- Fetal alcohol spectrum disorders (FASD) are a set of conditions that affect an estimated 40,000 infants born each year to mothers who drank alcohol during pregnancy, and children with FASD may experience mild to severe physical, mental, behavioral, and/or learning disabilities, some of which may have lifelong implications (e.g., brain damage, physical defects, attention deficits) (National Organization on Fetal Alcohol Syndrome)[6]
- In addition, increasing numbers of newborns are affected by neonatal abstinence syndrome (NAS), a group of problems that occur in a newborn who was exposed prenatally to addictive illegal or prescription drugs. (Virginia Department of Health)[7]

[4] https://www.drugabuse.gov/drug-topics/health-consequences-drug-misuse/prenatal-effects
[5] https://www.acog.org/patient-resources/faqs/pregnancy/tobacco-alcohol-drugs-and-pregnancy
[6] https://www.nofas.org/about-fasd/
[7] https://www.vdh.virginia.gov/opioid-data/neonatal-abstinence-syndrome-nas/#:~:text=Neonatal%20drug%20dependency%20or%20withdrawal,trembling%2C%20and%20increased%20muscle%20tone.

Child and Adolescent Development. The full impact of prenatal substance exposure depends on several factors. These include the frequency, timing, and type of substances used by pregnant women; co-occurring environmental deficiencies; and the extent of prenatal care. Research suggests that some of the negative outcomes of prenatal exposure can be improved by supportive home environments and positive parenting practices. (Child Welfare Information Gateway)[8]

The negative consequences of parental substance use continue beyond infancy. Children and youth of parents who use or abuse substances and have parenting difficulties have an increased chance of experiencing a variety of negative outcomes including:

- Poor cognitive, social, and emotional development
- Depression, anxiety, and other trauma and mental health symptoms
- Physical and health issues
- Substance use problems.

Parental substance use can affect the well-being of children and youth in complex ways. For example, an infant who receives inconsistent care and nurturing from a parent engaged in addiction-related behaviors may suffer from attachment difficulties that can then interfere with the growing child's social-emotional development. Adolescent children of parents with substance use disorders, particularly those who have experienced child maltreatment and foster care, may turn to substances themselves as a coping mechanism. In addition, children of parents with substance use issues are more likely to experience trauma and its effects, which include difficulties with concentration and learning, controlling physical and emotional responses to stress, and for and forming trusting relationships. (Staton-Tindall et al., 2013)[9]

B. Indicators of Parental Substance Use in Virginia

Multiple indicators show parental substance use is a substantial concern across Virginia.

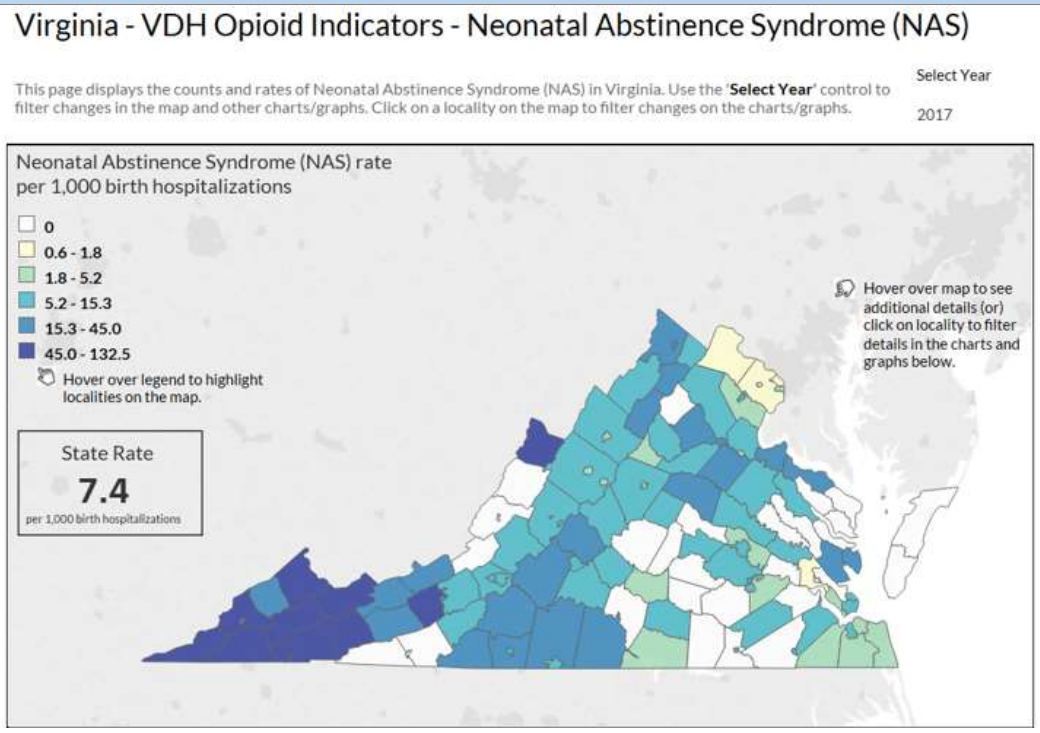
- As shown in **Exhibit 4.1**, NAS is a statewide issue, as reflected in the map showing the NAS rate per 1,000 live birth hospitalizations by locality in 2017. NAS rates vary remarkably across Virginia localities, with highest rates in rural areas, especially communities in southwest Virginia. (Virginia Department of Health, 2017)[10] NAS has also been increasing, as illustrated by the graphics showing trends in NAS rates and counts from 2012 to 2017.

- Separate data from the Virginia Hospital & Healthcare Association indicates that the number of NAS hospitalizations in Virginia rose from 741 in 2016 to 818 in 2017, followed by a drop to 742 in 2018. (VHHA, 2019)[11]

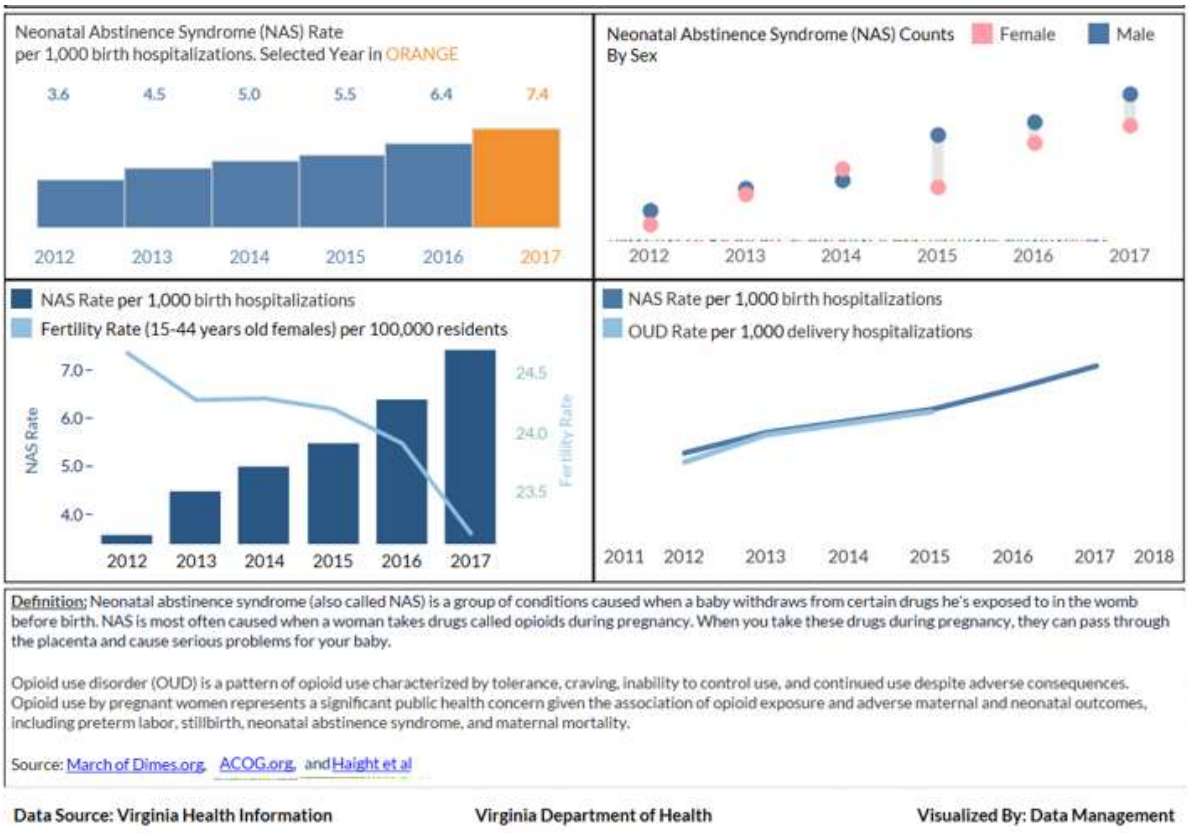
[8] https://www.childwelfare.gov/pubPDFs/parentalsubabuse.pdf
[9] Caregiver substance use and child outcomes: A systematic review. Journal of Social Work Practice in the Addictions, 13(1), 6-31.
[10] https://www.vdh.virginia.gov/opioid-data/neonatal-abstinence-syndrome-nas/
[11] https://www.vhha.com/research/2019/08/30/data-show-nas-birth-trend-largely-unchanged/

- Looking beyond newborns alone, in 2016 alcohol or other drug use was a contributing factor in child removal from the home in 2,223 child welfare cases, representing 29 percent of all removals in Virginia. (National Center on Substance Abuse and Child Welfare)[12]

Exhibit 4.1
Virginia Indicators of Neonatal Abstinence Syndrome



[12] https://ncsacw.samhsa.gov/research/child-welfare-and-treatment-statistics.aspx



Source: Inpatient hospitalization discharge data, Virginia Health Information; compiled by the Division of Population Health Data, Office of Family Health Services, Virginia Department of Health (2019)

C. Insights from Community Stakeholders

In a report provided by Project Link, local programs served 287 pregnant and postpartum women between 2018 and 2020. 77 of those women delivered infants while enrolled in the program. While Virginia MIECHV does not capture data related to substance use for the families it serves, the gaps in the services available to pregnant and postpartum women are evident across the state.

A significant service gap is access to residential treatment for pregnant and postpartum women. Virginia has eight dedicated residential treatment clinics in Virginia. Of those sites, not all of them will not allow a woman to bring her children with her into treatment. If they do allow this, there are many stipulations (e.g., age cut off, number of children that can be admitted with the mothers, rooms large enough to accommodate a family), that make utilizing the service difficult, if not impossible, for mothers who need it.

An additional gap is the lack of MAT providers in certain areas of the state. In southwest Virginia, there is a gap in accessing MAT services because the limited number of service providers cannot cover the large, rural catchment area in that part of the state.

Local Project Link sites also reported gaps and challenges in providing services. While the type of challenge it creates varies depending on the location of the program, lack of transportation is an issue reported across the board. One program located in rural southwest Virginia reported that "Often Project Link staff who assist with transportation have to leave the Project Link site at 6:00 AM in order to

provide transportation for individuals who live further out into more mountainous areas the catchment and ensure they arrive at the office at 9:00 AM for a three hour group, three times per week."

Other challenges reported by Project Link sites include not getting referrals prior to delivery and difficulty partnering with local departments of social services/child protective services. Another Project Link site reported that, "Many of our participants have had previous open cases with CPS and/or criminal histories. They face negative prejudices by legal and social services staff. This is further complicated by the participant's lack of communication skills, knowledge of individual rights and limited social supports."

Several of the challenges faced by Project Link sites are similar to that of home visiting programs in Virginia. Using the information provided for this needs assessment, MIECHV leadership will explore ways to strengthen relationships between local home visiting programs and Project Link sites, and address shared challenges in a collaborative manner.

Concerns about parental substance use are further illuminated by insights from professionals in the field. As shown in **Exhibit 4.2**, community service providers, community leaders, and other stakeholders surveyed for this needs assessment observe high levels of need for substance use treatment services for expectant parents and/or families with young children. The quotes from group interviews with home visiting providers illustrate the complications that can arise when assisting parents with substance use concerns.

Exhibit 4.2
Insights from Community Stakeholders

Observed Need for Substance Use Treatment

Please indicate the extent to which substance use treatment services are needed by expectant parents and/or families with young children in your community.

Response:	*Community Service Providers (n=57)*	*Community Leaders (n=31)*	*Other Stakeholders (n=20)*
Very needed	67%	58%	80%
Needed	26%	39%	20%
Somewhat needed	4%	3%	0%
Not needed	4%	0%	0%

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey.

Insights from Group Interviews with Home Visiting Providers

- *Meth and heroin are very big in the county I would say in the last couple of years. Those numbers have shot up I would think just from what we see.*
- *Part of our job as parent educators is to talk to parents about things related to parenting, but sometimes it's hard to get there…Or if they're coping with substances, for example, it's hard to really focus on parenting, in general. So, that's one of the challenges I experienced.*
- *There's a lot of drug addiction, drug use in our area and a lot of the families I work with have a criminal history a lot of times related to drugs. So that's an obstacle for them to be able to be eligible for certain services and even housing. So that's a challenge for them. So that's a pretty common challenge in our area.*

Source: Qualitative Summary Report for Virginia Home Visiting Needs Assessment.

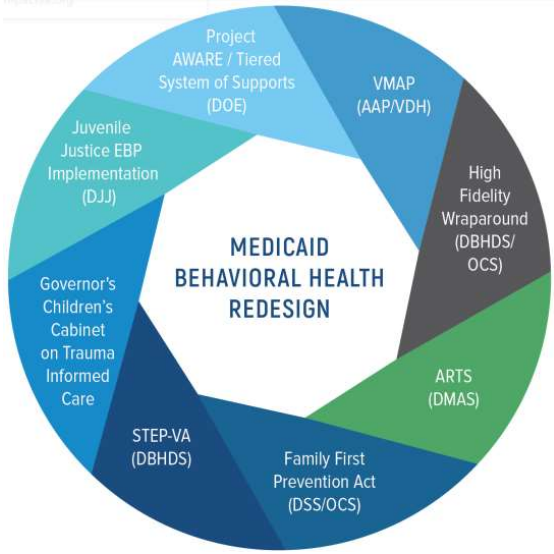
D. Virginia Strategies for Addressing Parental Substance Use

Virginia is implementing multiple coordinated strategies to help improve access to substance use treatment and counseling services for pregnant women and parents of young children. Key examples include Medicaid behavioral health redesign, Project Link, the Children's Cabinet, recent maternal and infant health initiatives, and the Family First Prevention Services Act.

Medicaid Behavioral Health Redesign. As illustrated in **Box 4.1**, multiple state agencies are collaborating to implement behavioral health redesign for Medicaid enrollees. The aims of the redesign are to:

- Keep Virginians well and thriving in their communities
- Improve behavioral health services and outcomes for members in current and expansion populations
- Meet people's needs in environments where they already seek support such as schools and physical health care settings
- Invest in prevention and early intervention services that promote resiliency and buffer against the effects of adverse childhood experiences.

Box 4.1
Medicaid Behavioral Health Redesign



Source: Virginia DBHDS

Project Link. Project Link is one key component of the behavioral health redesign effort. Project LINK is an interagency, community-based collaborative program designed to coordinate and enhance existing services to help meet the extensive and multiple needs of women and their children whose lives have been affected by substance use. Project LINK seeks to provide a full continuum of care by integrating prevention, early intervention, and treatment services with health care and other human and supportive services.

The Department of Behavioral Health and Developmental Services (DBHDS) administers and monitors 10 Project LINK programs throughout the state. Project LINK provides intensive case management, linkage to MAT, primary care, pediatricians and coordinates services for women and children who have a history, current use or who are at risk of using substances. Project LINK prevents gaps and barriers to treatment and is funded by the substance abuse block grant (SABG).

Project LINK currently partners with all 40 community services boards (CSB) in Virginia to deliver services to pregnant and parenting women. In Virginia, pregnant women are a priority population for SUD treatment services. A pregnant woman must be seen within 48 hours of a request for services with the CSB. If the woman cannot be seen within this time frame, she is provided interim services to include, but not limited to, brief counseling on pregnancy and SUD, access and coordination of OB/GYN and/or PCP, access to MAT or inpatient care, if needed. CSBs are required to contact the women's services coordinator with DBHDS when this occurs to assist with problem solving. Virginia has eight providers of inpatient treatment providing services to pregnant women and her children.

While Virginia has made strides to improve provision of substance use disorder treatment and counseling services, there are several barriers to treatment for pregnant and parenting women. Transportation is a barrier, especially for those women and families who are located in Southwest Virginia. Women need to travel farther, often well outside of their community, for services. In short, these services are not readily available in rural areas. Additionally, women continue to be fearful of receiving services due to the misunderstanding that child protective services will be involved, potentially leading to the possibility of having their children removed from their custody.

Currently, at the state level, a Maternal and Infant Health workgroup that includes DBHDS, VDH, DSS, DMAS, the Virginia Hospital and Healthcare Association, and other community partners meets monthly to focus on substance use issues. This group was designed to align the work of each state agency to meet the unique needs of this population.

Maternal and Infant Health Initiatives. Gov. Ralph Northam's budget proposal for FY 2021 and FY 2022 included a package of directives and funding to boost health care access and support for new moms and babies, as well as eliminate the racial disparity in the state's maternal mortality rate. Additionally, Virginia is completing the development of an innovative approach to improve coordination of services for families impacted by substance use disorder. *Pathways to Coordinated Care* is designed to ensure interagency collaboration and a comprehensive system of care to address the medical, mental health and social needs of families impacted by substance use disorder.

Family First Prevention Services Act. The Family First Prevention Services Act aims to keep children safe, strengthen families and reduce the need for foster care whenever it is safe to do so. Within Virginia, Family First services are coordinated by the Virginia Department of Social Services and operated collaboratively with other state and local agencies. Funding is available for trauma informed, evidence-based, foster care prevention services within the following categories:

- Mental Health Prevention and Treatment Services
- Substance Use Disorder Prevention and Treatment Services
- In-Home Parent Skill-Based Programs

The implementation of Family First has been extended to January 30, 2021. VDSS had several major Family First implementation activities scheduled for Spring 2020 that unfortunately have been cancelled and/or postponed due to COVID-19. These activities include training for specified providers in evidence-based practices and assisting localities in determining the needs of their communities which are critical to support the implementation of Family First. Implementing Family First remains a high priority for the Division of Family Services and implementation activities will continue with our state and community partners.

F. Opportunities and Challenges in Addressing Parental Substance Use

Virginia is facing both opportunities and challenges in addressing parental substance use and the related impacts on child health and well-being. The opportunity lies in collaborating across agencies at the state and community level to understand the needs of pregnant women and young families, and provide coordinated services for substance use prevention, treatment, and recovery. Potential benefits of this approach include more timely screening and intervention to help families avoid or reduce the profound

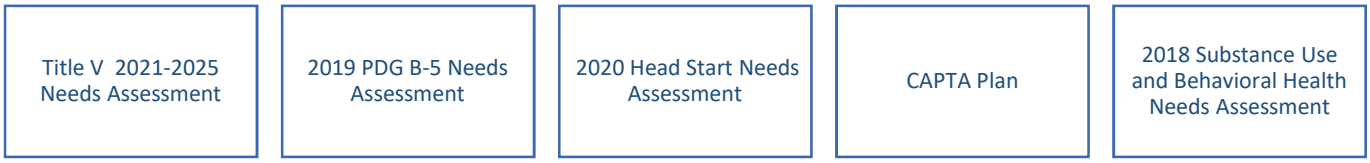
human and economic costs of substance use for children and parents. Home visitors can be key partners in this vital work.

Several challenges also arise as communities attempt to implement more coordinated models of family supports for addressing substance use issues. Funding streams must be aligned to support coordinated supports for families at the community level. Professional roles and responsibilities must be clarified as multiple agencies and professionals from different disciplines seek to serve families as partners who are facing multiple challenges. Systems and workflows for screening, referral, and follow-up must be designed, tested, and improved over time.

These operational requirements have implications for the home visiting workforce, including competencies, training, and supports that allow them to participate as partners with a manageable level of time and effort. As voiced in surveys and interviews conducted for this needs assessment, community service providers are encountering families facing multiple challenges that require intensive supports. Home visitors and other community service providers will need operating structures and professional supports that are agile, efficient, and tailored for the local context.

Section 5. Coordination with Other Needs Assessments

The **MIECHV Needs Assessment** was conducted in coordination with other needs assessment efforts in Virginia. Five of these studies are listed below and described in more detail in the following sections.



A. Virginia Title V 2021-2025 Needs Assessment

The Virginia Department of Health (VDH) Office of Family Health Services (OFHS) houses the state Title V program and complementary MCH programs. The Title V Team had the unique opportunity to leverage and align key needs assessment activities with MIECHV. Virginia's MIECHV program is housed within VDH OFHS, presenting prime opportunity to ensure combined efforts to gather the information and data required for both needs assessments. This opportunity ensured that programs avoided duplication of efforts, leveraged staff and fiscal resources, and aligned the data collected by each program. The Title V Director and the MCH Epidemiology Lead met periodically with Early Impact Virginia, a key Virginia MIECHV partner and facilitator of the state's MIECHV Needs Assessment. Data, tools, and information were shares seamlessly and utilized by both programs, and plans were discussed to ensure gap-filling efforts.

Every five years, Virginia's Title V Maternal and Child Health (MCH) Program conducts a statewide needs assessment of the health and well-being of women, children, youth, and families living in Virginia. The priority needs identified in the most recent needs assessment (for 2021-2025) are outlined below.

- ***Upstream / Cross-Sector Strategic Planning****: Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.*

- ***Community, Family, & Youth Leadership****: Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.*
- ***Mental Health****: Promote mental health across MCH populations, to include reducing suicide and substance use.*
- ***Finances as a Root Cause****: Increase the financial agency and well-being of MCH populations.*
- ***Racism****: Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.*
- ***MCH Data Capacity****: Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.*
- ***Reproductive Justice & Support****: Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.*
- ***Strong Systems of Care for All Children****: Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).*
- ***Maternal and Infant Mortality Disparity****: Eliminate the racial disparity in maternal and infant mortality rates by 2025.*
- ***Oral Health****: Maintain and expand access to oral health services across MCH populations.*

The state Title V program is in the process of increasing alignment of the goals, objectives, and metrics of various federal and state maternal and child health funding streams into a shared "Maternal and Child Health Agenda." A series of stakeholder meetings will be convened by VDH to review and contextualize the results from each needs assessment and identify opportunities for ongoing collaboration. This will leverage synergies through the collective impact approach to improve the health of women, children and families.

B. Virginia Preschool Development Grant, Birth through Five

In 2019 the Virginia Early Childhood Foundation published a needs assessment for the *Virginia Preschool Development Grant, Birth through Five.* Findings with relevance for home visiting programs include the following.

- ***Family Engagement****. Family engagement in planning and decision making is essential for positive preschool development. Parents can be engaged as partners in service planning for their own children. Parents can also be involved as key informants in parent policy councils required by federal funding.*

- ***Accountability and Measurement.*** *Shared data and clear accountability across programs and agencies can support planning, targeting services, evaluating outcomes and public investment, and advocating for resources.*

- ***Coordination and Communication.*** *Early childhood programs can create opportunities to prevent risk and minimize resources spent on remediation by identifying families and children who will benefit from support prior to, during, and after entering an early childhood program. Also, integrating elements of early care and education in policies and practices facilitates more*

comprehensive and seamless delivery of services and attention to quality early care and education across state agencies and programs.

- ***Finance.*** *Increased state funding levels can support resources for more than 30% of eligible children. Focusing on home visiting programs in particular, increased public expenditures in the last decade have allowed home visiting efforts in Virginia to expand, but funding remains heavily dependent on federal allocations and a lack of stable, predictable funding from year to year limits programs' ability to develop joint strategy and administration.*

- ***Data and Outcomes****. Individual programmatic and integrated data can provide insight on family service use. Shared data can be used to identify what programs or combinations of programs best serve children and families, including preventive assistance that minimizes remediation and supports positive outcomes for children and families.*

C. Virginia Head Start Needs Assessment

In 2019, the Virginia Head Start State Collaboration Office conducted a needs assessment of Head Start grantees within the Commonwealth of Virginia. The assessment included (a) examining the types and degree of relationships that grantees had with community partners and (b) identifying the level of difficulty associated with functioning in different areas. Key findings relevant for home visiting include:

- *Head Start grantees are continuing to develop new partnerships and strengthen existing ones. Relationships with providers for children with special needs, community services, and transition providers are stronger now than at any other time in the past.*

- *Current challenges identified by grantees are typically in the categories of health care, childcare, and professional development. At least 25% of Head Start grantees found it was difficult or extremely difficult to:*

    - *Ensure parents follow through with dentists' recommendations for children's dental care*
    - *Get full representation/active commitment on Health Advisory Committee*
    - *Get involved in state level planning and policy development around welfare/child welfare issues*
    - *Align policies and practices with other providers*

Several of Virginia's home visiting programs partner with classroom-based Head Start and Early Head Start programs at the local level. Enhancing the relationships between Early Head Start (and Head Start) home-based programs will further benefit families with young children in local communities.

D. Virginia Child Abuse Prevention and Treatment Act (CAPTA) Plan

CAPTA provides federal funding and guidance to states in support of prevention, assessment, investigation, prosecution, and treatment activities, and provides grants to public agencies and nonprofit organizations, including Indian tribes and tribal organizations, for demonstration programs and projects. Virginia's CAPTA plan is coordinated by the Virginia Department of Social Services and operated in collaboration with state agencies and local service programs.

- *Virginia's CAPTA plan includes targeted efforts to assure the safety of children within their homes by improving local department staffs' ability to properly identify and assess safety and risk factors within family systems and provide protective and rehabilitative services by focusing on the development and improvement of worker training, supervision, and formal tools.*

- *Emphasis has been placed on working with children under the age of two, children in out-of-family settings, substance-exposed infants (including the development of plans of safe care), receiving and responding to concerns of child abuse and neglect, and children diverted from foster care.*

- *Additionally, Virginia's CAPTA plan focuses on enhancing local department staffs' ability to utilize a strength-based, child-centered, family-focused, and culturally competent approach when working with children and families.*

Virginia's home visiting programs are part of the collaboration for CAPTA, and will continue to work with state and local partners to optimize use of CAPTA resources.

E. Virginia Statewide Substance Use and Behavioral Health Needs Assessment

In 2018 the Virginia Department of Behavioral Health and Developmental Services published the *Virginia Statewide Substance Use and Behavioral Health Needs Assessment*. Although the report is focused primarily on services provided through Virginia's state and community behavioral health system, a key theme of the report with relevance for home visiting is an emphasis on prevention and collaboration at the community level.

- ***Context.*** *Thirty-one prevention staff members from across the Commonwealth participated in SWOT (Strengths, Weaknesses, Opportunities, Threats) discussions, in which they identified several strengths and weaknesses of the prevention workforce, funding structure, and community services board (CSB) operations. In addition, participants identified external opportunities that could facilitate prevention work in the future, as well as threats that pose challenges to prevention work and may be areas to address in future years.*

- ***Strengths****. Virginia strengths include strong partnerships, coalition support, and passionate staff, all of which are essential to prevention work. CSBs are already successfully incorporating these items into their work in the priority areas.*

- ***Weaknesses****. Both CSBs and DBHDS highlighted funding, staff resources, and workforce skills as key internal weaknesses that hinder prevention work in the priority areas.*

- ***Opportunities****. DBHDS's emphasis on environmental strategies requires a switch from direct service to indirect, community-wide approaches. Many voiced the desire for additional trainings, support, and resources to shift their work in this direction.*

- ***Threats.*** *Larger trends in the cultural and social acceptance of substance use, and the alignment of funding with these priority areas, are perceived as major external threats to prevention work.*

- ***Recommendations.*** *After reviewing data trends, discussing with DBHDS and the State Epidemiology Outcomes Workgroup, and receiving input from stakeholders across the Commonwealth, three key areas for potential growth and action emerged:*
  - *Fund Priorities: Strategically impact priority areas by funding strategies and outcomes that address appropriate risk and protective factors.*
  - *Build Capacity: Support the prevention workforce across Virginia with training and peer learning opportunities.*
  - *Lead Initiatives: Lead efforts for statewide messaging, advocacy, collaboration, and decision-making that facilitate effective prevention work across the Commonwealth.*

Section 6. Conclusion

A. Summary of Major Findings

Box 6.1
Risk Factors in Need of Attention in Virginia

- Maternal mortality
- Infant mortality
- Maternal morbidity
- Access to prenatal care
- Low birthweight
- Preterm birth
- Teen pregnancy
- Child maltreatment
- Maternal substance use
- Neonatal abstinence syndrome
- Children with developmental delays
- Children with special health care needs
- Child maltreatment
- Food insecurity
- Economic distress

The **MIECHV Needs Assessment** is the product of a statewide collaborative effort to identify strengths and needs in Virginia's system of home visiting programs, with guidance from multiple advisory groups and insight from more than 150 community stakeholders. This section summarizes the major findings of the needs assessment in terms of four imperatives for home visiting in Virginia: addressing specific risk factors, collaborating to support community services, building community readiness, and listening to community stakeholders.

1. Addressing Identified Risk Factors

Section 2 of the report identifies a list of 74 (of 133) Virginia cities and counties as at-risk localities (also see **the needs assessment data summary tables (excel workbook).** for details). These localities include a mix of rural and urban communities that will receive priority focus as Virginia seeks to continuously strengthen home visiting services.

Of the 12 localities with no reported home visiting program (Exhibit 3.1), four of them – Brunswick, Buckingham, Lunenburg, and Prince Edward – fall into the highest quartile for concentration-of-risk. MIECHV will work together with their advisory council to determine how best to integrate the new list of 74 at-risk localities into the upcoming Request for Proposal process (Spring 2021).

This needs assessment will help MIECHV focus its efforts on addressing the array of risk factors that influence maternal, infant, and child outcomes. A list of these risk factors is shown in **Box 6.1**. In addressing these factors, it will be imperative to consider health disparities and health equity in efforts to improve access to home visiting services and other community services.

2. Collaborating to Support Community Services

Home visiting is a key asset for helping children and families achieve optimal health and well-being. But no single program or sector is equipped to fully address these risk factors on its own. Opportunities to increase collaboration include improving programmatic-level partnerships and systems-level coordination.

Enhancing the relationship between other home visiting programs and Early Head Start (and Head Start) home-based programs will further benefit families with young children in local communities. Targeting Early Head Start home-based programs to engage in existing workforce supports for home visiting in Virginia will help enhance relationships between them and other home visiting programs, and enable Early Head Start programs to provide more appropriate training and professional development to their home-based staff.

As outlined in *Section 3.1*, collaboration across the public and private sectors and across levels of government will be essential for producing improvement. Each of the following agencies plays a significant role in all or some part of the administration, funding, and delivery of home visiting services: Virginia Department of Social Services, Virginia Department of Education, Department of Behavioral Health and Developmental Services, Department of Medical Assistance Services and Virginia Department of Health.

The state Title V program is in the process of increasing alignment of the goals, objectives, and metrics of various federal and state maternal and child health funding streams into a shared "Maternal and Child Health Agenda." A series of stakeholder meetings will be convened by VDH to review and contextualize the results from each needs assessment and identify opportunities for ongoing collaboration. This will leverage synergies through the collective impact approach to improve the health of women, children and families.

The Governor and the General Assembly support the efforts of VDH to ensure that all agency professionals are collaborating. One of the many practical strategies for collaboration is to share results from various needs assessments addressing child and family needs in Virginia, as illustrated in *Section 3* and *Section 4* of this assessment.

3. Building Community Readiness

State level systems and supports are essential for supporting community home visiting programs. *Section 3.2* introduces a "framework for community readiness" as a tool for assessing family needs and strengthening home visiting services in Virginia communities. The nine elements of the community readiness framework are illustrated in **Box 6.2**. Early Impact Virginia plans to develop this framework into a practical toolkit that MIECHV community stakeholders can use to inform development of community capacity for home visiting.

Box 6.2
A Framework for Developing Community Readiness

- Assess needs for home visiting.
- Extend the reach of home visiting.
- Increase awareness of home visiting.
- Strengthen service capacity for home visiting.
- Support the workforce for home visiting.
- Implement evidence-based models for home visiting.
- Collaborate across sectors to optimize services.
- Foster a positive community climate for home visiting.
- Engage community leaders in supporting home visiting.

4. Listening to Community Stakeholders

State and local efforts to enhance and extend home visiting should be informed by community stakeholders including home visiting professionals and the families they serve. In this needs assessment we obtained input from more than 150 community stakeholders including home visiting professionals, community leaders, and others.

As outlined in **Box 6.3**, community stakeholders provided rich insight into the complexity of family life for parents with young children, especially when the family is in economic distress or a family member is managing a health or developmental challenge. Perhaps the most important insight is that home visiting is a deeply human service that works best when home visitors have time to develop trusting relationships with families.

Home visiting professionals also shared thoughtful analysis of the professional challenges they face in serving families with complex needs, along with ideas for how state and local systems can be better organized and coordinated to support their work on behalf of families. VDH and its collaborating partners will carefully consider these insights as the agency pursues multiple aims for strengthening the MIECHV program, home visiting, and other child and family services across Virginia**.**

Box 6.3
Stakeholder Insights about Community Capacity

- Building trust and relationships is essential for effective home visiting.
- There are high levels of need for a wide range of maternal, infant, and child services.
- Many families require intensive support to help them manage complex challenges.
- Attention to disparities and equity is essential for optimizing services.
- Resources and service capacity for home visiting are concerns in many localities.
- Home visiting programs face challenges recruiting and retaining professional staff.
- Home visiting professionals have positive views of professional development opportunities, and also offer practical ideas for improving education programs.
- Community support for home visiting is generally positive, but there is room for improvement in community collaboration and coalition building.

B. Dissemination Strategy

The **MIECHV Needs Assessment** will inform the systemic and statewide needs assessment for Virginia's home visiting programs that Early Impact Virginia has been mandated by the Governor and General Assembly to conduct once every three years. Additionally, the Virginia General Assembly has given Early Impact

Virginia the authority and responsibility to determine, systematically track, and report annually on the key activities and outcomes of Virginia's home visiting programs; conduct systematic and statewide needs assessments for Virginia's home visiting programs at least once every three years; and to support continuous quality improvement, training, and coordination across Virginia's home visiting programs on an ongoing basis.

In addition, VDH with the assistance of Early Impact Virginia will coordinate efforts to disseminate this needs assessment throughout Virginia. This needs assessment will inform efforts to develop community readiness and implementation strategy, including *Virginia's Plan for Home Visiting,* that supports MIECHV evidence-based models, as shown in **Appendix A**. A timeline of work leading up to this point, as well as moving forward into 2021 is outlined below:

- In 2019, Early Impact Virginia developed *Virginia's Plan for Home Visiting*, an outline for scaling and sustaining home visiting in Virginia.
- In 2019-2020, Early Impact and is conducting the Virginia Home Visiting Needs Assessment, legislatively mandated by the General Assembly, and also to meet the HRSA requirement for the MIECHV program.
- To accompany the needs assessment, Early Impact is creating a Virginia-specific Community Readiness Framework and Toolkit for use by state partners and local programs to operationalize the needs assessment and its related findings.
- After the needs assessment is complete, Early Impact Virginia, the Alliance for Early Childhood Home Visiting, and the Early Impact Virginia Leadership Council will use the community readiness framework and needs assessment to create the implementation plan for *Virginia's Plan for Home Visiting*. The implementation plan will have a special focus on strategic growth and sustainable financing that integrates Medicaid reimbursement and Family First Prevention Services Act funding streams.

These next steps will require a collaborative effort in which state, regional, and local organizations work together to optimize services for children and families.

Appendix A
Virginia's Plan for Home Visiting – The Framework

July 18, 2019 – Early Impact Virginia (EIV) is excited to announce that Virginia has adopted a plan to strengthen and grow home visiting in the Commonwealth. Virginia's Plan for Home Visiting was endorsed by the Children's Cabinet in May 2019, and is intended to guide the development of a comprehensive framework for coordination of home visiting program services within the early childhood system to ensure quality service delivery and sustainable growth. On June 5, 2019, Governor Northam referenced the plan and instructed state agencies to work to scale home visiting as part of his strategy to eliminate racial disparity in Virginia's maternal mortality rate by 2025. See the Governor's policy announcement here.

The Plan for Home Visiting was developed in collaboration with members of the EIV Alliance for Early Childhood Home Visiting. Alliance members represent Virginia's seven statewide home visiting models, as well as other early childhood partners from across the Commonwealth. Established as an informal collaboration in 2006, EIV has evolved over the years, and continues to improve coordination, build quality, and drive growth. Learn more about the plan and Early Impact Virginia's work to strengthen the home visiting system in the recently released EIV Annual Report 2019.

Virginia's Plan for Home Visiting is designed to capitalize on the system that is already in place, and build out a sustainable approach for the future that will yield the greatest return on investment and the best possible outcomes for Virginia's most vulnerable young children. To do that, our state needs to cultivate an agile and effective workforce, stabilize unpredictable, but essential, public funding streams and streamline administrative data collection and reporting so that programs can focus on putting families first.

What is the plan?
The Virginia Plan for Home Visiting is a framework designed to create a common understanding of our work and standardize expectations to facilitate future growth. The plan capitalizes on our existing system that includes diverse program models, best practice principles and quality standards. The plan is designed to unite all of the models under a broad understanding of our vision for home visiting that includes workforce development strategies, high quality services, streamlined administration, effective collaboration, and sustainable funding to yield the greatest return on investment and best possible outcomes for Virginia's most vulnerable young children.

Why do we need a plan?
Home visiting in Virginia is community-based and family-centered. Because communities and families have different needs, there are different models to meet those needs. While this supports our collective values and vision for services, it creates confusion among policy makers, funders, and families. Currently, less than 10% of the families in need are enrolled in home visiting services. Building a sustainable growth strategy requires a greater level of coordination across the field. It is important that we develop strategies to streamline our work by creating strong basic foundations for the field as a whole. These foundations create clear expectations for our stakeholders. Defining the key elements of our work creates the opportunity for supporting the highest quality services across communities and provides the framework necessary for shared growth.

How was the plan developed?
The Plan for Home Visiting, modeled after legislation that has passed in a number of states, was drafted by EIV Alliance members, including state home visiting leaders and state funding partners. The EIV Alliance includes state leaders from each program model, funding agencies and early childhood partners. Building on more than 10 years of collaboration through the Home Visiting Consortium, EIV was designed to support growth and sustainability across the field. EIV relies on the expertise of local providers and stakeholders, as well as state leaders in all of its work. The EIV Alliance works across multiple levels to guide the statewide home visiting agenda. Learn more about the Alliance structure and membership here.

Who is responsible for the elements in plan?
Because Virginia programs have well established systems for defining and assuring quality, there will be minimal impact on local providers. EIV Alliance Action Teams will develop recommendations for the key elements of the plan. Much of this work has been completed or is underway through existing Program Model Standards and EIV Action Teams, and EIV is committed to including local program staff and the voices of home visitors and families in their work as it continues. Visit www.earlyimpactva.org or contact us at (804) 359-6166 to learn more about how you can engage.

Virginia's Plan for Home Visiting: The Framework

WHY: Virginia leaders have long recognized the value of early childhood home visiting as an effective strategy for improving the health and well-being for families and their young children. Recent advances in the science around early brain development and the negative impact of childhood trauma and toxic stress on lifelong health have increased our understanding of the importance of investing in effective prevention strategies. Virginia home visiting programs consistently demonstrate strong evidence of effectiveness in a number of domains including maternal and child health, behavioral health, family self-sufficiency, parent-child relationships, and child maltreatment. Virginia home visiting programs are a proven prevention strategy for building resiliency and enhancing the overall health and well-being of families and the communities in which they live.

In 2015, the Commonwealth Council on Childhood Success recommended increasing Virginia's investment in early childhood home visiting to reach more families in need. This led to an annual increase of $6.75M in state funding for three Virginia home visiting program models; Healthy Families Virginia, CHIP of Virginia and Resource Mothers. Currently, more than ninety (90%) of the $33.7M invested in Virginia home visiting programs are public funds administered by state or local agencies.

The opportunity to strengthen the statewide home visiting system has been clearly identified by our state and local leaders. In its 2017 report, *Improving Virginia's Early Childhood Development programs,* JLARC finds that that Virginia's home visiting programs consistently demonstrate strong outcomes for families and communities. "However, these programs lack adequate administrative infrastructure to ensure effective coordination, evaluation, and planning across programs. The funding for voluntary home visiting programs in Virginia is unstable and difficult to predict each year, and this instability hinders the ability of these programs to operate in a consistent, strategic manner over time."

Virginia leaders acted swiftly during the following legislative session to address these recommendations by including legislation to support this work. The 2019-2020 budget signed into law by Governor Northam grants Early Impact Virginia *the authority and responsibility to determine, systematically track and report annually on the key activities and outcomes of Virginia's home visiting programs; conduct systematic and statewide needs assessments for Virginia's home visiting programs at least once every three years; and to support continuous quality improvement, training, and coordination across Virginia's home visiting programs on an ongoing basis.*

Virginia's home visiting system serves as an example of the important role that public/private collaboration can play in building effective, innovative approaches to service delivery. Sustaining and expanding home visiting services to achieve the promise of prevention requires a higher level of coordination across the early childhood system. While evidence based programming is essential to strong outcomes, so too is the need for maintaining model fidelity and efficiency to ensure the absolute best use of public and private investment. This document is designed to create the structure and expectations needed to support long-term sustainability. Capitalizing on the system that is in place and building a sustainable approach for the future will yield the greatest return on investment and the best possible outcomes for Virginia's most vulnerable young children.

WHO: The Leadership Council is convened by the Children's Cabinet – Health, Social Services, DBHDS, DMAS (HHR); DOE, Juvenile Justice, Commerce/Trade, and private partners

Early Impact Virginia member programs including CHIP of Virginia, Early Head Start, Healthy Families Virginia, Healthy Start/Loving Steps, Nurse Family Partnership, Parents as Teachers, and Resource Mothers.

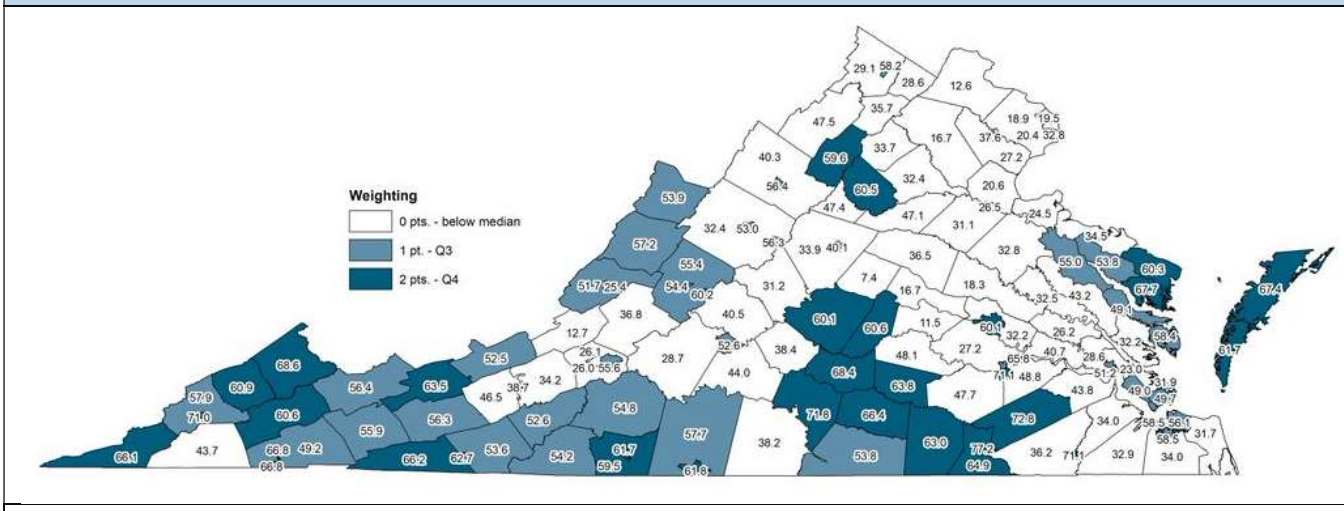
WHAT: Early Impact Virginia's Leadership Council will oversee the development of a comprehensive plan for the coordination of home visiting program services within the early childhood system to ensure quality service delivery and sustainable growth addressing the following key elements:

1. Qualified service providers
    a. Adopt Core set of competencies and required training for all home visiting staff;
    b. Adopt and implement professional certification based on competencies and DMAS provider criteria;
2. Quality Service Delivery/Model Fidelity
    a. Adopt Core set of standards and outcome indicators for programs,
    b. Adopt requirements for a monitoring framework;
3. Quality Assurance
    a. Adopt uniform reporting format for all state administered funding,
    b. Develop strategies to facilitate shared data collection and reporting capacity,
    c. Report demographic data and outcomes by and across program models,
    d. Conduct statewide needs assessments at least once every three years to identify gaps in home visiting service network;
4. Sustainability
    a. Funding strategies that promote quality, model fidelity, efficiency and accountability, including a common contract for home visiting programs (per plan definitions), consistent funding practices and support for the development and maintenance of the home visiting system including training, quality assurance, quality improvement and evaluation.
    b. Funding strategies that support sustainability through stream-lined financing strategies, diversification, braiding and promotion of cross-agency opportunities.
    c. Funding strategies that create stable, predictable revenue streams and leverage relevant statewide programs, including Medicaid, Family First Prevention Services Act, TANF, and so forth.
5. System Building
    a. All relevant child serving public agencies participate in statewide home visiting planning and evaluation activities through EIV membership,
    b. Develop strategies to increase awareness and identify eligible families at the earliest possible point.
    c. Promote cross-sector collaboration among relevant state organizations to reduce duplication and advance common goals:
        i. School Readiness Committee
        ii. Health Care providers (OBs, Primary Care Physicians, AAP, ACOG)
        iii. Federally Qualified Health Centers (FQHC) iv. DMAS and Managed Care Organizations (MCO)
        v. DBHDS and local CSBs
        vi. VDSS and local departments of social services
        vii. VDH and local health districts
        viii. Community action agencies
        ix. Universities
        x. Virginia Early Childhood Foundation/Smart Beginnings

xi. Virginia Hospital and Healthcare Association
xii. Virginia Association of Counties/Virginia Municipal League
xiii. Other key stakeholders

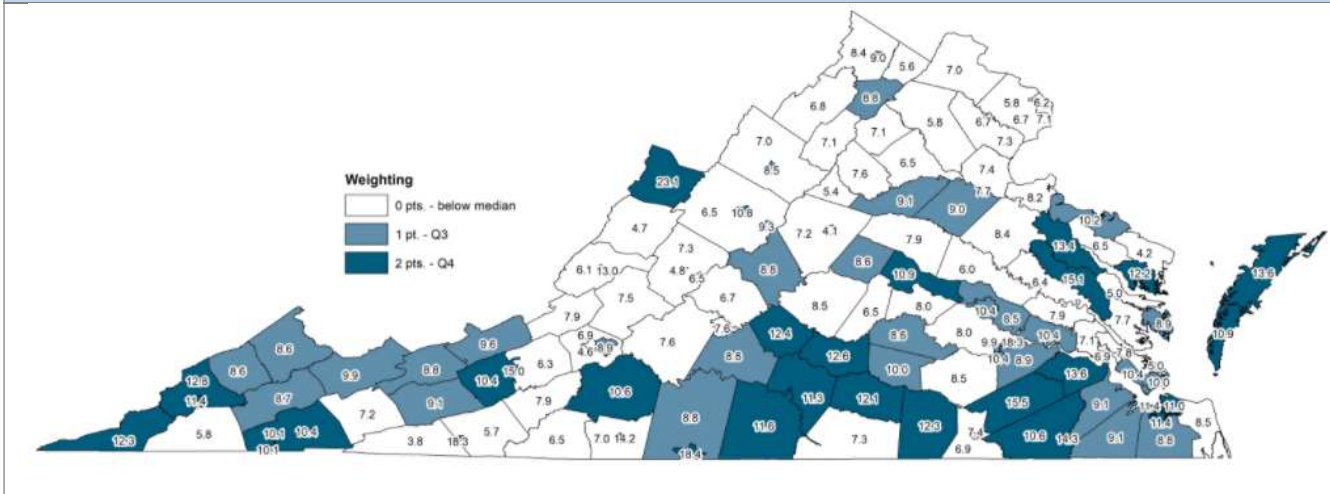
Appendix B
Needs Assessment Indicator Maps

Figure 1
Children Age 0-6 in Low-Income Households (2018)
(Weight = 0-2 points)



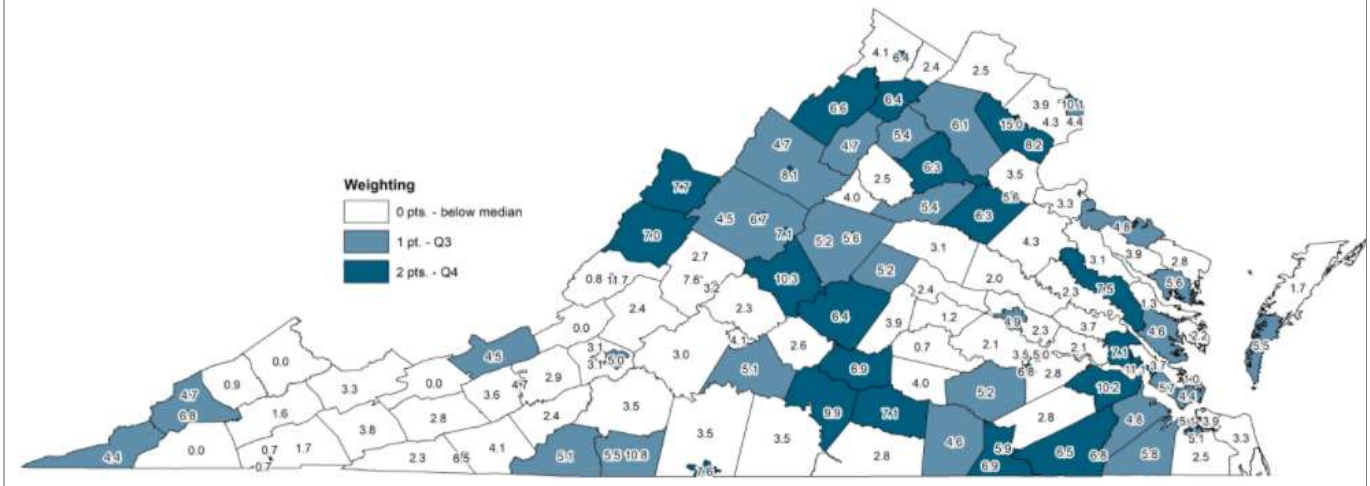
Source: EIV analysis of data from the United States Census Bureau American Community Survey.

Figure 2
Low Birth Weight Rate (2018)
(Weight = 0-2 points)



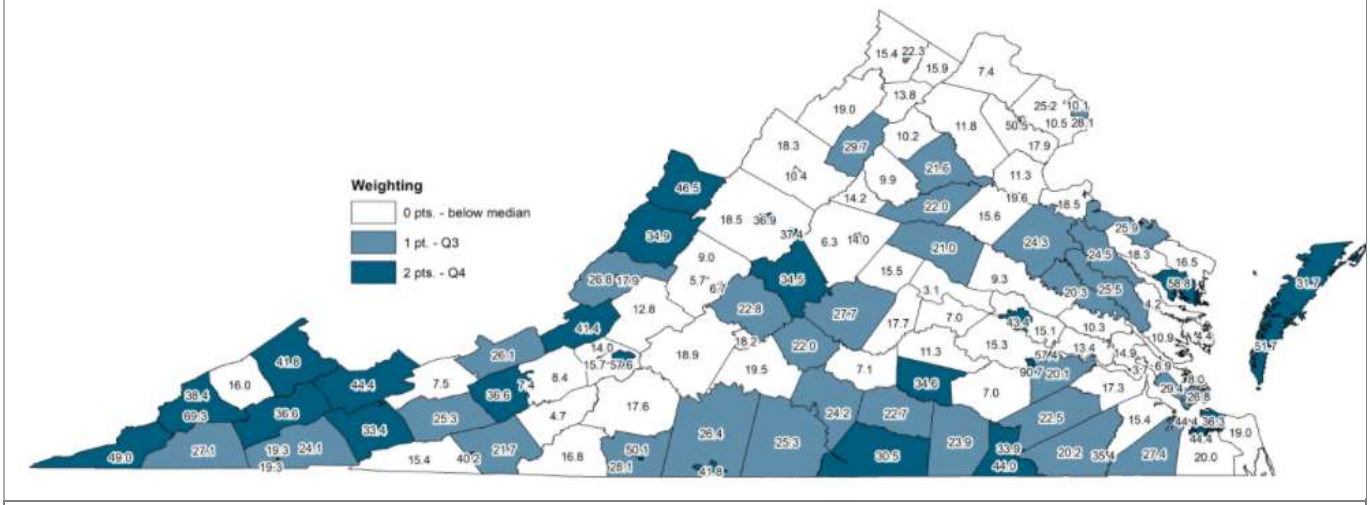
Source: EIV analysis of data from the Virginia Department of Health.

Figure 3
Late or No Prenatal Care Rate (2018)
(Weight = 0-2 points)



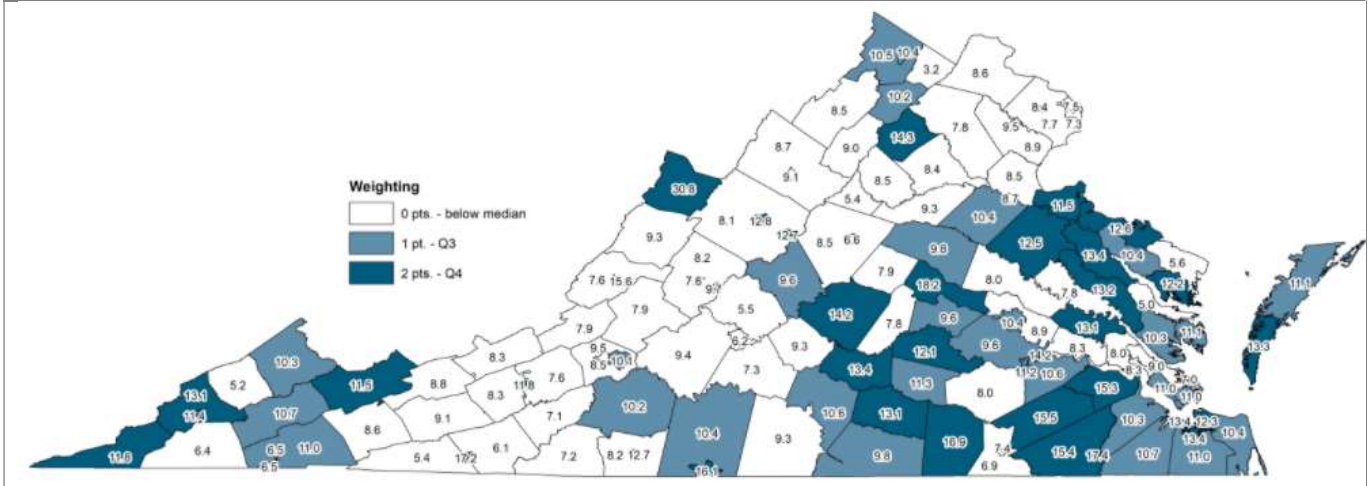
Source: EIV analysis of data from the Virginia Department of Health.

Figure 4
Teen Pregnancy Rate (2018)
(Weight = 0-2 points)



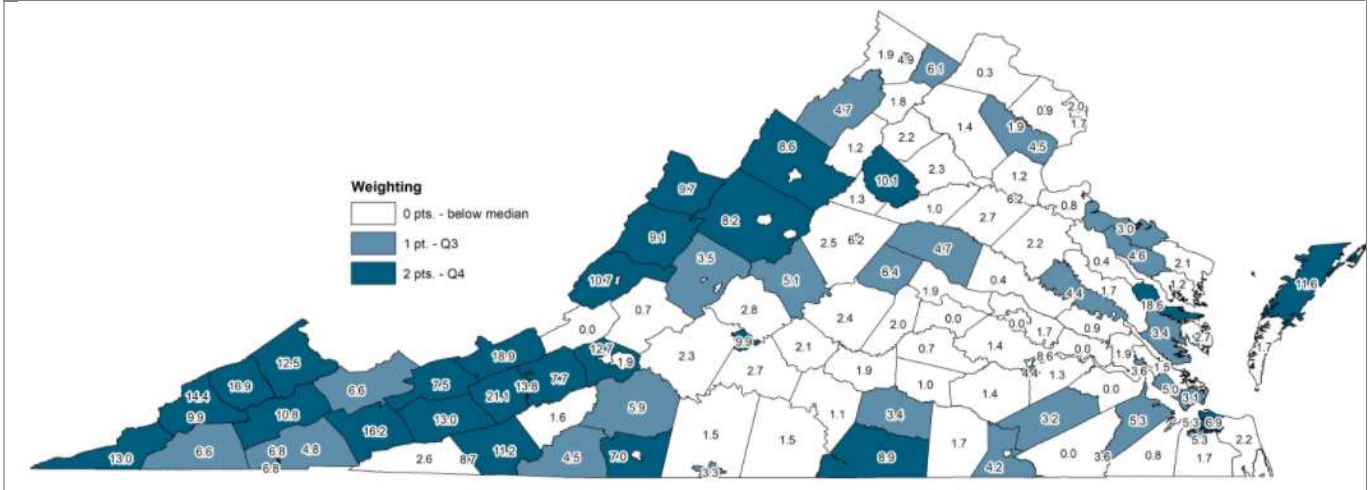
Source: EIV analysis of data from the Virginia Department of Health.

Figure 5
Preterm Birth Rate (2018)
(Weight = 0-2 points)



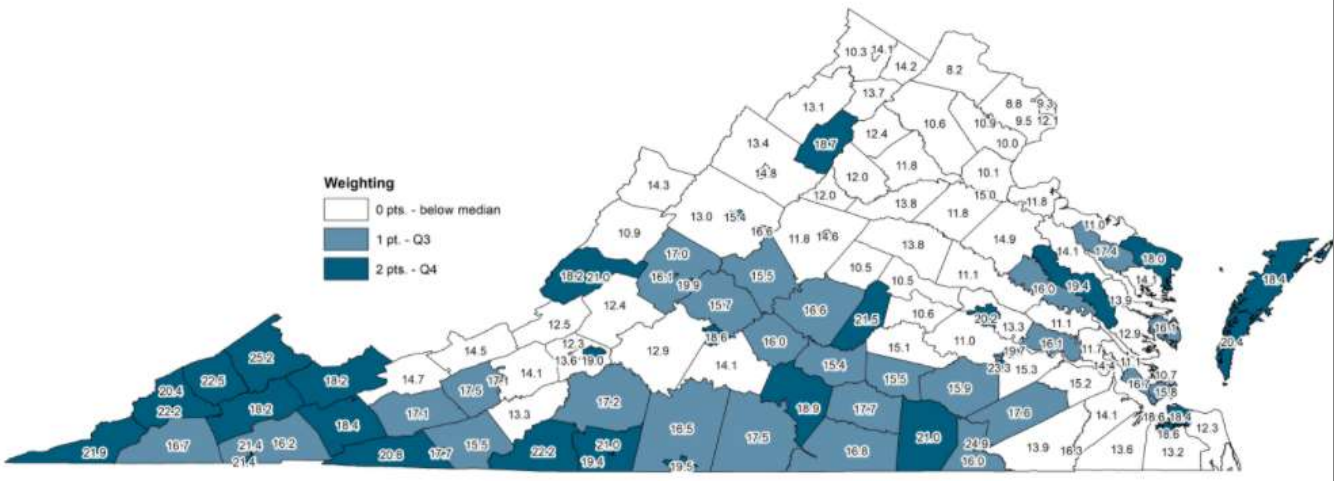
Source: EIV analysis of data from the Virginia Department of Health.

Figure 6
Child Maltreatment Rate (2016)
(Weight = 0-2 points)



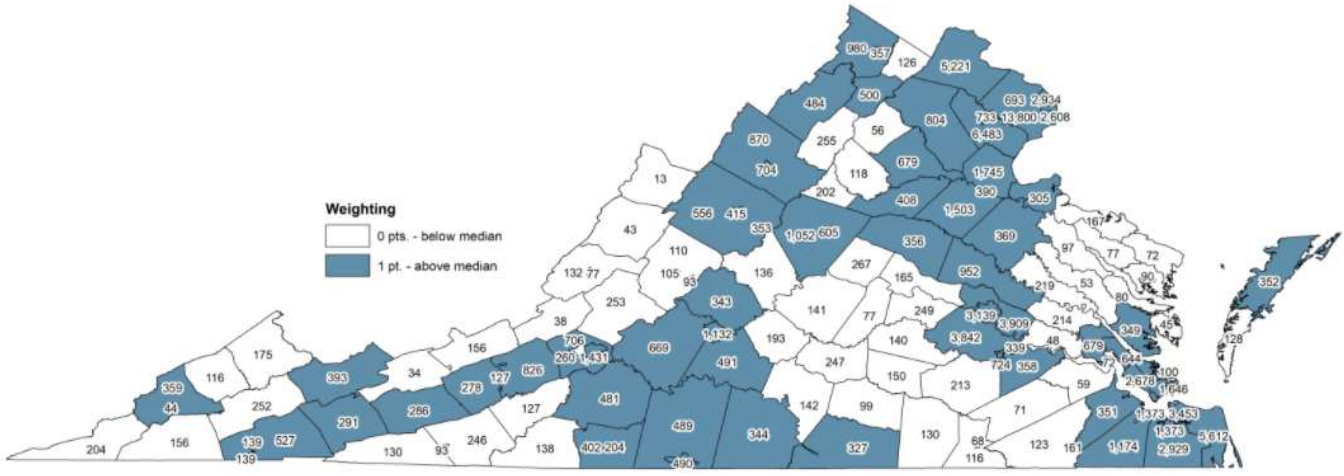
Source: EIV analysis of data from the Virginia Department of Social Services.

Figure 7
Children in Food Insecure Homes (2018)
(Weight = 0-2 points)



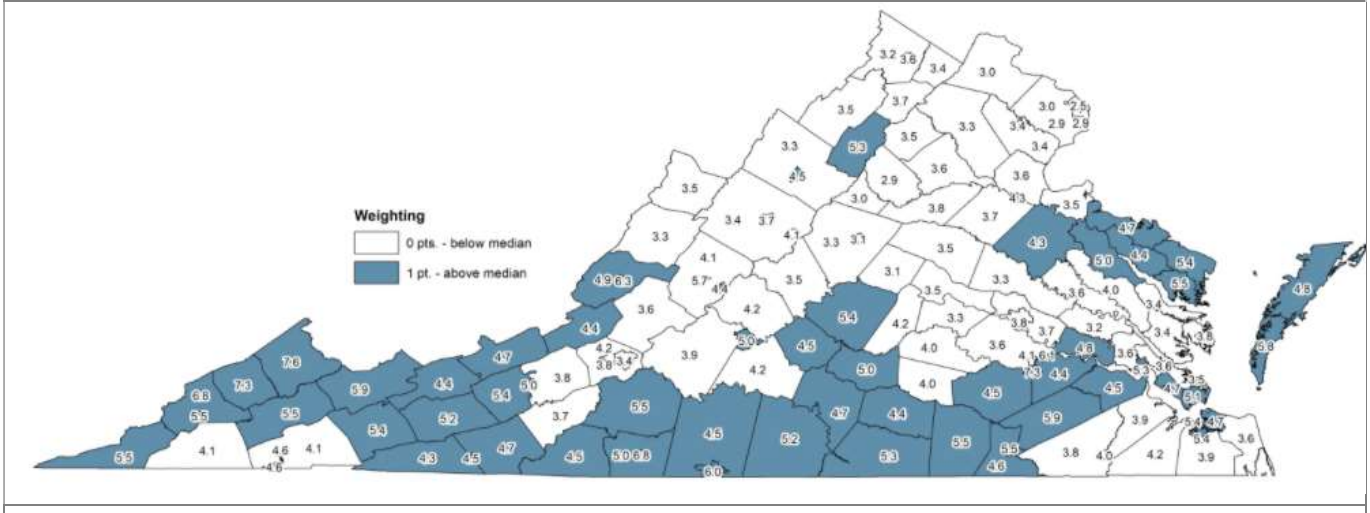
Source: EIV analysis of data from the Feeding America Map the Meal Gap database.

Figure 8
Live Births (2018)
(Weight = 0-1 point)



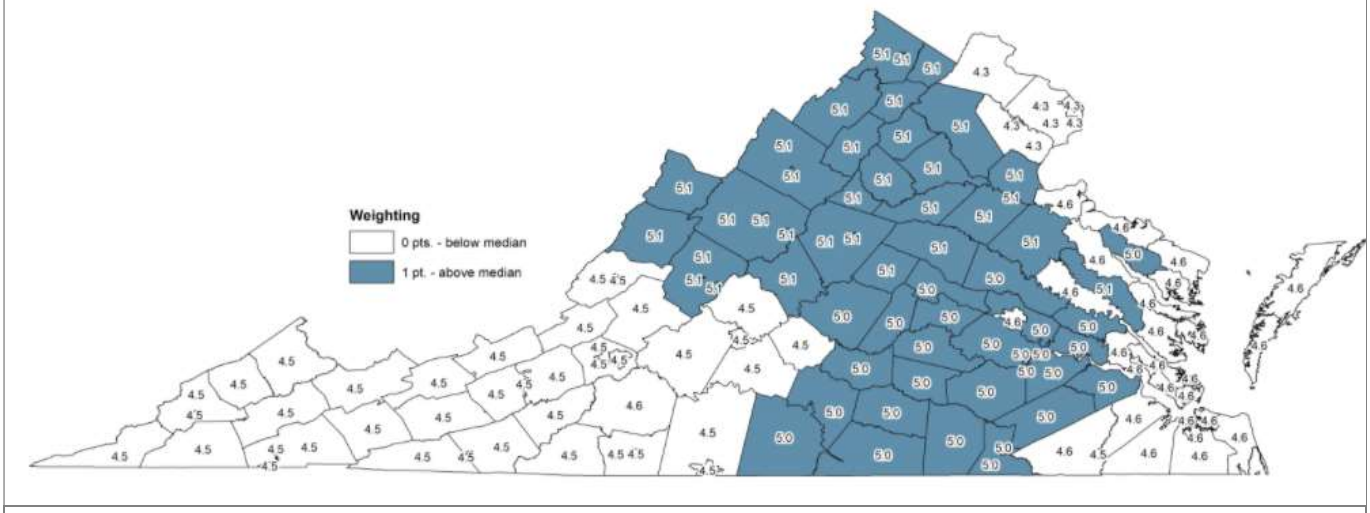
Source: EIV analysis of data from the Virginia Department of Health.

Figure 9
Unemployment Rate (2017)
(Weight = 0-1 point)



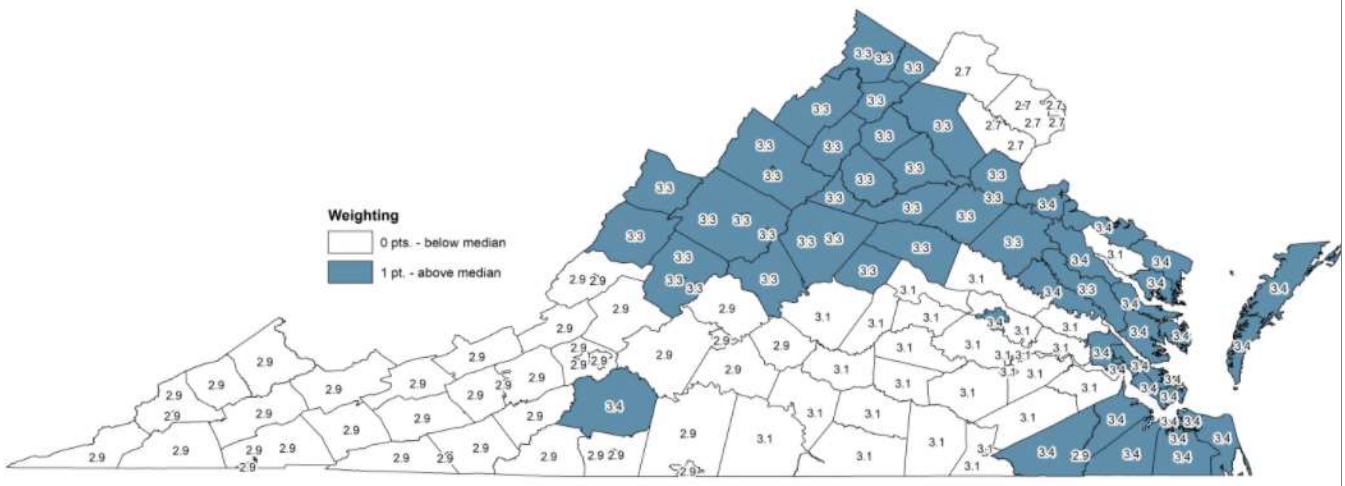
Source: EIV analysis of data from the Bureau of Labor Statistics.

Figure 10
Pain Reliever Abuse Prevalence Rate (2012-2014)
(Weight = 0-1 point)



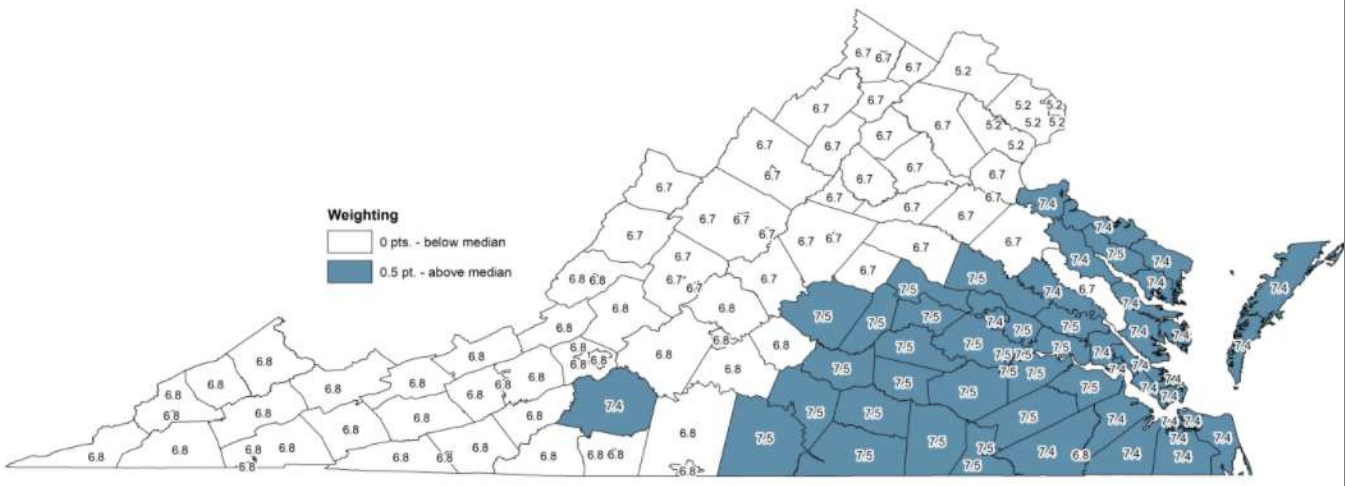
Source: EIV analysis of data from the SAMHSA National Survey of Drug Use and Health.

Figure 11
Illicit Drug Use Prevalence Rate (2012-2014)
(Weight = 0-1 point)



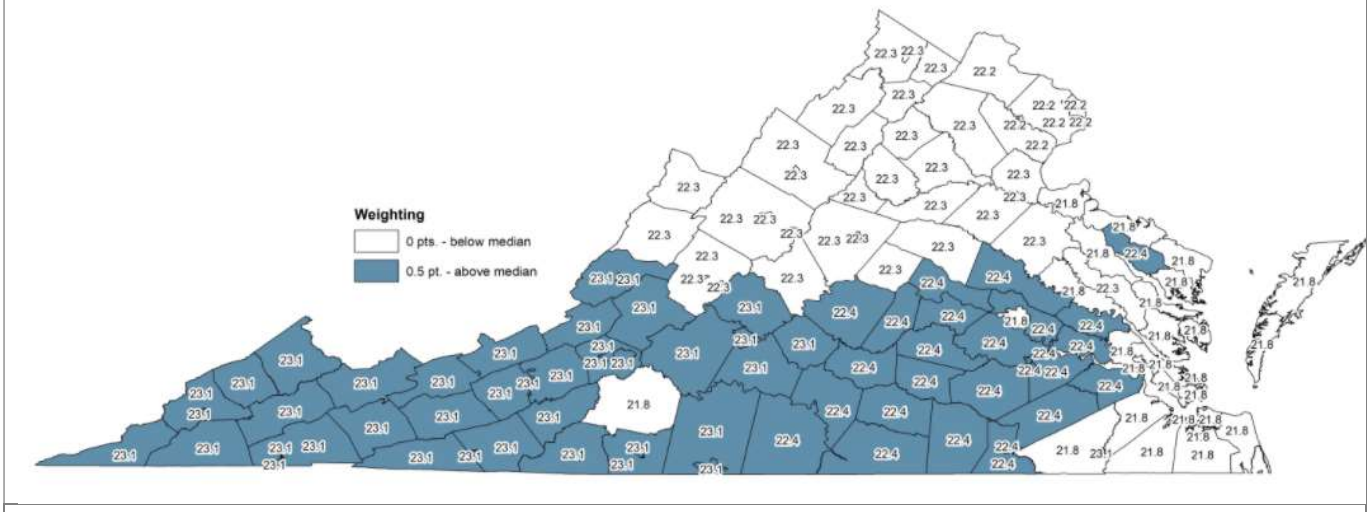
Source: EIV analysis of data from the SAMHSA National Survey of Drug Use and Health.

Figure 12
Marijuana Abuse Prevalence Rate (2014-2016)
(Weight = 0 – 0.5 points)



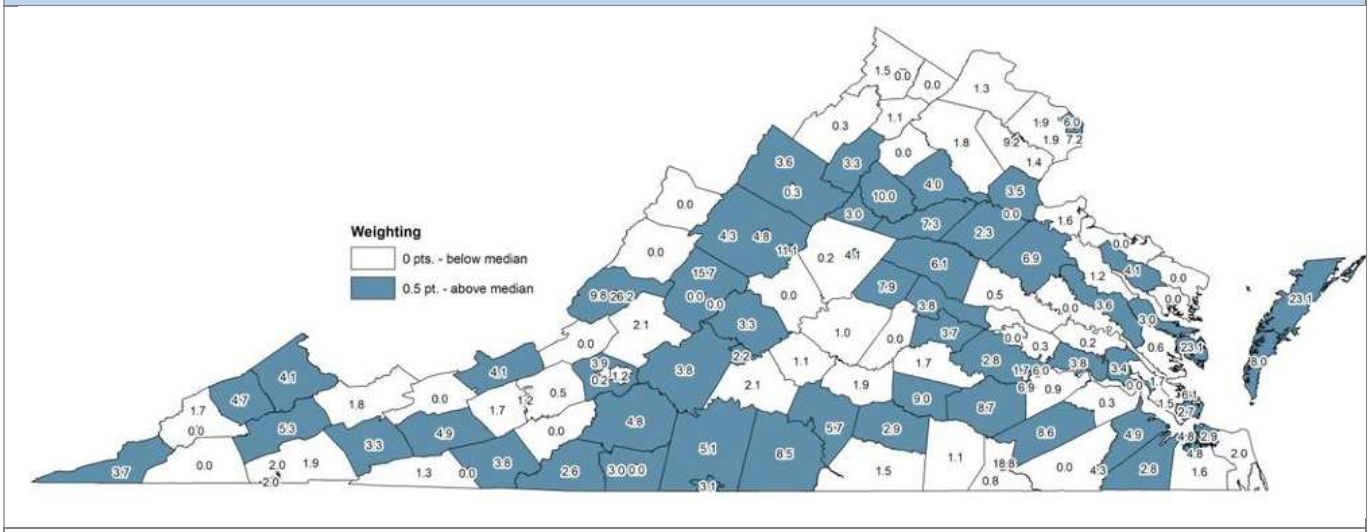
Source: EIV analysis of data from the SAMHSA National Survey of Drug Use and Health.

Figure 13
Alcohol Abuse Prevalence Rate (2012-2014)
(Weight = 0 - 0.5 points)



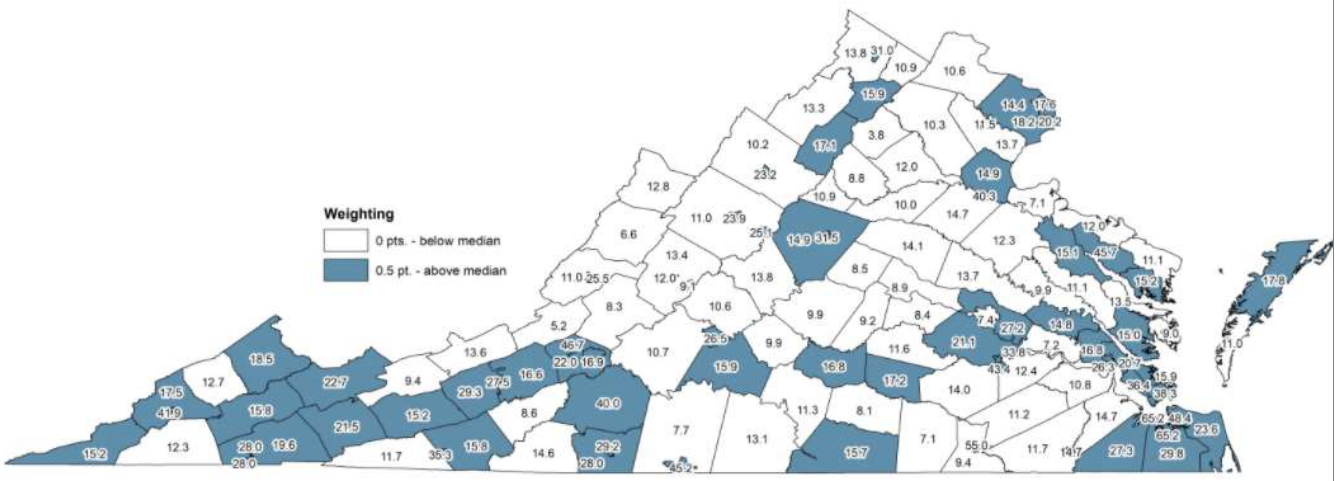
Source: EIV analysis of data from the SAMHSA National Survey of Drug Use and Health.

Figure 14
High School Dropout Rate (2017)
(Weight = 0 - 0.5 points)



Source: EIV analysis of data from the US Census Bureau American Community Survey 5-year estimates.

Figure 15
Crime Rate (2016)
(Weight = 0 - 0.5 points)



Source: EIV analysis of data from the Institute for Social Research at the National Archive of Criminal Justice Data.

Appendix C
Qualitative Summary Report for Virginia Home Visiting Needs Assessment

Early Impact Virginia Home Visiting Needs Assessment Qualitative Data Report

Prepared by

Kellie Carlyle, PhD, MPH

Table of Contents

HOME VISITING STAFF AND SUPERVISORS

Recruitment: Directory information for home visiting staff and supervisors was supplied to Dr. Carlyle's research team. In early 2020, each person was sent an email invitation to participate in a focus group (separate groups for staff and supervisors were conducted). In-person focus groups were held in March, before moving online in April due to COVID-19 restrictions. Due to COVID-19 impacts on participation, another round of emails was sent to all staff in summer with a final opportunity to participate in an online focus group.

Participants: Fifty-four home visiting staff and 17 supervisors participated in focus groups, for a total of 71 participants. In some organizations, staff implement multiple models (e.g. CHIP and PAT).

Region	Number of Participants
1	16
2	21
3	3
4	10
5	8
6	5
7	8
	71 Total

Model	Number of Organizations
Healthy Families	15
Parents as Teachers	10
Healthy Start	2
CHIP	6
Nurse-Family Partnership	1
Resource Mothers	2
Early Head Start Home-Based	1
Baby Care	1

FOCUS GROUP PROTOCOL FOR HOME VISITORS AND SUPERVISORS

*Note: different sections of questions were emphasized depending on whether the focus group was with home visitors or supervisors.

Let's get started by introducing ourselves. Please tell me your first name, which program you represent (i.e., CHIP, Early Head Start, Healthy Families, Healthy Start/Loving Steps, Nurse Family Partnership, Parents as Teachers, Resource Mothers) and how long you've been a home visitor.

These first questions are to help me understand a bit about the community you serve.

- Can someone please briefly describe the community? Is there anything else that anyone wants to add to the description?
- What are the most pressing challenges for your community?

[give one-pager with community indicators tailored to location]

- What is your reaction to these indicators? How do you see these issues play out in your community? Do you see any differences by race in the communities you serve?
- How do these indicators affect the families you serve?
- Do these seem to be the most important issues facing the families you serve? If not, which needs are most important for them?
- How do your programs try to address these needs? Which needs are more challenging to address? Why? Are there things that could make it easier to meet these needs?

Let's talk a little more about the specific home visiting programs and how well they are serving families.

- For your program, how do families become engaged with home visiting? What makes engagement easier? More challenging?
- Why do families stick with you? Why do they leave? (e.g., unable to meet their needs, aren't at the right stage of readiness, etc.)
- How are you figuring out why they leave (e.g., collect data, from what sources, anecdotal, etc.?)

- How often do you get families enrolled that aren't really a good fit for your services? (e.g. big chasm between child welfare and home visiting but there's nothing else there to help them, nothing else available in the community, etc.)
- Do you feel like your program allows you to give the parents what they really want or need to be successful?
- How are families involved in deciding how they will participate in the program?
- How much flexibility does your program give you to individualize services for each family? Are there ways in which the program restricts your ability to serve families?

Now that we've talked about how families enroll and engage with home visiting, let's talk a little about how you connect families with the other services that they may want or need.

- How do you know when a family needs a referral to community services? (e.g., is it something that you see in the home, something that the person says, something that you observe about the child/ren, or something identified through a screening process)
- What screening protocols or checklists do you use?
- What do you do when you think a family needs a referral? (e.g., give them info for an agency, help them make an appointment, help with paperwork, etc.)
- How do you know if they received the services you referred them to? Is there a formal follow up procedure?

Let's talk more about the resources available in the community you serve.

- What might make it more challenging for families to access resources? What makes it easier for them?
- What are the services/resources that you think your families need, but there isn't any place to refer them to? What creative ways have you found to address these gaps?
- Where would you put more resources if they were available? Are there any places you would hesitate to send some families, or have stopped referring to altogether? Why?
- What are the areas where you don't typically have problems accessing resources—where families immediately receive services?

As part of our process, we'd like to talk with people at other agencies in the community who might also serve your clients. We'd like your help in identifying who these agencies might be.

- Who are your top three partners in the community?
- Which agencies in the community would you like to partner with that you haven't been able to yet?
- Which other agencies do you refer families to that haven't been named yet? These could be referrals for substance use, mental health, domestic violence, developmental delays, food, housing, benefits, schools, employment and so forth***.***

Let's talk about how you or your organization coordinate with others to address the issues facing families in your community

- How do you coordinate with other agencies in your area? (e.g. referrals only or other ways?)
- What coalitions or coordinating entities like Smart Beginnings are you aware of in your community? (e.g., Trauma informed community networks, head start advisory council)

Tell me about your experiences with the offices at the regional or state level who help you implement your program or provide training or other supports (ex. Technical assistance contacts at VDH or Families Forward, Nursing Consultation, etc.).

- What has been particularly helpful?
- What would you like to see more of? What could the offices do differently?

- What do you know about Early Impact Virginia (formerly home visiting consortium)? In what ways do you interact with EIV? What has been particularly helpful about EIV? What would you like to see them do differently?
- How could EIV make your job easier? What supports would you like to see them provide?

We understand that this can be a very tough job and that there can be a lot of turnover.

- Who do you go to in your organization for support? Is it different based on the issue?
- What things does your organization do to help you feel supported? What things would you like to see them do to provide more support?
- What do you value most about your job as a home visitor?
- Tell me a little bit about what the onboarding process looks like for new home visiting staff members. Were there things you thought were particularly helpful? Things that could've been included that would've made it easier to get up to speed quickly?
- When people leave the organization, how are their clients transitioned?
- What suggestions do you have for keeping clients engaged when their home visitor changes? How can those relationships be maintained?
- What resources are available to ensure you feel like you have the knowledge and skills to do everything that the job asks of you? If not, what types of training or tools would be helpful for staff?
- How can EIV or your state office better support your professional development in ways that are meaningful for your personal and professional growth?

We really appreciate the work you do with families across Virginia. As the people on the front lines, what suggestions do you have for how to make home visiting even better for families?

- What would you like to be able to do that you aren't currently doing? What would make it challenging to achieve this? What would make it easier?
- If you could change one thing about your program that would allow you to better serve families, what would it be? (e.g., funding, screening requirements, policies, external factors, etc.)
- Within the home visiting system, where would you like to see more resources allocated?
- What other feedback do you want us to know about your state and national system?

Thank you for all of your comments today. Before we close, is there anything else you would like me to know?

FOCUS GROUP SUMMARY

THE FAMILIES WE SERVE AND THE COMMUNITIES IN WHICH THEY LIVE

The families served are diverse. There are many races and ethnicities represented; many do not speak English as a first language; refugee and immigrant families have concerns about documentation status. While a minority of organizations have an adequate proportion of bilingual staff, overall, there is a severe shortage across the state—both in terms of home visiting staff and health providers in the community. These clients also have notable difficulties navigating the U.S. healthcare and related systems. In addition, although differences may be magnified in rural areas, all regions highlighted the structural barriers that impact their clients, including lack of affordable housing and childcare, lack of accessible public transportation, and few employment opportunities or workforce development resources.

HOW HOME VISITING SERVES FAMILIES

One of the primary ways home visiting serves families is by connecting them to resources in the community; however, programs vary widely in the ways in which they help bridge the structural gaps, especially in regards to transportation and providing tangible goods to families. Because they are often the service providers most familiar with a family and use a trauma-informed approach, home visitors often serve as a "lifeline" for families, aiding families beyond the scope of their job. The supportive relationships between home visitors and the family are of utmost importance, often determining whether families stick with the program. When families do disengage with home visiting, it is typically because of staff turnover, families moving to a different service area, or other significant families issue arise.

COMMUNITY COORDINATION

There are some community coalitions related to early childhood and/or child and maternal health, but they vary widely in their organization and efficacy. In general, there is low reported community understanding of what home visiting is and how it can serve the community. This is compounded by the confusion of multiple home visiting programs in an area (which may or may not work together with a centralized intake coordinator). Most organizations expressed a desire for greater community collaboration and coordination, both within and outside of home visiting programs.

HOME VISITING STAFF REFLECTIONS

Having a "heart" for the job was described as the most important qualification for home visiting. Staff are generally satisfied with the onboarding process at the local level and very satisfied with the trainings from EIV. Many report high job satisfaction from relationships with clients, seeing their families accomplish goals, and their work environment and colleagues. While many participants appreciated the autonomy of their jobs, others felt that their positions were more rigid and that detracted from their job satisfaction. Several participants felt the caseload expectations were not aligned with the realities of doing the job on the ground. Similarly, participants expressed a desire for a greater understanding from supervisors of the context of their clients' lives and how those challenges impact home visiting. The low pay, lack of professional growth, and lack of appreciation for staff were the most commons reasons for staff turnover.

REACTIONS TO STATE LEVEL INVOLVEMENT

Experiences with TA/QA representatives across models was overwhelmingly positive. At the level of EIV home visitors were most aware of the trainings EIV provides and the conferences. The advocacy work at the state level

is very appreciated. Several supervisors noted a need for EIV to help identify where there is possible duplication and where programs can be more strategic about expanding to meet needs.

FOCUS GROUP THEMES

THE FAMILIES WE SERVE AND THE COMMUNITIES IN WHICH THEY LIVE

Demographics

Although some geographic areas have higher concentrations of specific racial or ethnic groups, overall, clients served by EIV programs are diverse. One person described their clients as:

> *A little bit of everything. Predominantly we work with Medicaid patients, so they are impoverished, most of my clients. We have a few military. We do have a few that we take on that don't exactly meet the Medicaid qualifications. But they have a need, a huge need of some support. And when I first started, it was a lot of single moms, but I do have some, a handful of married clients now as well. But the overlying thing is that there's just not enough money to make ends meet with these babies. They need to be linked to resources.*

> *So, our target population is just the working with anybody who children, prenatal through going off to school, up to age six. So, our average age is probably two-and-a-half-year-old. I think it's average. You average it all out. Race, ethnicity wise, we're probably about a 70% black, 20% Hispanic, 10% white mix for the ethnicities we serve in our program. And pretty much everybody's under the federal poverty line, 98%.*

> *We serve... right around 60 families. I would say probably just under a third of our families are refugees, primarily from Afghanistan. We have had a few other countries represented like Iraq we have right now. And so, we have... not quite a third, maybe like a quarter of our moms are Spanish speaking. The majority of them only speak Spanish. Some of them are bilingual. And then the remainder of our moms it's also still a mix. So, I would say we have a couple of moms who are not refugees, and not undocumented, but immigrants from Korea... Poland, other places. And then, everyone else is American and probably equally split between African American, Caucasian, and... a few moms who are Asian, but not from Afghanistan.*

Challenges Faced by Families

Some clients are undocumented and/or do not speak English as their first language. This creates barriers in accessing resources and navigating systems.

> *I work with a lot of undocumented girls. So that is very challenging just to get resources for them. They pretty much qualify for WIC and that's it*.

> *I would say 60 to 70 percent of our families are recent immigrant families and that has been growing in the time that I've been there. I would say our challenge for the families is there are not a lot of services for them that will serve people who are undocumented here.*

> *They're missing important phone calls because they'll call a doctors' office or someone important will call them, but when they pick up the phone they're speaking English, and instead of trying to find interpretation, I've had numerous moms tell me that they'll say no English, Spanish, and they'll hang up, and that is rude, very rude.*
> *Having worked for the health department, I know that they have language translation available for anything that's being sent to a person, and I know this with 100% certainty, and things still get sent in English.*
> *Families that have applied for Medicaid five times in a span of two months because they keep getting letters back in English and they don't understand what they're saying, asking for more documents, and*

they can't send the documents on time to get verified, because they don't know what's on the paper. I filled it out in Spanish, I got help to get this filled out, and then I get this paper and I don't know what it says. It shouldn't have to take them that long to get it, make it ...

The language barrier is tremendous. We don't really consider how, or at least I never considered how hard it would be to move to a country, not speak that language as my first language, and then trying to become a citizen. I mean, I read these documents. I was born here. I have all the resources I need to be able to understand these things, these applications for public, anything that you're trying to do to become on the pathway to citizenship, to get a job, to go to school, find childcare. Whatever it is, sign up for WIC. And some of these documents are confusing to me. So, I can't imagine if I don't speak English as my first language.

I would say challenges that my families face would be communicating, not amongst each other, but the system of which they're seeking help or assistance from. So, communication, 'cause not only are there language barriers, there's also cultural barriers.

There is also a lack of trust in the system and fear that accessing resources could impact their citizenship chances.

A lot of my mom's don't have [healthcare]. One, because they either can't afford it from the healthcare marketplace, or because they're scared to apply for it because of those new public charge laws. They don't know if it'll affect their path to citizenship. And there's just so much fear around it that it seeps into everything. And so, they don't know if they can keep getting WIC. They don't know if they can get subsidized childcare. They don't know what benefits that they can apply for without it impacting them, and so they don't, and it's hard.

I would also say other challenges would be from, as I think everybody, not just black American families, and Spanish speaking families, would be trust in the system. So, you definitely have to build trust also, and different structural rules set up by County government, or state government, or federal government sometimes can be barriers to accessing some of the things that they might need.

In addition to cultural barriers, clients also experience racism and other forms of discrimination.

A lot of my moms have expressed to me just daily racism that they face, and as a white woman, I mean, it's like I know it happens, but since I'm not the subject of it, I guess it's easy to forget how frequently it occurs. And it's an everyday thing for a lot of them, and a lot of it's based on religion too. Like some of the families I work with who are African American and Muslim, going to their temple, if it's in a white neighborhood, people don't like them parking there and getting out and will say things to them. So culturally, I think there's a lot of discrimination too, or lack of wanting to understand. I think another issue that a lot of my family's face, or the most common one, just people not taking the time to help them the way they would help a white person maybe.
I've had moms at the same hospital, great hospital, but depending on what race they are, some report first day in the hospital the nurses will really push them to breastfeed if it's a white mom, but if not then it's kind of instantly you should just use formula, don't worry about it, your baby didn't latch on right the first time, so it's fine, we'll just use formula. That's a huge difference, especially when we're talking about potential health of the mom and the baby to brush that off like that, but then you'll sit there and you're willing to try and get it to happen for other moms and families. That's just one difference, whereas the whole hospital experience, birth, recovery, all of that looks a little different, I'm sure, especially if people are dying, so yes, it's different.

And I think just access to quality prenatal care is also an issue. I feel like a lot of the families that I serve, if they have Medicaid, they have historical trauma of not trusting the medical systems. So, they are not always voicing their concerns, or if they are, they're not feeling heard.

Many of the mothers—especially new ones—seem to be isolated or lacking in support networks.

There's a lot of isolation that I see in the new mothers, especially, and where you try to get a feel for what their support network is. And there just really isn't anyone that they can lean on or anyone that they can get... Even just somebody to watch the kids in case of an emergency, just things like that. So yeah, that isolation is an issue that affects a lot of things.

The isolation, these young moms don't know how to reach out. They know how to do two-dimensional conversations on their phone. But they don't know how to develop the relationships they need to be a good mom. How to speak to their doctor, how to assert themselves for their child, how to hunt out resources. So, I spend a lot of times modeling and teaching them those things so that they are independent by the time they leave our program.

Some areas noted a heavy caseload of teen mothers.

The first one here, what caught my eye was the teen pregnancy rate. That's been an issue in Emporia for a long time. They have come up with different organizations and nothing seems to combat it. And we see it in our program. I have a lot of teen moms. My staff will be enrolling one this week who's 19, baby is 10 months old, and the next baby is due in July. I had another one who was 19, and last year she had a baby in January and another baby in October. So, it's a lot. We see everything here. Yeah, we see it.

While some home visitors did note issues with substance use, most did not find it to be as big of an issue among their clients as reflected in community indicator data.

We do have some addiction problems. I haven't had a lot of clients like that.

Marijuana very frequently, a lot of our families. And that they'll freely disclose that

I've gotten several referrals from people, and I'll make contact the first day, maybe even get to the first bit of the survey portion, and then they disappear, and you wonder, but both of them were heroin users, and involved in the methadone clinic. When you contact, it breaks your heart. You're like did you go back, are you okay, where are you? But after using my time to track them down and do our process, I have to close the case. It's definitely out there, it's definitely prominent. Marijuana is not great, but those families you can still work with. You just pretend you don't smell it. It's not like they're doing it in front of you. The harder drugs are drugs that people are sleeping or passing out. Sometimes you just don't know what you're going to walk into. We definitely see it.

Oh gosh, yes. Very much so, and especially in Louisa and Fluvanna as well. We have a lot of moms having babies that are born substance exposed and trying to get those moms connected with medication assisted treatment has been a big priority.

In some rural areas, however, drug use was mentioned more often.

But meth and heroin are very big in the county I would say in the last couple of years. Those numbers have shot up I would think just from what we see.

I wonder how accurate some of our drug use data is because I know from having gone into some doctors' offices some of the doctors don't report everything because depending on who the client is, who the person is ... Because I can remember one doctor's office, the mom was using opioids for pain. He was aware because he was prescribing it. Her numbers for edema were very high. Sitting there talking with her and her husband, they had two other children with them, and it was very obvious that they were not really getting any services. So, he was feeding them the medicine, but he wasn't reporting. And he was like, "Okay, just take these," you know? But I thought, because we were asked to come in his office and to help screen people and to try to recruit for our program, we thought he was being all deceptive. When we were trying to talk to him about it, he was like, "Yeah, yeah. Don't worry about her. I got her, I got her," but he's not reporting. He wasn't reporting all that. I've seen that too many times.

Common Structural Barriers Across Communities

There are common structural barriers across communities, including lack of public transportation, affordable housing, childcare, and employment opportunities.

Yeah, finances, transportation, housing, just overall limitations to being able to access resources.

I have another mom who ... She's a real go getter. She'd get on the bus, take her first child to daycare, take her second child to school then go to work. And then turn around and do the whole thing backwards. With limited income paying for the bus fares. So, it's transportation. They can't get in for appointments. They don't plan well to use the Medicaid cab for things. So, transportation and housing is a big one. It's hard to think about where your child's at developmentally when you don't know where you're going to lay your head to sleep.

Because it's hard to find affordable childcare. And probably more than half of our families would qualify for the childcare subsidy offered through DSS but there's no place that offers it.

It's the lack of quality affordable childcare. And we did have several daycares that did accept the childcare subsidy, but they no longer accept it because it wasn't getting used through the system in the correct way. They decided they weren't going to accept it.

Something we haven't mentioned was childcare for the other kids. That's a big thing, and doctors not wanting other kids there or Medicaid rides not taking other kids, or not having the car seats if you need to bring everyone. So, that's in addition to transportation.

Well, I was going to say, we can tell them about the resources, but if they're working at McDonald's minimum wage, $165 for a newborn baby in our area is more than what they would be bringing home.

I wish there were more resources that were easier to access regarding work development [. . .] I wish that that was something easier to help families get.

I do the Richmond area, and coming from New Jersey, where transportation is really accessible... When I moved down here, I was like "Oh God." You actually need a car, bus, a van or something. And transportation is the number one, besides childcare, issue that a lot of my clients, if they get a job, they can't keep it long, because like, "I got to find childcare and transportation." I have a client who just started school and her child goes to school about half day, but she gets, the client herself get out at one o'clock. So, she need that babysitter for that period of time. And then she needs a babysitter for Monday because her child goes to school Tuesday, Wednesday, and Thursday, and then she's figuring out by the time I get the bus from school, so it will normally be maybe an hour, but because she don't have transportation, it'll

take longer for her to get to her child. So those are the two biggest issues that I hear constantly: transportation and childcare. Affordable childcare.

If they're in a place in [Henrico] where the bus doesn't go to and they have to walk another mile, that's setting them up to fail. There's so many things that are a barrier for them, that is not something tangible that we can say, "Well, they just need this." But they can't get to it. It's always some sort of barrier that is systemic. That is not the client's fault.

Geographic Differences

There are important differences based on geographic region. For example, rural communities face unique challenges.

For our community it's a very rural area. We have a lot of families that do not have a car, they don't have a means of transportation. Also, there's very limited resources in our immediate region. So, for them to be able to seek certain services, they have to go a whole lot further distance which is also a challenge when they don't have transportation. And also, there's a lot of drug addiction, drug use in our area and a lot of the families I work with have a criminal history a lot of times related to drugs. So that's an obstacle for them to be able to be eligible for certain services and even housing. So that's a challenge for them. So that's a pretty common challenge in our area.

We serve a poor county area, and a few of the counties in our, well actually three of them in our region do not have a hospital where they can go within that county and deliver a baby. So, they have to go outside of their county to even be able to access that care.

Richmond

I have a lot of clients in Richmond. A lot of my clients are in public housing, and for the most part the ones that I have that have appointments, they keep their appointments. What I have found is that a lot of my clients who are in all of the counties, who started as referrals, and I ended up somehow getting the enrollment appointment, they were basically homeless. Those are the ones who are the hardest to retain, because you don't know where you're going to be the next day, so how do you know where you're going to have an appointment at? That's a huge challenge, no matter what county or city it is. If they basically have instability, instable housing, that's a problem. The ones who are in public housing are more likely to keep their appointments, because they have housing. If they're not working, they're more available.

I would say for the folks in the inner city Richmond area, which a lot of the clients that I work with live in, have experienced adverse childhood experiences, like you were talking about, and generational trauma. And so, with that comes an elevated risk of mental health issues, physical health issues. So, I think that is very common for the families that we work with.

So, we're in a city slash suburban environment with the families we have. So, transportation depends on where they are. If they're right in central Richmond, there's the GRTC bus system, there's the Pulse, but that you got to be just in the right place. And the bus system is very clunky. It still could be a number of transfers, and if you're lugging a baby in a stroller. So, transportation is still a big challenge for a lot of our families in isolation. And access to, I mean even though we, we are pretty rich with some resources and other nonprofits, or we got VCU, and we got Catholic charities, different things like that, getting in with them, the demand is larger because the population is larger. Accessing those resources. So, getting in to get mental health, medication, medical, all those things like that is still a big thing for our families. Especially our families who don't have legal status, trying to get in with the clinics, the couple clinics we do

have that serve uninsured. So yeah, that's probably our biggest challenges that folks face. Because without those two things, it's hard to function.

The poverty is so densely populated in Richmond. People are right on top of each other. That's why crime spikes when it's hot outside, everybody's irritated on top of each other and they're out on the streets and before you know, it, there's more gun violence and more fights and things like that. And our families live that every day and that contributes to these other stress factors. The illicit, the alcohol use and marijuana use and preterm birth and things like that.

Chesterfield

I think the county likes to project an image of affluence and that certainly does exist in Chesterfield County, but there are pockets of poverty too and I think those... That's typically the families that we serve. So, they tend to get overlooked in terms of services because the county likes to project that we don't have people here who need those services, and transportation is an issue there too. And not because there's probably not money for that, but that's just something the county chooses not to do [...] And the services are not there for... Even forget about poverty, just working class, like you can't even get universal pre-K unless your child has a disability because they feel like most moms are stay-at-home moms or whatever. It's this image of Chesterfield County being more affluent than it actually is.

Petersburg

Petersburg is kind of rural. It's not a city, it's a small town versus a city, but for this area, it is a city. Challenges would be getting consistent participation, not only from the participants who are receiving services, but even from members of the community to be on the consortium, or can, and I think a lot of that has to do with people are just really spread thin. In addition to that, transportation is a big issue.

Petersburg itself, there's no infrastructure, there's everything, like the schools that the children are going to, are terrible. I hear the horror stories, every day. Going to social services is extremely challenging. Finding a job is really hard, and how do you feed your family? Even going accessing food banks. It's like show up on this date, bring this, all these things. And if you don't meet one mark, you don't get food that day. So, everything is really hard. That is really challenging for folks, and it kind of shows in the data.

The difference between what's available resource-wise in Petersburg and Hopewell, and what's available in Chesterfield and Richmond city is vast.

Westmoreland

I'm glad that you say that because that's one of the biggest problems that we have in Westmoreland or ... well, in the 10 counties, there's no resources. Even for a pregnant woman teenager that comes to me and throws herself to me and says, "I didn't take your calls because I'm very depressed." And I'm like, "Okay. So, let me just hold CFP right now," because she say, "I'm pregnant." She's- […] And then she'd say she's trying to commit suicide. No, she's not okay. Well, let me see what appointments we can get because we have a waiting list. Kidding me? She's pregnant. She's already going to be in the postpartum depression. Somebody have to do something. So, I call her doctor and then Thursday, we're going to go to a doctor to see if they can do something. But there's no resources around right away to help these girls.

Emporia, Greensville County and Sussex County

Yeah. It's very rural as well. So, in an addition to the resources that was a limit is also like transportation barriers. And then also education is not very much a goal. It's a goal, but it's not really accessible to a lot of

the population that we serve. We're in an impoverished community. It was a very high rate of poverty for all three of the areas in which we serve. My population that we serve with our program is predominantly African American, but we do have a small percentage of Caucasian and Hispanic parents. Our challenges for our community are finding enough local resources to really support the needs of the families. And what we find is that as we always talk about when home visitors and stuff, we get together, there are things in silos. And you have this over here and this over here, but nobody really knows what the other is doing. So, resources is a big thing. A lack of them is a big thing in our area.

Charlottesville

I would want to expand services so that we could serve families in Greene County cause that's a County that no one can serve. Rosemary's program doesn't serve, the Healthy Families that is a little north of us doesn't serve. It's like this no man's land where no one can go. So, I would try to expand our programs so that we could serve those families as well. And maybe Buckingham too, while I'm at it, 'cause I don't think anyone goes there either.
And Nelson. Nobody's at Nelson either.

HOW HOME VISITING SERVES FAMILIES

Connecting Families to Resources

Home visiting programs vary widely in the ways in which they help bridge the gap in transportation needs for clients. Some programs have their own vehicles, some are part of state programs that have access to vehicles, some transport clients in their personal vehicles, and others are not allowed to transport clients at all. In addition, some have access to vouchers for buses or other forms of public transportation that they can give to clients.

Yes, I have many families that do not have transportation, so if for some reason they can't get the cab, then it's our responsibility to get them to their appointments, whether it's a pregnant mom, an infant, a child. I mean, we need to make sure that they have medical care and they get that medical care.

Well, we link families to resources in the area. We help provide transportation if necessary, so that they can get to these agencies or resources, they help them out.

I think with the program with all the things that we try to do is try to get them connected to resources, if one of those resources doesn't work then try another. We do a lot of calling for them if they can't do that. They don't have to do the calling. We have clinical social workers that work for our organization that we also offer to them. We really try to support them in all the different ways that we can to address one of those needs, but the fact is we can't always help them with all of them because there are many challenges like that they do have, and the best thing you can do is let them have someone to be able to get the problems, to be able to talk about their problems, and be able to have an outlet or someone to lean on, than maybe presenting them with a physical solution.

I think, going back to like the transportation being a big issue, especially for the Henrico program, our budget is like $20 for the whole year and it, and it costs $15 to get one family somewhere. So, we basically don't have the budget or ability to do that, even though we're telling about all these things they could do with their family or even groups that we might be hosting and they just can't go. So that's, I feel like, kind of a slap in the face to be like, "Oh, here, go do this. Just kidding. You can't."

Some programs have strong partnerships in the community with diaper banks and other organizations that provide free resources for the families. Home visitors can take these tangible products with them to visits which helps open the door and build the relationships. In other communities, no such resources exist.

> *We do provide diapers. Not enough for them to never have to go out and buy them but we help with bringing diapers and visit sometimes. We've received donations of baby items and clothing. So, if sometimes we will provide a family with those if they're in need.*

> *My family, if they need diapers, I have diapers at my office. I can bring them all year long, wipes. Whereas when I worked in Petersburg, we didn't have hardly anything to offer them in terms of ... I don't have anything to eat, or we don't know how we're going to make it through the weekend. So you become their resource for every single thing in their life versus just the parent education piece, where you can focus on that when you're not focused on putting out fires every week when you see them.*

Home visitors often end up trying to help clients navigate systems beyond the scope of their job.

> *And navigating that process too because healthcare systems work differently in different countries. And one example is, there's a mom that I'm with who's prenatal right now, and she's just wondering, what does it look like when I go to the hospital? What can I expect? Because she's had other children in her home country, but she doesn't really know... She hasn't been oriented or has a lot of questions about navigating that process. So, that's part of what we do.*

> *Not official translators, but for example, a family support worker that goes and do the visits in regular basis, will help families to understand what type of documents are coming to the home. It's not essentially the job that they have to do, but because we're trying to support those families, we're trying to work with them until they're able to navigate better. The idea is for us to be able to empower the family and not having them depending on us, because at some point, we're not going to be in the picture anymore. So, we want those families to be able to navigate the system by themselves.*

> *I mean, I feel the system to be so complex. And I think sometimes we take it for granted. Like, for instance, we recently got taxi for a mom and she had never been in a taxi before. And she had a very traumatic experience coming over the border, and such as this incredibly traumatic experience. And then we were asking her to get into a taxi with someone that she had never met before. And so, she was standing outside of the taxi and calling her worker. And she's like, "I don't know what to do. Do I get in, do I open the door? Do I need to tell them something? Do they know where I'm going?" So just things that we take for granted like, oh, well, the taxi will come pick you up. It doesn't mean anything to a lot of people who've never had an experience like that before. So, our staff really just... the depth of knowledge that they have about resources in the community and their understanding of the intricacies of them is so huge. I honestly think that they are just changing families in such a profound way that none of us can't even really understand at this point in the way that they're helping them.*

However, the boundaries for home visitors extending themselves in this way for families is not always clear.

> *I would say just being able to provide support to, for me specifically, my bilingual families, because I was recently kind of like, I don't want to say called out, but, it was brought to my attention that I was doing, I was walking to many support visits for my parents and that's me when families have appointments with WIC or the hospital or something, and they clearly said "We don't have interpretation." And I'm like, "Well, I'll just go with you and I'll interpret for you," because that's not something that I mind doing. I am mature and responsible enough to factor that into my schedule and not let that impact my other work or my other duties. But I was told that I was doing that too often or that I'm doing those in, doing that in addition to my standard two visits a month was something that I should cut back on. So I mean, I just explore, I guess*

a way to still do it, but also meet that, like I'll bring visit materials with me to local shows in the waiting room at the hospital, or whatever. So, it's still technically a visit, but it was just astounding to me that I was told that I was helping my families too much when... you know.

Participants expressed the need for additional resources to help those families who do not speak English. In addition to needing more bilingual staff, they noted challenges with other language assistance resources.

We use a language line, but it costs money per minute. And I mean, my supervisor told me just always do it anyway, because I kind of think it's unethical to be providing services if you aren't understanding each other or you don't have a way to ensure that, but the language line is really all we have besides using Google translate on your phone.

I wish that we had handouts translated into more languages.

One supervisor from Early Head Start expressed that they were able to meet most of their clients' needs.

Well, in Early Head Start the model is that family's needs are met in addition to serving the child. All of the home visitors that I have, have an educational component to their visit, but they also are what we call family advocates. So basically, they're doing case management; there is no limitation to what we can do with families as needs are presented. The one I think that stands out for our program, that again we're very fortunate about is that my staff can transport families in agency vehicles. I know that's a real blessing and I wish everyone could do that because then we can actually take them to the dentists, the doctor's appointments, housing, whatever their needs are. DSS, to WIC appointments, whatever. So, we're really blessed that we have that opportunity available to us and the agency cars are available. So, that's huge. There's very little we can't do with our families in meeting their needs.

Understanding the Context of Crisis

Numerous home visitors emphasized that families they serve are often in crisis and they need to meet them where they are at and work within the context of their hierarchy of needs.

Well, we have a curriculum that we're supposed to follow with our program. The girls couldn't care less about the curriculum. They were more worried about, "How are you going to help me get a job? How are you going to help me get daycare? What can you do for me? Instead of giving me the direction of making sure my child develops correctly." It's a different mindset that they have, and to break them from that mindset... It's, it's hard.

Part of our job as parent educators is to talk to parents about things related to parenting, but sometimes it's hard to get there, when a family is constantly in crisis. So, it's really hard to talk to a family about getting early intervention services. If they don't have food or their lights are about to get turned off or they're facing eviction. So, it's really hard to do that aspect of my job sometimes, when... Or if they're coping with substances, for example, it's hard to really focus on parenting, in general. So, that's one of the challenges I experienced.
"I got a light bill that's due and I need the money today. What can you do to help me?" They don't want to sit there, make a game, and create a toy, and... It makes no difference... I've got to get through, and I need your help. How am I going to get this done? How do I do this? Who can help me with this? Where can you direct me to go? Can you take me there?" Because they got all this other stuff on Maslow's hierarchy. I can't think... It's just like the child going to school and the child sitting there and the teachers trying to teach the class, but the child's hungry because they haven't eaten in two days. They've been... It's Monday morning, they ain't ate all weekend. Nobody fed them. There was no food in the house. I can't learn. How

am I going to learn when I can't concentrate because my stomach's growling and I'm hungry and I'm about to pass out? It's the same thing.
I have to spend a lot of time with them and I have to be patient. And I can't meet my timeline. I have to meet theirs. I had one mom say to me, baby was turning two. And I was able to finally talk her into a referral to Infant Intervention for a child's speech. And she's called me, and she said, "Susan, we should've done this a long time ago." I said, "Yeah, but you weren't ready." It's just good that we're doing it now. And she wasn't ready. So, you had to respect when they resist and just kind of be with them. And wait for them and reinforce that they're good moms. And then, I mean, that's just my approach. I try not to force it. I think of that clam on the sand. You can't force it open. You got to wait for the sun to warm it open.

I think a lot of the families that we serve don't have the resiliency and the skills to keep pushing when they want or need something and they run up against some idiot a desk who doesn't want to do their job. They have a tendency to get angry or shut down. And so, part of what we do is teach them the skills to, that's just one thing that we can do, is teach them how to handle that situation. And another thing I wanted to add that I love about this program is, one, that it's strength based. And two, that when I go into a home, I may think, this is a goal we need to work on, this is a crisis. And that's the furthest thing from their mind. We focus on what the family needs, not what we think they need, which I think is so important, because so many people just want to go in and be the savior and fix the problem right now, and as a nurse, we're fixers, right? So that's kind of a big learning curve for me, not to fix it, but to help the family learn to fix things for themselves.

Some of them are also really exhausted. We'll be having a visit at the end of the day and they've just come home from work. And so, we're like, "Okay, we're going to take 10 minutes and just relax and talk about whatever you want to talk about, whether it's where you just came from or what you're excited to be doing later this weekend with your family." And focusing on that first, I think just really directly supporting the parents so that they can be a parent.

However, some home visitors struggle with the balance of the empowerment approach and want to help families overcome structural barriers.

We're supposed to be based off of 'do with, not for', but we want to empower our clients, but just sending them somewhere blind just seems almost cruel. Like, go to the doctor because it's important. You do your six-month-old child check and you know, little Johnny gets shots, but you're not going to know what shots they are or what the doctors say. So that just seems kind of cruel. I think also when we talk about resources, a lot of times we do think the transportation or food desert, which, I know those things are important, as part of their basic needs, but one of my moms, which still bothers me to this day, has the issue with getting clothes washed. And when you have school age children, and not throwing anybody under the bus, but somebody suggests that they wash them in the bathtub. Well, you have two months' worth of laundry. It's not going to, how are you going to do that? And then we're going to hang them dry. They're going to get moldy like, well, like a mildew smell. If you wouldn't want to do it, I understand that we may not have the money in the budget to do it, but it's like, okay, we give a hundred dollar food cards out, so what's the difference? I don't know. I don't know the right way to fix the problem, but there are other problems that arise, but because they're not as well known or as many problems, we don't have a resource for it. One person's need is going to be different than another's, you know? And this person may need food and we may have something for that. But if you can't get to the doctor or don't understand what they're saying, English speaker or not, you should be able to, if we're told we're supposed to help people and understand the 'do with, not for,' but at the same time, let us help them. Like, the laundry is a need. And, having been at certain places in my life, if there is one need that could be like laundry, your whole existence can spiral the heck out of control because you don't have clean clothes. $5 can make or break your entire week. Like, there are things that, like I was saying earlier, might not be that big a deal. So, he's got a dirty shirt, but no, then the teacher calls a social worker. I mean, there can be just these

wormholes, that one little simple thing that's fixable could be fixed, but there's no option. If we, they have no one else to help them fix it. They have no other resource to help them fix it. And it can spiral.

Being able to acknowledge the very real challenges of the families they serve and working within those contexts, builds credibility with families.

I think they finally feel heard. I think they're often feeling disenfranchised and not heard. And I think that our program listens and meets them where they're at.

I think that one thing is being able to look at each family as an individual. What works for one family won't work for another. And being respectful because you're going into their home. You don't want them to be felt like, "Oh, you're coming in here. You're better than me." It's being on that family's level [...] And not judging them for their past or their ... everybody has a past. We want to help them change their future. And they can do that. So just helping them feel supported.

I think the strengths-based approach is something that I've noticed is different than any other program that I've ever worked in before. And I think it really helps just the humanity. Just recognizing that everybody has got struggles and challenges. And being that support person that exists for them with no judgment, I'm never pushing an agenda. I'm never promoting a certain approach or whatever. I'm just really there to listen and there to be, "I believe that you know what's best for you and your baby. And you have the right to make the choice that's best for your family." Somebody that's always supportive and always encouraging, I think a lot of our families find that really precious.

Relationships are Paramount

The relationships that home visitors have with the families is of utmost importance. The importance of respecting families, their culture, values, and autonomy, came up frequently.

Respect the family. Everybody has different cultures and values and the way they parent.

Because you're going to go into a lot of different homes that, depending on your culture or your background, what you may see, what you may hear, may not line up with your belief system or your value system, however, we can't project that onto our families.

The relationship, it's huge. A lot of our families are isolated and so to have someone who, not only is coming to the home in a consistent basis, but takes an interest in, like they said, their goals or just simply their children, or just giving them a pat on the back that says, "Mom, you're doing a great job in spite of all of the barriers that are in place," I believe that's what keeps families to that... keeps families returning to our programs. And then the resources that we offer, as well, and the connection that we have to the community, I really believe that's encouraging for many of our parents, and that's why they return. And it works to stay in the program.

Many home visitors felt that they became a primary source of support for the families they serve.

Just that source of support because, for a lot of people, there's very minimal social supports, friends, family. So, just knowing that we can be there to be a listening ear, not to judge, and to really just hear their concerns, I think it means a lot.

Referral Sources

Clients become engaged with home visiting programs through a wide variety of avenues. Referrals come from DSS, WIC, CPS, hospitals, healthcare providers, other clients, and numerous community organizations. Some programs actively recruit from hospitals and WIC offices, sending home visitors to recruit in person. Agencies also try to build relationships with local practitioners, especially OBGYN and Pediatricians—with varying levels of success, depending on the community. Many referrals come from clients currently or formerly enrolled in home visiting programs who share their positive experiences with friends and/or family members.

> *When you first come to WIC, you get your packet and registration, they slide in our self-referral form, which is just a half sheet, we just put basic information. And so, it's kind of a self-referral because the WIC worker's not selling the program to them. They're like, "Oh, this is what a home visitor will do." But then we have a community liaison who does our outreach, she'll call, and she'll do the whole spiel to them about why they may want to do home visiting.*
>
> *We have a partnership with VCU health systems, and we have an embedded nurse and parent educator that go in and do rounds. But you're seeing a mom as she delivered, so she's probably going to say yes, but then after a while, they're like, "What did I get myself into?" You know? Yeah. So, we do have some of that and that's a formal partnership, but we get it from all over. We get them from their regular doctors, we get them from CPS, school systems, other nonprofits.*
>
> *And some of our parents have been our best referral source. At one time, we had a mom, her daughter, the baby daddy sister, it was like five. Baby daddy's sister and cousin, and niece, yeah, all of them.*
>
> *We hold a support group every month as well. We do say that the support group is confidential. We don't invite outside people, but you know how teens are. They still bring their friend; they say it's their support system and sometimes the friend is pregnant. So, they refer that way.*
>
> *There's a lot of different, with the Spanish speaking family, it's a lot of word of mouth. And from my experience, because I have English and Spanish speaking clients in my caseload, the Spanish speaking clients are generally a lot more... I guess my Spanish speaking clients I've gotten willingly, I guess you could say, but my English-speaking clients have been referrals from like CPS or Social Services or something like that. So, the way they come in is different.*
>
> *Initially when we're getting the referral and we're going out, I usually try to get the parents to just talk, just talk about them, talk about their needs, talk about their kids or their pregnancy if they're pregnant, instead of just jumping in with all that CHIP does, because sometimes right away you'll find out, yes, this will be a good fit or no, it won't. But if you can get them to start talking about themselves or what they may need or think they need, it's helpful in the rapport building because then it gives you some building blocks to, okay, this is the needs that we can kind of meet through this program and then following through with it. So, if they're asking you about this or asking you about that, you've got the follow-up and the follow through and that helps build that trust and rapport with the families.*

Supervisors also commented on the importance of quick follow-up with interested families.

> *You lose people. If they heard about the program three weeks- and you know, before someone calls them, they're not going to commit to joining the program and participating. So- we have a policy around. Like within the same day, I'm assigning it, if possible. Same day you get it, you call. If you don't get them on the phone, you knock on their door and you know, so we really are persistent and it pays off, we have a pretty good enrollment rate.*

We do an enrollment visit that's basically demographic gathering, household information, and kind of just, we don't do a full on planned out visit that first time because there's so much paperwork to do. And then we do, what's called the foundation on one visit from parents as teachers, the next go around. And I'm encouraging folks to go out and get that done. Don't wait two weeks, go out either the same week, or the next week, and then get on a every other week schedule to start visiting with them. But yeah, that's our process for getting families enrolled in, I call it, laugh about it and say, it's like professional stalking. Because we're going to keep texting and drop by, leave a note on your door, but it's been pretty good for us. We don't leave people hanging too long.

Having a centralized intake expedites the process and makes the process less confusing for those doing referrals.

… we have that community liaison assistant. So, she's like a central intake person. She receives all referrals to the agency; she distills which program they go to. So at large, our whole entire agency serves Petersburg, Hanover, Richmond, Henrico, Chesterfield, so she gets the referral and then she'll say, "Okay, you're coming from this place, so this is the program that you will be served by."

For us, all the referrals come to me, and then I [supervisor] assign them to a parent educator. It used to be based on locality, which is city of Emporia, Greensville County, and Sussex County. That's what we do, after I assign the ones that are referred to us through referral sources. Such as the hospitals or outside referral sources. I called them first myself because I want to make that connection with them and sort of give them that warm and fuzzy feeling about the program. So, I talked to any of them that will answer their phones.

Incentives from the Community

Bringing families items from the community can be an effective way to keep them families engaged with the program. However, there are differences between what is and is not allowed in programs. For instance, some use giveaways as ways to engage families, whereas others are not allowed to, or allowed only during creative outreach.

Yes, we do try to build rapport but what keeps our girls opening the door for us is when we bring diapers and clothes and things they need for their babies. That is such a huge help to because sometimes they don't answer and I'm, "Hey I have your diapers." And all of a sudden, they're, "Sure. Come in." So that's a big motivator for them to see us to be honest.

We do give diapers on an as needed basis, but we don't put that out there. But I will say that every now and again, when you call and you can't get into that visit and you say, well, I want to come by for a visit, and just thinking about you. And going to drop some diapers off to you. You leave that message and you're going to get a call back saying, okay, well, yeah, you can come by for a visit tomorrow.

I kind of just recently found out that there are some times that we'll get donations of clothes or food or whatever, but it's not a common occurrence and it's not something that we want the families to expect, but I have very personal, strong feelings about if people want to give us things that can benefit our families, if there's families that their kids don't have clothes that fit, or they don't have food or things like that, that we could but especially the clothes and stuff that we could be giving them. Why can't we? And I've heard this and this, well they shouldn't be in the program for what they can get.

They should be in it because they want to be in it. But at the same time, how can they focus on wanting to learn the information if them and their kids are hungry. If the baby got on clothes, that's clearly too small and they're uncomfortable and there's all this other stuff going on. I don't see anything wrong with bringing ... I'm not saying, bring them something every time you see them, but there are some people that,

they're going to be a little bit more engaged and willing to receive the information from us. If they don't have to worry about that one little thing for that moment.

I think, interesting enough though, that we can't give out donations, but when a family goes on creative outreach, they want us to find tangible things, to try to get them to re-engage. And it's, how had we been able to bring them this onesie, yes that well, two weeks ago, maybe we would've heard from them instead of on the back, leaving it on their door when they don't talk to us anymore.

I think with our families the ones that you are having to kind of lure with those items and get them to open the door by bringing them something, that that works for a while but then that kind of fizzles out after so long.

One supervisor described her take on the importance of relationships over incentives thusly:

So, we don't do incentives. I know some folks do, but we don't. We just focus on the relationship piece. That is what we have, some very talented parent educators who, their relationship with their families is what keeps them coming back. The families keep opening the door for them. And just being able to bring those resources and bring that information and just have that support is huge. So yeah, I think that's how we're able to keep getting in there and being- and I also will say, we're not as flexible as maybe some programs may be. We don't do after hours visits; we don't do weekends. We're not answering our phones if you call us at 7:00 PM to respond to your crisis. We don't have on call. I do think it is interesting knowing that piece, that we do keep people engaged because that's not how it is for every program. Some folks will visit you on a Saturday or visit you at 7:30 PM. That's not us. And we don't do transportation. So, we don't do that though, I think it was kind of a wonder that folks do stay engaged, but it's got to be the relationship.

Keeping Clients Engaged

Most home visitors felt as though clients stick with them because of the relationships they formed, although some seemed to stay for the material goods provided (e.g., diapers).

I think that when you're able to build a trusting relationship with them and they know that you're someone that they can trust and someone that is there for them and if we say we're going to help them or try to help them, they know that we mean what we say, that they will stick with us.

And all I can think of is the relationship itself and the trust that we've built and just the consistency. And even if we miss a visit, we still are in contact and we still know what's going on. And so, I can't think that it's any one particular service or any one particular thing. It's just that bond and knowing that we're there.

I think it's a combination of things. I think it's the relationship they had with the home visitor. I think it's the tangible things that we can offer them. We do a diaper drive every year. We collected something like 14 thousand diapers. They know more than likely they can call us and say, "Hey, when you come out next week, can you bring me some diapers?" People appreciate that. I think it's ... we do monthly groups where it's just a get together. We have food, we have activities, it's all parent education, but it's wrapped in fun. So, I think it's a combination of things that keeps them engaged.

Others felt that the positive outcomes for program participation became evident to the families, compelling them to stick with it.

Once we have that established sharing, like I said, some of the resources. And then, they're like, "Oh, okay. This is actually really helpful. It's not just fun and it's not just a supportive relationship, but there's something that you know that I don't, that could be really useful for our family."

Our outcomes usually show every year that most of our families are well-connected to a medical home. So we're stressing the importance of that for parent and child so that can lead to those positive health outcomes, because they've got someone steady, reliable to go to when they're having anything going on with their health and talking about those health habits. And then looking at the population health measures and child maltreatment and CPS involvement, coming from a prevention model, all home visit programs have a prevention lens to them. Because of course we don't want to see folks get involved in CPS system, so just providing the education and delivering the Parents as Teachers model, because we use Parents as Teachers as well. It goes a long way to break from the generational expectations that have led to abuse.

I've said since I started this job it was a real eye opener. If you have these things in your tool box, and no one has ever put all this education and coping skills in your toolbox, you have to live with what you've got, and you can't use something that's not in your box of coping mechanisms, or resourcefulness, or whatever, if you were never taught that or shown that. You're using what you've got, and these moms are amazing and resourceful and strong, and they use what they've got in their toolbox. I think that's how I explain what I do a little bit to people when they ask what I do. It's like hopefully we can put some more things in their toolbox.

I always say that family educators have more the fun part and the nurses have more of the serious health issues and well visit appointments and things like that, keeping up with the important things. But also, there's not a lot of fun in that. It's another appointment that they have to keep. So I don't know that they stayed with it because of anything in the health, maybe some education, some stability with mental illness maybe, but I'd say it's more family education that they keep coming back for and stick with.

I have to say that that is one of the things that's really stellar about our program. And I don't have the stats at my fingertips. But we have very low infant mortality, very low preterm birth because of our interventions and following them up early on in their pregnancy. So, our statistics are very positive.

FAMILY DISENGAGEMENT FROM HOME VISITING

Staff Turnover

The most frequently mentioned reason for losing families is staff turnover. Although programs have processes in place to transition families between home visitors, staff do not always give enough notice to make transition visits possible. Other times, families are not willing to devote the time and energy to build another relationship with a new person.

I think it just has to deal with that relationship that you build and that rapport that you establish with the families that you work with. I think it's always helpful when you can maintain that same visitor in the home. Sometimes it's a challenge if they get to know someone and then they leave, and they have to get someone new. Sometimes that can cause them to leave the program.

It is difficult to keep parents engaged when they've already had this long-term relationship built up. But some helpful advice that my supervisor gave me was, see what they're most interested in about the program and what routines they had with their previous parent educator. You're not going to be the same

person, you're not going to have the same exact style, but you can try and see what was it about those visits and that relationship that they really appreciated and see what you can continue to make it a little bit more of a seamless transition.

In my experience for people that don't retain in the program, it's either that they have changed workers so many times that the second or third or fourth time that they change a worker, they're just, "I'm done with this."

Leave Service Area

When home visitors are notified that a family is moving out of the service area, they will often try to help connect the family with home visiting services in the new area. However, doing so requires families to sign forms allowing the home visitor to reach out on their behalf, and other logistical barriers. Many home visiting programs are still city-based, rather than regional. The implications of this are, in a place like Hampton Roads, a person could move five minutes away and be in a completely different service area. Several home visitors expressed frustration regarding the lack of ability to smoothly transition families from a model in one service areas within Virginia to another.

Sometimes they move out of the service area. So, we'll find that out later down the road. Oh, I moved to North Carolina or I moved to Hampton or somewhere, even though Hampton isn't that far away, but it's out of our service area. Sometimes we have no idea. We never hear back from them. Sometimes they tell us I don't want to be in the program anymore.

Family Challenges

Several participants noted that a variety of family challenges prompt families to disengage with home visiting, either temporarily or permanently.

Family stressors. Things going on that maybe they're not revealing to you. Which is fine, I don't have an issue with that. Also, if there's no connection between that person and their worker, they're out.

Because stuff happens and they do get a little distracted, and they'll forget. Sometimes something traumatic or something else is going on, so they get a little lost for a second. But then once you get them and you talk to them, you get them to say, "Ms. King, I forgot to tell you I changed my telephone number." And they're fine again, you know? But every now and then, you have a few and they'll fall off the wagon for a second. And once you get them, you just pull them right back in. Then usually they'll be okay.

Some families, perhaps, were not at the proper stage of readiness to engage with home visiting from the start.

I've had a couple of folks on my caseload who weren't able to be present for the teaching and curriculum moments and ended up having CPS involvement. And so, when those children are removed from the household, then our services are suspended. I mean we stay in for a while to support them and just see if things are going to go back. But I'd they don't go back then those families end up closing and we can't support them any longer.

One group of people that I know sometimes we end services with sooner than we would like, perhaps are those who do have CPS involvement. Maybe their CPS worker has referred them to our program and encouraged them to do the home visiting with us. Then they'll participate initially to get CPS off their back. As soon as their CPS case is closed, they start to respond less and less to our outreach attempts. Because our program is voluntary, that's their prerogative.

And there are some that they may have a lot of needs but they don't recognize that or they don't want to admit that they have needs and they don't want to admit that they need your help. And so, they push that away and sometimes when those types of people are going through a crisis instead of asking for help, they just shut down and close themselves off in a way and so we end up losing them.

Working with teen moms presents special challenges to their participation in home visiting, often because they are cohabitating with other adults (e.g., grandparents).

And then back to the piece about recruiting teenagers, the parents do get in the way. If there's some way that we could just educate the parents about the importance of the program, because we use WIC to do recruitment and I've had the mother of the teenager block me. Like, "What is this about that? Oh yeah. We'll think about it." Because they see it as a competition to their mothering.

I think some of the mothers think that you're going to get in their business. They're fearful of what you're going to find out. So that's why I think with the teenagers, a lot of the mothers do block. And that's what I figured for my teenage clients that I had in the past, their mothers were more fearful of what I'm going to find out, or what I'm going to tell. See we have a nurse and a clinical social worker. So, when people hear "social worker", that's an automatic, "No, not going to happen."

Even positive milestones or having their needs met can cause sometimes cause families to disengage.

Returning to work full time and out of the scope of when we can visit. Like if you called and say, I got a job and it's Monday through Friday, eight to four, we can't see you. I mean, congratulations. That's great. That's the aim, but we can't fit that in. It's our biggest reason when we looked at why people leave.

And for us, I hate to say it, but for some, they come in and they get their needs met. And once they get that utility bill paid, we might get one more visit in. And after that, it's like, okay, you paid my light bill. I'm done. They don't tell us that, but we know. When they get their needs met, it's like we're done. And then six months later, we get a referral because they're pregnant again and they want to come back to the program.

Creative Outreach

Participants were all very familiar with protocols for creative outreach to prevent program attrition.

We have a family service agreement, and in our family service agreement, it's two visits per month that they have to do. So, when we have to sign an agreement, the clients sign the agreement, and/or the clinical social worker and the nurse. So that agreement is we're in a relationship with you, you're in a relationship with us. So, when we don't see them for like three months, they go on creative outreach. Creative outreach, that's how we reach out to them. We try to reach out to them by the way of phone or a pop-in because they want us to do the pop-ins. We put that down, we note that down. And then after 30 days of trying to reach them by any means necessary, if they don't respond, then we close them out.

Usually if something happens and I don't hear from them and I can't reach them, I think about, okay, maybe the telephone number's changed because they change telephone numbers quite often. So, I try to go by there, but sometimes they also move quite often. I don't just shut them down right away. I kind of wait a month or two to see if I run into them. I double check and see if they got a work appointment coming up if they enrolled in the teen clinic or the OB clinic for an appointment.

So, we're like the last thing on her mind, but what I do when I call and leave that message, I like, "I'm just checking on you to see how you're doing." I don't say nothing about no visit. I just say, "I just want to make

sure you guys are okay," kind of ... So, then I'll say something like, "I'm just wanting to hear your voice, just to know you guys are okay," and then start back up the conversation like that. I don't want to be pushy because when ... I know me being a teen mom, when I was in crisis mode, I didn't want to be bothered with nobody because I'm in survival mode. I got to hustle and bustle and do what I got to do. So, I shut everything down. I get it. That's why I just call like, "Hey, I'm just checking in on you."

COMMUNITY COORDINATION

Community Coordination

At the home visitor level, there is not much awareness about the details of community coordination. That seems to occur primarily among organizational leadership.

> *I don't know if there's any council or group but I know that we do have someone representing our agencies, that go into Smart Beginnings meetings and then there are some meetings through the United Way that we attend. So just to keep that connection to the community and ensure that they're aware of the services we provide and that we're aware of all the different services that are available to our families in the area.*

> *We participate in our Smart Beginnings too. I don't go, but my boss goes. But even then, sometimes those meetings are so large that I feel like sometimes there's already an agenda they're coming with. And so, you get updates on things at a very broad level, but when it comes to those day to day partnerships, that's still kind of tough sometimes.*

Some regions do struggle with forming collaborations, either because resources are limited, or awareness of home visiting is low.

> *And then the partnerships, a lot of community partnerships are limited in our area as well [Hopewell]. It's very rural. It's very hard. They look at our program as not being important.*

> *And another thing is that Home Visiting is not publicized. It's something that you don't hear about, or I'm sorry, I know a lot about Healthy Families. That's really the only Home Visiting Program, but the other, I don't hear. I mean, people don't even talk about it either.*

Partnership Challenges and Opportunities

For a few home visitors, community referrals were challenging because they were not comfortable with their own knowledge of what the available resources were or how to navigate those systems.

> *Well that, and there's a huge issue with us knowing what resources there are, because our supervisors don't even know . . . I mean, that's all I ever do to try to find resources, but there's no ... and I don't know how to fix that. But if supervisors could try and figure out what resources there truly are and what that process is for them, that could be extremely helpful.*

> *Another systematic thing we've noticed lately that's really frustrating is every social services location, because Virginia doesn't have a socialized DSS system, it's so locality driven that it can also be driven by what worker you get for your benefits worker. Families are being told different things. We're trying to navigate that. Like okay how this family got approved for this benefit, this family's told they got to work to get the same benefit and their situation is similar. So, navigating those waters. And like you said, those relationships are key to try to figure that out. Knowing someone who works in that system and pulling*

them into the table, because otherwise you're going to be just as lost along with the clients. That's been a challenge too.

Participants identified several key challenges with partner agencies, including client resistance to certain agencies, long wait times, and general accessibility challenges with partner agencies.

There's a lot of resistance to DSS and CPS because of the stigma that's attached to it. So that's not one they work well with generally. But they'll work with them if I can get in there and support them and stand by them.

I wish we had a better relationship maybe with either the CSB or some other kind of mental health entity. Because for whatever reason, either our clients have a hard time accessing it or finding a goodness of fit for them or they start in the stock and you're, what happened, where was the follow up? So, it would be nice if we had somewhere where we can always refer to a couple places that were just really good in the community and maybe not already overloaded like the CSB.

I think just the resources, social services, that is our go-to resource and accessing services or... No one can ever get ahold of their worker. I feel like those are normal challenges, but it's magnified to me in Petersburg. I can't even get ahold of their worker. They don't return my phone calls either, which is hard when your family's having a struggle, and here I am having the same struggle. And so, I feel like that's magnified.

I think the most challenging for me has been communicating with other agencies that either don't have adequate staffing or have different standards of professional communication. So, leaving a message and expecting a timely call back and then never hearing from them. And knowing that this program offers a little piece of what these families actually need and knowing that there's other community agencies in place that are intended to assist with all those other pieces and parts.

All the psychiatrists in my area have a really long waiting list and even with our community service board, if people show up they may have to wait several hours before they can even get in for an assessment and there's not really a option of making an appointment for something like that for the intake assessment.

One family just made a call for an appointment and they were told it's going to be a 10 month wait. And the social and emotional issues don't get any better without diagnosis and treatment. So, you have those entities, whether it's home visitor, the parents, or the school, the teacher. You have all of them waiting to exhale for this child to getting in to see a pediatrician so we can know what's happening and basically put a name to it. And that's a challenge. It was a wait before, because we've been using the pediatricians over here ever since our program started, it went from a three month wait to now 10 months. And that speaks to the level and the urgency of the issues that are seen overall.

So childcare is a challenge and some other things, but I would not say there is a lack of resources in the County, because there are definitely good resources out there, but are they user friendly? Are they accessible? Are those resources understanding their audience and who needs to be served, too? And so, I wouldn't say there is not enough resources, but I do know that there are some areas outside of Fairfax County where there isn't a lot of good resources, or they're not user friendly.

Even if there are resources, that doesn't mean they're quality resources, would I want my grandchildren to go to them? No.

Some home visitors felt that community partners did not fully understand the contexts of their clients lives or the challenges they faced in accessing resources.

When you had sleep for dinner the night before, and you've done all of this and then, or you're five minutes late, you managed to get there and you're five minutes late and they tell you that can't be seen.

Some participants also noted challenges of coordinating with other agencies when there are multiple home visiting programs in an area, while others seemed to have smoother relationships.

So, we really need those connections because it would make life easier for us. But we don't really have that because of how huge Richmond is. And there's also competing programs like, city of Richmond has a healthy families program that only serves the East end of Richmond. Urban baby beginnings is a home visiting program that's cropping up in the city of Richmond that's a direct competitor to us. They're with the diaper bank and they're their own thing. And they're doing home visiting. I don't know what model they're using; I don't know who's funding them. But they're going out to the caravan box and doing intakes with them. And we're like, wait, what? That's where we don't have a formal partnership box of course, but they send referrals our way sometimes. So there's that piece there that also hinders that when you are in a larger community, because there's more people to talk to the,- even though we're a big agency, we're not the only game in town. And then we have some similar challenges in the other areas we serve.

So, you probably know by doing this, that Healthy Families starts with moms prenatally or before the baby turns three months old. So sometimes I'll get a referral for someone with a one-year-old. In that case, I still call them and see if they'd like me to refer them to Child Health Partnership. So, we work together and sometimes refer to each other too.

So, we coordinate really closely with our Healthy Families and Nurse Family Partnerships Programs. So, in the effort to do that we can work with Healthy Families to coordinate those goals and then we can transport whereas they can't. The difference is, is that in Hampton and Norfolk, there is no program such as ours. There's an Early Head Start Program in Newport News, but there is no Early Head Start Program in Norfolk nor is there in Hampton. They're only Head Start Programs and it's just based on what the grant applies for unfortunately.
This might sound funny coming from me because we are the early intervention provider in our community so we provide the services through IDEA for children birth to three, but we also contract some of our services out to Western Tidewater Community Services Board. So sometimes there isn't the best collaboration between the providers with our families who are in Home Base Services with young children under three and also in early intervention. That's probably the one area that I feel is the weakest in our community, but we're working on it. Because you know, again there's an overlap of services there. If service coordination is visiting the home or service providers are visiting the home, I don't want my staff to go there the same day and we need to coordinate the services that are provided since they're supposed to be working on the entire family on the IFSP. So, area that we need to coordinate our services so we're not overwhelming the family.

So, our Head Start regulations require us to collaborate, I mean it's in black and white. If there is another agency serving our family, we're supposed to coordinate services so that we're not duplicating. So, we have that in our requirements, but that doesn't necessarily in the other agencies requirements that we work with so early intervention doesn't have the same thing. So that becomes an issue.

Participants also identified areas where they thought were additional opportunities for collaboration or where collaborations worked well.

I wish we partnered with the school system better. Primarily, the elementary guidance counselors or somebody because we know that the schools, they have younger siblings and are pregnant moms and those kinds of things. And so, I don't think the schools really know what we do as far as the support. And

look at the contact they have with kids all the time, and they know of families and family needs. And especially if they're pregnant and have younger siblings.

A lot of the churches don't fully understand all that is going on in the community. How they can be of assistance other than just that Sunday service or that one service a week or a type of thing. We're saying we're looking at even just providing transportation and stuff like that, it could be a resource. But I think they're being brought around a little bit more with the trauma informed care approaches and then maybe people are reaching out to them for food pantry ideas and stuff like that because you could drive 40 miles in the areas where we live, and you won't see any grocery store, but you'll see churches, you'll see like at least 10 churches. So, it's there, but it's just very much not at the table on this.

I think our biggest partnerships are going to be other systems, like health systems. We also work with the YWCA, if we need additional training and support around intimate partner violence. We even do a lot of organizational level of teaming up with those types of partnerships.

Lastly, some participants expressed a desire for greater access to, or infrastructure for, community spaces where families could meet.

[…] a place where they could actually physically meet other moms and babies and have somebody there to guide them, not in their home but together with other moms. They build relationships. They find rides because some moms have cars, some moms don't. I just think that would be a very positive thing in our environment.

HOME VISITING STAFF REFLECTIONS

Onboarding Processes

Many home visitors were pleased with their onboarding processes, even when feeling overwhelmed by the case load.

Yes. It was very overwhelming. I started out with 14 clients. Not everybody does that now they start out with a smaller number, but I take that now as a vote of confidence from my supervisor. She was very affirming in that she said, "It's going to take you about a year to feel comfortable with what you're doing. Come to me at any time with questions. Ask your colleagues." She created an atmosphere that was very encouraging, and the expectations were appropriate. You're going to not be perfect at this. You got to ask questions. Nobody's looking down on you for doing that, come to us and we'll get through it together. So that was really extraordinary in my opinion, because I hadn't started at a job where it's been like that before. So, I felt comfortable that I could grow, and I could fit in.

CHIPs on loading process for me, it was very thorough. Any questions that I had, any information that I needed I was going to have a resource to get those questions answered. And when I first started the CHIP, I did shadow a nurse. So that was nice just to see what I was supposed to be doing. I had no questions.

Some reported variability in the onboarding process, based on the supervisor. Others felt they gained better knowledge from peers.

. . .Or even knowledge about certain things we're supposed to be doing. Hold up, "Why, I was supposed to be doing that this whole time?" But there's a huge gap in communication, on trainings depending on your supervisor.

I feel I learned more from my team members and peers training wise in every category than I did from any type of supervisor or for as far as in house goes. My first instinct, even to this day, if I have a question is to go to them, not supervisor, because that's how it's been. But that perspective is not incorporated. I honestly don't even feel the training is from people who have done this, or they're far removed, maybe did this 20 years ago.

Trainings

The overwhelming majority of participants were very happy with the trainings, their quality and effectiveness. The few critiques were related to the variety of topics covered.

I love the opportunity to connect with home visitors from across the state and learn about different program models and share ideas. I think the trainings usually offer topics that are universally applicable to the different programs and the populations we serve. I usually come away from trainings, feeling energized and supported.
Training gets to in the moment. What would you do in a home if this happened? How would you speak to someone like this? How would you problem-solve this unique family situation? I think it's just really helpful when it can start big, but then get down to those really specific questions. And I think whenever trainings get to that, it's really helpful.

I think the trainings are good in general, but they're general. And I just think they could vary it in terms of working with LGBTQ families, undocumented families. Those families face different issues than just typical issues. If they could vary it a little bit into things that we haven't heard, like we've probably all been to 10 breastfeeding trainings.

I'm just saying it's just too much. And then all of the training is duplication, duplication, duplication.

I think there does need to be some online trainings about racism and how it impacts your health and being aware that the black community has poor outcomes, but it's different than the Latino community. And just basically, don't beat around the Bush and let's be forward in an appropriate manner. And it's not like Early Impact Virginia has to reinvent the wheel. There's already information of webinars about this that are already out there. Black Mamas Matter has a toolkit, they have information and then I think it's The National Children's Health Equity.

Others expressed concerns with understanding the relevance of some of the trainings and with balancing trainings with other job duties.

They're all series. And I've got to complete them all by such and such date. In the meantime, I'm doing outreach, but then you turn around and tell me, my outreach is not enough because our numbers are low. What do you want me to do? The training or the outreach?

And then every time somebody offers a webinar, it doesn't matter who it is. What is it for, as long as they got something to do with early childhood, they want you to do this for...? Why do we all have to do it, can't one of us do it?

Do you know how many webinars I sat in on that have nothing to do with my job? But just because the Regional Director insisted that I do it. The numbers are going to stay down as long as you got me doing 50 zillion webinars 365 days a year, it don't make sense.

Job Satisfaction

Many participants reported job satisfaction stemming from the relationships they build with clients and seeing their families accomplish goals.

> *I do enjoy interacting with the families. And I do find that I have a lot in common with the people that I work with which is really nice. Before this job, I was a special education teacher and I really did see a need for a program like this. And I didn't even know really that this sort of thing existed, I just happened to find it. But this is exactly what I was thinking some of my students needed was their parents to have some support.*
>
> *I like what I do. I like connecting to the families.*
>
> *I think just having the joy of working with children. You have to have the heart for it to want to do something for this long. And seeing the success. Just like the success of seeing a family buy their first home or the joy they show seeing their child walk for the first time or saying ... Just those, of being a part of those firsts.*

Other participants praised their work environment and colleagues.

> *The group too that we work with. It is so unique. I've not ever worked with another group that is just supportive and caring as this group that we have. Here and there, we've lost people, but the replacements are just as good. So, I've never had that at anywhere else that I've worked. So that is huge. And when I left, I miss that. That was one of the biggest things that I missed and one of the biggest things that I came back for was I just didn't have that relationship anywhere else like we have it.*
>
> *Like I really appreciate working within a team setting, like the nurse and social worker. I said like today I had a joint visit that... It's just helpful to have somebody who is a little bit deeper, knowledgeable in a certain subject, whether that's the nurse, like in coming in with a health perspective or the clinical social worker coming in with those mental health, like hard skills and experience with those sorts of things. . . Makes me feel very supported. Because I feel like the family is getting the best service. And, also, I don't have to know everything because there's people on my team that actually know.*

While many participants appreciated the autonomy of their jobs, others felt that their positions were more rigid and that detracted from their job satisfaction. The degree of flexibility also varied by organization. Whereas some felt they had a good amount of flexibility, others felt their work hours were very rigid and restricted their ability to help some clients.

> *I like the autonomy of it. Although we have a supervisor, so much as long as I'm getting my work done as it's prescribed, I'm good. There's not a lot of micromanaging going on. My schedule is fairly flexible. We work 8:30 to 4:30, but when I schedule my people is up to my person and me. So, it's provides that level of flexibility. It also provides for me. I don't have to sit at a desk all day. I can be out, I can be in, so that's nice coming into the office when I need to, being out when I need to. Yeah.*
>
> *Well, what do I value the most about my job? Is surely not the pay. I think the flexibility, because we have to be flexible with our families and in turn, I think that the job can be flexible for us.*
>
> *It's not exactly flexible. We can't work midnight to 7:00 AM, for example, 'cause you can't do home visits at midnight. But if you do your home visits and you need to do your paperwork at 10:00 after your kids go to bed, you can do that. It's flexible, in that you can work around what you need to do. You don't have to be scared to go to the doctor's or something, like I've had at other jobs, where I might get yelled at if you*

take off to go to the dentist. Everybody needs to go to the dentist. I feel like it encourages work-life balance, is a way to sum that up.

We don't have access to our database when we're not there. And I get it because they say that they don't want us to work off the clock for free. But if I asked my supervisor, "I need to stay 15 minutes because its due in 48 hours and I need to finish it, can I come in 15 minutes late in the morning?" And she said, "No, manage your time." It's just like, "So, do you want it done in 48 hours, or do you want me to go home?" But if I had access to the system, if I chose to go home and watch Love is Blind, and it will be done. Then we both going to be happy. So, it gives us access to the system outside of the office.

Yeah. If there was a little bit more trust of like, we can do our jobs, I promise you we're great at our jobs, we have the resources and the knowledge to be able to complete our jobs without everyone, without micromanaging everything. Because I've been told too that at five o'clock you're still here, you're not supposed to be here after the five o'clock. Well, I was just, "Yeah, well." "You can't be here after five o'clock because then that means they're going to pay for the extra time." So, I said, "But if I'm just doing this or if I'm on the phone with a client, am I supposed to just hang up because it's five o'clock now and walk out the door?"

In many areas, participants commented on the low pay. However, some mentioned other benefits that seemed to help bring this gap.

Pay us more. Well that's a place to start. Because I think that could retain a lot of us. I'm not sure, yesterday, I was looking for a part time job. . . and we make $15. So, I can just go work at the grocery store.

This could be arbitrary, but I feel like we have a generous sort of perks like as far as PTO goes a lot more than most other nonprofits that I know of or have worked for. So, I feel like that's really valuable because they obviously honor and value us balancing the things that we experience at work and also time away from work. So that's encouraging to be supported in that way.

Also, with professional development I feel like having a supervisor that is curious about what my career goals are, and she asks about that and tries to see what resources there are for that. So, she was able to connect me to a symposium for breastfeeding so I could learn a little bit more about that and then bring that information out to my families.

So, they create those little incentives. And then they also have fun day once a year where just basically get together and play games and act silly and blow off steam and that's kind of a fun thing to look forward to as well.

Participant job satisfaction was also impacted by their perceptions of the workload. For example, some participants saw areas where there could be more efficiencies in their workflows, particularly in terms of utilizing technology better.

I think there's a lot of duplication in our paperwork I think even between the nurse and the family educator. And a lot of times it requires, logistically I can't be in the office every week because the office is about 45 minutes from the area that I cover. So, for me to take paperwork once a week, there's a few hours of a day right there. So those ladies have to call me for assessment scores and things like that. And that to me is that's time that we're both, I won't say wasting, but if the information was electronic then it's accessible and they don't have to make that phone call. I don't have to return that phone call. And that's really hard for me, especially if I haven't seen a family for three months and I'm questioning, what were we

working on the last time? What were they supposed to do? I have to access the chart which is 45 minutes away and that's not always feasible.

One universal database. Three different databases I have to enter the County's database, for anybody who receives service from the CSB that houses us. We have to enter stuff in there. We have a database for Healthy Families that we have to enter everything in there. If they're in the PAT program, they're the same database, but they look different based on what each one is asking for. So, if you do a visit for one family, you have to do a planning guide and two visit walls because they don't mirror each other. So, when it asks for certain information that goes into the County database and then the Healthy Families database asks for different information.

Several participants felt the caseload expectations were not aligned with the realities of doing the job on the ground.

Who came up with these numbers and decided that this is what a normal human can get accomplished in this job? Who decided the case load and the case weight in that we can do this, because if supervisors are saying it's stressful, if the people who are coming from Healthy Families America, or Healthy Families Virginia is saying, "I get it, it's hard, blah, blah, blah. But this is your job." But like who said that? If everybody knows that it's hard, everybody knows that it's stressful. If everybody knows that it's nearly impossible to reach, who is setting those standards?

I think it's most challenging to get the number of visits that we're required. I mean it's a pretty strict protocol that we're supposed to get a certain number of visits and I do some work with the program data and just looking at it's not just that. If we get a referral, how quickly we respond to that and we get them enrolled. And if they enroll in the program and they don't stay in the program, why didn't they stay? And worrying about all those numbers and making sure that everybody is doing everything that they could do to keep these families engaged and keep their visits and so there's just a lot of things that we're trying to do and do well. And it can be a little bit stressful sometimes.

Well, when you're trying, when we have our clients trying to do better, as they mentioned... Our numbers get cut short because they are starting a job or school, but then it ends for them. So, we, like maybe two a month, our numbers is low because, hey, we can't get the right schedule to get in their home.

A lot of my families need visits in the evenings. They don't always fit that 8:30 to 4:30 mold. So, the flexibility of
being able to schedule visits later or if I need to or if I need to schedule work over one day and not as much the day before for something that has going on personally with my kids, that's helpful as well.

But also, after hours, you know, our programs are nine to five or 8:15 to five. And the world doesn't work like that. And so, if I'm working nine to five and my client's working nine to five, how am I getting into the home?

I think one would be flexibility. I think a lot of times we stretch ourselves then, she works nine to five, but I work eight to four, but I'm about to be working until 5:30, two days a week because they want our client numbers to go up and I'm willing to meet with these people. These people can't meet until 4:30. So if I'm willing to extend myself for you, extend yourself for me.

People are busier than what those above know. People are not sitting at home waiting for you to come do a freaking home visit because they're busy, they're working, they're going to school, they're trying to make better. Everybody's not just sitting at home, collecting a check and all that kind of stuff. It's not like how it used to be back in the old days. And they're hard-pressed to find time for you to come and sit and do a visit

with them and go through things. And they're trying to pay bills, figure out how they're going to get to the daycare center to drop the baby off and then get from there to work and then come back and eat and cook and just... It's... They're doing the same thing you're doing. They're living. And I feel like home visiting needs to change. I think we need to incorporate some FaceTime or phone... I've been talking about this; I think ever since years ago [pre-COVID focus group]

Similarly, participants expressed a desire for a greater understanding from supervisors of the context of their clients' lives and how those challenges impact home visiting, as illustrated by this exchange:

Yeah. I think we just want to be treated we're not just number hungry robots. These are people, they have lives.
There are other outside factors that keep us from seeing them. And just some understanding of when that doesn't happen and not being a slap on the wrist, do better. 0% of the time do we cancel visits. It's always, unless we're sick. It's always, the clients canceling the visits. How are we supposed help them?

And when you don't have a roof over your head or food in your stomach, you don't care about the baby reaching milestones.

Exactly. And we understand that, but our supervisors, it feels sometimes-

Because the feedback we get at that point is, well, you didn't try hard enough. What could you be doing differently?

One supervisor acknowledged the many assessments required by Healthy Families, but felt the outcomes were worth the documentation.

The work being done with families is amazing. That's why when I moved, I was looking for a job in Healthy Families. Because when I say that we're changing lives, I don't mean now, I mean for generations, generations of lives and families are being changed because of the work being done through this program. HFA just has a ton of... What are their 153 standards or 173 standards or something? There's a lot of guidelines and expectations for how we're tracking and documenting work. I think that as far as the work that's in the field, the work that's being done with families is amazing. Now the staff do have a lot of assessments that they have to do with it. There's a lot of things that they have to remember. There's a lot of timeframes, this has to be done in this timeframe or else if it's done a week later or a day later, it's late and that doesn't count and things like that. There's a lot of assessments and things like that that they have to remember, but the work that's being done with families around attachment and bonding, reading cues, and communication, brain development, the ASQ's, all of that stuff, I think is stellar. I think that there is flexibility in the way that people can work with families based on those families' needs. I think there's just different components to it.

Some of the higher levels of attrition seems to be happening in geographical areas with proximity to universities whose workforce seems to draw more heavily from recent college graduates. The lack of professional growth was cited more often by these participants. Additionally, some participants felt lack of appreciation was leading to greater turnover.

We had an individual who did work in home visiting for an extended amount of time. It was her career, you would say. But the way our job is described to us is a steppingstone and administrators and supervisors often use that verbiage. This is a steppingstone. There's knowledge of absolutely no growth within our organization.

I think they see how quick people turn over, but it's like, they don't care. And if you don't care about something, then it's going to keep happening and you're not going to try to change it and you're not going to try to appease the people that are out here. Because I mean, they make it seem like their outcomes are decent. So, it's just like, if we're trying, if we're doing this, we have to be here because we want to be here because obviously it's not for money. There's no fame. We all have different backgrounds and degrees; we could be in many places at this point. So, it's just like care about your staff.

We have, I think 23 people total on our staff and I would say our turnover ebbs and flows. When I first started, we had a lot of people who had been in the agency for a long, long, long, long time, like years and years and years. We just had somebody retire after 25 years of employment. And we have, I think, the next longest tenured person, who's still with us, has been here, I think, 14 years. We have several that have been there around 10, for 11 years. But then we have had some new positions that started with grant, like pilot project type thing and we'd hire people for that. It may not be that that was exactly what they wanted to do or thought the job was going to be. So, they didn't stay very long. One of the things we find, in particular, in our Louisa County office, is it's hard to find people. We've had some challenges, filling nursing positions in that office, in particular. We also have had a lot of folks come to us that are fairly new out of school. They might be viewing this, excuse me, as like an entry level position that they'll stay with for a few years until they get married and move out of town with their spouse, or decide to go back to graduate school, which has happened in a couple of our cases.
I would say for people who have degrees, it's very much a steppingstone, kind of a job, right? It's not a job where people are looking to stay for a lifetime. It's like, this is my first two or three years to say that I've had a job and to build those skills and to learn how to work at it a professional agency. And then you move on.

Reflective Supervision

Most participants were very satisfied with their reflective supervision experiences and its impact on their wellbeing.

Yeah, I think having that we have supervision once a week being able to discuss with someone, just kind of have an outlet to be able to express frustrations and challenges and having feedback and someone to support me and whatever those challenges that I face, it's very helpful. It makes the job a lot less stressful.

Makes you feel that someone's got your back. For sure.

Yeah. I echo that. The reflective supervision. And then also we have weekly staff meetings which have doubled since we have all been working from home. I think they've been really trying to make sure especially because we had two new girls start right before the pandemic. So, they're making sure that we all feel connected and that we're getting to know each other and that we have all the support that we need. So those. And then too, our agency does fund little they call them fish cards where you can give a shout out basically to one of your team members. And so, at the agency staff meeting, if you get a fish card you can enter it in for a special prize.

Sometimes I think about things that I haven't considered before. And so, it's a fresh approach to something that I've been doing a particular way. I really have gotten a lot out of all the trauma informed things that they've done, because I think that's very applicable. Not only to my clients, but in my own life. It's shocking to me. I think it's important to realize it in yourself when you're working with clients. So, I think that some of the things that they propose, like the reflective supervision, was just happening organically prior to actually doing it. But still it's okay to quantify that and make that a more structured thing, I guess. It's another way of doing it and to make sure it's getting done.

Like the privilege thing. Sometimes supervision is really helpful for realizing the way that my experiences affect how I perceive things. And being able to realize that tangibly, can really, really shift how something is a problem, and make it seem not insurmountable anymore.

My supervisor is very helpful in terms of advocating for her staff. And there was a time where a coworker and I needed that advocacy and it was so appreciated that she was there and that she cared and that you could feel that she cared.

However, there were a minority of participants who did not feel that they were getting what they needed out of reflective supervision or that the supervisor personality was a good fit for the role, as illustrated by this exchange between participants:

There doesn't seem to be any formal training for our supervisors in that aspect, as you're saying, like, how do we reply to things? How do we deal with things? Reflective supervision is supposed to be something that they're going through, and every time we have a meeting and we're talking about these things, administrator will say, "Well, these are things you should have in reflective supervision. And if 80% of the people are coming to you with these worries and thoughts, clearly, we're not getting it. So that's frustrating. It's a boundary. It's a barrier for us to do our job because-

And it can't just be put on personality because if you don't have the ability to be compassionate and to be able to receive that information about reflective revision, and then give that to your supervisor, you shouldn't be supervising.

Exactly.

And that's something that's actually been said from a supervisor. "Oh, well, they're just not naturally compassionate. So, you can't expect them to behave that way." But no, this is literally your job.

Other participants expressed similar sentiments.

The same way they expect us to be kind, like no matter what our clients do, our clients could cuss us out, we will still need to go back tomorrow. We can get shut out, we still got to go back tomorrow. You're sitting in an office all day on the computer on the phone, on numbers, but we actually have to be in it and be stressed out about the outcome. So just for them to realize that the same way you expect us to take this and still be able to function and do our jobs with dignity and integrity and represent you well, the same way you should be treating us.

As far as the trauma-informed piece, I think that's something else that it's fair for us to have the expectation that there's going to be consistency across the board with all supervisors and how they respond to that, and with us about those things, instead of being told like, "Oh, that's not agency responsibility."

Like maybe they need to be brought to reality and be able to hear feedback from their employees without taking it in a manner that it's like, "Well, this is why I did this. And this is why I did that. And somebody's on my back, so I'm on your back." Everybody needs to just be able to hear what's being said and make adjustments accordingly.

Several participants also raised concerns specific to Richmond City. There are areas that have high crime rates where home visitors do not feel safe, as illustrated by the following exchange between participants:

We're going in places where you can't order pizza. Ambulance won't go without a police escort. And we go every day unescorted. . . And there's no communication on the upper level of, what has the activity been like last night? Anything like that. And when you're supporting people who are going in those places, you have to know those things.

It doesn't help when the bullets are flying, and you have a whistle.

Literally. And you're seeing drug deals in front of you literally.

This sentiment was also reflected in one supervisor's assessment of how their families feel.

There's a childcare center in the middle of Gilpin Court, and you could walk to it. It's friends, it's a nonprofit, sliding scale. They have a social worker and social support programs. And we have a parent say, "I'm scared to walk my child to and from school every morning for fear of getting shot." So, we see that play out and in that because it's just feels heavier lately.

Home visitors in this area also expressed a desire to feel more appreciation for their efforts and the circumstances in which they often work.

And then appreciation for you extending yourself or going the places that you're going, some sort of appreciation for the work that you're doing. And not just taking it for granted that, they've always known people to do these things, but it doesn't get any easier. Yeah. Just appreciation, emotional support. Some concern for being very mindful of safety and actually feeling they're paying attention to the news and they're paying attention to safety protocols, but that's not happening.

I think that's something that really needs to be worked on to make people feel supported, is to make people feel wanted that they're there and keep people probably nine months ago, I counted how many people have come and gone since I started. And my list was 45 people, which is to me, too many people in a three-year span.
You have all these employees, make them enjoy their environment. It has the potential to be such a fun, positive, happy environment. I think.

Other organizations seemed to excel at making their staff and supervisors feel appreciated.

Our agency does retreats twice a year. One of them is a reflective retreat and the other one is more on team building. We've brought in wonderful folks to help facilitate those retreats. Sometimes it might be somebody that brings in low ropes elements to focus on team building and sometimes it's therapists. We had somebody from the women's initiative come and talk about compassion fatigue. I think that knowing that we have those two days that are dedicated out of the office days to really focus on who we are as individuals and celebrating the work that we do, is validating.
We encourage use of the employee assistance program, and we have a walking trail by our office and encourage staff to take time out of their day to take a walk outside, to get some fresh air and some exercise. We have a board of directors that will sometimes host a lunch for us, which is nice. Once a year, we have an Imagine Awards banquet, which is really looking at celebrating the stories of families within our program who have overcome big obstacles and been able to improve their situation greatly. But this is also a chance to get dressed up, and eat a good meal, and have a night out with your colleagues, and your family and feel pampered a little bit.

REACTIONS TO STATE LEVEL INVOLVEMENT

Home visitor responses to questions about state level entities were somewhat limited. Supervisors were very positive about their interactions.

> *It's a very positive relationship. Our program feels really supported by Early Impact. When there are changes coming down the pipe, they keep us very well informed with what's going on. Things just don't catch you by surprise. I know it works for us. I know nothing jumps out of the dark and kind of scares the daylights out of you. You know, what's happening as either as it's happening or before it happens.*

Experiences with TA/QA representatives across models was overwhelmingly positive. At the level of Early Impact Virginia, home visitors were most aware of the trainings EIV provides and the conferences.

> *Are those conferences usually held in Richmond and out in that area? Yes. I wish we could be a part of those. They won't pay for us to go out there unless it's necessary.*

> *They are a lot of fun. And the motivational speakers, they really are motivational. And some are famous and you're, "I can't believe I'm here" type of thing.*

Several participants did mention the advocacy work that EIV does and that they had participated on Advocacy Day in the past.

> *I also really appreciate the advocacy piece. To help a family get connected to what they need and to watch them building flourish after they get what they need is really great. Sometimes they really just don't know how and because of the extra support that we provide and the advocating for them and really making sure that they're getting what they're needing, we are aware and know that the families are going to thrive as opposed to just survive.*

When asked what more EIV could do to support them, many participants could not come up with any unmet needs. Some suggested more information tailored to region, as well as a better understanding of the dynamics of rural areas.

> *Maybe stuff that's more specific to the region you work in. Trainings or information resources regarding, like specifically Fairfax or specifically the city of Alexandra related to those demographics that live there. Just so you understand more about the infrastructure of healthcare or whatever it is that's impacting the clients you work with.*

One model, Baby Care, did express a desire for EIV to know more about what they did.

> *I'm not sure that Early Impact really ... I feel like we're the redheaded stepchild sometimes, Baby Care. I know for a long time we weren't included, and we have to say, "Hey, wait, there's us. We want to come to this." So, I'm a nurse that went to a three-year program. They don't have them anymore. You can go two or four years. Three-year programs were wonderful because we had a lot of hands on experience. And when all that was politically changing, they grandfathered us in. And I kind of had that feeling about Baby Care. We may not have met all the steps, but organically we've been doing a lot of what they're talking about. So maybe coming and finding out about us and grandfathering in some of our experiences I think would be helpful to the organization.*

Lastly, one home visitor expressed the desire to see more positive data about the work they are doing.

> *I think it would be nice to hear about the positive side of the data. We're on the ground doing lots of work, checking boxes here, getting this here and then the data goes and then when it comes back, sometimes we*

don't hear enough of the, just went really well. Because of this, this many kids whatever, went to Head Start. Just the positive, more of the positive end of the data would be good to hear more often.

From an organizational perspective, supervisors were pleased with the coordination EIV has brought.

But yeah, I mean, so far it's been, it's been nice to have just somebody that kind of pulled together the common training needs of all the models and be responsive in real time to that because having worked in two different, well really kind of three different models, like a PAT Affiliate, a CHIP program, and having been in Healthy Families. Sometimes if you get... You have to silo certain things, cause there's fidelity to whatever your model is and your national program, but some things you need to be more fluid with, and it's nice to have somebody that can be an overarching bridge between all of that. Because at the end of the day, we're all doing the same type of work. It's early childhood home visiting. We're all measuring pretty much the same outcomes. So, having a unifying factor is helpful because otherwise it gets a little too confusing.

Some were still unclear about the role of EIV post-merger.

What I know is I'll be completely honest. I sometimes get confused between the exact differences between Early Impact Virginia and Families Forward, who merged into what. I think Families Forward and someone merged into Early Impact. I still get all of that confused in my mind, but I know they do a lot of great trainings and a lot of great people work there.
I've asked the question before to try to wrap my head around it. I think as I understand it Early Impact Virginia is the broader umbrella organization that the different home visiting models are underneath and that Early Impact Virginia does more of the advocacy and lobbying and trying to secure state support for home visiting programs across the state. I don't know if that's right or not.

Several also noted a need for EIV to help identify where there is possible duplication and where programs can be more strategic about expanding to meet needs.

And making sure that if we have too heavily... Like too many service providers on one area, 'cause they said that you got some, there are none… Hampton roads has what feels like a million home visiting programs. We're only so many, why do we need so many things? So, helping to unduplicate where you can, and I know that's very political because people get territorial with the [crosstalk 01:03:30] program model their communities, but then you got communities that is going inside. So yeah, I think that would be helpful as part of this process as a next step of hopefully that will come out of it and saying, this is how we can better address that and unduplicated where we're heavily saturated.

HOME VISITING DIRECTORS

Recruitment: Participants were recruited from surveys distributed by EIV to all home visiting directors. At the end of the survey, participants could enter their info if they were willing to be contacted to participate in an interview. Ten directors indicated they were willing to be contacted and were emailed by Dr Carlyle. Six directors completed interviews. Two were out of the office during the open period, and two did not respond.

Participants: The six directors represented New River Valley, Charlottesville, South Hampton Roads, Richmond/Petersburg, and Fairfax areas. CHIP, Healthy Families, and Nurse-Family Partnership home visiting models were represented.

INTERVIEW PROTOCOL FOR HOME VISITING DIRECTORS

Let's start by telling me a little about the community you serve.

- What are the strengths of home visiting programs (are the strengths of your home visiting program) in your community/region/state?
- What are the weaknesses of home visiting programs (are the weaknesses of your home visiting program) in your community/region/state?

Tell me about collaborating with other HV programs in your region. What makes it work? What makes it not work?

- How would you describe the collaboration and connection between home visiting and early childhood initiatives in your community/region/state?
- How do you coordinate with other agencies in your area? (e.g. referrals only or other ways?)
- What coalitions or coordinating entities like Smart Beginnings are you aware of in your community? (e.g., Trauma informed community networks, head start advisory council)
- Would community leaders support new home visiting programs? Why or why not?
- Are you aware of any proposals that have been submitted?

Has your program been asked to provide services that you feel are beyond the scope of home visiting?

- Frequency? What was the request? What did you feel was outside of what your program could/should be able to provide?

What do you see as sources of turnover? How do you try and prevent it?

- What are some ways your organization tries to make staff feel supported/appreciated?
- How are supervisors supported?

What suggestions do you have for how to make home visiting even better for families?

- What would you like to be able to do that you aren't currently doing? What would make it challenging to achieve this? What would make it easier?
- If you could change one thing about your program that would allow you to better serve families, what would it be? (e.g., funding, screening requirements, policies, external factors, etc.)
- Within the home visiting system, where would you like to see more resources allocated?
- What other feedback do you want us to know about your state and national system?

Tell me about your experiences with the offices at the regional or state level who help you implement your program or provide training or other supports (ex. Technical assistance contacts at VDH or Families Forward, Nursing Consultation, etc.).

- What has been particularly helpful?
- What would you like to see more of? What could the offices do differently?
- Tell me about the benefits and support that you see coming from your state model office (or state level director for Resource Mothers, Healthy Start, Family Spirit)? What is the most valuable support they provide?
- What do you know about Early Impact Virginia (formerly home visiting consortium)? In what ways do you interact with EIV? What has been particularly helpful about EIV? What would you like to see them do differently?
- How could EIV make your job easier? What supports would you like to see them provide?
- What kind of information would be most helpful (for handling issues identified in survey question about most challenging thing to manage in a HV program)?

Let's talk a bit about the transitions during COVID. What has this been like for your families? For staff?

- Did you notice/experiences any change in workforce due to COVID-19? What were they?
- What kind of technology equipment/support would be useful to help your program continue providing virtual visits/telehealth?
- Are there things you implemented because of COVID that you think you might like to keep in a post-COVID world?

How would you like to be able to use the report from the Virginia Home Visiting Needs Assessment?

Thank you for all of your comments today. Before we close, is there anything else you would like me to know?

INTERVIEW THEME SUMMARY

ORGANIZATION TYPE MATTERS

The needs of programs vary based upon the type of organization in which they are housed. For example, many CHIP programs are freestanding nonprofit organizations with their own Board of Directors to answer to, in addition to model and state level requirements. This gives them greater flexibility in many ways, but also require them to engage in significant fundraising and advertising specific to their model. Models housed within health departments are subjected to different regulations (e.g., no lobbying), often have more rigid schedules, but can have some of the most well-established partnerships with other governmental organizations like the Department of Social Services. Organizations that house multiple models seem to be most effective. Having a centralized intake allows potential clients to be directed toward the most appropriate program and to balance client loads effectively.

HOME GROWN VERSUS PROFESSIONALIZATION

There seems to be some tension between 'home grown' approaches and the professionalization of home visiting. This manifests in the composition of staff and rates of turnover as home visiting positions have moved toward requiring/desiring a college degree, whereas some areas have historically recruited from the communities they serve. Those with a college degree are more likely to view the job as entry level, move on quickly, and—at times—not relate as well to the families they serve. Those without a college degree, but who come from the target community, can require more training on paperwork and related tasks, but excel immediately in family relationship and meeting milestones with families. This professionalization is also reflected in the tensions some directors feel with leadership who has not come up through the home visiting system and experiences the job on the front lines—similar to the sentiments expressed by home visiting staff about supervisors who had not first been home visitors.

COMMUNITY AND HOME VISITING COORDINATION CHALLENGES

Most challenges with community coordination were traced back to challenges with community awareness of home visiting and challenges coordinating within and among home visiting programs themselves. One of the primary challenges is in advertising and communicating to the community what home visiting is. Across the board, directors felt that there was very little community understanding of what home visiting is. Whenever organizations try to do presentations to community boards or community agencies, "the audience ends up with their head spinning." It is challenging to communicate the various models and what the differences are between each. It seems to be more effective, or at least more understandable to the community, when home visiting in general is promoted versus individual programs. Similarly, if you just have one point of contact for the community, people seem to be more comfortable with referrals because they don't have to know which of the models was going to be the best fit for the client or try to make that decision of which organization to refer to. Having a unified home visiting campaign that can be tailored to local can be helpful, although these present challenges in some areas where there are multiple models and directors expressed concerns about adding individual model branding and stepping on toes of other agencies placing them in the same healthcare provider offices. Several regions expressed the need for additional oversight from EIV and direction in terms of figuring out how to best coordinate with other home visiting agencies in the region. There are concerns about the ways in which home visiting programs have come about in various regions, which were often tied to various sources of funding. This has led to duplication and administrative bloat. If sources of funding could be streamlined, more resources could be dedicated to serving client.

DIRECTOR INTERVIEW THEMES

ORGANIZATION TYPE MATTERS

The needs of programs vary based upon the type of organization in which they are housed. For example, many CHIP programs are freestanding nonprofit organizations with their own Board of Directors to answer to, in addition to model and state level requirements. This gives them greater flexibility in many ways, but also require them to engage in significant fundraising and advertising specific to their model. Models housed within health departments are subjected to different regulations (e.g., no lobbying), often have more rigid schedules, but can have some of the most well-established partnerships with other governmental organizations like the Department of Social Services. Organizations that house multiple models seem to be most effective. Having a centralized intake allows potential clients to be directed toward the most appropriate program and to balance client loads effectively.

> *I know, I freely admit that I am biased towards CHIP because I do feel like it is the most comprehensive program. Because it does have the nursing and the parent educator. And it does have the open enrollment through age six. We go a year longer to make sure those kids transition into kindergarten. To me, it is the most comprehensive program out there. So, there's nothing that these other programs do that CHIP doesn't do. But there are things that CHIP does that these programs don't, won't, and can't. And honestly, some of them aren't motivated to do. There's a different feeling if you work in a nonprofit that is definitely mission driven, than if you are in a big system like a health department. It's just a whole different culture. So when we're out there hauling thousands of pounds of Pine Sol, it wouldn't even occur to them to step up and do a program like that because it's not, it's just not in their work culture to do it. And years ago, the CHIP of Virginia board of directors came to this conclusion, too, that these programs are successful when they are in a nonprofit and not attached to a government entity. Because you can fundraise, you can get out there and do things, you can mold your program to fit the communities that you're serving. Because what we do in Chesapeake is different than what we do in Portsmouth. You can build your champions for your program in the community. You can make the business case to that community and say, "Hey, this is why we're here and this is why we're doing it." You can be a promoter of home visiting in early childhood. That's not part of the job description if you work at the Health Department.*

> *We've [CHIP] become the master of blending and braiding of funding to be able to serve our communities that do not come across as very needy. We have to raise a lot of our own money, which I think makes us fairly unique in the system, that we are a freestanding nonprofit. The only programs we do are for children under the age of six, so we don't also have a finance education program. This is our gig, this is what we do. So, it does allow us the flexibility to go after private funding where a lot of our counterparts in South Hampton Roads are in health departments or other agencies where this is not the priority. So, in order to serve Chesapeake and Virginia Beach, we raise a lot of our own money to do that.*

> *The other thing I don't think that EIV gets is the position of running a freestanding nonprofit. They've never done it. I don't think they understand how different it is for CHIP of South Hampton Roads versus a program that's housed in a health department. I can't go out and promote home visiting just in general because I have to go out and promote CHIP. And I don't think they ever understood that. So I'm not going to go to a doctor's office and talk about how wonderful home visiting is. I'm going to go to a doctor's office and say, "Hey, let me tell you about CHIP and what we can do for your families. And oh, by the way, would you like to be a monthly donor?" It's twofold. We market for families to come into the program at the same time as we're marketing for donors and for community, just community awareness about us. We have large events and do some PSAs and radio ads and things like that. But there was a feeling that that should all be about home visiting in general, but I can't do that. And I would also be the only one out there doing that because nobody else is in a position where they can.*

HOME GROWN VERSUS PROFESSIONALIZATION

There seems to be some tension between 'home grown' approaches and the professionalization of home visiting. This manifests in the composition of staff and rates of turnover as home visiting positions have moved toward requiring/desiring a college degree, whereas some areas have historically recruited from the communities they serve. Those with a college degree are more likely to view the job as entry level, move on quickly, and—at times—not relate as well to the families they serve.

> *What I will say is that we have folks sign an 18-month commitment letter when they start at CHIP. I haven't had anyone work less than 18 months in I don't know how long. And when they leave, they're leaving to stay in the field. Most of my parent educators are working on their master's degrees. Or have them already. So, we are definitely a training ground for folks. Which I don't think is a bad thing. It's hard having staff transition, but they're staying, again, they're staying in the field and they're learning here. We actually have quite a few alumni that work at the children's hospital. And they're still in communication with us constantly and doing referrals to us because they know what it's like and they can relate to their families that they're working with there and explain what CHIP is all about and home visiting.*

> *One of the things that it's hard to convey as you're interviewing candidates, especially the parent educator... We have nurses here too, but especially for the parent educator positions, is what is the work really like. You do your best of explaining it and doing all kinds of things, but when the reality sets in of somebody starts working, and it just came up the other day when I was talking to one of the supervisors about a fairly new parent educator, and the supervisor's saying to me...the parent educator's saying, "This isn't what I expected." Now we do our very best, but I think until you're in it, sometimes you just don't know, until you're really in it.*

Those without a college degree, but who come from the target community, can require more training on paperwork and related tasks, but excel immediately in family relationship and meeting milestones with families.

> *The world of early childhood home visiting, you hire people out of the community to work within the community. It has become so professionalized now, to where the expectation is you should have a college degree, It's just become over-professionalized. And it's really gotten away, at least in this area, okay, maybe in a smaller community, maybe not so much, but I know in the 13 years that I've been doing this, early childhood home visiting has just become too professionalized. And too many hoops that families need to jump through to be a part of the program. Too much, just too much. So staff turnover, here's what happens is, we typically end up hiring people just getting out of college, it's an entry-level job, they're only going to be here for a couple of years because they're probably going to go back to graduate school, or they're going to get out of the field entirely because several people get out of the field and go sell real estate. And the job market, the salary isn't a match, so we'll sometimes lose people to a government entity where there is an early childhood home visiting program but they pay better and the benefits are better. Salary and benefits are also a challenge for maintaining staff, and we've done a lot to help with enhancing staff engagement in the organization, but you can't compete when it comes to a salary, or people in their early years of their own professional development.*

> *We have one home visitor in particular, who is amazing in how she connects with families, and supports families, and she struggles all the time to meet the criteria of what counts a home visit, getting the right boxes checked in ETO, the screening tools, and she is amazing with families. And she will do this for a long time, that's the kind of people I think should be in home visiting, and get well compensated for that work, so that's more of how I see it. I know you know this, early childhood visiting is all about building a*

relationship with someone. And there's a skill set to be able to build that relationship and also meet all of the check boxes, it's a skill set.

But I will say this, it occurred... and now I'm going to talk about race, okay? And we do a lot of conversations here around race and all, we have a racial equity inclusion committee, the two times it's happened, it's been two young, white women. It was really new for them, but our black home visitors were like, I grew up hearing gun shots, I've grown up being exposed, and that's been a really interesting dynamic to see, in terms of just people's backgrounds.

Because of this professionalization, we're missing the opportunity to hire people who would be great home visitors, but they don't meet the educational criteria, and that's a real loss to this field.

This professionalization is also reflected in the tensions some directors feel with leadership who has not come up through the home visiting system and experiences the job on the front lines—similar to the sentiments expressed by home visiting staff about supervisors who had not first been home visitors.

I think the models have become too rule driven and they need to really think about what the families need. So what do I mean by rule driven? You have to meet minimal expectations related to a set of criteria and you have to conduct in a structured way for it to count as a home visit. So I think the models have really gotten away from the grass roots of what early childhood home visiting was designed to do. And I know, here, internally, we talk about that often, and our frustration.

Here's a good example. This survey thing. And I know, it's the pandemic. But it was sent out and you had 10 days to get it out to your key people. . . And I had full intention of sending this thing out to all these people. But then we have a huge uptick in COVID cases. Huge. And then we have a hurricane. And then people don't have power. When they finally get their power back, they don't have their internet back. So, we missed an opportunity to say, "Hey, I'm going to send this out to all of them," even though I don't know what it is. And I get it, you guys have got to move on, you got deadlines, too. But there was no understanding that during that uptick in COVID cases, during the hurricane, my focus was not going to be on a survey for EIV. It's that sort of thing.

Great, everybody's working remotely. I haven't worked remotely since this whole thing started because we have to be here because we have to serve the families. It all has to come back to the families, and I think sometimes EIV is just missing the mark when it comes to that. And it's because they're so far removed from the field. I don't think it's intentional. I think it's easy to forget.

I think the educational pieces that EIV have done have been outstanding. Always have. That's how they started and I think they're wonderful. We put all of our staff through it. That's been really good and I think they've standardized a lot of the training, which, that's really helpful. I think back to when I started and trying to find the right training for my staff all the time was almost a part time job. And so now it's all in one spot and it's so much easier. And good quality. The rest of EIV, I think nobody knows what they're doing and I am pretty well informed. It's a mystery, what EIV is supposed to be doing. I think things happened with the merger that nobody expected to happen, nobody was involved in any decision making. We asked for organizational charts for two years before we got anything. I don't think there is a good understanding of what's happening on the ground, at least in this area. I think there's a lot of people who have never done the work that are in charge of things that should've been at least more exposed to the work.

COMMUNITY AND HOME VISITING COORDINATION CHALLENGES

Most challenges with community coordination were traced back to challenges with community awareness of home visiting and challenges coordinating within and among home visiting programs themselves. One of the primary challenges is in advertising and communicating to the community what home visiting is. Across the board, directors felt that there was very little community understanding of what home visiting is. Whenever organizations try to do presentations to community boards or community agencies, “the audience ends up with their head spinning.” It is challenging to communicate the various models and what the differences are between each. It seems to be more effective, or at least more understandable to the community, when home visiting in general is promoted versus individual programs.

> *So I'm on the board of Minus Nine to Five, which is sort of like Smart Beginnings in South Hampton Roads. Run by the community health, or the Hampton Roads Community Foundation. And there's some players on that steering committee, no doubt. Lots of doctors and provosts and... And they asked for an explanation of home visiting in Virginia. And Laurel came down and she gave her presentation, which was fine. But let me tell you something. It takes months to really understand. And they just looked so perplexed. I'm like, "Here are these brilliant people." And Laurel gave a fine presentation for what it is, but the feeling when they left the room was, "why are there so many programs?"*
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> *It just doesn't make any sense and it makes us look ridiculous in this community, to have this many programs. Makes us look like we don't know what we're doing.*
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> *They don't. They don't. If you were to walk down the street and ask five people what home visiting was, they would have no idea. If you were to ask referral sources about home visiting, I think if you ask most of the OB/GYNs and pediatric practices, they might have some idea, but they don't make a whole lot of referrals because they don't know what they're going to get on the other end. And they certainly, if you do it through centralized intakes, centralized intake is them going to determine whether that family needs a nurse or not. And that's not really their role to do that. So, I think if they know home visiting, they know it through CHIP, and I'm not just trying to pat myself on the back. It's because we are the freestanding nonprofit that only does this. We are the ones out there, grassroots, raising money, so they hear our name more.*
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> *We just did a PSA and a radio commercial about equity and how it relates to CHIP. I don't think that's being done enough. Our whole thing is equity starts here and it starts with a healthy baby and a healthy mom. Equity starts when kids are ready for school. Typical things. We just have never talked about it in terms of home visiting, how equity relates to things. That's something that we, as home visiting in general, need to be looking at because we are on the ground doing the equity work. We've been doing it for a long time. We just never position ourselves that way.*

Similarly, if you just have one point of contact for the community, people seem to be more comfortable with referrals because they don’t have to know which of the models was going to be the best fit for the client or try to make that decision of which organization to refer to. Having a unified home visiting campaign that can be tailored to local can be helpful, although these present challenges in some areas where there are multiple models and directors expressed concerns about adding individual model branding and stepping on toes of other agencies placing them in the same healthcare provider offices.

> *I think you have to just start one on one, building up relationships, that's really what makes the difference. About seven years ago, there was the home visiting in the city of Richmond, [Whole Home Visiting Center], that was the clearinghouse for referrals and all, but that went away. And that offered a great opportunity for collaboration, but the players changed so there ceased to be an investment in that, but there was a lot of effort related to home visiting back in those days, and it's just not there like it used to be.*

The only other early childhood home visiting program that's in the footprint that we're in is Richmond Healthy Families, but they serve just a small part of the city, we serve all of the city. So, we'll get referrals that they're not serving in the city, they'll send us referrals. So right now, we don't have any competition with early childhood programming, but Urban Baby Beginnings and the doula initiatives that are occurring, certainly some of our pregnancy referrals are now going there.

Let's see, 11 home visiting programs in South Hampton Roads. My last count. We have Baby Care in Chesapeake, Portsmouth, Norfolk. We have, in Norfolk, there's also Loving Steps program. There is a PAT program, a Healthy Families program. In Suffolk, we have a nurse/family partnership and a Healthy Families program. Virginia Beach has Baby Care and Healthy Families, both housed in their health department. And then there's Urban Baby Beginnings, which we know they're here, but we don't know very much about them . . We do coordinate in that we have a South Hampton Roads home visiting alliance. And I have been at CHIP for almost 15 years now. The alliance has been there pretty much since I came. And I can tell you the agenda from our first meeting reads the same as the agenda from our last meeting. It's not about us not liking each other or a squabble, it's not that. It's just that there are so many programs, so we compete for dollars, we compete for families. And the standard of the quality of the service differs greatly, I think, from program to program sometimes. Particularly when there's not an evidence-based model. Baby Care in Chesapeake is fabulous. Baby Care in other cities, not so much.

And we don't all do the same thing. CHIP has nursing and the other programs either just have nursing or they just have parent educators, and we have both. So, it's kind of hard to put us all in one basket and promote home visiting when there are different programs and different outcomes.

Urban Baby Beginnings sort of took us by surprise. And we still haven't figured out their niche with us nor will they cooperate and talk to us. They're not part of the home visiting alliance, yet, that I know of. They've tried to get them involved. I don't know if they're working through centralized intake. I recently worked with some folks over there because they're part of a diaper bank, too, so I bought, I don't know how many thousands of diapers for this project through them and they're great to work with. And then I said, "Okay, so, let me give you these other supplies for your families because you're part of South Hampton Roads. We're all in it together." And they refused. Why would you refuse this for your families? Why would you refuse antibacterial hand soap during a pandemic?

Several regions expressed the need for additional oversight and direction from EIV in terms of figuring out how to best coordinate with other home visiting agencies in the region. Templates for decision trees and other algorithms that outline potential client flow could be helpful (see Fairfax County Health Department for an example).

Ideally, the data from the needs assessment would point EIV, Families Forward, the Commonwealth of Virginia, to do something to straighten out the mess in South Hampton Roads. With all these multiple programs. And I don't know. I feel like, from what I hear, we are really the only region that has this issue. Roanoke's got CHIP and a small Healthy Families program that's fairly new. I know northern Virginia has Healthy Families and a Nurse/Family Partnership. Southwest Virginia, they might have a CHIP. They have CHIP. They have a Healthy Families program. But nobody is dealing with six programs in one city. It's incredibly frustrating. And we spend so much time trying to collaborate. If we would just consolidate, nobody would lose a job. It's just working with the funders to make them understand how much more efficient and effective that this would be. And maybe it's [inaudible 00:51:23] two programs. Maybe it's CHIP and Healthy Families. Or maybe it's CHIP and Baby Care. I don't know. You have one, two, three Healthy Families sites in South Hampton Roads. Why don't they merge?

And the waste of resources is the big thing in my mind, because... So there's three Healthy Families sites, so all three of them have to be affiliates, they all three have to pay the affiliation fees, they all have to go through their TAQA, they have to pay for their training. It would save the state money to have one Healthy

Families site that one TAQA was responsible for instead of having three different sites. Same with Parents as Teachers. We all have to pay affiliation fees and go through APRs and blah, blah, blah. New systems, all Penelope, I don't know if that's going to cost us or not, but... Having one site makes more sense than having two sites.

There were concerns about the ways in which home visiting programs have come about in various regions, which were often tied to various sources of funding. This has led to duplication and administrative bloat. If sources of funding could be streamlined, more resources could be dedicated to serving clients.

Here's the history of why we have three models. The CHIP model, which is also Parents as Teachers is a part of that, CHIP was originally a stand-alone, 20-some year home visiting organization in the city of Richmond. In 2011, after a lot of due diligence on the part of Family Lifeline's board and CHIP's board, we merged. CHIP merged with Family Lifeline, so that's how we have the CHIP model under Family Lifeline. Family Lifeline already had the models, okay? And then when MIECHV came on the scene, because you needed to use an evidence-based model, we used Parents as Teachers. That was really initiated under MIECHV. That's how we ended up with three models, and it's kind of crazy making, because we have all these different funding sources too. So it's not only government revenue, but currently foundations. We have support from a number of foundations, individual donors, there's been a real, real concerted effort to recruit individual donors, especially at $1,000.

It came by city. And it was, here's money for Health Families in Chesapeake, here's money for Healthy Families in Norfolk, and here's money for CHIP in Chesapeake and here's money for CHIP in Norfolk. Now, we merged. We were CHIP of Chesapeake, then the state asked us to take over Portsmouth and then Norfolk. So it became CHIP of South Hampton Roads and then we expanded into Virginia Beach, which never had a CHIP site. The other programs have not done that, so that is part of the reason why we have so many separate programs. Some of the Healthy Families program are so small, but they still are carrying that administrative burden. Some of them have two employees, some might have three employees. It doesn't make sense to me why we have to have this many programs. People need to learn at the state level to coordinate a little bit better between the Health Department and the Department of Social Services where the funding is coming, and merge some of these programs together. It just would make more sense.

They would put aside what's going on in their individual agency and decide what's best for the community. Which is probably not having all those programs. Now, that's a tall order for anybody to say, "My program would be better off someplace else." That's not likely that anybody is going to say that. It's even rarer at the state level that they're going to say that that's the best way to go. But I think that's the work of that coalition. They need to figure out the best way to use the dollars that probably will be even more restricted, that come to this community to serve more families and stop paying all these administrative costs for individual sites. And I've told everyone, if it gets to that point and CHIP is no longer the way to go, I would cry my eyes out and hang out in my pajamas for a week, I'm sure. But it still would be the right thing to do. Because we trip over each other and waste money, and we don't do a good job promoting ourselves because we're all in our own little thing. We all do something slightly different.

I think at the state level, I don't know if they truly understand how regional this area has become. It's changed even in the 15 years that I've worked here. You don't really see things city by city anymore. It is, you have regional programming. And just for those reasons, five miles, you can move across the street in some areas of South Hampton Roads and be in a different city. One side of the street is in Portsmouth, one side of the street is in Norfolk. So, if you're only serving one of those cities, then that's a problem.

COVID

When asked about the challenges faced during COVID, most focused on the impact it is having on the families they serve. Home visitors have become the lifeline for families and are expanding their workload to help families navigate this new terrain.

> *Yeah, we actually... Our Norfolk case load is bulging. We can't one more Norfolk case. A lot of them are coming from CPS because I have a relationship with a lot of the CPS supervisors. And they're looking for another way to try and set eyes on these kids even if it is remotely. And then we've had some medical, more medically fragile children, that have come our way through CHKD. Which is hard because our nurses want to be out there laying hands on these kids. And we've started to do a couple that we couldn't figure out any other way but to go in the home. We got them all the PPE we could find and went in the home because we had a lady who had a Ziploc bag full of assorted prescription drugs. And she was just taking whatever she thought was right at the time. A lot of them were psychotropic. So, we had to go out and set up pill boxes. There was nobody else to do it.*
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> *Many of our families do not have the capability to do Zoom, don't have the hardware for doing Zoom, or our Latinx families, it's not something that they're comfortable even trying to do. So as of today, we're going to start using WhatsApp, and we had resisted using that, but we're going to now implement WhatsApp because it's become an equity issue. So many of our families are electing to only do phone calls, which means you can't observe parent child interaction, and help support that parent to enhance their interaction with their child.*
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> *I think we probably still only have the only bilingual team as far as home visiting goes. And our Hispanic population has been hit really hard and with some really devastating decisions to make about how mom and dad both get tested positive, dad's in the hospital. Mom's home, but asymptomatic for right now. They share a trailer with another family. How do you isolate mom and still take care of her kids? It's just been complicated. And then their fear of getting tested because they think ICE is around the corner.*
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> *I worked to get their minutes expanded when this whole thing first started. They had Medicaid phones with 350 minutes on it. So, I spent, I don't know how many days calling insurance companies and state legislators and calling US Senators and Congressmen and talking about this and moving it up the chain because nobody else had thought about that. So, I thought about the technology stuff first, too.*
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> *I never thought of tables and chairs. And I was a home visitor for years, and I'm sitting here scratching my head thinking, "Didn't all my families have tables?" And I think for the most part, they did. But then when you start talking about three or four kids sitting around a kitchen table all at different grade levels trying to do their work. And then some of them just don't even have kitchen tables, they were telling me. We got family with six kids that's living in a two-bedroom apartment. How are five kids going to go to school online? That's like, holy cow. It's a whole new experience. We're trying to figure out some of these problems for these families, and we really prided ourselves as not being a giveaway sort of organization. We have an incentive program that we do. But we've turned into sort of a giveaway program because they need it and they have no other way to find it and it's not about self-sufficiency. It's about immediate need.*
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> *People who lost income because of the pandemic. We have a lot of low wage earners on our case load. And seriously, we have everyone from a exotic dancer who lost her job to somebody who used to dress up like the Easter bunny at the mall who lost her job. It's just run the gamut, so the United Way and their COVID response fund. . . they actually allowed us to administer part of their fund to give direct assistance to our families. So, we've been paying rent and telephone bills. $56000 worth. In the past three months. It's just changed the way that we have to function.*