Maternal Infant and Early Childhood Home Visiting Program

North Carolina 2020

Statewide Needs Assessment

University of North Carolina at Chapel Hill

School of Social Work

Jordan Institute for Families

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Historical Context

The 2020 needs assessment was completed in the midst of significant social and public health events. The COVID-19 pandemic began its spread in early 2020, with the first case in North Carolina confirmed on March 3rd. On March 10th Governor Roy Cooper declared a state of emergency, and closed public schools and implemented a statewide stay-at-home order on March 30th. The health, economic, and social effects of COVID-19 are still being felt and the magnitude of the pandemic's impact is still not fully known. From conversations with home visiting partners during this time, we do know that most home visiting programs shifted almost seamlessly to virtual services. We also know that maintaining these virtual services throughout the COVID-19 pandemic has provided a lifeline for many vulnerable families in our state. Because this needs assessment focuses on data collected primarily in 2019, our findings do not reflect the current state of needs pertaining to COVID-19 in the summer and fall of 2020.

On May 25th, George Floyd was killed by police officers in Minneapolis, sparking nationwide protests demanding racial equity. His death catalyzed a broader reckoning with anti-Black racism in the U.S., exemplifying the many Black lives lost to senseless violence. In our report, we estimate that 68% of families served and 23% of home visitors in our state are Black. We recognize that Black families and communities live daily with the trauma of racial injustice, including the threat of violence, increased risk of mortality from COVID-19, and financial concerns due to the emerging economic crisis. We do not fully understand the impact of current events on the Black families being served in NC, but we recognize it as significant and important. As society reconsiders the roles of government and social services, including policing as well as home visiting, we must continue to examine how policy decisions advance racial equity and whether services reduce racial disparities.

Executive Summary

This report outlines the 2020 North Carolina (NC) Maternal Infant and Early Childhood Home Visiting (MIECHV) Needs Assessment, which examined existing home visiting programs and specific counties identified as at-risk through community assessments. The goal of this work was to highlight gaps in services for NC's at-risk populations and emphasize strengths in the state's home visiting programs.

The needs assessment identified six highest priority counties (i.e., Anson, Bertie, Richmond, Scotland, Vance, and Washington). These counties have the highest risk levels in the state but currently do not have a MIECHV-funded home visiting program. The five county-level domains of risk were: socioeconomic status, perinatal outcomes, substance use, child maltreatment, and crime. We performed Community Readiness Assessment sessions in the six highest priority counties to deepen our understanding of how these domains of risk impacted families and the county's readiness to implement a home visiting program. Stakeholders were asked to share knowledge about strengths, existing programs, and service gaps in their areas. In all six counties, stakeholders suggested that home visiting services could potentially benefit their communities, but all expressed the need for additional resources (e.g., funding, workforce development) for these services to be successful.

North Carolina's home visiting system continues to grow in its reach and continuum of services. Using a statewide survey and data provided from existing programs, we identified 13 active home visiting programs in NC, nine of which are evidence-based programs and therefore eligible for MIECHV funding. We estimate that in fiscal year 2018-2019, over **16,000 families** were served by home visiting programs and over **66,000 home visits** were provided in NC. However, North Carolinians' access to home visiting is primarily determined by where they live in the state: 12 counties served zero families with evidence-based home visiting programs, while 3 counties served over 1,000 families.

This report provides additional details about the county-level risk assessments, the inventory of home visiting programs in the state, and survey results regarding the quality and capacity of current home visiting programs. The results of this needs assessment will assist the NC Division of Public Health in identifying target populations and selecting home visiting strategies that best meet state and local needs.

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Introduction

The purpose of the 2020 North Carolina (NC) Maternal Infant and Early Childhood Home Visiting (MIECHV) needs assessment was to identify populations at the greatest risk for poor maternal and child health outcomes and support decision-making about home visiting models that best meet state and local needs.[1] The prior statewide needs assessment was conducted in 2010, at the initiation of the federal MIECHV program. A decade later, the NC MIECHV program is funding two models implemented in seven programs as part of growing system of statewide family support services. Like many programs, MIECHV services are limited in reach by funding. However, as part of the larger continuum of services, MIECHV programs provide critical support for NC's highest need families. Success of the larger system relies on the integration of MIECHV programs into the state's patchwork of public and private-funded home visiting services. This updated needs assessment provides comprehensive data on where needs in the state are greatest and identifies opportunities to strengthen and expand existing services.

This report has five sections. **Part I: County Risk Assessment** presents analyses of county-level quantitative data for a set of risk domains and indicators and identifies six "highest priority" counties with high risk and no MIECHV services. **Part II: Readiness for Implementing Home Visiting** presents findings from a qualitative analysis of focus groups conducted in the six high priority counties. These focus groups explored local readiness to implement home visiting programs. **Part III: Existing Home Visiting Programs** provides an in-depth inventory and descriptive analysis of existing home visiting programs in NC, focusing mainly on the quality and capacity of existing programs. The results of this section were primarily derived from a statewide survey conducted in late 2019. **Part IV: Substance Use Disorder Prevention and Treatment** focuses on the critical connection between home visiting and substance use services in NC. Like many other states in the region, NC is still recovering from a major substance use epidemic driven largely by untreated opioid addiction. Home visiting services offer a means of accessing treatment, particularly for pregnant women and new parents. This section describes the landscape of substance use services in NC and how to strengthen this service connection. **Part V: Coordination with other Needs Assessments** situates the MIECHV needs assessment within the larger context of public health and social services delivered in NC. We describe how the findings from this needs assessment were discussed with other state partners to inform how future efforts can continue coordination.

To begin, we will briefly describe the process of conducting the needs assessment. Our team at the University of North Carolina at Chapel Hill (UNC) utilized the resources provided by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) to guide our process. We also engaged public and private partners in the needs assessment process.[1] We primarily solicited feedback via an advisory group, which we convened regularly to provide updates and seek input. Advisory group members are listed in Table 1. Additionally, the UNC team held regular meetings with the NC MIECHV team and relied on their expertise for interpreting findings and engaging with local

[1] Health Resources & Service Administration, Maternal & Child Health. (2020). *Maternal, Infant, and Early Childhood Home Visiting Program supplemental information request (SIR) for the submission of the statewide needs assessment*. https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/miechv-needs-assessment-update-sir.pdf

partners. Further, the NC Home Visiting Consortium, convened by the NC Division of Public Health, provided input and resources for this work. The UNC team provided regular updates at each quarterly Consortium meeting.

Table 1: Advisory Group Members and Organizations

Name	Organization	Role
Serena Curry	Child First	Director of National Program Development
Diane Britz	Child First	North Carolina State Clinical Director
Kim Friedman	Family Connects International	Policy Engagement & Analysis Director
Rebecca Planchard	NC DHHS	Senior Early Childhood Policy Advisor
Hayley Young	NC DHHS	Data Office Director
Kelly Kimple	NC DHHS – Div. of Public Health	Women & Children's Health Section Chief
Marshall Tyson	NC DHHS – Div. of Public Health	Children & Youth Branch Head
Chris Bryant	NC DHHS – Div. of Public Health	MIECHV Project Director
Greer Cook	NC DHHS – Div. of Public Health	MIECHV Program Manager
Rebekkah Cook	NC DHHS – Div. of Public Health	MIECHV Professional Development Coordinator
Belinda Pettiford	NC DHHS – Div. of Public Health	Women's Health Branch Head
Rebecca Severin	NC DHHS – Div. of Public Health	Maternal Health Program Manager
Deborah Day	NC DHHS – Div. of Social Services	Community Based Programs Administrator
Karen McKnight	NC Division of Public Instruction	Statewide Head Start Coordinator
Mark Ownbey	NC DHHS – Div. of Public Health	HFA State Consultant
Amanda Leigh	NC DHHS – Div. of Public Health	NFP State Nurse Consultant
Starleen Scott-Robbins	NC DHHS – Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	Women's Services Coordinator
April Harley	Nurse-Family Partnership	NC Executive Director
Robin Roberts	Parents as Teachers	Regional Implementation Coordinator
Patti Learman	Parents as Teachers	State Coordinator
Safiyah Jackson	NC Partnership for Children	Early Childhood Systems Director
Donna White	NC Partnership for Children	Acting President
Melissa Godwin	UNC – NC Pregnancy and Opioid Exposure Project	Clinical Assistant Professor

Part I: County Risk Assessment

The first analytic phase of the NC MIECHV needs assessment identified communities at greatest risk for identified outcomes in the state. Guidance provided by HRSA directed our methodological approaches to quantitative risk assessment.

Risk Assessment Methodology

For the purposes of this needs assessment, HRSA defines "communities" as each of NC's 100 counties. However, geographic regions within counties (e.g., specific ZIP codes) could also potentially qualify as high-priority geographic areas. Further, HRSA guidelines identified five domains of risk to measure, with 13 specific risk indicators across these five domains. As noted by HRSA, "indicators were selected in collaboration with HRSA/MCHB to match as closely as possible the statutorily-defined criteria for identifying target communities for home visiting programs," with the exception of infant mortality and domestic violence, which were not included due to data limitations.[2] Therefore, these five domains (i.e., socioeconomic status, adverse perinatal outcomes, substance use disorder, crime, and child maltreatment) and 13 associated indicators reflect the population health outcomes targeted by most home visiting programs (Figure 1). Table 2 lists the definitions and data sources for the 13 indicators. Maps 1-13 display the risk levels (Z-score) for each indicator for each county.

HRSA's guidance for identifying at-risk counties (referred to as the "***Simplified Method***") uses the distribution of risk indicators to identify counties that are at least one standard deviation (SD) higher than the mean for all counties in the state. For North Carolina, if all 100 counties were placed on a bell curve, about 16 counties would fall above one SD in the high-risk direction. So, for each indicator, the analysis identified the 16 counties with the highest risk. As indicated in Figure 1, each domain contains either one, two, or four indicators. In the simplified method algorithm, if at least half of the indicators within a domain have Z-scores greater than or equal to one SD higher than the mean, then a county is considered high-risk for that domain. For example, the substance use disorder domain contains four indicators, so a county with at least two indicators in the high-risk range (i.e., greater than one SD), would be considered high risk for the substance use disorder domain. Then, the total number of domains identified as high risk is summed. Counties with two or more at-risk domains (out of five) were identified as high-risk counties.

[2] From the HRSA data summary: "Not included are indicators for infant mortality and domestic violence. Infant mortality was excluded from the Adverse Perinatal Outcomes domain because the level of suppression at the county level for 5-year aggregate data was too high for meaningful inclusion (all but 13 states have >50% of counties with suppressed data). Preterm and low birth weight births together are the second largest cause of infant mortality. Given that the other two indicators in the domain are direct precursors of infant mortality, we evaluated the extent to which similar counties were identified when infant mortality rate was included or excluded (among counties with non-suppressed data). The level of suppression for preterm birth and low birthweight was also substantial for individual year data. Thus, we compiled 3-yr and 5-yr aggregated data to obtain reliable estimates for smaller counties. Domestic violence was excluded because there are no national sources available with county-level data for domestic violence."

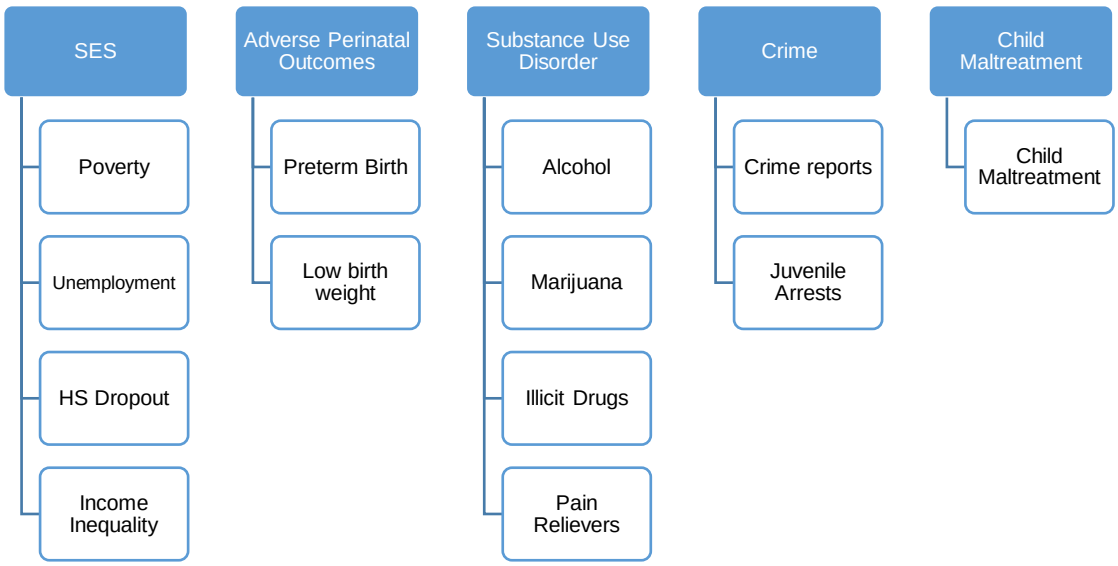

Figure 1. HRSA Risk Domains and Indicators

To complement HRSA protocols, we developed three additional "independent" methods to identify high-risk counties. Our team determined that the data sources identified in HRSA's Simplified Method provided strong indicators for identifying concentrations of risk. We also decided that the alignment of risk indicators with MIECHV statutes enhanced the policy-relevant nature of the analysis. Therefore, we used multiple methods as a sensitivity test to identify counties that consistently fell in the highest risk group across analytic methods. These methods used the same data sources but different quantitative methods from the Simplified Method. This approach ensured greater confidence in our identifications of higher-risk counties. We then explored those counties identified as high risk across all four methods (i.e., HRSA's Simplified Method + three independent methods).

The first independent analysis we conducted was the ***Equal Weight Method***. Like the Simplified Method, this method assesses all 13 indicators. However, this method gives all indicators equal weight regardless of their risk domain. In the Simplified Method, a county identified as high risk in a domain with fewer indicators (i.e., maltreatment) is more likely to be identified as a high-risk county than a county identified as high risk in domains with more indicators (i.e., SES). Clearly, this is a valid approach for identifying counties at higher risk overall. However, it is also reasonable to consider each of the 13 risk indicators as distinctly important and unique. For example, if a county was identified as high risk for poverty but not for unemployment, high school dropout, or income inequality, then the Simplified Method would not consider that county at high risk for the SES risk domain, even if poverty significantly impacted that county's residents. To address this limitation, the Equal Weight Method flagged counties as high-risk if their Z-scores were at least one SD above the mean for any four or more risk indicators, regardless of domain. We also calculated the average Z-score for each county for descriptive purposes (Map 14).

Our second independent method was the ***Limited Indicator Method.*** This method examined a narrower set of indicators that our team and advisory group perceived to be the highest priority for the NC

MIECHV program: 1) poverty, 2) unemployment, 3) preterm birth, 4) low birth weight, and 5) maltreatment. These indicators correspond to the SES, adverse perinatal outcomes, and child maltreatment domains and more closely align with NC MIECHV's focus on substance use and maternal and child health. Further, we examined these five indicators equally, meaning that counties were flagged as at-risk if their Z-scores were at least one SD above the mean for three or more of these five indicators.

Our third independent analytic method was the ***Latent Class Analysis Method*** (LCA). Briefly, LCA is a person-centered (or in this case, county-centered) method that attempts to identify groups of counties that have similar profiles or clusters of the 13 indicators. Using model-based estimation methods, we identified three "classes" or groups of counties in NC. *Class One* included 36 counties that had average to low risk across all domains. *Class Two* was characterized by 46 counties that had higher rates of indicators in the substance use domain but average to low risk in other domains. *Class Three* included 18 counties characterized by high risk in SES, perinatal outcomes, crime, and maltreatment domains, but relatively moderate risk in substance use. We considered *Class Three* counties to be high-risk counties.

Table 2: Risk Indicators, Domains, and Definitions used in County Risk Assessment

Domain	Indicator	Indicator Definition	Data Sources
Socioeconomic Status (SES)	1. Poverty	% population living below %100 FPL	2017 Census Small Area Income and Poverty Estimates
	2. Unemployment	% of the civilian labor force unemployed	2017 Bureau of Labor Statistics
	3. HS Dropout	% of 16- to 19-year-olds not enrolled in school with no high school diploma	2013-2017 American Community Survey
	4. Income Inequality	Gini Coefficient - 1 Yr. Estimate	2013-2017 American Community Survey
Adverse Perinatal Outcomes	5. Preterm Birth	% live births <37 weeks	2013-2017 National Vital Statistics System - Raw Natality File
	6. Low Birth Weight	% live births <2500 g	2013-2017 National Vital Statistics System - Raw Natality File
Substance Use Disorder	7. Alcohol	Prevalence rate: Binge alcohol use in past month	2012-2014 National Survey of Drug Use and Health
	8. Marijuana	Prevalence rate: Marijuana use in past month	2014-2016 National Survey of Drug Use and Health
	9. Illicit Drugs	Prevalence rate: Use of illicit drugs, excluding marijuana, in past month	2012-2014 National Survey of Drug Use and Health
	10. Pain Relievers	Prevalence rate: Nonmedical use of pain medication in past year	2012-2014 National Survey of Drug Use and Health
Crime	11. Crime Reports	# reported crimes/1000 residents	2016 National Archive of Criminal Justice Data
	12. Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17	2016 National Archive of Criminal Justice Data
Child Maltreatment	13. Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 children (aged <1-17) residents	2016 Administration for Children and Families Child Maltreatment

Results of County Risk Assessment

Map 15 shows county risk profiles based on these four different assessment methods. We identified 10 counties as "highest priority" because these counties were consistently in the highest risk group across all four assessment methods. Counties classified as high risk by two or three of the assessment methods were designated as "high priority." Counties identified as high risk by only one assessment method were designated as "priority" counties. Counties not identified as high risk by any methods were designated as "low priority." Across these four priority groups, the average Z-scores were $z = 0.46$ (highest), $z = 0.30$ (high), $z = 0.25$ (priority), and $z = -0.16$ (low).

Four of the ten highest priority counties already have home visiting programs currently funded by MIECHV. The remaining six counties (Anson, Bertie, Richmond, Scotland, Vance, Washington) do not currently receive MIECHV funding, but our survey results indicated that they may have other home visiting services available to families. We identified eight additional "high priority" counties that were identified as high risk by two or three methods. Two of these counties are current MIECHV sites (Columbus and Bladen); the remaining six counties (Greene, Martin, Mecklenburg, Stokes, Warren, Wilson) are not.

Review of Existing MIECHV Sites

This section briefly describes NC's current MIECHV program sites in order to provide additional details about the program's current implementation. Appendix 2 provides a more detailed fact sheet developed by HRSA to describe the NC MIECHV program in fiscal year 2019. Overall, NC's MIECHV programs funded two models (Nurse-Family Partnership and Healthy Families America) in a total of 14 counties, served a total of 402 households, and conducted 6,174 home visits. Notably, several of the current NC MIECHV programs are in counties that were not identified as high priority (i.e., high risk) by our needs assessment describes in the previous section. Phase Two of the county risk assessment includes adding in additional counties that are currently MIECHV sites; and providing relevant data. The additional counties described below are Buncombe, Burke, Durham, Gaston, Mitchell, Nash, and Yancey. Information from the NC Early Childhood Action Plan County Data Reports were used to supplement descriptions of these counties.

Buncombe County Nurse Family Partnership

The 2010 needs assessment identified multiple ZIP codes in Buncombe County as high-risk. Although we did not identify Buncombe County as high-risk in our current needs assessment, Buncombe has several negative maternal and child health outcomes that are higher than the state average. The county has a higher infant death rate for African American children (3.8 vs. 2.4 per 1,000), higher rates for children experiencing maltreatment, and less than 50% of eligible children enrolled in pre-kindergarten.[3] In 2017, 18% of children in the county under age 18 were living in poverty.[3]

Buncombe County's MIECHV site is based in the Department of Public Health. This site serves families in the 28715, 28748, 28803, and 28806 ZIP codes. The Buncombe NFP program seeks to help individuals improve pregnancy outcomes, child health, and economic self-sufficiency. Since its establishment in 2009, the program has served over 500 families. In fiscal year 2019, the site served 26 households and

[3] North Carolina Department of Health and Human Services. (2020). *North Carolina Early Childhood Action Plan: Buncombe County data report*. Retrieved August 14, 2020 https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-data/early-childhood-action-plan-county

completed 394 home visits.[4] Among program participant households in fiscal year 2019, 58% had a household income at or below the poverty line.

Gaston County Nurse Family Partnership

The current needs assessment identified Gaston County as a low-priority county. However, many county-level indicators demonstrate the need for MIECHV services in Gaston. Most notably, Gaston has higher rates of emergency room visits for children aged zero to eight (97 vs. 74 per 1,000) than the state overall. Additionally, Gaston County has a lower percentage of college- and career-ready students based on End-of-Grade 3rd grade reading assessments (40% vs. 45%).[5] In 2017, 22% of children under age 18 in the county were living in poverty.

The Gaston Community Action Partnership currently oversees a Head Start program with locations throughout the county. Head Start aims to promote school readiness for Gaston residents. The Gaston County Health Department serves as the lead agency for the MIECHV-funded NFP program, with a focus area of 38 census tracts in the county. In fiscal year 2019, the site served 79 households and completed 1226 home visits.[4] Among program participant households, 71% had a household income at or below the federal poverty line.

Northeastern Nurse Family Partnership at Halifax Community College

Northeastern NFP serves a five-county region comprised of Edgecombe, Halifax, Hertford, and Northampton Counties (funded by MIECHV) and Nash County (funded by state allocations). Halifax Community College serves as the new lead agency, which was previously Northampton County Health Department. In fiscal year 2019, 55 households were served, and 1058 home visits were completed.[4] Among program participant households in fiscal year 2019, 73% had a household income at or below the federal poverty line.

Edgecombe, Halifax, and Northampton Counties were all identified as highest priority communities by our analysis. Hertford was identified as a priority county and Nash County was identified as a low-priority county. However, several statistics indicate the need for MIECHV services in Nash, including a higher infant death rate than the state (8.3 vs. 7.1 per 1,000), a higher percentage of children considered food insecure than the state (21.9% vs. 20.9%), and a lower percentage of students reading at or above grade-level.[6] In 2017, 24% of children under age 18 in the county were living in poverty.

Robeson, Columbus, and Bladen Nurse Family Partnership

Bladen, Columbus, and Robeson Counties were all identified as high- or highest priority communities by our risk analysis. The Robeson County Health Department serves as the lead agency for this NFP program. In fiscal year 2019, 109 households were served, and 1110 home visits were completed.[4]

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[4] NC Division of Public Health, Women and Children's Health Section, Children and Youth Branch. (2019). *WHC: Maternal, Infant, and Early Childhood Home Visiting Program*. https://publichealth.nc.gov/wch/aboutus/ebhv.htm

[5] North Carolina Department of Health and Human Services. (2020). *North Carolina Early Childhood Action Plan: Gaston County data report*. Retrieved August 14, 2020 https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-data/early-childhood-action-plan-county

[6] North Carolina Department of Health and Human Services. (2020) *North Carolina Early Childhood Action Plan: Nash County data report*. Retrieved August 14, 2020 https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-data/early-childhood-action-plan-county.

Among program participant households in fiscal year 2019, 75% had a household income at or below the federal poverty line.[4]

Blue Ridge Healthy Families (Mitchell and Yancey County)

The Blue Ridge Healthy Families program implements the Healthy Families America (HFA) model. Blue Ridge Healthy Families provides home visiting services, parenting social events, a toy lending program, and child development workshops. This site also emphasizes parent communication with babies, nurturing babies, and active relationships between families and their medical providers. Our current risk assessment classified Yancey County as a low-priority county. However, Yancey had higher rates of child maltreatment, childhood food insecurity (23% vs. 21%), and higher asthma emergency room visits (16 vs. 9 per 1,000) compared to state averages.[7] In 2017, 26% of children under age 18 in the county were living in poverty.

Though not identified as a high-risk county overall, Mitchell County showed signs of a need for a MIECHV site in several indicators. Compared to state averages, Mitchell had higher rates of child maltreatment for ages 0 to 8 years and higher rates of childhood food insecurity (24% vs. 21%), as well as a very low percentage of eligible families receiving a daycare subsidy and enrolled in 4- or 5-star centers and homes in the county.[8] In 2017, 26% of children under age 18 in the county were living in poverty. Like Yancey, Mitchell County works with Blue Ridge Healthy Families to provide home visiting services through HFA.

Catawba Valley Healthy Families

Implemented by Children's Hope Alliance, the Catawba Valley Healthy Families program delivers the Healthy Families America (HFA) program to families in Lesser Burke County, as defined by ZIP codes with high needs. Our assessment classified Burke as a low-priority county, but its higher overall rates of several indicators emphasized the need for MIECHV services. Compared to state averages, Burke County has notably higher rates of child maltreatment (aged 0-8) and childhood food insecurity (23.5% vs. 20.9%), and shows higher numbers for days to reunification, guardianship, or custody for children aged 0-5.[9] In 2017, 22% of children under age 18 in the county were living in poverty.

In fiscal year 2019, 74 households were served by Catawba Valley Healthy Families and 1,559 home visits were completed.[4] Among program participant households, 41% had a household income at or below the U.S. Federal Poverty Guidelines.

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[7] North Carolina Department of Health and Human Services. (2020). *North Carolina Early Childhood Action Plan: Yancey County data report*. Retrieved August 14, 2020 https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-data/early-childhood-action-plan-county

[8] North Carolina Department of Health and Human Services. (2020). *North Carolina Early Childhood Action Plan: Mitchell County data report*. Retrieved August 14, 2020 https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-data/early-childhood-action-plan-county

[9] North Carolina Department of Health and Human Services. (2020). *North Carolina Early Childhood Action Plan: Burke County data report*. Retrieved August 14, 2020 https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-data/early-childhood-action-plan-county

Healthy Families Durham

Our current needs assessment identified Durham County as a low-priority county. However, Durham County showed higher infant death rates among African American compared to white infants than the state and a substantially higher average number of days to reunification, guardianship, or custody for children aged zero to three and aged six to eight.[10] In 2017, 24% of children under age 18 in the county were living in poverty.

Through the Center for Child and Family Health, Healthy Families Durham implements HFA through MIECHV support in a subregion of the county. Termed the East Durham Initiative, this support program was justified by criteria in the 2010 needs assessment. In fiscal year 2019, 59 households were served, and 827 home visits were completed.[4] Among program participant households in fiscal year 2019, 25% had a household income at or below the poverty line.

[10] North Carolina Department of Health and Human Services. (2020). *North Carolina Early Childhood Action Plan: Durham County data report*. Retrieved August 14, 2020 https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-data/early-childhood-action-plan-county.

Part II: Readiness for Implementing Home Visiting

The next section of this report provides information about community readiness for home visiting in the highest priority counties. Between June 29th and July 23rd, the team held meetings (ranging from 2-2.5 hours) with stakeholders in the six counties identified as highest risk. Stakeholders came from a variety of backgrounds including Departments of Social Services, Health Departments, and birthing centers. Engagement ranged from 4-10 participants in a virtual roundtable. The purpose of these meetings was to discuss each county's readiness to implement home visiting.

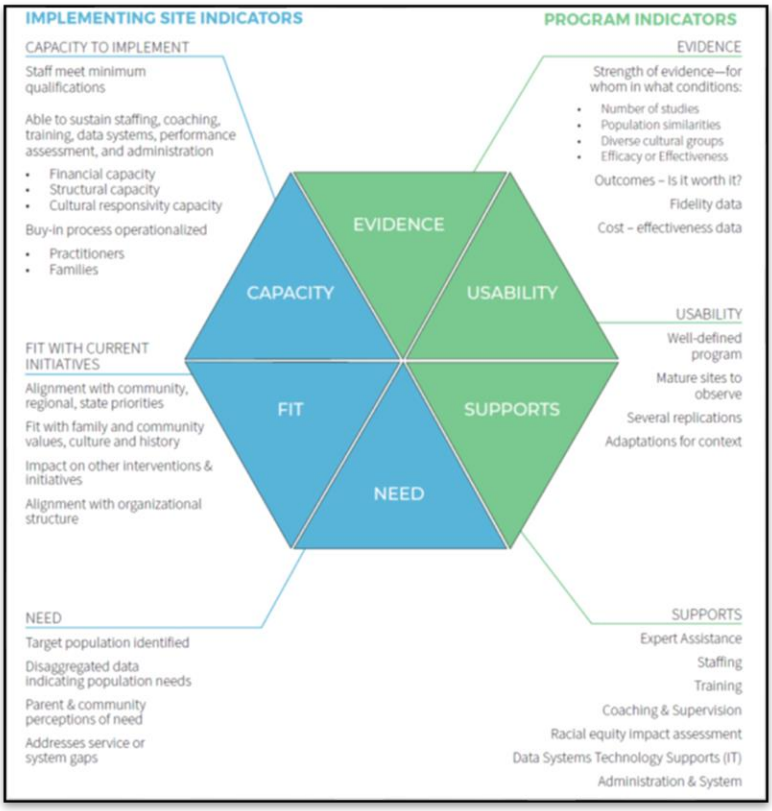

Figure 2. NIRN Hexagon Tool

The meetings included introductory information about home visiting programs and MIECHV, discussions of county-specific data, opportunities to share thoughts and opinions, and interactive polls. The team incorporated the National Implementation Research Network Hexagon Tool[11] as a guiding framework. This tool provides a structure for exploring readiness to implement a new program or practice. We also used the ZERO TO THREE home visiting planning tool as a resource for developing the facilitation guide.[12] The Hexagon Tool consists of three implementing site indicators and three program indicators (Figure 2). We did not include a discussion of evidence as a readiness indicator because we focused the discussions on the implementation of evidence-based home visiting. During the six community readiness sessions, we used interactive polls and discussion to explore indicators of need, fit, capacity, usability, and supports for implementing home visiting programs in each county. Using the Hexagon Tool, each readiness indicator had a set of questions for programs to consider based on their knowledge and responses to a corresponding rating scale (i.e., ranging from 1 to 5) used to summarize input from each participant group in each of the five indicators discussed. We

[11] Metz, A., & Louison, L. (2018). *The Hexagon Tool: Exploring context*. National Implementation Research Network, Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill. Based on Kiser, Zabel, Zachik, & Smith (2007) and Blase, Kiser & Van Dyke (2013).

[12] ZERO TO THREE. (2016). *Home visiting community planning tool*. https://www.zerotothree.org/resources/172-the-zero-to-three-home-visiting-community-planning-tool

report the summary scores for all five indicators by county in the individual sections below. Informal poll data were intended to add additional context to the qualitative discussion.

The "need" indicator examines information about the population of concern, levels of risk by geographic area, perception of need by county residents, and whether home visiting could address county needs. Ratings ranged from *strongly meets need* (5) to *does not meet need* (1). For the "fit" indicator, questions addressed how well home visiting services would align with the priorities and values of the county, how the level of fit would impact implementation, the county's level of buy in, and potential intersections of extant programs with home visiting. Ratings ranged from *strong fit* (5) to *does not fit* (1). The "capacity" indicator explored each county's current ability to implement the program via questions about the potential availability of finances, a host agency, a workforce, leadership, technology, facilities, and data collection capabilities. Ratings ranged from *strong capacity* (5) to *no capacity* (1). The "usability" indicator assessed participants' awareness of existing home visiting programs, replications and assessments of programs, definitions of home visiting and who it serves, and guidance on how to adapt home visiting for the county. Ratings rage from *highly usable* (5) to *not usable* (1). The "supports" indicator asked about implementation support, start-up costs, and training and curricula needs and availability. Ratings ranged from *well supported* (5) to *not supported* (1).

The team sought to understand the perspectives of people living and working in the highest priority counties and their perceptions of their counties' strengths and challenges. To ensure transparency, we started each discussion session by reviewing the data used to identify each county as highest risk as well as supplemental data from other sources relevant to maternal and child health. Representatives described areas of strength in their county such as positive interagency collaboration, resourcefulness, and community resilience. Participants were also invited to identify their counties' areas of need, including monetary resources, program engagement, and resource limitations associated with rural geography. We also asked participants to speak about their capacity for new or expanded home visiting programs and what challenges or needs would come up in practice. After these meetings, the research team gathered and summarized feedback for the counties involved.

Community Readiness Session Summaries

Readiness Session #1: Anson County

Anson County has higher-than-state averages for the following: preterm birth (15%), low birth weight (13%), infant mortality (11 per 1,000 live births), poverty (33%), crime (33 reported crimes per 1,000 residents and 2,271 crime arrests per 1,000 juveniles ages 0-17), unemployment (5%), child maltreatment (26 per 1,000 children aged 0-3 and 18 per 1,000 children aged 4-5), and children without health insurance (6%).[13]

Stakeholders identified county location, potential for economic development partnership, generosity, community resilience, and community mutual support as strengths. Organizations and agencies collaborate well with one another. The county's challenges include a reduced quality of life, poverty, and

[13] North Carolina Department of Health and Human Services (NC DHHS). (2019). *North Carolina provisional vital statistics*. https://schs.dph.ncdhhs.gov/data/vital.cfm; NC DHHS. (2020). *Early Childhood Action Plan county data reports*. https://www.ncdhhs.gov/about/department-initiatives/early-childhood/early-childhood-data/early-childhood-action-plan-county; NC Child. (2020). *2020 county data cards*. https://ncchild.org/what-we-do/insights/data/county-data-cards/

lack of jobs, transportation, and internet access. Further, there is low awareness/uptake of programs among county residents. Programs have experienced success in the past by "meeting people where they were," though difficulties in obtaining funding to support programs remains a barrier.

Average stakeholder responses to the polling questions are listed in the associated table. Stakeholders expressed interest in and a need for a home visiting program in the area, as well as the ability to support to support the implementation of a program. A lack of financial resources was identified as the primary barrier to moving forward.

Anson County	Average Rating
Need	4.0
Fit	4.1
Capacity	3.1
Usability	4.0
Supports	3.9

Readiness Session #2: Bertie County

Compared to statewide rates, Bertie County has higher rates of preterm birth (13%), low birth weight (13%), poverty (27%), marijuana use in the past month (8%), and unemployment (6%).[13] Strengths identified during the discussion with stakeholders included the county's racial and ethnic diversity, community resources such as after school and summer programs, and the support that community members provide to one another. Challenges included the rurality and size of the county, limited resources, limited or poor-quality internet access, poverty, employment, and an inadequate number of health care providers. Further, programs may face challenges associated with community members' distrust of service providers coming into their homes.

Stakeholders expressed interest in a home visiting program in Bertie County. Identifying a trusted implementing agency, strong marketing of services, and the need for identified program supports are key factors in assessing the viability of implementing a home visiting program.

Bertie County	Average Rating
Need	3.2
Fit	3.6
Capacity	2.6
Usability	4
Supports	3

Readiness Session #3: Richmond County

Compared to statewide rates, Richmond County has higher rates of preterm birth (16%), low birth weight (12%), infant mortality (9 per 1,000), poverty (26%), crime (48 per 1000 residents), binge alcohol use in the last month (19%), and unemployment (9%). [13] Stakeholders identified strong collaboration between organizations and agencies in the community as a key strength, as partners work together and support one another. The economy, increased substance use, inadequate services and supports for the Latinx community, and ensuring the sustainability of programs were identified as key challenges.

Key recommendations for implementing a home visiting program in Richmond County include: co-producing the program with the population served, identifying what makes a program successful in advancing improvement in outcomes, and addressing the root causes. Stakeholders also emphasized the need for a strong sustainability plan with funding to maintain all components of a program and the need to identify a program suited to the rural setting of this county.

Richmond County	Average Rating
Need	3.9
Fit	3.1
Capacity	3.2
Usability	3.9
Supports	4

Readiness Session #4: Scotland County

Compared to state-level averages, Scotland County experiences higher rates of preterm births (15%), low birth weight (17%), infant mortality (8.9 per 1,000 live births), crime (47 reported crimes per 1,000 residents; 1,968 crime arrests per 1,000 juveniles ages 0-17), child maltreatment (46 per 1,000 children aged 0-3; 27 per 1,000 children aged 4-5), teen pregnancy (46%), unemployment (8%), and poverty (26%).[13] Strengths of Scotland County that were highlighted by stakeholders included the collaborative relationship between organizations and agencies and the county's strong sense of community and family. Stakeholders also underlined potential challenges associated with financial support and transportation.

Scotland County	Average Rating
Need	3.2
Fit	4
Capacity	3
Usability	4.7
Supports	4.7

Transparency and strong relationships with the community are important factors for new programs. Stakeholders expressed interest in home visiting, particularly regarding one model. However, challenges associated with funding and staff retention were raised as a concern, as program sustainability was a key priority expressed by stakeholders.

Readiness Session #5: Vance County

Compared to statewide rates, Vance County has higher rates of preterm birth (12%), low birth weight (13%), infant mortality (12 per 1,000 live births), poverty (23%), crime (41 reported crimes per 1,000 residents), binge alcohol use in the past month (18%), nonmedical use of pain medication in the past year (5%), unemployment (6%), child maltreatment (30 per 1,000 children age 0-3; 26 per 1,000 children aged 4-5), and children without health insurance rates (7%).[13] Stakeholders in Vance County identified strong collaboration as a key strength of their community. Challenges discussed include staff retention, lack of resources in the county, transportation, availability of jobs, poverty, and food insecurity.

Vance County	Average Rating
Need	3.8
Fit	4.1
Capacity	3.6
Usability	4
Supports	3.4

Stakeholders indicated that building trust with community members, assessing a program's fit for the community, and planning implementation would be key for ensuring home visiting programs' success. A desire to think about whether a program is the right fit and plan for its implementation was key for this community.

Readiness Session #6: Washington County

Rates of low birth weight (12%), infant mortality (16%), poverty (41%), crime (56 per 1000 residents) , unemployment (7%) , child maltreatment (20%), and children without health insurance (11%) are higher in Washington County than in North Carolina overall.[13] Stakeholders identified the relationships between partner agencies and organizations, relationships with fellow leaders in the community, and willingness to collaborate as strengths of the county. Additional strengths discussed were the ability to form relationships with partners and the potential for a greater impact on the population served because of the small size of the community. Stakeholders identified challenges

Washington County	Average Rating
Need	3.3
Fit	4
Capacity	3
Usability	4
Supports	4

with accessing funding, restrictive eligibility for programs or opportunities, and distance to hospitals with obstetrical and delivery services.

Stakeholders observed the need for home visiting programs to consider how to reach the greatest number of individuals given the travel time between locations in their community. Overall, there is a high level of interest in a home visiting program, though assistance, support, and guidance will be needed to achieve implementation readiness.

Community Readiness Sessions Findings

Throughout the Community Readiness Assessment Sessions, participants expressed high interest in a home visiting program in their communities. A prime concern for stakeholders was the financial resources required to support and sustain these programs, including by offering competitive wages to recruit a workforce (e.g., nurses) to implement these programs. Participants also underlined the need to partner with trusted community organizations and stakeholders in establishing home visiting programs, particularly to mitigate distrust related to individuals coming into the home. Building trust will also require educating service recipients about the intent of the program and the role of the home visitor. In sum, there is a demonstrable need and desire for these services, yet these counties currently lack the financial resources to implement a home visiting program.

Part III: Existing Home Visiting Programs

Methodology

This section of the report shifts from a discussion of county-level risk assessments to a broader review of the range of home visiting programs available in NC. Information about individual home visiting programs across the state was collected through an online Qualtrics software-based survey. The survey included programs funded by NC MIECHV as well as programs funded by other sources. The survey was first developed as part of statewide landscape study conducted in 2017. The landscape study survey was cross walked with the MIECHV needs assessment requirements to ensure that all relevant domains were collected. The survey was developed through an iterative process with feedback from the advisory group. Appendix 1 includes the full version of the survey.

Recruitment and Response

Advisory group members and key informants helped our research term assemble an inventory list of current home visiting programs in NC. This list was used to develop personalized survey links unique to each site, which allowed respondents to complete portions of the survey, logout, and return later to enter additional information without data loss. In addition to the survey invitations sent to targeted respondents, we widely distributed an anonymous survey link through existing communication channels, including partner e-mail lists (e.g., listservs). Advisory group members, including funders, reached out directly to the programs with which they were connected to request that they complete the assessment. The MIECHV needs assessment survey was open from November 2019 to April 2020.

Data Analysis

Univariate descriptive statistics were calculated for survey responses using SPSS software. Data were collected at the agency or site level.

Results: Inventory and Capacity of Home Visiting Programs

To measure the capacity of home visiting programs in North Carolina, we used the 2020 statewide survey to identify the number and types of individuals and families who received services in NC from 2018-2019. In addition to the survey data collected from individual sites, we requested service data for each of the evidence-based national models operating in NC. We also reviewed information available online from each model to identify any additional programs in operation that were not identified through the survey or key informant requests. Tables 3 and 4 provide detailed information about the inventory of home visiting programs in NC. Table 3 provides the name of the model, the number of sites and counties it operates in, and information about the evidence supporting the effectiveness of the model.

Table 3: Inventory of Home Visiting Program Models, Number of Counties Served, and Evidence Review

Model	Website	# Sites	# Counties	EBP-MIECHV[3]	EBP-NCPC[4]	CEBC Scientific Rating[5]
Adolescent Parenting Program[1]	https://www.teenpregnancy.ncdhhs.gov/app.htm	25	24	NR	EI Promising	3

Attachment and Biobehavioral Catchup	http://www.abcintervention.org/	16	10	Yes	EB Established	1
Book Harvest Book Babies	http://bookharvestnc.org/programs/book-babies/	2	2	NR	NR	NR
Child First	http://www.childfirst.org/	5	26	Yes	NR	NR
Early Head Start – Home Based	https://eclkc.ohs.acf.hhs.gov/programs/article/home-based-option	17	29	Yes	NR	3
Family Connects	http://www.familyconnects.org/	3	4	Yes	EI Promising	NR
Healthy Families America	http://www.healthyfamiliesamerica.org/	3	5	Yes	EB Established	1
Home Instruction for Parents of Preschool Youngsters	https://www.hippyusa.org/	1	1	Yes	NR	2
Nurturing Parent Program	https://www.nurturingparenting.com/	4	7	No	EI Promising[2]	NR
Nurse-Family Partnership	https://www.nursefamilypartnership.org/	14	23 and Eastern Band of Cherokee Indians	Yes	EB Well Established	1
Parents as Teachers	https://parentsasteachers.org/	36	39	Yes	EB Established	3
ParentChild+	https://www.parentchildplus.org/	2	1	No	NR	3
Safe Care - Augmented	https://safecare.publichealth.gsu.edu/	1	1	Yes	EI Promising	2

Notes. NR = Not Rated; EI = Evidence-Informed, EB = Evidence-Based

This inventory includes programs where home visits are frequent and are the primary service offered. We do not include several maternal and child health and child welfare programs operating in North Carolina that offer home visits as supplemental services such as the Part C Early Intervention Program (NC Infant Toddler Program), care management services such as Care Management for High-Risk Pregnant Women and the Care Management for At-Risk Children Program, or child welfare in-home services such as Intensive Family Preservation Services. These programs are a critical part of the continuum of family support programs but are beyond the scope of the MIECHV needs assessment.

[1] The Adolescent Parenting Program sites use either the Partners for a Healthy Baby (*n* = 15) or the Parents as Teachers curriculum (*n* = 10). The Partners for a Healthy Baby Program (https://cpeip.fsu.edu/phb/) has not been rated by the identified groups. On June 1, 2020 all APP programs have transitioned to the PAT model.

[2] The North Carolina Partnership for Children has rated NPP program versions differently. NPP: Parents and Their Infants, Toddlers, and Preschoolers is rated as "EI-Promising." The other NPP programs for children 0-5 years are rated as "EI-Emerging" (i.e., Young Parents and Their Families; Nurturing Skills for Families; and Nurturing Fathers).

[3] The MIECHV evidence-based practice designation (*Yes/No*) is from the Home Visiting Evidence of Effectiveness literature review.

[4] The NCPC rating is drawn from the NC Partnership for Children's Smart Start Resource Guide NC of Evidence-Based and Evidence Informed Programs and Practices.

[5] The CEBC scientific rating is from the California Evidence-Based Clearinghouse for Child Welfare: 1 = *well-supported*, 2 = *supported*, 3 = *promising*.

Table 4. Counties of Operation by Home Visiting Program Model for 2018-2019														
County	**APP**	**ABC**	**BB**	**CF**	**EHS**	**FC**	**HFA**	**HIPPY**	**NFP**	**NPP**	**PAT**	**PC+**	**SC**	**TOTAL**
Alamance	28	X									101			**129**
Alexander					53									**53**
Alleghany														**0**
Anson					22									**22**
Ashe											34			**34**
Avery														**0**
Beaufort				56										**56**
Bertie				16	30									**46**
Bladen				1										**1**
Brunswick				61										**61**
Buncombe	7	X			88				291		20			**406**
Burke					63		49							**112**
Cabarrus	24	X									66			**90**
Caldwell	29				36									**65**
Camden				1										**1**
Carteret				33	15									**48**
Caswell					33									**33**
Catawba	15				75						95			**185**
Chatham					33									**33**
Cherokee											79			**79**
Chowan				3										**3**
Clay														**0**
Cleveland									134					**134**
Columbus	18			27					69		19			**133**
Craven		X		63	15									**78**
Cumberland	32				10					19				**61**
Currituck				26										**26**
Dare				16							14			**30**

County	APP	ABC	BB	CF	EHS	FC	HFA	HIPPY	NFP	NPP	PAT	PC+	SC	TOTAL
Davidson	17					144					150			**311**
Davie											49			**49**
Duplin				2							9			**11**
Durham		12	330		36	1804	120				120			**2422**
Edgecombe	17			2					43					**62**
Forsyth			343			1977			243		343			**2906**
Franklin											6			**6**
Gaston	23	X							97					**120**
Gates				1										**1**
Graham														**0**
Granville											30			**30**
Greene														**0**
Guilford	53	X			201	3300			340	287	84			**4265**
Halifax				3					20		3			**26**
Harnett	18													**18**
Haywood									45					**45**
Henderson	31				123						51			**205**
Hertford				10					3		26			**39**
Hoke											25			**25**
Hyde				8										**8**
Iredell											51			**51**
Jackson		X							44					**44**
Johnston		1												**1**
Jones				1	15									**16**
Lee	28										45			**73**
Lenoir											15			**15**
Lincoln														**0**
Macon					8				19		2			**29**
Madison														**0**

County	APP	ABC	BB	CF	EHS	FC	HFA	HIPPY	NFP	NPP	PAT	PC+	SC	TOTAL
Martin				17							11			**28**
McDowell					10				35					**45**
Mecklenburg		X			29				363	X	306	X		**698**
Mitchell							15							**15**
Montgomery														**0**
Moore														**0**
Nash				12					41					**53**
New Hanover	23	50		115							50			**238**
Northampton				19					18					**37**
Onslow	40			29	144									**213**
Orange	23	X			65									**88**
Pamlico				11	15									**26**
Pasquotank				17										**17**
Pender		X		46										**46**
Perquimans				6										**6**
Person											26			**26**
Pitt				78					103		24			**205**
Polk					1				7					**8**
Randolph											45			**45**
Richmond					22									**22**
Robeson	24								217					**241**
Rockingham	19								72		105			**196**
Rowan	19										25			**44**
Rutherford					4				89					**93**
Sampson					33		X				60			**93**
Scotland	14													**14**
Stanly														**0**
Stokes										25	25			**50**
Surry										25	25			**50**

County	APP	ABC	BB	CF	EHS	FC	HFA	HIPPY	NFP	NPP	PAT	PC+	SC	TOTAL
Swain									22					**22**
Transylvania					0									**0**
Tyrrell				4										**4**
Union					22					X				**22**
Vance	25										19			**44**
Wake		X		2	169			52	109		172		X	**504**
Warren														**0**
Washington				18										**18**
Watauga	16													**16**
Wayne				1							40			**41**
Wilkes														**0**
Wilson	37	X												**37**
Yadkin										50	50			**100**
Yancey							21							**21**
Eastern Band of Cherokee Indians									78					**78**
TOTAL	**580**	**63**	**673**	**705**	**1370**	**7225**	**205**	**52**	**2502**	**406**	**2420**	**0**	**0**	**16201**

Note. X = program identified but service count not reported.

APP = Adolescent Parenting Program; ABC = Attachment and Biobehavioral Catchup; BB = Book Babies; CF = Child First; EHS = Early Head Start; FC = Family Connects; HFA = Healthy Families America; HIPPY = Health Instruction for Parents of Preschool Youngsters; NFP = The Nurse-Family Partnership; NPP = Nurturing Parenting Program; PAT = Parents as Teachers; PC+ = Parent-Child Plus; SC = SafeCare

[a] Family Connects added Watauga County site in 2020; HFA added Sampson County in 2020

We identified 13 home visiting models operating in NC.[14] The efficacy of home visiting is supported by a wealth of rigorous research. Moreover, external raters have reviewed this research to determine which programs are "evidence-based." Evidence-based programs are identified using the Home Visiting Evidence of Effectiveness (HoMVEE) tool used by HRSA to identify programs eligible for MIECHV funding.[15] There are currently 9 HRSA-designated evidence-based programs in NC: Attachment and Biobehavioral Catchup, Child First, Early Head Start-Home Based Option, Family Connects, Healthy Families America, Home Instruction for Parents of Preschool Youngsters, Nurse-Family Partnership, Parents as Teachers, and Safe Care Augmented.

Because definitions of "evidence-based" can vary, Table 3 also includes designations from the North Carolina Partnership for Children's Resource Guide of Evidence-Based Programs and Practice (NCPC) and the California Evidence-Based Clearinghouse for Child Welfare (CEBC). The Adolescent Parenting Program has not been reviewed by HomVEE but is designated as "evidence informed promising" by NCPC and "3-promising" by CEBC. The Nurturing Parent Program does not meet HomVEE's criteria for evidence-based programs but was designated as "evidence informed promising" by NCPC. ParentChild+ (formerly the Parent-Child Home Program) does not meet HomVEE's criteria for evidence-based programs but has been designated as "3-promising" by CEBC. The Book Babies program was developed in Durham and is currently undergoing rigorous evaluation, but it has not been rated by these three external sources.

Table 4 provides an inventory of programs by county. We identified 179 home visiting provider-county pairs (one home visiting program may serve multiple counties), spanning 13 home visiting programs operating in 88 counties and the Eastern Band of the Cherokee Indians. The most widely available programs in terms of number of counties served are Parents as Teachers (39), Early Head Start-Home Based Option (29), Child First (26), and Nurse-Family Partnership (23 counties and Eastern Band of Cherokee Indians). Several programs (i.e., HIPPY, SafeCare, ParentChild+) operate in only one county. Guilford County has the greatest diversity of program offerings (7), followed by Durham and Wake County (6 each). On average, a given county in NC has 1.8 home visiting programs.

Estimating the total number of individuals and families served by home visiting statewide is challenging. Based on survey responses and additional information provided by models, our needs assessment identified **16,201 families served** and **66,641 home visits** provided in 2018-2019. The National Home Visiting Resource Center developed state profiles for all states as part of the 2019 Home Visiting Yearbook.[16] The state profile for NC is provided in Appendixes 2 and 3 and includes an inventory of 9 programs designated by HRSA as evidence-based. Their review identified 106 local agencies, 86,550 home visits provided, 13,240 families served, and 13,471 children served.

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[14] We follow HRSA's definition of home visiting: "programs where home visits are frequent, and are the primary service offered." We do not include several maternal and child health and child welfare programs operating in North Carolina that offer home visits infrequently or as supplemental services such as the Part C Early Intervention Program (NC Infant Toddler Program), care management services such as Care Management for High-Risk Pregnant Women and the Care Management for At-Risk Children Program, or child welfare in-home services such as Intensive Family Preservation Services. These programs are a critical part of the continuum of family support programs but are beyond the scope of the MIECHV needs assessment.

[15] U.S. Department of Health and Human Services (US DHHS). (2020). *Home visiting evidence of effectiveness*. https://homvee.acf.hhs.gov/index.php/

[16] National Home Visiting Resource Center. (2020). *2019 yearbook*. https://nhvrc.org/yearbook/2019-yearbook/

Results: Types of Families Served

The families served by home visiting services in NC and those services' goals generally reflect the target populations and program goals for the models operating in the state. Figures 3 and 4 display survey results about home visiting target populations and outcomes. The most common target population was low-income children and families (58%) and the most common outcome was child health and development (61%).

Figure 3. Target Population of NC Home Visiting Programs

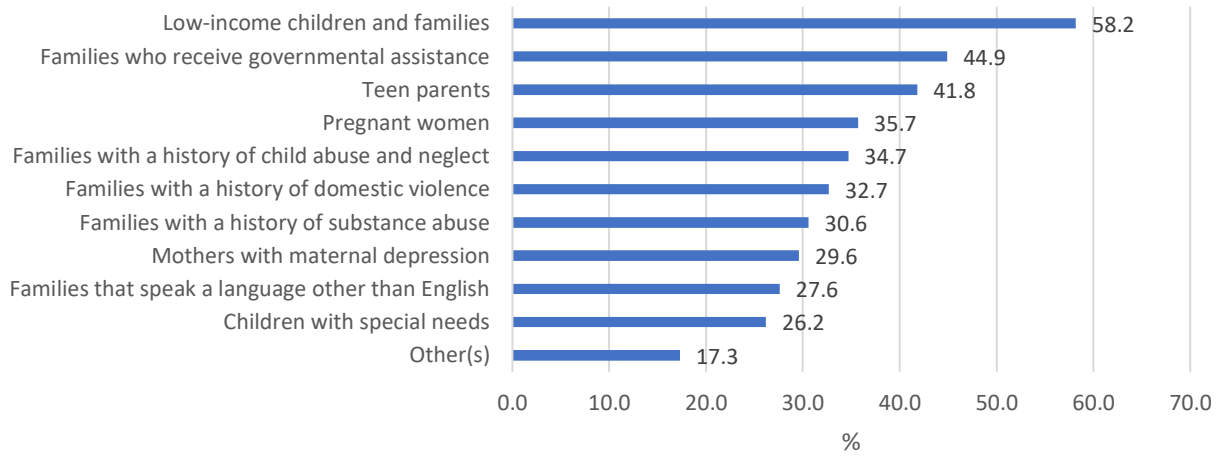
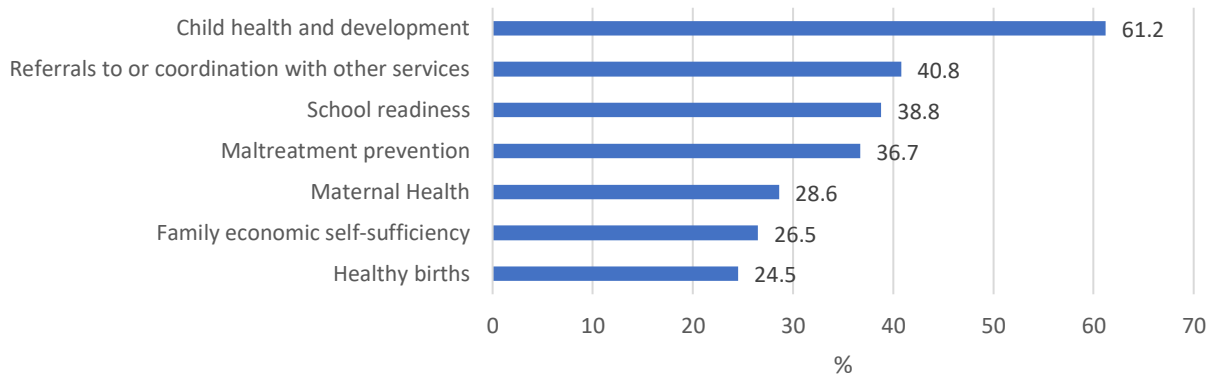


Figure 4: Primary Target Outcomes of Home Visiting Programs

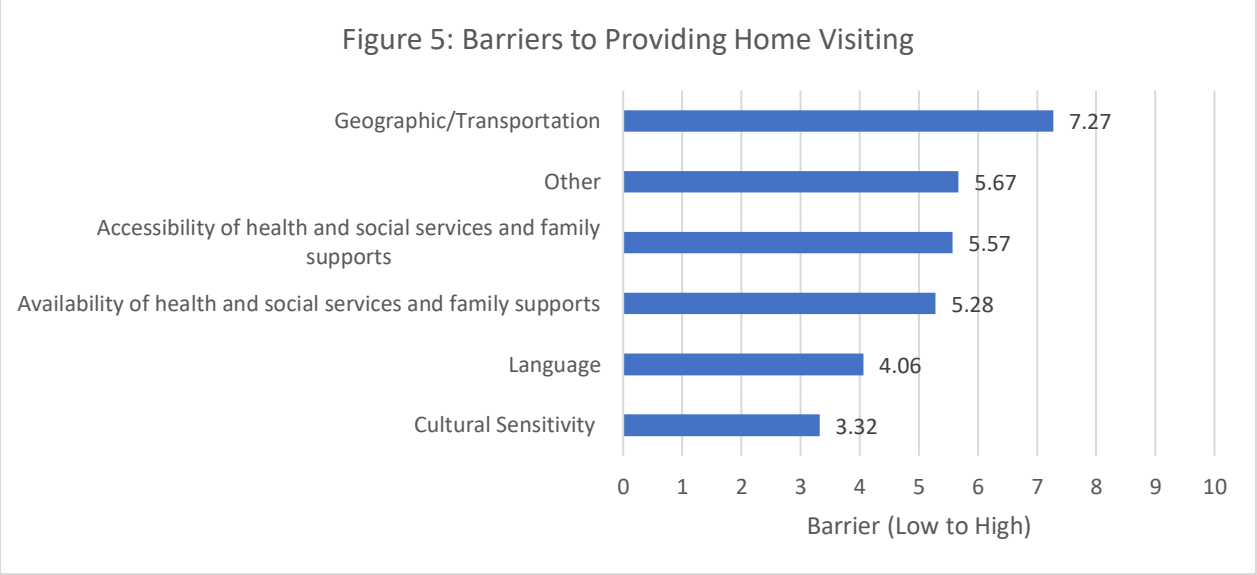


Results: Gaps in Home Visiting Services

Measuring attrition across home visiting programs is complicated by those programs' varying definitions of attrition, program engagement, and program completion. The survey asked respondents to report the percentage of families that completed or graduated from a program, based on their own definitions. Based on this item, 59% of families who exited a program completed or graduated. Survey results indicated that 52% of programs had a waitlist, 32% had no waitlist, and 16% were not allowed to

maintain a waitlist due to their funding or model specifications. Among programs with a waitlist, the average number of families on the waitlist was 14.1, and the largest reported waitlist was 40 families. We asked survey respondents to report the percentage of staff retained during the reporting period. Among those who reported this data, average staff retention was 90%.

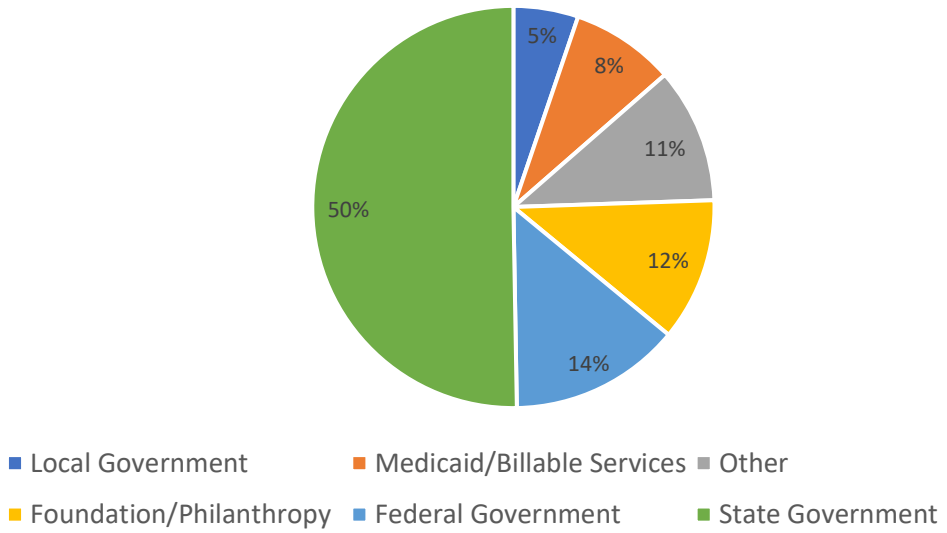
Using a 0-10 scale, survey respondents identified barriers to delivering home visiting services. Results (Figure 5) indicate that geographic/transportation (*M* = 7.3) issues were the greatest perceived barrier of those listed and cultural sensitivity was perceived to be the lowest barrier (*M* = 3.3). The "other" barrier category had the second highest rating (*M* = 5.7). The 13 unique text responses to the "other" category included categories of affordable childcare, affordable housing, poverty, and services for undocumented parents



Results: Costs and Funding of Home Visiting

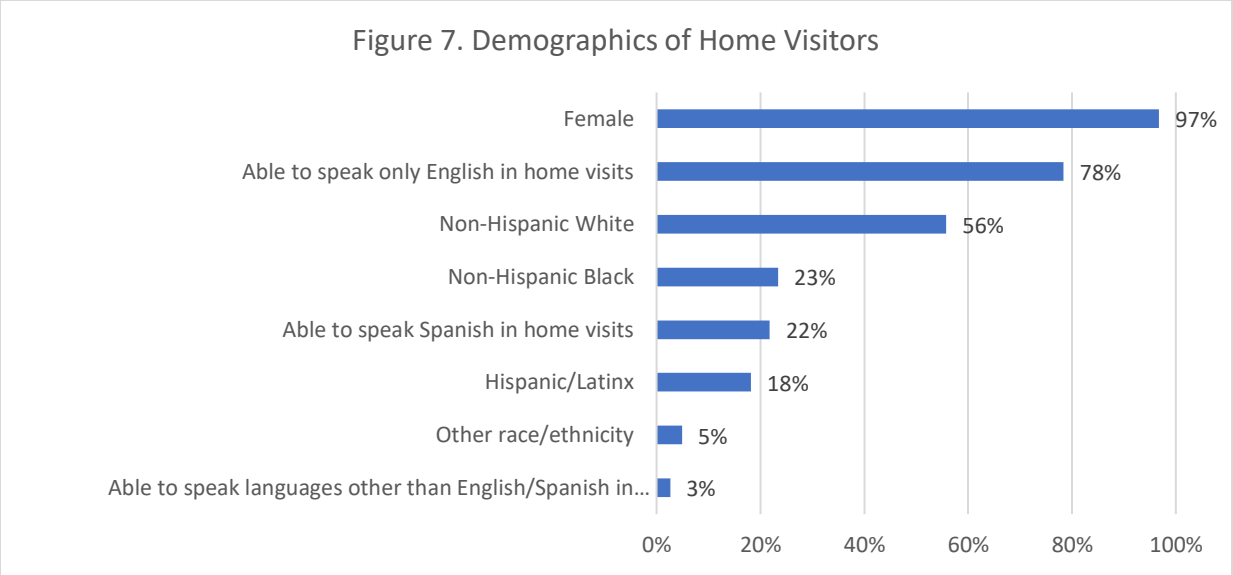
Home visiting programs in NC are funded by numerous public and private sources, and most individual community programs operate using a patchwork of funding sources. We asked survey respondents to report the proportion of their overall financial support from federal, state, local, foundation, or billable services (i.e., Medicaid). Survey responses indicated that state government (50%), federal government (14%), and foundation funding (12%) were the three largest funding sources. When asked whether programs' overall funding levels had changed in the past year, 45% of respondents reported that funding had stayed the same, 17% said funding increased, 11% said funding decreased, and 27% did not respond. The average cost per family ranges greatly between programs, but the average reported program cost per family was $4,500.

Figure 6. Home Visiting Funding Sources



Results: Home Visiting Staff

Home visiting programs vary greatly in staffing structure, requirements, and qualifications. Based on survey results, a home visiting program has on average 4.5 full-time home visitors, 1 part-time home visitor, and 1 supervisor. On average, each program has less than 1 vacant full-time home visitor position. As shown in Figure 7, 97% of home visitors are female, 56% are White, 23% are Black, 18% are Hispanic/Latinx, 22% can speak Spanish in home visits, and 78% speak only English in home visits. Only 5% of home visitors are a race or ethnicity other than Black, White, or Hispanic/Latinx and only 3% of home visitors can speak a language other than English or Spanish in home visits. Most home visiting programs reported requiring home visitors to have a 4-year degree (74%), a minimum level of experience for employment (74%), certification or accreditation (68%), and model-specific trainings (99%). On average, programs have 2.7 professionally licensed home visitors on staff.

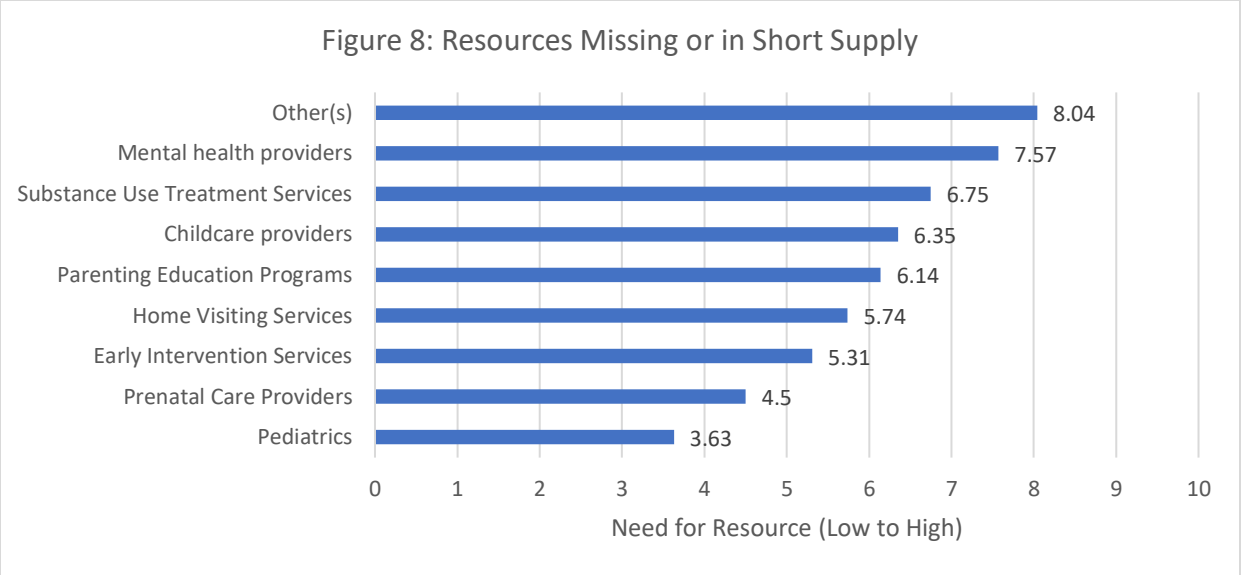


Results: Barriers to Community Services

We asked respondents to rate on a 0-10 scale the extent to which specific resources for families were missing or in short supply in their community (Figure 8). Mental health providers (*M* = 7.6) was the greatest identified need, followed by substance use treatment services (*M* = 6.6). In contrast, pediatrics (*M* = 3.6) and prenatal care providers (*M* = 4.5) were rated as relatively more accessible. The "other" category had the highest average rating (*M* = 8.0) and included 35 open-ended responses. The most salient "other" barriers related to transportation (11), housing (9), childcare (4), mental health (4), family planning (2), and parenting education (2).

North Carolina is currently rolling out a new statewide care coordination platform called NCCARE360.[17] Although this service was not available statewide during the survey response period, 25% of respondents reported using NCCARE360.

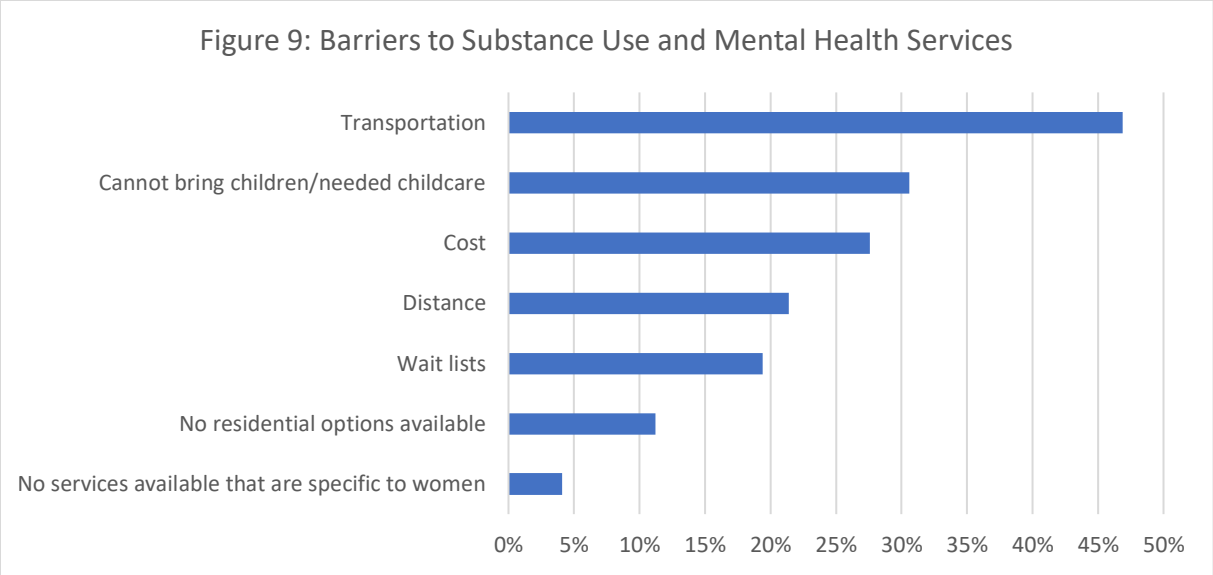
[17] NCCARE360. (2020). *Building connections for a healthier North Carolina*. https://nccare360.org/



We asked several questions addressing respondents' awareness of substance use and mental health services. The vast majority of programs (89%) reported working with providers who delivered behavioral health services and providers who served pregnant women specifically (85%). Among all home visiting programs, 52% provide referrals to behavioral health providers and 14% receive referrals from substance use providers. Only 14% of programs reported having a behavioral health provider on staff and 5% reported a substance use provider on staff.

In light of the U.S.'s opioid epidemic, we also asked about respondents' awareness of specific programs and services related to substance use services. The vast majority of respondents (91%) reported awareness of behavioral health or substance use services for pregnant and parenting women and families. However, only 30% of respondents reported awareness of Plan of Safe Care policies[18] and 63% reported awareness of access to office-based services or medicated assisted treatments (MAT; now referred to as medications for opioid use disorders [MOUD]) such as methadone or buprenorphine. When asked about the greatest barriers program participants face when seeking behavioral health services, transportation (47%) was the most common perceived barrier, followed by lack of childcare (31%). The availability of residential options (11%) and services specific to women (4%) were less commonly perceived challenges to receiving services.

[18] NC DHHS. (2020). *Infant plan of safe care*. https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/infant-plan-safe-care



Results: Community and Organizational Relationships

To measure community buy-in and support, we provided a 0-10 scale ranging from *no support* to *total support*. The average level of community buy-in and support was high (*M* = 7.4, *SD* = 2.1, median = 8). Over 75% of respondents reported a 7 or higher for this item. Coordination of services in early childhood is an ongoing challenge and priority in these communities. Further, 83% of respondents reported that their community had a local early childhood system coordination entity or council. We had expected this figure to be closer to 100%, given that NC has a comprehensive statewide Smart Start network consisting of 75 local partnerships.[19]

Part IV: Substance Use Disorder Prevention and Treatment

This section provides information about opioid use among women in the perinatal and postnatal period, current treatment programs in NC, barriers to treatment, and potential opportunities for collaboration in the state. The NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services has offered perinatal-focused substance use treatment services since the early 1990s and has done significant work to centralize service coordination and promote integrated care models. Despite these efforts, there continues to be a gap in services for treatment that disproportionately impacts rural and low-income families.

This part of our needs assessment focused on the opioid epidemic and home visiting as an important part of the state's Opioid Action Plan. Families served by home visiting programs struggle with substances other than opioids (e.g., alcohol, tobacco, and other prescription drugs) that can have a devastating impact on pregnant women and children. Given NC's focus on opioid use disorder treatment policies and programs and the ongoing opioid epidemic, we decided to highlight this type of addiction and associated services specifically. Ongoing collaboration with statewide agencies, including the NC

[19] Smart Start. (2020). *Smart Start*. http://www.smartstart.org/

Division of Public Health and the NC Division of Social Services as well as local healthcare and behavioral health providers and agencies, is vital for increasing service access and awareness of the opioid epidemic's impact on families in North Carolina.

Although we primarily discuss services for women, fathers and male caregivers also suffer from substance use disorders and can benefit from treatment. Although, home visiting programs have historically developed services for pregnant women and female caregivers, most programs are eager to engage all members of the family, including fathers and male caregivers.

Opioid Use

In the U.S., drug overdoses involving opioids accounted for almost 70% of the 67,367 overdose deaths in 2018. That year in NC, nearly five people died every day from an opioid overdose.[20,21] This epidemic is disproportionately impacting women, who are more likely to be prescribed opioids and use them for longer than men.[22] Between 2015 and 2017, opioid use in the past month among pregnant women increased nationally from 19,000 to 32,000 – an alarming statistic give than opioid use among pregnant women is associated with increased likelihood of preterm labor, early onset delivery, poor fetal growth, and stillbirth.

Intrinsically, pregnant women want to improve their health to support their child.[22] Mothers who are unable to quit or cut back on their opioid use likely have a substance use disorder, a diagnosable medical condition of the brain that results in continued use despite negative consequences. Regular use of opioids by pregnant women can result in the child being born with a condition known as Neonatal Abstinence Syndrome (NAS). NAS can have a time-limited impact on a child's central nervous system, autonomic nervous system, gastrointestinal system, and respiratory system. Fortunately, when prenatal opioid exposure is known, NAS can be anticipated and met with care plans created in advance, as NAS symptoms are transient and treatable. In NC, from 2004 to 2015 the rate of infants identified with drug withdrawal syndrome increased by 511%.[23] However, this number does not differentiate infants exposed to prescribed opioids (e.g., for medication-assisted treatment [MAT]). The state's number of infant hospitalizations associated with drug withdrawal increased 230% from 2009 to 2018 (i.e., from 3.2 to 11.1 hospitalizations per 1,000 live births).[24]

Clearly, preventing opioid use among pregnant women in NC will have demonstrable benefits. Treatment for opioid use among pregnant women can have significant outcomes, including preventing a

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[20] NC DHHS. (2020). *NC Opioid Action Plan data dashboard*. https://injuryfreenc.shinyapps.io/OpioidActionPlan/

[21] The NC Opioid Action Plan was released in June 2017 and updated in June 2019. See NC Opioid and Prescription Drug Abuse Advisory Committee. (2019). *North Carolina's Opioid Action Plan: Updates and opportunities*. https://files.nc.gov/ncdhhs/OAP-2.0-8.7.2019_final.pdf

[22] Jones, H. (January 25, 2019). *The opioid epidemic: The landscape of comprehensive care for women with opioid use disorder and their children* [PowerPoint slides]. Raleigh, NC: 2019 NC Public Health Leaders' Conference. https://publichealth.nc.gov/phl/docs/OpioidEpidemicComprehensiveCareforWomenandTheirChildren(Jones).pdf

[23] North Carolina Pregnancy & Opioid Exposure Project. (2014). *Pregnancy and opioid exposure: Guidance for North Carolina*. https://ncpoep.org/wp-content/uploads/2015/03/NCPOEP_toolkit.pdf

[24] NC DHHS, Injury and Violence Prevention Branch. (2019). *NC overdose data: Trends and surveillance*. https://www.injuryfreenc.ncdhhs.gov/DataSurveillance/StatewideOverdoseSurveillanceReports/CoreOverdose-SlideSet-November2019.pptx

substance-exposed pregnancy, improving birth outcomes, improving the quality of life for women and children, leading in turn to recovery and reduced costs to healthcare and other systems.

Substance Use Treatment

Substance use treatment for pregnant and parenting women can have several positive effects on the quality of their and their children's life and health.[23] Levels of care and approaches to treatment vary depending on an array of factors including the severity of the substance use, patient needs, availability of services, and capacity to pay. Addiction treatment services (ranging from least to most intensive) include early intervention, outpatient, intensive outpatient/partial hospitalization, residential/inpatient, and medically managed intensive hospital/inpatient services. Encouragingly, NC remains at the forefront of treatment service provision and continues to adapt these services to the needs of mothers and families.[25] North Carolina also offers gender-specific treatment options such as treating the mother-child dyad, providing essential services like childcare and transportation, and family residential services for pregnant and parenting women who require a higher level of care.[26] The following section details the specific programs and services available in NC.

Capacity for Substance Use Treatment and Counseling

According to the 2019 North Carolina Home Visiting Needs Assessment survey, 52% of home visiting programs made referrals to mental or behavioral health providers and 36% made referrals to substance use providers. Although this data does not show whether services were received, it indicates the presence of these services and many home visiting programs' awareness of them. In 2017, Governor Roy Cooper launched the North Carolina Opioid Action Plan to decrease opioid overdoses in the state by decreasing the supply of opioids, supporting families, increasing harm reduction programming, addressing non-medical drivers of health, and expanding access to treatment and recovery.[27] As a result of this action plan and the funding it made available, more North Carolinians have access to robust services that address aspects of substance use beyond addiction. Beyond the traditional, general population inpatient and outpatient treatment, the state also has initiatives, positions, and resources designed specifically for pregnant and parenting mothers. Through these tailored programs, a strong capacity management system, and educational materials, NC is offering pregnant and parenting mothers a robust network of services, which we enumerate below.

North Carolina Perinatal and Maternal Substance Use and CASAWORKS for Families

The North Carolina Perinatal and Maternal Substance Use and CASAWORKS for Families are two initiatives focused on holistic substance use treatment for pregnant and parenting mothers. To increase access to services, all programs in the initiative are available to families regardless of whether the services are located in their geographic area. The initiative consists of 28 residential and outpatient programs in 13 counties across the state. All programs employ gender-specific and trauma-informed behavioral health treatment. The care they provide extends beyond substance use to include behavioral

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[25] Godwin, M., Green, S., Jones, H., & Robbins, S. (2020). Perinatal substance use disorders treatment. *North Carolina Medical Journal*, *81*(1): 36-40. https://doi.org/10.18043/ncm.81.1.36

[26] North Carolina Pregnancy & Opioid Exposure Project. (2014). *Pregnancy and opioid exposure: Guidance for North Carolina*. https://ncpoep.org/wp-content/uploads/2015/03/NCPOEP_toolkit.pdf

[27] NC Opioid and Prescription Drug Abuse Advisory Committee. (2019). *North Carolina's Opioid Action Plan: Updates and opportunities*. https://files.nc.gov/ncdhhs/OAP-2.0-8.7.2019_final.pdf

health services, parenting support, therapy, referrals for coordinated medical care for both mothers and children, transportation services, case management, and job readiness. All the residential programs serve women, and some provide MAT/MOUD. Some of the specific treatment models used by these programs include:

- Seeking Safety
- Beyond Anger and Violence
- Beyond Trauma
- A Healing Journey for Women
- Helping Women Recover
- The Matrix Model
- Cognitive Behavioral Therapy, including Dialectical Behavioral Therapy
- Contingency Management
- Motivational Interviewing

Specific parenting support programs include:

- Nurturing Program for Families in Substance Abuse Treatment and Recovery
- Strengthening Families Program
- Circle of Security
- Celebrating Families!
- Triple P

As shown by evaluations of these programs over multiple years, participating mothers and children have improved outcomes including healthier birth weights, lower recidivism with child welfare, fewer days in foster care compared to families not receiving services, increased use of pediatric services, increased family bonds, and reduced parent conflict.[24]

North Carolina Perinatal Substance Use Specialist

The Alcohol Drug Council of North Carolina has a dedicated specialist position, co-funded by NC DMH/DD/SAS and DPH Maternal and Child Health Section, to provide program and treatment information and referrals for pregnant and parenting women. Each week, this specialist sends out a list of available beds in residential treatment to various providers as part of overseeing their capacity.[24] They also provide warm hand-off referral services to Local Management Entities-Managed Care Organizations (LME-CMO) throughout the state for geographically specific treatment services.

North Carolina Pregnancy & Opioid Exposure Project

The NC Pregnancy and Opioid Exposure Project[28] is a project of the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. This project offers information about the types of services available for pregnant and parenting mothers whose children have been exposed to opioids and hosts an interactive map of those services in NC. The map specifies the services available at various locations, including the agency, service type(s), county, address, contact information, and

[28] North Carolina Pregnancy and Opioid Exposure Project. (2020). *North Carolina Pregnancy & Opioid Exposure Project*. https://ncpoep.org/

whether they accept Medicaid. The website also contains resources for service providers, including a document (*Pregnancy and Opioid Exposure: Guidance for North Carolina*) with information for professionals in multiple fields about opioid exposure during pregnancy.[29]

Local Management Entities-Managed Care Organizations (LME-MCO)

The North Carolina Department of Health and Human Services (NCDHHS) currently contracts with Medicaid-managed care organizations (i.e., Local Management Entities-Managed Care Organizations [LME-CMOs]) to manage, facilitate, coordinate, and monitor services in specific geographic areas related to substance use disorders, mental health, and intellectual or developmental disability services. A phone-based screening, triage, and referral program is in place to help individuals seeking services if they reside in the catchment areas for a specific NCDHHS LME-MCO.[30] Although they do not exclusively offer gender-based care, these organizations have a greater knowledge of the targeted services for perinatal women who are Medicaid beneficiaries.

Plan of Safe Care

Federal policy requires each state to develop a plan to address the needs of substance-exposed infants, including requirements for referrals to child protective services, safe care plan development for the infant, and the substance use disorder treatment needs of the family or caregiver.[31] The goals of the NC plan are: 1) to include infants, children, and families in the Plans of Safe Care; 2) to support the health of the infant and mother rather than penalizing the mother and family; and 3) to increase access to treatment and support for all women with a substance use disorder and their children. The local child welfare agency sends a referral to the Care Management for At-Risk Children program (CMARC, formerly CC4C) and care mangers create a plan of care and provide assessments, referrals, and services.[32] Home visiting programs are among the community resources that care managers can refer families to and coordinate with other services.

Medicaid Care Management

In the Care Management for High Risk Pregnancies (CMHRP) program, Medicaid-eligible pregnant mothers at risk of having preterm births are served by nurses and social workers in collaboration with health care providers who help them access prenatal services (e.g., drug screenings and home visits).[33] The program also offers educational materials to healthcare providers through their Pregnancy Medical Home (PMH) Care Pathway, including a report with extensive recommendations for providers at all levels of treatment (i.e., screening, assessment, intervention, referral, and patient management). For

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[29] Community Care of North Carolina. (2019). *Pregnancy Medical Home Program care pathway: Management of substance use in pregnancy*. https://www.communitycarenc.org/sites/default/files/2019-07/PMH_Pathway-Management_of_Substance_Use_in_Pregnancy-2019.pdf

[30] NC DHHS, NC Medicaid Division of Health Benefits. (2020). *Local management entities*. https://medicaid.ncdhhs.gov/providers/programs-and-services/behavioral-health-idd/local-management-entities

[31] Administration for Children & Families. (2017). *CAPTA program instruction*. https://files.nc.gov/ncdhhs/ACYF-CB-PI-17-02%20CAPTA%20CARA.pdf

[32] NC DHHS. (2020). *Infant plan of safe care*. https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/infant-plan-safe-care

[33] Community Care of North Carolina. (2019). *Pregnancy Medical Home Program care pathway: Management of substance use in pregnancy*. https://www.communitycarenc.org/sites/default/files/2019-07/PMH_Pathway-Management_of_Substance_Use_in_Pregnancy-2019.pdf

interested providers, Governor Cooper's North Carolina Opioid Action Plan has established the *Menu of Local Actions* webpage displaying local strategies being implemented in communities across the state along with information and resources.

Gaps in Services

As described above, treatment services are available to all pregnant women or women with children throughout North Carolina, regardless of where they live, through the North Carolina Perinatal and Maternal Substance Use and CASAWORKS for Families initiatives. In the 2020 MIECHV Needs Assessment Survey, over 30% of participants indicated that families with a history of substance abuse were a primary target population for their program, while other participants indicated that current drug use results in ineligibility for services in their program. Over 90% of survey participants indicated their awareness of mental health and/or substance use treatment providers in the state, and nearly 86% indicated that their agency works with providers serving pregnant women with mental and/or substance use treatment needs. These high levels of awareness and collaboration parallel statewide increases in buprenorphine prescriptions, the number of individuals served by treatment, and the number of peer support specialists in the state as part of the North Carolina Opioid Action Plan. Between 2013 and 2019, the number of individuals served annually by substance use treatment programs more than doubled from 9,912 to 21,117.[20] Our readers should note that Northampton, Washington, Halifax, and Bertie counties both had high rates of pain medication use and were identified as "highest priority" by the North Carolina MIECHV Needs Assessment. Opportunities for closing gaps in services include increased awareness of programs and resources available in North Carolina, including through the LME-MCOs, by home visitors.

Barriers

In the 2020 MIECHV need assessment survey, participants reported that transportation (47%), need for childcare (31%), and cost (28%) were the biggest barriers to mental health and substance use disorder treatment. Indeed, barriers to substance use disorder treatment and counseling are present in each stage of the process. For instance, healthcare professionals consistently miss signs and symptoms of addiction among women and are less likely to screen them for substance use disorders. Without being screened and identified, women are less likely to connect with treatment for substance use. At the same time, only 4% of MIECHV survey participants indicated a lack of gender specific services as a barrier to mental health and substance use treatment.

Lack of health insurance coverage presents another significant barrier. At six weeks postpartum, women who are not eligible for standard Medicaid lose access to their healthcare benefits and often disengage from the health system, including primary care visits. Because primary care providers can complete substance use screenings and referrals, losing access to healthcare means that potentially fewer new mothers will get screened and referred. When women who are in treatment lose Medicaid coverage, some discontinue treatment due to their inability to pay out of pocket for services (e.g., MAT) despite the potential availability of state funded services through the LME-MCO. For pregnant and parenting women, attending substance use treatment programs may cause them to feel shame due to associated stigma and fear of losing their child(ren) to social services. In a Substance Abuse and Mental Health Services Administration survey of women who needed and perceived a need for treatment,

cost/insurance barriers (34%) and social stigma (29%) were the second and third most prevalent reasons for not receiving substance use disorder treatment.[34]

Opportunities for Collaboration

To increase access to substance use disorder treatment and counseling for pregnant and parenting women in North Carolina, we must leverage current statewide efforts to end the opioid epidemic and the know-how of partners engaged in that work. Collaborative efforts should address related gaps in services and barriers to services in NC, including transportation, Medicaid/insurance issues, program capacity, stigma, and identification and referral of clients.

Governor Cooper's North Carolina Opioid Action Plan includes seven strategies for addressing the opioid epidemic in the state. They are:

1. Creating a coordinated infrastructure
2. Reducing the oversupply of prescription drugs
3. Reducing the diversion and flow of illicit drugs
4. Increasing community awareness and prevention
5. Increasing naloxone availability and linkages to care
6. Expanding access to treatment and recovery
7. Measuring impact

Part of the 6th strategy entails two agendas targeting pregnant women: 1) increasing the number of OB/GYN and prenatal prescribers with DATA waivers to prescribe MAT and 2) supporting pregnant women with opioid addiction in recieving prenatal care, SUD treatment, and having healthy birth outcomes. The Opioid and Prescription Drug Abuse Advisory Committee (OPDAAC) offers a promising venue for promoting these agendas. Created as part of the state's Opioid Action Plan, the OPDAAC allows individuals, agencies, and communities to provide information about their practices, successes, and issues related to curbing OUD. It also allows these groups to network and meet subject matter experts to increase their toolkit for serving mothers and forge coalitions with groups focused on this population. The state plan is also driving efforts to increase access to MAT services and improve integrated care. Increasing inter-agency communication and awareness (e.g., through OPDAAC) may improve rates of screening in primary care and emergency room settings and, in turn, increase referrals to agencies and programs offering gender-informed care.

By coordinating with LME-MCOs and local service providers (e.g., outpatient and inpatient SUD treatment centers, mental health providers, primary care providers, and hospitals), the MIECHV program can better help pregnant and parenting mothers access Medicaid and other publicly funded services and at the same time expand affordable services to help alleviate the financial burden of treatment.

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[34] Substance Abuse and Mental Health Service Administration (SAMHSA), U.S. Department of Health and Human Services. (2015). *Substance abuse treatment: Addressing the specific needs of women* [HHS Publication No. (SMA) 15-4426]. https://4ee72909-7c3b-44f3-8f59-49b2d8a1fa15.filesusr.com/ugd/210306_e77e3fb0db6149b7b4079306df0d2962.pdf

Part V: Coordination with other Needs Assessments

Home visiting programs in North Carolina are embedded within larger maternal and child health systems as well as early childhood and child protection systems. To ensure the NC MIECHV needs assessment is integrated with these systems, we coordinated with representatives of the Title V Maternal and Child Health Block Grant (Title V MCH Block Grant), Head Start, and Child Abuse Prevention and Treatment Act (CAPTA) programs in North Carolina throughout the project. Representatives of these programs also served as members of the Advisory Group, enabling them to hear about the approach of the needs assessment and provide feedback.

Once data collection was completed, the team also held a focused workgroup discussion with these group representatives to share findings and discuss opportunities for future service coordination. During this discussion, representatives from Title V, NC Division of Social Services, and the statewide Head Start collaboration office at the NC Division of Public Instruction shared information about the needs assessment processes associated with their respective programs. We briefly describe several examples of areas of overlap and continued communication that emerged for each of these sectors.

First, the workgroup examined key areas of overlap with the broader Title V needs assessment. This needs assessment was conducted by the Women's and Children's Health Section of the NC Division of Public Health and incorporates processes from the Maternal and Child Health Block Grant needs assessment into a continuous needs assessment process. Fortunately, the Women's and Children's Health Section also oversees the MIECHV program, creating natural alignment between the NC Title V and MIECHV needs assessment and broader program goals. The Women's and Children's Health team will also incorporate MIECHV needs assessment findings into their review of priorities and activities relevant to home visiting. The Title V needs assessment used a variety of quantitative and qualitative approaches to understand the needs of women and children. Focus group discussions about the perinatal/infant health domain identified several priorities relevant to home visiting: promoting postpartum care and support, improving access to prenatal care, preventing substance use (including tobacco and alcohol), supporting father involvement, and increasing breastfeeding.

The Title V needs assessment also identified several priority needs relevant to home visiting programs: improving access to high quality integrated health care services; promoting safe, stable, and nurturing relationships; preventing infant/fetal deaths and premature births; increasing health equity; eliminating disparities; and addressing social determinants of health. The workgroup's review of the NC MIECHV needs assessment findings included a discussion of other programs compatible with home visiting services.

Second, three representatives from the NC Division of Social Services participated in discussions of the Child Abuse Prevention and Treatment Act (CAPTA) needs assessment and child welfare services, highlighting two opportunities for service coordination. For one, discussions underscored that comparatively few respondents (30%) were aware of Plan of Safe Care policies. Future coordination will involve examining which home visiting models were more aware of Plan of Safe Care to allow for focused outreach and communication to increase awareness and professional development regarding implementation of Plan of Safe Care policies. The second potential area of coordination related to

planning around the implementation of the Family First Prevention Services Act (FFPSA).[35] NC MIECHV needs assessment data will provide a foundation for future coordination with NC DSS as they develop an array of evidence-based programs, including approved home visiting programs, for inclusion in the state FFPSA plan.

The workgroup also reviewed the 2019 report of the NC Community Child Protection Teams Advisory Board, which included recommendations for improving the child protection system at state and local levels. Several recommendations resonate with the findings of the NC MIECHV needs assessment. The first recommendation was to "improve access to behavioral health services of children, youth, and families served by child welfare." As discussed, MIECHV survey respondents similarly reported that behavioral health providers were the most needed resource in the community. The report also recommended promoting the safety of vulnerable infants and strengthening the Plan of Safe Care approach by informing and clarifying practices, policies, and procedures. This recommendation also aligns with our survey's findings that home visiting agencies reported less familiarity with Plan of Safe Care policies.

Third, the needs assessment findings were reviewed in the conversation with the Head Start statewide coordination office. Although each local implementing agency conducts their own needs assessment, the statewide coordinator identified the great value in the MIECHV needs assessment data for informing statewide planning regarding Early Head Start-Home Based Option services. Given that resources for Head Start are always limited, some local programs are considering whether to continue offering slots for Early Head Start home visiting. The MIECHV needs assessment provides useful information about the availability of other home visiting programs in the community that could potentially replace Early Head Start. Moreover, as programs apply for Head Start funding, the risk assessment and services data will be useful for justifying funding requests for expansion slots.

Clearly, the 2020 MIECHV needs assessment's findings have demonstrable relevance to many priority areas across the NC Department of Health and Human Services as well as many initiatives beyond the state. Beginning in 2019, North Carolina created a new Home Visiting and Parenting Education (HV/PE) System planning workgroup (Appendix 7), which includes stakeholders from NC DHHS and many public and private entities and provides an arena for continued connection, collaboration, and coordination. Fortunately, its new acting director has been a member of the MIECHV needs assessment advisory group, ensuring that our assessment data will directly inform the statewide body most responsible for developing home visiting services in the future. As the quality and availability of home visiting continues to grow through the state, the results of the 2020 MIECHV needs assessment will provide a strong foundation of knowledge to inform areas of growth and ongoing strategic planning.

[35] The Family First Prevention Services Act (FFPSA), enacted as part of Public Law (P.L.) 115–123, authorized new optional title IV-E funding for time-limited prevention services for mental health, substance abuse, and in-home parent skill-based programs for children or youth who are candidates for foster care, pregnant or parenting youth in foster care, and the parents or kin caregivers of those children and youth (Administration for Children & Families. [2020]. *Title IV-E Prevention Program*. https://www.acf.hhs.gov/cb/title-iv-e-prevention-program).

Conclusions

Key Findings

Through the 2020 MIECHV Needs Assessment, the team identified the counties listed below as at risk. We acknowledge that any county not included in this list will not be eligible for MIECHV funding.

1. Anson County
2. Bertie County
3. Bladen County
4. Brunswick County
5. Buncombe County
6. Burke County
7. Carteret County
8. Cherokee County
9. Cleveland County
10. Columbus County
11. Cumberland County
12. Durham County
13. Edgecombe County
14. Gaston County
15. Greene County
16. Guilford County
17. Halifax County
18. Hertford County
19. Iredell County
20. Lenoir County
21. Martin County
22. McDowell County
23. Mecklenburg County
24. Mitchell County
25. Nash County
26. New Hanover County
27. Northampton County
28. Onslow County
29. Pender County
30. Person County
31. Richmond County
32. Robeson County
33. Scotland County
34. Stokes County
35. Vance County
36. Warren County
37. Washington County
38. Wilson County
39. Yancey County

Dissemination

A brief summary of the findings of the 2020 MIECHV Needs Assessment was presented to the Home Visiting and Parenting Educations System planning workgroup, the Home Visiting Consortium, and the MIECHV needs assessment advisory group. The Jordan Institute for Families has a section of its website dedicated to sharing information about the 2020 MIECHV Needs Assessment. This information includes a brief summary of the 2020 MIECHV Needs Assessment, as well as three issue briefs. The topics of these briefs are 1) County Risk Assessment, 2) Home Visiting Programs in North Carolina, and 3) Home Visiting and Substance Use Disorder Treatment. The availability of these briefs was announced at the 2020 NC Infant & Early Childhood Mental Health, Home Visiting & Parent Education Conference and shared with Home Visiting Consortium Members. Additionally, the Jordan Institute for Families is sharing a brief announcement about the MIECHV needs assessment in its upcoming newsletter, including a link to information posted online. Once the final report is approved, it will be shared on this website.

Appendix

Appendix 1: 2020 Needs Assessment Survey

Thank you for participating in this survey as part of the **North Carolina Statewide Needs Assessment** for the **Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program**, administered by our team at the Jordan Institute for Families in the School of Social Work at the University of North Carolina at Chapel Hill.

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.

The purpose of the MIECHV need assessment is to:
1. Identify at-risk communities;
2. Understand the needs of families; and
3. Assess services in NC communities' early childhood systems.

We are also collecting information about **parenting education programs** in North Carolina. Parenting programs are an important part of the continuum of early childhood services available to families in your community.

Our findings will **describe** the home visiting and parenting education service landscape in North Carolina and will **not evaluate** any specific program.
If you have any questions you can email us at homevisitingstudy@unc.edu. The final needs assessment will be available in fall 2020.

This study was reviewed by the UNC Office of Human Research Ethics (IRB# 19-0970).
Please answer each question to the extent that you are able. We understand all programs are different and we want to capture the diversity of services in the continuum. You may want to have several people from your local organization work together to fill out this survey. There are several "modules" that request information regarding program administration, service delivery, service population, early childhood systems, and substance use and behavioral/mental health services. Different types of information and sources might be needed for each of the modules.
Please respond to this survey based on your organization's experience in fiscal year 2018 - 2019 (July 1, 2018 - June 30, 2019).

A few terms that we want to define to clarify for the purposes of this survey: Home Visiting Program: a specific home visiting program or model being delivered at the local level (such as Nurse-Family Partnership or Early Head Start-Home Visiting).

Local Organization: the agency that houses and administers the home visiting and/or parenting

education program(s) such as a health department or local Smart Start. In some cases, the local organization is a home visiting or parenting education program affiliate.
First, please provide contact information for someone we can contact if more information is needed later.

- ○ First/Last Name _____
- ○ Local Organization Name _____
- ○ Local Organization Address _____
- ○ Email Address _____
- ○ Phone Number _____

What is the role of the primary contact for this survey?

- ○ Executive Director
- ○ Program Manager
- ○ Data/Evaluation Lead
- ○ Other

This section includes questions regarding administration of your **home visiting program** and structure of your **local organization**. The purpose of these items is to get an understanding of how different **home visiting programs** are organized, supported, and funded.
What is the **home visiting program** model that your organization implemented in fiscal year 2018-2019? (Check all that apply)

- ☐ Nurse-Family Partnership
- ☐ Parents as Teachers
- ☐ Early Head Start - Home Visiting
- ☐ Healthy Families
- ☐ Family Connects
- ☐ Attachment and Biobehavioral Catch-up (ABC)
- ☐ Child FIRST
- ☐ Home Instruction for Parents of Preschool Youngsters (HIPPY)

☐ Other(s)

We want to know about your typical staffing patterns in fiscal year 2018-2019.
How many home visitors, both full-time and part-time, were employed on your staff? Do not count vacant positions, only those positions that were filled.

- ○ Full-time home visitors: _____
- ○ Part-time home visitors: _____
- ○ Home visiting supervisors (full- or part-time): _____

How many positions were vacant?

- ○ Full-time home visitors _____
- ○ Part-time home visitors _____
- ○ Home visiting supervisors (full- or part-time) _____

In order to meet the needs of your community in fiscal year 2018-2019, how many home visitors, both full-time and part-time, do you think you would have needed?

- ○ Full-time home visitors: _____
- ○ Part-time home visitors: _____
- ○ Home visiting supervisors (full- or part-time) _____

What percentage of your staff did you retain in fiscal year 2018-2019?
What were the demographics of your program's home visiting staff (all home visitors and supervisors) in fiscal year 2018-2019?

Approximately what percent (%) were:
non-Hispanic White
non-Hispanic Black
Hispanic/Latinx
Other race/ethnicity
Female
Able to speak only English in home visits
Able to speak Spanish in home visits
Able to speak languages other than English/Spanish in home visits
The next set of questions are about the funding of your **home visiting program** in fiscal year 2018-2019.

What financial resources supported your **home visiting program** in fiscal year 2018-2019? Estimate the percent of support your home visiting program received from each funding source. **The sum of all funding resources should add to 100%.**

	Federal Government	State Government	Local Government	Medicaid/Billable Services	Foundation/Philanthropy	Other
2018						

In fiscal year 2018-2019, did your funding increase, stay the same, or decrease compared to fiscal year 2017-2018?

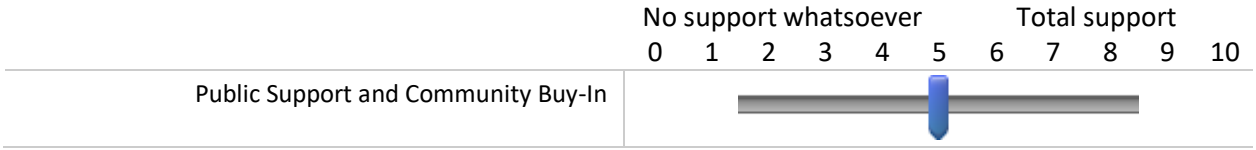
- ○ Increased
- ○ Decreased
- ○ Stayed the same

What would be your best estimate of the average cost per family to deliver your **home visiting program** as designed in fiscal year 2018-2019?

In fiscal year 2018-2019, did your **local organization** develop a regular report regarding service utilization and outcomes?

Do you have a stakeholder advisory group?

In your community, how would you rate overall public support and community buy-in for your **home visiting program** in fiscal year 2018-2019?



Who would you identify as your **home visiting program's** primary target/priority populations in fiscal year 2018-2019? (Check all that apply.)

- ☐ Low-income children and families
- ☐ Children with special needs
- ☐ Families that speak a language other than English
- ☐ Teen parents
- ☐ Families who receive governmental assistance
- ☐ Families with a history of child abuse and neglect
- ☐ Families with a history of domestic violence
- ☐ Families with a history of substance use
- ☐ Mothers with maternal depression
- ☐ Pregnant Women
- ☐ Other(s)

In fiscal year 2018-2019, what were the eligibility criteria to receive home visiting services through your program?
Were there any further exclusion criteria that made someone ineligible for services?
Please describe any barriers to recruitment of program participants.
What were the demographics of your program's participants (the parents/caregivers) in fiscal year 2018-2019?
About what percent (%) were:
non-Hispanic White
non-Hispanic Black
Hispanic/Latinx
Other race/ethnicity
Female
Speak only English in the home
Speak Spanish in the home
Speak languages other than English/Spanish in the home
Medicaid-eligible
What were your **home visiting program's** primary target outcomes in fiscal year 2018-2019? (Check all that apply.)

- ☐ Healthy births

- [ ] Child health and development
- [ ] Maternal health
- [ ] School readiness
- [ ] Maltreatment prevention
- [ ] Family economic self-sufficiency
- [ ] Referrals to or coordination with other services
- [ ] Other

What was the typical starting salary range for full-time home visitors employed at your **local organization** in fiscal year 2018-2019?

- ○ Less than $10,000
- ○ $10,000 - $19,999
- ○ $20,000 - $29,999
- ○ $30,000 - $39,999
- ○ $40,000 - $49,999
- ○ $50,000 - $59,999
- ○ $60,000 - $69,999
- ○ $70,000 - $79,999
- ○ $80,000 - $89,999
- ○ $90,000 - $99,999
- ○ $100,000 - $149,999
- ○ More than $150,000

What was the minimum education requirement for full-time home visitors employed at your **local organization**?

- ○ Less than high school
- ○ High school graduate

- ○ Some college
- ○ 2-year degree
- ○ 4-year degree
- ○ Professional degree
- ○ Doctorate

Did you require a minimum level of experience for full-time home visitors employed at your **local organization**?

- ○ Yes
- ○ No

If so, how many years of experience?
In fiscal year 2018-2019, were individual home visitors required to be certified or accredited to work in your **home visiting program**?

- ○ Yes
- ○ No

If so, what certification or accreditation did you require?
Are home visitors required to complete any trainings based on the model?

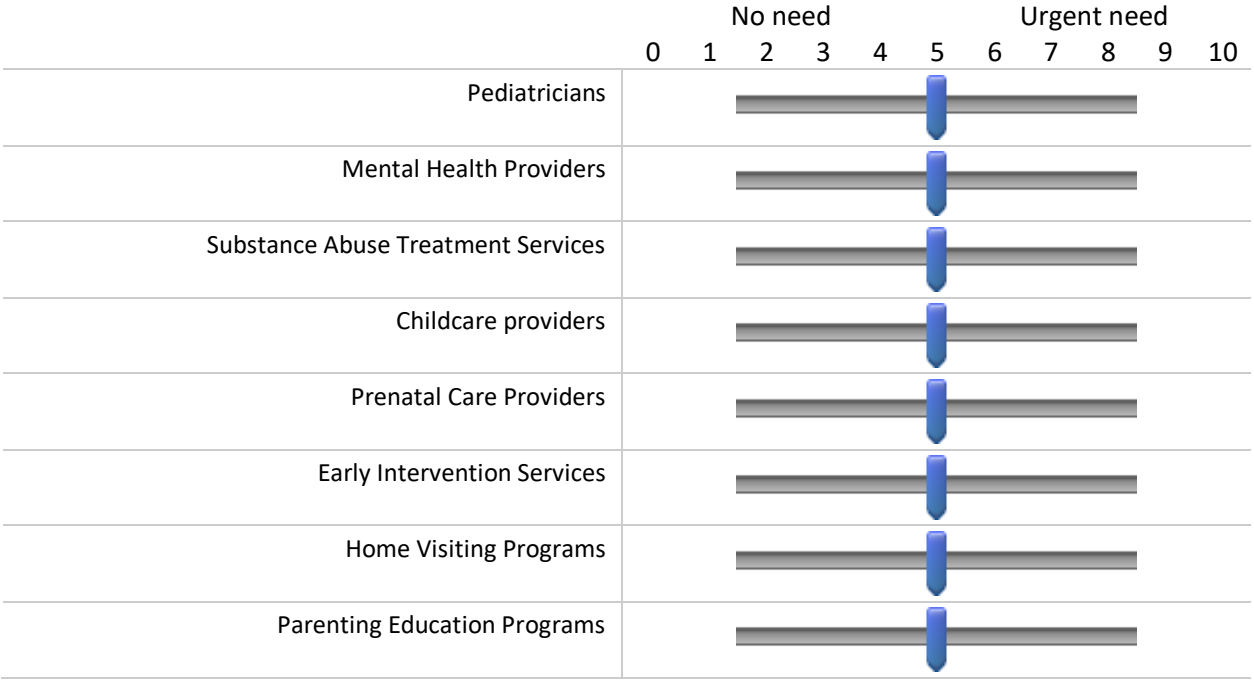
- ○ Yes
- ○ No

If so, please describe the required training.
How many of your home visitors had a professional license in fiscal year 2018-2019?
What professional development opportunities were available to your staff in fiscal year 2018-2019?
We want to know the local areas where programs provide **home visiting services**, so we are asking you to list the specific counties you serve. We will use this information to create local service maps across the state. This will help us all better understand where more services are needed. We realize that you may not collect data at the county level, so please provide your best estimate based on the information you do collect and your knowledge of your service area.
For each row, please write the following:
1) a county in your service area;
2) the total number of caregivers that you served in that county in fiscal year 2018-2019; and
3) the estimated number of caregivers you could have served in that county.

Repeat this information for each county in your service area.
This set of questions is about the families served by your **local organization** in fiscal year 2018-2019.
Did your **local organization** have a waitlist?

- ○ Yes
- ○ No (not at capacity)
- ○ No (not allowed to have a waitlist by funder or model)

About how many families were on the waitlist at a time?
Of the families who left your program in fiscal year 2018-2019, what percent completed the program, based on whatever program standard you use to indicate "completion" or "graduation"?
Please provide a summary estimate of the total number of actual home visits provided by your **local organization** in fiscal year 2018-2019. This is the total aggregate number of home visits across all families and all home visitors.
The following questions pertain to your **local organization** and any home visiting program(s) housed within it.
What resources for families were missing or in short supply in your community in fiscal year 2018-2019?



What barriers did your program(s) face in fiscal year 2018-2019?

0 1 2 3 4 5 6 7 8 9 10

Geographic/Transportation	
Language	
Cultural Sensitivity	
Availability of health and social services and family supports	
Accessibility of health and social services and family supports	

Does your organization use NCCARE360?

- ○ Yes
- ○ No
- ○ Not sure

In your community, is there a local early childhood system coordination entity or council?

- ○ Yes
- ○ No
- ○ Not sure

If yes, what group is the lead agency or backbone organization?
Is your organization aware of mental/behavioral health and/or substance use services for pregnant and parenting women and families?

- ○ Yes
- ○ No
- ○ Not sure

Is your organization aware of Plan of Safe Care policies in your community?

- ○ Yes
- ○ No
- ○ Not sure

Is your organization aware of access to office-based services or Medicated-Assisted Treatment (MAT) such as Methadone or Buprenorphine serving pregnant and parenting women?

- ○ Yes
- ○ No
- ○ Not sure

In fiscal year 2018-2019, did your local organization work with providers delivering mental/behavioral health and/or substance use services?

- ○ Yes
- ○ No

In fiscal year 2018-2019, did your local organization work with providers serving pregnant women delivering mental/behavioral health and/or substance use services?

- ○ Yes
- ○ No

Select the ways in which you worked with these providers.

- ☐ Referrals by your program to mental/behavioral health providers
- ☐ Referrals by your program to substance use providers
- ☐ Referrals by mental/behavioral health providers to your program
- ☐ Referrals by substance use providers to your program
- ☐ Your program has mental/behavioral health providers on staff
- ☐ Your program has substance use providers on staff

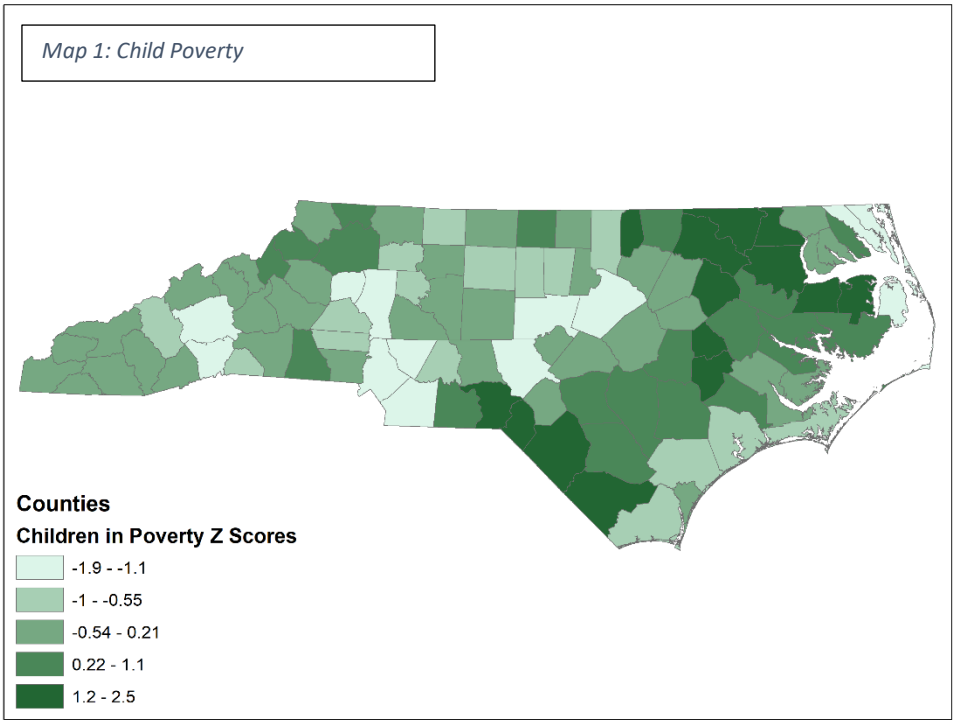
What were the greatest challenges faced by your program participants who were seeking these services? Select the top 3 barriers.

- [ ] Wait lists
- [ ] Transportation
- [ ] Distance
- [ ] No residential options available
- [ ] Cannot bring children/ needed child care
- [ ] No services available that are specific to women
- [ ] Cost

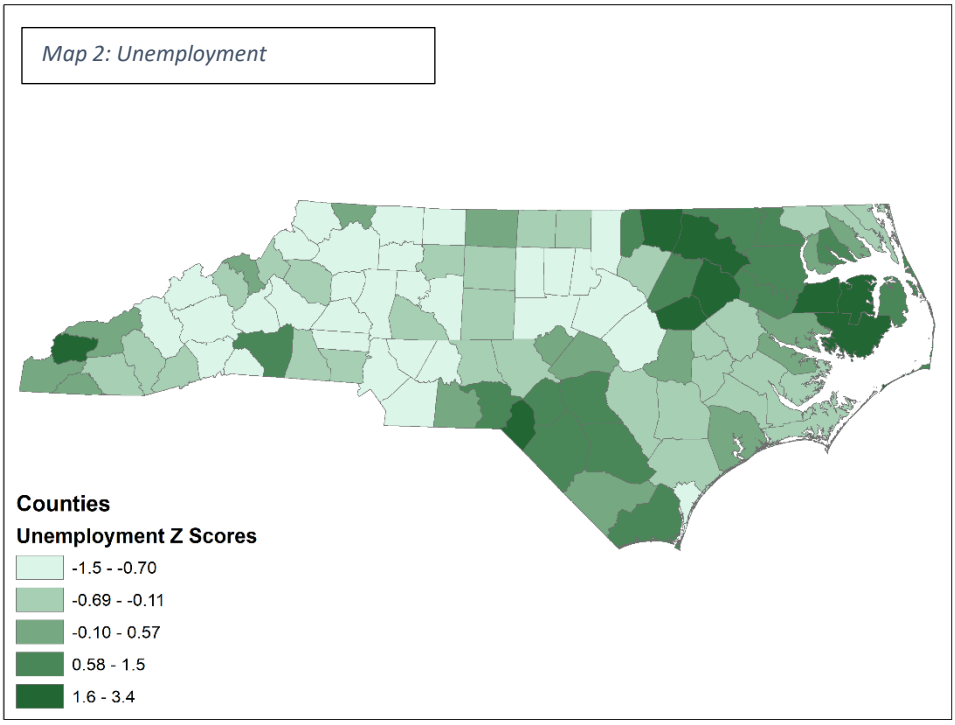
This is the end of the survey. Please use the following space to fill in any additional information that you think is important for us to understand about your home visiting/parenting education program(s) or the field(s) of home visiting/parenting education in North Carolina.

Appendix 2: Risk Indicator Maps

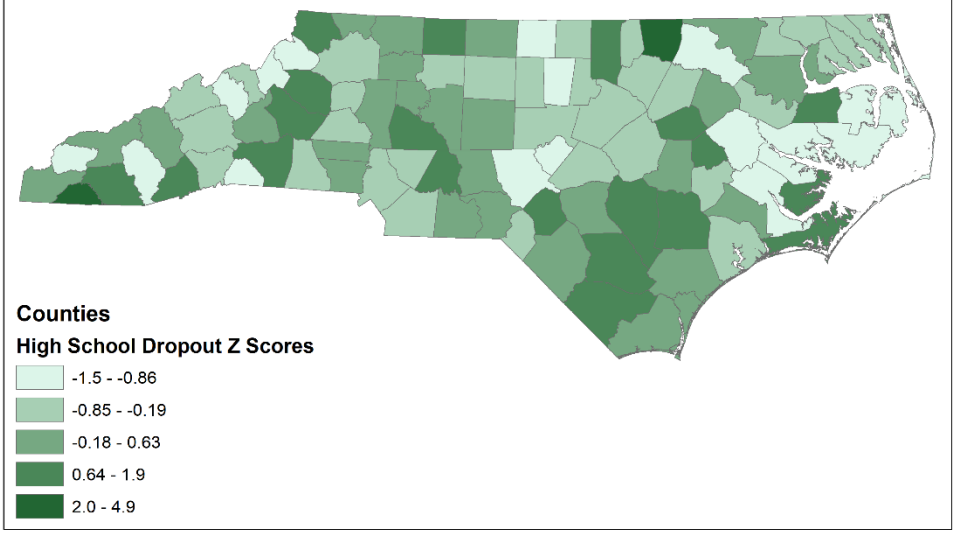
Map 1: Child Poverty



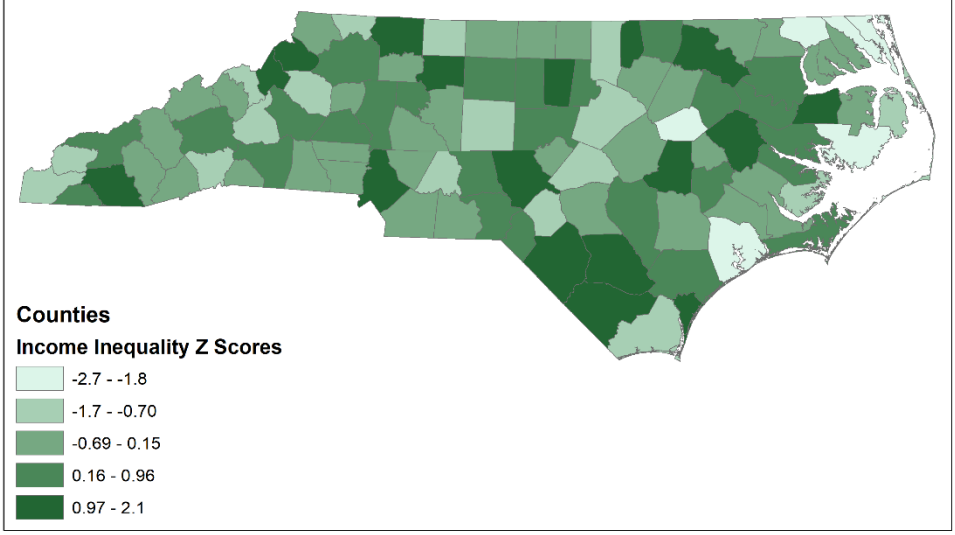
Map 2: Unemployment



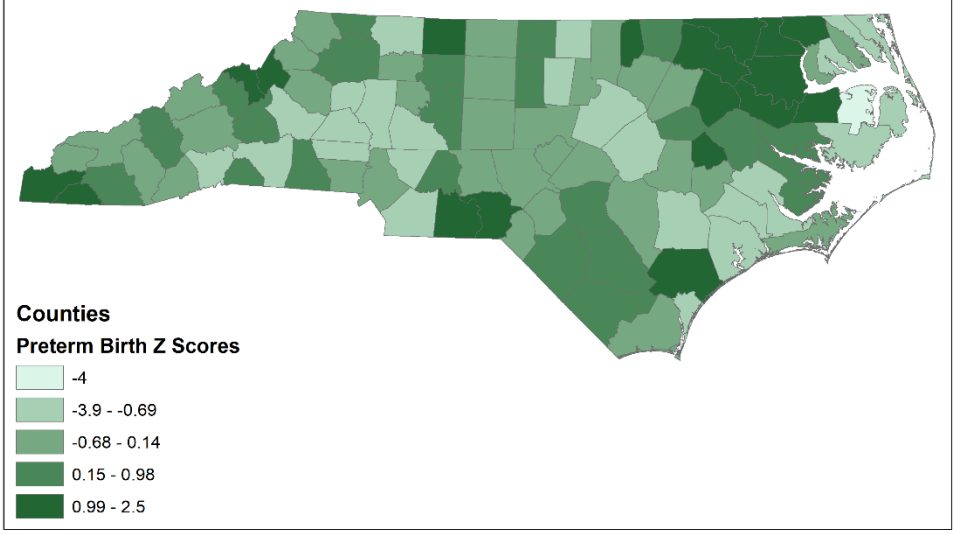
Map 3: High School Dropout



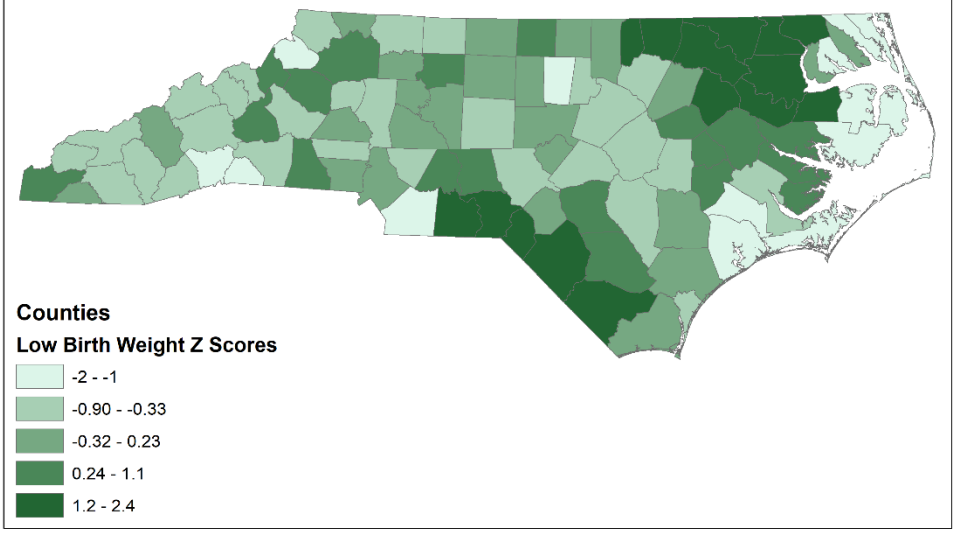
Map 4: Income Inequality



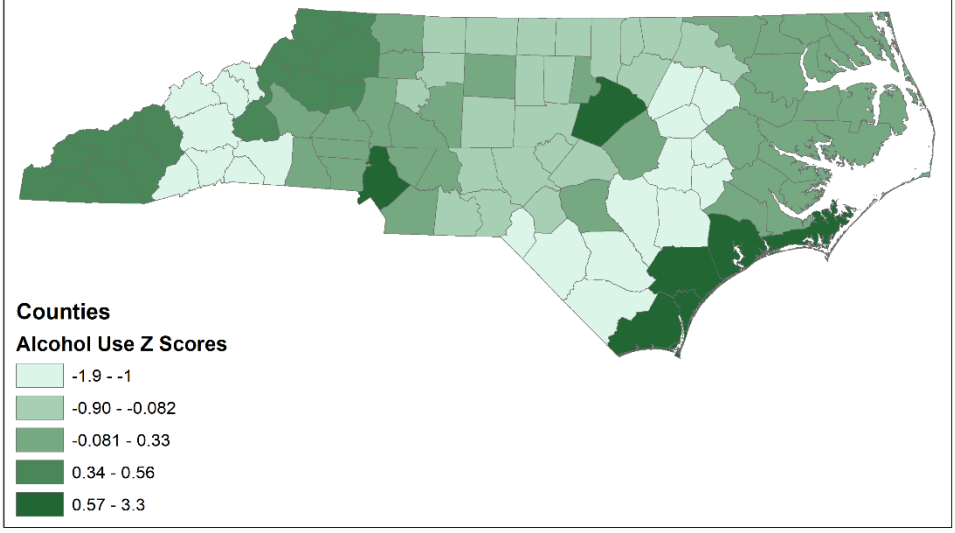
Map 5: Preterm Birth



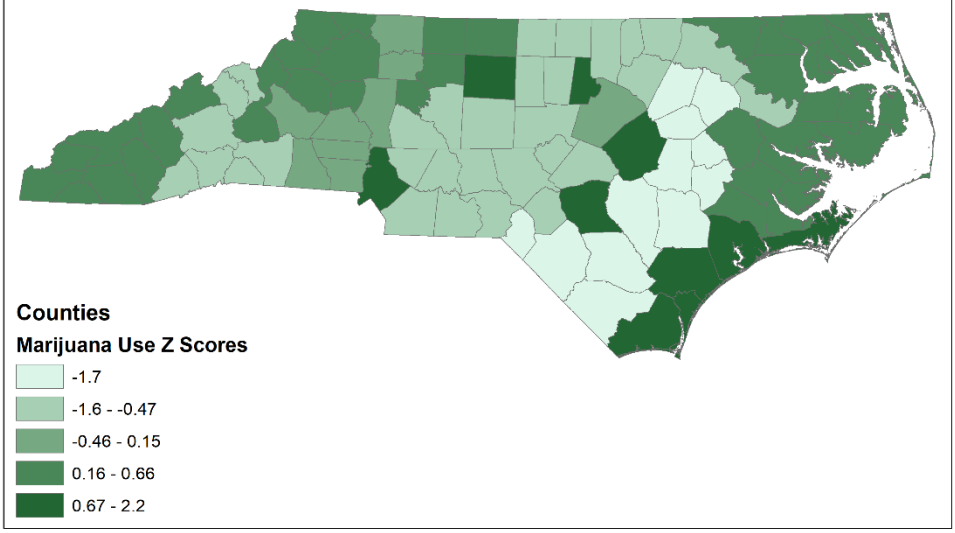
Map 6: Low Birth Weight



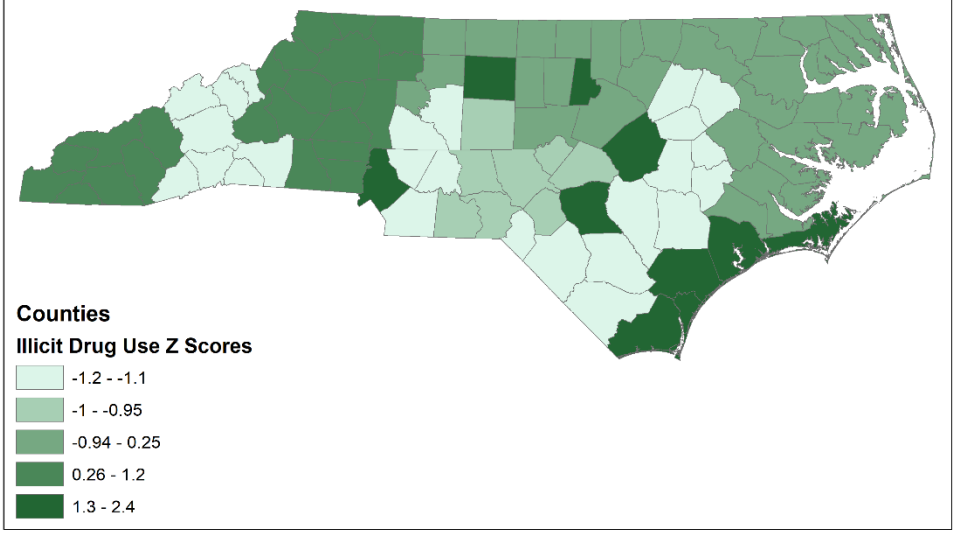
Map 7: Alcohol Use



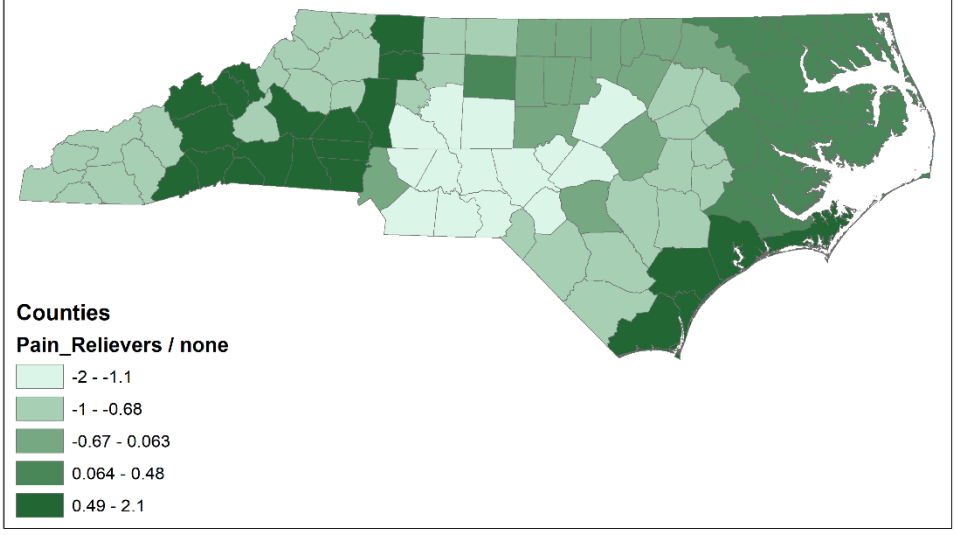
Map 8: Marijuana Use



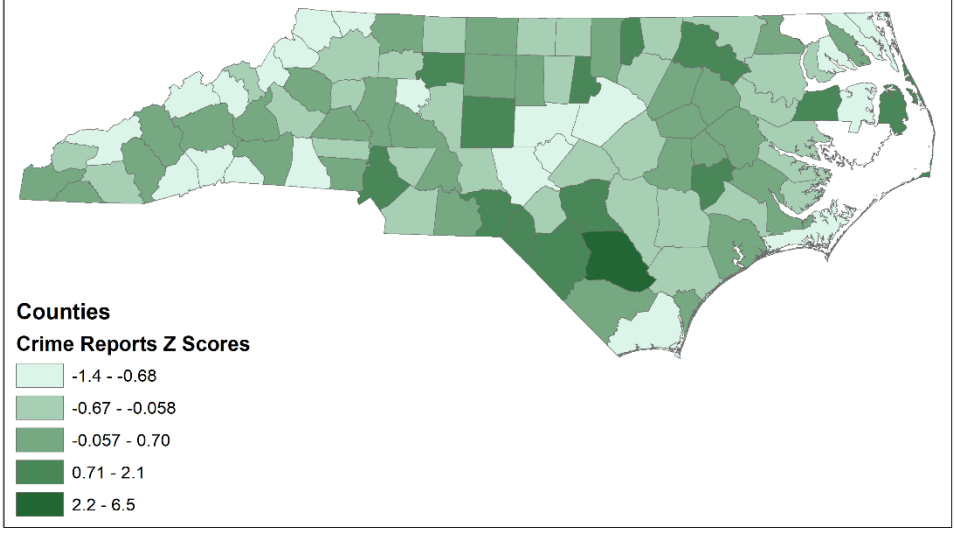
Map 9: Illicit Drug Use



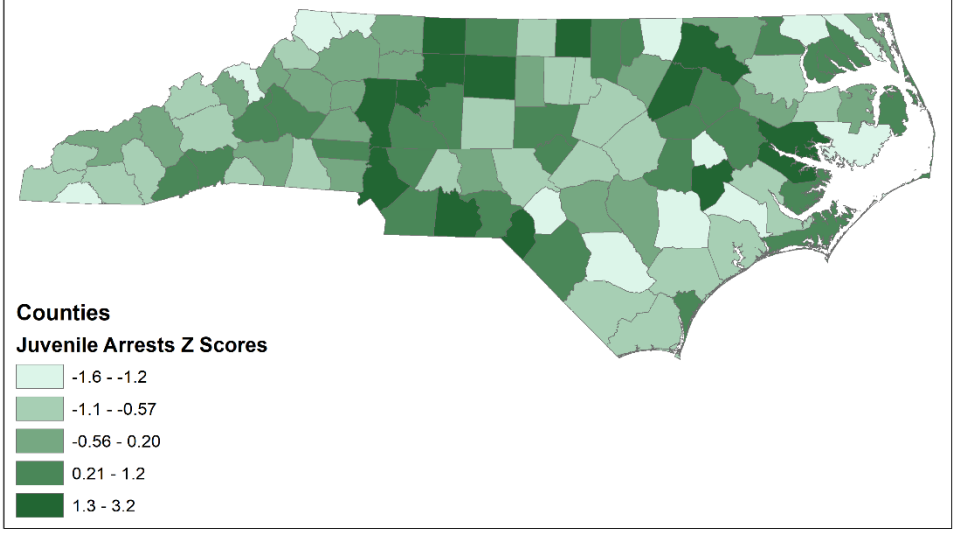
Map 10: Pain Relievers



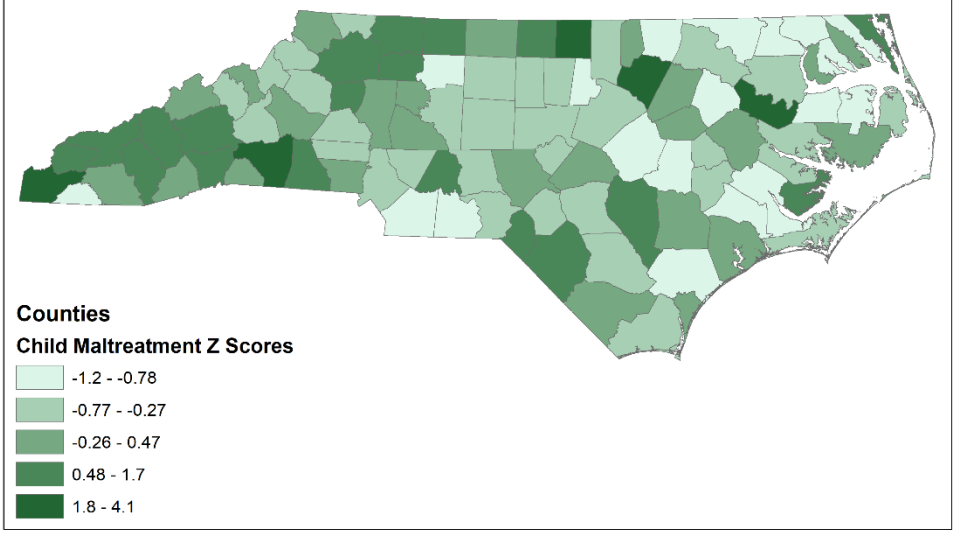
Map 11: Crime Reports



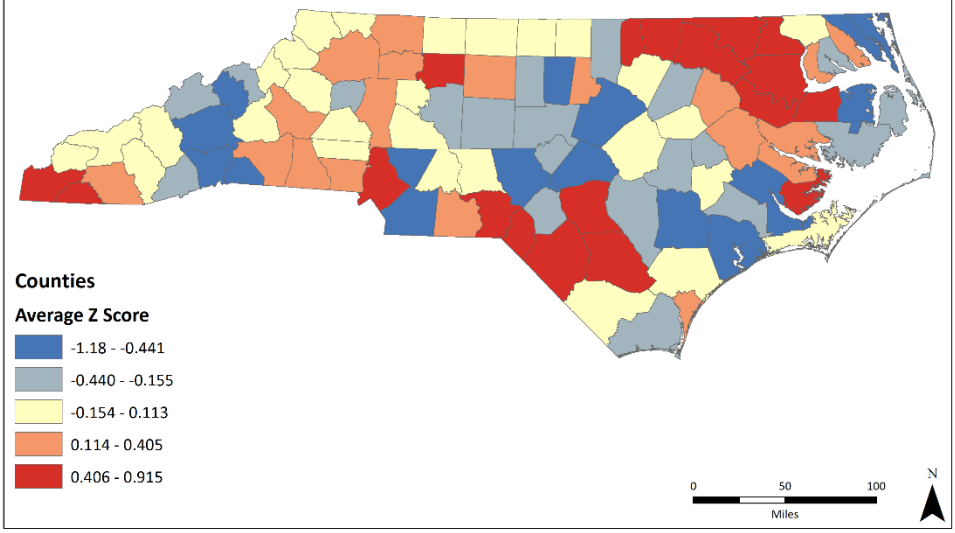
Map 12: Juvenile Arrests



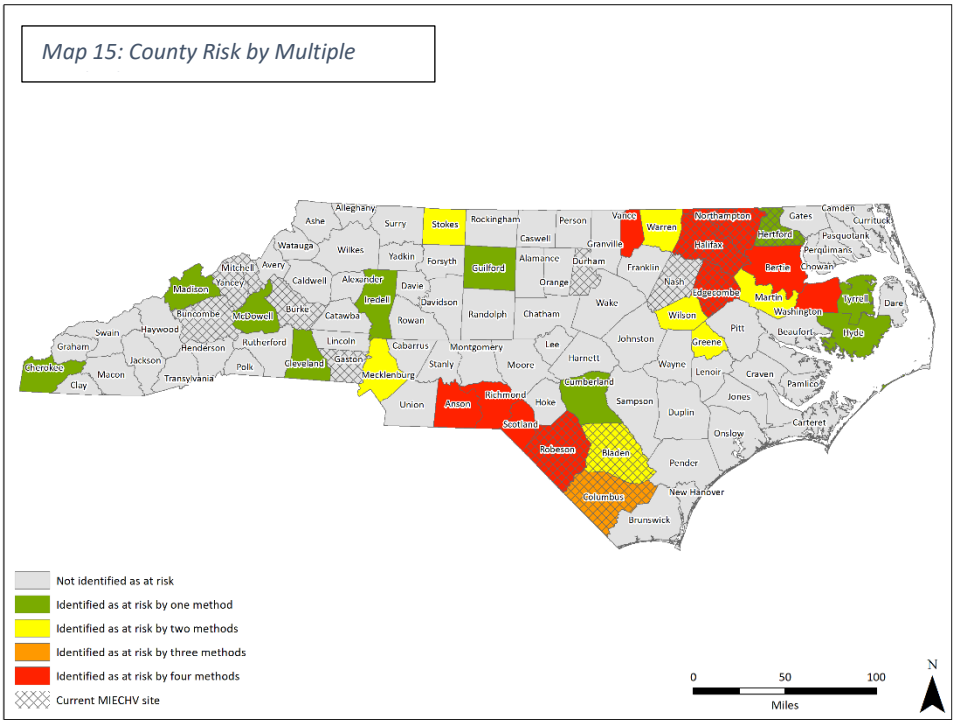
Map 13: Child Maltreatment



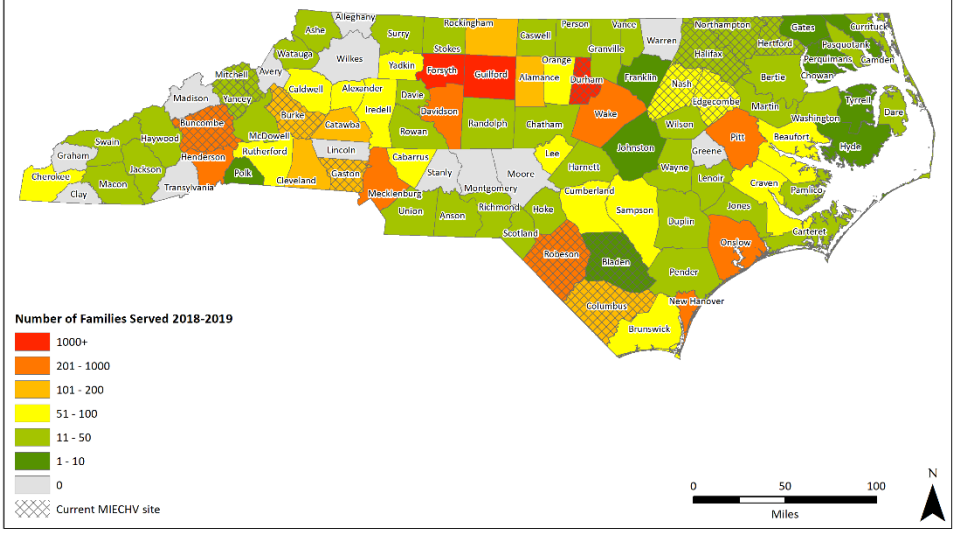
Map 14: Average Risk (Z-Score)



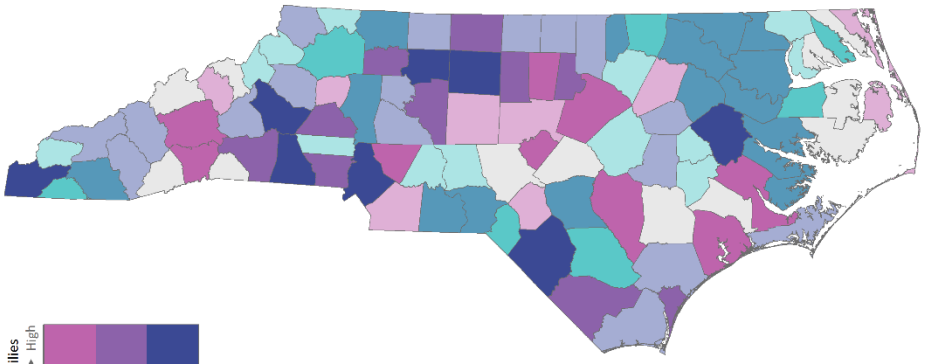
Map 15: County Risk by Multiple

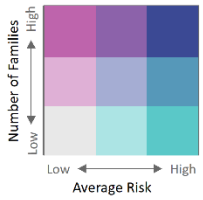


Map 16: Number of Families Served



Map 17: Bivariate Map of Risk (Z-Score) and Number of Families Served by Home Visiting





Appendix 3: Detailed County Risk Tables by Method and Current Home Visiting

County	Risk Group (# Methods)	High Risk by Simplified Method	High Risk by LCA Method	High Risk by Equal Weight Method	High Risk by Limited Indicator Method	Average Risk Z-Score	Current MIECHV Site	EBHV Model in County
Alamance	0 - Low Priority	No	No	No	No	-0.20	No	Yes
Alexander	0 - Low Priority	No	No	No	No	-0.29	No	No
Alleghany	0 - Low Priority	No	No	No	No	-0.09	No	No
Anson	4 - Highest Priority	Yes	Yes	Yes	Yes	0.24	No	Yes
Ashe	0 - Low Priority	No	No	No	No	-0.13	No	Yes
Avery	0 - Low Priority	No	No	No	No	0.07	No	No
Beaufort	0 - Low Priority	No	No	No	No	0.35	No	Yes
Bertie	4 - Highest Priority	Yes	Yes	Yes	Yes	0.55	No	Yes
Bladen	2 - High Priority	Yes	Yes	No	No	0.39	Yes	Yes
Brunswick	1 - Priority	No	No	Yes	No	0.25	No	Yes
Buncombe	0 - Low Priority	No	No	No	No	-0.49	Yes	Yes
Burke	0 - Low Priority	No	No	No	No	0.33	Yes	Yes
Cabarrus	0 - Low Priority	No	No	No	No	-0.51	No	Yes
Caldwell	0 - Low Priority	No	No	No	No	0.02	No	Yes
Camden	0 - Low Priority	No	No	No	No	-0.84	No	Yes
Carteret	1 - Priority	No	No	Yes	No	0.41	No	Yes
Caswell	0 - Low Priority	No	No	No	No	-0.07	No	Yes
Catawba	0 - Low Priority	No	No	No	No	0.01	No	Yes
Chatham	0 - Low Priority	No	No	No	No	-0.36	No	Yes
Cherokee	1 - Priority	Yes	No	No	No	0.45	No	Yes
Chowan	0 - Low Priority	No	No	No	No	0.21	No	Yes
Clay	0 - Low Priority	No	No	No	No	0.41	No	No
Cleveland	1 - Priority	Yes	No	No	No	0.28	No	Yes
Columbus	3 - High Priority	Yes	Yes	Yes	No	0.07	Yes	Yes
Craven	0 - Low Priority	No	No	No	No	-0.28	No	Yes
Cumberland	1 - Priority	Yes	No	No	No	0.54	No	Yes
Currituck	0 - Low Priority	No	No	No	No	-0.48	No	Yes
Dare	0 - Low Priority	No	No	No	No	-0.24	No	Yes
Davidson	0 - Low Priority	No	No	No	No	-0.21	No	Yes
Davie	0 - Low Priority	No	No	No	No	-0.14	No	Yes
Duplin	0 - Low Priority	No	No	No	No	-0.56	No	Yes
Durham	0 - Low Priority	No	No	No	No	0.11	Yes	Yes
Edgecombe	4 - Highest Priority	Yes	Yes	Yes	Yes	0.21	Yes	Yes
Forsyth	0 - Low Priority	No	No	No	No	0.39	No	Yes
Franklin	0 - Low Priority	No	No	No	No	-0.12	No	Yes
Gaston	0 - Low Priority	No	No	No	No	0.19	Yes	Yes
Gates	0 - Low Priority	No	No	No	No	-0.04	No	Yes
Graham	0 - Low Priority	No	No	No	No	-0.05	No	No
Granville	0 - Low Priority	No	No	No	No	-0.26	No	Yes
Greene	2 - High Priority	No	Yes	No	Yes	-0.20	No	No
Guilford	1 - Priority	Yes	No	No	No	0.37	No	Yes
Halifax	4 - Highest Priority	Yes	Yes	Yes	Yes	0.66	Yes	Yes
Harnett	0 - Low Priority	No	No	No	No	-0.50	No	No
Haywood	0 - Low Priority	No	No	No	No	0.04	No	Yes

County	Risk Group (# Methods)	High Risk by Simplified Method	High Risk by LCA Method	High Risk by Equal Weight Method	High Risk by Limited Indicator Method	Average Risk Z-Score	Current MIECHV Site	EBHV Model in County
Henderson	0 - Low Priority	No	No	No	No	-0.56	No	Yes
Hertford	1 - Priority	No	Yes	No	Yes	0.49	Yes	Yes
Hoke	0 - Low Priority	No	No	No	No	-0.37	No	Yes
Hyde	0 - Low Priority	No	No	No	No	-0.19	No	Yes
Iredell	1 - Priority	Yes	No	No	No	0.26	No	Yes
Jackson	0 - Low Priority	No	No	No	No	-0.08	No	Yes
Johnston	0 - Low Priority	No	No	No	No	-0.10	No	Yes
Jones	0 - Low Priority	No	No	No	No	-0.20	No	Yes
Lee	0 - Low Priority	No	No	No	No	-0.46	No	Yes
Lenoir	1 - Priority	No	Yes	No	No	-0.14	No	Yes
Lincoln	0 - Low Priority	No	No	No	No	-0.04	No	No
Macon	0 - Low Priority	No	No	No	No	0.13	No	Yes
Madison	0 - Low Priority	No	No	No	No	-0.34	No	No
Martin	3 - High Priority	Yes	Yes	No	Yes	0.75	No	Yes
McDowell	1 - Priority	No	No	No	Yes	-0.06	No	Yes
Mecklenburg	2 - High Priority	Yes	No	Yes	No	0.59	No	Yes
Mitchell	0 - Low Priority	No	No	No	No	-0.36	Yes	Yes
Montgomery	0 - Low Priority	No	No	No	No	-0.17	No	No
Moore	0 - Low Priority	No	No	No	No	-0.55	No	No
Nash	0 - Low Priority	No	No	No	No	-0.32	Yes	Yes
New Hanover	1 - Priority	No	No	Yes	No	0.54	No	Yes
Northampton	4 - Highest Priority	Yes	Yes	Yes	Yes	0.41	Yes	Yes
Onslow	1 - Priority	No	No	Yes	No	0.01	No	Yes
Orange	0 - Low Priority	No	No	No	No	-0.57	No	Yes
Pamlico	0 - Low Priority	No	No	No	No	0.41	No	Yes
Pasquotank	0 - Low Priority	No	No	No	No	0.25	No	Yes
Pender	2 - High Priority	Yes	No	Yes	No	0.46	No	Yes
Perquimans	0 - Low Priority	No	No	No	No	-0.21	No	Yes
Person	1 - Priority	Yes	No	No	No	0.04	No	Yes
Pitt	0 - Low Priority	No	No	No	No	0.37	No	Yes
Polk	0 - Low Priority	No	No	No	No	-0.57	No	Yes
Randolph	0 - Low Priority	No	No	No	No	-0.37	No	Yes
Richmond	4 - Highest Priority	Yes	Yes	Yes	Yes	0.43	No	Yes
Robeson	4 - Highest Priority	Yes	Yes	Yes	Yes	0.39	Yes	Yes
Rockingham	0 - Low Priority	No	No	No	No	-0.01	No	Yes
Rowan	0 - Low Priority	No	No	No	No	-0.14	No	Yes
Rutherford	0 - Low Priority	No	No	No	No	0.16	No	Yes
Sampson	0 - Low Priority	No	No	No	No	-0.29	No	Yes
Scotland	4 - Highest Priority	Yes	Yes	Yes	Yes	0.41	No	No
Stanly	0 - Low Priority	No	No	No	No	-0.19	No	No
Stokes	1 - Priority	Yes	No	No	No	0.05	No	Yes
Surry	0 - Low Priority	No	No	No	No	0.31	No	Yes
Swain	0 - Low Priority	No	No	No	No	0.07	No	Yes
Transylvania	0 - Low Priority	No	No	No	No	-0.29	No	No
Tyrrell	0 - Low Priority	No	No	No	No	-0.29	No	Yes
Union	0 - Low Priority	No	No	No	No	-0.73	No	Yes
Vance	4 - Highest Priority	Yes	Yes	Yes	Yes	0.60	No	Yes
Wake	0 - Low Priority	No	No	No	No	-0.72	No	Yes

County	Risk Group (# Methods)	High Risk by Simplified Method	High Risk by LCA Method	High Risk by Equal Weight Method	High Risk by Limited Indicator Method	Average Risk Z-Score	Current MIECHV Site	EBHV Model in County
Warren	2 - High Priority	Yes	Yes	No	No	0.42	No	No
Washington	4 - Highest Priority	Yes	Yes	Yes	Yes	0.74	No	Yes
Watauga	0 - Low Priority	No	No	No	No	-0.12	No	No
Wayne	0 - Low Priority	No	No	No	No	-0.29	No	Yes
Wilkes	0 - Low Priority	No	No	No	No	0.27	No	No
Wilson	2 - High Priority	Yes	Yes	No	No	-0.09	No	No
Yadkin	0 - Low Priority	No	No	No	No	0.12	No	Yes
Yancey	0 - Low Priority	No	No	No	No	-0.51	Yes	Yes

Appendix 4: MIECHV State Profile for North Carolina
Appendix 5: NHVRC Home Visiting Yearbook NC Profile
Appendix 6: NC Child County Data Cards for High-Risk Counties
Appendix 7: HV/PE Systems Plan
Appendix 8: State Leaders Letters

North Carolina's MIECHV Program FY 2019

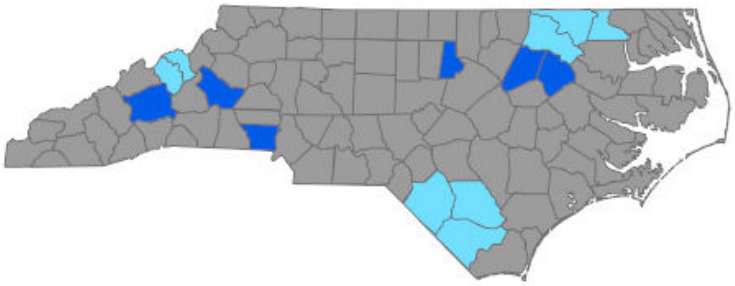
HRSA's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

- Supports the North Carolina Home Visiting Program and provides voluntary, evidence-based home visiting programs for at-risk pregnant women and families with children through kindergarten entry
- Builds upon decades of scientific research showing that home visits by a nurse, social worker, early childhood educator, or other trained professional during pregnancy and in the first years of a child's life helps prevent child abuse and neglect, supports positive parenting, improves maternal and child health, and promotes child development and school readiness

North Carolina MIECHV Program At-a-Glance

Rural counties:
Bladen, Columbus, Halifax, Hertford, Mitchell, Northampton, Robeson, Yancey

Non-rural counties:
Buncombe, Burke, Durham, Edgecombe, Gaston, Nash



Participants
821

Households
402

Home Visits
6,174

North Carolina Targets Community Needs

MIECHV Program awardees serve high-risk populations. Awardees tailor their programs to serve populations of need within their state.

- 66.9% of households were low income
- 25.3% of households included someone who used tobacco products in the home
- 13.8% of households reported a history of substance abuse

Evidence-Based Home Visiting Models in North Carolina

Healthy Families America (HFA)

Nurse-Family Partnership (NFP)

North Carolina Performance Highlights

- **Depression Screening:** 97.5% of caregivers enrolled in home visiting were screened for depression within 3 months of enrollment or within 3 months of delivery
- **Postpartum Care:** 87.8% of mothers enrolled in home visiting received a postpartum visit with a healthcare provider within 8 weeks of delivery
- **The 2018 Inaugural North Carolina Home Visiting Summit:** Workshop sessions included child behavior and development, continuous quality improvement, preventing domestic violence, family engagement, and maternal and infant mental health. Over 250 home visitors were in attendance.

NHVRC STATE PROFILES

North Carolina

Families Served Through Evidence-Based Home Visiting in 2018

Models implemented in North Carolina included Attachment and Biobehavioral Catch-Up, Child First, Early Head Start Home-Based Option, Family Connects, Healthy Families America, Home Instruction for Parents of Preschool Youngsters, Nurse-Family Partnership, Parents as Teachers, and SafeCare/SafeCare Augmented. Statewide, 106 local agencies operated at least one of these models.

86,550
home visits provided

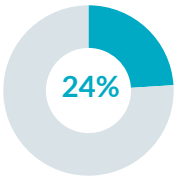
13,240
families served

13,471
children served

Race

- 5% American Indian/ Alaska Native
- 1% Asian
- 30% Black
- <1% Native Hawaiian/ Pacific Islander
- 47% White
- 15% Multiple
- 1% Other

Ethnicity



Hispanic or Latino

Caregiver education

No high school diploma

Child age

- 24% < 1 year
- 43% 1-2 years
- 33% 3-5 years

Child insurance status

- 88% Public
- 3% Private
- 9% None

Primary language

- 90% English
- 9% Spanish
- 2% Other

NHVRC STATE PROFILES

North Carolina

Potential Beneficiaries in 2018

In North Carolina, there were 565,100 pregnant women and families with children under 6 years old not yet in kindergarten who could benefit from home visiting. These families included 713,100 children.

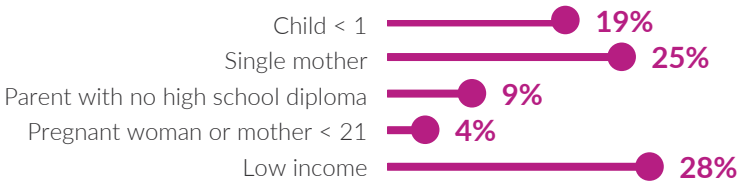
713,100 children
could benefit from home visiting

Of the 713,100 children who could benefit—

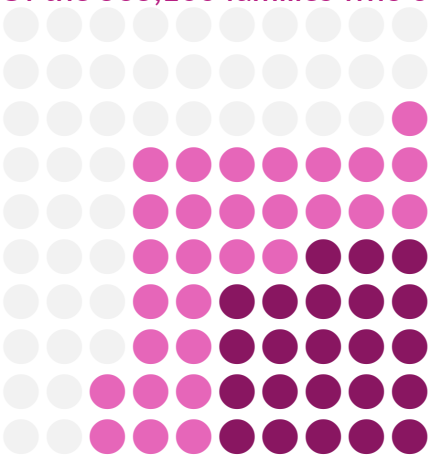
Infants	Toddlers	Preschoolers
< 1 year	1-2 years	3-5 years
113,700	241,100	358,300
16%	34%	50%

565,100 families
could benefit from home visiting

Many home visiting services are geared toward particular subpopulations. The NHVRC estimated the percentage of families who could benefit in North Carolina who met the following targeting criteria:



Of the 565,100 families who could benefit—



52% of families met one or more targeting criteria

23% of families met two or more targeting criteria

Notes • NHVRC State Profiles present data provided by evidence-based models, which include both MIECHV and non-MIECHV data. • Percentages may not add up to 100 due to rounding. • Public insurance includes Medicaid, CHIP, and TRICARE. • Low income is defined as family income below the federal poverty threshold. • Single mothers include single, never married mothers or pregnant women. • ABC reports children served, families served, and home visits only. • EHS data may be underreported. Data include EHS programs providing home-based services only. EHS race, ethnicity, and primary language data include children and pregnant caregivers. EHS does not report home visits or families served. The number of children served was included as a proxy for families served. • Family Connects reports families served only. The number of families served was included as a proxy for children served. • HFA reports primary language of caregivers. • PAT data for child insurance status and primary language are not included. • In 2018, SafeCare/SafeCare Augmented met standards of evidence as determined by HomVEE. This profile includes SafeCare/SafeCare Augmented (SafeCare) data. SafeCare does not report the number of children served. The number of families served was included as a proxy for children served. SafeCare does not report caregiver education, child age, or child insurance status.

The NHVRC is led by James Bell Associates in partnership with the Urban Institute. Support is provided by the Heising-Simons Foundation and the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the foundations. For details about the methodology, see the *2019 Home Visiting Yearbook*.

National Home Visiting Resource Center
www.nhvrc.org

NORTH CAROLINA

2020 NC DATA CARD

Child population:	2,311,348
Percent under age six:	31%
Number of live births:	118,957

A STRONG START

Women who receive early prenatal care: 68.0% (2018) — 68.6% 2017

Babies born at a low birthweight: 9.3% (2018) — 9.4% 2017

Babies born pre-term: 10.4% (2018) — 10.5% 2017

FAMILY ECONOMIC SECURITY

Children living in poor or low-income homes: 45.9% (2018) — 46.7% 2017

Children in households that are food insecure: 20.1% (2017) — 20.9% 2016

Median family income: $52,413 (2014-18) — $50,320 2013-2017

NURTURING HOMES & COMMUNITIES

Delinquency rate per 1,000 youth ages 6-15: 16.2 (2018) — -- 2017

Children assessed for abuse or neglect per 1,000: 52.2 (2018) — 55.8 2017

Teen births per 1,000 girls ages 15-17: 7.9 (2018) — 8.9 2017

HIGH-QUALITY EDUCATION

3rd grade students scoring proficient in reading: 56.8% (2018-19) — 55.9% 2017-2018

High school students graduating on time*: 86.5% (2019) — 86.3% 2018

Residents with bachelor's degree or higher: 30.5% (2018) — 29.9% 2017

HEALTH & WELLNESS

Children without health insurance: 5.0% (2018) — 5.3% 2017

Infant mortality per 1,000 live births: 6.8 (2018) — 7.1 2017

Child deaths per 100,000: 57.4 (2018) — 57.8 2017

NC Pathways to Grade-Level Reading whole-child Measure of Success.
Learn more at: www.buildthefoundation.org/pathways.

NC Child
The Voice for North Carolina's Children

NORTH CAROLINA

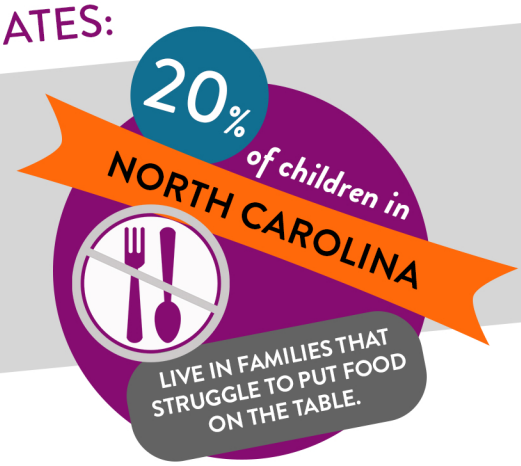
HERE'S WHAT IS CHANGING FOR KIDS SINCE THE PANDEMIC STRUCK

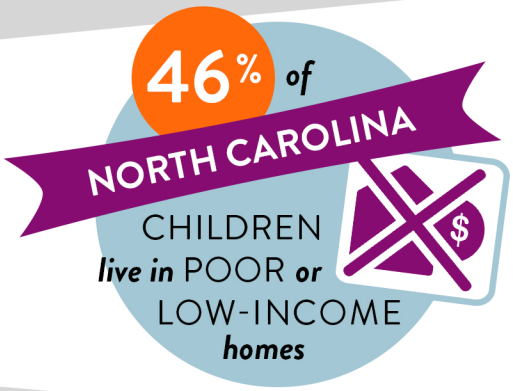
Fallout from the Coronavirus pandemic has meant that many more families are struggling with basic needs. This North Carolina Data Card highlights key indicators of child well-being that elected officials should track, and respond to, in their communities.

- These data benchmarks indicate how North Carolina's children were faring before COVID-19 struck.
- Many families are fighting new and increased stressors like job loss, hunger, untreated health concerns, and isolation away from community support. Traumatic episodes like these are shown to have long-term impacts on children's healthy development.
- Officials should use these data points as a baseline and watch for changes as we move from emergency response into long-term recovery.

QUESTIONS for ELECTED OFFICIALS and CANDIDATES:

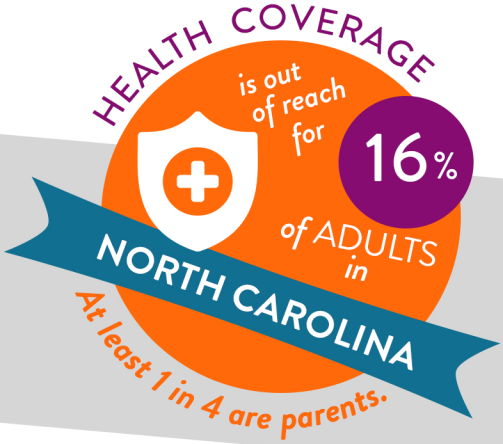
1. Many families are experiencing hunger for the first time. School and child care-based feeding programs have become lifelines in many communities. *What is your plan to ensure families can continue meeting basic needs, like affordable food?*





2. When the emergency period ends, a second crisis will hit many families. Parents and caregivers will have to pay off months of housing, utilities, and other bills that were put on hold. *What policies will you focus on to help families who are financially struggling to make ends meet so they can provide for their children?*

3. Hundreds of thousands of North Carolina families have lost the health insurance they previously received through their jobs. *What is your plan to get affordable health coverage to more parents and caregivers in North Carolina?*



Share this North Carolina Data Card with leaders and elected officials in your community!

NC Child
The Voice for North Carolina's Children

For complete data notes and sources, visit www.ncchild.org. Contact Whitney Tucker, Policy Director, with questions at whitney@ncchild.org

ANSON COUNTY

2020 NC DATA CARD

	NORTH CAROLINA		ANSON	
Child population:	2,311,348	Child population:	5,111
Percent under age six:	31%	Percent under age six:	29%
Number of live births:	118,957	Number of live births:	263

A STRONG START

Women who receive early prenatal care:	Babies born at a low birthweight:	Babies born pre-term:
58.9%	**16.3%**	**14.8%**
2018	2018	2018
62.9% 2017	14.8% 2017	14.8% 2017

FAMILY ECONOMIC SECURITY

Children living in poor or low-income homes:	Children in households that are food insecure:	Median family income:
58.8%	**22.6%**	**$39,126**
2018	2017	2014-2018
61.8% 2017	23.3% 2016	$38,123 2013-2017

NURTURING HOMES & COMMUNITIES

Delinquency rate per 1,000 youth ages 6-15:	Children assessed for abuse or neglect per 1,000:	Teen births per 1,000 girls ages 15-17:
28.5	**78.4**	**- -**
2018	2018	2018
- - 2017	65.7 2017	- - 2017

HIGH-QUALITY EDUCATION

3rd grade students scoring proficient in reading:	High school students graduating on time*:	Residents with bachelor's degree or higher:
49.0%	**83.0%**	**9.6%**
2018-2019	2019	2018
45.1% 2017-2018	84.0% 2018	9.2% 2017

HEALTH & WELLNESS

Children without health insurance:	Infant mortality per 1,000 live births:	Child deaths per 100,000:
5.6%	**7.6**	**79.4**
2018	2018	2018
4.3% 2017	3.9 2017	89.6 2017

NC Pathways to Grade-Level Reading whole-child Measure of Success.
Learn more at: www.buildthefoundation.org/pathways.

NC Child
The Voice for North Carolina's Children

BERTIE COUNTY

2020 NC DATA CARD

	NORTH CAROLINA		BERTIE	
Child population:	2,311,348		Child population:	3,712
Percent under age six:	31%		Percent under age six:	28%
Number of live births:	118,957		Number of live births:	179

A STRONG START

Women who receive early prenatal care:
74.9%
2018
77.2% 2017

Babies born at a low birthweight:
11.7%
2018
13.5% 2017

Babies born pre-term:
11.2%
2018
12.3% 2017

FAMILY ECONOMIC SECURITY

Children living in poor or low-income homes:
66.4%
2018
68.2% 2017

Children in households that are food insecure:
24.1%
2017
25.2% 2016

Median family income:
$33,143
2014-2018
$31,287 2013-2017

NURTURING HOMES & COMMUNITIES

Delinquency rate per 1,000 youth ages 6-15:
8.0
2018
- - 2017

Children assessed for abuse or neglect per 1,000:
47.6
2018
40.8 2017

Teen births per 1,000 girls ages 15-17:
- -
2018
- - 2017

HIGH-QUALITY EDUCATION

3rd grade students scoring proficient in reading:
38.0%
2018-2019
30.1% 2017-2018

High school students graduating on time*:
78.3%
2019
84.1% 2018

Residents with bachelor's degree or higher:
13.4%
2018
12.3% 2017

HEALTH & WELLNESS

Children without health insurance:
5.3%
2018
5.0% 2017

Infant mortality per 1,000 live births:
5.6
2018
11.7 2017

Child deaths per 100,000:
84.5
2018
81.8 2017

NC Pathways to Grade-Level Reading whole-child Measure of Success.
Learn more at: www.buildthefoundation.org/pathways.

NC Child
The Voice for North Carolina's Children

RICHMOND COUNTY

2020 NC DATA CARD

	NORTH CAROLINA		RICHMOND	
Child population:	2,311,348		Child population:	10,267
Percent under age six:	31%		Percent under age six:	31%
Number of live births:	118,957		Number of live births:	555

A STRONG START

Women who receive early prenatal care:	Babies born at a low birthweight:	Babies born pre-term:
57.5%	**11.40%**	**12.8%**
2018	2018	2018
60.1% 2017	15.0% 2017	15.5% 2017

FAMILY ECONOMIC SECURITY

Children living in poor or low-income homes:	Children in households that are food insecure:	Median family income:
60.1%	**26.3%**	**$36,091**
2018	2017	2014-2018
64.8% 2017	27.0% 2016	$33,607 2013-2017

NURTURING HOMES & COMMUNITIES

Delinquency rate per 1,000 youth ages 6-15:	Children assessed for abuse or neglect per 1,000:	Teen births per 1,000 girls ages 15-17:
31.8	**- -**	**- -**
2018	2018	2018
- - 2017	60.0 2017	- - 2017

HIGH-QUALITY EDUCATION

3rd grade students scoring proficient in reading:	High school students graduating on time*:	Residents with bachelor's degree or higher:
50.3%	**80.9%**	**13.9%**
2018-2019	2019	2018
46.4% 2017-2018	81.0% 2018	14.3% 2017

HEALTH & WELLNESS

Children without health insurance:	Infant mortality per 1,000 live births:	Child deaths per 100,000:
7.4%	**5.4**	**63.2**
2018	2018	2018
4.9% 2017	13.9 2017	66.2 2017

NC Pathways to Grade-Level Reading whole-child Measure of Success.
Learn more at: www.buildthefoundation.org/pathways.

NC Child
The Voice for North Carolina's Children

SCOTLAND COUNTY

2020 NC DATA CARD

	NORTH CAROLINA		SCOTLAND	
Child population:	2,311,348		Child population:	8,282
Percent under age six:	31%		Percent under age six:	32%
Number of live births:	118,957		Number of live births:	443

A STRONG START

Women who receive early prenatal care:	Babies born at a low birthweight:	Babies born pre-term:
62.3%	**16.7%**	**15.3%**
2018	2018	2018
67.9% 2017	13.4% 2017	10.1% 2017

FAMILY ECONOMIC SECURITY

Children living in poor or low-income homes:	Children in households that are food insecure:	Median family income:
67.3%	**28.3%**	**$35,617**
2018	2017	2014-2018
65.8% 2017	30.6% 2016	$32,739 2013-2017

NURTURING HOMES & COMMUNITIES

Delinquency rate per 1,000 youth ages 6-15:	Children assessed for abuse or neglect per 1,000:	Teen births per 1,000 girls ages 15-17:
31.7	**88.9**	**- -**
2018	2018	2018
- - 2017	93.8 2017	- - 2017

HIGH-QUALITY EDUCATION

3rd grade students scoring proficient in reading:	High school students graduating on time*:	Residents with bachelor's degree or higher:
38.9%	**81.2%**	**15.5%**
2018-2019	2019	2018
38.6% 2017-2018	87.1% 2018	15.9% 2017

HEALTH & WELLNESS

Children without health insurance:	Infant mortality per 1,000 live births:	Child deaths per 100,000:
6.2%	**6.8**	**81.3**
2018	2018	2018
6.5% 2017	11 2017	67.8 2017

NC Pathways to Grade-Level Reading whole-child Measure of Success.
Learn more at: www.buildthefoundation.org/pathways.

NC Child
The Voice for North Carolina's Children

VANCE COUNTY

2020 NC DATA CARD

NORTH CAROLINA		VANCE	
Child population:	2,311,348	Child population:	10,690
Percent under age six:	31%	Percent under age six:	31%
Number of live births:	118,957	Number of live births:	562

A STRONG START

Women who receive early prenatal care: 57.7% (2018) — 55.1% 2017

Babies born at a low birthweight: 12.50% (2018) — 12.0% 2017

Babies born pre-term: 14.6% (2018) — 11.0% 2017

FAMILY ECONOMIC SECURITY

Children living in poor or low-income homes: 67.9% (2018) — 68.6% 2017

Children in households that are food insecure: 24.3% (2017) — 25.8% 2016

Median family income: $37,282 (2014-2018) — $35,246 2013-2017

NURTURING HOMES & COMMUNITIES

Delinquency rate per 1,000 youth ages 6-15: 24.5 (2018) — - - 2017

Children assessed for abuse or neglect per 1,000: 74.7 (2018) — 80.1 2017

Teen births per 1,000 girls ages 15-17: - - (2018) — 21.8 2017

HIGH-QUALITY EDUCATION

3rd grade students scoring proficient in reading: 50.0% (2018-2019) — 45.7% 2017-2018

High school students graduating on time*: 86.7% (2019) — 82.1% 2018

Residents with bachelor's degree or higher: 12.9% (2018) — 12.1% 2017

HEALTH & WELLNESS

Children without health insurance: 6.5% (2018) — 2.5% 2017

Infant mortality per 1,000 live births: 12.5 (2018) — 10.3 2017

Child deaths per 100,000: 66.1 (2018) — 69.5 2017

NC Pathways to Grade-Level Reading whole-child Measure of Success.
Learn more at: www.buildthefoundation.org/pathways.

NC Child
The Voice for North Carolina's Children

WASHINGTON COUNTY

2020 NC DATA CARD

	NORTH CAROLINA		WASHINGTON	
Child population:	2,311,348		Child population:	2,584
Percent under age six:	31%		Percent under age six:	29%
Number of live births:	118,957		Number of live births:	129

A STRONG START

Women who receive early prenatal care:	Babies born at a low birthweight:	Babies born pre-term:
72.1%	**10.1%**	**8.5%**
2018	2018	2018
71.6% 2017	9.7% 2017	9.0% 2017

FAMILY ECONOMIC SECURITY

Children living in poor or low-income homes:	Children in households that are food insecure:	Median family income:
71.2%	**28.2%**	**$35,512**
2018	2017	2014-2018
70.9% 2017	27.4% 2016	$34,557 2013-2017

NURTURING HOMES & COMMUNITIES

Delinquency rate per 1,000 youth ages 6-15:	Children assessed for abuse or neglect per 1,000:	Teen births per 1,000 girls ages 15-17:
15.3	**52.6**	**- -**
2018	2018	2018
- - 2017	55.5 2017	- - 2017

HIGH-QUALITY EDUCATION

3rd grade students scoring proficient in reading:	High school students graduating on time*:	Residents with bachelor's degree or higher:
37.0%	**78.8%**	**11.3%**
2018-2019	2019	2018
34.3% 2017-2018	72.5% 2018	9.1% 2017

HEALTH & WELLNESS

Children without health insurance:	Infant mortality per 1,000 live births:	Child deaths per 100,000:
10.3%	**15.5**	**88.6**
2018	2018	2018
3.1% 2017	22.4 2017	69.9 2017

NC Pathways to Grade-Level Reading whole-child Measure of Success.
Learn more at: www.buildthefoundation.org/pathways.

NC Child
The Voice for North Carolina's Children

Home Visiting and Parenting Education System
SYSTEM ACTION PLAN

STRATEGIC VISION for home visiting and parenting education in North Carolina, in the service of the ECAP vision:

All families have access to a range of parenting education supports, from the prenatal period to age eight, within a coordinated delivery system, which will positively impact parent-child relationship and family and child well-being.

Goals for Home Visiting and Parenting Education System

CHOICE To advance a continuum of home visiting and parent education models and intensity, with equitable access to families in need and seeking the services.

QUALITY SUPPORTS To align and coordinate home visiting and parenting education in a manner that maximizes the potential of the workforce and each model, leverages the best of knowledge and supports across the early childhood system, and results in mutually reinforcing activities across models and the system.

RACIAL EQUITY To build and maintain a system that remediates racial and economic inequities through the equitable access points, quality and distribution of services.

INTEGRATION To develop a system that will advance home visiting and parenting education while fully integrating home visiting and parenting education as part of the bigger system of early childhood, maternal and child health, and social services in North Carolina.

IMPACT To develop and operationalize, supporting at a systemic level, strategies that maximize resources, support efficiency in operations, allow for leveraging of model impacts and implementation approaches, and are continuously informed by outcomes for children and families.

Goal: Area the work most supports	**Outcomes**	**Strategies and Activities**	**Timeline/Responsibility**	**Output**
System Component: Governance and Administration				
Integration	A The governance structure for home visiting and parent education will fully represent programs, funders, prenatal to eight agencies, communities and families, use a systems approach to support the multi-model, locally variable implementation approach which is flexible and targets need, and ensure cross sector engagement within the prenatal to eight system.	A1 Determine appropriate governance structure to lead the NC home visiting and parent education system. A2 Map out necessary membership, roles and responsibilities, expectations of the governance entity. A3 Determine decision making approach of governance. A4 Establish a subcommittee approach to leverage participation at multiple levels and greater numbers, including incorporating parent/family voice. A5 Advance local governance entities and how these entities are part of the overall governance structure, advancing the same collaborative and systemic approach at the local level as the state, and provide a feedback loop in to the structure. A6 Develop programming/activities of governance structure with budget and potential funding sources. A7 Develop strategic approach and activities for both state and local governance entities, including budgets, to advance the multi-model, locally variable approach to HV and PE implementation. A8 Establish communication and knowledge sharing systems between new NC HVPE governance structure and current prenatal to age eight governance structures.	A1- A5 September – November 2019 Governance Planning small group	Recommendation on Governance approach and structural elements for January Systems plg group meeting Commitments from funders/administrators to approach

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Choice	B Home visiting and parenting education stakeholders will utilize common messages across multiple systems to support awareness and knowledge of the role of these programs, to increase access to programs and local choice, and to advance the collaborative approach to a HVPE system.	B1 Develop communication tools and approaches to advance an overall understanding of what home visiting and parenting education is and the potential impact, and clarity for families on what resources are available. B2 Implement communications strategy for different audiences. B3 Analyze and respond to other common messaging and education needs; initial needs identified: continuum of services in a community; different silos and partners that need engagement; shifting the mindset around role and value of HVPE. B4 Explore options for a centralized intake approach, to improve coordination and family experience, while advancing the local approach to the HVPE system. B5 Utilize existing resources and create new tools to communicate impact of services and system to policy makers.		
Impact	C Organizations will have a decrease in the administrative burden they face in running home visiting and parenting education programming.	C1 Establish common outcomes and program expectations across funding sources. C2 Align reporting requirements, use the same report forms and monitoring tools. C3 Align funding cycles and evaluations (such as RFPs) C4 Develop a feedback loop to understand program and family experiences of the administration system, with process for modifying current or developing new administrative strategies, in direct response to the feedback. C5 Explore a single portal for entry of reporting requirements.		
Racial Equity	D Leadership, oversight, and management of HVPE at both state- and local-levels are structured to advance opportunities, fairness, and access to resources for those historically and currently effected by racial inequity.	D1 Research existing approaches to equity values and principles in the state and across peer states through Pritzker, Think Babies, national HV and PE work, to learn from equity approaches used. D2 Develop definition and values around equity for the HVPE system, in alignment with other state and local efforts. D3 Assess current mechanisms for reviewing performance on equity and addressing disparities, at state and local systems levels and program implementation level. D4 Assess how system governance should support existing mechanisms and the role of HVPE governance in the performance review mechanisms that need to be developed and implemented specific to the HVPE system. D5 Establish plan for the development and implementation of these mechanisms.	D1-D2 Systems Planning, small group focused on equity, November – December 2019	

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System Component: Financing Strategies and Funding Mechanisms				
Impact	E Home visiting and parenting education stakeholders will utilize comprehensive information on funding of the programs (federal, state and local), the role of aligning funding, and the funding needs of local programs and system-level supports as part of their system approach and in guiding decisions.	E1 Explore strategies for disseminating revenue and expense study information. E2 Develop training tools to support local communities to use revenue and expense model to support their financing efforts. E3 Gather and review local strategies for financing multi-model home visiting approaches to create funding management systems with centralized strategies aligned to the best practices of local. E4 Run analysis of revenue and expense model data to support understanding of budgetary impact of shared strategies for reporting and monitoring (common outputs, forms, reporting structures). E5 Run analysis of the program benefits to functioning as part of a local system. E6 Craft messaging and communication efforts around funding to address what it takes to run programs (admin) as well as the state and local system needs.		
Quality Supports	F Home visiting and parenting education stakeholders will improve the funding mechanisms used for programs and the system, with integrated funding sources and distribution systems.	F1 Develop models (some in current practice) of layering funding for continuum of models, with demonstration of how funding requirements are met through the approaches, and plan for education on layered funding in response to current understanding of layering. F2 Develop resources to support implementation of a continuum of models, funded by multiple sources, in communities (tool on the key elements of success for that approach across communities) F3 Analyze challenges and systemic barriers faced by communities implementing funding, for individual and continuum of models, as well as quality/system supports, to determine policy and administrative changes to address. F4 Run revenue and expense modeling reflective of the workforce and professional development areas of the system, under fully funded mosaic of models in communities. Highlight potential mechanisms to fund the workforce and professional development needs. F5 Develop mechanisms to measure the impact of aligning and layering of funding on the implementation of programs and the overall HVPE system.		
Racial Equity	G Build and maintain a system that supports the policies and financing required to ensure children are not disadvantaged by racial and other inequities.	G1 Develop values and policies related to fiscal administration that aligns with equity values laid out in the governance system. G2 Leveraging local assessment and planning work, identify inequities in access and funding across the state. G3 Review current funding streams and administration processes with an equity assessment lens, analyzing information gathered to inform policy and process changes. G4 Develop and implement a plan to target funding to address identified inequities. Plan will include measurement of progress on addressing inequities.		

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		G5 Explore potential processes to monitor equity in implementation of financing strategies and administration. G6 Develop and implement mechanisms to review performance related to equity approach.		
Integration	H The diversity and stability of funding for home visiting and parenting education will increase (will increase to meet x of the demand).	H1 Develop a catalogue of current and potential funding sources. H2 Explore the role of alignment of funding streams and the understanding of the potential approaches to alignment across the current, and potential, funding sources. H3 Using HVPE fiscal model to analyze the funding gap, based on yearly service expansion targets, and leveraging all potential funders for these services. H4 Map the role of aligning current funding and how to leverage funding based on level of restrictiveness, in order to maximize the sources available and make those less restrictive options available to meet need. H5 Analyze use of Medicaid funding and Family First Prevention Services Act funding for home visiting. H6 Establish communication and information sharing systems with other aspects of the prenatal to age eight system, specific to the financing needs and approach of all services and system components (e.g., child care fiscal modeling, system-wide fiscal modeling; need for strategic thinking on places to share resources and implementation strategies).		

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RACIAL EQUITY To build and maintain a system that remediates racial and economic inequities through the equitable access points, quality and distribution of services.

INTEGRATION To develop a system that will advance home visiting and parenting education while fully integrating home visiting and parenting education as part of the bigger system of early childhood, maternal and child health, and social services in North Carolina.

IMPACT To develop and operationalize, supporting at a systemic level, strategies that maximize resources, support efficiency in operations, allow for leveraging of model impacts and implementation approaches, and are continuously informed by outcomes for children and families.

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System Component: Assessment and Planning				
Choice	A statewide expansion plan for home visiting and parenting education will include community driven assessment and planning, and leverage the community approach, to guide decisions regarding investments and program expansion.	1 Assess sources for accurate data on current service delivery and capacity to inform a statewide expansion plan and develop capacity to maintain this data. 2 Identify sources for expansion plan components and gather information on these, including but not limited to: deserts, organizations in communities with capacity to lead effort, funding needs (from fiscal modeling), and need from the communities. 3 Develop strategies to identify expansion targets that address inequities in access. 4 Develop strategies and measures within plan to allow locally driven selection and implementation of models and local variability in implementing the continuum of supports to programs. 5 Outline responsibilities, expectations, and activities of local as part of the statewide expansion plan, including delineating the use of the local coordinating entity to implement the vision and the plan. 6 Finalize multi-year statewide expansion plan.		
Racial Equity	Cross-system and interagency assessment and planning aligns with all equity change levers: personal, interpersonal, institutional and structural; and results in organizations that intentionally	1 Facilitate disaggregation of state-level data, including service utilization and needs assessment data sources, in order to analyze data from perspective of equity change levers. 2 Develop technical assistance on using state-level needs assessment data sources, identifying gaps in data and strategies to address, and how data leads to a response plan. 3 Develop a community assessment process to guide a consistent, collaborative approach in communities, aligned with equity change levers, that is inclusive of community need, continuum of service possibilities,		

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	contribute to racial equity and economic justice outcomes.	capacity of organizations, workforce and more. 4 Analyze resources for community assessment frame to ensure they address racial equity in data, and are focused on response planning across all equity change levers. 5 Anticipate and plan for a needs based approach to capacity building in communities that targets greater resources and investments to those historically disenfranchised and under resourced communities.		
Impact	Communities have the services and supports that best match their needs.	1 Ensure funding for community assessment and planning, separate from the pursuit of new funding for services, and develop these funding strategies in concert with those to fund the work of a local coordinating entity responsible for HVPE system. *[Cross reference: G&A A7]* 2 Develop a system development TA approach, to support assessment, local decision making and the development of local plans to respond to assessment. 3 Implement priorities and principles for the engagement of parent and family voice, in step with family engagement in other aspects of state work and ensuring meaningful participation. 4 Establish long term prioritization of need, with consensus across stakeholders, in order to move through expansion with a multi-phase approach.		
Quality Supports	The statewide plan for the expansion of home visiting, and the assessment and planning that informs this plan, will support local systems in their ability to maintain a multi-model approach in their community.	1 Ensure that the statewide approach to expansion is clearly messaged to include the community driven approach to multiple models and local expansion that is based on need, not on funding or competition. 2 Develop a communication structure and feedback loop across state and local that advances the local coordinating entity and how these entities are part of the state HVPE systems governance structure. 3 Survey communities to determine what supports they need to do the big tent approach to HVPE (perceived need for permission from models and funders, etc?) 4 Develop principles and strategies, with associated resources and TA, to support collaboration among models, in order to meet community need and implement plan.		
System Component: Monitoring and Accountability				
Choice	Throughout NC, communities are informed on which programming works best for given populations and use this information to guide decisions on the parenting education and home visiting services offered in their communities.	1 Explore a precision medicine style approach to developing an understanding of what programming works best for which people and when, and sharing out this information to better match models with communities. 2 Develop scale up plan that will ensure coverage of programs in every county in NC, in response to the needs of communities (related to Assessment and Planning component). 3 Integrate strategies for scaling programs that address the continuum of program options available in counties and target program capacity according to maintaining the continuum. 4 Set and measure system against benchmarks of success in scaling up the continuum of programs.		

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Integration **Impact**	Measures for monitoring and accountability of home visiting and parenting education implementation are aligned across funders and models and demonstrate linkage to statewide goals for prenatal to eight system. The HVPE system will be responsible for system-wide outcomes (develop measures, track, analyze and report on) and will formulate and support implementation of system responses to outcomes as necessary.	Develop objectives and priorities for monitoring and accountability which reflect the system goals of increasing efficiencies in funding and program administration and understanding the overall impact of HV and PE programming. Monitoring - Survey reporting structures are used across the state in HV/PE programs. Identify "gold star" examples of reporting structures that work well (DPH, DSS, any funders, model consultants) - Identify key areas of efficiency to monitor, considering how state system or policy changes could increase these efficiencies. Accountability - Crosswalk program outcomes across models, and HV and PE, to find overlaps, common outcomes across programs. - Map data indicators that feed up to the larger measures in ECAP in order to demonstrate how HV and PE are part of impacting these outcomes. - Explore a data capture system and data use agreements to engage all models and funders in the system (look to work of ECIDS and ECAP as models for this work). - Complete an analysis of all outcome reporting in order to determine policy implications and the outcome areas that may be appropriate for considering impact of HVPE from system lens. - Identify outcomes in parent behavior (well child visits, reading to kids, getting immunizations) that move the needle. Outcomes may include elements already tracked by models, goal of this approach is to pull them together in a dashboard style tracking that considers the program impact from the systems level, instead of just the individual program lens. - Establish an accountability goal for the system, and a evaluation report on this goal, which demonstrates the impact of a functional system and can be used in building the case for continual investments in HVP and the system.		
Racial Equity	Shared leadership and collective power offers new and reconstituted systems of accountability. Policy and programs are developed and monitored for their impact and outcomes that contribute to both racial inequities and racial equity on all levels—personal, interpersonal,	1 Identify data points for disaggregating family outcomes data by race, establish tracking of data points not currently in use. 2 Develop system for monitoring family outcomes data at the system level, analyzing data results and planning responses to the data. 3 Analyze exists measures, and develop/recommend new, to address the impact of model fidelity with marginalized populations. 4 Develop and implement measures to assess the impact of adjusting model implementation to account for population differences.		

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	institutional and structural.	5 Explore measures in place, or in need of development, to address levels of racial equity: personal, interpersonal, institutional, and structural, across policies and programs. 6 Develop monitoring approach for all levels of racial equity, which integrates in existing monitoring, and adds new addressing multiple levels of racial equity work.		

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System Component: Continuous Quality Improvement, Implementation and Evaluation				
Integration	An integrated approach to quality, implementation and evaluation will support understanding needs across models, ensuring consistency in the experience of models, and ensuring that programs have access to standard supports that maximize program impact.	1 Develop core strategies of this integrated approach encompassing the following progression of the work: i. information gathering, ii. analysis from a systems perspective with goal of common experience of programs, iii. develop strategies to address gaps identified in analysis. 2 Outline shared commitments to this work, engage with stakeholder groups around these commitments and develop roles and responsibilities to support the work. Concepts include: - Function across models and funders/administering entities. Work will coordinate across these entities, not add more work to programs that function under these different entities. - Role of each entity is to share their knowledge and successes to benefit the NC system: work will leverage the shared expertise from existing models in order to address the gaps found in quality improvement, implementation supports and evaluation efforts. - Strategies to address identified gaps may include building cross model activities that mirror examples from peer models. - Strategies to address program access to standard supports, regardless of funder, model or location variances. 3 Demonstrate the role of the integrated approach in supporting the achievement of overall goals for children and families held by the state. Align these concepts for HVPE with the goals and evaluation laid out in the Early		

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		Childhood Action Plan.		
Quality Supports	The quality and capacity of home visiting and parenting education programs will be supported by a coordinated, comprehensive and fully accessible continuous quality improvement system.	1 Complete an analysis of quality assurance strategies and supports across models/programs including those that are part of the broader prenatal to eight system: the goals, services, and measures. 2 Map existing quality improvement efforts of state agencies and organizations supporting prenatal to eight programming, in order to have an understanding of the landscape of this work and where strategies can be leveraged, built upon, or mirrored in supporting HVPE, or possibly see modifications to streamline work with programs and result in efficiencies. 3 Review map of existing efforts, and develop response plan, with goal of achieving consistency and common experience of supports for implementation across model type, funder and program location. Ensure strategies leverage role of existing systems (i.e. Smart Start Eval/CQI; DSS/PCANC) to meet identified needs. 4 Explore providing consistent implementation science support, training and resources across the state, how this would be rolled out, and the overall impact of this approach on programs meeting their model and funder requirements.		
Impact	North Carolina home visiting and parent education stakeholders will develop and implement an evaluation plan and structure that is fully representative of programs, funders, communities and families, and advances policies that demonstrate the impact of the multi-model, locally variable approach, as part of achieving goals	1 Complete an assessment of current outcomes tracked by all models/programs to identify where they align currently or could align. Develop alignment tools on evaluation (e.g., processes, products, messaging, guidance on where appropriate to evaluate multiple models on same variables). 2 Align statewide system measures, those captured across all models/program with funder measures (contract measures for which programs are responsible). 3 Determine where there are measures across HV and PE that may be shared, where measures differ and how differences in outcomes are important to these two services and their existence in the same community space. 4 Outline a common set of existing metrics, coordinate these with ECAP measures, and develop an evaluation plan and structure that addresses both these threads and has flexibility for additional data. Ensure that the metrics and plan support an increased understanding of family outcomes across the state. 5 Analyze evaluation plan to ensure equity in approach. 6 Work with funders, public and private, to develop and promote a shared agenda around evaluation, with consistent measures and outcome scales across models and programs. 7 Assess potential resources to support a shared approach to evaluation, such as state data positions. 8 Expand and include local efforts around Early Childhood Integrated Data System (ECIDS), to work toward a integrated data system that fully captures the work and is capable of the disaggregation of data necessary to apply an equity lens to understanding outcomes.		
Racial Equity	North Carolina will develop a coordinated, comprehensive and	1 Engage in a process to review and understand how strategies to assess quality are driven by equity levels of change and how these are implemented across models and programs.		

Goal: Area the work most supports	Outcomes	Strategies and Activities	Timeline/Responsibility	
	fully accessible continuous quality improvement process with data systems that support program- and system-level decision-making related to closing racial disparities.	2 Analyze what gaps in assessment of quality, implementation supports and evaluation exist and what strategies could be developed at a state level to support CQI and implementation consistently across the state. 3 Explore the variations in CQI necessary to address the needs of diverse communities, for instance, those historically-disenfranchised communities with more challenging social and economic conditions. 4 Develop out the components of a multi-tiered approach to monitoring quality improvement, implementation and evaluation, that uses strategies aligned with equity levels of change. 5 Complete an analysis of current implementation supports for parent/family engagement and leadership that uses an equity lens. Develop cross model/funder implementation supports for meaningful parent engagement and leadership that use an equity lens in the work and can be implemented across the state.		
Choice	An integrated approach to quality, implementation and evaluation will support family access to programs and ensuring families are engaged in programs.	1 Maintain resource documents on programs: target population (by funding source, program); services delivered. 2 Ensure communication, outreach, and resource tools are in place to share program requirements and objectives along the continuum of services. 3 Scan existing approaches to shared referral and centralized intake, the coordination across state and local entities required, and the support from HVPE governance needed for the development and maintenance of these strategies in each community. 4 Develop strategies to leverage existing coordination of model purveyors and of service providers, assess and understand where purveyors and providers currently work together, and how to build more strategies for their work and coordinated services that will support families in accessing a service. 5 Explore early childhood family navigator concepts (Healthy Opportunities examples) to address family access and community coordination aspect of implementing expansion plan.		

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System Component: Professional Development, Training and Technical Assistance				
Integration	Home visiting and parenting education system will ensure consistency and accessibility of programs and communities to professional development,	1 Develop the continuum of supports through a plan that encompasses the shared workforce and professional development needs across the spectrum of HVPE programming, as well as their discreet needs. 2 Compare and contrast training offerings provided by each model, including the core competencies addressed by the training. 3 Map and develop a repository of existing trainings and technical assistance opportunities that plots content		

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	training and technical assistance supports.	along a continuum from beginner to advanced, links to competencies, informs on the offering entity and gives information that may increase intake by programs. 4 Identify funding and other resources to ensure the professional development area of the HVPE systems is able to be sustained and to include programs that may not currently be included in model-specific or statewide trainings. 5 Work within the other family support programming, and the broader prenatal to eight system, to ensure that the HVPE professional development plan is aligned with, accessing and sharing as appropriate, training and technical assistance of other programs.		
Quality Supports	Home visiting and parenting education workforce will have access to and utilize professional supports aligned to core competencies for the delivery of HV and PE programming.	1 Determine the areas of core competencies for HV and PE workforce (professionals and volunteers and areas for consistency across professional supports and shared competencies for all models. Areas to include: trauma-informed, child development, family engagement, cultural competencies, equity, and others to be identified. 2 Consider use of nationally established competencies for HV and PE. 3 Develop a plan for ensuring accessible, consistent integration and support once the core competencies have been defined. Map multiple options for how shared competencies would be integrated to the NC higher education, professional development, certification, and endorsement systems, based on the purpose for utilizing shared competencies. 4 Develop core training content (leveraging what may exist on the topics) in order to ensure cross program-type access to training that advances competency in identified areas (those areas identified initially: racial equity, family/community engagement, trauma informed practice, self-care, protective factors).		
Impact	Alignment of workforce and professional development, training and technical assistance will increase retention of quality staff and improve organizational sustainability.	1 Utilize knowledge of training needs and demands to begin assessment of gaps in current offerings. 2 Launch a statewide professional training needs assessment that cuts across models, funders and home visiting and parenting education, to gather more information on training needs. 3 Identify gaps in technical assistance opportunities and ways to model additional offerings on successful initiatives in place. 4 Develop a strategic approach to increasing training and technical assistance offerings, from the models, the scope and needed capacity and the investment needed. 5 Work with program leadership and quality support staff on the content and strategies needed to ensure the professional development approach encompasses the program management as well as professionals who deliver coaching, technical assistance and coaching. 6 Utilize Home Visiting Consortium and convening of parenting education purveyors as an advisory body to assess and build response plan for addressing training needs. 7 Engage with Prevent Child Abuse North Carolina to support assessing training needs across parenting education models.		

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Choice	Home visiting and parenting education stakeholders will have increased opportunities for professional growth and development that functions across models and is locally driven and accessible.	1 Develop role for the local system entities to identify the local need and readiness and establish implementation supports that are responsive to their local context, coordinate the state or regional supports that address their local context. 2 Support this local responsiveness with a state system approach that is fully resourced to meet professional development and TA needs while leveraging the existing structures. 3 Develop opportunities for regional or statewide learning collaboratives (communities of practice) to build capacity in quality improvement cycles around specific shared areas for improvement. 4 Identify an approach to learning collaboratives that ensures the concept is shared across models and funding entities. Resource to make accessible to all programs and develop content in shared areas applying across models. E.g., one model or funder, or collective of models/funders may lead on a given area but the model will encompass all models in the region. 5 Apply implementation science as an element of professional growth and development, including trainings on program implementation at organizational level. Based on survey of programs (from Monitoring and Accountability section) select two to three areas of professional practice to apply implementation science approach to. 6 Develop strategy for training on areas of implementation science, broadly, and the content areas identified in the program survey.		
Racial Equity	Workforce development system align efforts to recruit and support practitioners in developing competencies and enhancing practice to understand their own values, beliefs, implicit biases, unconscious racism, actions, as well as their own relative privileges.	1 Identify inequities in access and other structural barriers programs having to engaging with training and professional development opportunities. 2 Develop competencies and identify training and professional development activities addressing individual values, beliefs, implicit biases and unconscious racism in practice. 3 Develop a plan to integrate additional training and mentoring resources on values, beliefs, implicit biases, unconscious racism, relative privileges and actions, in to existing model and topical trainings. 4 Facilitate the development of these resource materials and ensure training on implementation of the materials is widely available and tailored to different training, TA and mentoring engagements. 5 Explore measures to assess comprehension of these concepts and behavior changes in these areas, support implementation of measures across workforce development system. 6 Support the development of a pipeline of diverse home visiting and parenting education professionals, reflective of diversity of NC families and communities.		

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Re: North Carolina MIECHV Needs Assessment

Dear Mr. Bryant:

As partners in North Carolina's effort to create a comprehensive early childhood system, we appreciate the opportunity to coordinate regarding the MIECHV Needs Assessment. The North Carolina MIECHV Needs Assessment includes information that reflects our collective efforts to coordinate with one another as representatives of the Title V, Head Start, and CAPTA programs. We discussed the approach to the Needs Assessment, we reviewed the final document, and we concur with the findings.

As North Carolina strives to improve health and developmental outcomes for young children in the state, we see evidence-based home visiting programs as one of several service strategies necessary to reach that goal. The support of the Maternal, Infant, and Early Childhood Home Visiting program is a key component of the system of home visiting and parenting education programs throughout the state. The needs assessment provides a mechanism for to increase understanding of at-risk communities. Further, the needs assessment includes an analysis of the quality and capacity of existing early childhood home visiting programs as well as capacity in North Carolina to provide substance abuse treatment and counseling to families in need of those services. This informs our decision making as we consider strategies for coordination and disseminating resources. North Carolina's implementation plan will include steps to assure that the necessary infrastructure is in place to support programs and monitor effectiveness; and continue coordination with fellow agencies.

Sincerely,

Karen McKnight

Karen McKnight, M.Ed.
Head Start State Collaboration Office
NC Department of Public Instruction

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
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September 21, 2020

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Kathy Stone
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NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK T. BENTON • Assistant Secretary for Public Health
Division of Public Health

September 25, 2020

Christopher T. Bryant, M.Ed.
Health & Wellness Unit Manager
MIECHV Project Director
NC Division of Public Health, Children & Youth Branch
N.C. Department of Health and Human Services
5601 Six Forks Road, Building Two
1928 Mail Service Center
Raleigh, N.C. 27699-1928

Re: North Carolina MIECHV Needs Assessment

Dear Mr. Bryant:

As one of many partners in North Carolina's effort to create a comprehensive early childhood system, we appreciate the opportunity to coordinate regarding the MIECHV Needs Assessment. The North Carolina MIECHV Needs Assessment includes information that reflects our collective efforts to coordinate with one another as representatives of the Title V, Head Start, and CAPTA programs. As the Title V Director and also Chief of the Women's and Children's Health Section, which houses MIECHV and home visiting programs, we shared information on the Title V Needs Assessment, discussed the approach to the MIECHV Needs Assessment, reviewed the final document, and concur with the findings.

As North Carolina strives to improve health and developmental outcomes for young children in the state, we see evidence-based home visiting programs as one of several service strategies necessary to reach that goal. The support of the Maternal, Infant, and Early Childhood Home Visiting program is a key component of the system of home visiting and parenting education programs throughout the state. The needs assessment provides a mechanism to increase understanding of and better serve at-risk communities. Further, the needs assessment includes an analysis of the quality and capacity of existing early childhood home visiting programs as well as capacity in North Carolina to provide substance abuse treatment and counseling to families in need of those services. This informs our decision making as we consider strategies for coordination and disseminating resources. North Carolina's implementation plan will include steps to ensure continued coordination with partners and that infrastructure is in place to support programs and monitor effectiveness.

Sincerely,

Kelly Kimple, MD, MPH, FAAP
NC Title V Director
Chief, Women's and Children's Health Section
Division of Public Health, NC Department of Health and Human Services