Aug 23 HVS Commitee Homework Readings

- Equity Lens
- National Home Visiting Resource Center (At-A-Glance and Primer)
- Children's Institue 2019 Policy Brief
- Executive Summary, Appenix D ,and E of MIECHV 2020 Needs Assessment

HIGHER EDUCATION COORDINATING COMMISSION

Oregon Equity Lens

The Oregon Equity Lens was adopted by the Higher Education Coordinating Commission (HECC) in 2014 as a cornerstone to the State's approach to education policy and budgeting. The Equity Lens was originally developed by and adopted by the former Oregon Education Investment Board (OEIB), and is implemented by the Oregon Chief Education Office in addition to the HECC.

CHIEF EDUCATION OFFICE

Oregon Equity Lens: Preamble

In 2011, the Oregon Legislature created the Oregon Education Investment Board, which had a vision of educational equity and excellence for each and every child and learner in Oregon. The OEIB believed that we must ensure sufficient resource is available to guarantee student success, and that the success of every child and learner in Oregon is directly tied to the prosperity of all Oregonians. As the Higher Education Coordinating Commission, with our Oregon education partners, we continue this critical work started by the OEIB and reaffirm that the attainment of a quality education strengthens all Oregon communities and promotes prosperity, to the benefit of us all. It is through educational equity that Oregon will continue to be a wonderful place to live and make progress towards becoming a place of economic, technologic and cultural innovation.

Oregon faces many growing opportunity and systemic gaps that threaten our economic competitiveness and our capacity to innovate. The first is the persistent gap of student growth as measured by graduation rates, state assessments and daily attendance for our growing populations of communities of color, immigrants, migrants, and rural students navigating poverty. While students of color make up 35% of the educational pipeline in our state[1]— our opportunity and systemic gaps continue to persist. As our diversity grows and our ability to meet the needs and recognize the strengths of these students remains stagnant or declines—we limit the opportunity of everyone in Oregon. The persistent educational disparities have cost Oregon billions of dollars in lost economic output[1] and these losses are compounded every year we choose not to properly address these inequalities.

The second opportunity gap is one of disparity between Oregon and the rest of the United States. When the OEIB started this work, Oregon's achievement in state benchmarks had remained stagnant—and in some communities of color had declined—while other states had begun to, or had already surpassed, our statewide rankings. Disparities in educational attainment can translate into economic decline and a loss of competitive and creative capacity for our state. We believe that one of our most critical responsibilities going forward is to implement a set of concrete system changes and policies to deliver a truly student-centric education system that improves outcomes and opportunities for students across Oregon.

Chief Education Office

Vision Statement

Our vision is to build and coordinate a seamless system of education that meets the diverse learning needs of students from cradle to career, and ensures each student graduates high school with the support and opportunities to prosper.

Higher Education Coordinating Commission

Vision Statement

The State of Oregon's Higher Education Coordinating Commission (HECC) is dedicated to fostering and sustaining the best, most rewarding pathways to opportunity and success for all Oregonians through an accessible, affordable and coordinated network for educational achievement beyond high school.

The primary focus of the equity lens is on race and ethnicity. While there continues to be a deep commitment to many other areas, we know that a focus on race by everyone connected to the educational milieu allows direct improvements in the other areas. We are committed to explicitly identifying disparities in education outcomes for the purpose of targeting areas for action, intervention and investment. We are simultaneously committed to identifying strengths in communities and promising practices in our educational systems.[2]

Oregon Equity Lens: Beliefs

We believe *that everyone has the ability to learn and that we have an ethical and moral responsibility to ensure an education system that provides optimal learning environments that lead students to be prepared for their individual futures.*

We believe *that speaking a language other than English is an asset and that our education system must celebrate and enhance this ability alongside appropriate and culturally responsive support for English as a second language.*

We believe *students receiving special education services are an integral part of our educational responsibility and we must welcome the opportunity to be inclusive, make appropriate accommodations, and celebrate their assets. We must directly address the over-representation of children of color in special education and the under-representation in "talented and gifted."*

We believe *that the students who have previously been described as "at-risk," "underperforming," "under-represented," or minority actually represent Oregon's best opportunity to improve overall educational outcomes. We have many counties in rural and urban communities that already have populations of color that make up the majority. Our ability to meet the needs of this increasingly diverse population is a critical strategy for us to successfully reach our State education goals.*

We believe *that intentional and proven practices must be implemented to return out of school youth to the appropriate and culturally sustaining educational setting. We recognize that this will require us to challenge and change our current educational setting to be more culturally responsive, safe, and responsive to the significant number of elementary, middle, and high school students who are currently out of school. We must make our schools safe for every learner.*

We believe *that ending disparities and gaps in achievement begin in the delivery of quality Early Learner programs and culturally appropriate family engagement and support. This is not simply an expansion of services—it is a recognition that we need to provide services in a way that best meets the needs of our most diverse segment of the population—0-5 year olds and their families.*

We believe *that resource allocation demonstrates our priorities and our values and that we demonstrate our priorities and our commitment to rural communities, communities of color, English language learners, and out of school youth in the ways we allocate resources and make educational investments.*

We believe *that communities, parents, teachers, and community-based organizations have unique and important solutions to improving outcomes for our students and educational systems. Our work will only be successful if we are able to truly partner with the community, engage with respect, authentically listen, and have the courage to share decision-making, control, and resources.*

We believe *every learner should have access to information about a broad array of career opportunities and apprenticeships. These will show them multiple paths to employment yielding family-wage incomes without diminishing the responsibility to ensure that each learner is prepared with the requisite skills to make choices for their future.*

We believe *that our community colleges and university systems have a critical role in serving our diverse populations, rural communities, emerging bi-lingual students and students with disabilities. Our institutions of higher education, and the P-20 system, will truly offer the best educational experience when their campus faculty, staff and students reflect this state, its growing diversity and the ability for all of these populations to be educationally successful and ultimately employed.*

We believe *the rich history and culture of learners is a source of pride and an asset to embrace and celebrate.*

Finally, we believe *in the importance of supporting great teaching. Research is clear that "teachers are among the most powerful influences in (student) learning."* [3] *An equitable education system requires providing teachers with the tools and support to meet the needs of each student, and a dedicated effort to increase the culturally and linguistically diverse educators who reflect Oregon's rapidly changing student population.*

Case for Equity

Oregonians have a shared destiny.

Individuals within a community and communities within a larger society need the ability to shape their own present and future, and we believe that education is a fundamental aspect of Oregon's ability to thrive. Equity is both the means to educational success and an end that benefits us all. Equity requires the intentional examination of systemic policies and practices that, even if they have the appearance of fairness, may in effect serve to marginalize some and perpetuate disparities. Data are clear that Oregon demographics have been changing to provide rich diversity in race, ethnicity, and language.[4] Working toward equity requires an understanding of historical contexts and the active investment in changing social structures and practice over time to ensure that students from all communities have the opportunities and support to realize their full potential.

Oregon Equity Lens: Purpose

The purpose of the Equity Lens is to clearly articulate the shared goals we have for our state, the intentional policies, investments and systemic change we will make to reach our goals of an equitable educational system, and to create clear accountability structures to ensure that we are actively making progress and correcting where there is not progress. As the Chief Education Office executes its charge to align and build a cradle to career education system and the Higher Education Coordinating Commission executes its charge to foster pathways for postsecondary success, an equity lens is useful to ensure every learner is adequately prepared by educators for meaningful contributions to society.

The Equity Lens confirms the importance of recognizing institutional and systemic barriers and discriminatory practices that have limited access and success for many students in the Oregon education system. The Equity Lens emphasizes historically underserved students, such as out of school youth, emerging bilingual students (English language learners), and students in some communities of color and some rural geographical locations, with a particular focus on racial equity. The result of creating a culture of equity will focus on the outcomes of academic proficiency, civic awareness, workplace literacy, and personal integrity. The system outcomes will focus on resource allocation, engagement, communications, data collection and analysis and educator hiring, preparation, and development.

Oregon Equity Lens: Objectives

By utilizing an equity lens, the Higher Education Coordinating Commission aims to provide a common vocabulary and protocol for resource allocation, partnership, engagement, and strategic initiatives to support students and communities.

The following questions will be considered for resource allocation and evaluating strategic investments:

1. Who are the racial/ethnic and underserved groups affected? What is the potential impact of the resource allocation and strategic investment to these groups?
2. Does the decision being made ignore or worsen existing disparities or produce other unintended consequences? What is the impact on eliminating the opportunity gap?
3. How does the investment or resource allocation advance opportunities for historically underserved students and communities?
4. What are the barriers to more equitable outcomes? (e.g. mandated, political, emotional, financial, programmatic or managerial)
5. How have you intentionally involved stakeholders who are also members of the communities affected by the strategic investment or resource allocation? How do you validate your assessment in (1), (2) and (3)?
6. How will you modify or enhance your strategies to ensure each learner and communities' individual and cultural needs are met?
7. How are you collecting data on race, ethnicity, and native language?
8. What is your commitment to P-20 professional learning for equity? What resources are you allocating for training in cultural responsive instruction?

Creating a culture of equity requires monitoring, encouragement, resources, data, and opportunity. The HECC will apply the Equity Lens to policy recommendations, and internal, and external practices as education leaders.

Oregon Equity Lens: Definitions

Equity: Equity in education is the notion that each and every learner will receive the necessary resources they need individually to thrive in Oregon's schools no matter what their national origin, race, gender, sexual orientation, differently abled, first language, or other distinguishing characteristic.

Underserved Students: Students whom systems have placed at risk because the systems have operationalized deficit-based thinking. Deficit thinking is the practice of having lower expectations for certain groups of people based on demographics or characteristics that they share. In doing so, an "at-risk" narrative is formed, in which students navigating poverty, culturally and linguistically diverse students, and/or historically underserved groups, and their families are pathologized and marginalized. This includes students who are treated differently because of their gender, race, sexual orientation, dis/ability, and geographic location. Many students are not served well in our education system because of the conscious and unconscious bias, stereotyping, and racism that is embedded within our current inequitable education system.

Race: Race is a social —not biological—construct. We understand the term "race" to mean a racial or ethnic group that is generally recognized in society and often by government. When referring to those groups, we often use the terminology "people of color" or "communities of color" (or a name of the specific racial and/or ethnic group) and "white." We also understand that racial and ethnic categories differ internationally, and that many local communities are international communities. In some societies, ethnic, religious and caste groups are oppressed and racialized. These dynamics can occur even when the oppressed group is numerically in the majority.

White Privilege: A term used to identify the privileges, opportunities, and gratuities offered by society to those who are white.

Embedded Racial Inequality: Embedded racial inequalities are also easily produced and reproduced—usually without the intention of doing so and without even a reference to race. These can be policies and practices that intentionally and unintentionally enable white privilege to be reinforced.

40-40-20: In 2011, the State of Oregon enacted legislation (ORS 350.014) creating the 40-40-20 educational attainment goal: that by 2025 all Oregonians will hold a high school diploma or equivalent, 40% of them will have an associate's degree or a meaningful postsecondary certificate, and 40% will hold a bachelor's degree or advanced degree.[5] 40-40-20 means representation of every student in Oregon, including students of color.

Disproportionality: Over-representation of students of color in areas that impact their access to educational attainment. This term is a statistical concept that actualizes the disparities across student groups.

Opportunity Gap: The lack of opportunity that many social groups face in our common quest for educational attainment and the shift of attention from the current overwhelming emphasis on schools in discussions of the opportunity gap to more fundamental questions about social and educational opportunity.[6]

Culturally Responsive: Recognize the diverse cultural characteristics of learners as assets. Culturally responsive teaching empowers students intellectually, socially, emotionally and politically by using cultural referents to impart knowledge, skills and attitudes.[7]

[1] U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimate.
[2] Alliance for Excellent Education. (November 2011). T*he high cost of high school dropouts: What the nation pays for inadequate high schools.*
[3] Hattie, J. (2009), *Visible learning: A synthesis of over 800 meta-analyses relating to student achievement*. P. 238.
[4] ODE (2016), *Oregon Statewide Report Card, 2015-16: An Annual Report to the Legislature on Oregon Public Schools.*
[5] *The Opportunity Gap* (2007). Edited by Carol DeShano da Silva, James Philip Huguley, Zenub Kakli, and Radhika Rao.
[6] The 40-40-20 statute was updated with the passage of HB 2311 (2017), refocusing it on students in the educational pipeline.
[7] Ladson-Billings, Gloria (2009- Second Edition, 1994). *The Dreamkeepers: Successful Teachers of African American Children;* Gay, Geneva (2010). *Culturally Responsive Teaching: Theory, Research, and Practice*. New York: Teachers College Press.
** NOTE: The Equity Lens was edited in 2017 by the Higher Education Coordinating Commission with technical and data related updates.*

National Home Visiting
Resource Center

Helping Children & Families Thrive

Home Visiting at a Glance

Early childhood home visiting is a service delivery strategy that matches expectant caregivers and caregivers of young children with a designated support person—typically a trained nurse, social worker, or early childhood specialist. Services are voluntary and provided in the family's home or another location of the family's choice. A two-generation approach, home visiting delivers both caregiver- and child-oriented services to help the whole family. It views child and family development from a holistic perspective that encompasses—

- Child health and well-being
- Child development and school readiness
- Positive caregiver-child relationships
- Caregiver health and well-being
- Family economic self-sufficiency
- Family functioning

What Do Home Visitors Do?

Gather family information to tailor services

- Screen caregivers for concerns like postpartum depression, substance use, and domestic violence[i]
- Screen children for developmental delays

Provide direct education and support

- Provide knowledge and training to make homes safer
- Encourage positive parenting practices
- Promote safe sleep practices
- Offer information about child development

Make referrals and coordinate services

- Help pregnant caregivers access prenatal care
- Check to make sure children attend well-child visits
- Connect caregivers with job training and education programs
- Refer caregivers as needed to mental health or domestic violence resources

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operating in the United States met standards of evidence as determined by the Home Visiting Evidence of Effectiveness (HomVEE) project.

How Can Home Visiting Help?

Home visiting has a strong evidence base, with many studies showing it works.[ii]

Home visiting participants are more likely to **access prenatal care** and **carry babies to term**.[iii]

Home visitors teach parents to **engage with children** in positive, nurturing, and responsive ways, thus **reducing maltreatment**.[iv]

Home visiting **improves children's early language and cognitive development**, as well as academic achievement in grades 1 through 3.[v, vi]

Enrolled parents have **higher monthly incomes**, are more likely to be **enrolled in school**, and are more likely to **be employed**.[vii, viii, ix, x]

Studies have found a **return on investment of $1.80 to $5.70** for every dollar spent on home visiting.[xi, xii]

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National Home Visiting Resource Center

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The NHVRC is a partnership of James Bell Associates and the Urban Institute. Support is provided by the Heising-Simons Foundation and previously was also provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the foundations.

National Home Visiting
Resource Center

Helping Children & Families Thrive

Home Visiting Primer

About the National Home Visiting Resource Center

The National Home Visiting Resource Center (NHVRC) is a source for comprehensive information about early childhood home visiting; its growing evidence base; and its potential impact on children, families, and communities. The center's goal is to support sound decisions in policy and practice to help children and families thrive.

To support this mission, the NHVRC will—

- Publish original products, including the *Home Visiting Yearbook*
- Build an online collection of home visiting resources and research
- Create a space to share professional and personal experiences with home visiting

Join the conversation at
nhvrc.org

The *Home Visiting Primer* was adapted from chapter 1 of the *2017 Home Visiting Yearbook* developed by James Bell Associates with the Urban Institute. Support was 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.

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In this primer

Introduction

The *Home Visiting Primer* serves as an introduction to early childhood home visiting, a proven service delivery strategy that helps children and families thrive. Home visiting has existed in some form for more than 100 years, paving the way to a healthier, safer, and more successful future for families. It connects parents-to-be and parents of young children with a designated support person who guides them through the early stages of raising a family. For many, it is a bridge to becoming the kind of parents they want to be so they can unlock their child's potential.

Home visiting is voluntary and tailored to meet families where they are—from a teenage single mother in Phoenix to an expectant military couple near the Smoky Mountains to a Native American woman raising a grandchild with special needs in North Dakota. Depending on the family's circumstances, the home visitor might talk with them about their child's developmental milestones, coach them in positive parenting, connect them with needed services, and even help them create a resume so they can find a job. Home visiting is cost effective, with demonstrated improvements in child health, well-being, and school readiness and parent self-sufficiency.

Through our *Home Visiting Yearbook*, the National Home Visiting Resource Center (NHVRC) aims to provide the most comprehensive picture available of home visiting on the national and state levels. This primer provides context for the *Yearbook* data by establishing what home visiting is and its potential impact on families. It presents—

- Background information that defines home visiting and outlines its history
- Highlights from the evidence base for home visiting, describing its demonstrated impact on critical needs
- An overview of the funding sources for home visiting services

What Is Home Visiting?

Few experiences are as rewarding and challenging as parenthood. Many parents still remember the friends and relatives they turned to for advice after discovering they were expecting a child. Unfortunately, not everyone has a built-in system to help them navigate a child's early years.

Early childhood home visiting is a service delivery strategy that matches expectant parents and parents of young children with a designated support person—typically a trained nurse, social worker, or early childhood specialist. Services are voluntary and provided in the family's home or another location of the family's choice, often reaching socially or geographically isolated families.

A two-generation approach, home visiting delivers both parent- and child-oriented services to help the whole family. It views child and family development from a holistic perspective that encompasses—

- Child health and well-being
- Parent health and well-being
- Child development and school readiness
- Family economic self-sufficiency
- Positive parent-child relationships
- Family functioning

Home visiting can benefit all families that welcome a child into their lives. For families facing additional stressors, such as unemployment or health concerns, a consistent lifeline can provide the stability they need to get back on their feet. Home visitors get to know each family over time and tailor services to meet its needs. A home visit might include an assessment of child and family strengths and needs, provision of information on child developmental stages and progress, structured parent-child activities, family goal setting, assistance addressing crises or resolving problems, coordination with needed community services, or emotional support during stressful times.[i]

Brief History

Early childhood home visiting is not new. As early as 1883, private charities sent home visitors to provide guidance and model healthy behaviors to the urban poor.[ii] Over time, new professions were created to support families in the home. The Settlement House movement of the early 1900s propelled the Progressive Era in the United States, promoting visiting nurses, teachers, and social workers.[iii] Federal interest in the needs of mothers and young children led to the passage in 1935 of Title V, the Maternal and Child Health Program (which was later converted to a block grant). In the 1960s, the War on Poverty increased awareness of early child care and child development.

In the early 1970s, C. Henry Kempe, a crusader for the prevention of child maltreatment, advocated for a universal approach to prevention through a network of home health visitors.[iv] Influenced by this approach, modern home visiting began with Hawaii's implementation of the Healthy Start Project in 1975.[v] In 1977, David Olds initiated the first randomized control trial of what would become the Nurse-Family Partnership model, marking the beginning of rigorous evidence building in home visiting.[vi] Political and community support for home visiting also began to gather and, bolstered by state and foundation funding, led to the creation of the first Parents as Teachers program in 1981.[vii]

Bipartisan support for evidence-based home visiting led to MIECHV.

The bourgeoning development of home visiting models continued throughout the 1990s. In 1992, Healthy Families America emerged from the National Committee to Prevent Child Abuse (now Prevent Child Abuse America),[viii] with funding support from Ronald McDonald Children's Charities (now Ronald McDonald House Charities). Critical to the design of Healthy Families America was the development of infrastructure to replicate the model, including training, technical assistance, and an accreditation system to assess implementation. This laid the groundwork for the national expansion of home visiting models a decade later. Models also emerged from practice communities and academic settings, including Minding the Baby, which began in 2002 as a collaboration of the Yale Child Study Center, Yale School of Nursing, Fair Haven Community Health Center, and Cornell Scott-Hill Health Center.[ix]

In the new millennium, several models established national offices, and six of the largest models collaborated to create a national forum.[x] Its focus was to improve home visiting and develop benchmarks for measuring quality. In 2009, the U.S. Department of Health and Human Services (HHS) established the Home Visiting Evidence of Effectiveness project (HomVEE) to review the evidence base for home visiting models.[xi] Bipartisan support for evidence-based home visiting led to the creation of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) in 2010. Congress reauthorized MIECHV funding in 2015 (through 2017), and again in 2018 for an additional 5 years.

Home Visiting: A Timeline

1899
Mary Richmond publishes her manual for home visiting, "Friendly Visiting Among the Poor: A Handbook for Charity Workers."

1900–1920s
Settlement houses for the urban poor are expanded.

1935
Congress passes Title V, the Maternal and Child Health Program.

1960s
The War on Poverty emphasizes support for early child care and development.

1970s
C. Henry Kempe proposes home health visiting to prevent child abuse and neglect.

1974
Congress passes the Child Abuse Prevention and Treatment Act.

1975
Hawaii implements the Healthy Start Project.

1977
David Olds begins randomized clinical trials that lead to Nurse-Family Partnership.

1981
The Missouri Department of Education designs first Parents as Teachers program.

1992
Healthy Families America is established.

1994
Head Start expands home visiting to children from birth to age 3 (Early Head Start).

2000
National Home Visiting Forum convenes for first time.

2009
HHS launches HomVEE to review the evidence base for home visiting models.

2010
Congress invests $1.5 billion in home visiting through MIECHV.

2011
Pew Charitable Trusts hosts the first National Summit on Quality in Home Visiting Programs.

2018
Congress reauthorizes MIECHV funding for an additional 5 years.

Home Visiting Models

Home visiting models vary based on factors such as their target audience, the outcomes they prioritize, and the duration and frequency of home visits. Some models are designated as evidence based because they meet rigorous HomVEE criteria for evidence of effectiveness. Other home visiting models are grounded in practice or research but have not yet met the HomVEE standards of evidence (although they might meet some of the criteria). Both types play an important role in the home visiting landscape.

The *Home Visiting Yearbook* primarily presents data on evidence-based home visiting. As of August 2018, 20 home visiting models met HomVEE criteria for evidence of effectiveness (see nhvrc.org/discover-home-visiting/models):

- Attachment and Biobehavioral Catch-Up (ABC)
- Child First
- Early Head Start Home-Based Option (EHS)
- Early Intervention Program for Adolescent Mothers
- Early Start (New Zealand)
- Family Check-Up (FCU)
- Family Connects
- Family Spirit
- Health Access Nurturing Development Services (HANDS)
- Healthy Beginnings
- Healthy Families America (HFA)
- HealthySteps[1]
- Home Instruction for Parents of Preschool Youngsters (HIPPY)
- Maternal Early Childhood Sustained Home-Visiting (MECSH)
- Minding the Baby
- Nurse-Family Partnership (NFP)
- Oklahoma's Community-Based Family Resource and Support (CBFRS) Program[2]
- Parents as Teachers (PAT)
- Play and Learning Strategies (PALS)
- SafeCare

MIECHV requires state awardees to devote the majority of funds toward implementing evidence-based models. Additionally, 3 percent of MIECHV funds are set aside to further bolster the home visiting evidence base through research and evaluation.[xii]

[1] During a recent update, HomVEE revised the HealthySteps profile to include changes to the model, noting home visiting is not HealthySteps' primary service delivery strategy. States could implement HealthySteps with MIECHV funds in fiscal years 2014 and 2015 but could no longer do so beginning in fiscal year 2016.

[2] Oklahoma's Community-Based Family Resource and Support Program is no longer in operation. See https://homvee.acf.hhs.gov/models.aspx for details.

Why Home Visiting?

The first 5 years of life are the building blocks for children's future health, development, and academic achievement.[xiii] In fact, children's early experiences and interactions with adults shape brain development and serve as the foundation for subsequent learning.[xiv, xv, xvi]

Early childhood home visiting empowers parents and caregivers to meet their family's needs and to engage more fully in their children's care and growth. Participation benefits adults and children alike.

Studies have found a return on investment of $1.80 to $5.70 for every dollar spent on home visiting.[xvii, xviii] For example, home visiting can reduce child emergency room visits, lowering health care expenses.[xix] It can help identify developmental and social-emotional delays so children can access services early, lowering future mental health and special education costs. Among adult participants, outcomes include higher employment rates and tax revenues, reduced criminal activity, and reduced reliance on welfare programs.[xx] This strong return on investment is consistent with established research on other types of early childhood interventions.[xxi]

Studies have found a return on investment of $1.80 to $5.70 for every dollar spent on home visiting.

Home visiting has a strong evidence base, with many studies showing that it works.[3] As a two-generation approach, home visiting has the potential to improve outcomes across a range of domains, such as child health, school readiness, parent economic self-sufficiency, and parenting practices. Not all domains have been well studied or have demonstrated improvement across all home visiting models.[4] Here we highlight examples of home visiting's demonstrated impact on critical needs.[xxii, xxiii, xxiv]

[3] For a more comprehensive review of the evidence base for home visiting, see *Components Associated with Home Visiting Program Outcomes: A Meta-Analysis*, retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24187111.

[4] For details about models by outcome domain, see evidence reviews conducted by HomVEE, Home Visiting Evidence Effectiveness: Outcomes, retrieved from https://homvee.acf.hhs.gov/outcomes.aspx.

Healthy Babies

Access to prenatal care prevents birth complications for both infants and mothers and reduces health care costs.[xxv] Unfortunately, national data reveal that not all babies get a healthy start:[5]

- Six percent of expectant mothers had delayed or no prenatal care.[xxvi]
- Ten percent of infants were born prematurely.[xxvii]
- Approximately 6 percent of infants died before age 1.[xxviii]

Home Visiting as Part of the Solution

Home visitors work with expectant and new mothers to ensure optimal care in pregnancy and infancy. Indeed, pregnant home visiting participants are more likely to access prenatal care and carry their babies to term.[xxix] Home visiting also promotes infant caregiving practices like breastfeeding, which has been associated with positive long-term outcomes related to cognitive development and child health.[xxx]

Safe Homes and Nurturing Relationships

Preventable injuries and abuse happen all too frequently to children in the United States:

- Twenty-five percent of children aged 0-5 visited the emergency room because of accident or injury between 2010 and 2013.[xxxi]
- Unintentional injuries were a leading cause of death and disability among children aged 1–4.[xxxii]
- The rate of substantiated child abuse was 9 per 1,000 children under 18, with the majority of victims under age 1.[xxxiii]

Home Visiting as Part of the Solution

Home visitors provide parents with knowledge and training to make their homes safer. For example, educating parents about how to "baby proof" their home can reduce unintentional injuries. Home visitors also teach parents how to engage with their children in positive, nurturing, and responsive ways, thus reducing child maltreatment.[xxxiv]

[5] Data presented in this section are from 2016 unless otherwise indicated. For national and state data about maternal and child health indicators of well-being, consult the *Home Visiting Yearbook*.

Optimal Early Learning and Long-Term Academic Achievement

Because the early years of life are critical to brain development, parent-child activities like reading together are linked to future academic achievement. Nationally, many children do not get the start they need to launch a positive academic trajectory:

- Sixty-five percent of fourth graders failed to meet standards for reading proficiency in 2017.[xxxv]

Home Visiting as Part of the Solution

Home visitors offer parents timely information about child development, helping them recognize the value of reading and other activities for children's learning. This guidance translates to improvements in children's early language and cognitive development, as well as academic achievement in grades 1 through 3.[xxxvi, xxxvii]

Self-Sufficient Parents

Many people do not have the education and job opportunities they need to successfully navigate the transition to parenting and adulthood:

- For 14 percent of children under 18, the head of household had less than a high school diploma.
- For another 44 percent of children under 18, the head of household had only a high school diploma.[xxxviii]
- Approximately 3 in 10 children under age 18 lived in families where no parent had regular, full-time employment.[xxxix]

Home Visiting as Part of the Solution

Home visitors help parents set goals to promote their financial self-sufficiency. This support translates to better education and employment outcomes. Compared with their counterparts, parents enrolled in home visiting have higher monthly incomes, are more likely to be enrolled in school, and are more likely to be employed.[xl, xli, xlii, xliii]

How Is Home Visiting Funded?

Early childhood home visiting is provided to participants at no cost to them. Agencies blend dollars from funding sources at the federal, state, and local levels to cover the cost of services. MIECHV has provided a significant boost of federal funding for evidence-based home visiting, but MIECHV awardees and other agencies that operate home visiting programs seek diverse funding streams to reach the many more families who could benefit.

Aside from MIECHV, states may allocate federal dollars toward home visiting from Title V of the Maternal and Child Health Block Grant Program, Temporary Assistance for Needy Families, Medicaid, Healthy Start, and the Community-Based Child Abuse Prevention Program. For example, prior to first receiving MIECHV funds in 2010, Louisiana combined state general funds, federal maternal and child health dollars, Medicaid dollars, and Temporary Assistance for Needy Families funding to support implementation of the Nurse-Family Partnership model.[xliv] For decades, states have also drawn on a mix of general and dedicated funds to support home visiting, including tobacco settlements and taxes, lotteries, and budget line items. Funding is made available through health, education, and human services agencies.

States, local agencies, nonprofit organizations, and research institutes also leverage private dollars to develop, implement, and expand home visiting services. Examples of organizations that support or have supported home visiting include the United Way, March of Dimes, and philanthropic partners such as the Robert Wood Johnson Foundation, Heising-Simons Foundation, W. K. Kellogg Foundation, Richard W. Goldman Family Foundation, Pew Charitable Trusts, and others.

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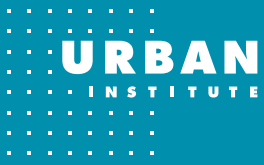
Developed by James Bell Associates in partnership with the Urban Institute. Support provided by the Heising-Simons Foundation and the Robert Wood Johnson Foundation.



CHILDREN'S INSTITUTE POLICY BRIEF • 2019

Voluntary Home Visiting

Supporting Children and Families

Loving, nurturing relationships between parents and children are essential for young children's healthy development. Parents need support to provide the best foundation for their children. Voluntary home visiting programs can help parents create better opportunities for themselves and their families.

Parenting can also be extremely difficult for expectant and new parents experiencing the stresses of poverty, substance abuse, domestic abuse, or mental health challenges.

Voluntary home visiting programs can help. Home visitors provide practical information and support on a range of issues including maternal and child health, parent-child interactions, and early learning.

Currently in Oregon:

LESS THAN 20 PERCENT	**Home visiting programs reach VERY FEW eligible families.[1]**

Who Could Benefit:

217,000 FAMILIES	**Of these families, NEARLY 60,000 are low-income.[2]**
20 MONTHS	**Children from low-income families typically enter kindergarten nearly 2 YEARS BEHIND wealthier peers in cognitive development.[3]**
41 PERCENT	**ALMOST HALF of children in foster care are ages 0–5.[4]**
NEARLY 5,000	**THOUSANDS OF CHILDREN ages 0–4 are victims of maltreatment.[5]**
10–15 PERCENT	**Emotional and behavioral disorders, often the result of trauma and toxic stress, affect NEARLY 1 IN 6 CHILDREN.[6]**
NEARLY 1 IN 4	**NEARLY 25 PERCENT of new mothers experience depression during and after pregnancy. Half of these mothers are still depressed when their child reaches 2 years old.[7]**

Benefits of Home Visiting

Supportive, loving relationships and stable environments are essential for healthy brain development. Negative experiences can have adverse effects on a young child's developing brain. Children exposed to prolonged neglect or abuse, extreme poverty, parental substance abuse, severe maternal depression, or violence in the home or community experience toxic stress. This causes the body's stress response to stay elevated, disrupting young children's brain development. Toxic stress can lead to behavioral and emotional problems with lifelong effects.

Home visiting can disrupt negative early childhood experiences, and provides the greatest benefits to families with the most significant needs. While Oregon is making progress with important investments in home visiting programs, a lack of funding and capacity in the system means too many families lack access to these essential services.

As Oregon's population becomes more ethnically and linguistically diverse, culturally specific home visiting has become increasingly necessary. For vulnerable families who live in rural communities, the challenge of receiving vital home visiting services is further complicated by lack of access to home visitors and increased driving time and costs.

Home Visiting **INCREASES:**

- Optimal child development and health
- Confidence and competence of parents
- School readiness for children

Home Visiting **DECREASES:**

- Child abuse and neglect
- Maternal depression
- Low-weight births and other preventable childhood health conditions

Oregon's Home Visiting Programs[8]

	Counties	Families Served
Early Head Start* A national evidence-based model serving low-income families through home-based and center-based services.	18–20[9]	2,200[10]
Family Support and Connections A program serving low-income families accessing Temporary Assistance for Needy Families (TANF).	All 36	1,600
Healthy Families Oregon* An evidence-based model serving families at risk of child abuse and neglect.	35	3,300
Nurse Home Visiting* An array of programs serving low-income families and families with disabled children or chronic health conditions. Nurse-Family Partnership is evidence-based.	30	4,900

* These are evidence-based programs.

Build the System

Voluntary home visiting programs are an essential element in a system of support, beginning with prenatal care, to ensure young children are developmentally and academically prepared for lifelong success. For Oregon's voluntary home visiting programs to better support families and improve outcomes for children, the programs must be effectively coordinated and aligned, and must be offered alongside a continuum of other parenting support and early learning programs.

Some communities in Oregon are leading the way in building a coordinated system.

In Douglas, Lake, and Klamath counties, community partners are coming together to implement a coordinated referral system that connects expectant mothers and families with young children to early learning and parenting support services. Through relationships and dedicated time, partners have improved communication between programs and are now working on an outreach plan to ensure all families know about the early childhood resources in the region.

In Linn, Benton, and Lincoln counties, the Family Connects program complements and strengthens existing community services and aims to provide nurse home visits to every family with a newborn. Family Connects is designed to support parents and other family members with newborn care, help respond to immediate needs for support and guidance, link families to community services, and help new parents connect with their infant to sustain healthy development and family well-being.

Notable Progress Toward Building Oregon's Home Visiting System

1993 — **Oregon Legislature creates Healthy Families Oregon (formerly Healthy Start).** Program provides home visiting services to first-time parents.

2010 — **Oregon receives first Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program grant.** Funds high-quality, evidence-based home visiting services as well as workforce development to strengthen the state's home visiting system.

2012 — **Oregon conducts statewide home visiting needs assessment.** Assessment finds that only a small fraction of eligible families receive home visiting services, and persistent racial and ethnic disparities exist in home visiting participation.

2015 — **Best Beginnings Committee established.** Created by the Early Learning Council to build on MIECHV progress to ensure better coordination and alignment across Oregon's multiple home visiting programs.

2016 — **With MIECHV funds, Oregon invests in the Michigan Infant Mental Health Endorsement (IMH-E®).** The purpose is to promote competencies in providing high-quality, culturally sensitive, relationship-focused infant and early childhood mental health services among home visiting and other early childhood and family support professionals.

Policy Recommendations

Offer universal first home visits for all families.

All families can benefit from parenting support and connections to community resources. To improve the lives of children and families, Oregon can provide universal first home visits for all families. In a first home visit, families would receive crucial information about how to support their child's health and development, connect to community-based resources like parenting education and play-and-learn groups, and engage with longer-term home visiting programs for families who need and want that service. Universal home visits have also been proven to reduce emergency room visits, improve mental health for mothers, and increase positive parenting. A state investment in universal first home visits will also help Oregon access significant federal funds through the Medicaid program.

Invest in programs that strengthen parent-child bonds.

Programs and services offered by effective home visiting programs, Relief Nurseries, Healthy Families Oregon, and Oregon Parenting Education Hubs can help many more families. Additional funding for effective programs that keep children safe, increase positive parenting, and support intact families will reach more of the 129,000 young children in Oregon living at or below 200 percent of the federal poverty threshold. Investing in these programs and services is a critical part of the continuum of services necessary for building partnerships with families to support healthy and on-track development for children.

Citations and Credits

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Oregon Statewide Maternal, Infant & Early Childhood Home Visiting Program 2020 Needs Assessment

Acknowledgments

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Executive Summary

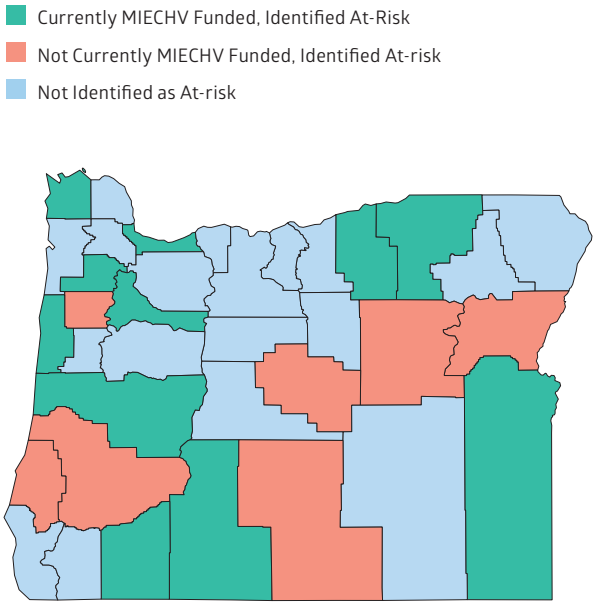
Purpose and Overview

As part of the federal requirements for Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding, Oregon conducted a statewide needs assessment to ensure that MIECHV funds continue to be directed to communities and families most likely to benefit from evidence-based early childhood home visiting (HV) services. Portland State University's Center for Improvement of Child and Family Services (PSU) was contracted by the Oregon Health Authority to complete the needs assessment. The needs assessment used a mixed-method approach (see "Summary of Needs Assessment Data Collection Methods"), building off of the required data and methodology provided by the Health Resources and Services Administration (HRSA), and adding information reflecting the unique strengths and challenges in Oregon's communities.

Communities with Concentrations of Risk

A set of risk domains and indicator data were provided by HRSA. These were analyzed for all 36 counties in Oregon. Five risk indicators (2 socioeconomic status, 2 adverse perinatal outcomes, and 1 child maltreatment) were added to HRSA's original set to better identify counties with greater need for early childhood HV services. As a result, 15 counties were identified "at-risk" (i.e., defined as at-risk[a] in at least two of the six risk domains). Three counties currently receiving MIECHV funds were not identified through the Phase One analysis: Jackson, Umatilla, and Yamhill. Based on our work with these communities, we knew there to be continued need for MIECHV services. Thus, these counties were moved into Phase Two analysis, which examined specific localities and population groups within each county for needs and gaps in services that were not captured in the Phase One analysis. Based on this Phase Two analysis, it is recommended that MIECHV-funded HV services within those counties be focused on key local areas identified as having multiple risk factors and/or lacking existing early childhood services.

Counties identified as at-risk and the current status of MIECHV services



Counties Identified as At-Risk in Phase One Analysis

Currently Served by MIECHV	*Not Currently Served by MIECHV*
Clatsop	Baker
Klamath	Coos
Lane	Crook
Lincoln	Douglas
Malheur	Grant
Marion	Lake
Morrow	Polk
Multnomah	

Counties Not Identified as At-Risk in Phase One Analysis

*MIECHV Funded Slots to Shift**	*Phase Two Assessment for At-risk Identification*
Jefferson	Jackson
Tillamook	Yamhill
	Umatilla

*Slots will be supported by other existing programs

a At-risk calculation = z-score greater than or equal to one standard deviation higher than the mean of all counties in Oregon.

Quality, Capacity, and Coordination in Home Visiting and Substance Use Disorder Systems

Summarized below are key findings related to Oregon's (1) current capacity to provide high quality HV services to families; (2) substance abuse treatment system and its capacity to effectively support pregnant women and families with young children; and (3) areas for improving the coordination of HV and substance use disorder (SUD) systems.

Home Visiting System Capacity

Currently, Oregon's HV programs do not have the capacity to serve all families who may be eligible. Estimating unmet need in Oregon is extremely complicated, for many reasons (e.g., lack of coordinated HV data system, enrollment data across programs cannot be provided as unduplicated counts, differences in eligibility criteria). Given these caveats however, this needs assessment found that using HRSA's estimate of the number of families potentially in need, **Oregon currently provides evidence-based HV services to approximately 18% of potentially eligible families**. However, if an alternative estimate of need is used that reflects the number of young children living in poverty in the state, **this figure drops to only 8%**.

In addition to Oregon's overall low capacity to provide evidence-based HV, some families and geographic regions may be particularly underserved. Further, while clearly Oregon lacks capacity to provide HV to all families who are eligible for services, this gap would be even larger if eligibility criteria were broadened. There was a shared sense among both professionals and parents that many families who could benefit are not able to be served because of existing eligibility criteria. Particularly underserved communities that were identified included:

- Families of color, and/or who speak languages other than English (African American, American Indian/Native American, non-Hispanic immigrant and refugee communities);
- Families living in frontier, geographically large, and/or isolated areas;
- Families involved with the child welfare system;
- Working families; and
- Families who do not meet HV program eligibility requirements (e.g., slightly over income requirements).

Summary of Needs Assessment Data Collection Methods

Census, Survey, and Home Visiting Program Enrollment Data Compilation and Analysis

1. County census and other data to identify risk levels defined by demographic, social, and economic factors;
2. Geographic and supplemental risk factor analysis in targeted counties;
3. Home visiting enrollment data from:
   (1) Nurse-Family Partnership,
   (2) Healthy Families Oregon,
   (3) Early Head Start,
   (4) Relief Nurseries,
   (5) Babies First!,
   (6) CaCoon, and
   (7) Family Support & Connections;
4. Multiple estimates of potential unmet need;
5. Review of past early childhood needs assessments and Oregon-specific research and reports.

Home Visiting System Qualitative Data

1. Interviews with 9 HV statewide leaders;
2. Interviews and focus groups with local HV leaders and program staff (4 counties; 14 program leads, 27 home visitors); and
3. Parent focus groups (5 groups, 35 parents, 20 English-speaking, 15 Spanish-speaking).

Substance Use Disorder System Analysis

1. Review of existing documents and data;
2. Interviews with 4 SUD statewide leaders; and
3. Interviews with local SUD leaders (3 counties, 7 leaders).

Barriers to Identifying and Enrolling Potentially Eligible Families

There are many reasons why families are not identified for and enrolled in HV services. The most common barriers cited by statewide HV leaders include:

- **Eligibility requirements.** Families might benefit, but they don't quite meet the program's eligibility requirements related to stage of pregnancy or age of child, income, and Medicaid eligibility.
- **Lack of a coordinated intake and referral system.** This also includes the lack of coordinated, shared HV program data that can.
- **Inability to quantify unmet need in the community.** Data are needed to accurately assess unmet need (e.g., comprehensive screening or other population data related to eligibility criteria, number of families who would qualify for and likely to participate in HV services).
- **Lack of community awareness, misperceptions, and/or lack of trust in HV services.**

Barriers to Quality Services for Families of Color and Families Speaking Languages other than English

In addition to the barriers named above, the needs assessment suggested that families of color and/or families speaking languages other than English face additional barriers to enrollment in and receipt of high quality HV services. In particular, stakeholders noted:

- **Lack of culturally-specific, community-based providers and programs.** There is a lack of investment in culturally-specific, evidence-based HV program models (e.g., Family Spirit) or research-informed culturally-specific programs implemented by community-based organizations. In some cases, funds are not available to offer a salary high enough to attract skilled bilingual/bicultural staff. Local models for hiring and retaining bilingual/bicultural Latinx staff could provide examples for other communities to create these pathways (e.g., training and education for participants/program graduates).
- **Need for building better connections at the state and local level between HV programs led by Native American/American Indian communities and state and local organizations.**

Meeting the Needs of Families with SUD

Home visitors often work with families facing SUD issues. Statewide HV leaders largely felt that home visitors are knowledgeable about treatment resources in their communities, but that partnerships between HV programs and SUD treatment/recovery services vary from county to county. State SUD leaders generally did not know very much about HV services and how home visitors work with families with SUD issues, but felt that having home visitors doing SUD screenings and providing support is good for children and families. Stakeholders felt that HV programs can better meet the needs of families struggling with SUD issues in the following ways:

- **Increase home visitors' knowledge and skills**, especially related to motivational interviewing (while acknowledging level of expertise needed and high expectations placed on home visitors already).
- **Increase home visitors' understanding of the dynamics** of SUD, treatment, and recovery.
- **Strengthen the quality of supervision** that provides support and information to home visitors for their work with families with SUD issues.
- **Increase shared knowledge, understanding, and coordination** between home visitors and SUD providers and programs.

Increasing Quality through Workforce Development

Investments in the HV workforce can help to increase the quality of services provided to Oregon families. Key workforce needs that were identified included training, quality supervision, and better compensation and worker retention.

- **Training needs.** Professional development supports, especially those involving ongoing coaching and mentoring to improve home visitors' skills and confidence in working with families with SUD, maternal depression, and family violence remain a high priority. Motivational interviewing is another area in which home visitors reported having some training but relatively few expressed confidence in their skills. Finally, the HV workforce would benefit from continued training and support for improving trauma-informed practice training.

- **Quality of supervision.** Home visitors benefit from high quality reflective supervision. In the Region X Workforce Study,[11] 69% of Oregon's home visitors reported participating in regular reflective supervision. About 19% of home visitors did not agree that their agency gives them enough supervision specific to helping families with SUD, mental health, and/or family violence issues.
- **Home visitor compensation and job retention.** More than two-thirds (68%) of Oregon's home visitors reported earning less than $20 per hour, with 12.4% reporting earning less than $15 per hour.[11] With low compensation and high work demands, turnover is an important consideration. A recent Oregon study found that home visitors who received quality supervision and felt supported by their organization as valued professionals remained in their positions longer.[12]

Opportunity to Strengthen the Home Visiting System: Family Connects Oregon

Oregon lawmakers recently authorized funding to begin a phased implementation of the evidence-based Family Connects universally-offered HV model, known locally as Family Connects Oregon (FCO). This model is designed to provide brief (up to two) home visits to all families immediately after birth. Statewide HV stakeholders believe that FCO will bring a number of benefits to Oregon's HV system, and address some of the known barriers to identified and enrollment by:

- **Strengthening community awareness** of HV (general population and community partners, e.g., other HV services, medical providers, auxiliary services).
- **Increasing receptivity to longer duration HV services.** FCO could potentially "open the door" by letting families see that extended HV can be supportive.
- **Improving referral pathway and coordination** across HV programs at the local level.
- **Increasing available data, and therefore understanding of, community needs and gaps.**

Despite the potential benefits, a number of implementation challenges were also named:

- **Current capacity (e.g., slots) in existing HV programs is inadequate** for the predicted increase in referrals.
- **Current HV workforce may not have the capacity** to support FCO and existing HV programs, thereby exacerbating HV workforce shortages in many parts of the state.
- **HV programs may not be ready to implement** coordinated referral, screening, and enrollment processes.
- **Community alignment phase was underfunded or unfunded**, which may have impeded the extensive collaborative work needed to plan for FCO implementation.
- **Communities may not be ready to accept** HV services (e.g., see them as appropriate for people in need rather than as a universal standard of care).

Substance Use Disorder (SUD) System

Another requirement of the needs assessment was to describe Oregon's current capacity to provide SUD treatment, recovery, intervention and prevention services to meet the needs of pregnant women and parents with young children. Currently in Oregon:

- Most SUD treatment in Oregon is private (non-profit), outpatient, and is not specific to pregnant and parenting women. Although they are a priority population (i.e., must be served within a specified time frame), only half of treatment facilities have specific programming for women, and one-quarter have programs for pregnant and postpartum women.[16]
- Screening and referral to treatment occurs in a variety of primary care, clinic, and hospital settings.
- Community-based prevention efforts are underway in all 36 counties, 9 federally recognized Native American tribes, and 6 Regional Health Equity Coalitions.

Prevalence and Scope of SUD Treatment Need

The prevalance of SUD among families receiving HV is likely higher than in the general population. Although there are not precise estimates, data examined suggest the following:

- 9.4% of all Oregonians aged 12 and older reported having SUD; the rate of use is highest (17.2%) in the 18-25 age group, which is a primary age group for MIECHV-funded HV services.[17]
- Self-reported estimates are lower for pregnant women (2.3% reported needing help with an alcohol or drug problem). Within HV populations, estimates range from 15% to 43% (self-report and home visitor assessment, respectively) of participants needing help.[9,11] Estimates are even higher for families involved in child welfare (e.g., 3 in 4 child welfare cases had alcohol and/or drug involvement at the time children were removed from their homes).[15]

Gaps in the SUD Service Delivery System

The needs assessment revealed a number of gaps in Oregon's SUD system.

- **Behavioral health is underfunded.** Nearly all of Oregon's spending on substance misuse issues is for compliance, regulation, and the cost social/health problems related to substance misuse; less than 1% is used for prevention, treatment, and recovery.[19] OHA's behavioral health services budget is largely considered inadequate to meet the needs of all Oregonians. Within that budget, 81% is allocated to mental health and only 19% is spent on substance abuse treatment services; thus, SUD treatment is particularly under-resourced.[15]
- **Unmet SUD treatment needs.** 8.9% of all Oregonians aged 12 and older needed but did not receive SUD treatment in the past year; the rate of unmet need is highest (16.5%) in the 18 to 25 age group, a primary age group for MIECHV-funded HV services.[17]
- **Large gap between need and receipt of SUD treatment.** Estimates range from 60% to 90% (depending on data source and age group).[15] The treatment gap is smaller among pregnant and parenting women (estimated one-third to half have unmet treatment needs), but it is larger among the HV population (estimated two-thirds have unmet treatment needs).[18,21]
- **Wide range of gaps in SUD services.** Identified service gaps included residential treatment for parents who want to access treatment with their children, esp. fathers; culturally-specific services; service options in rural and frontier counties, especially harm reduction/medication-assisted treatment (MAT); prevention resources and evidence-based programs; and aftercare, recovery, and ongoing supports for health and wellbeing.

Barriers to the Receipt of SUD Services

There are a number of barrier that individuals face when seeking SUD services in Oregon.[20]

- **Lack of coordination with other systems.** When individuals try to navigate more than one service system, they have difficulty accessing and completing SUD services.
- **Stigma and bias.** Parents, and pregnant women in particular, face stigma associated with SUD, making it more challenging to disclose substance use and to seek treatment. The threat of child welfare involvement and removal of children is another barrier. Some providers are opposed to evidence-based harm reduction practices like MAT. Some parents do not trust that heath care professionals in rural areas will provide the most current, evidence-based services.
- **Geographic barriers**, especially in rural, frontier or other isolated communities. Extensive travel is required to access treatment of not locally available, which can separate parents from their families.
- **Lack of support for families.** There are few treatment options allowing families to stay together, especially for fathers. Parents miss out on opportunities to learn how to parent their children when newly sober, a time when additional support is needed.
- **Insurance and reimbursement structures.** Insurance approvals and processes do not align with the long-term needs of SUD treatment and can disrupt services and discourage continuous care. Risk pools with different benefits, providers, etc. create more system fragmentation, making it difficult to navigate.
- **Inadequate data systems.** Public data systems do not have reliable data, and private data systems are inaccessible. This makes it difficult to estimate treatment need and service gaps.

Opportunities to Collaborate

There are a number of opportunities for state and local partners in Oregon to collaborate around the SUD service delivery system and other social service systems.

- **Increase the level and quality of integration** between mental health and SUD systems to create a more seamless behavioral health system.
- **Ensure there is no "wrong door"** such that people can access treatment no matter where they present, which requires collaboration between multiple service systems.
- **Create services that do not require parents to navigate multiple systems**, but provide "one-stop shopping" with connections to multiple systems.
- **Explore ways for HV programs to collaborate with SUD treatment services**, especially with peer mentor and system navigation approaches.

There are a number of activities underway in Oregon to strengthen the SUD system. Some notable efforts are:

- **Alcohol and Drug Policy Commission's 2020-2025 Oregon Statewide Strategic Plan** calls for developing a robust SUD system, including prevention and recovery, focused on the most vulnerable populations. Key recommendations include the expanded use of peers, system navigators, and intermediary supports; improved data systems; a reevaluation of commercial and private insurance reimbursement structures.
- **Federal SAMHSA grants** (Combined Block Grant, Targeted Opioid Response Grant) aim to fund SUD services for uninsured or underinsured individuals and involve a range of partners (e.g., primary care, law enforcement, child welfare, county health) to strengthen collaboration and coordination across the state.

Conclusions and Next Steps

Results of this needs assessment support continued investment into the following counties: Clatsop, Jackson, Klamath, Lane, Lincoln, Malheur, Marion, Morrow, Multnomah, Umatilla, and Yamhill. It is important to note, however than within Jackson, Yamhill, and Umatilla counties there are particular localities that warrant intentional outreach to ensure families in those areas have access to evidence-based HV. Further, a number of other counties were identified as having a higher level of community and demographic risk factors that make them priorities for expansion of HV services, should resources become available, specifically: Baker, Coos, Crook, Douglas, Grant, Lake, and Polk counties. Finally, both Jefferson and Tillamook counties, which received some MIECHV funding previously, will continue to provide evidence-based services through other existing statewide programs.

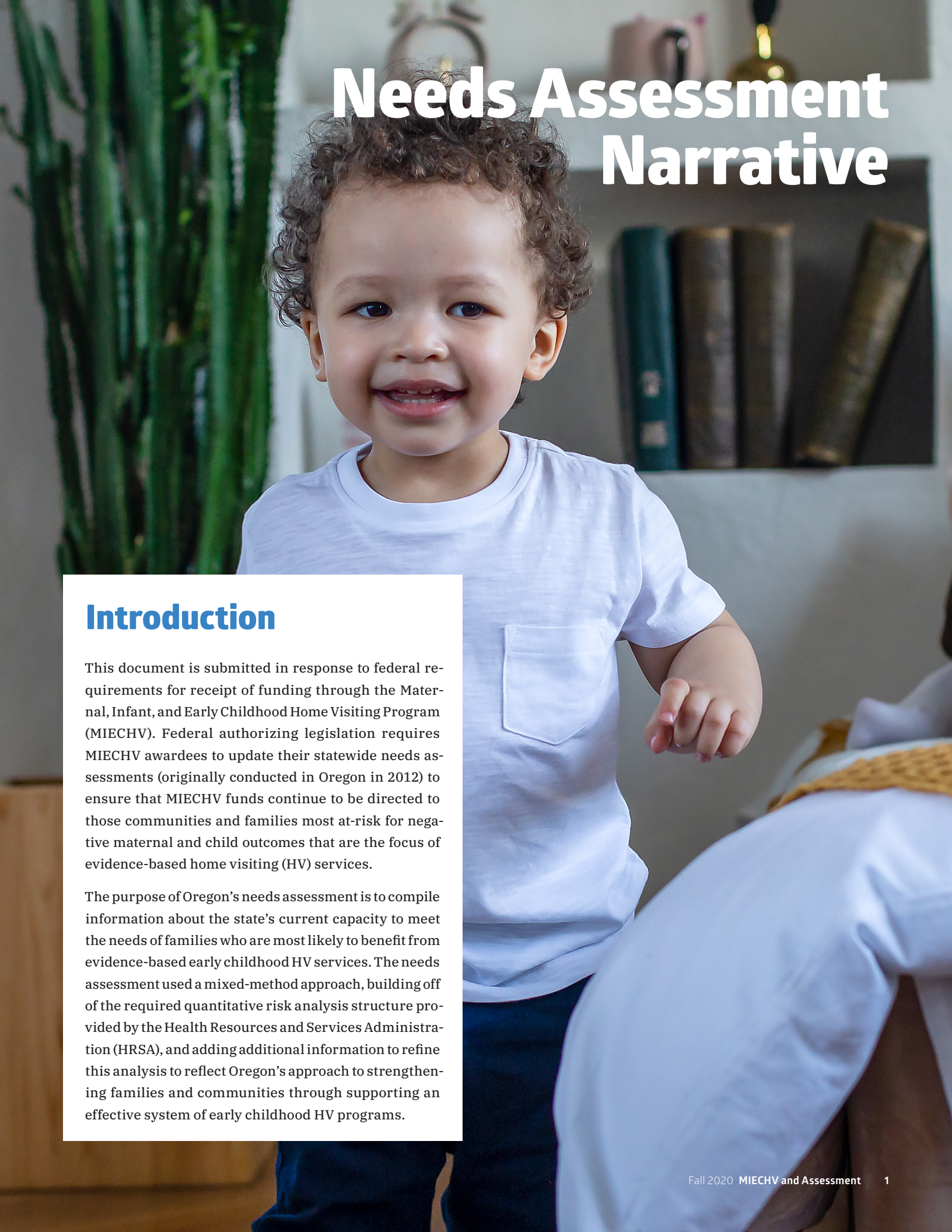
To continue to improve the quality of Oregon's HV systems, support for the workforce is critically important. In particular, this report suggests that creating professional development pathways and ensuring adequate compensation for bilingual and bicultural home visitors is a priority. Intentional investment of funds into expanding the state's capacity to offer culturally-responsive HV, through implementation of evidence-based culturally specific models and/or through engaging more culturally-specific organizations to test adaptation and new approaches is another important priority. In addition to strengthening and expanding culturally-specific HV, the needs of Oregon's rural and geographically isolated communities continues to be a critical concern.

Increasing opportunities and capacity for supporting pregnant women and families with substance use disorder is another clear priority. Increased partnership and collaboration between HV and substance use disorder programs and systems leaders is an important next step in addressing this issue.

Overall, the state's capacity to provide HV, and in particular, evidence-based HV, is low, and additional investments are needed to expand these services to other communities and families with young children. Addressing the gap between available services and unmet need will take continued investment of resources, not just in HV program slots and direct service, but also in the systems and infrastructure needed to ensure that programs are supported by effective professional development, data systems, and collaborative leadership work.

Contents

Needs Assessment Narrative



Introduction

This document is submitted in response to federal requirements for receipt of funding through the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV). Federal authorizing legislation requires MIECHV awardees to update their statewide needs assessments (originally conducted in Oregon in 2012) to ensure that MIECHV funds continue to be directed to those communities and families most at-risk for negative maternal and child outcomes that are the focus of evidence-based home visiting (HV) services.

The purpose of Oregon's needs assessment is to compile information about the state's current capacity to meet the needs of families who are most likely to benefit from evidence-based early childhood HV services. The needs assessment used a mixed-method approach, building off of the required quantitative risk analysis structure provided by the Health Resources and Services Administration (HRSA), and adding additional information to refine this analysis to reflect Oregon's approach to strengthening families and communities through supporting an effective system of early childhood HV programs.

1 Identifying Communities with Concentrations of Risk

Phase One: Simplified Method

To identify at-risk counties in Oregon, we first applied the simplified method provided by HRSA for Phase One of the needs assessment.[a] We noted several areas in which we felt the simplified risk indicators did not adequately reflect the work of maternal and early childhood home visitation in Oregon. First, we noted that crime was one of the required two domains determining a county's at-risk status in eight of the nine counties. Further, we noted that the indicators for crime (crime reports and juvenile arrests) were somewhat distal outcomes for evidence-based HV. While HV research has demonstrated impact on juvenile arrests, these indicators felt somewhat distal to the work of home visitors and the data we ask them to collect. Thus, we added several indictors specifically related to the pre- and perinatal period. We also felt that some indicators (such as child maltreatment and child poverty) would be more relevant if focused more specifically on the early childhood period and/or improved based on locally available data to improve stability of the indicator (e.g., using 3-year state averages) and expanded to include high priority costly outcomes (e.g., foster care placements). Thus, in our modified risk analysis we gave consideration to other indicators that are more proximal to the work of HV programs, and have identified additional risk indicators, domains, and data sources that supplement the original data provided in the simplified method.

Modifications and Additional Data for Oregon Risk Assessment

After consulting with our Training and Technical Assistance Associate at HV-PM/CQI TA and discussing enhancements with our Regional Project Officer, we modified the original simplified risk indicators and domains in the following ways:

Domain 1. Socioeconomic status. Two new indicators (childhood poverty; childhood food insecurity) were added to the simplified indicators (poverty; unemployment; high school dropout; income inequality).

Domain 2. Adverse perinatal outcomes. Two new indicators (no first trimester care; inadequate prenatal care) were added to the simplified method (pre-term birth; low birth weight).

Domain 3. Substance use disorder. No changes were made to the simplified method (alcohol; marijuana; illicit drugs; pain relievers).

Domain 4. Crime. No changes were made to the simplified indicators (crime reports; juvenile arrests).

Domain 5. Child maltreatment. We chose to modify the simplified indicator, child maltreatment, by changing from a 1-year data period for children 0-17 years old, to a 3-year average for children age 0-5 years old. Additionally, we added an indicator (children in foster care).

Domain 6. School readiness. We added one new domain to reflect Oregon's emphasis on the importance of the 0-3 age period for building children's school readiness (3rd grade English proficiency).

a Results of each stage of the Phase One analysis are detailed in the required Excel Worksheet provided to HRSA, available upon request.

The modifications made to the simplified risk indicators and domains are highlighted in Table 1. A detailed description of each risk indicator is provided in the attached Needs Assessment Data Summary (Excel file). Below we provide the rationale for Oregon's modified risk indicators and domains that align with the statutory definition of risk.[1]

Domain 1. Socioeconomic status. The two additional risk indicators (childhood poverty; childhood food insecurity) enhance the simplified poverty-level indicator. The addition of two child-focused socioeconomic indicators improves the identification of the population eligible for evidence-based HV.

Domain 2. Adverse perinatal outcomes. Two additional risk indicators (no first trimester care; inadequate prenatal care) were added to this domain. The risk indicators provided for the simplified measure (pre- term birth, low birthweight) are both outcomes of inadequate prenatal care. These additional risk indicators helped us to identify counties where evidence-based HV could have the greatest impact on the outcomes measured.

Domain 5. Child maltreatment. We modified the age range for the rate of child maltreatment to 0 to 5 years to better represent the population of children eligible to participate in evidence-based HV. We added an indicator (children in foster care) for a more comprehensive picture of the relationship between maltreatment and out of home placement. Finally, to account for wide fluctuations in low population counties we used a three-year average for these indicators.

Domain 6: School readiness (new). We considered the Pregnancy Risk Assessment Monitoring System (PRAMS) data for early language and literacy question "how frequently do you read, tell stories or sing to your baby" and found we were unable to make meaningful comparisons for all 36 counties. As such, we looked for other indicators related to early language and literacy. We added this as a domain to complement the five domains in the simplified method and better reflect the breadth of the MIECHV benchmarks. This risk domain has one indicator: 3rd grade English proficiency.

Table 1. Modified risk indicators and related domains

Domain	Original Risk Indicator	Modified Risk Indicator
Socioeconomic Status	1. Poverty 2. Unemployment 3. High school dropout 4. Income inequality	1. Childhood poverty ***new*** 2. Childhood food insecurity ***new***
Adverse Perinatal Outcomes	1. Pre-term birth 2. Low birth weight	1. No first trimester care ***new*** 2. Inadequate prenatal care ***new***
Substance Use Disorder	1. Alcohol 2. Marijuana 3. Illicit drugs 4. Pain relievers	*No change*
Crime	1. Crime reports 2. Juvenile arrests	*No change*
Child Maltreatment	1. Child maltreatment, 0-17 years old, 1-yr data	1. Child maltreatment, 0-5 years old, 3-year ave. data ***modified*** 2. Children in foster care,* 0-17 years old, 3-year ave. data* ***new***
6. School Readiness ***new***	*None*	1. 3rd grade English proficiency ***new***

*% at least 1 day in foster care

Methodology for Determining At-risk Counties

We applied the same method of data analysis provided in the simplified method to our modified risk indicators and domains for Phase One, specifically:

- For a county to be considered at-risk, the county should have two or more domains at-risk.
- For a county to be considered at-risk within a domain, at least half of the risk indicators in the domain for the county have a z-score greater than or equal to one standard deviation higher than the mean of all counties in Oregon (meaning that the county is approximately in the worst 16% of all counties in the state).

Results of Phase One Analysis

Data on the modified risk indicators and domains were analyzed for all 36 counties in Oregon. As a result of the Phase One data analysis, a total of 15 counties were identified as at-risk based on a determination that they were at-risk in at least two of the six domains. In comparison, per the simplified method, only nine counties were identified as at-risk.

Table 2 below lists the 20 counties previously and currently identified as at-risk and eligible for MIECHV funding for evidence-based HV. Fifteen counties were identified as at-risk through the Phase One data analysis. An additional three counties were found at-risk through Phase Two analysis. Of the identified at-risk communities, there were two counties identified as at-risk in the original needs assessment and which currently have MIECHV-funded HV, but which no longer meet risk thresholds. These two communities, and two Local Implementing Agencies (LIAs), represent an enrollment of 18 Healthy Families America (HFA) slots. We are working with the state multisite administration for HFA, Healthy Families Oregon (HFO), to assure that there is no service disruption within those communities.

Of the 18 counties found at-risk, seven were newly identified as at-risk and eligible for MIECHV-funding for evidence-based HV. Without additional funding it is unlikely we will be able to expand or increase enrollment; however, MIECHV has current grant agreements with LIAs who administer HFA programs regionally in the case of four counties meaning they would have greater flexibility to apply their MIECHV funding where it is most needed. One county does not currently have an evidence-based HV program to receive funding. As such, there are only two counties identified as at-risk for which there may be a delay in reaching with MIECHV funds.

The results for each stage of the risk analysis process for Oregon's additional indicators are included in the attached Needs Assessment Data Summary (Excel file). Fifteen counties were identified as at-risk, including eight currently funded counties (Clatsop, Klamath, Lane, Lincoln, Malheur, Marion, Morrow, and Multnomah) and seven counties not currently receiving MIECHV funding (Baker, Coos, Crook, Douglas, Grant, Lake, and Polk counties). Three communities that are currently receiving MIECHV funds were not identified through the Phase 1 process. Based on our knowledge and work in these communities, we knew there to be continued need for MIECHV services based on local needs. Thus we moved to Phase Two to collect additional information to more thoroughly identify specific smaller at-risk geographic areas within these counties, county-specific risk and gaps in services, and to explore specific at-risk populations that may be prevalent within these counties but were not well-described by the quantitative county-level analysis. These counties were: Jackson, Umatilla, and Yamhill counties. The methods and findings from the Phase Two analysis are provided below.

Table 2. Results of Phase One needs assessment: At-risk counties and the current status of MIECHV services

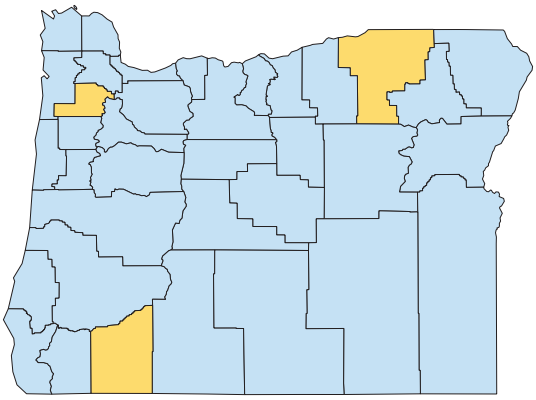
Counties Identified as At-Risk in Phase One Analysis

Currently Served by MIECHV	*Not Currently Served by MIECHV*
Clatsop	Baker
Klamath	Coos
Lane	Crook
Lincoln	Douglas
Malheur	Grant
Marion	Lake
Morrow	Polk
Multnomah	

Counties Not Identified as At-Risk in Phase One Analysis

*MIECHV Funding to Shift**	*Phase Two Assessment for At-risk Identification*
Jefferson	Jackson
Tillamook	Yamhill
	Umatilla

*Slots will be supported by other existing programs



Phase Two Methodology and Analysis: Jackson, Umatilla, and Yamhill Counties

Quantitative Data: County-Specific Methods

First, the research team reviewed data from the Early Learning Map of Oregon (ELMO)[2] related to risk indicators set forth by HRSA. Data were pulled by zip code for each of the three risk counties to examine patterns of risk compared to the county and state. Second, to supplement ELMO data, various recent county needs assessments were reviewed (e.g., Early Head Start, Oregon Office of Rural Health, Eastern Oregon Coordinated Care Organization).

Qualitative Data: County-Specific Methods

The research team used interview and focus group methods to collect qualitative information about each of the three counties. **HV leaders** (e.g., Director, Supervisor) from each program in the county were identified and invited to be interviewed. Those who agreed (3-4 per county for a total of 11 HV leaders) were interviewed via Zoom or by phone. HV leaders represented 6 programs in Oregon: Babies First!, Healthy Families Oregon, Nurse-Family Partnership, Early Head Start, Relief Nursery, and Family Spirit. The HV leaders interviewed then prepared a list of **home visitors** from their programs. All of the home visitors were invited to participate in a county-specific focus group conducted via Zoom (4-8 per county for a total of 18 home visitors). Home visitors represented 3 programs in Oregon: Healthy Families Oregon, Nurse-Family Partnership, and Early Head Start. **Substance Use Disorder (SUD) leaders** from each county health department, regional Coordinated Care Organizations (CCOs), and treatment facilities were identified and invited to participate in an interview. Those who agreed (1-3 per county for a total of 7 SUD leaders) were interviewed via Zoom or by phone.

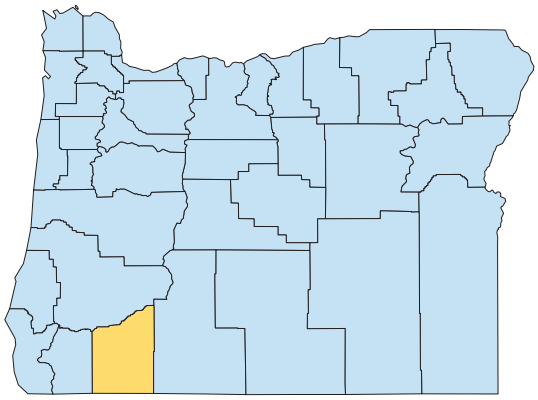
Phase Two Risk Analysis Key Findings

The Phase Two risk analysis key findings reflect specific geographic regions and populations within the three counties that appear to be particularly at-risk. Additional risk data, as well as qualitative data collected from HV program directors, SUD treatment leaders, and home visitors in each of these counties are provided in county-specific case studies (see Appendix B).

Jackson County

Jackson County is located in southern Oregon along the California border. ELMO data indicates that Jackson county has a moderately high rate of children under age six living in poverty (27%) in relation to the state (20%).[2] Further, Jackson County is higher on several important intergenerational risk factors compared to the state, including homelessness, family economic strains, key health and perinatal health indicators, and rates of child abuse or neglect (see Table 3). At the same time, Jackson County lacks quality early childhood services. Jackson County has less available, affordable child care than many areas of the state, with only 19% of low-income children having access to a child care slot, and only about one-third enrolled in preschool (34.9% in Jackson County compared to 43.4% in Oregon). As shown in Appendix A, Jackson County also has relatively low capacity to provide HV services, relative to the rest of the state. For example, it is estimated that Jackson County can only serve about 6% of children ages 0-6 who are living in poverty through evidence-based HV, compared to 8% statewide.

Within Jackson County there are specific geographic areas where needs, risk factors and/or lack of resources are especially pronounced compared to the county and state overall: Butte Falls, Phoenix/Talent, Rogue River, Shady Cove, and White City.[2,3,4] These represent key areas for expanded screening and recruitment for MIECHV-funded HV slots in this county. For more details about risk factors specific to these geographic regions, see Appendix B, Jackson County Case Study.



Butte Falls

- Low rates of child health insurance, high proportion of homeless students, high student absenteeism in K-12, and low achievement of statewide early learning (3rd grade) benchmarks.

Phoenix/Talent

- High populations of young children, with low rates of health insurance and low access to affordable, quality child care; low achievement of early learning (3rd grade) benchmarks.
- This community suffered extensive devastation in the Oregon wildfires of summer 2020.

Rogue River

- Extremely low access to affordable child care, low rates of child health insurance coverage, high student homelessness and chronic absenteeism, and low achievement of early learning benchmarks (3rd grade).

Shady Cove

- Low rates of adequate prenatal care, low access to medical and mental health service providers, and low achievement of early learning (3rd grade) benchmarks.

White City

- Low access to affordable child care, and no available high quality child care.

Figure 3. Jackson County detail

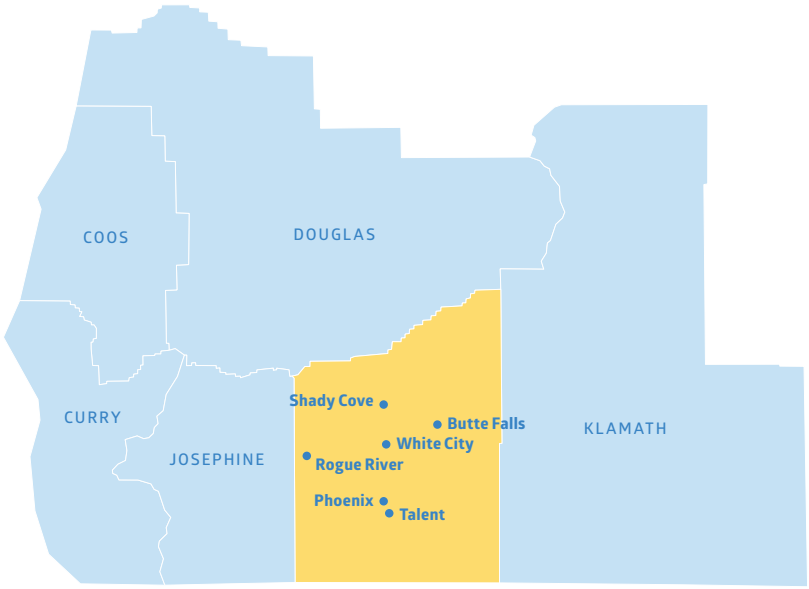


Table 3. Jackson County risk factor data

Indicator	Jackson County	Oregon
Percent smoked during pregnancy*	14.1%	10%
Unemployment	4.8%	4.1%
Households receiving food stamps (SNAP)	21.6%	18.8%
Students eligible for free/reduced lunch	54.1%	49.3%
Homeless students K-12	8%	3.9%
2-year-olds up-to-date on vaccines	63%	68%
Rate of child abuse/neglect per 1,000 under 18	19%	12.8%
Infant mortality per 1,000 births	5.2%	4.6%
Pre-term birth	8.5%	7.9%
11th grade abstaining from tobacco, past 30 days	91.7%	92.3%
11th grade abstaining from alcohol, past 30 days	65.7%	70.2%
11th grade abstaining from marijuana, past 30 days	73.7%	78.4%

Note. Data presented were extracted from the Jefferson Regional Health Alliance (JRHA) 2018 Community Health Assessment of Jackson and Josephine Counties (2019) except as noted.[3] Data sources and year data were collected differed depending on the health assessment reviewed for this report. Thus, Oregon estimates for certain indicators may not match across all three counties (Jackson, Umatilla, and Yamhill).

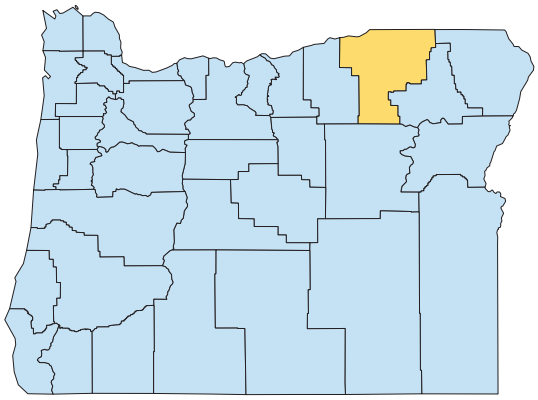
*Oregon Tobacco Facts (2018)[5]

Umatilla County

Umatilla County is a remote rural county in eastern Oregon. While Umatilla County was not identified as higher risk in Phase One analysis, additional data suggests it remains a key area in which HV services are needed. There are high levels of other risk factors (see Table 4) as well as limited access to key family services such as child care, prenatal care, primary care, mental health, and HV. ELMO data indicate that Umatilla county had a moderately high rate of children under age six living in poverty (30%) in relation to the state (20%).[2] Further, Umatilla County is higher than the state overall for several important risk factors such as childhood poverty, student eligibility for free and reduced lunch, and children living with single parents (see Table 4). Perhaps most importantly for HV, infant mortality in Umatilla County is almost twice the rate of the state overall, as is the case for postpartum maternal depression. Almost half of Umatilla County mothers screened positive for postpartum depression, compared to just 1 in 5 for mothers in Oregon. Further, rates of smoking and alcohol and drug use among teens all consistently exceed state averages.

In Appendix A, it is clear that Umatilla currently has the capacity to serve fewer potentially at-risk families through HV than many other counties in Oregon. For example, this county currently has the capacity to serve only about 7% of the children under age 6 living in poverty with evidence-based HV services.

Within Umatilla County, there are specific geographic areas where needs, risk factors and/or lack of resources are especially pronounced compared to the county overall: Echo, Athena, Milton-Freewater, Hermiston, and Pendleton.[2,4] These represent key areas for expanded screening and recruitment for MIECHV-funded HV slots in this county (see Appendix B, Umatilla Case Study, for specific data related to these communities).



Echo

- High rates of childhood poverty and low access to affordable child care, low rates of child health insurance coverage, and no quality child care.

Athena

- Extremely low availability of affordable and/or high quality child care.

Milton-Freewater

- Low access to medical and mental health care providers, low rates of adequate prenatal care, low access to high quality child care, and high rates of chronic absenteeism in kindergarten.

Hermiston & Pendleton

- Low rates of adequate prenatal care, and low access to mental health services.

Figure 4. Umatilla County detail

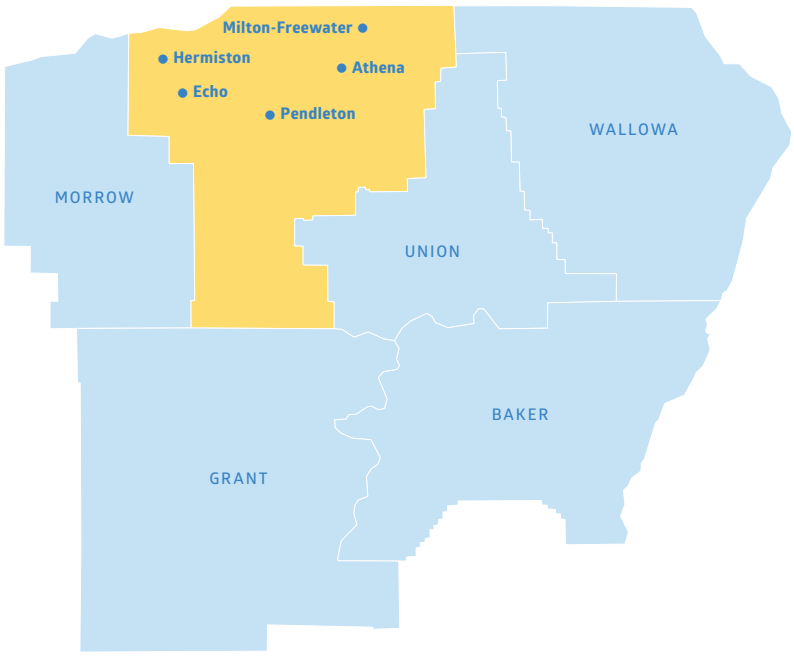


Table 4. Umatilla County risk factor data

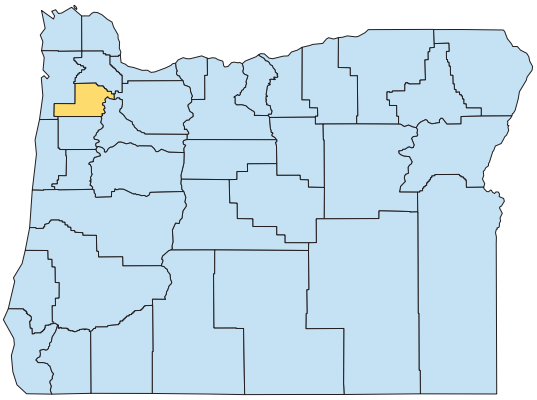
Indicator	Umatilla County	Oregon
Unemployment	5.4%	4.9%
Students eligible for free/reduced lunch	63.4%	47.6%
% Single parent homes	12.7%	8.3%
Infant mortality per 1,000 births	7.4%	4.6%
Maternal depression during pregnancy	28.9%	20.1%
Maternal depression postpartum	47.6%	21.3%
11th grade abstaining from tobacco, past 30 days	71.4%	81.1%
11th grade abstaining from alcohol, past 30 days	33.5%	44.7%
11th grade abstaining from marijuana, past 30 days	55.5%	60.5%

Note. Data were extracted from Eastern Oregon Coordinated Care Organization (EEOCO) Umatilla County Health Assessment (2019).[6] Data sources and year data were collected differed depending on the health assessment reviewed for this report. Thus, Oregon estimates for certain indicators may not match across all three counties (Jackson, Umatilla, and Yamhill).

Yamhill County

Yamhill County is a geographically varied area southwest of Portland and northwest of Salem, Oregon's state capital. ELMO data indicate that Yamhill County has more children living in poverty and less access to publicly funded child care (see Table 5) than the rest of the state.[2]

ELMO data further highlight specific geographic areas where needs, risk factors and/or lack of resources are especially pronounced compared to Yamhill county overall, or compared to the state of Oregon overall: Newberg, Amity, Sheridan, Carlton, and Lafayette (see Appendix B, Yamhill County Case Study, for details).



Newberg

- High proportion of young children living in poverty, with low rates of parental employment, high average housing cost, and low access to affordable childcare.

Amity

- Low rates of child health insurance coverage, low access to affordable childcare, and high rates of chronic kindergarten absenteeism.

Sheridan

- High proportion of young children living in poverty, with low rates of access to quality and/or affordable child care; high rates of chronic kindergarten absenteeism.

Carlton

- High housing cost relative to income, and low rates of child health insurance coverage.

Lafayette

- High proportion of children speaking languages other than English, with high need for linguistically specific services and educational supports;
- Low rates of child health insurance coverage.

Figure 4. Yamhill County detail

Table 5. Yamhill County risk factor data

Indicator	Yamhill County	Oregon
Children 0-4 living in concentrated or high poverty	56.5%	43.4%
Children 0-5 with no parent in the workforce	11%	8.1%
Enrollment in publicly funded preschool	22.9%	27.1%
Access to publicly funded child care slots, 0-2	0%	4.6%
Access to publicly funded child care slots, 3-5	25.4%	37.4%

Note. Data presented were extracted from the Preschool Development Grant (PDG) Strength and Needs Assessment, 2019.[7] Data sources and year data were collected differed depending on the health assessment reviewed for this report. Thus, Oregon estimates for certain indicators may not match across all three counties (Jackson, Umatilla, and Yamhill).

Summary of Risk Analysis Findings

In our county-level analysis of risk across the state, we made a number of adjustments to the set of indicators provided by HRSA to incorporate additional data that the MIECHV Advisory Board and key stakeholders felt was particularly important to understanding risk for pregnant persons and families with young children in Oregon. In doing so, we were able to better identify those counties that are likely to have greater needs for early childhood HV services. Additionally, because a guiding principle for Oregon's HV system is to sustain funding to functioning programs, we collected and analyzed additional data within three counties that are current recipients of MIECHV funding but were not identified through the quantitative county-level analysis as being above the threshold used to define "at-risk." This analysis found that while at the county-level these areas may not be higher than average in risk, there remain deep pockets of need, where access to critical early childhood, medical, and other services is difficult, and where family risk factors and needs are high. This information will be used to help programs do more focused outreach and engagement in these particular communities to ensure that families who are most in need of HV supports are enrolled and served in MIECHV-funded programs. Moreover, while additional funding for HV is not currently available, the analysis identified key communities that could benefit from increased HV capacity, in the event that expansion funding from sources other than MIECHV become available.

Required List of At-risk Counties

Submitted with this report is Oregon's Needs Assessment Data Summary (Excel workbook) that provides additional detail about each step of the Phase One Risk Analysis, based on HRSA's Data Summary templates. See Table 7 in the Data Summary, and Appendix A, for a final list of at-risk counties, as well as information about HV capacity (numbers served and estimated need). Key information and the process for compiling this information and developing these capacity estimates is described in the "Home Visiting Quality and Capacity" section, below. We also provide a number of important caveats and considerations for interpreting this information, and emphasize that developing estimates for HV capacity for Oregon is a complex and challenging process.

2 Identifying Quality and Capacity of Existing Programs

As part of the requirements for this needs assessment, the research team worked to compile information about HV capacity, including information about funded program slots, annual enrollment of children/families, and "point in time" information about program enrollment. However, Oregon, like many states, lacks a coordinated data system that provides this information consistently across different program models. Thus, in estimating capacity there were a number of challenges, and the final estimates (shown in Appendix A for identified at-risk counties and in Figures 1 and 2 for statewide capacity) must be understood in the context of several important limitations and caveats (described below). Because of these complexities, several different estimates of unmet need, defined as program enrollment capacity (numbers served or numbers that could be served based on funding) divided by the estimated number of families or children who may meet eligibility requirements (unserved eligible families/children).

Home visiting programs in Oregon are administered by three different state agencies, as well as by other local organizations, and use a variety of different HV program models (see Appendix C for a summary of key statewide models). Thus, the HV system is quite complex, and not centrally administered. The Oregon Health Authority (OHA) administers MIECHV funding, and directly oversees most Nurse-Family Partnership (NFP) programs. In addition, two other major evidence-based programs are in place: Early Head Start (EHS) and Healthy Families Oregon (HFO, a state-accredited Healthy Families America program). Both of these programs are administered by the Oregon Early Learning Division (ELD), part of the Oregon Department of Education (ODE). MIECHV funds are used to support additional capacity within these two existing programs. Further, Oregon's Association of Relief Nurseries[8] operates a widely delivered, research-informed program that includes both HV and therapeutic classroom services for young children. OHA also operates and partners to provide other HV programs, including Babies First!, which offers home visits during the perinatal period to low income families, and CaCoon, which provides HV for children with qualifying special health needs. Nurse Family Partnership (NFP) programs also operate in parts of the state, funded by both MIECHV and/or other local funding sources. The Oregon Department of Human Services (DHS) also offers another widely-implemented program, known as Family Support and Connections (FSC), which provides HV to families with children ages 0-18 who are receiving Temporary Assistance for Needy Families (TANF) but at-risk for involvement with child welfare services. Finally, there are a number of other programs funded and operating in local communities (e.g., funded through county governments and/or operated by independent nonprofit agencies); these programs were not included in the current needs assessment. Because of the non-centralized delivery of early childhood HV services and the lack of consistently collected, readily available HV enrollment data, gathering information related to the number of families being served in Oregon is challenging.

Important considerations for interpreting capacity estimates include the following:

1. Enrollment information is potentially duplicated. There is no way to provide an unduplicated count of families receiving HV. While duplication of services in most of the evidence-based HV programs is likely to be minimal, some programs, such as CaCoon, which provides HV for children with special health care needs, and FSC, which provides family stability supports to families at imminent risk of involvement with child welfare, are not necessarily designed to be "stand alone" HV services and may operate in partnership with other evidence-based HV models. Moreover, some programs strategically "hand off" families based on children's ages. For example, EHS provides HV through age 3 years; programs that end services earlier may transition families from one program to another to ensure continuity of support. Thus, all numbers and capacity estimates (Figure 1 and Appendix A) represent potentially duplicated counts of families across programs. Moreover, a decision was made to exclude two of Oregon's statewide programs (CaCoon and FCS) in our total count of families served due to the likelihood of duplication of family counts as well as their ability to provide services to a much larger age range (0-21 years) than typical early childhood HV models.

The lack of a coordinated, shared data system and consistently collected enrollment data make it difficult to accurately estimate gaps in home visiting program capacity.

2. Unit of Analysis. Programs were not able to consistently provide counts based on either the number of families or the number of children (either of which would have allowed a more consistent enrollment counts). HRSA estimates of potential need for service were at the family level (total number of families meeting criteria). Oregon-specific data used by the Preschool Development Grant (PDG) Needs Assessment reflected the number of children who are potentially eligible for services.[7] Thus, the final estimates include both family and/or children depending on the program. This may have led to some duplication. For example, programs (EHS, Babies First!) that provided data at the child level would potentially inflate the count of the number of families served using the HRSA estimate as the denominator.

3. Enrollment Period. Most programs were not able to provide a current snapshot of the number of families/children enrolled, and instead provided the total number of families or children served in the most recently available program year. Total annual enrollment does not represent the capacity of the current HV system at a given time. Even snapshots of currently served families may not accurately reflect capacity, as programs may be under-enrolled (although HV stakeholders reported waiting lists and significant unmet need, which suggests this issue may be minimal). To show the difference between estimates based on program annual vs. current enrollments, we conducted a sensitivity analysis of estimated need (see Figure 4). In this example, based on NFP data, it is clear that estimating "capacity" using the number of families served in a one-year period significantly over estimates the number of families that can be served at any point in time.

4. Varying Program Eligibility Criteria. Adding to this complexity is the requirement to estimate the potential need for HV. Estimates of need ideally should comprise data from families who would be eligible for services, but are unable to be served due to program capacity. However, Oregon's current HV programs use a variety of different criteria to determine eligibility, with no two programs having the same set of characteristics defining who is eligible for services. HRSA provided one estimate of the potential number of families in need of HV, defined as the number of families with children under age 6 years living in poverty and meeting at least one other risk factor (low maternal education (less than high school), maternal age (under age 21 years), and pregnancy status, based on Census Data. This is a fairly conservative estimate of need in relation to the eligibility criteria for most of Oregon's evidence-based programs. For example, HFO requires families to have at least two of a wide variety of social and demographic risk factors, but has no income criteria. Conversely, EHS requires only that families be less than 100% federal poverty level (FPL), with no other specific eligibility criteria. Thus, for Oregon's PDG Needs Assessment, a statewide stakeholder advisory group recommended a less stringent figure for estimating need, based on children living in poverty (100% or below the FPL).[7] Therefore, to better reflect the population of families who are potentially eligible for HV in Oregon, we provided additional calculations based on this denominator in Appendix A. **Even this estimate, however, may significantly underestimate the number of families who could potentially benefit from HV services**.

Estimates of Current Capacity for Oregon's Home Visiting Programs

Total annual program enrollment for the following programs is provided in Appendix A for the identified at-risk counties as well as for the state overall: Nurse Family Partnership (NFP); Healthy Families Oregon (HFO); Early Head Start Home Based (EHS); Oregon Relief Nursery (RN); and Babies First. Statewide, these programs provided services to a potentially duplicated count of 8,946 families/children. Evidence-based programs (HFO, NFP, and EHS) provided services to about half that number (4435 families/children). The estimated unmet need varies depending on which estimates of need and/or type of HV program are included. Using HRSA's estimate (Figure 5) of the number of families potentially needing HV (24,489 families), it is estimated that Oregon is currently providing services to about one-third (37%) of families in need of HV. However, if only evidence-based HV programs are examined, this figure drops to 18% of families served.

However, as described previously, both the state's MIECHV Advisory Board as well as the Advisory Board for Oregon's PDG Needs Assessment recommended a less restrictive denominator that better reflects the wider array of families that Oregon believes may benefit from HV. Specifically, the recommendation was to use the number of children ages 0-6 living in poverty. This results in a much larger estimated gap between current capacity and need for services. For evidence-based programs only, Oregon is currently serving only about 8% of potentially eligible families. If other Oregon HV programs are included, the gap is still large, with the combined models only able to serve about 15% of the families in need.

Oregon is currently providing evidence-based home visiting to approximately 8% of young children living in poverty.

Figure 4. Range of estimates for Oregon home visiting capacity and need

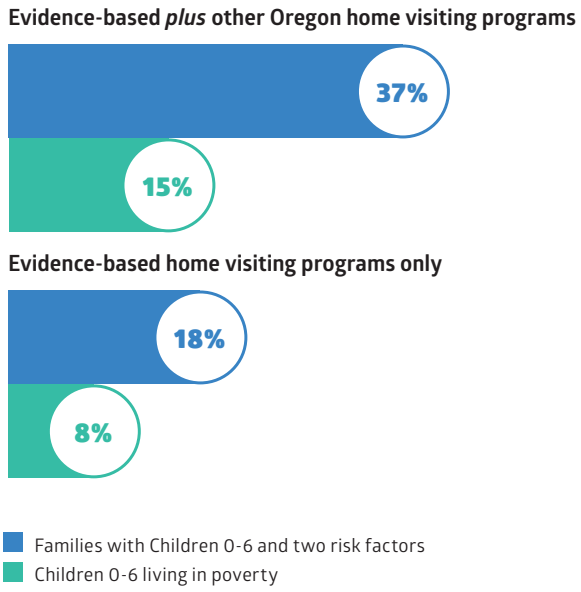
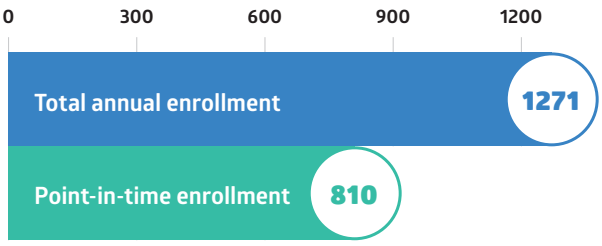


Figure 5. An example comparison of home visiting capacity estimates using point-in-time vs. total annual enrollment



This figure provides an example using data provided by the Nurse-Family Partnership program, of different approaches to estimating HV capacity.

3 Supplemental Quality and Capacity Data

To better understand the current barriers, challenges, and needs of Oregon's HV system, the needs assessment research team compiled additional information from three sources: (1) prior research done in Oregon; (2) interviews with state-level informants knowledgeable about Oregon's HV system; and (3) a series of 5 parent focus groups (3 in English, and 2 in Spanish) to hear from parents about their experiences with HV and their ideas for improvement.Key findings from the parent focus groups are summarized below and included in Appendix D.

Related Research Findings: Home Visiting Capacity in Oregon

Some programs have documented waiting lists and/or other issues related to capacity. For example, the most recent HFO report[9] found that of the families who were screened and determined eligible for services, 478 families, representing 39% of those determined to be eligible, were not offered a HV program slot due to capacity limits (e.g., programs were "full"). However, given the relatively limited number of potentially eligible families that are screened by HFO, this number no doubt reflects a substantial under-count of actual unmet need. While quantitative data about the number of families on waitlists for different HV programs was generally not available, stakeholders described many programs as having significant waiting lists for services (see below). Waitlists are common in Head Start (HS) and EHS programs, although specific numbers of families on these waitlists were not available.

Home Visiting State Leader Interviews: Purpose and Methods

In order to further describe the current capacity of Oregon's HV system, the needs assessment research team conducted 11 interviews with key state leaders in the HV sector involved with one or more of the major HV models in Oregon: Babies First!, CaCoon, EHS, Family Connects, HFO, NFP, Oregon RN, and Parents as Teachers (PAT). Three of these programs (EHS, HFO, and NFP) receive MIECHV funds and receive technical support from Oregon's state-level MIECHV team. Interviews were conducted using the Zoom meeting platform, which provided transcripts for coding through the automated transcription feature. Interviews were coded by a senior researcher knowledgeable about the HV programs in Oregon and were reviewed for accuracy by the data collectors/interviewers. Key stakeholders played a variety of roles in supporting HV programs, including quality assurance, technical assistance and consultation to supervisors and program leads; training and professional development supports; contract monitoring and oversight; and communication and information dissemination.

Parent Focus Groups: Purpose and Methods

Five virtual parent focus groups were held using Zoom (with and without video). Focus groups included a total of 35 parents. Three were conducted in English (20 parents), and two were conducted in Spanish (15 parents). Parents were recruited by sending information about the focus groups via email to HV program directors and staff across the state, as well as to key local organizations known as the Early Learning Hubs that coordinate local early childhood programs. Parents were provided a $50 electronic gift card for participating. An attempt was made to include parents from all of the major statewide HV programs, with mixed success. The following programs were represented in the parent focus groups: CaCoon, EHS, Early Intervention, HFO, NFP, RN, and local HV programs. Topics included reasons for participation, barriers to engaging parents, perceived benefits of HV, and parents' perceptions of the cultural and linguistic responsiveness of the services provided. Parents were also asked for their recommendations about how to improve HV. Results of the parent focus groups were transcribed and coded to identify key themes by the research team members who were involved in facilitating or supporting the sessions. Results are incorporated below, noting areas in which parent perceptions mirrored or differed from those shared by state-level HV leaders.

Current Capacity for Providing Home Visiting for Families in Need

Virtually all state-level HV leads described Oregon as unable to provide sufficient HV services to meet estimated levels of need. Some programs, like the RN and EHS, reported significant and ongoing waitlists. Typical waiting lists for HS and HS HV programs was described as in excess of 100 families at any given time; the RN statewide lead reported similar waiting lists for their services:

"For my programs, Relief Nurseries, we currently have a waiting list. We have a waiting list that is double the size of who we are currently serving statewide. We were and are working to address that issue." *—State-level HV Stakeholder*

Other programs, like NFP and HFO, in which enrollment is restricted to certain pre- and perinatal periods, estimate that there are significant gaps in identifying and successfully recruiting and enrolling families. Programs with mandates to serve broad populations of families cited data describing their lack of capacity. For example, an HFO leader cited specific data related to their goal of serving all high risk parents of newborns:

"There's more than 42,000 births in Oregon [annually]. We screen about 13% of them, and [of those] about 69% consent to come into services. So, we really serve a fraction, a very small fraction, of families [who may be eligible]." *—State-level HV Stakeholderr*

Even programs with narrow target populations (e.g., CaCoon) or families involved with TANF or children welfare (e.g., FSC) reported gaps in available services for families who might qualify:

"So, care coordination is an essential health care need for children and youth with special health care needs and approximately one in five Oregon children younger than the age 18 has a special health care need. Local public health authorities don't have the capacity to provide every Oregon child under the age of 18 with care coordination support…"
—State-level HV Stakeholder

Challenges in Increasing Home Visiting Systems Capacity

State program leads shared a number of challenges to creating a system that would have the capacity to identify, recruit, and serve all families who need and could benefit from HV services, in addition to the known challenge of inadequate funding. The biggest challenges identified were: (1) workforce capacity; (2) specific program eligibility requirements; (3) lack of data infrastructure; and (4) lack of coordinated screening and referral systems.

High job demands and low pay likely contribute to high rates of turnover among home visitors.

Workforce capacity

Virtually all stakeholders talked about issues in recruiting and retaining an adequate HV workforce. Several noted specific issues related to the challenge of doing this in rural/geographically remote regions and ensuring a culturally and linguistically diverse workforce. Others talked about the challenge of retaining staff given relatively low pay and high expectations for home visitors to have an expansive knowledge base and skill set. Pay for home visitors relative to similar fields was noted as well (e.g., early elementary education, other fields of nursing). Nurses in particular, as well as persons of color and bilingual staff, were described as especially hard to recruit and retain, and even more so in rural/frontier areas. Notably, rural/frontier communities are also seen as areas in particular need of HV program capacity expansion. One approach to address this is to more intentionally develop professional pathways for former

HV program recipients; HS was mentioned as a program that has a history of supporting former participants to engage in professional development and become program staff.

"I think in rural communities there's a lot of evidence that it's hard to find people who have early childhood background and child development background and training…I think there's an immense need to continue efforts around growing our own home visitors. I think recruiting from families that have received services…" *—State-level HV Stakeholder*

Lack of consistently collected, coordinated home visiting program data

Several stakeholders noted that the current lack of a coordinated, robust statewide data in Oregon was a barrier to both ensuring that potentially eligible families could be identified and referred to an existing program, as well as to inform and build evidence for unmet need. This lack of shared data about which families are (or are not) being identified and enrolled was also noted as **an equity issue**, in that state leads and other program managers lack the information needed to identify specific groups of families who may not be adequately represented and served by current HV programs. Several program leads reported being unable to accurately examine data in a way that would allow analysis of enrollment and retention by family race/ethnicity or language.

Lack of coordinated screening, identification and referral

A few regions in Oregon have made progress in developing integrated, cross-program systems for identification and referral of families to local networks of HV programs. However, these models were described as limited in scope and very much "under development." A few examples were the coordinated public health enrollment system within Multnomah County (Portland); a cross-program community-based network in Marion and Polk counties; a pilot project in Douglas County; and similar models in Yamhill and Umatilla/Morrow. One stakeholder shared their vision for a fully functional integrated referral system:

"We don't have some of that infrastructure of how do we connect prenatal, how do we connect birth pediatricians, home visiting as all part of a very natural piece to support the children and families…" *—State-level HV Stakeholder*

Stakeholders talked about some of the challenges in developing this kind of integrated, coordinated system. Another issue that remains in some areas of Oregon is an inter-organizational sense of competition for resources and families. While progress has been made in creating a collaborative culture in which HV programs work together to provide a seamless system of supports, in some areas there is remaining work to be done.

Stakeholders noted that creating a well-informed community network of organizations and people who refer families to HV is time consuming. The level of "on the ground" work to raise community awareness about HV both among families and among potential referral partners was noted as a challenge, especially when doing this work is rarely in the "job description" of most home visitors.

"I think there are two big barriers…the first barrier is having people who are willing and able and thinking about referring into the program. And so it takes a lot of work in the community from the supervisors to reach out to all the people who would refer, whether that's WIC or OB offices or pediatric offices or schools or any kind of services that are provided for folks that would refer. And then there's this struggle between having time to actually visit with clients and get paid for that versus going out and getting clients." *—State-level HV Stakeholder*

Lack of a shared screening tool across HV programs

Related to the lack of an integrated system is the lack of consistent screening tools. Even within some programs (e.g., CaCoon, EHS) the screening and eligibility tools used were described as varying considerably from program to program. Other programs currently use their own model-specific screening tools. While there have been some efforts at the state level to create and implement a universal HV screening tool, to date there has been limited progress in doing so. Again, some local efforts to create a coordinated system have developed a shared screening/referral tool, but these vary by county and region.

Complex nature of home visiting programs

Another challenge in developing coordinated referral networks was the issue of how to best communicate to families and/or referring partners about the complex HV system and different programs. This was noted as particularly challenging in urban areas with many different HV programs which often operate independently. Communities that have implemented more successful approaches to coordinated referral have addressed this challenge by messaging a "no wrong door" strategy that links to an integrated system, thus making the issue of navigating eligibility requirements something that trained coordinators manage, rather than having families or other providers make referrals to specific programs.

"Honestly, I think the hard piece is going to be how do we, on the ground, combine all these different programs into a seamless system? We need to just have home visiting—if you make it too complicated then people have really a more difficult time getting referrals." *—State-level HV Stakeholder*

Another concern is that so many programs are currently full ("at capacity"). While some statewide programs have attempted to implement broad-based (population) screening for HV eligibility, state program leads reported that, not surprisingly, the knowledge that programs are full and/or have waiting lists is a significant deterrent to robust population screening.

Lack of community awareness and acceptance of home visiting as normative

Another challenge to develop a system that could successfully engage and serve all families in need of supports was the fact that HV services are still not considered normative, and carry with them stigma (e.g., only for low-income or at-risk families). As well, they are generally not widely known and accepted as the kind of support that could benefit all new parents. This theme was strongly communicated by parents, who noted that in their communities many families don't know about HV and if they do, feel that receiving services and supports is stigmatizing.

"I feel like there should be more resources for those that aren't just low income, and I feel like it's not widely spread enough that people know about these programs, and I feel like there needs to be some more ways to get it out into the community." *—Parent Participant*

In particular, a key theme among parent participants was belief that HV can lead to child welfare involvement. One parent noted that their community HV program information is linked to the child welfare/DHS website, further elevating this concern.

"The only place that I've seen Healthy Families advertise is through the DHS office, and I know there's kind of a lot of stigma through in home programs around that, and I think maybe if it was maybe a little more widespread advertised rather than just there." *—Parent Participant*

Additionally, a number of parents shared that they were initially hesitant to engage in HV services because of fear of being judged by the home visitor.

"I think no matter what, the idea of people coming in your home, it's so personal, especially in the beginning because they are a stranger. I felt hesitant. I didn't understand it. If it hadn't been for it being explained to me, I just didn't really understand it. I think whenever I think of home visit, it's usually like in a negative context, for people who have problems or may not be good parents." *—Parent Participant*

State and parent stakeholders said that seeking parenting help should be normalized. State-level leaders noted that the implementation of universally-offered HV through the emerging Family Connects Oregon program could help to address this issue and build support for HV as "normative" (for more details, see section below, "Building Coordinated HV Systems"). Stakeholders also noted families' lack of trust in government systems (especially under current political policies related to immigration) as a barrier to HV.

"I totally agree with and would validate the fact that it should be normalized, parenting and motherhood. If you need the support and you want it, and it shouldn't even be a need, if you want it, it should be there totally normal." *—Parent Participant*

Reasons parents accept home visiting

In thinking about how to best communicate with parents about potential program benefits, it is worth noting the key reasons why parents indicated that they "said yes" when they were offered services. The main reasons included:

- Desire for information about parenting, child development, breastfeeding, and child health. Spanish speaking parents in particular shared that doctors do not listen to their concerns, or dismiss their input about their child's development, noting that home visitors were open and receptive.

"I had a really tough birth experience with a lot of complications and we were approached by a Healthy Family person in the hospital…The way it was presented was like, we're here to basically help monitor your daughter's milestones and make sure she is growing in all the different areas. And it was just like, absolutely, I'll take all the help that I can get. Pretty simple." *—Parent Participant*

- Desire for emotional support, and help with postpartum depression and stress. Spanish-speaking parents talked about their struggles with postpartum depression, and noted the importance of the support they received from home visitors around this issue:

"A mi me ayudó bastante con la depresión, también porque me daban muchos consejos…Yo me estreso bastante con éllos y me ayudaban a darme consejos, como hacerlo. Por eso estoy muy agradecida con ellos por toda la ayuda que me han brindado."
"It helped me a lot with depression, also because they gave me a lot of advice…I get stressed a lot with them [her children] and they helped me give me advice, how to do it. That is why I am very grateful to them for all the help they have given me."
—Spanish-speaking Parent Participant

- Help with a child born with special needs.
- Help with material resources, especially since the start of the COVID19 pandemic.
- Support for the parents' self-care.

"Es mi obligación cuidarlos. Pero no, la verdad es que ella me enseñó que hay un punto en el que si yo necesitaba simplemente dormir, descansar y tomar tiempo para mí, para poder seguir teniendo fuerzas y estar al 100, como se dicho, para seguir cuidando a mis hijas. Y eso, la verdad, me lo enseñó el HV y me ayudó mucho con eso, algo que yo no lo hubiera sabido."
"It is my obligation to take care of them. But no, the truth is that she taught me that there is a point where if I just needed to sleep, rest and take time for myself, so that I can continue to have strength and be at 100, as I have said, to continue taking care of my daughters. And that, the truth, the HV taught me and helped me a lot with that, something that I would not have known." *—Spanish-speaking Parent Participant*

- Goal setting for parent, family, and child rearing.

Parents provided a number of suggestions for how to get information about HV out to more families, including:

- Doing more community-based outreach directly to parents, especially to places where families needing support might be living (women's shelters, homeless shelters, prenatal clinics, legal aid clinics, self-sufficiency offices);
- Providing parents with information about HV at the hospital when children are born (note that this is part of the goal of the universally-offered Family Connects model);
- Providing more flexibility in the number of home visits families are required to receive each month;
- Providing weekend and evening hours for home visits ;
- Providing information that frames HV as normative, something all parents need; and
- Using more friendly language when introducing the program (avoiding legal jargon, frightening descriptions of 'mandatory reporting.'

"…the final line in a document that you're signing says, oh, by the way, we're mandatory reporters, or something to that effect. It scares people. If they only knew exactly what mandatory reporting is and what they're there for, then maybe people wouldn't be so scared…They're not out to get you, they're out to protect you." *—Parent Participant*

Gaps in Services: Which Families Are Not Being Enrolled and Engaged in Home Visiting?

Existing data and feedback from state and parent stakeholders identified a number of groups that Oregon's current HV system struggles to enroll and engage. The two most frequently mentioned groups were (1) families living in remote rural and frontier regions of the state; and (2) culturally and linguistically diverse families. Other groups identified included (3) families involved with child welfare services and (4) families who don't meet specific eligibility requirements, in particular those just above income cut-offs. Stakeholder perspectives and additional data related to these potential disparities in unmet need are summarized below.

Families of Color and Families Speaking Languages Other Than English

Stakeholders noted the ongoing need to improve the ability of HV to meet the needs of Oregon's growing racially and linguistically diverse families. This included both ensuring that programs were effectively engaging these families, as well as identifying the need for more culturally-specific programs to best meet their needs. An important opportunity for supporting more of these programs is currently under development, related to a new funding stream that was passed in the 2020 legislative session, which established dedicated funding for culturally-specific early childhood programs. However, whether these funds are currently at-risk due to the recession is unknown.

Home Visiting Enrollment Data: Families of Color

Program enrollment data for HFO, Babies First!, CaCoon, EHS, and NFP that is disaggregated by child race/ethnicity was provided in the statewide PDG Needs Assessment.[7] These data are shown in Table 6. Unfortunately the programs do not record this information in a way that allows for comparison across models. Specifically, for the programs operated by OHA, families may choose multiple race/ethnicity categories, so the percentages do not reflect mutually exclusive categories. Other programs provided the information in such a way that these categories represent unduplicated counts (HFO, EHS, and RN).

Data suggest that these programs are serving a population that is, at minimum, representative of the **general population** of young children (ages 0-4) and births to mothers of different racial/ethnic backgrounds. When considering the MIECHV-funded programs, for example, 35-47% of the persons served by these programs are Latinx (compared to 22% of the Oregon 0-4 population); 4-12% African American (2.5% of the Oregon 0-4 population) and 1-4% Asian (3.9%-5.2% statewide); and 0.5-5% American Indian/Alaska Native (1.2% of the population of young children). There is some variability across program models, likely due to a small number of culturally-specific/culturally-responsive programs in some geographic areas. However, this distribution differs among those who are living in poverty and/or are at potentially higher risk. For example, for children 0-18 living in poverty, 49% are white, 5% are African American, 35% are Latinx/Hispanic, 2.3% are American Indian/Native American, and 10% are multi-racial.[7] When compared to the demographic characteristics of families living in poverty, programs may be under-serving African American families (although this varies by program) and American Indian/Native American families.

Consistent with these statistics, state leaders described the current HV system as generally doing well in terms of enrolling and recruiting Latinx and Spanish-speaking families (and in some cases cited data comparing enrolled families to population demographics as evidence). Several noted that the growing cultural and linguistic diversity in Oregon's population is increasingly challenging. For example, stakeholders talked about being less able to support and adequately serve Russian and Eastern European immigrant families, African refugees and immigrants, and a variety of Asian and Pacific Islander communities, all of which are increasing in number in Oregon.

> "I think in Oregon we, we actually do provide fairly high percentages of services to families that speak Spanish and if you look at Early Head Start and Healthy Families data, I think you'll see potentially much higher percentages of Hispanic and Latino families that are accessing those services as compared to their sort of percentage of the population. I think that a lot of our Latino families are very, seem interested in those services and are more likely to engage in what was offered to them."
>
> *—State-level HV Stakeholder*

Figure 6. Oregon home visiting program enrollment by family race/ethnicity[1]

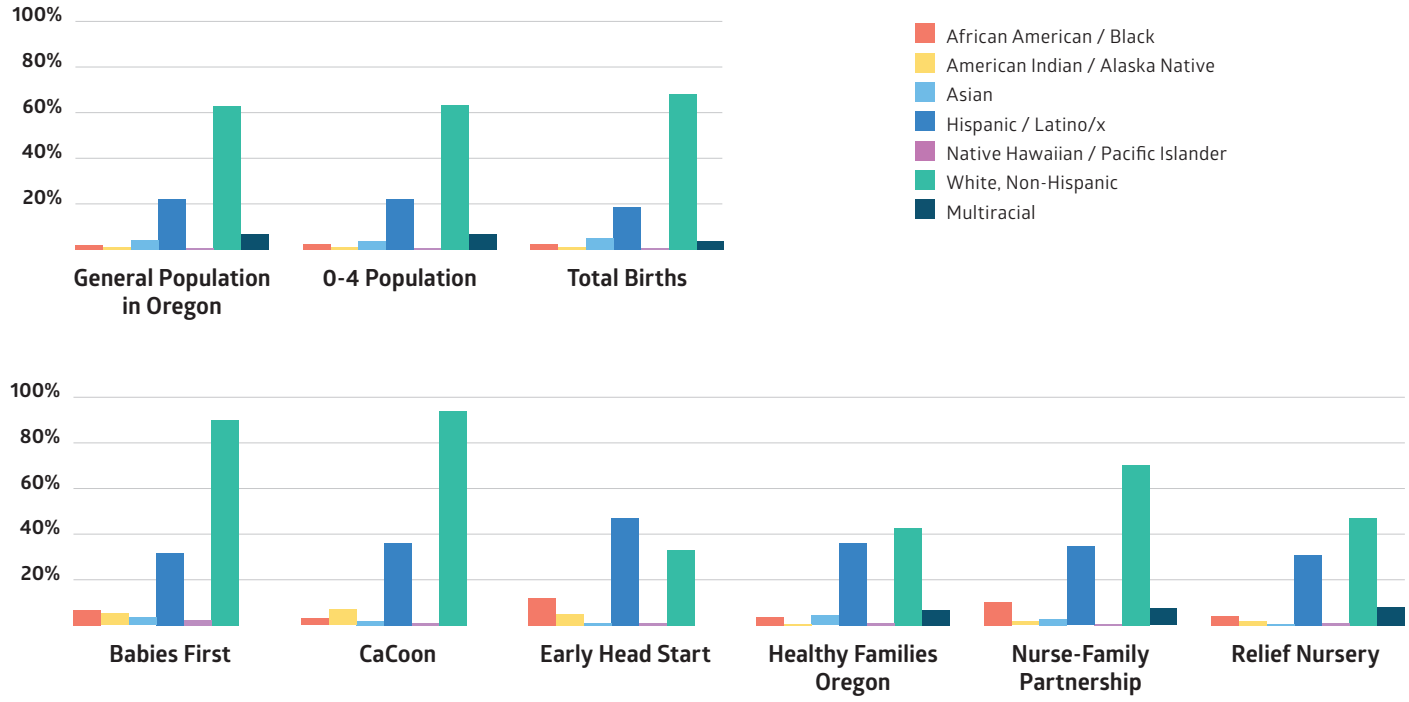


Table 6. Oregon home visiting program enrollment by family race/ethnicity

Program	African American	American Indian/ Alaska Native	Asian	Latina/o/x	Hawaiian/ Pacific Islander	White	Multiracial
Babies First!*	7%	5%	3%	32%	2%	90%	n/a
CaCoon*	3%	7%	2%	36%	1%	94%	n/a
Early Head Start	12%	5%	1%	47%	1%	33%	n/a
Healthy Families Oregon	4%	<1%	4%	36%	<1%	43%	7%
Nurse-Family Partnership*	10%	2%	3%	35%	<1%	70%	7%
Relief Nursery	4%	2%	<1%	31%	1%	47%	8%
Oregon General Population	2%	1%	4%	22%	<1%	63%	7%
Oregon Children 0-4 years	2%	1%	4%	22%	<1%	63%	7%
Total Births	2%	1%	5%	19%	<1%	68%	4%

Note. Healthy Families Oregon, Relief Nursery, and Early Head Start percentages are exclusive, such that each client can only select one race/ethnic category. Babies First!, Nurse-Family Partnership, and CaCoon percentages add up to more than 100% since clients could select more than one race/ethnic category. Babies First! percentages are based on the number of children served, while Healthy Families Oregon and Nurse-Family Partnership percentages are based on number of caregivers served. Relief Nursery, Early Head Start, and CaCoon enrollment numbers are from the Preschool Development Grant Needs Assessment. Oregon 0-4 race/ethnicity data from Kids Count, 2017. Oregon birth data from 2015-2017 Vital Statistics.

Lack of Culturally-Specific Services for African American/Black Families

Stakeholders noted the lack of culturally-specific services for African American/Black families, and that these services are primarily found in Multnomah County (Portland).

"I think once you venture very far from the Portland metro area, the services are not necessarily as diverse as the local communities." *—State-level HV Stakeholder*

Lack of Culturally and Linguistically Responsive Services for Non-Latinx Immigrant and Refugee Families

Current HV services do not adequately reach the increasing population of immigrants and refugees who speak languages other than Spanish, and who are living outside the Portland Metro region. The large number of different languages spoken, a lack of cultural knowledge, and the increasing need for culturally responsive practice were named as challenges to the current system's capacity.

"As we see demographics changing, I've also experienced times where we've had Russian families or Somali and families who don't feel like they have that connection that way and can't be served in their own language. I think that we maybe have paid a lot of attention to one culture in one language and not really acknowledging the wide diversity that Oregon is starting to really develop." *—State-level HV Stakeholder*

Lack of Culturally Specific Programs for Serving Indigenous/Tribal Communities

Finally, several stakeholders identified tribal and indigenous communities faced considerable unmet need. While state stakeholders noted that there are sometimes connections between local tribes and county-specific HV organizations, they did not feel they knew enough about programs that are being run through tribal organizations (other than a few more widely known in the Portland metro region) and/or the extent of their services. State stakeholders also noted that there has not been enough work to develop collaborations and partnership with these programs. Reasons for this are not clear, but point to a critical disconnect in state and local HV programs. Providing more resources and supports to local tribal organizations providing culturally-specific services, and addressing systemic barriers is clearly an important priority.

"I don't feel we've been able to reach our tribal populations. And there's a lot of reasons for that…when I talk to rural partners about this their response is that '[tribal organizations] want to do their own services, they want to do their own thing.' And, you know, to some extent, that's accurate, but I think there's a lot of work that could be done to make it possible to build more trust with those communities and learn from each other." *—State-level HV Stakeholder*

One culturally-specific program serving AI/NA families that was included in our local (county) case study interviews was the Family Spirit program, one of the few evidence-based culturally specific HV models.[10] In 2012, Oregon was awarded federal funds through the MIECHV Tribal Home Visiting legislation to support the Confederated Tribes of Siletz Indians to implement a culturally-specific program. Originally, the tribes adopted the HFO model in addition to the culturally-specific Family Spirit program. This federal funding ended in September 2018, but has continued with funding from local sources.

We spoke to a local HV program staff currently working at Family Spirit, which serves tribal members living in 11 different counties. The interview highlighted the disconnect between both state HV systems and this culturally-specific program, as well as challenges to effectively meeting the needs of NA/IA families due to systemic barriers. First, it was noted that switching from HFO to a culturally-specific model with less restrictive eligibility requirements led to significant increases in enrollment. In particular, being able to serve families with more than one child (e.g., not first-time parents) was important for serving this community. Additionally, with MIECHV funding, services were available to a broad range of tribes across the state; now, funding restricts services to members of the Siltez tribe.

"…it [losing MIECHV funds] did decrease the number of individuals we can serve because now they must be Siletz tribal members. And so that's one thing that losing the funding with the maternal MIECHV grant took away from us is being able to serve all tribal members." *—County-level HV Stakeholder*

Further, the program stakeholder noted that there are systemic barriers to establishing referral pathways with other agencies such as WIC (Women, Infants, and Children Nutrition Program) and DHS, attributing this primarily to staff turnover at these agencies, which undermines ongoing efforts to inform these staff about the program and encourage them to refer tribal members for services. Finally, Family Spirit stakeholders shared that other HV programs operating in the community sometimes did not refer tribal families to them due to a lack awareness of the tribal program and/or reluctance to refer outside their own HV model:

"But if somebody comes to [a County Public Health office] and says, 'I'm interested in home visiting'...sometimes it seems that program doesn't want to let go of that family because they're like, 'oh, they came to us and we're more likable'. If they identify as Native, you should really let them know that we have a native-specific, culturally sensitive program. Maybe they should come to us." *—County-level HV Stakeholder*

"I think the biggest thing is making other programs more aware of the tribal program and allowing families the option to participate in those programs." *—State-level HV Stakeholder*

Geographic Limits on the Ability to Serve Families of Color and Families Speaking Languages other than English

Finally, there was a sense that the ability of the statewide system to provide culturally-specific services to racially and linguistically diverse populations was primarily concentrated in the Portland metropolitan area, despite evidence that these populations are increasing in many of Oregon's rural and frontier regions. While there are culturally- and linguistically-specific, community-based programs outside the Portland area, they are limited in scope and leave other regions without culturally-appropriate programs. Where they do exist, state leads suggested that community-based, culturally-specific programs could be used as examples for how to effectively serve families on a broader scale, and noted the importance of funding to expand these programs.

"I think that in Oregon there are some programs who are being run by folks who are literally from the regions that they're serving. They are they are well within their capacity and the bandwidth to provide translation services and to just be culturally competent in the services that they offer. I definitely think that that's a need that's being met,...things can always be better, of course, through funding, through more hiring, and just by developing the programs and programmatic operations to be more culturally competent." *—State-level HV Stakeholder*

Families Living in Rural or Frontier Locations

Families living in geographically remote frontier and rural communities are also under-served in Oregon's current HV system. Within frontier areas, the obvious challenges are travel and the time it takes to get to/from family homes, as well as meeting the needs of extremely socially isolated families. A related challenge is how to create sustainable programs to serve small populations of families. Several counties in more remote locations have struggled to maintain consistency in HV program providers, due to the relatively high expense and complicated nature of maintaining a staff adequately trained and supervised to serve a small numbers of clients. This may mean having only one or two home visitors and having a supervisor who likely inhabits multiple other professional roles to support full-time employment. Staffing more generally, in terms of finding professionals with adequate training to work as home visitors (and in particular, nurses) was also described as a challenge. Finally, it was noted that these areas also have fewer HV and other services generally, which increases the burden on the staff working in these areas to do even more to support each family.

"It's been my observation that some of the most challenging families can also be those families that are very isolated and difficult to reach you know geographically, as well as culturally, because many of those families who choose to live geographically isolated do so for a reason that that's where they want to be and they aren't excited about government programs necessarily and home visiting." *—State-level HV Stakeholder*

One key stakeholder speculated that if there were universal HV services available for every birth in frontier areas, that this could make a drastic difference in child welfare and other services, and might be possible given the relatively small number of births:

"It just made me think if there were enough prevention home visiting programs that every birth in Malheur, every birth in going up Baker, all of those counties up the Eastern corridor. Blue Mountain Early Learning Hub, if every birth got a home visitor that was there for three years, I think that what they would need for other services down the line would drastically be cut in half." *—State-level Stakeholder*

Families Involved with Child Welfare Services

Several stakeholders noted that because HV is considered to be a primary (or in some cases, secondary) prevention approach, few are able to enroll and serve families with active child welfare cases. Some models (Relief Nursery, Early Head Start) do serve these families, but their capacity is highly limited. Healthy Families America has recently developed a model variation specific for families with child welfare involvement, but that model has yet to be explicitly adopted in Oregon.

"...when children are reunited with their families and the child welfare case closes, there is not a service home visiting or otherwise, that's publicly funded to support those families as they're trying to work through reunification and getting the family back together." *—State-level HV Stakeholder*

Working Families

Parents in focus groups noted that working families may have difficulty participating in HV, both because of home visitors' "rigid" schedules (e.g., providing services only during the usual business day), and because working parents are simply too tired to successfully engage in home visits due to their joint responsibilities for working and providing care to young children and families. Families also mentioned that they can be dropped from some HV programs if they do not meet a strict schedule of regular visits, which can be very challenging for some parents.

"I know in my experience, that was one reason I actually almost stopped because it was like I would go to work full time, get home around five, and the services with the home visitors had to be in person. So, I would have to pretty much try and get dinner done, get all my kids settled for the night, and then turn around and have a home visit. It was very inconvenient because they don't really do services on weekends, so it does make it a lot harder to try and participate in them with having the normal like nine to five job." *—Parent Participant*

Families Who Don't Meet Income (or other) Requirements

As shown previously, Oregon lacks capacity to provide HV to those families with known risk factors and/or who are eligible for specific programs. At the same time, stakeholders shared that this gap in capacity would be even larger if eligibility criteria were broadened. There was a shared sense that many families who could benefit are not able to be served because of program eligibility requirements. State key stakeholders and parents noted that some families are unable to participate because of eligibility requirements, with income being the most frequently mentioned factor getting in the way of enrolling families. Several programs use income (EHS) or Medicaid eligibility as a criterion for enrollment (sometimes because this allows billing for services), but noted that many families don't meet the income eligibility requirement (185% of FPL) and are likely still in need of the support HV provides:

"I have been hearing emerging conversations fairly consistently about families who don't quite meet eligibility criteria but… would benefit from the service. For example Early Head Start and NFP are both income-based programs. There's an income component to eligibility. Healthy Families as a national model doesn't. It does get often utilized as a risk factor in Oregon, because we don't have capacity to serve every family that might be eligible for it." *—State-level Stakeholder*

Other specific eligibility requirements were seen as "getting in the way" as well. For example, NFP was noted by state leads as having very specific enrollment criteria, limiting that program's ability to widely serve potential families; similarly, income criteria for enrollment in EHS and Babies First!, and specific risk screening criteria (HFO) were all described as barriers to enrolling families. This is partly related to the complexity of the various eligibility requirements and lack of coordinated intake and referral system for HV, and partly due to the consensus opinion among these state leads that a large population of families would likely benefit from HV but not quite fit existing program eligibility requirements (see further discussion below).

In general, state leads and parents shared a belief that HV services, at some level, are the kind of basic parenting and child development support that would ideally be available to all:

"I think every single parent could use the supports that are available out there whether or not they fall in any category of any kind other than being a parent. That has nothing to do with income, has nothing to do with status in the community, has nothing to do with ethnicities or gender preferences. Parenting is not easy and they don't come with instructions." *—State-level HV Stakeholder*

"You know, being a new mom, even that alone, if that's your only criteria…that's a huge thing that you need some extra support for…if we hadn't had some unique situations we probably wouldn't have made the list, yet we still are vastly benefiting from it." *—Parent Participant*

4

Current Home Visiting Quality and Areas for Improvement

In assessing areas in which Oregon's HV system needs to improve in terms of the *quality* of services delivered, parent and state program stakeholders were asked specifically about the ability of the current system to provide quality services to: (1) culturally and linguistically diverse families; and (2) families with Substance Use Disorder (SUD). These findings are summarized below. Additionally, we identified and incorporated the limited data available related to the training and supervision needs of the HV workforce, and information about family retention in services. Finally, parent focus groups included questions that addressed families' perceptions that services were (or were not) culturally-responsive.

Improving Programs' Ability to Provide Culturally Responsive Services to Culturally and Linguistically Diverse Families

In addition to the issues described previously related to lack of adequate identification and enrollment of some racially and linguistically diverse families, state leaders shared their perspectives about the quality of the current services being provided to these families, and ideas for strengthening quality in this area. Interview questions focused on how to better improve the quality of services being provided to Oregon's increasingly culturally and linguistically diverse families. Parent focus group questions asked how HV programs had "incorporated their family's traditions or beliefs into their home visits" and whether their home visitor "shared something about parenting or taking care of your baby that was new or different from what is more traditional or typical in your family" (both positive and negative examples).

Parents' Experiences of Culturally Responsive Home Visiting

Parents described ways that programs were incorporating or showing respect for their cultural and family traditions. This included both more general descriptions of respectful services, as well as some specific examples of using culturally-responsive approach, such as the use of a worksheet and activity focused on having the parent reflect and share family traditions and values, and of supporting the mother to communicate about their culture with her children:

"In the beginning of our home visits, she had done a little worksheet with us on what our family's values and goals were. And she likes to stick with those and ask us how those are progressing or give us ideas if we get stuck on that. So she's been extremely conscientious about working with us on what we value and I really respect that." *—Parent Participant*

"Sometimes I don't know how to tell what we believe in to my kids, you know. So my home visitor, she brings books to read [with my] kids about our traditions…That's what I like about her, you know…She brings different books to talk about 'Okay, this is you.'" *—Parent Participant*

"Vivo con mi mamá y mi papá. Entonces mi mamá tradicional es como la segunda mamá de mi niño. Mi mamá, es la que sí cuida a los niños, tiene más enfoque en los niños. La enfermera viene y, nos pide a las dos la opinión, porque sabe que yo adoro la opinión de mi mamá. Entonces nos acepta eso y habla con las dos al mismo tiempo, nos incluye a las dos del lugar. A veces dice uno, usted es la mamá y tú debes estar haciendo todo este. Y en parte ya no se incluye y entiende la cultura de nosotros. Sé que mi mamá solo es la abuela, pero tiene un rol más grande con este niño."

"I live with my mom and dad. So my traditional mom is like my child's second mom. My mom is the one who does take care of children, she has more focus on children. The nurse comes and asks us both for our opinion, because she knows that I adore my mother's opinion. So she accepts that from us and talks to both of us at the same time."—*Spanish-speaking Parent Participant*

A number of families provided more general descriptions of services as being respectful of family dynamics, traditions, and values. Some parents shared that their visits have a tone of respect for the family's values, and for different parenting styles of various caregivers in the family (e.g., mother and father with different beliefs about discipline). Another strategy that reflected the value of respect for the family was described as a home visitor practice of first checking in with the parent before presenting activities to the family:

"...When she tried to introduce new stuff she would always ask, 'Are you guys okay with me trying to talk about this?' That's something she would always do...Before she would bring it in, or start talking about it, she would ask my opinion...She was never pushy."—*Parent Participant*

"[My HV was] always really good at the beginning of the session, saying 'Hey, these are options that we have for today. Is there anything that you need to talk about or anything that you want to do specifically, and if not, these are things that we can do. What are you interested in?' Kind of really letting me direct things." —*Parent Participant*

Another parent shared that their home visitor had the same bicultural family background that they did, and that this opened up an opportunity to share issues related to being in a bicultural (Mexican and White) family.

"My home visitor is also bilingual, so she knows some of the different background traditions and things that are different ways. My kids are Mexican and so she's able to incorporate all that with you know my side and his side. It's helpful because you know the grandparents always have something to say, and so it's two different beliefs and so she's able to relate with all of that." —*Parent Participant*

Parents shared several examples of learning things that were different from the way they had been parented themselves, and which helpful to them in raising their own children:

- Ideas for creative play and activities to stimulate children's development; and
- Learning new ideas about and helping parents to problem-solve parenting challenges.

Spanish-speaking parents, in addition to the themes described above, also mentioned the following as important ways that home visitors showed support for their family:

- Including all family members, including grandparents and/or older children if present, in the visits; and
- Being respectful of the family's religious beliefs, and asking the families whether or not they felt comfortable with a given topic.

"Somos católicos y si ella me platica algo que a mí no me agrada escuchar, los digo y ella me entiende. Entonces pues ha sido muy, muy fuerte la manera en que ella sí me ha apoyado. Me da lo que necesito y eso me agrada bastante, me ha ayudado bastante."
"We are Catholics and if she tells me something that I don't like to hear, I say it and she understands me. So, the way she has supported me has been very, very strong. It gives me what I need and that pleases me a lot, it has helped me a lot."
—*Spanish-speaking Parent Participant*

Parents in both Spanish language focus groups also shared extensively about how spanking as a form of discipline is a much more common practice in the cultures in which they were raised, but that they appreciated the support they got from home visitors in developing new strategies for discipline. They described home visitors as helping them to find patience, and helping teach them ways to correct their children using other, non-physical strategies.

"En mi pueblo somos criados a puro puro golpe. La mayor parte del tiempo, desde que ya hiciste algo y van a ver golpes. No es necesario recurrir sólo a eso, y hablando con más palabras, con más calma, todo mejora y entienden más. Entonces, eso me ha metido mucho en mi cabeza de que no es lo principal que debe recurrir. Lo he borrado, se ha alejado de mi familia."
"In my town we are raised by sheer blow. Most of the time, since you've already done something and they're going to see hits. It is not necessary to resort only to that, and speaking with more words, more calmly, everything improves and they understand more. So that has gotten into my head a lot that it's not the main thing to turn to. I have erased it, it has moved away from my family."—*Spanish-speaking Parent Participant*

"Es muy similar a todo lo que ellos dijeron. ¿Tenemos las mismas tradiciones, verdad? Todos somos hispanos, somos lo mismo. Venimos de eso, de que pegamos mucho y venimos aquí intentando mejorar. La verdad es que hacer eso (hitting) no es bueno. No es bueno para nadie."
"It is very similar to everything others said. We have the same traditions, right? We are all Hispanic, we are the same. We come from that, we spank a lot and we come here trying to improve. The truth is doing that (hitting) is not good. It is not good for anyone." —*Spanish-speaking Parent Participant*

Support for mental health was also described as something that is not a part of these parents' traditional culture, where it is more common to not bring up or talk about depression or other issues. Several Spanish-speaking parents shared how they appreciated the support from their home visitor in helping them to normalize their feelings of depression, and to support them to seek additional help without feeling stigmatized.

Need for Increasing the Cultural and Linguistic Diversity of the Home Visiting Workforce

There was a strong consensus among state leaders that the state has work to do to better recruit and train a culturally and linguistically diverse workforce, although they noted that a few programs in specific counties have a strong history of successfully engaging bilingual/bicultural Spanish speaking staff. Some shared that these staff are often considered highly marketable and more likely to leave their positions because of the low salaries paid to home visitors. Stakeholders again noted that a key role of local programs could be to develop ways to better identify, support, and train individuals living in those communities (including former clients) to become HV professionals, thus increasing the number of bilingual/bicultural individuals in the HV workforce "pipeline." In addition to noting the need to broaden the workforce itself, several stakeholders also mentioned getting frequent requests for more training in cultural competency and cultural responsiveness from programs.

Not having bilingual staff raises additional barriers to adequately serving linguistically diverse families, with stakeholders noting that having materials translated is insufficient to adequately serve these families, and working through interpreters is difficult in the context of deeply relational HV models. These stakeholders clearly reflected an awareness that **translation is a necessary but not sufficient part of delivering quality HV**.

"Retaining staff is a complicated issue of why staff stay and why staff leave but we can better meet these needs by having staff that mirror those families and speak those languages. It's cultural too. We had a hard time retaining [culturally specific African American] staff for the same reasons. As soon as a staff person got the right education and experience, then their world opened up of what they could be doing. You really can't pay them $12 an hour to do Child Abuse Prevention in Oregon, which is what we were doing, unfortunately. Then we didn't retain the staff. It's hard to serve African American families without the staff that really understand that experience."

—State-level HV Stakeholder

Only about two-thirds of Oregon's home visitors reported sharing a common primary language with the families they serve.

Quantitative data that describes the racial and linguistic diversity of HV program staff in Oregon is not widely available. State-level programs do not keep information about the HV workforce in any systematic way at this time. This is a clear gap in information that could help support and inform efforts to diversify the HV workforce more broadly. Some limited information is available through the Region X Workforce study, which found that among Oregon's home visitors (including White home visitors) **slightly less than half reported sharing a common race, ethnicity, or culture with families on their caseloads**.[11] Only about two-thirds (63%) reported sharing a common primary language with the families they serve.

This survey also collected information about the number of home visitors who speak Spanish, finding that 13.4% reported speaking Spanish, and even fewer supervisors reported speaking Spanish, 11.1%. Within one of the largest HV programs in Oregon, HFO, about 25% of families speak Spanish, indicating a clear gap in the ability to serve these families in their native language.[11]

Successes & Challenges in Engaging & Retaining Culturally Diverse Families in Home Visiting Services

Another way to examine the current ability of HV programs to meet the needs of culturally and linguistically diverse families is to look at family engagement and retention information. While currently in Oregon there is not consistently available data for most HV programs that tracks program acceptance or retention rates, one exception is for the statewide Healthy Families Oregon program, which is required to collect and analyze acceptance and retention information on an annual basis. The most recent data available are shown in Table 7.[9] As can be seen, slightly more than two-thirds of families who are screened and determined to be eligible for HV agree to participate in services, and participate in a first home visit. Latinx families are the group most likely to accepted, compared to White families and families with other racial/ethnic backgrounds. Further, Spanish-speaking families are also more likely to accept offered services. Retention rates similarly suggest that Latinx and Spanish-speaking families are more likely to remain in services as well, with 84% of Latinx families staying in the program for at least 12 months, compared to other families.

Table 7. Healthy Families Oregon annual program acceptance and retention analysis

	Primary Caregiver's Race/Ethnicity			Primary Language Spoken at Home		
Program	**Latinx**	**White**	**Other Race**	**English Speaking**	**Spanish Speaking**	**Total Statewide**
Accepting Home Visiting Services	60%	51%	45%	49%	65%	69%
Retained for at least 12 months	84%	69%	65%	85%	68%	72%

Meeting the Needs of Families with SUD

Questions were included in the interviews with HV state leads to learn more about how HV services are supporting families with SUD issues. In addition, we interviewed key state-level staff [a] who work closely with the SUD treatment system as well as the DHS-Child Welfare Parent Advisory Council (many of who have lived experience with the SUD system). The findings below summarize the perspectives of these groups of stakeholders. State HV leads generally felt that home visitors and supervisors are knowledgeable about available resources in their communities, while noting that there was considerable variation from county to county in the quality of partnerships between HV programs and SUD treatment/recovery services, and the depth of understanding among home visitors about how to effectively support parents in need of treatment. State SUD leads shared that they do not feel knowledgeable about HV services or how home visitors work with families around SUD issues. However, they felt that having community-based providers doing SUD screenings and treatment is good for children and families. HV and SUD stakeholders both shared that programs and staff working in the Portland metro region generally had more access to and knowledge of treatment resources than in other parts of the state.

"Actually, I think as a program each of the program sites does have a good rudimentary understanding of what [SUD] resources are available…They're certainly not experts, but I think they're quite capable of getting that information."

—State-level HV Stakeholder

Overall, HV and SUD stakeholders described a number of ways to strengthen the capacity for HV programs to meet the needs of families struggling with SUD issues: (1) increasing home visitor skills; (2) increasing home visitor knowledge about the dynamics of SUD, treatment, and recovery; (3) increasing the quality and depth of supervision related to SUD; and (4) developing strong partnerships between the SUD and HV systems.

Increasing Home Visitor Skills

A number of HV stakeholders commented on the fact that the career trajectories for many home visitors emphasizes child development and parenting, and doesn't equip them with skills or expectations about how to work with parents with SUD, mental health, or other serious adult-focused challenges. Several also noted the "fine line" in defining the role of the home visitor and felt it was important to recognize the boundaries and limits of what is expected of them in regards to these issues.

"It's a complex field, substance abuse and recovery, and it's a whole field into itself. And so for home visitors, after a year of training or so, to really be able to say recognize where somebody is in their kind of path of abuse and recovery or, you know, preparedness for recovery, where they are, I would suspect that it's pretty difficult for home visitors."

—State-level HV Stakeholder

HV and SUD stakeholders also described the need for ongoing training and skill development focused on support for families with SUD. Ideas included: (1) increasing knowledge about identifying and supporting "stages of change" or motivational interviewing skills; (2) providing opportunities for home visitors to receive Chemical Dependence Counselor Assistant (CDCA) certification; and (3) trauma and crisis intervention training. One HV stakeholder noted the importance of increasing these skills so that home visitors would be better equipped to continue engaging with parents who are actively using so they could be there to support the children and ensure the children's safety:

a Interviewed three statewide leaders in the SUD system in Oregon, and conducted one focus group with the Parent Advisory Council to Oregon's Department of Human Services—Child Welfare (8 parents from across the state with lived experience with SUD/recovery and child welfare involvement).

"I think the state of mind that parents are in when they're using is that they're not in the right frame of mind to necessarily make the best choices and home visitors, I think, have some distinct challenges in ensuring truly that the children at the heart of this family situation are safe and I would imagine there's plenty of times where they're not always able to keep connected to the family enough to know what's going on and if the children are safe and thriving." *—State-level HV Stakeholder*

SUD leads also thought that it would be important for home visitors to have motivational interviewing skills and an understanding of treatment readiness (i.e., stages of change). According to the Parent Advisory Board, home visitors should not expect that by making a referral parents will follow through. To this end, connecting home visitors with Recovery Mentors or other service providers with lived experience could be helpful. Moreover, one SUD leader suggested trauma or crisis intervention training (e.g., Psychological First Aid) could help home visitors prevent crisis situations and connect parents to services.

Increasing Home Visitor Knowledge of Dynamics of SUD, Treatment, and Recovery

SUD leaders noted that home visitors coming from early childhood, mental health, medical, or counseling backgrounds might have a poor understanding of SUD. In particular, the Parent Advisory Council thought that it would be difficult to have "natural" conversations with parents about SUD, especially if they do not have lived experience with, or at least training and some degree of understanding of, SUD issues. One HV leader expressed a similar concern:

"I think that this is an area that we often hear every year that home visitor supervisors and staff really want more information on. So, [they] want more knowledge of what services are available, but also want more training and personal knowledge to be able to speak to substance use treatment and recovery. It's not something that our home visitors often feel very comfortable discussing." *—State-level HV Stakeholder*

SUD stakeholders suggested that without an understanding of SUD, home visitors may hold bias toward parents struggling with substance use. When HV stakeholders were asked whether they felt home visitors' ability to support families with SUD was influenced by existing biases related to their perceptions of parents who abuse substances, perceptions were mixed.

"The knowledge of substance use disorder has expanded dramatically…but there's still embedded beliefs systems that don't understand or believe that substance abuse disorder is actually a clinical biological disorder. It's not a choice. So, there's still challenges with people's belief system…those parents still want to be good parents to their children in spite of the fact that they have their own issues too that need to be dealt with." *—State-level SUD Stakeholder*

Increasing Quality and Depth of Supervision and Support Related to SUD

In describing the importance of supervision, HV stakeholders noted how reflective supervision could be used to effectively work through implicit biases held by home visitors about parents using substances, as well as help support home visitors to understand and deal with their own emotional reactions to working with parents who are at different places in their recovery. At the same time, HV stakeholders noted that supervisors themselves are not consistently knowledgeable and skilled in SUD issues and recovery, another area for improvement.

"I think it probably comes up a lot [implicit bias when working with SUD involved families], and I think that said, unless that there are supports for that home visitor in terms of their own reflective supervision and professional development those pieces that it could impact the relationship that they're having with that family and the work that they're doing should be something that we continue to focus on." *—State-level HV Stakeholder*

SUD leads agreed that practice supports through supervision, and even having a multidisciplinary team to provide additional support, would be beneficial for home visitors. One HV leader suggested something similar:

"[the home visitor is] the one person that visits the home so they have that relationship where a family might disclose some of these [challenges] that they're facing. And then the responsibility to support that family and accessing services falls to them rather than a team of support. And so I think that that's a challenge. They have such a great task in being that one support for that family and trying to help them navigate different systems and follow through with referrals and accessing other services, I think, is a challenge."
—State-level HV Stakeholder

Developing Stronger Partnerships between Home Visiting and SUD Systems

A final way to strengthen the ability of HV programs to meet the needs of families with SUD is to increase coordination and connection between HV and SUD systems. Lack of partnership was noted as a problem at the state and local levels. Stakeholders felt that by increasing connections between the two systems and intentionally identifying areas for potential integration of services, there could be significant improvements to ensuring comprehensive, effective support for families struggling with SUD. At both the state and local levels, HV stakeholders shared their perceptions that there was little knowledge of HV services among SUD treatment providers, which was seen as a missed opportunity to partner to ensure more effective treatment and recovery.

"But I think at the state level and at the local level, we really need to make sure we're fully engaging our partners you know, in substance use, in housing, in all the other kinds of supports that the families who typically receive home visiting services also connect with and how might we better organize ourselves to make sure that the early childhood system really is comprehensive and seamless and family centered."
—State-level HV Stakeholder

HV leaders felt that the level of knowledge among treatment providers about HV was likely to vary considerably by county, but noted that there was no system-wide effort to develop or address coordination between these two service systems. Most felt the level of coordination was low, and noted that this was reflected at the state level.

Efforts to build these connections could emphasize the important role that home visitors could play in supporting the parent with treatment readiness, accessing treatment, during treatment, helping to stabilize the family and address emergent needs, and continue to work with the parent to maintain positive parent-child relationships during and after treatment. The role of home visitors during transitions from inpatient to outpatient, and/or from not having custody of their children to actively parenting again while in recovery were also noted as important for contributing to long-term effective SUD treatment. Substance Use Disorder leadership pointed out the importance of supporting parenting during all stages of SUD:

"You have to understand the generational trauma….you get people who love their children and want to parent but don't know how…The system fails in that, 'here's residential treatment. There. Done. Okay, now let's give them back the kids expect them to do this, that, and the other.' No. They're not always ready for that." *—State-level SUD Stakeholder*

State HV stakeholders felt it would be important to do more outreach and education of treatment providers about this potential supportive role. One SUD leader suggested that HV programs should be part of their local Alcohol and Drug Advisory Planning Committees so they develop a "working relationship with other community partners" and "know the work that these other community partners do."

"[SUD providers] would benefit from knowing what the role of a home visitor is and that this is like a unique opportunity to meet families where they're at and like have a partnership with someone who has this established relationship that might be able to reinforce the work that is happening because a lot of our own visitors are really skilled in motivational interviewing which is super helpful when it comes to substance use disorders." *—State-level SUD Stakeholder*

It is important to mention that contributing to the lack of partnership is a lack of available prevention, treatment, intervention, and recovery services, and in particular services designed to support pregnant women and parents with children (see section on SUD Capacity). While stakeholders noted that MIECHV-funded staff are required to do screening for SUD, many programs do not have a similar requirement, so may not be identifying families in need of support. At the same time they noted that screening without having referral resources in the community is a frustrating experience for home visitors.

"There's four inpatient treatment facilities that allow children in the entire state or something. So, it's just abysmal. I would say that the resources in rural areas, it's just almost nothing."
—State-level SUD Stakeholder

One HV stakeholder talked in detail about the tremendous potential that bringing HV services to families who are dealing with SUD can have on increasing family preservation and avoiding out-of-home placement as well as on providing supports to parents transitioning from inpatient treatment to transitional housing or home—this latter was described as an especially important link in the supports for families with SUD that is currently lacking.

"What I'd like to see more of is programs where when a family is identified as having substance issues, we're keeping the family unified…The home visiting and other services are all wrapped around that family and they have the treatment right on site and these housing complexes and just trying as many strategies as we can to keep the parents in the right mindset and children who are attached to their parents." *—State-level SUD Stakeholder*

Finally, one home visitor shared a story of how HV services effectively supported a family in which the mother had lost custody of prior children because of her struggles with substance use disorder. This story was shared by a home visitor working with the Family Spirit program, Oregon's only culturally-specific evidence-based HV program for American Indian/Native American families:

"I have a mom who had an open [child welfare] case and she has seven children and has lost all seven children. And while participating in the home visiting program she gained one of her children back. And then three, four months later, another one was reunited and then three or four months later, another two were reunited. So she ended up getting four of her seven children back. The first three were permanently adopted out before she got engaged in home visiting. And so they were promptly adopted out. But she went from living in an inpatient drug and alcohol treatment facility to now having four of her kids reunited back to her, graduating drug and alcohol treatment and living in her own apartment and now working towards buying her first house." *—State-level HV Stakeholder*

Substance Use Disorder leaders called out Parent Mentors, also known as Recovery Coaches, as a SUD service particularly compatible with HV services in that they also work "in the field." An SUD leader felt the combination of support for SUD and parenting could help parents better identify their needs and advocate for getting those needs met.

Building Quality Home Visiting Through the Workforce

Additional Training Needs

Several recent surveys of home visitors in Oregon examined workforce issues such as training needs, supervision quality, and compensation and educational background. The first, and largest, was conducted as part of the Region X MIECHV Innovations Grant.[11] This survey included 186 Oregon home visitors across multiple models and funding streams, as well as 63 supervisors. A key finding from this survey was that while most home visitors report having taken coursework in child development (73.5%) and family health and well-being (66.5%), fewer home visitors report taking specialized coursework in working with families or children with special needs (34.3%). However, professional development offers an opportunity to fill in gaps in home visitors' formal coursework; for example, 76% of home visitors report participating in professional development training on families or children with special needs.

Oregon's MIECHV Oregon Retention Evaluation[12] captured data related to the MIECHV-funded workforce and included staff perceptions of their level of confidence and training specific to working with families with substance use, mental health, and Interpersonal Violence. A survey was conducted with 59 MIECHV-funded home visitors (representing about 80% of the MIECHV-funded home visitors). Results found that:

- 67% of home visitors indicated that they would benefit from more training in addressing parents' MH concerns;
- 80% felt the need for more training in substance abuse concerns; and
- 71% for more training in intimate partner violence (IPV).

Many also felt they would benefit from additional experience in conducting assessments related to these issues. Only 31% of those surveyed were "very confident" in their skills at assessing parents for MH issues; 19% were "very" confident assessing for SUD issues and 20% were "very" confident assessing for IPV issues. This reflects an ongoing challenge in strengthening the home visitor workforce to build their capacity to support families with these complex issues. Finally, while most home visitors reported having at least some training in Motivational Interviewing (MI), 12% had never been trained in this approach. When asked how they would describe their proficiency in using M, I 49% self-described as being either a "novice" or a "beginner;" 44% described themselves as being 'intermediate" in experience, and only 7% reported that they felt they had "advanced" level skills.

A similar survey conducted with 50 home visitors across multiple models in mostly rural Southern Oregon also identified the need for more training related to helping families address more challenging issues such as mental health and SUD.[13] In this survey, over half (52-58%) of home visitors reported a desire for more formal training in how to address parents' mental health challenges, how to support parents with SUD, and how to support families with IPV.

Strengthening the Quality of Home Visiting Supervision

Supervision, and specifically, reflective supervision, is a key aspect of successful HV practice, as well as for retaining home visitors in the workforce. The Region X workforce survey asked a series of questions about the quality of supervision being received.[11] These results showed that 78.5% of home visitors agreed that they have a trusting relationship with their supervisor and 68% agreed that their supervisor help them to be reflective, while only 62.6% agreed that their supervisor helps them explore cultural considerations in their work. It should be noted that this survey included programs that require reflective supervision specifically, as well as those that do not.

In southern Oregon, 69% of home visitors reported participating in reflective supervision, considered the "gold standard" for supervision for home visitors.[13] At the same time, results also found that supervisors could benefit from additional support to increase their ability to support home visitors to address families substance abuse and mental health issues. Only about a third (34%) of home visitors reported that the supervision received related to families' mental health challenges was "always helpful;" 31% reported that supervision for family substance use/abuse was "always helpful" and some more (40%) reported IPV-related support from supervisors was always helpful. Perhaps even more striking was that about one-fourth of home visitors reported **they did not receive any supervision** in any of these topics.

Supervision that is experienced as emotionally and professionally supportive" may also improve home visitor job retention. A small qualitative study conducted as part of the MIECHV Region X Innovations grant found that workers who left their position during the 18 months of the study reported that additional supervisor and organizational may help improve staff retention, specifically noting that more reflective support and supervision, greater organizational flexibility, and broader organizational and community appreciation of the work of home visitors may be particularly important.[11] A number of these home visitors described the supervision they received as oriented towards task management, rather than on supportive reflection.

Improving the Workforce through Increasing Home Visitor Compensation

State-level stakeholders felt that one of the biggest challenges in recruiting and retaining a qualified HV workforce was the relatively low rate of pay provided for HV. Especially for home visitors with specific skills such as speaking multiple languages or being nurses, and in particular in frontier and rural areas, the problem of low pay was repeatedly emphasized. The Region X Workforce Study collected some information about home visitor compensation across program models, including wages and benefits; these data largely back up the idea that home visitors are not adequately paid for the high level of skilled work they are being asked to provide.[11] The majority (68%) of home visitors reported earning less than $20 per hour, with 12.4% reporting earning less than $15 per hour. Additionally, there are disparities in pay across ethnic groups, with Latinx home visitors making on average $18.46 per hour and White home visitors making on average $22.30 per hour. Despite low wages, most did report having adequate health benefits (96% receiving health insurance; 93% receiving dental insurance, and 80% receiving vision insurance) and paid vacation and sick leave (over 94%). About three-fourths reported having employer contributions to retirement and employment related life insurance benefits. Far fewer reported paid family leave (less than 40% of home visitors, and only 22% of supervisors). 43% reported either never having gotten a wage increase or not having a wage increase in more than a year.

The MORE study showed that, when a number of program, home visitor, and family characteristics were used to predict family retention (length of enrollment), that controlling for other factors, families were more likely to stay enrolled if they had (1) more children in the household; (2) home visitors who reported more active engagement activities during the first 90 days of enrollment (e.g., doing family goal planning, frequent contacts, provision of material goods) and (3) whose home visitors reported receiving more organizational and supervisory support (e.g., regular supervision, support for professional well-being).[12]

Building Coordinated Home Visiting Systems: the Role of Universal Home Visiting/Family Connects

In historic early childhood legislation in 2020, Oregon lawmakers authorized funding to begin a phased implementation of the evidence-based Family Connects (formerly Durham Connects) universally-offered HV model.[14] This model, known as locally as Family Connects Oregon (FCO), is designed to provide brief

(up to two visits) home visits to all families immediately after birth, and to assess and refer families as needed to additional HV or other services. In Oregon, universally-offered home visits were seen as a mechanism both for increasing capacity to identify and support families, but also as a way to strengthen the HV system by having common point of entry for families with newborns into a coordinated HV referral system. Eight regions, encompassing 18 of Oregon's 36 counties, were funded to be "Early Adopters" for the first phase of implementation. Prior to implementation is a community alignment phase, during which programs come together and create a plan to coordinate across existing HV programs. It is worth noting that the effort to pass legislation to fund FCO was met with significant resistance to what was perceived as the state's effort to mandate HV for all families. This led to the revision of language and messaging about FCO, from simply "universal home visiting" to "universally-offered home visiting," to emphasize the voluntary nature of the service. For simplicity, in this document we refer to FCO as "universal home visiting."

In addition to HV and SUD statewide leadership interviews, the research team conducted a case study of FCO implementation in Malheur County. Two HV leaders and 3 SUD leaders were interviewed, 5 home visitors participated in a focus group, and a research team member participated in a HV Network meeting (8 HV leaders and providers attended), the county's primary mechanism for information sharing and HV case staffing. Key findings are summarized below; for additional detail related to Malheur County, see Appendix B, Malheur County Case Study.

Key Expected Benefits of Universally-offered Home Visiting

While service delivery under the FCO program will not start until January 2021, stakeholders shared their thoughts about what they hope will come from this statewide effort.

1. **Strengthen community awareness of HV,** both among the general population and community partners (other HV services, medical providers, and other auxiliary service programs). The hope was that HV would become part of the normative postpartum standards of care, thereby increasing the acceptability of HV services, creating community support for funding, and for health insurance providers to pay for HV services.

> "...especially with this FCO community alignment process, my hope is that all the providers, all the community members will be talking about it, thinking about it. And, that the referral process will be strengthened even in pregnancy...and then post postpartum, that will have this larger group of people...that would have been missed." *—State-level HV Stakeholder*

2. **Increase receptivity to extended HV services.** Some stakeholders hope that FCO will help "open the door" to longer duration HV by allowing families to see, under relatively low-commitment circumstances, that extended HV can be supportive. One Malheur County HV stakeholder described HV as "the most effective way to help parents" because it is relationship-based and it takes place in the privacy of their own home. Increasing access to HV services would allow families to "recognize that we're not judging, we're not doing this because we don't think they know, but because we really want to support them and help them."

3. **Improving referral pathways and coordination across HV programs.** There is also the hope that FCO will help improve the systems for integrated, coordinated referrals across HV models at the local level. As noted previously, there are currently only a few, locally-isolated models for doing coordinated referral for HV, and these efforts still struggle to engage the broader community. FCO was seen as a major step forward in providing a mechanism and model for strengthening this system. One challenge identified is that FCO operates in the postpartum period, and therefore wouldn't specifically increase coordinated referrals for pregnant mothers.

> "The best-case scenarios [with Family Connects] would be that we would see an increase in referrals, see an increase in overall and collaboration with health departments and sort of closer relationships with them, which I am convinced would benefit families and services..." *—State-level HV Stakeholder*

One statewide stakeholder also mentioned that FCO could help improve identification and referral into Oregon's program to support families with children with special health needs:

> "...universally offered home visiting may also be able to identify babies and siblings of babies that go through the program who can be referred to the CaCoon program or to other home visiting programs." *—State-level HV Stakeholder*

A Malheur County stakeholder said that HV can be "an introduction to public health services and just referral to all the other community services that are available to them." Although geographically large, Malheur is a frontier county with only 3.2 people per square mile. With such a small population, a single supervisor at the county health department is the primary conduit for cross-program referrals, and case staffing takes

place during a monthly HV Network meeting. Should there be a marked increase in the number of families identified through FCO, home visitors noted that they may need to expand their current system (add staff, increase the length or frequency of the HV Network meetings).

4. Increase available data and understanding of community needs and resource gaps. A hope is that FCO will facilitate data collection that could illustrate gaps in available resources and family needs. By conducting systematic assessments with families to identify needed referrals and tracking which services are/are not available in communities, stakeholders thought these data could be used to "make a case" for where additional resources were most needed across the state. This would require the development and implementation of a robust database, and for FCO staff to reliably track families. However, community resource mapping could be beneficial if individual-level referral tracking is not feasible.

"I'm looking forward to having numbers [about family needs]. We can talk about anecdotal information, like 'There aren't enough mental health supports for families' kind of thing. And I do believe that that is true, but we can't really quantify it [now]. Then we can take it to our state legislature and say this is an unmet need in our state and we need to fund it."

—State-level HV Stakeholder

Challenges with Family Connects/UHV

While numerous potential benefits of FCO were identified, stakeholders also noted challenges including (1) system readiness; (2) family readiness; (3) program overlap and coordination; and (4) workforce capacity.

1. Home visiting system readiness. Statewide stakeholders noted that communities vary considerably in their history of HV program coordination. Several noted that the community alignment phase was unfunded, and thus the extensive planning work required was not adequately resourced. Indeed, with only one staff working on FCO implementation in Malheur County (which was interrupted by the COVID-19 pandemic), the unfunded community alignment phase made it difficult to make progress. Stakeholders also noted that without a careful planning process, more silos in HV services, rather than fewer, could develop if implementers "get stuck on meeting the requirements of whatever has been put in front of us" and they "lose touch with the real purpose of it."

2. Family readiness and community norms. As described previously, many families still see HV as government intrusion, and have little trust in HV programs to provide support. Coupled with the stigma that HV is only for those at-risk or in need (e.g., low income), this will continue to be a barrier until the idea of home visitation becomes more normative across the state. In Malheur County, HV stakeholders described how people in their community have a "cultural orientation that family should take care of family" and that "you shouldn't have strangers helping you."

3. Existing programs and coordination. Oregon, like many states that have implemented different HV models through state and local agencies, has a history of "competition" between programs. Work has been done to create a sense of shared commitment to a system of HV programs, thereby mitigating many of these issues. Nonetheless, statewide stakeholders named "politics of service providers" and programs feeling "protective of their turf" as a potential barrier to FCO success. In particular, some noted the importance of connecting FCO to the other major HV program that does in-hospital screening and referral (Healthy Families Oregon). Interestingly, this was not a barrier named in Malheur County, a rural community with a very small population. HV stakeholders reported that they work together to find the best program for families rather than compete for them.

4. Workforce challenges and gaps. Finally, the FCO program requires that home visitors be nurses, and a twofold concern that (1) local communities would have difficulty recruiting and retaining nurse home visitors for FCO positions; and that (2) the need to fill these positions would exacerbate existing workforce shortages for public health nurses. One statewide stakeholder expressed concern about attracting nurses to HV because the "pay scale is not comparable to what they would make in another nursing profession or professional job." Not surprisingly, expanding the HV workforce in rural and frontier communities, and in terms of culturally-specific home visitors, was seen as especially challenging. It is noteworthy that these HV workforce issues were not named as a challenge in Malheur County.

5 Capacity for Providing Substance Abuse Treatment, Intervention, and Prevention Services in Oregon

The next section of this needs assessment summarizes data related to Oregon's current capacity to provide substance use disorder (SUD) treatment, recovery, and prevention services to meet the needs of pregnant women and parents with young children. To compile these findings, we first reviewed existing documents and related needs assessment describing SUD systems in the state. Second, we interviewed key state leaders representing the SUD system. Finally, we obtained the limited available data on current SUD services being provided to pregnant women and parents with young children. Results are described below.

Overview of SUD Treatment and Intervention Services

OHA delivers substance use disorder intervention and treatment services through a coordinated care model, in which each of 15 contracted Coordinated Care Organization (CCO) provides services for its members. Substance use disorder treatment is a required service, including outpatient, residential, gender- and culturally-specific, and specialty services such as medication-assisted treatment (MAT). The treatment providers are licensed and/or certified by OHA in order to be eligible for reimbursement either indirectly, through their CCO, or directly through the Oregon Health Plan's fee for service. Treatment providers are also required to provide services to priority populations, including intravenous drug users and pregnant women, within a specified time frame.

Oregon has 475 outpatient locations, 13 detoxification facilities, and 64 residential programs run by 158 provider agencies.[15] The 2018 National Survey of Substance Abuse Treatment Services (N-SSATS) helps paint a picture of the types of SUD treatment services provided. Based on 229 participating substance abuse treatment facilities, 86% of these facilities are private (130 non-profit and 66 for-profit), and the others (33 facilities, or 14%) are operated by local, state, federal, or tribal entities.[16] The vast majority offer outpatient treatment (89% provided regular, intensive, day treatment, detoxification, and/or MAT such as methadone or buprenorphine maintenance or naltrexone). Most of the facilities (86%) accept Medicaid for payment. Fifty-eight percent of these facilities reported having specific programming for adult women, and 24% (54 facilities) reporting having programs tailored for pregnant and postpartum women.

Fewer than 1 in 4 substance abuse treatment facilities in Oregon provide programs designed for pregnant women and families with young children.

Overview of SUD Prevention Efforts

Oregon's alcohol and drug use prevention strategies include state and community interventions, public health communication campaigns, surveillance, infrastructure, administration and management functions. OHA's Public Health Department (PHD) has a number of sections working on prevention efforts in Oregon. The Health Promotion and Chronic Disease Prevention (HPCDP) section leads initiatives for alcohol, tobacco and marijuana prevention efforts, and the Injury and Violence Prevention Program (IVPP) leads opioid prevention efforts. Maternal and Child Health, Adolescent and School Health, and the

HIV Program coordinate and implement prevention programs and initiatives. PHD's substance use prevention sections coordinate with OHA's Behavioral Health Addiction, Recovery and Prevention Unit as well as other Behavioral Health program areas. Community-based prevention efforts (alcohol, tobacco, and other drug use) are underway in all 36 counties, nine federally recognized Native American tribes, and six Regional Health Equity Coalitions (RHECs). Screening, Brief Intervention, and Referral to Treatment (SBIRT) has been implemented in a variety of settings across the state with the goal of preventing, identifying, and reducing alcohol and drug use.

Prevalence and Scope of SUD Treatment Need

In the Oregon population aged 12 and older, substance use is relatively common—an estimated 58.5% used alcohol and 20.9% used illicit drugs in the past month. In the 18 to 25 age group, these estimates reached 62.7% and 36.0%, respectively. Among Oregonians aged 12 and older, 9.4% percent reported having a substance use disorder (SUD), and up to 17.2% in the 18 to 25 age group.[17]

Studies of families participating in HV programs suggest somewhat higher prevalence. For example, the Region X Workforce Study found that 14.8% of Oregon families had SUD issues according to home visitor/supervisor reports (n=186 home visitors and n=63 supervisors).[11] The most recent Healthy Families Oregon evaluation found that 12% of families who were screened for initial program eligibility self-reported having someone with substance use issues in the household.[9] However, of those families enrolled in HV, results of the more comprehensive family assessment conducted by home visitors indicated that 43% (n=650 families) had either current or past history of substance use concerns. Further, over one-fourth (29%) of mothers screened at birth scored as potentially at-risk for depressive symptoms, and 50% of those enrolled in HV had current or previous mental health issues.

Prevalence estimates are lower among pregnant women. Pregnancy Risk Assessment Monitoring System (PRAMS) data (based on surveys mailed to a statewide sample of mothers of babies born in 2017, n=1,473 respondents) suggest that 2.3% of women reported needing help with an alcohol or drug problem in the 12 months before their child was born. In terms of marijuana in any form, 9.0% used during their most recent pregnancy and 9.6% used since their child was born.[18]

Families involved in the child welfare system have higher SUD prevalence. Between 2014 and 2017, 3 in 4 child welfare cases had alcohol and/or drug involvement at the time children were removed from their homes. As well, 9.2% of children were assessed as having physical issues from being drug affected, and another 12% were determined to be drug exposed.[15] Methamphetamine abuse was named as "the greatest threat to child safety, and the primary drivers of children being placed in foster care once they come under the scrutiny of child abuse investigations."

Although estimates vary, evidence suggests that at least 10%—and perhaps ranging up to 50%—of pregnant women or parents with young children need SUD or mental health services.

Gaps in the SUD Service Delivery System for Home Visiting Service Populations

Oregon spends an estimated $6.7 billion on issues related to substance misuse, but less than 1% of that funding is used for prevention, treatment, and recovery. Instead, it is used to pay for the cost of social and health problems related to substance misuse and regulation and compliance with laws governing the sale and use of substances.[19] In the 2017-19 biennium, 81% of OHA's behavioral health services budget was allocated to mental health ($1.9B) and 19% ($430M) was spent on substance abuse treatment services.[15] Although there have been efforts in recent years to increase treatment capacity, there is an unbalanced continuum of care for SUD, resulting in untreated or misplaced individuals (accessing the emergency department, wrong level of care, multiple treatment episodes) and few aftercare and recovery support services.[20]

Unmet Need for SUD Treatment Services

Given how funds have been allocated for SUD services, it is not surprising that Oregon has significant SUD treatment gaps. In the Oregon population aged 12 and older, 8.9% reported that they needed but did not receive SUD treatment in the past year, and it ranged up to 16.5% in the 18 to 25 age group.[17] An analysis done by the Oregon Criminal Justice Commission estimated a SUD treatment need gap of 82-90% depending on age group (see Table 8).[15]

Within the same publication, the Commission also did a more recent analysis of 2017 Medicaid data and found that 8.2% of enrollees (70,304 members) had SUD, and of these 40.1% (28,214 members) received residential, outpatient, or primary care treatment services. The 59.9% gap has grown from 26.1% in 2011. Although it is difficult to estimate a precise SUD treatment gap due to data quality, changes in tracking systems, lack of data about privately funded treatment, etc., the Commission concluded that "the majority of people in Oregon who could benefit from some type of addiction treatment intervention don't receive it" (Commission Report, Appendix B, pg. 53).[15]

"The majority of people in Oregon who could benefit from some type of addiction treatment intervention don't receive it."

—Oregon Criminal Justice Commission Report

Table 8. Estimated SUD treatment gap 2015-16

Age Range	% Needed but did not Receive Treatment[1]	Population Count[2]	Treatment Count[3]	Treatment Count Gap	Gap %
12–17	6.14%	18,000	1,784	16,216	90%
18–25	16.83%	70,000	7,026	62,974	90%
26+	8.50%	233,000	42,289	190,711	82%

1 National Survey on Drug Use and Health (NSDUH) 2015-16.

2 Calculated by multiplying the population estimates for each age category (2015 single-year estimates from the U.S. Census Bureau) by the NSDUH Rate of needing but not receiving SUD treatment. Number represents the total number of people needing (meeting criteria for SUD) but not receiving substance abuse treatment.

3 Treatment counts including DUII and methadone clients taken from the Measures and Outcomes Tracking System/Medicaid Management Information Systems (MOTS/MMIS).

Pregnant and Parenting Women

The above analyses are based on all Oregonians, however. It is much more difficult to determine SUD treatment gaps for pregnant and parenting women. Medicaid claims data from 2019 show that 8.7% of women aged 18 to 55 who were pregnant or had children received some type of SUD treatment service (ranging from assessment or UA to residential treatment; 13,395 of 154,583 women).[21] If NSDUH estimates apply to pregnant and parenting women, treatment need could be closer to 16%, suggesting that nearly half of these women had unmet treatment needs. Focusing on pregnant women, 2017 PRAMS data shows that of those who reported that they needed help with an alcohol or drug problem in the 12 months before their child was born, approximately one-third (0.8% of respondents) did not receive it.[18]

In a study of Oregon Healthy Families Oregon clients, 5.2% of enrolled mothers (65 of n=1,425) accessed substance abuse treatment services within two years of receiving HV compared to only 3.7% (52 of n=1,405) of mothers not enrolled in HFO.[22] As described above, the proportion of families participating in HV services with SUD issues is approximately 15% based on home visitor reports, thus suggesting an even larger gap for a HV population (i.e., an estimated 2 in 3 mothers enrolled in HFO with SUD issues did not access treatment).

One statewide SUD leader explained that pregnant women are a priority population; thus, in theory they can access treatment services ahead of others. Further, these women have access to Oregon Health Plan coverage, which "at a systemic level ensures access to treatment for a lot of women." At the same time, there are not many treatment services specific to pregnant and parenting women in Oregon, and they face other barriers to access.

"...for outpatient treatment...they're [pregnant women, parents with young children] supposed to be prioritized and then... if they cannot get into the level of care that they need...all providers, they are required to connect them to interim services within 48 hours, and that includes things such as prenatal care...but then something I don't know about, and I'm pretty sure there is some systemic barriers to it, is better outreach to pregnant women who are homeless. And if they don't know, they don't have access to treatment. They also don't seek treatment." *—State-level Stakeholder*

Lack of Residential Treatment for Parents

Data from 2019 suggests that there are 13 residential treatment facilities in Oregon that allow parents to have their children, for a total of 375 slots for women, 10 slots for men, and 199 beds for their children (not as clients).[23] All of the facilities require that children are under the age of 10, and for nine facilities children cannot be older than 5 years old. Based on claims paid in 2018 (DSSURS data), 1,024 women aged 12 and older who received residential treatment services, with an average length of stay of 44 days.[23]

Statewide SUD leaders underscored the need for residential treatment beds for fathers and their children (less than 3% of the slots are for men with children, as described above). Furthermore, there is a lack of services to support the whole family—in addition to centers providing parenting skills training and beds for children to stay with their parents, there is only one residential treatment center in Oregon that serves the whole family together. Furthermore, social distancing needs due to the coronavirus has decreased the number of available beds and increased waiting lists.

"...that is a big service gap. A big service gap. It doesn't invite dads to pick up the role they need to and it doesn't invite... families to work together to create a whole healthy system for a child." *—State-level Stakeholder*

Only 13 of Oregon's 64 residential treatment facilities allow parents to remain with their young children.

Lack of Culturally-Specific SUD Services

Statewide SUD leaders noted a lack of culturally-specific treatment services in Oregon. Indeed, only 19% organizations specified that they provided culturally-specific services (43 out of 223 listed).[24] With communities of color experiencing the largest unmet need for SUD services and a range of disparities related to SUD (e.g., drug arrests and incarceration),[25] the importance of culturally-specific treatment delivered by diverse service providers cannot be overstated. Indeed, communities of color are underrepresented in Oregon's behavioral health workforce, and especially Hispanic providers.[26]

A statewide SUD leader also pointed out that the behavioral health system doesn't fully acknowledge the diversity that exists in Oregon, and therefore is not doing enough to serve all of the cultural communities. In this way, a lack of culturally-specific services is both a gap in Oregon's SUD system as well as a barrier to accessing treatment for people who prefer culturally-specific services.

"...people tend to...if it's culturally specific...to think about English and Spanish. Yes, like there are other underserved communities... especially like in the Portland metro region. And you often hear people say, 'Oh, like Portland has mostly white people'...But that's not true. There is this huge cultural representation and communities there but it's kind of like almost erasing those communities, which means there is probably like nobody doing specific outreach to them." *—State-level Stakeholder*

Fewer than 1 in 5 of Oregon's substance abuse treatment facilities provides culturally-specific services.

Lack of SUD Services Options in Rural and Frontier Counties

Oregon's population is 33% rural (1,390,536), with an additional 2% (93,887) residing in frontier areas.[5] Rural communities experience a lack of service options from treatment to recovery.[20] At the same time, rural communities are experiencing an increase in SUD, including overdose and fatalities as well as access to MAT.[25] Recommendations for pregnancy and opioids included a call for an increase in access to treatment programs for pregnant women and mothers, which is particularly challenging in rural and frontier Oregon.[27]

Exacerbating the SUD treatment gap is the difficulty of establishing a trained, stable workforce in rural and frontier areas of the state.[20] A study of the behavioral health workforce found that Eastern Oregon (mostly rural and frontier) had a consistent shortage of licensed behavioral health providers.[26]

Lack of Prevention Resources

It is important to note Oregon's lack of investment into evidence-based substance use disorder prevention programs. Less than 2% of state funding for evidence-based practices is used to pay for prevention programming. Moreover, evidence-based youth prevention programs are typically delivered at school settings and often do not focus specifically on substance use. To the extent that evidence-based prevention programs can prevent SUD, the lack of investment deprives Oregonians of opportunities to improve health at a significant cost savings.[25]

Lack of Aftercare, Recovery, and Ongoing Supports

Oregon lacks ongoing services focused on recovery and wellbeing.[20] Statewide SUD leaders, and the Parent Advisory Council in particular, named a number of gaps in services related to people transitioning out of treatment (aftercare, housing, etc.) and long-term recovery, especially where they can be with their children. They also discussed the need for wraparound-type services for an extended period of time in order to best serve families in the child welfare system.

"For addicted parents who get their life together to create skills and systems that work for a family, to then identify what they want to do [for work] and how they're going to support their family in that decision, it's about a two year [process]."
—State-level Stakeholder

Barriers to Receipt of Prevention, Intervention, Treatment and Recovery Services in Oregon

Oregonians face a number of barriers to the receipt of prevention, intervention, treatment and recovery services related to (1) fragmented systems, (2) stigma, (3) geography, (4) lack of support for families, and (5) insurance and reimbursement structures.

Fragmented Systems

According to statewide SUD leaders, the SUD service system is not well coordinated with behavior health, child welfare, HV, and other types of community-based services. For example, the Parent Advisory Council described how people with significant mental health experiences (i.e., dual diagnosis) are often discouraged from accessing SUD treatment until they are "stabilized," but also that they cannot stabilize until they have their SUD under control. Or, they are denied treatment because their behaviors are perceived as too extreme, underscoring potential treatment provider bias toward clients with significant mental health issues. People who have developmental delays are similarly caught up in the "runaround" and easily "fall through the cracks." A second example from a statewide SUD leader is that the child welfare system works independently from the SUD system, often with divergent and conflicting goals.

"I myself have said things that I believed about DHS until I educated myself and found that they were not true. I mean, it's hard to partner and we really should partner in the interest of the child when both sides don't understand each other's role."
—State-level Stakeholder

Another issue raised by statewide SUD leaders is the number of CCOs and the lack of communication and collaboration between them. When someone is ready for treatment, the services they need are not always available (e.g., no local beds in residential) and so they get placed on a waiting list.[20] Attempting to get the services they need outside of their CCO's catchment area can be overwhelming in time and scope, with statewide SUD leaders describing it as a "near impossible task."

Both resulting from and contributing to system fragmentation is unreliable public data collection systems and inaccessible private data collection systems (due to confidentiality) leading to an inability to track and assess the quality or appropriateness of service outcomes.[20]

Stigma

The stigma associated with substance use disorder is a deterrent for anyone seeking treatment or support.[15,20] It has also been reported that individuals presenting with SUD in primary care settings are stigmatized.[20] Statewide SUD leaders also noted that for those who are pregnant or parenting, the bias is compounded by a fear of child welfare involvement and/or removal of their children. As one statewide SUD leader commented:

"There's such a stigma that comes with it. So, I mean, if you look at the history of Alcoholics Anonymous alone. That was the man's game. Because women didn't seek [support]. Because we're nurturers, we're caregivers. We got drunk and died in secrecy. Then introduce the child into that mix. If I say I'm an alcoholic, then they will take my child. I'm not saying that ever out loud and that stigma is alive today. The threat of these consequences has always outweighed the benefits of this, because until you start to reap these benefits, you don't understand their value." *—State-level Stakeholder*

Geographic Barriers

Transportation and geographic mobility are barriers to accessing services. In remote areas of rural and frontier counties, accessing SUD services requires extensive travel. In terms of residential treatment, parents need to be able to quickly relocate, sometimes large distances away from family, or risk losing a bed when it becomes available.[20] In some cases, the full continuum of SUD services is not available in the local area, thereby requiring individuals to travel long distances to access the appropriate level of care.[20] The Parent Advisory Council described another type of geographic barrier pertaining the rural areas of the state that they termed "rural bias." They explained that people fear they will not get the proper SUD services from rural providers so they do not seek treatment at all.

Lack of Support for Families, Especially Fathers

The lack of residential services that allow parents to retain custody of their young children is a significant barrier. For parents (and especially fathers), the options for residential treatment are often to either have your children stay with family or friends while in residential treatment, or to allow child welfare to place children in foster care (see "Gaps in SUD Service Delivery System" above).

"So that is a huge service gap. Overall, the lack of beds for children with parents in the state of Oregon. It has been my experience that it creates a huge problem. When someone with an addiction problem is ready to go to treatment, they're ready. Something has driven them to make that decision. The window is small, small. You need to act right away and having horrific waitlists for children to get into treatment is not cohesive with how addiction should be treated." ***—State-level Stakeholder***

Participants in the Parent Advisory focus group advised that the SUD system would be strengthened if there were more treatment programs that allowed families to stay together and if there were more intensive outpatient treatment models that supported parents at a lower level of care, thereby allowing families to remain intact. This group suggested that ideally, parents would not have to go to treatment, but rather, much like a HV model, treatment could be brought to the parents in their homes.

Insurance and Reimbursement Structures

Effective SUD treatment relies on affordability and continuous care. For example, statewide SUD leaders commented that insurance approvals and funding do not align with the long-term needs of SUD treatment (e.g., often approvals for residential stays are for seven days at a time). Those who are uninsured, under-insured, or insured individuals who experiences insurance provider turnover will face barriers in accessing and completing treatment, not to mention maintaining long-term recovery programs.[25]

A related issue is that the healthcare system fragments patients into different risk pools with complex and inconsistent configurations of benefits, healthcare providers, services, data systems, and reimbursement structures. This type of fragmentation creates inefficiencies in the state SUD system and barriers for those in need of its services.[25]

6 Findings from Prior Needs Assessments

To build from information that had previously been compiled related to describing the need for services for pregnant women and families with young children, we identified a number of existing needs assessment documents, and summarized key findings in Table A5, Appendix E. Further, key needs that were identified in the Title V Maternal and Child Health Block Grant needs assessment were used by this team to develop specific linkages to the HV field based on their identified priority areas, as shown in Table A4, Appendix E. The priority areas identified by these prior needs assessments are summarized below.

1. **Increase HV capacity**, specifically for:
   - Providing culturally specific programs; and
   - Providing more evidence-based services.
2. **Workforce development priorities:**
   - Ensuring home visitors have training and support needed to support access to well woman care for pregnant/parenting mothers;
   - More training to support home visitors to address and support oral health concerns and facilitate access to dental services for pregnant women;
   - More training and support for home visitors to identify and support women to address substance use disorder and maternal depression;
   - Workforce development efforts and trainings such as Facilitating Attuned Interactions (FAN) training, reflective supervision, and early ACES screening could help improve the ability of the HV workforce to successful address these issues; and
   - Provide more trauma-informed trainings, coaching, and support for home visitors.
3. **System changes and improved coordination:**
   - Increase prenatal referrals for HV, in order to reduce smoking during pregnancy and improving rates of breastfeeding. The Oregon Infant and Toddler Assessment (2018) also called on work to reduce disparities in birth outcomes for women of color.[28]
   - Improve coordination with and referral to other health prevention and treatment services, including:
     - Smoking cessation training and services (e.g., Mother's Care),
     - Substance use prevention and treatment, and
     - Maternal depression.
   - Identify ways to integrate developmental screening and referral done through HV with those done in health care and other early childhood settings will be an area for ensuring strong coordination for HV systems. This was also identified by the Oregon Infant and Toddler Assessment (2018) as an area in need of improvement.[28]
   - Ensure home visitors successfully connect families with young children to needed food and housing supports, to address high rates of food insecurity and homelessness for Oregon's children.
4. **Infrastructure needs:**
   - Sufficiently resource and implement a comprehensive data system for HV;

- Increase pay for home visitors Create more professional development pathways for linguistically and culturally diverse home visitors.

Stakeholder Input Related to Needs Assessments

There was intentional work to ensure coordination and information-sharing across key recent statewide needs assessments. First, the MIECHV needs assessment was conducted by the research team that conducted Oregon's Preschool Development Grant (PDG) Birth-Age Five needs assessment, which ensured integration of data and recommendations from this earlier effort throughout this document. Second, MIECHV state team leaders participated on the PDG Needs Assessment statewide advisory committee, and there was intentional staff overlap within the OHA on both the Title V and MIECHV needs assessment work teams. Steering committees for these needs assessments also included several of the same key stakeholders, who were engaged in providing input about key findings and recommendations.

Implications for MIECHV Needs Assessment

Data and results from prior needs assessments informed this work in several ways. First, results and priorities from prior needs assessments were integrated with findings from this needs assessment to expand and/or emphasize key priorities, with weight given to issues and needs identified in these other bodies of work. Second, data from the PDG needs assessment were incorporated directly into this work, using HV data collected during that effort (specifically, data that were broken out by race/ethnicity) and by using PDG data for the county-level analysis (Phase Two) to identify geographic and other specific communities at high risk within some counties. Finally, reviewing the methods and findings from prior needs assessments informed the research team in developing interview protocols and data collection methods. For example, stakeholder interviews focused questions about capacity and quality of HV on areas that were not examined in prior needs assessments, such as understanding specific barriers and challenges related to recruitment and screening.

7 Conclusions and Dissemination

Oregon's Current Capacity for Delivering Evidence-Based Home Visiting Services

While estimating unmet need in Oregon is extremely complicated, and final figures should be interpreted with caution, it is clear that capacity for providing HV falls dramatically short of the potential need for services. This needs assessment estimates that Oregon is currently able to provide evidence-based HV services to about 8% of children aged 0-6 who are at or below 100% of the federal poverty level. Looking across a broader array of Oregon's HV programs (e.g., not evidence-based) it can be estimated that the state provides services to about 15% of children aged 0-6 living in poverty. In addition, Oregon stakeholders noted that this gap would be even larger if eligibility criteria were broadened. There was a shared sense that many families who could benefit from HV are not able to be served because of specific program eligibility requirements.

Data from several sources identified specific geographic areas of the state, as well as specific subgroups of families that are likely to be especially under-served for a variety of reasons:

- Families of color and families who speak languages other than English, and in particular, African-American, American Indian/Native American, and non-Hispanic immigrant and refugee communities;
- Families living in frontier/geographically large/isolated communities;
- Families involved with child welfare services, as an additional support for family reunification, preservation, or stability post-reunification;
- Working families; and
- Families who do not meet specific program eligibility requirements (e.g., families who are just over income requirements).

Priorities for Quality Improvement in Home Visiting

This report also identified a number of high priority areas for ongoing work to improve the quality of services being provided. These included increasing capacity for culturally-specific and responsive services, strengthening the HV workforce in their capacity to meet the needs of families dealing with substance use, mental health, and interpersonal violence challenges, and focusing on improving workforce retention through supervision and increased compensation. In particular, priority areas for future investment and ongoing work include:

1 Improve the Quality and Availability of Culturally-Specific Home Visiting Programs, by:

- Investing in more culturally-specific organizations and culturally-specific HV programs, especially in rural and frontier areas of the state;
- Intentionally creating pathways and supports to increase the number of bilingual and bicultural home visitors; and
- Conducting research to build the evidence base for more culturally-specific program models.

2 Continue to Strengthen the Home Visiting Workforce, by:

- Focusing on providing effective professional development supports, especially those involving ongoing coaching and mentoring to improve home visitors' skills and confidence in working with families with SUD, mental health, and IPV challenges;
- Implementing professional development supports for home visitors to reduce the effects of unintended bias towards families with SUD;
- Increasing quality and consistency of supervision, especially reflective supervision and supervision specific to supporting families with multiple needs and challenges; and
- Increasing home visitor job retention by increasing compensation.

3 Continue to Improve Home Visiting Infrastructure and Coordination, by:

- Providing resources to improve HV data systems, ensuring consistently collected information that can be readily available to support coordinated decision-making at the program and policy levels;
- Supporting shared learning from early implementation of the Family Connects Oregon program, and building off lessons learned from these efforts at improved system coordination;
- Supporting outreach and coordination between SUD treatment and HV systems, and identifying opportunities for these systems and programs to collaborate, both locally and at the state level; and
- Improving coordination and connection between HV programs being operated by or within tribal/Native American/American Indian communities and other existing state and local programs.

4 Improve Community Awareness and Positive Perceptions of Home Visiting, by:

- Supporting ongoing communication by state and local HV stakeholders that strengthens understanding about HV and what it is to other professional sectors as well as to the broader community;
- Learning from early implementation of FCO about effective ways to message and promote acceptance of these services; and
- Ensuring local program staff use family-friendly, accessible language in offering services to families and that paperwork and documentation is written and framed in accessible, family friendly language.

5 Increase Statewide Capacity for Substance Use Disorder Services for Pregnant Women and Families with Young Children, by:

- Partnering with state SUD leadership to ensure the needs of pregnant and parenting families are prioritized when resources become available through state or federal funding for expanded SUD services;
- Considering strategic partnerships to develop improved models for supporting parents with SUD who are involved in HV, such as providing Peer Mentors or Recovery Coaches to these families;
- Considering ways to provide more HV services to families post-reunification and/or post-treatment exit, to stabilize families and provide support during challenging transitions; and
- Improving the quality and availability of data related to SUD services for pregnant women and families with children.

Dissemination Plan for MIECHV Needs Assessment

Results of this needs assessment will be shared widely with key state, county, and other stakeholders and policy makers. Current dissemination plans include:

1. Providing key findings in communications to MIECHV-funded partners and programs;
2. Including key findings in the regular MIECHV statewide newsletter;
3. Posting the needs assessment report on the OHA website;
4. Presenting key findings and sharing the final report with the MIECHV Advisory Board as well as with other key stakeholder groups via webinar and/or other presentation mechanisms; and
5. Sharing results with key local early childhood advocacy groups.

Appendix A. Final List of At-Risk Counties & Current Home Visiting Capacity

County	Served by at least one HV program	Served by EB HV program	Served by MIECHV-funded HV program	# Families Served NFP	# Children Served Babies First![a,b]	# Families Served HFO	# Children Enrolled Early Head Start Home Based[A,c]	# Families Served Relief Nurseries[A]	Total # Served in EB HV	Total # Served in EB + other OR Models	Estimated # Families in Need (HRSA)	Estimated # of Children in Need [d]	% Served (all HV, HRSA)	% Served (EB HV, HRSA)	% Served (All HV, under 6 in poverty)	% Served (EB HV, under 6 in poverty)
Baker	Yes	Yes	No	0	0	11	0	0	11	11	110	265	10%	10%	4%	4%
Clatsop	Yes	Yes	Yes	0	53	49	0	0	49	102	292	436	35%	17%	23%	11%
Coos	Yes	Yes	No	0	56	15	18	0	33	89	793	1,103	11%	4%	8%	3%
Crook	Yes	Yes	No	0	25	6	0	31	6	62	60	405	104%	10%	15%	1%
Douglas	Yes	Yes	No	0	165	37	72	286	109	560	840	1,884	67%	13%	30%	6%
Grant	Yes	Yes	No	0	30	8	2	0	10	40	19	110	210%	52%	36%	9%
Jackson	Yes	Yes	Yes	164	158	78	16	74	258	490	2,196	4,049	22%	12%	12%	6%
Klamath	Yes	Yes	Yes	0	7	73	24	0	97	104	332	1,113	31%	29%	9%	9%
Lake	Yes	Yes	No	0	1	3	0	0	3	4	39	235	10%	8%	2%	1%
Lane	Yes	Yes	Yes	256	203	181	66	547	503	1,253	2,644	4,946	47%	19%	25%	10%
Lincoln	Yes	Yes	Yes	99	175	0	0	0	99	274	363	938	75%	27%	29%	11%
Malheur	Yes	Yes	Yes	0	38	28	17	61	45	144	152	1,168	95%	30%	12%	4%
Marion	Yes	Yes	Yes	0	136	273	69	216	342	695	2,457	6,785	28%	14%	10%	5%
Morrow	Yes	Yes	Yes	0	14	12	4	0	16	30	30	261	99%	52%	11%	6%
Multnomah	Yes	Yes	Yes	398	174	458	350	270	1,206	1,650	5,328	10,791	31%	23%	15%	11%
Polk	Yes	Yes	No	0	26	9	13	45	22	93	516	1,127	18%	4%	8%	2%
Umatilla	Yes	Yes	Yes	52	7	45	24	81	121	209	523	1,865	40%	23%	11%	7%
Yamhill	Yes	Yes	Yes	57	113	55	110	96	222	431	663	1,737	65%	33%	25%	13%
Risk Counties Total				**1,026**	**1,381**	**1,341**	**786**	**1,707**	**3,153**	**6,242**	**17,357**	**39,218**	**36%**	**18%**	**16%**	**8%**
State Total				**1,271**	**2,185**	**2,035**	**1,129**	**2,326**	**4,435**	**8,946**	**24,489**	**58,548**	**37%**	**18%**	**15%**	**8%**

Notes. To avoid duplicate counts, Parents as Teachers programs are not uniquely included in this table. Most PAT programs we were able to contact either use the PAT curriculum rather than the PAT program model, or use the PAT program model to supplement another model (e.g., Early Head Start Home-Based) and are thus represented in other program counts. Evidenced-Based programs include NFP, HFO, and Early Head Start.

a For local service areas that include more than one county, ACS 2017 5-year estimates of the Total Population of Children Under 5 were used to estimate the number of clients assigned to each county.

b 8 children served in more than one county

c Multnomah, Umatilla, Gilliam, Morrow, and Grant counties' counts also include Head Start Home Based programming

d Number of children 0-6 at or below 100% FLP, PDG

Appendix B. County Case Studies

Jackson County: A Closer Look at Home Visiting Capacity, Community Needs, and the Substance Use Disorder System

As part of the MIECHV needs assessment, the research team conducted more in-depth analysis and data collection for Jackson County. Although Jackson County was not identified through the Phase One risk assessment, experience and data suggest that there are clearly unmet needs in this area. To better understand where there are pockets of community need, groups who are not well-represented in current enrollment patterns, and/or areas lacking early childhood or other community resources, we conducted a mixed-method case study to collect additional data (see "Case Study Methods").

Case Study Methods

- Review of existing population data and needs assessments for specific localities within Jackson County*
- Qualitative interviews with 4 home visiting (HV) and 2 substance use disorder (SUD) treatment program leaders
- A (virtual) focus group including 8 home visitors representing 3 HV program models (Early Head Start, Healthy Families Oregon, Nurse-Family Partnership)

*Early Learning Map of Oregon (ELMO); Oregon Office of Rural Health (2018); Jefferson Regional Health Alliance 2018 Community Health Assessment of Jackson and Josephine Counties (2019); Oregon Tobacco Facts (2018)

Phase Two Risk Analysis Key Findings

Jackson County is located in southern Oregon along the California border. It has grown to be the sixth largest in population of all Oregon's counties.[a] One-third (31%) of Jackson County residents live in unincorporated areas. 80% of the population identifies as White and 13.5% identify as Hispanic/Latino.[b] Jackson county has a moderately high rate of children under age six living in poverty (27%) in relation to the state (20%).[c]

Jackson County is higher on several important intergenerational risk factors compared to the state, including homelessness, family economic strains, key health and perinatal health indicators, and rates of child abuse or neglect (see Table A1). At the same time, Jackson County appears to lack quality early childhood services, as evidenced by a low number of learning facilities/providers that meet the minimum quality standard for child care in the state's Spark system (see findings in specific localities below).[d] Jackson County has less available, affordable child care than many areas of the state, with only 19% of low-income children having access to a child care slot, and only about one-third enrolled in preschool (34.9% in Jackson County compared to 43.4% in Oregon). As shown in Appendix A, Jackson County also has relatively low capacity to provide HV services compared to the rest of the state. For example, it is estimated that Jackson County can only serve about 6% of children ages 0-6 who are living in poverty through evidence-based HV, compared to 8% statewide capacity.

a https://jacksoncountyor.org

b https://census.gov/quickfacts/jacksoncountyoregon

c Early Learning Map of Oregon, or ELMO, estimates are based on the most recently available five-year U. S. Census Bureau's American Community Survey (ACS) data. These estimates have significant margins of error, especially for small counties. For the purposes of this report, the midpoint of the range is reported (e.g., 15-20% would be reported here as 17.5%). https://oregonearlylearning.com/PDGAssessment#ELMO

d https://oregonearlylearning.com/spark

Table A1. Jackson County risk factor data

Indicator	Jackson County	Oregon
Percent smoked during pregnancy[a]	14.1%	10%
Unemployment	4.8%	4.1%
Households receiving food stamps (SNAP)	21.6%	18.8%
Students eligible for free/reduced lunch	54.1%	49.3%
Homeless students K-12	8%	3.9%
2-year-olds up-to-date on vaccines	63%	68%
Rate of child abuse/neglect per 1,000 under 18	19%	12.8%
Infant mortality per 1,000 births	5.2%	4.6%
Pre-term birth	8.5%	7.9%
11th grade abstaining from tobacco, past 30 days	91.7%	92.3%
11th grade abstaining from alcohol, past 30 days	65.7%	70.2%
11th grade abstaining from marijuana, past 30 days	73.7%	78.4%

Note. Data presented were extracted from the Jefferson Regional Health Alliance (JRHA) 2018 Community Health Assessment of Jackson and Josephine Counties (2019) except as noted. Data sources and year data were collected differed depending on the community needs assessment reviewed for this report. Thus, Oregon estimates for certain indicators may not match across all three counties (Jackson, Umatilla, and Yamhill).

Within Jackson County there are specific geographic areas where needs, risk factors and/or lack of resources are especially pronounced compared to the county and state overall: Butte Falls, Phoenix/Talent, Rogue River, Shady Cove, and White City.[b,c,d] These represent key areas for expanded screening and recruitment for MIECHV-funded HV slots in this county.

Butte Falls

- Low rates of child health insurance (70.5% of children 0-6 vs. 95% in Jackson County and 96.5% in Oregon).
- 29.6% of K-12 students in Butte Falls School District (BFSD) were homeless in 2017, the highest rate in the state (3.9% in Oregon).
- 43.3 % of BFSD students in grades 3-5 met grade level standards in language arts in 2017 compared to 49.6% statewide.
- 30.6% of BFSD K-12 students were chronically absent (absent 10% or more school days) in 2017 compared to 19.7% in Oregon.

a Oregon Tobacco Facts (2018). sharedsystems.dhsoha.state.or.us/DHSForms/Served/le9139.pdf

b Early Learning Map of Oregon, or ELMO, estimates are based on the most recently available five-year U. S. Census Bureau's American Community Survey (ACS) data. These estimates have significant margins of error, especially for small counties. For the purposes of this report, the midpoint of the range is reported (e.g., 15-20% would be reported here as 17.5%). https://oregonearlylearning.com/PDGAssessment#ELMO

c Jefferson Regional Health Alliance 2018 Community Health Assessment of Jackson and Josephine Counties (2019). jacksoncareconnect.org/docs/default-source/Community-Health-Assessment-Docs/jrha-cha-012419-final.pdf?sfvrsn=0

d Oregon Areas of Unmet Health Care Need Report (2020). https://www.ohsu.edu/sites/default/files/2020-08/2020%20Areas%20of%20Unmet%20Health%20Care%20Needs%20Report.pdf

Phoenix/Talent

- 72% of children under 6 in Phoenix, and 80.5% in Talent, had health insurance coverage compared to 95% in Jackson County and 96.5% in Oregon.
- Less than 0.5% of children under 5 living in poverty in Talent have access to publicly-funded child care.
- No early learning facilities/providers meet the minimum quality standard for child care in the state's Spark system in both Phoenix and Talent.
- 39% of children ages 5-17 years living in Talent speak a primary language other than English, compared to 20.5% in Oregon, indicating unique linguistic and cultural needs. Services for children and families in this area require resources (e.g., bilingual/bicultural staff, translation support, interpreters, culturally-specific programming) to meet these needs.
- Only 38% of Phoenix/Talent School District students in grades 3-5 met grade level standards in language arts in 2017 compared to 49.6% statewide.
- This community suffered extensive devastation from the Oregon wildfires in the summer of 2020.

Rogue River

- Extremely low access to affordable child care: <0.5% of children 0-5 living in poverty have access to publicly-funded child care.
- 78% of children under 6 had health insurance coverage vs. 95% in Jackson County and 96.5% in Oregon.
- 21% of Kindergarteners in the Rogue River School District (RRSD) are chronically absent compared to 16.8% in Oregon.
- 13.1% of K-12 students in RRSD were homeless in 2017, the 11th highest rate in the state (3.9% in Oregon)
- 42% of RRSD students in grades 3-5 met grade level standards in language arts in 2017 compared to 49.6% statewide.

Shady Cove

- Shady Cove was identified by the Oregon Rural Health association as one of Oregon's areas with greatest unmet need.[a] Particularly concerning is inadequate prenatal care and lack of physical and behavioral health services:
  - 122.2 per 1,000 babies are born having had inadequate prenatal care, a rate twice that of Oregon overall (59.6 per 1,000).
  - Low capacity for primary medical care providers in Oregon based on a ratio of primary care visits provided to visits needed: 0.23 compared to 1.19 in Oregon.
  - No mental health care providers in this area compared to 1.19 full-time equivalent (FTE) per 1,000 in Oregon.
- 74.5% of children under 6 had health insurance coverage compared to 95% in Jackson County and 96.5% in Oregon.
- 34.4% of Eagle Point School District students in grades 3-5 met grade level standards in language arts in 2017 compared to 49.6% statewide.

White City

- 5% of children under 5 living in poverty have access to a publicly-funded child care slot.
- No early learning facilities/providers with a Spark level 3 or higher.

a Oregon Office of Rural Health (2020). https://www.ohsu. edu/oregon-office-of-rural-health/about-ruraland-frontier-data

Qualitative Case Study Findings

As part of the Jackson County risk assessment, we spoke with four HV county leadership members, representing Early Head Start (EHS), Healthy Families Oregon (HFO), Nurse-Family Partnership (NFP), and a Relief Nursery (RN) that also provides various other services including SUD-focused support. We also spoke with two county SUD leaders. And, finally, we conducted a focus group with eight home visitors representing EHS, HFO, and NFP.

Consistent with the quantitative data, key stakeholders interviewed named the following needs as most pressing for Jackson County families:

- Affordable housing and reduced homelessness;
- Jobs and economic opportunity;
- Lower cost, higher quality childcare, especially for children ages 0-3 years old;
- Drug and alcohol use services, less stigma associated with use (can be a barrier to getting help); and
- Interrupting intergenerational issues (e.g., family violence, parenting issues)

"So we have a program for moms and their kids and the dads and their kids. Oftentimes it's the whole family. The mom is in our Home Program and the dad is in our Dad's Program and the kids are in between the parents while they're in treatment…So I took this job and I went over to the Home Program for the first time. And we were talking to one of the clients who was there, one of the women, and she said, 'Oh, I love this place. I remember it from when my mother was here.'" *—SUD Leader*

Home Visiting Capacity and Quality in Jackson County

Interviews with county HV leaders provided information about strengths, barriers, and gaps in the HV system in Jackson County.

Community Collaboration

Community collaboration is a key strength in Jackson County's HV system. One HV leader described their partnerships as "*very strong…always have been*." An HV provider shared their belief that "*we need to be a team for the family, not separate entities*." There is also a commitment to increasing collaboration between agencies, an area in need of continual improvement.

The core of their collaboration is the Home Visiting Leadership Team, made up of leaders from MIECHV-funded agencies including EHS, HFO, and NFP, as well as the Southern Oregon Early Learning Services Hub leader who receives funds to support MIECHV training. Prior to the disruption of COVID-19, the team met monthly to discuss training, referrals, and other ideas to improve HV services. Trainings include all HV programs, helping to create a sense of inter-agency fellowship. Home visitors across agencies are encouraged to work together, learn from each other, and to understand each program's strengths. This enables them make referrals to programs that best meet each parent's needs. For example, home visitors from other agencies often refer mothers receiving Medication-Assistant Treatment (MAT) to NFP because nurses are more familiar with supporting medical needs and, when parents return to work, they are often referred to EHS where they can also receive child care. HV trainings help build relationships between service systems (e.g., SUD treatment). HV Leadership Team members sit on community boards, which also facilitates agency collaboration.

An often-mentioned barrier to better collaboration with other agencies was HIPAA and other policies (e.g., 42 CFR) to protect patient confidentiality. One HV leader said that although they are meant "*to protect people…I think it becomes a barrier for people getting the help they need*." Another challenge is the lack of understanding in the community of what home visitors do, and a shared feeling among home visitors that their work is not respected by other professionals.

Jackson County's **HV referral process** entails service providers (e.g., primary care, hospitals, DHS, non-profits) and community members reaching out to the HV Leadership Team, which then refers the family to one of their HV programs. Although HV stakeholders thought this simple referral process works well, there are also vulnerabilities. An HV leader said that due to a lack of understanding of their work, a recent hospital policy change revoked their agency's access to patients receiving care. Although nurses and other health care workers were on board with HV services, "*the bureaucratic people up above*" created the policy. Another example is the potential for duplication of services among HV programs when referrals come from different sources and people are referred to multiple programs. Furthermore, parents cannot choose their own HV program—the HV Leadership Team decides which program best matches the family's need. Thus, Jackson County would benefit from an improved, coordinated HV referral system that allows family choice.

HV Capacity and Workforce

HV stakeholders shared there is always a waitlist for services, particularly for Spanish-speaking families, and they would like additional funds to hire more home visitors.

"I wish that we had more money to serve more families. I think that, unfortunately, we have to turn away a lot of families because we don't have the capacity to serve them. I would love to have one or two more home visitors and not close families due to 'caseload full.'" *—HV Leader*

HV leaders shared that **home visitor retention** is somewhat low and burnout is somewhat high, but workers are passionate about what they do and most leave due to promotion or to advance their education. Some home visitors serve a large number of high-needs families, but HFO is working to even out caseloads by completing risk assessments when families first enroll. Another workforce issue is low pay; however, a recent grant for preschool education requires an increase in teacher salaries, which will include EHS home visitors.

HV leaders described the **importance of clinical supervision**; EHS includes an additional small group/peer-to-peer learning experience described as "*secondary prevention*." In these small groups, staff share experiences, work through biases, and more generally support and learn from each other. HV leaders said that small group supervision is well received and contributes to workforce retention.

HV leaders also described quarterly **trainings** (before COVID-19). The HV Leadership Team identifies community needs and brings in trainings based on those needs (e.g., racial bias, FAN (similar to Motivational Interviewing), and annual SUD trainings). Additional training needs, according to home visitors, include managing child behavioral issues, parenting (e.g., power struggles with children), and supporting families using medical marijuana.

"We have done a lot of motivational interviewing training and we've really focused a lot in the last couple years on ACES and how to build resilience in families. And I think that all of those trainings have built skills home visitors didn't even know they had, so they have a better toolbox of skills to bring into the home around those challenging conversations." *—HV Leader*

Capacity for Meeting Families' Cultural and Linguistic Needs

Jackson County had an 18.7% increase in its Hispanic/Latinx population between 2011 and 2016, compared to 13.3% statewide.[a] HV stakeholders reported that there is good support for Hispanic/Latinx families, but also room for improvement. Home visitors also shared limitations in their ability to support some smaller linguistically-diverse populations (e.g., Russian, Pakistani).

HV stakeholders named several barriers to enrolling, engaging, and serving community members that primarily speak a language other than English. As previously mentioned, there is a **lack of understanding of what home visitors do** and the benefits of the service. For example, one linguistically-diverse family didn't consider the service because they didn't know that a home visitor could work around the language barrier. Home visitors also described having limited access to and insufficient funding for materials in languages other than English (e.g., Russian language children's books). Having a home visitor who speaks the family's primary language is best, but home visitors have strategies to manage **language barriers** (e.g., help from family members, translation services available in the community, over-the-phone translation service, apps such as Google Translate). They also noted that the workarounds have their challenges, including access to and comfort with technology, interrupted flow of conversation, and privacy issues.

For Hispanic/Latinx families, particularly in the current political climate, an intense fear of deportation inhibits their willingness to enroll in HV services. All HV leaders shared having at least one bilingual/ bicultural Latinx staff; some felt they had an appropriate number, while others said they needed more staff. One HV leader shared the importance of having bilingual/ bicultural home visitors:

"I can share that with the political climate that we have right now, we have a lot of families who are not documented citizens and that has really been a fear for families to enroll in services. Especially as well, my home visitors [were all] white women. So I think that might have been a barrier to families to accept accessing services. Now that I have a bicultural/bilingual home visitor, it seems like we've had a little momentum shift and that community is so large in our area with the migrant farm workers that I have here. We're just a very large population of Spanish-speaking families. So to have better representation for those families has been amazing." *—HV Leader*

a https://census.gov/quickfacts/jacksoncountyoregon

In addition to having bilingual/bicultural staff, HV leaders shared providing **racial bias trainings and adapting HV services** to meet different cultural needs. For example, HVs are trained to support some families' culturally-based preference to have their children sleep in bed with them, while providing information for families to make informed decisions. Program flexibility, according to a family's needs and level of engagement, was described as a key factor in providing quality HV services for all families.

Other Barriers and Gaps in the HV system

HV stakeholders named a number of other barriers to service and gaps in the HV system. Related to the recurring issue that the community isn't aware of or doesn't understand HV services, **some families do not want home visitors in their homes** for fear of being judged or becoming involved with the child welfare system. It is also difficult to reach families who are homeless. HV stakeholders said that parents are important "*recruiters*" because they help other parents overcome fear and build trust. HV leaders said that home visitors are skilled mandatory reporters in that they are able to take a strengths- and relationship-based approach, enabling them to meet extreme needs before it becomes necessary to report the family to child welfare.

Families who are interested in HV services face **eligibility requirements** that can block them from getting the support they need. Interview and focus group participants shared some of the problems with certain eligibility requirements:

- The income cut-off is too low (e.g., excludes two-parent families working low-wage jobs).
- Gestational age limit is too early (e.g., excludes parents who take longer to engage, particularly if using substances while pregnant).
- Limiting the service to first-time mothers leaves out those who may have given birth previously but are now parenting for the first time (e.g., excludes clients who had their parental rights previously terminated).

"...each one of our MIECHV programs currently have very limited scope in whom they can serve. So there's this huge group of people that really just kind of get left out of being able to be served by home visiting programs, which is why I'm trying to grow our home visiting so that we can serve more people that aren't able to be served by those other programs that have a more narrow scope...[The Relief Nursery] is based on risk factors. It's not income-based. It's...based on what's going on with you as a family." *—HV Leader*

Home visitors also thought that families who do not meet any program eligibility requirements could benefit from HV services. Moreover, the need for the emotional support provided isn't prioritized when considering eligibility and funding.

It can be challenging to reach out to and serve people living in **remote rural areas**. One HV leader suggested that people move to those areas "*because it's cheaper and...because there's no police out there*" and "*they can be left alone*." With fewer resources available in rural areas, families have more unmet need. Families often lack basic services such as phone and internet, grocery stores, and reliable transportation. Some home visitors reported serving families living more than a 90-minute drive away, often in rugged terrain, limiting their time to meet needs and serve additional families. In many of these areas, HV may be one of the only services available.

Substance Use Disorder in Jackson County

HV stakeholders and substance use disorder (SUD) leaders reported that the most commonly abused substances in Jackson County are methamphetamine, heroin, alcohol, marijuana, and tobacco. Many shared that families facing SUD are often experiencing multiple issues and polysubstance use. The legalization of marijuana has also caused some confusion about its safety:

"I think the fact that it's legal makes people think of marijuana just like you would smoke a cigarette in front of your kids. A lot of our staff have mentioned that, you know, they still have to tell families, 'Don't smoke around your child.'" *—HV Leader*

Strengths of the SUD system

There are many services available for parents with SUD in Jackson County, including: Eat, Sleep, Console; Kangaroo; and Orchid Baby Program. All three are programs for mothers who used while they were pregnant. The Orchid Baby Program at the Family Nurturing Center (FNC) connects parents with home visitors and other services. FNC was mentioned many times as an integral community service provider with a number of innovative programs.

SUD-specific services in Jackson County include residential facilities geared toward parents such as the Reddy House, Mom's Program, and Dad's Program, which allow a certain number of children under the age of 5 to stay with their parents while they're in treatment. Dad's Program is one of the only programs in Oregon to allow children to stay with their father in treatment. Pregnant women or women with newborns get priority for residential treatment, but beds are limited. Other SUD programs have designated counselors and peers who work with pregnant women and parents.

"The peer mentors, I think, are kind of the secret sauce in the addiction world…As a peer mentor, they have much more of an ability to say 'I really have been on the path. Walk with me,' and they use that in a different way. And so, that has changed the SUD world, I think, in ways that I have never seen before…So a pregnant woman might get hooked up with a Certified Recovery Mentor who's had three children in her addiction and her fourth being clean and sober and knows the DHS system and knows what it's like to feel guilty but can't stop…If you can hook them up that can make a huge, huge difference…" *—SUD Leader*

HV and SUD leaders both reported that county leaders are working to address the SUD issues in Jackson County. For example, the Coordinated Care Organization (CCO) in Jackson County provides funds for agencies to buy phones for those receiving SUD services. One SUD leader described efforts for SUD service providers to collaborate with DHS, medical clinics, and community justice services.

"We try to do collaborative stuff. And Zoom makes it so easy, where I can pull a meeting together, a 15-minute meeting, with people from our CCO, from DHS, all the counselors, the peers, anybody involved. We can pull together really quickly and have a quick staffing where that used to take weeks to get people's schedules squared away." *—SUD Leader*

Barriers and Gaps in the SUD system

Key barriers to SUD treatment for families are (1) stigma and fear of losing one's kids, (2) unconscious bias about addiction as a moral failure, (3) the co-occurrence of addiction with other problems (e.g., poverty, mental health issues), (4) a lack of treatment options for the whole family, (5) billing and payment structures, (6) waiting lists, (7) and a lack of access to treatment in rural communities.

"I think they get very, very afraid that if they say I want help that somebody's going to swoop in and take their kids. That's probably the number one thing." *—SUD Leader*

"There's still a lot of morality attached to addiction. You know, you shouldn't have done that. This is willful. There's a lot of moral judgment. And people do it unconsciously." *—SUD Leader*

"Our community is really well known for its significant drug use and mental health disorders and lack of mental health resources, which I think contributes again to that continued drug use." *—HV Leader*

The lack of collaboration and communication between agencies, especially DHS, is a significant gap in the system.

"I feel there is a lot of division between agencies and if we could come together more, maybe we can have less families fall through the cracks." *—HV Provider*

A SUD leader also described too much focus on intervention and not enough on prevention, and that some interventions, such as MAT, only provided a substitute drug. They felt more money should be put into research on better prevention strategies.[a] A SUD leader also shared barriers in terms of inadequate funding for the Medicaid population, complicated and piecemeal funding structures, and the fact that outreach and needed supports for getting parents to treatment are not billable.

"…even getting from Jackson County to Josephine County for a meeting at a residential treatment for a kid—if it came down to putting gas in the car, they didn't have money for that. We'd have to give them money. A flat tire wasn't just a jack it up, put on a spare, and go get a new one. It was, 'I don't have a spare. Plus, I don't have gas. Plus, I have a broken foot.' But these are the kind of barriers that a family faces. And we don't get paid for doing any of it other than a set fee from the CCOs or a set fee from the Oregon Health Authority. And we're expected to do the treatment. And there's only so much you can do with that money." *—SUD Leader*

Home Visiting and SUD Services

A number of the home visitors said that SUD was not currently an issue for many of their clients, but it had been in the past. They also conceded that it's more difficult to really see what's going on right now due to the pandemic. Others described ongoing, high-level support for clients with SUD. Due to the nature of HV services (e.g., provide in-home services, build trusting relationships), statewide SUD leaders thought that **home visitors are well positioned to support parents throughout the SUD process**. Home visitors can help identify when there is an issue, help parents decide to seek treatment, take parents to treatment, support parents during treatment, and provide much needed support after they leave.

a It is important to note that MAT is an evidence-based SUD treatment and harm reduction practice for Opioid Use Disorder. See https://www.samhsa.gov/medication-assisted-treatment

HV and SUD providers are largely **not familiar with each other's services and do not often collaborate**. The annual SUD training helps home visitors stay abreast of available services, while shifting funding streams and high turnover creates a void. One area in which there is collaboration is between HV services and some of the residential treatment centers. For example, a doctor who coordinates MIECHV referrals also started a program for mothers with SUD. FNC, a key agency in the community, houses HV services, SUD support, and other programs with an internal referral system to ease access and help keep services connected. Collaboration between the HV and SUD systems has the potential to bridge the gap between parents and treatment providers.

Malheur County Case Study: Early Adopters of Family Connects Oregon

Overview

Malheur County is located in the southeast corner of Oregon. The second largest county in Oregon, it is 94% rangeland and has 3.2 inhabitants per square mile.[a] With such a low population density, it is considered a frontier county. Malheur County is 77.5% White and has a growing population of people with Hispanic or Latino origins (31.5%). Approximately 35% of the households in this county having children under age 18 living with them.[b]

Malheur County is an early adopter of Family Connects Oregon (FCO), and the lead agency for planning and implementation is the Eastern Oregon Early Learning Hub (EOELH), which includes Baker, Malheur, and Wallowa Counties. The purpose of this case study was to gather information from HV and substance use disorder (SUD) system stakeholders to learn more about the HV system and FCO implementation, as well as the nature of collaboration between HV and SUD services in the county.

Case Study Methods

- Qualitative interviews with 2 home visiting (HV) and 3 substance use disorder (SUD) treatment program leaders
- A (virtual) focus group including 5 home visitors representing 3 HV program models (Early Head Start, Relief Nursery, Babies First!)
- A (virtual) focus group with 8 Home Visitor Network team members

Home Visiting System

Capacity of Home Visiting Programs to Enroll All Families Who Might Benefit

Healthy Families Oregon (HFO) in Malheur County served 4% of potentially eligible families.[c] Consistent with this finding, HV leadership and providers said that there is not enough capacity to serve all families that would qualify and/or benefit from HV in Malheur County. Home visitors said they have seen an increase in the need for their services over the past five years, especially for Early Intervention services through the Educational Service District (ESD). HV leadership mentioned that they "*dropped*" their HFO program because it was too expensive; however, when it is re-instated with another provider agency they hope to be able to identify and serve more families. Despite increased need, home visitors generally agreed that they have the capacity to serve all families who are identified and referred.

Malheur County's HV system has two key strengths. First, the Home Visiting Network is a group of providers from multiple service systems (including HV, education, behavioral health, early intervention, and child welfare) who work together to find the best programs for families. They meet monthly to collaborate and do HV case coordination. Second, the HV workforce is quite stable. Home visitors suggested that most of them have been doing HV-type work for at least five years. They called low turnover the "*secret to our success*" in that it allows for continuity and relationship building, along with a high level of skill.

"And that's why I appreciate the Home Visiting Network meetings that we have each month because I wouldn't know [more detailed information about] some of these people or their programs…" *—HV Provider*

Barriers to Enrolling Families & Expansion

Although home visitors felt they were able to serve all *referred* families, they also thought that they do not have the capacity to serve all *potentially eligible* families. This suggests that many families are not being identified for HV services. Indeed, HV leadership and providers named a number of barriers to identification and enrollment.

a https://www.malheurco.org/

b https://archive.vn/20200213012919/http://factfinder.census.gov/bkmk/table/1.0/en/DEC/10_DP/DPDP1/0500000US41045

c Burton, M., Green, B.L., Miao, A.J., Pears, K.C., Scheidt, D., & Tremaine, E. (2019). Oregon Preschool Development Grant Strengths & Needs Assessment, Birth through Age 5. https://oregonearlylearning.com/wp-content/uploads/2020/04/psu-or-pdg-report-2020-02-11-pages-web.pdf

- **Parents are not looking for a home-based program**—they are looking for a place for their children to go while they work. Home visitors said that families are more interested in HV programs that also provide center-based child care (e.g, Early Head Start, Relief Nursery).
- **There is a misperception that HV is for people *"in trouble"*** or "*coming from a child abuse situation*." The stigma associated with HV gets in the way of people asking for assistance and education through HV services.

"DHS is involved with a lot of the families that are in our area and I just think that they really do get scared that you're going to take my kids away from me. And it's like, 'No, that's not why we're here. We're here to help you. We're here to make you stronger as a parent'...I think if parents were a little bit more receptive to it, that the home visiting programs would be more successful here." *—HV Provider*

- **Families do not know about HV services.** Home visitors talked about having "*community recruitment events*" to build family awareness. Many families live in remote areas, so it is hard to advertise to and recruit families who are not part of other systems. A related issue is that programs do not have enough referring partners. DHS (self-sufficiency and child welfare) and the County Health Department work closely with HV programs, but other providers (e.g., primary care) may not know enough about HV or have the information they need to make HV referrals.

"...I think it's parent education in the most friendly way to get it...I really wish we could get it out there so people understood what a great thing it could be and how helpful it can be. And the importance of the earlier we start giving [services to] children, the better the thing is going to be for kids...we have been able to get kids into early intervention programs sooner than they would have if they waited till kindergarten started." *—HV Leader*

- **The community has a *"cultural orientation"* that *"family should take care of family"*** and that you shouldn't have strangers helping you. Home visitors said that people living in poverty are used to going without and not asking for help. They also mentioned that some families do not trust home visitors because they are seen as part of the government.

"...we go into the home to do our visit and then showing up in a county vehicle...So, not wanting others to know that they're receiving services or just the fact that there's a government entity trying to come into their home...I think trust could be a barrier." *—HV Provider*

- **It can be challenging to meet all families' cultural and language needs.** Spanish language resources have become more available, but it is harder to meet the needs of other groups (e.g., recent Somali immigrants). Respect for family traditions was also seen as important, although at least one noted experiencing some discomfort with family traditions. There was also some awareness among home visitors of cultural differences in parenting practices.

"Be prepared to eat food you've never eaten before...they get really offended if you refuse the food. I have food allergies so I have to be cautious...it was that barrier of trying to get them to understand it, and thankfully they did have older children get could explain it to them for me." *—HV Provider*

"...our beliefs as far as raising children are completely different... they're coming into a whole new different world. And here we are trying to push our belief systems on them when they've been raised completely different." *—HV Provider*

- **Transportation and navigating a large geographic region** are challenging for both the families and the home visitors. HV stakeholders commented that it is hard to find home visitors who are "*willing to drive all over the place*." In addition, some programs do not allow home visitors to bill time for transit.

"...we're supposed to serve the whole territory of your county. But since Malheur county is so large and we do have to serve a certain number of families every week. It's not always feasible to drive out to Jordan Valley [an isolated community] once a week." *—HV Provider*

- **Family mobility and homelessness** make it difficult to keep track of families (get them enrolled, keep them enrolled). One home visitor reported serving three families currently living in their cars.
- Many families may benefit from or want HV, but **do not meet eligibility criteria** for the program. Home visitors had several examples, mostly related to income requirements.

Family Connects in Malheur County

FCO is being coordinated by the Eastern Oregon Early Learning Hub, a three-county consortium (Baker, Malheur, Wallowa) with members representing health, K-12 education, social services, early learning programs and businesses. The vision for Malheur County is to offer HV to all families and make sure they find the best fitting program for each family. In addition, they hope to prevent families from becoming involved in the child welfare system. In Malheur County, the Health Department and its nurse HV program will provide FCO services. Work has started in developing partnerships with agencies including

hospitals, Malheur ESD, Valley Family Health Care, Malheur County Health Department, and the Eastern Oregon Coordinated Care Organization (EOCCO; a network of health care providers who serve people covered by the Oregon Health Plan).

HV and SUD leaders and home visitors outside of the Health Department were generally not aware of FCO. One SUD leader said that the SUD system is generally not well-connected to the HV system.

"I feel like this is an area that is not well known and not well recognized and so therefore, probably not capitalized on as much as it could be for this population." *—SUD Leader*

The COVID-19 pandemic has impacted progress on FCO alignment and start up. Just as the Health Department was starting their FCO work, the COVID-19 pandemic hit. Although things are now on hold, Malheur County is looking forward to building partnerships, increasing collaboration with the other two counties (Baker, Wallowa), and identifying more families to serve. Should there be a marked increase in the number of families identified, home visitors noted that they may need to move away from their current process for cross-program referrals (i.e., a single supervisor as the primary conduit) to a more systemic approach. Ideas included longer or more frequent Home Visiting Network meetings, and/or involving more people in the work.

"Maybe more coordination, when we have our monthly home visiting network meeting. Maybe say if [supervisor] was unable to get to them or you know that she was available to attend that meeting that she'd be able to pass it off to [other home visitors] to see if any other organization can take the families." *—HV Provider*

How Family Connects Could Benefit the Social Service System

Despite the fact that most HV leaders and providers were not aware of FCO activities, they were able to describe how a universally-offered HV program would benefit Malheur County. One benefit is that **FCO would help more families know about HV services**, thereby increasing recruitment and filling program slots.

"...we have gone through the experience of having spots open and really having to recruit really, really intensely and reaching out their organizations to see if they have referrals...I think this would be a really interesting way to make more of an effort with recruitment, but maybe not as exhausting." *—HV Provider*

The second benefit identified is that **FCO would create more openness to HV services** among families and the community. HVs thought that word of mouth in the community after families experienced FCO would help to build trust. One HV leader described HV as "*the most effective way to help parents*" because it is relationship-based and it takes place in the privacy of their own home. Increasing access to HV services would allow families to "*recognize that we're not judging, we're not doing this because we don't think they know, but because we really want to support them and help them*." Home visitors thought it would be "*good marketing*" for HV, allowing both families and providers to learn more about programs.

"I would hope that our program would become better known in the community...I think it would just give us all the opportunity to really learn about other programs so that we are better able to sell it to families who I know...[and] once the baby's born, they go home and they're very satisfied with the services to where they tell their friends, family, neighbors..." *—HV Leader*

Although SUD leaders in Malheur County generally did not know very much about FCO, they saw the potential for universal HV to **increase SUD screenings in the community**. One SUD leader thought there have been "*missed opportunities for that screening to take place when pregnant moms or new moms connect with the medical community*." If women were not screened during their pregnancy, postpartum HV services could provide another opportunity to help them connect to treatment and recovery services. Another SUD leader thought that FCO could be "*an introduction to public health services and referral to all the other community services that are available*." In this way, the public health system could "*wrap around families as a whole and not just the one kid who needs the referral*," including elderly living in intergenerational homes, pregnant teens, and other children in the home. It brings services into the home in a "*supportive, non-judgmental way*."

Challenges to Family Connects Oregon

To date, the two principal challenges to FCO implementation have been the **unfunded community alignment phase** and the **COVID-19 pandemic**, which markedly interrupted HV services and pulled the Health Department's resources away from FCO efforts. As such, coordination activities are stalled in Malheur County.

"Because it [FCO] doesn't come with any money up front, we really struggled with taking this on with no money. It's been a ton of work for [FCO lead]—all these calls, all this planning and everything." *—HV Leader*

HV stakeholders also anticipated other challenges that are consistent with those mentioned above in terms of the stigma associated with HV services, navigating HV program eligibility requirements, and managing identification, referral, and enrollment.

SUD System

SUD leaders are concerned about methamphetamine, opioid, marijuana, and alcohol use in Malheur County. Often parents facing addiction issues become involved with the child welfare system, their children are placed in foster care, and there are limited opportunities for family treatment. An associated issue is criminal justice involvement, which can get in the way of treatment and work against supporting the family unit. Being that the county has very remote areas, one SUD leader was concerned about isolation: "*they may not even have any neighbors*" and "*domestic violence or domestic tension going on in the family.*"

Strengths of SUD System in Serving Pregnant Women & Families with Young Children

SUD treatment available in Malheur County is not specific to pregnant women and families with young children. As one SUD leader said, "*I haven't necessarily evaluated our program from the pregnant women and perspective as a unique unit.*" Thus, most of the information reported here is for the SUD system more generally.

Malheur County SUD leaders described their SUD system as having a range of strengths:

- The SUD system in Malheur County has, as one SUD leader put it, a "***good connection with the criminal justice system****...we do serve really well when someone's referred by probation and parole or, if they're already in the jail, we do a really good job of connecting with them in the jail.*" Following release from jail, there are **transitional housing services** for women (pregnant women are there but it does not serve families or allow children).
- A residential facility is soon reopening in the area. In collaboration with DHS and their Federally Qualified Health Center (FCHC, or a community health center with funding to serve rural & frontier communities), the residential treatment facility will provide **parenting supports during and after treatment**. This clinic and area emergency rooms strive to **screen every person** with an appointment for alcohol/drug use and depression.
- One SUD leader described their **marijuana prevention program** as "*pretty strong...especially with Malheur County being new to having dispensaries in town as of this year.*"
- **Peer-delivered services** are growing in Malheur County, which will enable them to "*do a lot of great outreach with people that we believe may have a substance use disorder because that's really our goal...[to] find people who aren't engaged in any services.*" This SUD leader went on to say, "*I really like home visiting because it meets people where they are...there's still such a big stigma around these things, especially for pregnant women who might be using or drinking.*"
- The EOCCO has a **Malheur Community Advisory Council** that brings together leaders from various service systems for planning, needs assessment work, and community listening sessions.

SUD System Challenges

In addition to strengths, the Malheur County SUD system also faces challenges, especially as it relates to pregnant women and parents with young children.

- **Behavioral health services do not to take a "whole" view of the parent**. Instead, the focus is on the disorder, the diagnosis, and the treatment plan. As one SUD leader said, "*I don't think the parenting aspect is really too much integrated into the work at the clinic.*" Another SUD leader described how residential treatment rates are higher for men because mothers don't want to leave their children, so women tend to have more unmet need.
- **SUD treatment hasn't always done a great job**, especially when people are mandated. "*What we're hearing from people is that they're not getting the care that they need.*" Malheur County, according to a SUD leader, has high rates of emergency department use for mental health crises, which often involves a substance use issue. Loopholes in the system (e.g., patient has to be medically cleared before they can receive SUD services) create fragmentation and "*people just end up walking out against medical advice.*" Moreover, there is a lack of dual diagnosis services available.
- The SUD treatment system could be **better connected with public health** in order to reduce infectious disease (HIV, hepatitis), connect people with peer mentors, and provide early assessments. This harm reduction approach could increase options for people with SUD issues. Also, Malheur County does not have a detox center. As one SUD leader said, "*people cannot go into treatment if they're detoxing...they're doing it in jail...and then sometimes they'll get sick enough, they go to the hospital.*"
- Malheur County's **SUD workforce doesn't have the capacity to serve** everyone in need of outpatient SUD services. A SUD leader said, "*...that's not just a matter of funding and being able to support those positions, but it's also a matter of...being able to find trained compassionate quality care providers that fit the agency's mission and vision and want to do that work.*"
- There is not a robust **recovery community and other supportive services** in Malheur County. Safe and affordable housing is often not available and family resource centers

"*don't really exist in our area*." There are some faith-based organizations that do food assistance, but as one SUD leader put it, "*once you're graduating out of treatment and you're still in an area that maybe doesn't have some of those opportunities for healthy and safe activities, there's a good chance of falling back into old ways of life that lead you off the recovery pathway.*"

- **Transportation** in Malheur County is challenging. Outside of the largest town, the surrounding areas do not have treatment programs, public transportation, social service organizations, public health offices, or community corrections. There are new efforts with telehealth, but broadband connections in rural and frontier communities are problematic.

SUD leaders interviewed thought the SUD system in Malheur County would benefit from a wraparound-type, "***one-stop shopping***" or a "*centralized location that kind of covers at all*." Rather than individuals having to travel from place to place and navigate complex systems, their service providers would meet them there. In this way, people could be served in the "*least restrictive location*" and would be treated as a "*whole person*." Another SUD leader pointed to the importance of an "***army of peers who would be paid***, *we'd have money to pay for them billed into our capital rates, so people would hire more peers…and culturally specific peers, like being able to match people up with language, culturally-specific peer services.*"

Home Visiting and the SUD System

SUD leaders saw the potential of connecting HV and SUD services. More than one SUD leader suggested **pairing home visitors with SUD providers**, or with peer mentors.

"It'd be cool to have a home visiting program that could actually tap consultants who are more of that kind of boundary spanning expert—SUD and early learning—and bring them with them. Then have a dual kind of session." —*SUD Leader*

"…our mentors are working with our home visitors…what's been ideal is to have a peer and home visitor in the situation in a way that's…seen as a support. It's very important that we're not seen as law enforcement." —*SUD Leader*

"…just giving referrals and phone numbers out to people who need help—they're not going to call up that phone number and say, 'I was told that I need help'…so many barriers to advocating for themselves, to being honest about the situation. A home visitor could do that…'I can take you to your appointment and I'm going to be back next week…and the goal is to have a happy, healthy life in recovery back with your kids and that is totally possible.'" —*SUD Leader*

One SUD leader pointed out the importance of **building relationships** ("*…the very first step is we need to know who to talk to. Bring the two organizations together.*"). Next, the organizations would need to address business processes:

"…making sure that we have the right MOUs or business associate agreements or what have you, in place to allow for that coordination to happen. Again, trying to keep that focus on it being seamless for the consumer so they aren't having to go through a choppy process or break down their motivation or their engagement because of a bureaucratic system." —*SUD Leader*

Home Visitor Skills Related to SUD

SUD leaders thought it was a **good thing for home visitors to do screenings and referrals for SUD issues**. One SUD leader said, "*…sometimes in order to meet someone where they are and really build that rapport to empower them to want to seek out the full assessment and to participate in that, I think screenings in the community provide a great stepping stone…*" However, it is important for the information collected during the screening to be transferred to the treatment provider to **create a seamless experience**:

"I would like to see a good translation of what's collected there in supporting that assessment. And so when I have screens taking place through one organization and then a referral for assessment and treatment with a different organization and the strictness of 42 CFR [regulations about protecting client records], I think that creates a hurdle for clients that often can be scary for them. It's already terrifying to admit you have a problem and to try to seek out treatment for that. But if you have to then repeat yourself over and over to different individuals. And it shouldn't be a consumer's responsibility to know that." —*SUD Leader*

Another important issue for SUD leaders is that **home visitors must have training on SUD screening** and "*know their responsibility in utilizing those skills*." There was a sense that as long as home visitors operated within the boundaries of their education and alcohol/drug certification level, then having them screen parents is useful. Along these same lines, another SUD leader thought that **home visitors would need to** "***address their own biases*** *and any kind of stigma they might have themselves around people that use or drink…*" Even using a word like '*addict*' or '*druggie*' can "*absolutely shut them down*." They went on to say that many people see SUD as "*a choice…[and not] as a disease and a chronic health condition.*" In return, it would be important for **SUD providers to increase their understanding of early learning**, brain development, and trauma.

Umatilla County: A Closer Look at Home Visiting Capacity, Community Needs, and the SUD System

As part of the MIECHV needs assessment, the research team conducted more in-depth analysis and data collection for Umatilla County. While overall, Umatilla County was not among the counties identified through the Phase One MIECHV risk assessment as highest in potential need, experience and data suggest that there are clearly unmet needs in this frontier area of Oregon. To better understand where there are pockets of community risk, groups of families who are not well-represented in current enrollment patterns, and/or lacking in key early childhood or other community resources, we conducted a mixed-method case study to collect additional data (see Case Study Methods). It is worth noting that data collection for this case study was challenging due to a local resurgence of COVID-19 cases that occurred during our data collection window, limiting availability of many of the public health and program staff we attempted to contact.

Case Study Methods

- Review of existing population and other data for specific geographic locations and prior needs assessments specific to Umatilla County*
- Interviews with 3 home visiting (HV) and 3 substance use disorder (SUD) treatment program leaders
- A (virtual) focus group with 4 home visitors representing different two program models (Early Head Start and Healthy Families Oregon)

*Early Learning Map of Oregon (ELMO); Oregon Office of Rural Health (2018); Eastern Oregon Coordinated Care Organization (2019).

Phase Two Risk Analysis Key Findings

Umatilla is a remote rural county in eastern Oregon. While Umatilla was not identified as higher risk in Phase One analysis, additional data suggests it remains a key area in which HV services are needed. These include additional demographic risk factors (see Table A2) as well as limited access to key family services such as child care, prenatal care, primary care, mental health, and HV. Early Learning Map for Oregon data indicate that Umatilla county had a moderately high rate of children under age six living in poverty (30%) in relation to the state (20%).[a] Further, Umatilla County is higher than the state overall for several important risk factors such as childhood poverty, student eligibility for free and reduced lunch, and children living with single parents. Perhaps most importantly for HV, infant mortality in Umatilla County is almost twice the rate of the state overall, as is the case for postpartum maternal depression. Almost half of Umatilla County mothers screened positive for postpartum depression, compared to just 1 in 5 for mothers in Oregon. Further, rates of smoking and alcohol and drug use among teens all consistently exceed state averages.

a Early Learning Map of Oregon (ELMO). https://oregonearlylearning.com/PDGAssessment#ELMO

In Appendix A, it is clear that Umatilla currently has the capacity to serve fewer potentially at-risk families through HV than many other counties in Oregon. For example, this county currently has the capacity to serve only about 7% of the children under age 6 living in poverty with evidence-based HV services.

Table A2. Umatilla County risk factor data

Indicator	Umatilla County	Oregon
Childhood poverty rate	25.3%	20.4%
Unemployment	5.4%	4.9%
Students eligible for free/reduced lunch	63.4%	47.6%
% Single Parent homes	12.7%	8.3%
Infant mortality per 1,000 births	7.4	4.6
Maternal depression during pregnancy	28.9%	20.1%
Maternal depression postpartum	47.6%	21.3%
11th grade abstaining from tobacco	71.4%	81.1%
11th grade abstaining from alcohol	33.5%	44.7%
11th grade abstaining from marijuana	55.5%	60.5%

Note. Data were extracted from Eastern Oregon Coordinated Care Organization's (EEOCO) Umatilla County Health Assessment (2019).[a] Data sources and year data were collected differed depending on the health assessment reviewed for this report. Thus, Oregon estimates for certain indicators may not match across all three counties (Jackson, Umatilla, and Yamhill).

Within Umatilla County, there are specific geographic areas where needs, risk factors and/or lack of resources are especially pronounced compared to the county overall: Echo, Athena, Milton-Freewater, Hermiston, and Pendleton.[b,c] These represent key areas for expanded screening and recruitment for MIECHV-funded HV slots in this county.

Echo

- Less than half a percent of children ages 0-5 living in poverty had access to publicly-funded child care.
- 77% of children under age 6 had health insurance compared to 96.5% in Umatilla County, one of the lowest percentages in the county.
- No early learning providers meet the minimum quality standard for child care in the state's Spark system (rating of 3 or higher), severely limiting access to quality child care.

a Eastern Oregon Coordinated Care Organization (2019). Umatilla County Community Health Assessment. https://www.eocco.com/eocco/-/media/eocco/pdfs/cha/cha_umatilla.pdf

b Early Learning Map of Oregon (ELMO). https://oregonearlylearning.com/PDGAssessment#ELMO

c Oregon Office of Rural Health (2020). https://www.ohsu. edu/oregon-office-of-rural-health/about-ruraland-frontier-data

Athena

- No early learning providers had a Spark rating of 3 or higher.
- No licensed child care facilities with at least one child using a DHS subsidy (ERDC or TANF), an indication that low income children are not being served.
- 9.5% of children ages 0 to 5 had access to a child care slot, a rate lower than the county (19%) and the state (24%).

Milton-Freewater

- 15% of early learning providers had a Spark rating of 3 or higher.
- 24% of kindergartners were chronically absent (absent 10% or more days), greatly exceeding the state average of 16.8%.
- One of the lowest capacities for primary medical care providers in Oregon based on a ratio of primary care visits provided to visits needed: 0.1 in Milton-Freewater compared to 0.7 in rural Oregon and 0.93 in Oregon overall).
- 0.1 mental health providers per 1,000 people, compared to 0.74 in rural Oregon and 1.7 statewide.
- 7.4% of pregnancies had late or inadequate prenatal care, compared to 5.8% in rural areas and 5.7% statewide.

Hermiston

- 0.4 mental health providers per 1,000 people, compared to 0.74 in rural Oregon and 1.7 statewide.
- 7.7% of pregnancies had late or inadequate prenatal care, compared to 5.8% in rural areas and 5.7% statewide.

Pendleton

- 8.4% of pregnancies had late or inadequate prenatal care, compared to 5.8% in rural areas and 5.7% statewide.

Qualitative Case Study Findings

As part of the Umatilla County risk assessment, we spoke with three home visiting county leaders, representing Early Head Start (EHS), Nurse-Family Partnership (NFP), Babies First!, and Healthy Families Oregon (HFO). We also spoke with three regional SUD leaders. Finally, we conducted a focus group with four home visiting staff representing EHS and HFO.

Home Visiting Capacity and Quality

Home visitors and program leaders reported that even when fully staffed, they do not have the capacity to serve all interested families in Umatilla County. Staff turnover and the time it takes for onboarding and training new staff exacerbate this problem.

> "We have somewhat high turnover in home visiting programs, not as high as say child welfare but then you just have to go through the whole training process again and working on adding families again so that can kind of impact it as well. Even with full caseloads we still don't have the capacity to serve all families."
>
> *—HV Leader*

Which families are not being enrolled and engaged in services?

Interview and focus group participants noted that there are not enough home visitors who are bilingual and bicultural, and therefore, families speaking languages other than English and who are from outside of the U.S. are not being enrolled and engaged in services as well as they should be. In Umatilla County, Korean and Guatemalan communities are reported as not receiving HV services. In particular, Guatemalan families are not being served adequately, as home visitors need knowledge of multiple dialects.

Home visitors described how they work to be creative in how they can provide services to families whose language they do not know. Home visitors may use mobile applications for translating and interpretation, but they felt that this can present a barrier to smooth communication and building relationships with families. Bilingual children often help to interpret for their parents and caregivers; however, the sensitive nature of some conversations makes this inappropriate at times. Home visitors reported that the paperwork involved in their work is especially difficult and time-consuming, and they expressed concerns about how well complicated issues like mental health and domestic violence are being communicated.

"We are struggling with that Guatemalan aspect and we are having more and more and more Guatemalan families come. My understanding is that there's not even a Guatemalan interpreter really within the state of Oregon. Well, when there's 36 different dialects and we have three that are predominant, I don't know any one person that speaks all three of those dialects. Let alone in a rural area. And then how do you translate through a phone? And it's really hard because you're trying to build these personal connections with the families that you serve and these home visitors really take pride and really strive to have these deep personal connections with the families that they serve." *—HV Provider*

Workforce Issues and Challenges

A few workforce issues are identified as a barrier to serving bilingual and bicultural families. Home visiting (and public health more broadly) staff do not reflect the demographics of the population in Umatilla County, regarding language and race/ethnicity but also including socioeconomic status and family structure. Home visitors need to rely on other staff within their organizations to support translation and interpretation needs; however, these staff are not trained in HV and have other job duties to address. Home visiting staff acknowledged that training can be helpful in learning about diverse cultures, and ideally, they would be able to collaborate with community members with lived experience. These experts could help home visitors meet the cultural and linguistic needs of families; however, many of these people are nervous about working with organizations when there are frequent Immigration and Customs Enforcement (ICE) raids in Umatilla County.

Gaps in the Home Visiting System

Program and System Issues

Stakeholders described several issues that contribute to the system's inability to serve all families who may want and need HV services. First, they shared that Umatilla County families have a multitude of complex needs for home visitors to address. Of central concern is the high rate of postpartum depression. Almost half of Umatilla County mothers screen positive for postpartum maternal depression, whereas the rate for Oregon mothers overall is just 1 in 5 (20%). Infant mortality in Umatilla County is almost twice the rate of Oregon. Additional issues that families in Umatilla County face include affordable housing, transportation, substance use disorder, and child welfare involvement. Meeting these various complicated needs requires strong coordination with other systems. Home visitors acknowledge that these challenges can be even more difficult for families who are new the U.S. and unfamiliar with available programs and how to access them. Home visiting programs can offer the opportunity to connect families to vital resources. Home visitors identify needing training to understand the key issues that families face, know about available resources, and how to talk with families about sensitive, personal topics.

Just as home visitors need to be knowledgeable about the other systems that can support families, HV programs also need to ensure that these systems are aware of HV and its many benefits for families. Some providers, such as hospitals where babies are delivered, seem to refer only very high-risk families, and home visitors wonder if this is because hospital staff do not know the plethora of ways home visitors can assist families. There is limited collaboration across service sectors, an issue shared by SUD providers as well (see below). Keeping providers educated about HV is challenging, though, with high turnover rates among partner organization staff.

"We rely on others to refer to us. And so can we improve the communication that our partners are in speaking of home visiting. Normalizing it. Sometimes it seems like just for the quote unquote desperate, or just for somebody who's especially high needs or high risk in some kind of way rather than just looking at the system. This is something that anybody could benefit from it and just more broadly casting that net. I think that is something that we've battled. And how do we educate our referring partners that this is okay? And a lot of those places will have staff turnover, so you're just seeing a lot of new faces over time." *—HV Leader*

Rural areas in Umatilla can be challenging for HV programs to serve, which is discussed in more detail below. The funding structure of the HV system contributes to this challenge, though, in prioritizing urban areas through population-based funding formulas as well as billing structures that don't take into account more costly travel expenses for HV in frontier communities. In rural and especially frontier areas, they noted that home visitors might need to travel two hours one-way to see a family; more visits can be done in a limited time period in urban areas. Additionally, adhering to fidelity in terms of caseloads and number of visits provided evidence-based HV models is more of a challenge in rural areas, which home visitors felt is not considered as these models are designed, implemented, and evaluated.

"When you talk about, well, we could be serving twenty-five families in one city because there's enough people versus serving only three families because of the amount of time. That's a bit drastic but those are conversations that we have constantly. We have to serve them too, so it's an ongoing struggle around travel funding." *—HV Leader*

Finally, home visitors described other program requirements that may be a barrier to families receiving HV services. These include strict eligibility requirements that omit families with moderate risks from being served, and strict timing restrictions that are in place for prenatal eligibility (e.g., for Nurse Family Partnership services). Increasing overall HV capacity would help to allow more than just the families with the most risk to get served. The available hours for home visits are also a challenge for caregivers working full-time Monday through Friday, and these families may be interested in HV if weekends were available to them for meeting. This is particularly impactful in the farming communities in Umatilla County, where working long hours is necessary to provide for families.

An important source of referrals to HV programs comes from hospitals after the birth of a child. While this is clearly a good time for starting HV services, communicating to new parents about the program can be a challenge. Many parents are overwhelmed at the hospital and may not completely process the information they receive about HV. If a HV screener is able to meet with families for the first time in the hospital, parents may be hesitant to discuss sensitive, personal information and may not fully disclose the risk factors needed to be eligible for services. For this reason, screeners will try, as their workload allows, to follow up with families after they have had time to acclimate to having a new baby in the home. When babies are delivered on a weekend, or if families go to a hospital in Washington (as is common in northern Umatilla county), then they get missed entirely by HV screeners.

"We come in and a lot of the times, the first time we meet them is in the hospital and it's the first time we met them. Asking really personal questions and so a lot of the times, you can tell that they're not lying, but that maybe they're not disclosing as much because it's my first time meeting them and I built up no rapport and so they don't qualify for services when they probably really do in actuality. I think they definitely fall through the cracks." *—HV Provider*

Underserved Areas Within Umatilla County

Within Umatilla County, more remote areas such as Ukiah, Pilot Rock, Athena, Weston, and Milton-Freewater were identified as particularly difficult to serve because they are remote. ELMO data indicates that access to quality, affordable child care is limited in these areas, and the Office of Rural Health reports fewer healthcare providers in these rural areas too. Home visiting programs often rely on child care and healthcare providers to refer families for services, so they may not even be aware of families who would benefit from HV services. Without HV program offices in these rural areas, home visitors are difficult to recruit who are able and willing to reach remote locations, and programs struggle to have a presence in these communities. Additionally, home visitors identified a common mindset they have observed in rural areas that people should not need help raising children, that the government should not provide direction on child-rearing, and that such involvement is an invasion of privacy.

"There's such a need in the larger areas that they have to prioritize travel. Like we have some families like in the rural mountain area on the east side of the county. And with that portion, they won't go to even if they are less resourced and there are more barriers to getting resources. They don't serve them because it takes their home visitor longer to see them and so it means that they miss out on a client that's conveniently located." *—HV Leader*

Outreach to Families

Home visiting staff recognize that successful communication and outreach to families is a gap in the HV system. They shared that families perceive a stigma related to having a home visitor, as parents feel judged by professionals and judged for needing assistance. Caregivers also worry that HV is connected to DHS Child Welfare. Undocumented family members fear that involvement with HV services may lead to connections with ICE, jeopardizing the services their families do receive or their ability to remain in the U.S. Therefore, more communication and outreach to help address these beliefs and barriers (especially to rural and immigrant families) is important so that families understand the many benefits of HV services.

SUD System

As already noted, families involved in HV services have complex needs that require home visitors to collaborate with other systems. SUD services are important for many of the families being served by home visitors in Umatilla County. In Umatilla County, most SUD services operate through the county's Human Services department, though there are some private providers as well.

Strengths of SUD system

The Umatilla County CARE Program helps people navigate the SUD system; the CARE Program is free for anyone with a child and also helps families connect with other county services. The county also has peer support mentors available who offer support and guidance from their own lived experience. Umatilla County does not have any waitlists for outpatient services and

offers a variety of individual and group treatment options to ensure everyone seeking services can get them. Anyone who calls the county about SUD treatment is seen (even if just a virtual visit) within five days, and a pregnant woman who is using will be seen the same day that she calls.

Gaps in SUD system

Umatilla County's SUD system is not without its challenges. While outpatient services do not have any waitlists, inpatient treatment is difficult to get into and waitlists are lengthy. There are limited treatment and recovery options in Umatilla County, so clients who have already been through a program once or twice or who did not have a positive experience, do not have additional options. For parents, transitional housing that allows children is in high demand. Parents receiving outpatient services may also struggle because daycare is not provided. There is only one Relief Nursery, which is located in Pendleton, so child care while parents participate in treatment or recovery services can present a barrier to their ability to accessing those services.

SUD program leaders also acknowledge the difficulty accessing services in Umatilla County for people in need of both SUD and mental health treatment. They report that both systems often deny their services if symptoms with the other are present. This leaves many people bouncing back and forth between systems or giving up on accessing any services at all.

"Our mental health providers will not serve substance use disorder clients because they say it's a substance use disorder. But then they also need mental health treatment and it's an ongoing struggle in our communities. It is a neverending challenge. Well, it's a mental health issue. Well, no, they're using substances. You know, it's this battle back and forth and the client really gets lost." *—SUD Leader*

Home Visitor Knowledge of SUD Services

Home visitors acknowledge that substance use is a serious concern for families in Umatilla County, with methamphetamines, alcohol, marijuana, and opioids being the most prevalent substances. Families who have gone through or are going through treatment seem open with home visitors about their experiences with treatment and recovery. Home visitors also remark that caregivers learning about stages of change, coping strategies, and mindfulness in treatment and recovery seems helpful to their HV services too.

Home visitors receive some training about SUD and community resources, but they also identified additional training needs about how to connect families with resources and how to navigate difficult conversations about SUD with families. SUD leaders recommend home visitors develop awareness of bias they might have around SUD and parenting issues, highlighting the value of a nonjudgmental approach. Home visitors should know how to screen for SUD and how to make referrals if necessary, while also understanding how to support families in various stages of change.

"Knowing where to go is easy, but recognizing, referring, how to have those difficult conversations, what does treatment looks like, how to help a family who's going through that. You know, let's say it's the spouse of the parent we're serving or the partner. How do we support them?" *—HV Leader*

Home Visiting and SUD Coordination

Home visiting and SUD staff acknowledged that coordination among their systems is a challenge but that when they are able to work together it can be helpful for families. There was strong belief that the broader social service culture in Umatilla County needs to shift to be more collaborative. Home visitors would like to be able to talk to families about SUD services from a position of having relationships with SUD staff and having positive things to say about specific programs. Staff turnover can make relationship-building difficult, but the Community Advisory Council provides an ongoing opportunity to become familiar with various service providers in Umatilla County. Home visitors also suggested creating regular meetings for case consultation and learning about each other's services and processes for accessing services.

"I would say, one of the things that we struggle with is the collaboration, the relationship, between us and those who are providing those treatment services. If we could collaborate more—and that is true for child welfare as well—like if we could collaborate more with those caseworkers, um then we'd be able to better support those families as a team versus trying to do it one-sided. I think that that is kind of a barrier that we experience." *—HV Leader*

Yamhill County: A Closer Look at Home Visiting Capacity, Community Needs, and the Substance Use Disorder System

As part of the MIECHV needs assessment, the research team conducted more in-depth analysis and data collection for Yamhill County. Although Yamhill County was not identified through the Phase One risk assessment, experience and data suggest that there are clearly unmet needs in this area. To better understand where there are pockets of community need, groups who are not well-represented in current enrollment patterns, and/or areas lacking early childhood or other community resources, we conducted a mixed-method case study to collect additional data (see "Case Study Methods" box).

Phase Two Risk Analysis Key Findings

Yamhill County is a geographically varied area southwest of Portland and northwest of Salem, Oregon's state capital. Data suggest that Yamhill County has more children living in poverty and less access to publicly funded child care (see Table A3).[a] Yamhill county's largest cities, McMinnville and Newberg, have experienced 23.9% and 24.3% population growth between 2000 and 2014.[b] The Community Assessment also reported that although Yamhill County has experienced a slight decline in its poverty rate among families with children under 5, certain areas (e.g., McMinnville, Amity, and Carlton) have seen increases of 4.9% to 7.7%.

Case Study Methods

- Review of existing population data and needs assessments for specific localities within Yamhill County*
- Qualitative interviews with 4 home visiting (HV) and 1 substance use disorder (SUD) treatment program leaders
- A (virtual) focus group including 6 home visitors representing 3 HV program models (Early Head Start, Healthy Families Oregon)

*Early Learning Map of Oregon (ELMO); Preschool Development Grant Strength and Needs Assessment (2020); Head Start of Yamhill County Community Assessment 2015-2016.

a Burton, M., Green, B.L., Miao, A.J., Pears, K.C., Scheidt, D., & Tremaine, E. (2019). Oregon Preschool Development Grant Strengths & Needs Assessment, Birth through Age 5. https://oregonearlylearning.com/wp-content/uploads/2020/04/psu-or-pdg-report-2020-02-11-pages-web.pdf

b Head Start of Yamhill County Community Assessment 2015-2016. http://yamhillheadstart.org/resources/display/annual_report_community_assessment_community_partnerships

Table A3. Yahmill County risk factor data

Indicator	Yamhill County	Oregon
Children 0-4 living in concentrated or high poverty	56.5%	43.4%
Children 0-5 with no parent in the workforce	11%	8.1%
Enrollment in publicly funded preschool	22.9%	27.1%
Access to publicly funded child care slots, 0-2	0%	4.6%
Access to publicly funded child care slots, 3-5	25.4%	37.4%

Note. Data presented were extracted from the Preschool Development Grant Strength and Needs Assessment, 2020. Data sources and year data were collected differed depending on the community needs assessment reviewed for this report. Thus, Oregon estimates for certain indicators may not match across all three counties (Jackson, Umatilla, and Yamhill).

Yamhill County has experienced population growth and demographic shifts from 2000 to 2014 (Head Start of Yamhill County Community Assessment 2015-2016). The largest cities, McMinnville and Newberg, grew 23.9% and 24.3%, respectively. Although Yamhill County as a whole has experienced a slight decline in poverty among families with children under 5, localities such as McMinnville, Amity, and Carlton have seen increases of 4.9 to 7.7%.

The Early Learning Map for Oregon highlights specific geographic areas where needs, risk factors and/or lack of resources are especially pronounced compared to Yamhill County or to Oregon overall: Newberg, Amity, Sheridan, Carlton, and Lafayette.[a] Issues include higher poverty rates; less high quality, affordable child care; less health insurance coverage; less affordable housing; and more chronic absenteeism in school.

Newberg

- 25% of children 0-6 are living in poverty (<100% Federal Poverty Level, or FPL), compared to 20% in Oregon.
- 6.5% of children living in poverty (ages 0-5) have access to publicly funded child care, compared to 22.5% in Oregon.
- 18% of children ages 0-5 have no parent in the workforce, compared to 8% in Oregon and 12% in Yamhill County.
- 39% of occupied housing units cost more than 30% of income, compared to 36% in Yamhill County.

Amity

- 0.5% of children ages 0-5 have access to a child care slot (publicly or privately funded), compared to 24% in Oregon.
- 16.7% of kindergarten children in the Amity School District are chronically absent (absent more than 10% of school days) compared to 14.8% in Yamhill County.
- 76% of children under 6 have health insurance, compared to 96% in Yamhill County and 96.5% in Oregon.

Sheridan

- 29% of children ages 0-6 are living in poverty (<100% FPL), compared to 22.5 % in Yamhill County and 20% in Oregon.
- 2.5% of children ages 0-5 have access to a child care slot (publicly or privately funded), compared to 24% in Oregon.
- 0.5% of children living in poverty ages 0-5 have access to publicly funded child care, compared to 22.5% in Oregon.
- 19.8% of kindergarteners are chronically absent, compared to 14.8 % in Yamhill County and 16.8% in Oregon.

a Early Learning Map of Oregon (ELMO). https://oregonearlylearning.com/PDGAssessment#ELMO

Carlton

- 41.5% of occupied housing units cost more than 30% of income, compared to 36% in Yamhill County.
- 64% of children under 6 have health insurance compared to 96% in Yamhill County and 96.5% in Oregon.

Lafayette

- 36% of children ages 5-17 have a primary language other than English compared to 20.5% in Yamhill County and in Oregon, indicating unique linguistic and cultural needs. Services for children and families in this area require resources (e.g., bilingual/bicultural staff, translation support, interpreters, culturally-specific programming) to meet these needs.
- Only 72% of children under 6 have health insurance, compared to 96% in Yamhill County and 96.5% in Oregon.

Interviews with key stakeholders in Yamhill County underscore the quantitative findings. Yamhill County families face domestic violence, challenges associated with being undocumented residents, homelessness, food insecurity, and lack of support and isolation (especially among Latinx and rural families).

"Most of my families on my caseload they are Hispanic families. The main issue that they have is that they came from other countries, they don't have a lot of support here. So that's my main thing to connect them with other families, you know, but that wasn't really, you know, they feel lonely here." *—HV Provider*

Additionally, some families in Yamhill County are managing mental health and substance abuse issues, which compound with parenting stress. One home visitor shared that families with mental health issues could use more specialized support.

"Most of my caseload deals with pretty severe mental health issues. And while they are connected, and most of them were referred from mental health, they're really not satisfied with the mental health support they receive…Having a mental health support person or group in this county and focused heavily on postpartum mental health issues would be amazing. Not every counselor is created equal and to have just a couple that we knew that could really handle targeted postpartum depression and anxiety and sometimes psychosis would be really awesome." *—HV Provider*

Yamhill County Home Visiting Landscape

Home Visiting Capacity

Yamhill County utilizes a core referral system to enroll families in the county's HV programs. HV services are advertised and promoted in health care settings and community gathering places throughout the community. Yamhill County health professionals do not need to know the eligibility criteria and focus of each HV programs, but instead refer families to the core system. HV program representatives then come together and assign families to the programs with available slots and that are able to best meet the family's unique needs. Some HV program supervisors and providers described the county's core referral system as a strength.

"We've tried to streamline the process by having it be a universal referral so that the community partners don't have to be experts on which home visiting programs we have. That's helped." *—HV Leader*

"…at any given time, specific programs might not have capacity but that's the benefit of our referral system…if one program doesn't have capacity but a family has need, another program [is] able to accommodate. So, specific programs may fill up from time to time but our overall capacity doesn't." *—HV Leader*

"I think we do a really good job of reaching a lot of families because the county is so cohesive. You know, we have the core referral system, which really helps in making sure that families who are getting services from another agency also can get services from our agencies as well. So, if a parent goes in for mental health services and they have young children, they might get referred to Head Start or Healthy Families…Can I say that it's 100% effective? No, because…we don't know how many families are out there that are not getting reached." *—HV Provider*

The core referral system also poses enrollment challenges for certain programs. Some programs are required to maintain a waitlist and are at capacity (e.g., Early Head Start), while some home visitors expressed frustration with their (in)ability to recruit and serve families.

"We have lots of capacity. I feel like we are inundated with home visiting programs. It's actually been impacting my program's ability to enroll families." *—HV Leader*

"We don't have enough families signing up because we're not reaching [them] but I can say that we all have space and have a need on our caseloads right now for more families. We're willing, we're able, we have the funding and the supplies, the time, and we are all maybe 50 to 60 percent full, some of us a little more, that we can take on a ton more." *—HV Provider*

Some HV leaders have more success going outside the core referral system.

"I think there might be some challenges with [the core referral] process, in terms of who gets first dibs to referrals…I know that's been part of my goal as a program manager is to kind of go rogue at this point and just start with doctors and say, 'Hey, this is what we do.' You know, you can choose either to go through family core or just come to us or whatever. But it's been a real struggle." *—HV Leader*

Barriers to Serving All Families

While the core referral works well for some programs, others struggle to reach the families in need of services. HV leadership and providers shared additional barriers to reaching, engaging, and enrolling all families that could benefit from HV services in Yamhill County.

- **Screening processes**. Screening processes can be intimidating to prospective families. Parents may not want to share personal information with screeners whom they have just met.

"Maybe they qualify for our programs, but they maybe won't say that they have anxiety or that they have depression or that they're having problems with alcohol or drugs because they don't want to open themselves up to that through a screening process. And so then they just don't qualify for our program because they don't answer 'Yes' to a question. And so we miss those opportunities to help people because in this first meeting of screening to somebody they don't even know, they don't answer a question." *—HV Provider*

- **Paperwork can be intimidating for families**. The paperwork to enroll families is not necessarily at an understandable reading level for some families.

"I just think there's some huge gaps when it comes to speaking to people, getting them into the program, explaining things. I mean, it's not at a first-grade level. Most of these forms are difficult and even our family forms have to be so professional and for an impoverished person [it can be] terrible." *—HV Provider*

- **Program-specific eligibility criteria**. Program-specific eligibility criteria can limit enrollment in programs because families who would otherwise benefit from HV cannot be served, even if they are close to meeting the criteria. Home visitors said that income caps, child age, and number of children in the family are the criteria that most commonly limit enrollment. One home visitor added that parents' *perception* of program eligibility requirements can prevent them from applying.

"In Healthy Families, there's not an income restriction, but one of the barriers that we face is a little bit the opposite of that… People don't go through the screening because they assume they make too much money. You can qualify for our program by just having experienced anxiety and depression. And so we can take a lot of people that might have been turned away from Early Head Start and kind of have this blanket support where we get to pick up the people that didn't qualify. But we're missing it because they think they make too much money for both and they don't even come to us. Or they qualify, and they think someone else needs it more. And it's really hard to explain to them, but they've been offered this position for a reason and not to worry so much about that." *—HV Provider*

- **Stigma and fear**. The majority of HV stakeholders in Yamhill County agreed that stigma about HV is a persistent barrier to enrolling families. Families can be concerned about letting a stranger into their home who may judge their parenting practices and/or report them to government agencies. Some specific groups for whom stigma and fear is especially salient are:
  - **Latinx families**. Yamhill county has a significant population of Latinx families that could be served by HV programs. Many of these families are undocumented, and carry unique fears about being deported if they receive public services.
  - **Isolated families in rural areas**. Some families living in remote areas of Yamhill County could benefit from HV services, but hold unique fears about home visitors coming into their home.

"We have a lot of communities kind of on the fringe of the county, and they don't really want people in their homes…But with [the] Healthy Families program, we have to actually be in the home. There's not a whole lot of flexibility around that, like there might be some other models. That actually has been a barrier to engagement pre-COVID with some folks. Where they're very, you know, 'All home visitors are government spies.'" *—HV Leader*

Barriers to Serving Specific Groups of Families

Latinx families in Yamhill county face unique barriers to participating in HV programs. HV staff said that Latinx parents are more likely to work variable shifts or multiple jobs, which makes it challenging to schedule home visits during home visitors' working hours.

"We see that a lot of Latino families work jobs, and that makes it really hard for home visiting because it's a struggle for them to find the time that's going to work best for their family. And because you want the kids there, too. And it's also hard for home visitors. You know, when you have a caseload of 10 families, maybe four of them are working and you've got to figure out creatively how we're going to visit them every week, especially a lot of folks have shift work that changes and they never quite know what their schedule is going to be…Sometimes it's just too much for them and they drop." *—HV Leaders*

Additionally, Latinx families in Yamhill are often multigenerational or include caregivers other than parents. One supervisor suggested that HV models, as they currently exist, may not be able to fully support these families' needs.

"In Yamhill County, we have a lot of kith and kin care and especially our Latino families and some of our rural families rely on their family members to provide that care. Including both the caregivers and the parents into the concept of home visiting I think is also important." *—HV Leader*

Families in rural portions of Yamhill County are particularly impacted by physical isolation. Families struggle to find transportation to travel to more populated towns where services are located. While home visitors are able to come out to those families' homes, the majority of referral strategies in Yamhill are tied to agencies based in more populated areas.

"Every other town in Yamhill County is rural. You know, so they're small towns, not a lot of services. They have to travel to get to them so they either have to travel to Salem or McMinnville, or Newberg…sometimes even Portland to get services…" *—HV Provider*

"Quite a few of my families only have one driver in the family. That's a two-parent household. One drives, and it's usually the mom that doesn't even know how to drive. And some of them know how to drive…but they're not supposed to drive…and then trying to get them to get on a bus and to go across town is really hard, especially if they don't speak English and they feel like they're going to get lost in who knows where." *—HV Provider*

HV Coordination with Substance Use Disorder System

Substances Abuse in Yamhill County

HV and substance use disorder (SUD) stakeholders agreed that methamphetamine and alcohol are the most prevalent substances being abused in Yamhill County. Opioids were mentioned but are not of primary concern. They also acknowledged the complex ways in which SUD interacts with stressors (e.g., parenting young children, generational trauma).

"Because we take families based on income first, we're getting families who might get referred [to a SUD program], or they know the program because they were in the program…or they had kids in the program but they're still using. And so we've had quite a few families that are using. But [whether] we have families that are in recovery or we have families who are using, we support them, help them get into recovery, and move forward. So you know, we kind of have the spectrum in the program." *—HV Provider*

"Largely it's recovery, although I'm sure all of the other pieces [trafficking, selling] exist. Perhaps just either we're less aware of it or maybe it is hopefully just less pervasive. But, you know, certainly there's a ton of complexity when it comes to these families. Generally speaking, long histories of generational trauma…all the things that often go hand in hand with a SUD." *—SUD Leader*

Strengths and Gaps in SUD System

Strengths of the SUD system for pregnant and parenting women in Yamhill County include integration with prenatal visits, a harm reduction approach to healthcare, and peer-based programs.

→ **Prenatal Visit Integration:**

"The majority of the women in the whole county have at least one prenatal visit, the majority have far more than that. Right, but it's a pretty rare thing for just a mom to come into the hospital and deliver a baby without anyone [knowing]…And so having that strong connection with [prenatal visits], I think, is incredibly powerful both from the treatment standpoint as well as from just the trying to de-stigmatize the work because everyone goes to their prenatal provider. And so it's a nice place for them to be able to get connected to resources." *—SUD Leader*

→ **Harm Reduction:**

"I think that our health care system is really…shifting its mindset to a harm reduction approach when it comes to working with families and in terms of setting up our systems… And so just the conversations that I'm having with people feel much more collaborative in terms of that shared understanding of harm reduction and sort of meeting people where they're at and all those things… Because I think that also helps create like a place of non-judgment, and those types of things that are so critical." *—SUD Leader*

→ **Peer Program:**

"A lot of times when we know that there is someone who is experiencing substance use disorder, we will get them connected with [a peer-based organization], where they can really have a peer walk alongside them and sort of help them navigate this new world and new system. They are also the sort of 'go to' for families when they are maybe not in a place of being ready to engage in treatment yet. And we find that it is usually more effective to have a peer do that sort of work…" *—SUD Leader*

Notable gaps in the SUD system for pregnant and parenting women in Yamhill County include coordinating with insurance companies and the stigma patients experience around seeking SUD treatment.

→ **Insurance Coordination:**

"There's [a] lack of parity in terms of private insurance covering the cost of SUD treatment or even just mental health treatment like Medicaid does. Private insurances make it really challenging for an organization like us, that has hundreds of therapists that are ready to provide service…It's one of those really weird things, typically in people generally associate Medicaid with less access and when it comes to behavioral health…it actually is the opposite." *—SUD Leader*

→ **Stigma Associated with SUD:**

"There's a ton of stigma…huge stigma around substance use disorder around addiction in general. And then when you add a pregnancy on top of it, there's just so much shame." *—SUD Leader*

HV and SUD Service Coordination

HV leaders said that home visitors have varying knowledge of SUD services in Yamhill County. Responses ranged from having no knowledge of these services to very good understanding of them.

"None. At least for mine. Our home visitors have zero training on that. And I know that they encounter it a lot. We do have programs that they partner with. But in terms of actual education on that, they don't have any." *—HV Leader*

"Our staff are comfortable asking the questions to the families and the families are comfortable explaining. Many of them become peer mentors…I think we are pretty well versed in it here, but I think wherever I go, I see a lot of people who don't understand and so there's a lot of judgment. I think that's really a big area that everybody could gain knowledge in substance misuse because it's so broad and it goes hand-in-hand with mental health, depression, anxiety." *—HV Leader*

"I think that we have a very good understandin. All of our programs are nurse-based. We also partner with the treatment, transitional treatment and recovery housing. And so we have a nurse dedicated to people that we're going through that housing system…" *—HV Leader*

Home visitors in Yamhill County described parallels between the goals of SUD treatment services and HV. They want SUD service providers to know that they can be a partner or an "*added person*" in a family's recovery journey because they are "*trying to support the families and the goals that they're trying to do in recovery.*" As one home visitor put it:

"We're kind of that bridge that connects all of the services to the family because we have the strongest relationship with the family because we're in the home once a week seeing that family, visiting that family. We're building a relationship…" *—HV Provider*

Appendix C. Overview of Oregon's Home Visiting Program Models

Home Visiting Program & Mission	Lead Agency	Funding	Point of Entry	Ages Served	Target Population/ Eligibility Requirements	Geographic Areas Served	HRSA Evidence-Based?
Babies First! Optimal development and overall health, case management, safety net for children who don't qualify for other programs	Oregon Health Authority, Maternal & Child Health Local public health departments	State General Funds Medicaid Targeted Case Management & Administrative Claiming, Local Health Departments Federal funding formula, leveraging Title XIX funds, other local funds	Referral during pregnancy or at birth from hospitals, WIC, physician, other pediatric public health clinics	Birth-5 years	Pregnant women, children birth to 5, with multiple risk factors, including chronic health conditions, dev. delay	Statewide	N
CaCoon Management of complex health conditions with improved functioning; care coordination	Oregon Center for Children & Youth with Special Health Care Needs (OCCYSHN)	Title V Block Grant Medicaid Targeted Case Management Medicaid Admin. Claiming	Referral from hospitals, pediatric providers, WIC, other LPHA community partners, and family self-referrals	Birth-21 years	Children and youth with special health care needs—triage based on needs	Statewide	N
Healthy Families Oregon Prevent child abuse and promote school readiness; healthy growth and development; supporting positive parent-child attachments using an infant mental health lens	State—Oregon Early Learning Division; OHA (MIECHV funded) Local—16 program sites corresponding with each of the 16 Early Learning Hub regions	State General Funds MIECHV Medicaid Admin. Claiming Some county general funds/small grants	Hospital screening, community-based referrals	Prenatal-3 or 5 years (locally determined)	Prenatal mothers or parents of newborns screened w/two or more risk factors (demographic/ psychosocial); optional additional local criteria	Statewide except for one county	Y
Relief Nurseries Prevent child abuse and develop positive parent-child bonding and attachment; child development	State—Oregon Association of Relief Nurseries, Oregon Early Learning Division Local—Varies	State General Funds Title XX Early Learning Account (SSA) Local county and other grant funds Local fundraising	Various referral sources	Prenatal-6 years	Children at high risk for child welfare involvement, 5 risk factors for abuse and neglect, triaged for demographic/family/ psychosocial risk	Statewide: 20 counties (except Clatsop, Columbia, Tillamook, Wasco, Sherman, Gilliam, Wheelier, Morrow, Union, Wallowa, Coos, Curry, Lake, Harney)	N
Family Support & Connections Child abuse and neglect prevention; reduce families entering child welfare system; provide parenting education and support development of parental protective factors	State—Oregon Department of Human Services Self-sufficiency Programs Local—Central Office	Community-Based Child Abuse Prevention Funds Federal Funds State General Funds	DHS—ODHS Self-sufficiency local programs	Parents with children between 0-18	TANF families at-risk of child welfare intervention with 10% of slots for non-TANF families; all families must meet TANF eligibility	Statewide Variety of local community organizations	N

Overview of Oregon's Home Visiting Program Model CONT.

Home Visiting Program & Mission	Lead Agency	Funding	Point of Entry	Ages Served	Target Population/ Eligibility Requirements	Geographic Areas Served	HRSA Evidence-Based?
Nurse Family Partnership Child Health & Development and Self-Sufficiency	Oregon Health Authority, Maternal and Child Health Local public health departments	MIECHV Local county general funds and grants Medicaid, targeted case management Variety: county general, Medicaid, Targeted Case Mgt. Healthy Start prior to Healthy Families America	WIC, prenatal providers, health care providers	Prenatal-2 years	First births, < 28 weeks gestation, Low income, ? Teen mothers?	9 Counties: Washington, Multnomah, Yamhill, Lincoln, Lane, Jackson, Deschutes, Umatilla/Morrow	Y
Early Head Start, Oregon Prekindergarten Prenatal-3 years Home-Based Model Promote healthy prenatal outcomes, enhance development, healthy family functioning, parent-child bonding	State—Oregon Early Learning Division and Office of Head Start Region X Local—State and Federal Grantees	Federal with match (20% in-kind) State General Funds	Various community referrals, self-referral	Prenatal-3 years	<100% FPL, up to 10% over income; families who are homeless, foster children, families on public assistance automatically eligible; priority for children with special needs	Expansion currently with state funding 30 eligible grantees; in addition, migrant and tribal grantees	Y
Head Start, Oregon Prekindergarten Home-Based Model Mostly similar [to EHS] unless noted				3-5 years			
Parents As Teachers (PAT) Home-Based Model	Varies: county and other general funds, grants	Unknown/varies	Various referrals	Prenatal-5 years	Varies		Y

Appendix D. Parent Focus Group Findings

Parents' Experiences in Oregon's Home Visiting Programs

As part of the statewide HV needs assessment conducted to meet requirements for renewed federal MIECHV funding, the research team sought to include the perspectives and voices of parents who participate in HV programs by conducting five "virtual" parent listening sessions using Zoom (both with and without video). Parents were invited to participate by sending information about the listening sessions via email to HV program directors and staff across the state, as well as to key local organizations known as the Early Learning Hubs that serve a coordinating role for local early childhood programs. Three sessions were conducted in English with 20 participants, and two sessions were conducted in Spanish with 15 participants. All 35 participating parents were mothers. Parents were provided a $50 electronic gift card for participating. An attempt was made to include parents from all of the major statewide HV programs with mixed success. The following programs were represented in the listening sessions: CaCoon, Early Head Start, Early Intervention, Healthy Families, Nurse Family Partnership, Relief Nurseries, and a few other local HV programs. The listening sessions were transcribed and coded to identify key themes by the research team members who were involved in facilitating or supporting the sessions.

Parents discussed their reasons for participating in HV programs, barriers to engaging parents, perceived benefits of HV, and parents' perceptions of the cultural and linguistic responsiveness of the services provided. Parents also made recommendations about how to improve HV programming. Key themes from these listening sessions are described below.

Why do parents say yes to home visiting programs?

Parents shared that they agreed to participate in HV programs because they desired prenatal and parenting support, including information on child development and parenting, access to resources and services in their area, and emotional support. While all parents were seeking support, there was variation in why parents wanted the support of a home visitor.

Mothers experiencing pregnancy and parenting for the first time wanted guidance from a knowledgeable expert. This was especially true for new mothers without family members who lived locally or were supportive.

"I just remembered it was introduced to me when I was pregnant, right when I left the WIC office…They called me and they offered me the [HV] program and honestly I didn't know anything about it. But I say yes, because I was a first time mom and I was, and I didn't have any help…So when they called me and they said, we're like a first time mom program and…we help you with programs around the county and stuff. And then I said, Yeah, okay. Yeah, let's do it."

Parents who had recently moved to a new location shared that they did not know what sort of resources were available where they lived, and wanted someone familiar with the area to help connect them to the community.

Spanish speaking parents also had concerns about navigating a new community with the addition of language and cultural barriers.

"Yo llege a Healthy Families por mi doctora. Y no lo hice por ninguna necesidad en específico, sólo que soy nueva en el país, y también era mi primer bebé, y vi interesante que tuviera un apoyo, una ayuda de alguien que me pudiera proporcionar. Qué se puede hacer aquí en Oregon con los niños? Qué actividades puedo hacer con él. Alguien que fuera a mi casa a socializar, cuando estaba tan chiquito y no podía salir. Me parece interesante tener ese apoyo extra fuera de la familia. Alguien que viera desde afuera y me pudiera traer nuevas cosas y también interactuar con la comunidad, mi trabajadora me me proporcionan mucha información de qué se está haciendo en la comunidad. Dónde puedo ir antes, cuando se podía participar en bibliotecas o actividades fuera de la casa, ella me daba toda esa información, que para mí era desconocida totalmente. Porque no sabí que aquí se podía hacer tantas cosas con la comunidad. Mi país no es igual y me parece interesante aceptarlo."

"I joined Healthy Families because of my doctor. I did not do it for any specific need, other than that I am new to the country and it was also my first baby. I thought it was interesting that I could have support from someone who could help me. What sorts of things can you do here in Oregon with kids? What activities can I do with him (my child)?…My visitor provides me with a lot of information about what is happening in the community. Places we could go, back when we could still go to libraries participate in activities outside the home. She gave me all that information, which was completely unknown to me. I didn't know you could do so many things within the community here, my country is not the same, so I thought it would be interesting to accept it."

Some parents wanted the perspective of someone outside of the family who could offer a different perspective.

"Se siente uno apoyado por alguien aparte, que no es de la familia. Uno tiene un apoyo afuera del núcleo familiar, que puedes decirle también cómo te sientes y sabes que van a darte una solución o una opción de cómo puede sobrellevar este tiempo difícil."

"You feel supported by someone separate, who is not family. You have support outside the nuclear family, someone who you can tell how you feel, and you know that they will give you a solution or options for how you can cope with this difficult time."

Some parents had negative experiences (e.g., with the child welfare system) and wanted the support of a home visitor to help them be successful moving forward.

A few mothers had complications during or after pregnancy and wanted support for these issues.

"I had a really tough birth experience with a lot of complications and we were approached by a Healthy Family person. In the hospital…The way it was presented was like, we're here to basically help monitor your daughter's milestones and make sure she is growing in all the different areas. And it was just like, absolutely, I'll take all the help that I can get. Pretty simple."

How do home visitors help families?

Parents joined HV programs to receive parenting and child development support, access to resources and services in their area, and emotional support.

Parents described that their home visitors support their parenting skills and child's development by 1) providing ideas and supplies for activities, 2) providing resources and information about parents' specific concerns (e.g., breast feeding, developmental delays, challenging behaviors), 3) and helping them set goals and develop routines.

"[What we] were really grateful for, both me and my husband, was that we had somebody that could come in and kind of walk us through things that we were concerned about. My oldest was really lagging in talking, so they helped us navigate the system about what needed to be checked, and it turned out that he needed tubes in his ears. And now, you know, a year later, he's thriving… But it was nice to have somebody that was calm and wasn't quite in panic."

"My goal was like, I'm starting work the end of this week here and she's helping me get on track with a pumping schedule… something we can live with that would help me continue to breastfeed. That's something I wanted to do so bad."

Parents also talked about the value of home visitors in obtaining material resources, such as car seats and diapers, and financial resources, such as rental and utility assistance.

Others described how home visitors helped connect them to, and supported interactions with, service providers in their area. In particular, several parents talked about suffering from postpartum depression, and home visitors were able to connect them to specific supports for this issue.

"A mi me ayudó bastante con la depresión, también porque me daban muchos consejos,.Yo me estreso bastante con éllos y me ayudaban a darme consejos, como hacerlo. Por eso estoy muy agradecida con ellos por toda la ayuda que me han brindado."

"It helped me a lot with depression, also because they gave me a lot of advice…I get stressed a lot with them [her children] and they helped me give me advice, how to do it. That is why I am very grateful to them for all the help they have given me."

Spanish-speaking parents shared that their concerns about their child's development were sometimes dismissed by their child's doctor, but noted that their home visitors took their concerns more seriously and were sometimes able to help communicate their concern to their child's doctor. If the concerns were still dismissed by the doctor, the home visitor was able to connect them with other resources that could actually help them.

"Yo le estaba diciendo a los doctores que no comía, que no podía chupar la mamila.Yo llamaba a cada rato, le decía no está comiendo y los doctores dicia sí está comiendo. Y yo me sentía bien frustrada, porque a veces miraba la mamila y eran ocho onzas y en todo el día él comía cinco onzas. Y la doctora me decia no es cierto. Le digo, si es cierto, tengo la mamila aqui, lo medí nomás, tomo cinco onzas, me faltan tres y me dice que no y no. Entonces yo, estaba desesperada y la HV también me miraba y ella lucho con los doctores para que hacían algo. El niño, no estaba bien. Pesaba 11 libras a los nueve meses y los doctores me decían da le más, más fórmula y menos agua. A que sea más concentrado con más calorías, pero yo yo le decía pero no puede ir al baño, llora y sangra porque está constipated, no puede. Los doctores, cómo me juzgaban un poco loca y me decían es normal. Y la HV a la que de nuevo es la que me apoyó y comenzó como a buscar más respuestas, porque si el niño ya estaba bien flaquito, A hora tiene su tubo y ya subio 6 libras."

"I was telling the doctors that he was not eating, that he could not suck the bottle. I called every so often, I said he is not eating and the doctors said yes he is eating. And I was very frustrated,

because sometimes I would look at the eight ounce bottle, and all day he would eat five ounces. And the doctor told me it's not true. I told him, yes it's true, I have the bottle here, I just measured it, he drink five ounces, he has three to go, and he (the doctor) would say no and no. So I was desperate and the HV saw that, she fought with the doctors to get them to do something. The child was not well. He weighed 11 pounds at nine months and the doctors told me just give him more, more formula and less water. To make it more concentrated with more calories, but I told the doctor but he can't go to the bathroom, he cries and bleeds because he's constipated, he can't. The doctors, they judged me as a little crazy and told me it's normal. And the HV again supported me and started looking for more answers, because if the child was already very skinny, now he has a tube and has already gained 6 pounds."

These parents' felt that their home visitors prioritized their emotional well-being. Home visitors assured parents that what they were going through was normal, helped them set self-care goals, and encouraged them to take moments for themselves.

"Es mi obligación cuidarlos. Pero no, la verdad es que ella me enseñó que hay un punto en el que si yo necesitaba simplemente dormir, descansar y tomar tiempo para mí, para poder seguir teniendo fuerzas y estar al 100, como se dicho, para seguir cuidando a mis hijas. Y eso, la verdad, me lo enseñó el HV y me ayudó mucho con eso, algo que yo no lo hubiera sabido."
"It is my obligation to take care of [my children]. But no, the truth is that [my home visitor] taught me that there is a point where if I just needed to sleep, rest and take time for myself, so that I can continue to have strength and be at 100, as I have said, to continue taking care of my daughters. And that, the truth, the HV taught me and helped me a lot with that, something that I would not have known."

How do home visitors incorporate and respect families' culture and traditions?

Parents consistently reported that their home visitors were interested in learning about and supporting their families' values, traditions, and cultures. As cultures and traditions varied across families, parents shared some of the ways home visitors were able to support them in this area. **These different strategies included the following**:

- A few parents shared that their home visitors engaged directly with their families' culture by providing culturally specific materials (e.g., children's books) and facilitating discussions about their culture with families and children. For example, one parent described not knowing how to communicate her religious and cultural beliefs to her young children, and how her home visitor was able to support her.

"Sometimes I don't know how to tell what we believe in to my kids, you know. So my home visitor, she brings books to read [with my] kids about our traditions…That's what I like about her, you know… She brings different books to talk about 'Okay, this is you.'"

- Parents of bicultural families described how home visitors were able to facilitate conversations with their whole families.

"My home visitors…have been really good about bringing in books and activities and just conversations that we can have with our older ones…My husband's Mexican, but he's pretty white. So my two little ones are very white and…my oldest is really dark skinned. He's got a different dad, my other two are kind of in the middle. So we've got a whole array of skin color, even just in our home which adds to a lot of questions. When I was pregnant, my daughter was very concerned about what color the baby would be…My home visitors did a fantastic job helping guide our conversations about normalizing that a lot of families…look a little bit different."

- Multigenerational families were grateful that their home visitor included everyone in discussions, and that they included the family as a whole. For example, some parents noted that, while their home visitor was intended to help them with their youngest child, their home visitor focused on supporting the family as a whole, including older children.

"Vivo con mi mamá y mi papá. Entonces mi mamá tradicional es como la segunda mamá de mi niño. Mi mamá, es la que sí cuida a los niños, tiene más enfoque en los niños. La enfermera viene y, nos pide a las dos la opinión, porque sabe que yo adoro la opinión de mi mamá. Entonces nos acepta eso y habla con las dos al mismo tiempo, nos incluye a las dos del lugar. A veces dice uno, usted es la mamá y tú debes estar haciendo todo este. Y en parte ya no se incluye y entiende la cultura de nosotros. Sé que mi mamá solo es la abuela, pero tiene un rol más grande con este niño."
"I live with my mom and dad. So my traditional mom is like my child's second mom. My mom is the one who takes care of children, she has more focus on children. The nurse comes and asks us both for our opinion, because she knows that I adore my mother's opinion. So she accepts that and talks to both of us at the same time, she includes us both in the place. Sometimes one says, you are the mom and you must be doing all this. And in part the culture of us is no longer included and understood. I know my mom is just the grandmother, but she has a bigger role with this child."

- Some parents shared that their home visitors respected their families' religious beliefs and holiday celebrations.
- Many Spanish-speaking parents described how their religious beliefs were taken into account by their home visitor when offering support and resources.
- Home visitors helped families decorate for holidays and provided materials that were aligned with how families celebrate. A Spanish-speaking parent shared that her home visitor also provided information about how holidays like Christmas and Halloween are typically celebrated in the United States.
- A few parents expressed that they do not have family traditions. Their home visitors, however, expressed interest in supporting the development of family traditions, if they wish to do so.
- When presenting new or different information from what a parent might traditionally do, parents reported that home visitors are very respectful of parents' interests and values.

"In the beginning of our home visits, because we've been doing it weekly, she had done a little worksheet with us on what our families values and goals were. And she likes to stick with those and ask us how those are progressing or give us ideas if we get stuck on that. So she's been extremely conscientious about working with us on what we value and I really respect that."

"...When she tried to introduce new stuff she would always ask, 'Are you guys okay with me trying to talk about this?' That's something she would always do...Before she would bring it in, or start talking about it, she would ask my opinion...She was never pushy."

"We had kind of an old school parenting style...we disciplined. I also have a mixed family where my oldest son has a dad and a different family and she kind of acknowledged that yeah, sometimes not every parent disciplines and there's often one who disciplines and one who doesn't discipline. I'm getting constant scrutiny from my ex and it's so nice to hear that. I'm married now, have a family, and their brothers, like that we're able to facilitate the kind of parenting style that we want and not be wrong about it necessarily. And I'm not talking about punishment, I'm talking about discipline. But it's nice to see these are trends and that I'm not alone. It's really nice to hear that she's excited for my family, you know? So that was really nice."

What barriers might keep families that could benefit from home visiting from participating?

Parents reflected on who in their communities may not be participating in HV programs and what they believe is getting in the way of those families from participating. The parents identified five barriers to participation in HV programs:

1. stigma and fear of seeking or needing help in their parenting efforts,
2. insufficient program outreach, particularly for isolated families, and lack of knowledge about HV,
3. strict program eligibility requirements,
4. intimidating screening processes and paperwork, and
5. inflexible visiting hours once families are in the program.

Many parents agreed that there is a stigma associated with receiving HV support. They shared their own experiences with fear of inviting a stranger into their home, and that peers and family would judge them for needing help with parenting. They speculated that this stigma and fear could prevent other families from seeking or accepting the service.

"I think no matter what, when the idea of people coming in your home, you know, it's so personal, especially in the beginning because they are a stranger. I felt hesitant. I didn't understand it. If it hadn't been for it being explained to me, I just didn't really understand it. I think whenever I think of home visit, it's usually in a negative context, for people who have problems or may not be good parents."

A few parents shared that their family and other members of their cultural group hold a stigma about seeking help in general, and specifically around parenting.

"The first time when I had Home Visiting, I [didn't] even tell my family because everybody starts, you know, making fun of me. Like, 'why [do] your kids need that?...'"

Undocumented families in particular may be afraid of receiving services for fear of being deported by ICE.

Some parents shared that families with a history with child welfare involvement or drug use may be very suspicious of home visitor's role as mandatory reporters. There is a fear that HV is child welfare and that their children might be taken away from them.

"The only place that I've seen Healthy Families advertise is through the DHS office, and I know there's kind of a lot of stigma through in home programs around that, and I think maybe if it was maybe a little more widespread advertised rather than just there."

"The [screener's] approach was, I think, for me, it was maybe a little bit weird…'Hey, I know that you have a substance abuse history. We're here to help you. We want to come into your home.' I have nothing to hide, [but] it was like, this is weird…But, sure. Okay, yeah, I [was] into it, but I could see where for a lot of other people it would be like, absolutely not. There's no way."

Parents described a lack of knowledge in their community about what HV even is. Additionally, they highlighted specific groups in their community who are particularly unaware of this resource: Latinx families (especially who have recently moved to the area) and families living in rural areas who are isolated from services.

Nearly all parents agreed that strict eligibility requirements can get in the way of families receiving HV services. The most common requirement mentioned in this context was income cut-offs, where a family that makes a few dollars over the cut off is ineligible for support from certain programs.

A few parents described that the initial screening and program enrollment interactions can be intimidating; questions are often overly personal; and enrollment paperwork is not family-friendly.

"…the final line in a document that you're signing says, oh, by the way, we're mandatory reporters, or something to that effect. It scares people…"

Once families are enrolled in the program, if their home visitor's scheduling is not flexible, working families may not be able to find the time to meet with the home visitor. They may be unable to meet visiting requirements and drop from the program.

"I know in my experience, that was one reason I actually almost stopped because it was like I would go to work full time, get home around five, and the services with the home visitors had to be in person. So I would have to pretty much try and get dinner done, get all my kids settled for the night, and then turn around and have a home visit. It was very inconvenient because they don't really do services on weekends, so it does make it a lot harder to try and participate in them with having the normal like nine to five job."

How could home visiting programs be improved to better reach and serve families?

To address stigma and fear around HV services, these parents advocated for normalizing seeking help with pregnancy and raising children. In fact, one parent suggested that, with a magic wand, she would have HV programming continue until children turn 18.

"I totally agree with and would validate the fact that it should be normalized, parenting and motherhood. If you need the support and you want it, and it shouldn't even be a need, like if you want it, it should be there like totally normal."

To address poor awareness of HV services, these parents suggested increasing community outreach: advertising at community locations such as women's shelters and domestic violence shelters, telling all new parents about HV in the hospital, targeting advertisements to people moving into the community, and advertising using social media platforms, like Facebook and Nextdoor.

To address the barrier of strict eligibility requirements, these parents recommended that programs re-evaluate the requirements and how they are enforced, especially income requirements. One parent shared that if she were granted a magic wand to improve HV programs, she would make sure programs had enough funding to reach and serve more people, regardless of their eligibility.

"You know, being a new mom, even that alone, if that's your only criteria…that's a huge thing that you need some extra support for…if we hadn't had some unique situations we probably wouldn't have made the list, yet we still are vastly benefiting from it."

To address intimidating screening and enrollment processes, these parents suggested that enrollment paperwork be simplified (e.g., lowering the reading-level) and include a friendly description of what a mandatory reporter is. Parents also wanted paperwork once in the program to be streamlined.

"If they only knew exactly what mandatory reporting is and what they're there for, then maybe people wouldn't be so scared… They're not out to get you, they're out to protect you."

To address the barrier of scheduling challenges, these parents recommended having home visitors with swing shifts (evening and weekend hours) to allow working parents to participate. Additionally, parents suggested that strict requirements around the number of visits per month be relaxed, such that parents are not under threat of losing the service if they are unable to make the required number.

Appendix E. Prior Statewide Needs Assessments

Table A4. Implications of Maternal Child Health Title V Block Grant needs assessment for home visiting systems

Identified Priority Areas for Oregon	Key Findings	Relevance to Home Visiting Services	Implications for MIECHV Needs Assesment
Well Woman Care	Consistently identified as a high priority area through existing needs assessments, stakeholder/partner surveys, and community members Significant barriers exist to accessing well woman care, especially for women of color, immigrant/refugees, and women in rural areas	HV can help improve access to health care by pregnant/parenting mothers, and help address disparities in access for POC	Ensuring HVs have training and support needed to support access to well woman care for pregnant/parenting mothers
Oral Health During Pregnancy	Consistently identified as a high priority area through existing needs assessments, stakeholder/partner surveys, and community members Significant barriers exist to accessing oral health care identified, especially for Latinx women, rural/immigrants, and women in rural areas	HV can support access to oral health for pregnant women and young children; insurance and other issues remain systemic barriers	Workforce development and training may be needed to support home visitors to address and support oral health concerns and facilitate access to dental services for pregnant women Policy and practice changes that increase prenatal referral to HV could improve outcomes in this area
Smoking During Pregnancy	Significant barriers exist to accessing well woman care, especially for women living in rural areas. Was not identified as a high priority by partners serving communities of color, although rates of smoking during pregnancy are highest for NA/AI women	Smoking cessation is a key component of many evidence-based HV curricula	Linking smoking cessation training and services (e.g., Mother's Care) to a broader array of HV models could increase public health impact of HV on smoking during pregnancy Policy and practice changes that increase prenatal referral to HV could increase public health impact on smoking during pregnancy
Breastfeeding	Consistently rated as the top priority among infant health concerns, especially for communities of color, immigrant/refugee women, and women living in rural areas Oregon consistently exceeds national rates of breastfeeding (ever, and exclusively at 6 months)	HV programs support breastfeeding mothers, and when offered prenatally, can encourage and support initiation of breastfeeding Culturally specific home visitors can help address cultural barriers to breastfeeding for some communities	Work to improve the ability of HV programs to engage families prenatally could help improve rates of breastfeeding initiation Focused work to sustain breastfeeding practices for culturally specific communities in which rates are lower could be a potential area for ongoing CQI for HV programs
Developmental Screening	Consistently rated among the highest priorities for children's health Most likely to be prioritized by agencies working with communities of color, children with disabilities, and rural communities Also seen as a high priority by families of color, refugee/immigrant families, and rural families Developmental Screening is a key priority for state Early Learning Division and CCOs	Developmental Screening and referral is a key required component for evidence-based HV MIECHV funded programs have engaged in ongoing CQI related to strengthening developmental screening and referral	Identifying ways to integrate developmental screening and referral done through HV with those done in health care and other early childhood settings will be an area for ensuring strong coordination for HV systems

Table A4. Implications of Maternal Child Health Title V Block Grant needs assessment for home visiting systems CONT.

Identified Priority Areas for Oregon	Key Findings	Relevance to Home Visiting Services	Implications for MIECHV Needs Assesment
Adverse Life Experiences (Pregnancy)	Oregon has identified reducing exposure to toxic stress and ACES as a statewide priority Communities of color in particular have higher rates of exposure to ACES and rate reducing the incidence of toxic stress and trauma as among the highest priorities	HV programs have the ability to both reduce exposure to toxic stress and early adverse experiences for children, as well as to mitigate the impacts of these exposures HV programs strengthen important protective factors, building resilience to ACES	Workforce development efforts and trainings such as use of the FAN, reflective supervision, and early ACES screening could help improve the ability of the HV workforce to successful address these issues
Impact of Drug Use/ Misuse on Pregnant or Parenting Women	Rates of use of marijuana and opiods among pregnant women have been increasing in Oregon Community agencies and local governments have identified addressing prenatal exposure to substances, and in particular, to marijuana and opiods, as a key priority Tribal partners are especially likely to see addressing substance use during pregnancy as a priority	Home visitors can provide early screening for substance use and abuse among pregnant women Home visitors can effectively facilitate identification and referral of families to substance use treatment Home visitors can be effective supports for women in recovery	Workforce development for home visitors that helps them to effectively identify and refer families to treatment services is an ongoing need in the field HV programs and staff could benefit from closer partnership with providers in the treatment and recovery system Treatment providers may underutilize HV programs as a resource for supporting mothers in recovery
Maternal Mental Health	Rates of maternal depression are highest among African American, American Indian, and Hawaiian/Pacific Islander families in Oregon Maternal mental health was mentioned as a priority in 90% of county health assessments Maternal mental health was among the top three priorities for partner agencies	Evidence-based HV programs often include regular and ongoing screening for maternal depression HV programs can effectively identify and refer mothers for mental health treatment	More support for ensuring home visitors have the skills and knowledge needed to support mothers to engage in treatment for maternal depression may be beneficial Home vistitors may also benefit from more training and specific strategies for supporting depressed mothers to strengthen their parenting skills

Table A5. Findings from recent Oregon early childhood needs assessments

Document Name	Year	Geographic Area/ Focus Population	Key Needs Identified
Oregon Head Start Collaboration Office Survey	2017	Preschool	Effective strategies for supporting children's challenging behavior in the classroom Systems to ensure children who are transitioned to alternative placements get re-evaluated and re-integrated into Head Start/OPK More workforce/career development opportunities specifically EC/ECE degree programs Additional workforce and facilities for preK expansion
Oregon Infant Toddler State Needs Assessment	2018	Infant-toddlers; various sources	Overall access to prenatal care is good, but disparities exist for families of color Disparities for families/children of color on a variety of indicators of pregnancy outcomes Information system and process for "closing the loop" for developmental screening (screening, referral, follow up, and service outcome) Connections between primary care screenings and screenings done by EC/HV providers More focus on training PCPs to use billing codes for early childhood mental health, and including key Infant ECMH services as well Food insecurity for families with young children High rate of homeless/unsheltered families with children
OR Head Start Association	2018	Statewide	Staff retention and salary (1 in 6 staff leave in a 12 month period)
State Health Assessment	2018	Statewide	Low rate of childhood immunizations, especially in some counties Housing affordability; housing costs are high and rates of affordable housing are low Food insecurity especially for families with young children Disparities in kindergarten readiness skills for children of color Disparities in educational outcomes for grades 1-4 for children of color Rural communities lack access to health care providers Price of infant/toddler child care (63% of annual income for minimum wage workers) Oregon Preschool (OPK) and Oregon Early Head Start (OEHS) are under-resourced to serve eligible children (60% and 8% respectively) Single mothers in Oregon have highest food insecurity of any state Disparities in high rates of IPV among persons of color Supports for incarcerated mothers (75% of incarcerated women have children) Maternal depression rates are high (almost 30% among new mothers) Preventive dental care for children under age 2 is lacking
PDG Needs Assessment	2019-20	Statewide	Increase culturally specific and culturally responsive early childhood services Support professional development pathways for culturally and linguistically diverse early childhood service providers Increase pay for early childhood providers Provide more workforce development to increase the level and quality of trauma-informed practice in the early childhood workforce Invest in a comprehensive early childhood data system Increase state capacity to provide more evidence-based early childhood and parenting programs

Appendix F. Providing Home Visiting During COVID-19 Statewide Closures

Voices from the Field

Background

The information below was collected as part of the 2020 MIECHV statewide needs assessment conducted by Portland State University. During the data collection period, the COVID-19 pandemic led to statewide closures and a far reaching "stay at home" order, which significantly impacted HV programs' ability to support families. As of this writing, national and state guidelines continue to recommend that HV programs refrain from doing in-person visits with families (September, 2020), and it is not known when this may change.

To learn more about service delivery during this time, questions were added to the needs assessment protocols to capture information about the experiences of families and HV programs during the COVID-19 public health crisis. The research team conducted interviews with 9 statewide HV leaders, 14 local program leaders and 27 home visitors in four rural and frontier counties (Jackson, Malheur, Umatilla, and Yamhill counties) and from 35 parents (20 English-speaking, 15 Spanish-speaking) across Oregon involved with HV services (see *Oregon MIECHV Needs Assessment, 2020* for more details). Programs represented included Oregon's MIECHV-funded programs (Healthy Families Oregon, Early Head Start, and Nurse-Family Partnership) as well as other major statewide models (Oregon Relief Nurseries, Babies First!, CaCoon, and Family Care & Connections) and a few locally-administered models (Family Spirit, Parents as Teachers). These stakeholders discussed the challenges and successes related to HV that have arisen during this global pandemic.

Program Challenges

Home visiting program stakeholders noted the several significant challenges in providing HV services during the COVID19 closures:

1. Reduced number of community-based referrals;
2. Increased complication of delivering services and logistical challenges; and
3. Increased stress on the HV workforce both from transitions to remote visits and increased worry about the families they work with.

A common challenge for HV programs that leaders reported relate to **difficulties receiving referrals** since the start of the COVID-19 pandemic, and a general slow-down of incoming referrals. First, families are not interacting with community providers who typically act as referral sources as much or in the usual ways. Healthcare, education, and social service providers who would usually make referrals to HV may therefore not be identifying families who could benefit from HV, as their attention concentrates on adjusting and responding to the pandemic. Second, and for similar reasons, HV programs have difficulty maintaining relationships with these providers in order to stay on their radars as a helpful resource for the families being served. Many HV referrals come from healthcare providers, who understandably have shifted their energy and resources to COVID-related issues. Finally, HV programs are not able to promote their services to the community as they normally would through various community-based fairs and outreach activities. As a result, some home visit programs have experienced a decline in referrals.

Home visiting leaders highlighted the **stress** that responding to COVID-19 puts on all of their staff. This was identified as being related to two issues: (1) the challenge of transitioning to remote HV services; and (2) increased concern and worry about the families that workers support.

Program leaders noted that the need for HV services in terms of being able to provide critical material and emotional support to families has not slowed down (this need has arguably increased), but the delivery of those services has become much more complicated. Therefore, staff have been working long hours under complex circumstances to figure out how to meet the families' needs as well as the needs of the home visitors

providing services. Home visitors and leadership address having to reconfigure paperwork and data management so that everything is accessible online; reevaluating which documents really need a signature and which can wait; and creating virtual opportunities to support home visitors as regular staff meetings, case consultations, and trainings can no longer take place in person. Home visiting programs also deal with the challenge of getting staff who are not tech savvy up to speed on the many different platforms for virtual contacts. Not only do these staff need to learn new technologies, they then have to be prepared to teach families how to use these new modes of communication and troubleshoot with them.

In addition to the initial difficulties of transitioning from office-based work to work from home, home visitors continue to face new stressors related to remote HV. Home visitors and leadership acknowledge that many home visitors take their positions because of the opportunity to interact and engage with families, building helping relationships with them. COVID-19 alters that experience drastically, and HV leadership **worry about burnout for home visitors** who do not have the positive connections that are central to their work enjoyment. Compounding this, it was clear that home visitors are worried about the families they work with and all of the added stressors in those families' lives, trying to help as much as they can in the midst of ever evolving information, recommendations, and expectations.

Challenges to delivering home visits remotely

Logistics

Issues with technology are a common barrier to service provision, and certainly not just for the home visitors providing services. Families sometimes do not have the necessary products for virtual visits like smart phones and laptops. They also lack the services needed such as reliable internet or adequate data plans, or are unfamiliar and uncomfortable with how to operate new technology. Additionally, household members often **share technology**, so a caregiver's availability to participate in a remote home visit may be limited when others use it for work, school, socialization, and so forth. As home visits transitioned to virtual platforms, home visitors have needed to figure out how to accommodate a range of technological and scheduling obstacles.

"We tried the zoom thing. But for some reason, we couldn't get it to work, so we've just been doing regular phone calls… [My son] does come in [to] say hi and stuff but he won't stay for the whole visit. He'll stay for like 15 minutes and then come and go." *—Parent*

The challenge that families have with **lack of adequate technology** is not unique to HV, as almost all services have gone virtual. Therefore, these families' need for support may be even greater, particularly if they have to access new resources such as unemployment benefits or rent and utility assistance. Home visitors strive to help families through these processes and connect them to resources, but they also recognize that families may not be able to prioritize home visits as they previously did. Home visitors identify houseless families as especially vulnerable to these concerns, and this is also a population that home visitors struggled to contact when quarantine began. This is, of course, an immense stressor for those families, as well as for home visitors who worry and care about them.

Another, albeit more minor concern that was described was related to being able to secure enough resources and materials to share with families. Whereas home visitors could typically have a few glue sticks, scissors, and similar items to take with them to home visits, they now leave such supplies with families to use for activities. As a result, home visitors need more of these materials to distribute to families.

Irreplaceable Aspects of In-Person Home Visits

"And for me the virtual visits have been so hard. For work, I'm on zoom all day long. So it's not a big deal for me. But for a two year old, she wants to grab the computer and my phone and run away…She loves [her home visitor]. She wants to play with her and hang out with her, but talk to her on the phone? Absolutely not. And so most of our visits have been cut short because [when] we're losing her, we're done. That's it. I think actually every single [visit] has been cut short significantly…I'm really missing having her come to my house. I'm really missing it. And I know that [my daughter] is too. And that's just the situation that the whole world is in." *—Parent*

Home visitors and caregivers acknowledged that some aspects of in-person home visits cannot be replicated through remote platforms. Simply stated, **home visitors and families miss being together**. Home visitors lament that they cannot fully sense body language and emotions through a screen. They also worry about environmental concerns, such as missing outlet covers or empty cupboards for example, and signs of abuse or neglect that they are not likely to notice during a virtual visit, if they are even seeing children at all. Home visitors also pointed out that building relationships with families who are new to HV is difficult without in-person interactions, and they may struggle to maintain engagement.

"How do you do this parent survey over the phone when you can't read mom's body language or really get the tone of what's going on with her emotions and also feel like you're supporting her?" *—Home Visitor*

"This disease or pandemic has left those of us who do not have friends alone, and well, these people who come to visit us were and are still our friends. But now they are by phone and it is no longer the same, it has left us alone again. That's what I think."

"Esta enfermedad o pandemia ha dejado solas a las que no tenemos amigas, y pues estas personas que vienen a visitarnos pues eran y son todavía nuestros amigos. Pero ahora sí por teléfono y ya no es lo mismo nos ha dejado como solas otra vez. Eso es lo que yo pienso."

Privacy and confidentiality are additional concerns during this pandemic. Home visitors shared that they feel they **cannot address sensitive topics** with caregivers as they would typically be able to do during in-person home visits. They felt that during virtual visits, caregivers may not be comfortable discussing issues like domestic violence or substance use, for example, because of others who could possibly overhear them. Furthermore, virtual visits were described as more susceptible to interruptions (for families and for home visitors). Home visitors might typically help a caregiver put dinner on the table for children while also engaging in aspects of the HV curriculum for that week, for example. During virtual visits, they shared that caregivers struggle to simultaneously meet their children's needs and participate in a remote visit. They also noted that this can be true for home visitors who are now at home with their families and balancing multiple roles and responsibilities at once.

Home visitors also described having **difficulty implementing HV curricula** as intended. This is in part due to the challenges just mentioned with regard to caregivers' attention during home visits. Additionally, home visitors reported that they spent a lot of their time during these remote visits focused on meeting the basic needs of families and helping them to connect to vital resources during this public health crisis. As a result, home visitors felt that they did not have time to cover in-depth issues related to child development or parent education.

"It is no longer the same because we cannot do the activities we used to do, maybe they tell me how to do them, but, well, I don't do them correctly. In reality they (the home visitors) continue to watch out for us but that would be the only thing. We do keep in touch, but the way I can do activities for my child is very, very different from the way we would activities while she was present."

"Ya no es lo mismo porque no podemos hacer las actividades que hacíamos, tal vez me dice como hacerlas, pero, pues no las hago correctamente. Pero pues en realidad sigue estando al pendiente de nosotras pero eso sería lo único. Si seguimos en contacto, pero es muy, muy diferente la manera en que yo le puedo hacer ejercicios a mi niña, a como ella los haría estando ella presente."

Program Successes

Despite all of these challenges, home visitors and leadership identified a plethora of modifications that are going well for them. They noted that overall, home visitors have adjusted well to providing virtual services, and leaders often remark at how impressed they are with the ability of home visitors to adapt and overcome challenges and think creatively about engaging with families. As home visitors have been forced to do their work differently, they have come up with a number of innovative ideas for approaching their work.

Many home visitors attributed success they have with families to the **increased ability to be flexible** with how they interact with families. This includes the frequency of remote visits and the platforms they use. Home visitors use many modes for virtual visits (e.g., Zoom, Skype, FaceTime, etc.), and they are also willing to talk on the phone, email, and text. Home visitors reported being able to tailor their approaches to do what works best for families and what families are most comfortable doing. For example, one home visitor set up a Facebook group so that families can support each other and share community resources. They felt that having more options for providing visits and resources allows families to get the information that they need in the ways that are most comfortable for them.

There also seems to be a pattern of home visitors having **more, but shorter, contacts with families**. Home visitors recognize that it is unrealistic to expect families to be on the phone or video conference for an hour and a half; however, it can be helpful to send a text that just says 'I'm thinking about you and I'm here if you need anything'. This flexibility reflects a pivot towards providing home visits that are arguably **being more directed by families and their needs**. Finally, home visitors also shared that because they are not traveling to see families, they have greater availability and time to respond to families as needed.

"The creativity that came out of that was so fabulous. Sometimes it was like sending just a text of I'm thinking of you today and I hope you can get outside and take a walk or dropping by on the front porch and then running to the car some activity materials that the family could do with their kids at home."

—Home Visiting Program Leader

Additionally, while home visitors and leaderships point to challenges with maintaining connections with other providers, they also report **working more closely with other organizations** to help meet community needs. Organizations have been able to secure COVID-19 grants and can use these additional funds to support families' needs in ways they were unable to do previously (e.g., technology, basic needs). Home visiting programs and other community organizations collaborate to connect families with those resources as well as work together to create lists of resources that are available for families.

Successes with Families

Parents emphasized a multitude of ways that they have benefited from having a home visitor during the COVID-19 pandemic. They expressed appreciation for the material and intangible resources received by their home visitors. One commonly discussed resource is that families can rely on their home visitor for clear, accurate information related to COVID-19. This was particularly useful for families at the start of the pandemic as caregivers describe feeling lost and unsure how to keep their families safe and needs met. Information about COVID-19 changes from day to day and may differ depending on the source, but **families trust home visitors as consistent, reliable sources of information** and recommendations for assuring their families stay safe.

"We are working with Oregon Health Authority to get better information to families. So that's kind of the next step. But because we're working with a super vulnerable population who's system wary, so they're scared to go to the doctor. They're scared to ask for help. They are afraid if they're identified as being sick, who's going to care for myself or my child? You know, all of those kind of fears that kind of coincide." *—Home Visiting Program Leader*

During this public health crisis, nurse home visitors were described as especially important for families who are not able to attend in person appointments with traditional healthcare providers. Nurse home visitors reported being able to provide important feedback and assurance to caregivers quickly and easily about health-related concerns. Families expressed worry about how their children are adjusting to all of the changes in their lives and were grateful for the expertise of a nurse with whom they can talk about changes in sleep, behavior, and so forth.

Parents talked about the support they received from home visitors with a variety of **crucial tangible resources**; examples include food, diapers, wipes, gas cards, laundry vouchers, clothing, utility assistance, mortgage/rent assistance, masks, phones, computers, and activities. They shared that home visitors were able to deliver these goods to families so that they do not have to leave to get them. Some home visitors noted that for families who have only started services since the pandemic, providing these resources helps build rapport with these newly enrolled families. In dropping off these resources, home visitors get to be physically present, even though not inside homes, and have the opportunity to be more than a voice over the phone or face on a screen. They described that children enjoy waving to home visitors from a window and eagerly anticipate new activities to enjoy.

Home visitors shared that one benefit of the pandemic is that **caregivers seem to have an easier time asking** for the resources they need. Home visitors posit that needing help has become normalized in general and so families do not feel ashamed to ask for help. This seems to be true of basic supplies like toilet paper or diapers as well as for reaching out about mental and emotional health support too.

"Some of the successes are we've been able to stay connected to families and they've been able to reach out however they do that, whether it's texting or zoom calls or phone calls, but they're able to reach out and say specifically what they need. And then, you know, we're able to help them to find those resources. Because this is a time when we're so worried about people and their resources." *—Home Visitor*

For some families, **virtual visits appear to be working better for them**. Home visitors and HV leadership shared that some families who had been struggling to engage prior to COVID-19 have been in more contact during the pandemic. Some families like that with virtual visits or calls, someone is not coming into their home, and **they do not feel judged** about their home environment or appearance. Some families appreciate that they do not need to block off an hour or more to spend with the home visitor and can check in about specific issues as needed. Home visitors also recognize that **working parents, fathers in particular**, who are now at home more have the ability to engage with HV services as they had not previously been able to do. Because home visitors remain flexible to tailor services to families' preferences, many families are able to engage more in those services.

"In the beginning (prior to the pandemic) I was participating regularly, but then I didn't have time anymore. Now, I'm washing dishes and I can still pay attention. These days I keep saying that I think I like this better! This way I can do both things at the same time and it works very well for me."

"Al principio, iba bien seguido y ya después no tenía tiempo. Y ahorita estoy lavando los trastos y estoy bien atenta. Y digo yo hoy no creo que me gusta mejor así. Así estoy haciendo las dos cosas al mismo tiempo y pues a mí se me hace muy bien."

Finally, **home visitors are sources of support for caregivers** during these unprecedented times. Parents discuss the difficulties they encounter trying to find new activities for children to do at home or struggling to entertain children of varying ages. They praise their home visitors for offering ideas as well as supplies to promote family interaction. They described home visitors as creative in coming up with a variety of activities, including low-energy suggestions for when caregivers are fatigued. They have also included **self-care supplies for caregivers** to ensure they are taking care of their own needs. Furthermore, parents talked about the role that home visitors play by simply being a connection for them to someone outside of their home. Caregivers talked about the increased feelings of isolation, particularly for single parents and families in rural areas. Home visitors were described as **providing structure and a sense of normalcy**, and as being a trusted support that caregivers can contact with questions, frustrations, or merely for an adult conversation.

"In my case, my oldest daughter, did have at first like an episode of depression. So the Home Visitor helped me with advice and ideas to mitigate all that with my child, and also in some way for me as an adult. Because when all this began, it seemed to be something new, unknown. We were scared and all that. But I think that by talking with her, she gave me information that I did not have or we shared things and I began to see this pandemic from another point of view."

"En mi caso, mi niña, la más grande, sí tuvo tuvo al principio como un episodio de depresión. Entonces (the HV) me ayudó con consejos y ideas como para mitigar todo eso con mi niña. y también de alguna manera a mí como adulto. Pues al principio, cuando comenzó todo esto, era algo nuevo, desconocido. Estábamos asustados y todo eso, pero. Creo que hablando con ella, de alguna manera ella también me daba información que yo no tenía o compartíamos cosas y empecé a ver cómo toda esa pandemia desde otro punto de vista."

"I think just having the extra support. I'm a single mom, so knowing that I can talk to somebody every couple weeks is really helpful and somebody that cares and checks up on both of us. It's just helpful, but we miss the interaction, like the physical interaction, but it's still like super helpful, you know." *—Parent*

In conclusion, COVID-19 has disrupted lives across the globe and continues to present new challenges for families and home visitors to address. With creativity and resilience, home visitors help support families through this tumultuous time and continue to provide vital resources that families in Oregon need.

"Just to be in relationship with these families. And I think it's helped them better conceptualize the work, really focus on infant mental health. And we talk a lot about, you know, this is a global trauma that we're experiencing and we're thinking about these babies. What are they going to remember from this when they're 10, 15, 20 years old? How do we help that felt experience and how do we help that parent be there for their kid during this time, even though it can feel scary for parents or not? How do we show up for people so that these little kids aren't maybe significantly impacted as they otherwise might be?"
—Home Visitor

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