Washington State
Home Visiting Needs Assessment

September 2020

Washington State Department of CHILDREN, YOUTH & FAMILIES

Washington State Department of Health

the Ounce

Table of Contents

Abbreviations

ACF	Administration for Children and Families
BSK	Best Starts for Kids
CAPTA	Child Abuse Prevention and Treatment Act
CBCAP	Community Based Child Abuse Prevention
CPP	Child Parent Psychotherapy
CQI	Continuous Quality Improvement
CSO	Community Services Office
CUP	Chemical-Using Pregnant (Women)
DBHR	Division of Behavioral Health and Recovery
DCYF	Department of Children, Youth & Families
DOH	Department of Health
DSHS	Department of Social and Health Services
EHS-HB	Early Head Start –Home Based
ELA	English Language Arts
ESIT	Early Support for Infants & Toddlers
ESSS	Early Steps to School Success
HCA	Health Care Authority
HRSA	Health Resources and Services Administration
HSCO	Head Start Collaboration Office
HVAC	Home Visiting Advisory Committee
HVSA	Home Visiting Services Account
ICM	Infant Case Management
LIA	Local Implementing Agency
MCH	Maternal and Child Health
MCHBG	Maternal and Child Health Block Grant
MIECHV	Maternal, Infant, and Early Childhood Home Visiting Program
MSS	Maternity Support Services
NAS	neonatal abstinence syndrome

NFP	Nurse Family Partnership
NIRN	National Implementation Research Network
OFM	Office of Financial Management
OIAA	Office of Innovation, Alignment, and Accountability
OSPI	Office of Superintendent of Public Instruction
PCAP	Parent Child Assistance Program
PAT	Parents as Teachers
PDG	Preschool Development Grant
PDSA	plan, do, study, act
RDA	Research and Data Analysis
RSE	relative standard error
SAMHSA	Substance Abuse and Mental Health Services Administration
SD	standard deviation
SES	Socioeconomic Status
SRT	Self-Reflection Tool
SFY	state fiscal year
STEEP	Steps Towards Effective Enjoyable Parenting
SUD	substance use disorder
TANF	Temporary Assistance for Needy Families
WSHA	Washington State Hospital Association
WSN	Women Services Network

Summary

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is a voluntary, evidence-based home visiting service for at-risk pregnant women and parents with young children up to kindergarten entry. The MIECHV Program is a federally-funded program administered by the Health Resources and Services Administration (HRSA). Washington State conducted the 2020 MIECHV Needs Assessment to identify communities with concentrations of defined risk factors, assess the quality and capacity of existing home visiting services in the state, assess the state's capacity for providing substance abuse treatment and counseling services to pregnant women and families with young children, and to coordinate and, as appropriate, build on other needs assessments occurring during the same time period, January 2019 – October 2020.

In Section II, we present the methods and data used to identify communities with concentrations of risk, and the results of the analyses. Washington State used the modified simplified method (a z-score analysis method) following guidance provided by HRSA and reviewed publicly-available data provided by HRSA as well as data abstracted by Department of Health for 23 indicators across six domains: socioeconomic status, maternal and child health, domestic violence and crime, child maltreatment, education, and behavioral health. We conducted three analyses: 1) a county-level analysis to identify counties with concentrations of risk; 2) a school locale-level analysis to uncover pockets of needs within smaller geographic units; and 3) a race-ethnicity analysis to further identify priority populations with an equity lens. School locales represent school districts or groups of school districts that include a minimum of 20,000 residents, are similar in character, and typically occupying contiguous territory. County-level analysis identified 17 counties as at risk while school locale-level analysis identified 30 school locales of the total 118 school locales in Washington, together representing 30 counties (Phase 1). We added one county (Benton) known to be at risk (Phase 2), bringing the total at-risk counties to 31 of the 39 counties in Washington. Race-ethnicity analysis identified four race-ethnicity groups as the priority groups: non-Hispanic American Indian/Alaskan Native, Hispanic, non-Hispanic Black, and non-Hispanic Pacific Islander groups.

In Section III, we assess the capability of existing home visiting programs to meet the needs identified. This includes an accounting of the current capacity to serve families and an assessment of the quality of those services. The 2019 Washington Home Visiting Scan identified ten models, funding 9,863 family slots across 32 counties. In the 31 at-risk counties identified in Section II, 9,419 family slots are funded for home visiting services in 27 counties. We considered data provided by HRSA on estimated need of eligible families in the 31 at-risk counties (32,333 families) as well as an alternate estimated need of eligible families identified by Washington State (44,329 families). Washington's estimated need was represented by low-income births among teen mothers and mothers with low education (Medicaid or Women, Infants, and Children Program [WIC] births from 2016-2018 as identified in Birth Certificate data). We estimate that only 21% of the need identified by Washington and 29% of the need estimated by HRSA are met in 31 at-risk counties. Washington understands that the estimated need of home visiting services is not synonymous with the number of families who may choose to participate in home visiting, drawing a distinction between need estimates and potential for service expansion. In addition to the overwhelming unmet need, gaps in

staffing and community resources have been identified. High home visitor attrition, low pay, and an aging workforce have been identified as major gaps in the Region X Workforce Study. There are limited culturally appropriate community resources to address the socioeconomic and behavioral health needs of families, especially for immigrants and people experiencing homelessness. These issues and gaps while evident long-before the COVID-19 pandemic, have intensified with the pandemic leaving home visitors with an insufficient supply of appropriate referrals to respond to increasing family needs in these areas.

Despite this overwhelming unmet need and gaps in services, Washington has seen some successes with thoughtful, participatory expansion of services over the past few years including increased state funds over the last four years. The private-public partnership with Ounce Washington (formerly Thrive Washington) has been critical in leading communities through structured community planning processes to assess readiness and fit for starting up new home visiting programs. Washington's portfolio model approach reflects our commitment to offering services that match the different needs across diverse communities. Supporting community exploration and matching communities with relevant models is one of the key strengths of Washington's program.

In Section VI, we assess the current needs and services to address families' needs for substance use disorder. While the needs for substance use treatment and counseling services increased during the past decade, this is not being met by an increase in access or availability in treatment in all locales, especially the appropriate care options for pregnant women and families with young children. Barriers to receipt of treatment and counseling services include fear of stigma, fear of losing their children, childcare, transportation, and housing. Inter-agency work is underway to expand access to treatment and counseling services for pregnant and parenting women, improve identification of cases, and strengthen connections between welfare, providers, and public health.

Finally, in Section V, a summary of how this work informed and was informed by different needs assessments run concurrently in Washington is presented. A few themes resonated across these assessments, including but not limited to the challenges of poverty and inability to meet basic family needs such as housing, food, childcare, and transportation; inequitable access to services and resources across the state and an overall lack of adequate resources; the breadth of health needs from maternity care to mental health and substance use disorder; and the value of prioritizing racial, cultural and economic equity in the services we provide to reach all peoples with the services that meet their needs.

2020 Washington State MIECHV Home Visiting Needs Assessment

I. Introduction and Background

1. Background: A brief history of home visiting programs in Washington State

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program is a voluntary, evidence-based home visiting service for at-risk pregnant women and parents with young children up to kindergarten entry. The MIECHV Program is a federally-funded program authorized by the Social Security Act, Title V, Section 511, and is administered by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF).[1]

In Washington State, the MIECHV Program is administered and led by the Department of Children, Youth & Families (DCYF). Ounce Washington (formerly Thrive Washington[2]), the private-public partner, and the Department of Health (DOH) are key partners in supporting this work providing technical assistance for model fidelity and reporting and evaluation, respectively. In 2010, the same year that the MIECHV Program started, the Washington State Legislature established the Home Visiting Services Account (HVSA) to leverage public and private dollars to support home visiting services and infrastructure. Between 2010 and 2019, the HVSA received a steady increase in funds through MIECHV, state general fund appropriations, state dedicated Marijuana Account funds from Initiative 502, a unique partnership with the Washington State Department of Social and Health Services (DSHS) that invested Temporary Assistance for Needy Families (TANF) funds to expand services to very low income TANF-eligible families, as well as private funds raised by Ounce Washington.

2. Purpose of the needs assessment for Washington State

Per funding requirements, the 2020 MIECHV Needs Assessment must identify communities with concentrations of defined risk factors, assess the quality and capacity of existing home visiting services in the state, and assess the state's capacity for providing substance abuse treatment and counseling services to pregnant women and families with young children. The intent is to coordinate and, as appropriate, build on other needs assessments occurring during the same time period, January 2019 – October 2020. Specifically, Washington will use the needs assessment to:

1) Understand the current needs of families and children
2) Identify at-risk communities at the county level and school locale level
3) Identify priority racial-ethnic groups, using an equity lens to develop and make accessible services that meet the needs of all communities
4) Understand the quality and capacity of home visiting services and gap in services
5) Understand the state's capacity for providing substance abuse treatment and counseling services to individuals and families in need of them

[1] Social Security Act, Title V, Section 511. Maternal, Infant, and Early Childhood Programs. Available at: https://www.ssa.gov/OP_Home/ssact/title05/0511.htm.

[2] Thrive Washington transitioned to Ounce Washington in February 2020.

6) Coordinate with other needs assessments such as the Title V Maternal and Child Health Block Grant program needs assessment, Head Start needs assessment, Title II of Child Abuse Prevention and Treatment Act (CAPTA) needs assessment, and Preschool Development Grant (PDG) needs assessment
7) Inform public and private stakeholders about the unmet need for home visiting in our state
8) Direct technical assistance resources to enhance home visiting service delivery and improve coordination of services in at-risk communities

3. Process for conducting the Home Visiting Needs Assessment

Starting in early 2019 and following guidance provided by HRSA, staff at DCYF and DOH began developing the work plans for the needs assessment. A Needs Assessment Steering Committee was formed, which consisted of the Strengthening Families Washington administrator, Home Visiting Project Manager, Prevention Program & Data Specialist at DCYF, epidemiologists at Home Visiting Unit of DOH, and Vice President of Capacity Building and Manager of Quality Improvement of the Ounce Washington. The Steering Committee met monthly to discuss the approach, methods, and timeline for the 2020 needs assessment. Qualitative information was gleaned from the Home Visiting Scan, a scan of all home visiting services in Washington State including those programs funded locally, privately or otherwise, that is updated periodically by DCYF to inform needs assessment sections related to home visiting capacity in Washington State. To guide the work for this assessment, the Steering Committee referred to the previous 2010 MIECHV needs assessment, 2017 statewide needs assessment, home visiting expansion work, the Region X Innovation Grant Workforce Study, and community home visiting planning and exploration work led by Ounce Washington. In addition, home visiting epidemiologists gathered quantitative data from stakeholders, such as partners from Research and Data Analysis (RDA) of DSHS and maternal and child health (MCH) epidemiologists and opioid epidemiologists at DOH. To examine the capacity for providing substance use disorder treatment and counseling services, information was gathered through key informant interviews of subject matter experts from DOH, DCYF, Health Care Authority (HCA), and from communities. To coordinate and benefit from other needs assessments, DCYF and DOH staff had reoccurring conversations with stakeholders. Results were discussed first within the Needs Assessment Steering Committee then with the Home Visiting Advisory Committee (HVAC) members. Final results of the 2020 Needs Assessment will be shared with the broader home visiting community through webinars and the final report in Fall 2020, as described in the Conclusion portion of this report.

In the following sections, we present the methods and data used to identify communities with concentration of risk (Section II), reviewing both the HRSA-provided data and the Washington supplementary data and methods. In Section III we assess the capability of existing home visiting programs to meet the need identified. This includes an accounting of the current capacity to serve families and an assessment of the quality of those services. Next a summary and analysis of current needs and services to address families' needs for substance use disorder. Followed lastly by a summary of how this work informed and was informed by different needs assessments run concurrently in Washington.

II. Identifying Communities with Concentrations of Risk

Washington State used the modified simplified method to identify communities with concentrations of risk. We conducted three analyses: 1) a county-level analysis to identify counties with concentrations of risk; 2) a school locale-level analysis to uncover pockets of needs within smaller geographic units; and 3) a race-ethnicity analysis to further identify priority populations with an equity lens.

1. Phase One: Modified Simplified Method

In previous years, Washington State conducted the 2010 MIECHV needs assessment and the 2017 State Home Visiting Needs Assessment.[3] The selection of domains, indicators, and methodology for 2020 were informed by these prior needs assessments, discussions within the Steering Committee, and inputs from stakeholders such as MCH epidemiologists, opioid epidemiologists, Director of Office of Innovation, Alignment, and Accountability (OIAA) at DCYF, and partners from RDA/DSHS. For the 2020 MIECHV needs assessment, Washington used the modified simplified method identified by HRSA, adding one domain and adding or substituting several indicators, as will be discussed in detail below.

For the 2020 needs assessment, HRSA interprets the term "community" to mean a county or county equivalent and requires states to submit the final list of at-risk communities as at-risk counties. In addition to the county-level analysis, Washington State used the geographic unit of school locale for sub-county data analysis. The school locale-level analysis helped us identify smaller communities with higher risk in both densely-populated counties and sparsely-populated counties. School locales[4] were developed by RDA/DSHS as a geographic unit for the purposes of policy-making and implementation at the Washington State agency level. School locales represent school districts or groups of school districts that include a minimum of 20,000 residents. The school districts grouped into a school locale are: part of a single Educational Service District, similar in character, and typically occupy contiguous territory. At this population threshold, we are less likely to need to suppress data due to small numbers. School locales are usually smaller than a county, but there are some exceptions. Several school locales exist at the border of county lines. As we have seen with COVID-19 spread in Washington State, county borders are sometimes artificial and do not represent the border of "communities" while school locales may better represent the communities where populations with similar characteristics reside. A complete list of school locales and their associated school districts are included in Appendix A.

In addition to identifying geographic communities with concentrations of risk, Washington examined the needs of families by racial-ethnic groups as it did for the prior 2010 and 2017 needs assessments. Race-ethnicity analysis revealed health, socioeconomic, and educational disparities in our state, and identified populations that home visiting programs should prioritize in an effort to address and mitigate the adverse effects of systemic racism and inequity that persist in our society.

Description of Domains and Indicators

[3] Washington State Home Visiting Needs Assessment 2017 Report. Available at: https://www.dcyf.wa.gov/sites/default/files/pdf/OFCHI_HVNA_report.pdf

[4] Washington State Department of Social and Health Services. Risk Profiles for Locale Areas. https://www.dshs.wa.gov/ffa/rda/4/53/locale

HRSA suggested and provided data on five domains and 13 indicators for 2020 Home Visiting Needs Assessment. In addition to these, Washington State decided to add a domain (Education), added or substituted several indicators within each domain, and in some cases, expanded the definition of a domain. We also used the most up-to-date data we could obtain and multiple years of data to ensure sufficient sample size to conduct the school locale-level analysis. We used the same datasets for county, school locale, and race-ethnicity analyses so that the results are comparable. However, some indicators were not available by school locale or by race/ethnicity. **Table I** summarizes the domains and indicators used for county-level, school locale-level, and race-ethnicity analyses.

Table I. Domains and Indicators Included for Analysis

Domains and Indicators	**County-Level Analysis**	**School Locale-Level Analysis**	**Race-Ethnicity Analysis**
Socioeconomic Status (SES)			
Poverty	X	X	X
Unemployment	X	X	X
High School Dropout	X	X	
Income Inequality	X		
Limited English-speaking Household	X	X	X
Female Headed Household	X	X	X
Maternal and Child Health (MCH)			
Preterm Birth	X	X	X
Low Birth Weight	X	X	X
Infant Mortality Rate	X		X
Pre-pregnancy Obesity	X	X	X
Domestic Violence and Crime			
Domestic Violence	X	X	
Crime Reports	X		
Juvenile Arrests	X		
Child Maltreatment			
Child Maltreatment	X	X	
Education			
Kindergarten Readiness	X	X	X
3rd Grade English Language Arts (ELA)	X	X	X
3rd Grade Math	X	X	X
Behavioral Health			
10th Grade Alcohol Binge Drinking	X		X
10th Grade Drug Use Including Marijuana	X		X
Neonatal Abstinence Syndrome Incidence	X		
Drug Overdose Deaths	X		X
Depression	X		X
Suicide Rate ages 14-54	X		X

The following six domains were used by Washington State to assess needs: Socioeconomic Status (SES), Maternal and Child Health (MCH), Behavioral Health, Domestic Violence and Crime, Child

Maltreatment, and Education. The domains are similar to the five domains suggested by HRSA (SES, Adverse Perinatal Outcomes, Substance Use Disorder, Crime, and Child Maltreatment), which align with the statutory definition of "at-risk communities". In addition, Washington added the Education domain since decades of research supports that home visiting helps promote school readiness.[5] School readiness and achievement are also two of the long-term outcomes of MIECHV as mentioned in statute.[6]

For the SES domain, we added proportion of limited English-speaking households and proportion of female headed households with children under 6, as the Steering Committee believed that these SES measures better represented communities with greater need for home visiting in Washington. These indicators were also used for the 2017 statewide needs assessment.

For the MCH domain, we added infant mortality rate because it is one of the two Leading Health Indicators of Healthy People 2020 objectives in Maternal and Infant Child Health topic area.[7] Together with preterm birth rate, infant mortality is a national health priority. We used seven years of data to account for small numbers of infant deaths in some counties. We also added pre-pregnancy obesity as a measure of maternal morbidity, which represents an indicator of "at-risk prenatal, maternal, newborn, or child health" as mentioned in the statute.[8] As described in the Title V Maternal and Child Health Block Grant (MCHBG) needs assessment, maternal morbidity is an issue of worsening trend in Washington State. Between 2008 and 2018, diabetes during pregnancy, hypertension during pregnancy, and pre-pregnancy obesity increased by 75%, 53%, and 12%, respectively. Obese and overweight women currently make up over 50% of pregnancies in Washington.

For the Crime domain, Washington added an indicator of domestic violence offenses per 1000 persons and called it the "Domestic Violence and Crime" domain. For Child Maltreatment, Washington used its own data for the children (age birth-17) identified as victims in reports to Child Protective Services (CPS) that were screened in for further action, per 1,000 children (age birth-17).

Instead of the stand-alone "Substance Use Disorder" domain, Washington added two indicators of mental health (depression and suicide rate) and called the domain "Behavioral Health". This is because mental health issues often coexist with substance use disorders, and they are inherently related. Home visiting programs address mental health along with substance use, by screening and referring clients to providers when needed. For indicators of drug and alcohol use, we did not use the provided indicators from National Survey of Drug Use and Health of Substance Abuse and Mental Health Services Administration (SAMHSA) because estimates for the Substance Abuse Treatment Planning Region were imputed for county estimates. There are differences within each Substance Abuse Treatment Planning Region and regional data were not nuanced enough to capture the needs of the counties. In place of SAMHSA's indicators, Washington used the following

[5] U.S. Department of Health and Human Services, Administration for Children and Families, Home Visiting Evidence of Effectiveness (HomeVEE). Available at: https://homvee.acf.hhs.gov/.
[6] Social Security Act, Title V, Section 511. Maternal, Infant, and Early Childhood Programs. Available at: https://www.ssa.gov/OP_Home/ssact/title05/0511.htm.
[7] Healthy People.gov. Maternal, Infant, and Child Health. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health/objectives
[8] Social Security Act, Title V, Section 511. Maternal, Infant, and Early Childhood Programs. Available at: https://www.ssa.gov/OP_Home/ssact/title05/0511.htm.

four indicators to represent drug and alcohol use in the communities: 10th grade alcohol binge drinking, 10th grade drug use including marijuana, neonatal abstinence syndrome (NAS) incidence, and drug overdose resident deaths. Additional details about the domains and indicators are included in Tab2-Description of Indicators located in the Data Summary workbook.

Description of Analysis Methodology

Washington used the modified simplified method for the analysis (See Tab 1-Modified Simplified Method Overview of Data Summary). The following algorithm was used to identify at-risk counties and priority groups for Washington State:

1. Obtain raw, county-level data for each indicator from the listed data source as defined in Tab 2-Description of Indicators of Data Summary. In addition, school locale-level data were obtained for each indicator when available. (Tab 4a-Raw Indicators). Indicators by race-ethnicity categories were obtained when available. (Tab 4b-Raw Indicators – Race-Eth).
2. Compute mean of counties and standard deviation (SD) for each indicator as well as other descriptive statistics (number of missing, range, etc.) During this step, some indicators were determined not viable for the needs assessment. (Tab 3-Descriptive Statistics).
3. Standardize indicator values (compute z-score) for each county so that all indicators have a mean of 0 and a SD of 1. (Tab 5a-Standardized Indicators). Z-score = (county value - mean)/SD. For school locale-level analysis, the county-level mean and SD for each indicator were used to standardize indicator values. For race-ethnicity analysis, the mean and SD of seven race-ethnicity groups were used to standardize indicator values.
4. Using the resulting z-scores for each county, calculated the proportion of indicators within each domain for which that county's z-score was greater than or equal to 1 (Tier 1) or 0.5 (Tier 2), that is, the proportion of indicators for which a given county is in the highest 16% (Tier 1) or 31% (Tier 2) of all counties in the state. If at least half of the indicators within a domain have z-scores greater or equal to 1 SD (Tier 1) or 0.5 SD (Tier 2) higher than the mean, then a county is considered at-risk on that domain. The total number of domains at-risk (out of 6) is summed to capture the counties at highest risk across domains. Counties with 2 or more at-risk domains is identified as at-risk. (Tab 6a-Tier1 At-Risk Domains [SD1] and Tab 6b-Tier2 At-Risk Domains [SD0.5]).
5. Similarly, using the resulting z-scores for each school locale, calculated the proportion of indicators within each domain for which that school locale's z-score was greater than or equal to 1 (Tier 1) or 0.5 (Tier 2). If at least half of the indicators within a domain have z-scores greater or equal to 1 SD (Tier 1) or 0.5 SD (Tier 2) higher than the mean, then a school locale is considered at-risk on that domain. The total number of domains at-risk (out of 5) is summed to capture the school locales at highest risk across domains. School locales with 2 or more at-risk domains is identified as at-risk. (Tab 6a-Tier1 At-Risk Domains [SD1] and Tab 6b-Tier2 At-Risk Domains [SD0.5]).
6. For race-ethnicity analysis, the total number of domains above or below the thresholds were identified for Tier 1 and Tier 2 approaches. A group with 2 or more domains above or below the threshold (out of 4) is identified as a priority group for each tier. (Tab 6c-Tier1 Race-Ethnicity [SD1] and Tab 6d-Tier2 Race-Ethnicity [SD0.5]).
7. Combining the results of county-level and school locale-level analyses, the final list of at-risk counties was created. The final list of at-risk counties was created based on Tier 2 criteria. (Tab 7-At-Risk Counties.)

Washington used a tiered approach in which a higher threshold (Tier 1, SD=1) and a lower threshold (Tier 2, SD=0.5) for z-scores were used to identify at-risk counties and priority groups. The use of the lower threshold (Tier 2, SD=0.5) aligned better with the methods Washington used for the 2010 MIECHV needs assessment and 2017 state needs assessment. The Steering Committee agreed that communities identified using the lower threshold all qualified and benefited from receiving home visiting services. Therefore, the final lists of at-risk counties and priority groups were created for MIECHV purposes based on Tier 2 criteria. The Tier 1 selection provides a narrower ranking of communities that may be prioritized for services, pending State and local resources, as we reflect on the greatest needs and our ability to support home visiting.

Indicators for the Education domain were different from other indicators in that they represented better outcomes when the value was higher (e.g., % Kindergarten ready) while other indicators indicated worse outcomes when the value was higher. To make the z-score values easy to compare, we calculated z-scores for education indicators in a way that higher z-scores indicates higher risk (i.e., higher z-scores for lower kindergarten readiness).

As mentioned earlier, school locales are usually smaller than a county, but there are some exceptions. School locale borders and county borders often do not perfectly align. To account for these issues and to identify the appropriate at-risk counties based on school locale-level analysis, the following procedure was used. School locales are either a school district or a group of school districts, with 20,000+ population. Washington State Office of Superintendent of Public Instruction (OSPI) assigns a county to each school district even when a school district crosses a county border. In other words, the main county in which a school district resides is always identifiable. Sometimes, a school district covers areas in two or more counties. In this case, if at least a third of the area of a school district is in a county, then we associated that county with the school district. When a school locale was determined to be "at-risk", we examined all the school districts within the school locale, and identified the associated counties for each school district. As a result, some school locales identified multiple counties as "at-risk". This is justifiable because the school districts within each school locale have similar characteristics even though they cross county borders. If we only examined school districts as the unit of analysis, we would not have been able to conduct most analysis due to small numbers. School locale-level analysis allowed us to examine the groups of school districts that are similar in characteristics, to identify geographic areas with greatest needs, which often crossed county borderlines.

Data were suppressed according to the DOH Agency Standards for Reporting Data with Small Numbers.[9] In general, unweighted data was suppressed when any cell was 0<n<10 or relative standard error (RSE) was ≥30%. For Healthy Youth Survey, county-level data was suppressed when only one district participated for the entire county in the survey in 2016 and 2018.[10] For education domain, data were already suppressed at the school district level by OSPI if the numerator was <10 or the performance was >90%.

For race-ethnicity analysis, race and ethnicity data for each indicator were obtained from the same data sources as described in Tab 2-Description of Indicators of Data Summary, when available. For

[9] Washington State Department of Health Agency Standards for Reporting Data with Small Numbers. May 2018. Available at: https://www.doh.wa.gov/Portals/1/Documents/1500/SmallNumbers.pdf

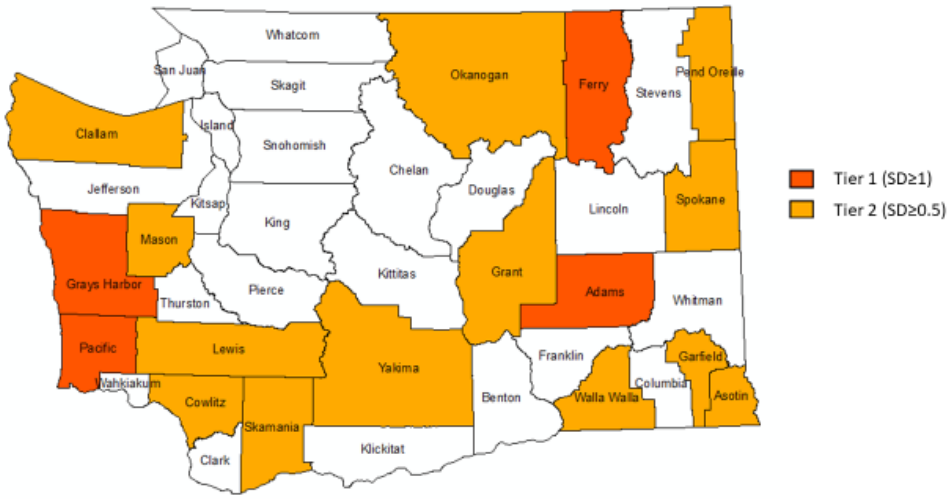
[10] Healthy Youth Survey Data Analysis & Technical Assistance Manual. December 2019. Available at: https://www.askhys.net/Docs/Analysis%20Manual%20for%202018%2012-5-19%20final.pdf

this analysis, the mean and SD of seven race-ethnicity groups were used to calculate the z-scores. The race-ethnicity groups considered were: Hispanic, non-Hispanic American Indian/Alaska Native, non-Hispanic Asian, non-Hispanic Black, non-Hispanic Multiple Race, non-Hispanic Pacific Islander, and non-Hispanic White. These are the categories used in past needs assessments and are available in several data sources for Washington State.

Results of Phase 1: County-Level and School Locale-Level Analysis

Figure 1 shows the result of the county-level analysis. Tier 1 county-level analysis identified four counties (Adams, Ferry, Grays Harbor, Pacific), and Tier 2 county-level analysis identified an additional 13 counties (Asotin, Clallam, Cowlitz, Garfield, Grant, Lewis, Mason, Okanogan, Pend Oreille, Skamania, Spokane, Walla Walla, Yakima) as at-risk. Together, 17 counties were identified as at-risk using the county-level analysis.

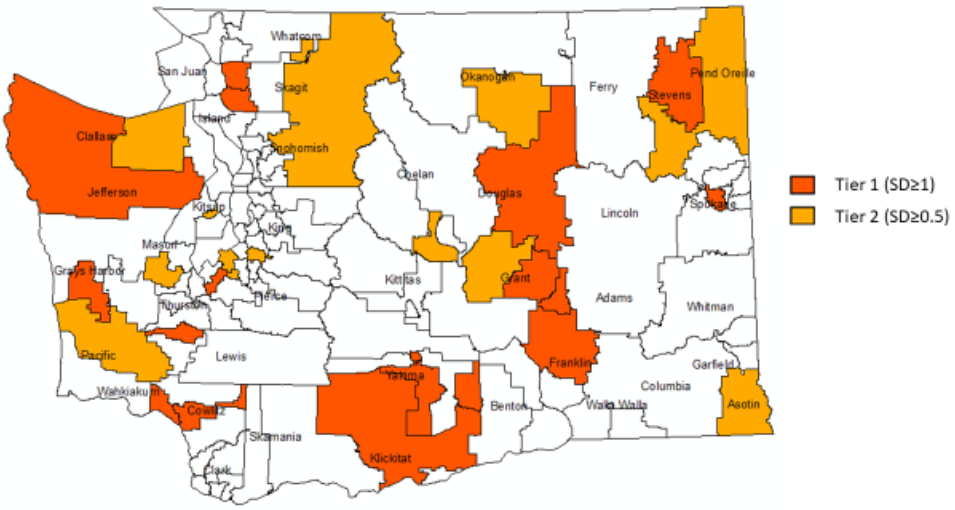
Figure 1. Results of Tier 1 and Tier 2 County-Level Analysis



SD: Standard Deviation

Figure 2 shows the results of the school locale-level analysis. A total of 17 school locales (Locale 1, 9, 14, 16, 20, 22, 23, 33, 39, 44, 46, 76, 92, 99, 107, 111, and 112) were identified as at-risk in Tier 1 analysis and additional 13 school locales (Locale 10, 28, 32, 34, 38, 45, 69, 79, 81, 94, 97, 102, and 105) were identified as at-risk in Tier 2 analysis (Figure 2). Together, 30 school locales (out of 118) were identified as at-risk using the school locale-level analysis. Detailed results of both the county-level analysis and the school locale-level analysis are shown in Data Summary Tab 6a-Tier1 At-Risk Domains (SD1) and Tab 6b-Tier2 At-Risk Domains (SD0.5).

Figure 2. Results of Tier 1 and Tier 2 School Locale-Level Analysis



SD: Standard Deviation

While results of Tier 1 and Tier 2 analyses using different thresholds of z-score may show different levels of risks, the number of domains affected shows the multitude of issues communities are facing. **Figure 3** shows the number of domains affected using Tier 2 county-level analysis. In Tier 2 county-level analysis, the counties that showed the greatest number of at-risk domains were Asotin, Cowlitz, Ferry, and Yakima (4 domains each).

Figure 3. Number of Domains Affected in Tier 2 County-Level Analysis

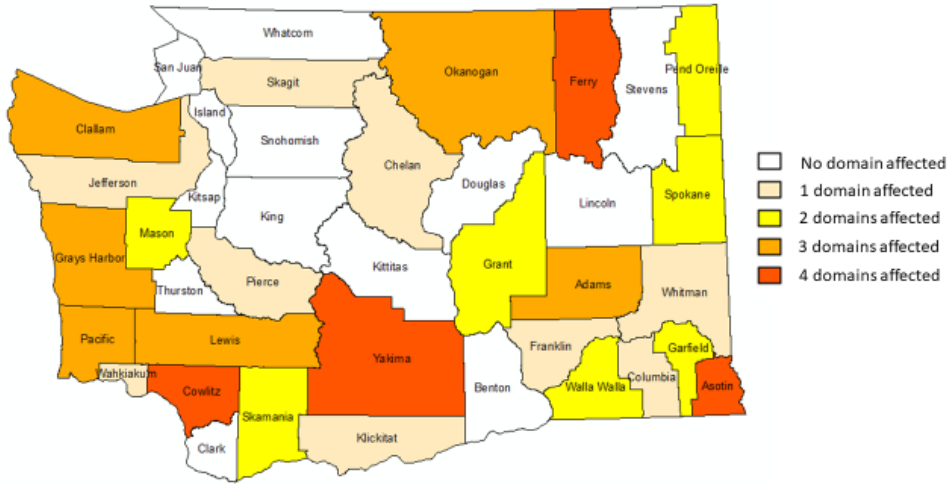
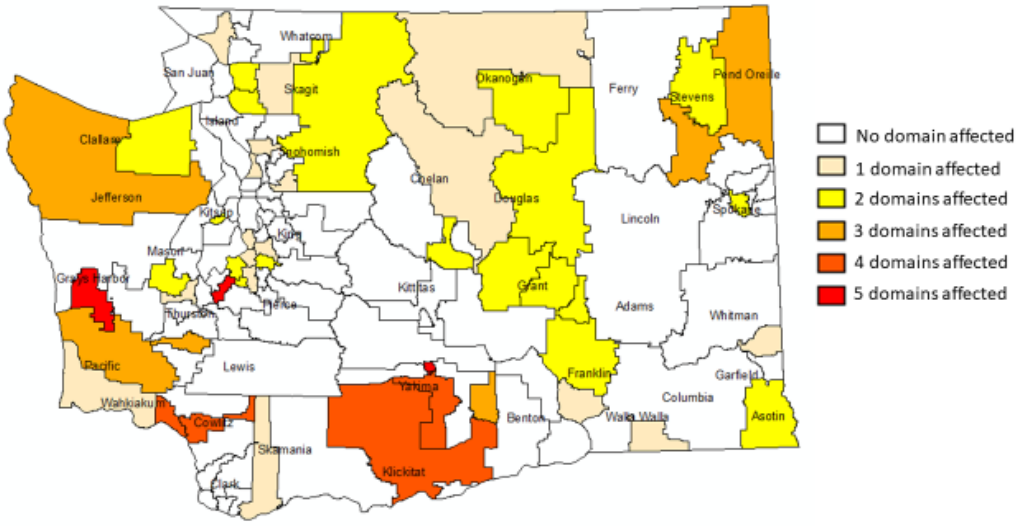


Figure 4 shows the number of domains affected using Tier 2 school locale-level analysis. For school locale-level analysis, data were available for up to five domains. The school locales that showed the greatest number of at-risk domains were Locale 14 (Yakima) in Yakima County, Locale 76 (Clover Park) in Pierce County, and Locale 99 (Aberdeen, Cosmopolis, Hoquiam) in Grays Harbor County each with all 5 domains, plus Locale 20 (Goldendale, Bickleton, Mabton, Mount Adams) in Klickitat and Yakima County, Locale 22 (Toppenish, Union Gap, Wapato) in Yakima County, Locale 111 (Longview) in Cowlitz County, and Locale 112 (Kelso) in Cowlitz County each with 4 domains.

Figure 4. Number of Domains Affected in Tier 2 School Locale-Level Analysis



2. Phase Two: Adding Counties Known to be At-Risk

The Steering Committee decided to add Benton County as an additional county known to be at-risk. Benton County was identified as an at-risk county in the 2010 MIECHV needs assessment and at elevated risk in the 2017 statewide needs assessment. Benton County has one of the highest proportions of Hispanic population in our state. Washington State Office of Financial Management (OFM) estimates that 42% of the child population ages 0-2 in Benton County are Hispanic. Benton County has the fifth largest number of Hispanic children ages 0-2, only after King, Yakima, Pierce, and Snohomish.[11] (See Appendix A).

The reason why the county did not emerge as at-risk in the Phase 1 analyses may be due to the availability of data and the fact that the county includes both high-risk and low-risk locales. Benton County is associated with three school locales: Locale 24 (Prosser, Kiona Benton, and Paterson), Locale 25 (Finley and Kennewick), and Locale 30 (Richland). Locale 24 is adjacent to Yakima County,

[11] Office of Financial Management. Estimates of April 1, 2019 population by age, sex, race and Hispanic origin. Available at: https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin

and thought to be at-risk. The school locale-level analysis showed that Locale 25 and Locale 30 do not show any increase in z-score for any of the measures thus are considered low-risk. On the other hand, for Locale 24, there were several indicators that were concerning. Locale 24 has a high proportion of female headed households with children under 6 (z-score of 0.7), a high proportion of limited English-speaking households (z-score of 0.8), and a very low rate of kindergarten readiness (z-score of 1.3). Due to small numbers, some variables were missing for Locale 24 (e.g., high school drop-out rate, 3rd grade English Language Arts [ELA]). Therefore, the county-level analysis was likely affected by the fact that the county includes low-risk locales, and the school locale-level analysis may have been insufficient due to sample size and data availability.

We learned from COVID-19 data and the care coordination work for COVID-19 response at DOH that Benton County as a whole and especially parts of Benton County adjacent to Yakima County were hardest hit during the early months of the pandemic because of essential workers in agriculture and food packing plants, and also because people moved between the county borders for work, to socialize, to take care of family members, to see a doctor, etc. As of September 9, 2020, Benton County had the sixth highest number of confirmed COVID-19 cases and the sixth highest number of COVID-19 deaths after King, Yakima, Snohomish, Pierce, and Spokane. Yakima and Benton County along the county border have similar communities in terms of demographic characteristics and socio economic status, and as evidenced by the COVID-19 pandemic, includes one of the most vulnerable population in our state.

3. Final List of At Risk Counties

Combining the results of Phase 1 (county-level and school locale-level analyses) and Phase 2, there were 31 counties identified at risk and could benefit from home visiting services in Washington State. **Table II** shows the final list of at risk counties and how they were identified by each analysis. Using the modified simplified method, a total of 19 counties (Tier 1) and 30 counties (Tier 2) were identified as "at-risk" using the threshold value of 1 and 0.5 of z-scores, respectively. Using the county-level analysis alone, we would have only identified 4 counties (Tier 1) and 17 counties (Tier 2). By adding the school locale-level analysis, we were able to identify small pockets of areas with risk, especially in more densely populated counties such as King, Snohomish, and Pierce County. Detailed results for the county-level and school locale-level analyses are shown in Tab 6a-Tier 1 At-Risk Domains (SD 1) and Tab 6b-Tier 2 At-Risk Domains (SD 0.5) of the Data Summary.

Table II. Final List of At-Risk Counties Identified in Phase 1 (County and School Locale-Level Analysis) and Phase 2

	County-Level Analysis		School Locale-Level Analysis		Phase 2
At-risk Counties	**Tier 1: Domains SD≥1**	**Tier 2: Domains SD≥0.5**	**Tier 1: Domains SD≥1**	**Tier 2: Domains SD≥0.5**	**County known to be at risk**
Adams County	X	X	X	X	
Asotin County		X		X	
Benton County					X
Chelan County				X	
Clallam County		X	X	X	
Cowlitz County		X	X	X	
Douglas County			X	X	
Ferry County	X	X			
Franklin County			X	X	
Garfield County		X			
Grant County		X	X	X	
Grays Harbor County	X	X	X	X	
Jefferson County			X	X	
King County				X	
Kitsap County				X	
Klickitat County			X	X	
Lewis County		X	X	X	
Mason County		X		X	
Okanogan County		X	X	X	
Pacific County	X	X		X	
Pend Oreille County		X		X	
Pierce County			X	X	
Skagit County			X	X	
Skamania County		X			
Snohomish County				X	
Spokane County		X	X	X	
Stevens County			X	X	
Thurston County				X	
Walla Walla County		X			
Whatcom County				X	
Yakima County		X	X	X	
31 Counties	**4 Counties**	**17 Counties**	**16 Counties**	**26 Counties**	**1 County**

SD=standard deviation; SL=School Locale

4. Race-Ethnicity Analysis

Table III summarizes the results of the race-ethnicity analysis. Tier 1 analysis identified the non-Hispanic American Indian/Alaskan Native group as the only priority group while Tier 2 analysis identified four race-ethnicity groups as priority groups: non-Hispanic American Indian/Alaskan Native, Hispanic, non-Hispanic Black, and non-Hispanic Pacific Islander groups. These are the groups that are experiencing disparities in at least two of the four domains considered (SES, MCH, Behavioral Health, and Education). Most notably, the non-Hispanic American Indian/Alaskan Native group experienced disparities in all four domains considered in the Tier 2 analysis.

We also examined where the children of priority groups resided within our state. We used the population estimates from Washington State OFM April 1, 2019 data to examine the numbers and proportions of children ages 0-2 by priority group.[12] (See Appendix B for details). Non-Hispanic American Indian/Alaskan Native, Hispanic, non-Hispanic Black, and non-Hispanic Pacific Islander children ages 0-2 accounted for 1.3%, 25.2%, 4.3%, and 0.9% of the total population of children ages 0-2 in Washington State, respectively. The largest number of non-Hispanic American Indian/Alaskan Native children ages 0-2 resided in Yakima, King, Pierce, Spokane, and Snohomish County, together accounting for just 49% of non-Hispanic American Indian/Alaskan Native children ages 0-2. The majority (59%) of Hispanic children ages 0-2 resided in King, Yakima, Pierce, Snohomish, and Benton County. For both non-Hispanic American Indian/Alaskan Native and Hispanic children ages 0-2, 95% were scattered throughout 20 counties. On the other hand, non-Hispanic Black children ages 0-2 and non-Hispanic Pacific Islander children ages 0-2 were more concentrated in densely populated counties: 82% of non-Hispanic Black children and 83% of non-Hispanic Pacific Islander children resided in King, Pierce, Snohomish, and Spokane County.

Table III. Summary of Results for Race-Ethnicity Analysis.

Race/Ethnicity	Tier 1 Priority Group (# of domains SD≥1)	Tier 2 Priority Group (# of domains SD≥0.5)
Hispanic		X (2)
Non-Hispanic American Indian/Alaskan Native	X (3)	X (4)
Non-Hispanic Asian		
Non-Hispanic Black		X (2)
Non-Hispanic Multi-Race		
Non-Hispanic Pacific Islander		X (2)
Non-Hispanic White		

Note: SD=standard deviation

[12] Office of Financial Management. Estimates of April 1 population by age, sex, race and Hispanic origin. Available at: https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin

5. Discussion

In Phase 1, county-level analysis identified 17 counties as at risk, and school locale-level analysis identified additional 13 counties as at risk for a total of 30 at-risk counties. In Phase 2, we added one county (Benton) as the county known to be at risk, bringing the total at-risk counties to 31. Our selected method reflects the level of risk as we understand it in our state. Using the threshold of 1 for z-score allowed us to identify the most at-risk counties, yet the number of domains affected are also important. The threshold of 0.5 for z-score cast a larger net to identify at-risk counties which is more consistent with the previous needs assessment and Washington's expansion planning. The Committee and HVAC members agreed that 30 counties identified in Phase 1 and one county identified in Phase 2 are in need of home visiting services. Additionally, members agreed that Tier 1 analysis did not sufficiently identify all at-risk communities even with the school locale analysis.

There are limitations that need to be considered when interpreting the results. For the simplified method, as more and more variables were considered, the measurement bias was reduced due to reliance on multiple variables (instead of one variable) to represent a construct or domain. However, our ability to identify at-risk counties was reduced when too many variables were included – possibly because of measuring slightly different constructs within a domain. Although the domains were meant to be equally weighted, domains that had smaller number of indicators or that included similar variables consistently identified more counties than others, thus this method may not have allowed us to weight the domains equally (See **Table IV**). Nonetheless, because only two domains were required for counties to be identified as at-risk, it was a reasonable method to identify at-risk counties.

Table IV. Number of counties and school locales identified in each domain (Tier 2 analysis)

	County Analysis At-Risk Counties	**School Locale Analysis At-Risk School Locales**
Socioeconomic Status (SES)	7 Counties	17 School Locales
Maternal and Child Health (MCH)	9 Counties	17 School Locales
Domestic Violence and Crime	10 Counties	23 School Locales
Child Maltreatment	12 Counties	20 School Locales
Education	12 Counties	22 School Locales
Behavioral Health	7 Counties	Not available

Race-ethnicity analysis identified four race-ethnicity groups as the priority groups: non-Hispanic American Indian/Alaskan Native, Hispanic, non-Hispanic Black, and non-Hispanic Pacific Islander groups. Of these groups, the non-Hispanic American Indian/Alaskan Native group was the only group identified in Tier 1 analysis and experienced disparities in all four domains in Tier 2 analysis. The results were again consistent with the previous needs assessment. The distribution of children by race-ethnicity across the state showed that non-Hispanic American Indian/Alaskan Native and Hispanic children ages 0-2 were scattered throughout the state, which included densely populated counties as well as rural counties. On the other hand, non-Hispanic Black and non-Hispanic Pacific Islander children ages 0-2 were mainly in the densely populated counties (King, Pierce, Snohomish, and Spokane). A concern was raised by HVAC members and stakeholders that prioritizing certain racial/ethnic groups may not necessarily align with counties and school locales. Further work is

needed to examine how best to serve geographic communities of risk while also addressing racial/ethnic disparities in our state.

Since the COVID-19 pandemic started in early 2020, it has adversely affected the most vulnerable communities throughout Washington State. As seen nationally, COVID-19 has taken a disproportionate toll on communities of color in our state, specifically the same race-ethnicity groups we identified in this needs assessment as our priority groups. Between mid-January and mid-August in 2020, age-adjusted case rates per 100,000 population were over seven times higher for Hispanic and non-Hispanic Pacific Islander groups compared to non-Hispanic Whites; and over 2.5 times higher among non-Hispanic Black and non-Hispanic American Indian/Alaska Native groups compared to non-Hispanic Whites. Noting that non-Hispanic White group is the largest population in Washington, hence comparisons to the Total Population may dilute the disparities we see.[13] These results suggest that inequities in socio-economic status, education, physical, mental and emotional health are all interrelated and that they are disproportionately affecting a wide range of outcomes for the racial and ethnic minority groups.

III. Identifying Quality and Capacity of Existing Programs

In 2010, Washington State pioneered a unique approach to home visiting, with a public-private partnership between DCYF and Ounce Washington. Ounce Washington is a key partner in building the statewide home visiting system. The HVSA brings together state, federal and private dollars to support a portfolio of high-quality proven and promising programs.

In this section, we assess the quality and capacity of existing home visiting programs to meet the needs of communities we identified in Section II. This includes an accounting of the current capacity to serve families and an assessment of the quality of those services. To guide the work in this section, we referred to efforts led by both DCYF and Ounce Washington, including a statewide home visiting scan of home visiting services (led by DCYF), the Region X Innovation Grant Workforce Study, the Self-Refection Tools (SRT) completed by programs to self-assess capacity and quality of their services (led by Ounce Washington), and community home visiting planning and exploration work (led by Ounce Washington).

1. Capacity of home visiting services in Washington State

The HVSA conducts a statewide scan of home visiting services biennially, and has since 2014. The purpose of the scan is to identify specific models providing home visiting services and the number of funded family slots they support throughout the state, regardless of funding source or implementing agency. The 2019 Home Visiting Scan identified ten models, funding 9,863 family slots across 32 counties as of Fall 2019 (**Figure 5**). In the 31 at-risk counties identified in this Needs Assessment (**Table II**), 9,419 family slots are funded for home visiting services.

The home visiting models in the Home Visiting Scan include; Early Head Start –Home Based (EHS-HB), Nurse-Family Partnership (NFP), Parents as Teachers (PAT), ParentChild+, Community Based Outreach Doula Program, Steps Towards Effective Enjoyable Parenting (STEEP), Family Spirit, Child

[13] Washington State Department of Health. COVID-19 Morbidity and Mortality by Race, Ethnicity and Language in Washington State. August 12, 2020. Available at: https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/data-tables/COVID-19MorbidityandMortlaitybyRaceEthnicityandLanguageinWaState.pdf

Parent Psychotherapy (CPP), Early Steps to School Success (ESSS) and Parent Child Assistance Program (PCAP). The HVSA funds 8 of the 10 models, as of Fall 2019, though not exclusively. It is estimated that the HVSA funds approximately one-quarter of identified family slots in the state, with a mix of MIECHV and state funds. The Scan inventoried basic information about each model including program goals, population focus, duration of services, workforce requirements, and distribution of funded slots. EHS-HB, NFP and PAT have the largest presence with programs in 32 counties serving two-thirds of all the family slots. ParentChild+ is almost exclusively serving King County (95% of ParentChild+ slots) and accounts for 38% of the total family slots in King County. One in ten slots are served by PCAP whose reach covers 75% of the counties with home visiting.

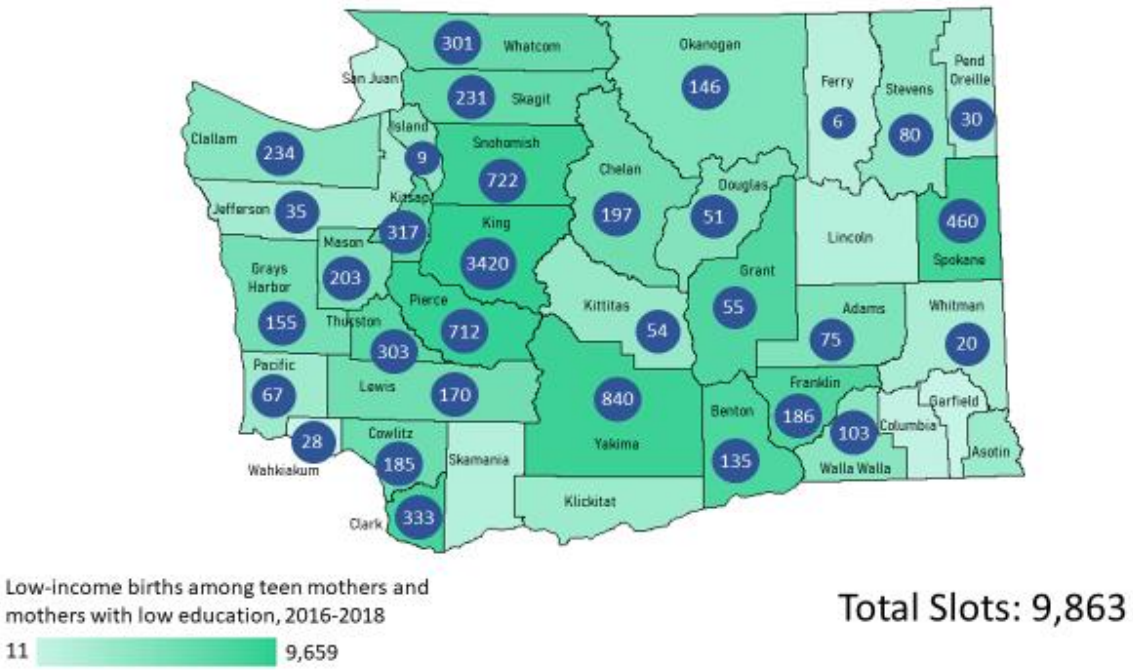
The Scan does not include statewide programs who serve families in a more flexible service and reimbursement model and do not have static family slots such as:

- First Steps/Maternity Support Services (MSS) and Infant Case Management (ICM) funded by Medicaid and administered by the Washington State Health Care Authority (HCA);
- Early Support for Infants & Toddlers (ESIT), the federal Individuals with Disabilities Act (IDEA) part C program. Part C requires ESIT to serve all eligible children statewide. There were 19,647 enrolled infants and toddlers served in the state fiscal year 2019 (July 1, 2018 - June 30, 2019).
- King County Best Starts for Kids (BSK) community-designed home-based services, funded by a tax levy approved by voters in November 2015. BSK expands the availability of home-based services that draw upon local community knowledge and practice to develop approaches that are designed for and valued by specific communities, and/or addressing populations not well-served by other programs.[14]

Of the 39 counties in Washington all but seven are served by one or more of the traditional home visiting models. These counties (Asotin, Columbia, Garfield, Klickitat, Lincoln, San Juan, and Skamania) have a high probability that families living in the counties are served by ESIT, MSS/ICM, or some other community service organization.

[14] King County. Best Starts for Kids Awards Made. October 2018. Available at: https://www.kingcounty.gov/depts/community-human-services/initiatives/best-starts-for-kids/programs/awards.aspx

Figure 5. Home Visiting Slots by County and Need



Note: Counties that do not have slots listed may still be receiving services by some of the programs listed under additional services that could not provide a slot by county breakout of their services at this time.

2. Gaps in the delivery of early childhood home visiting services

HRSA provided an estimated need of eligible families in each county (see Data Summary, Tab 7) estimated by the following method. Using the American Community Survey 2017 1-year Public Use Microdata Sample (PUMS) data, HRSA first identified families with children under the age of 6 living below 100% of poverty line and families in poverty with a child under the age of 1 and no other children under the age of 6 (a proxy for families with a pregnant woman). Next, the number of families were restricted if the families belonged to one or more of the following at-risk populations: 1) mothers with low education (high school diploma or less); 2) young mothers under the age of 21; and 3) families with an infant (child under the age of 1). The populations (e.g., low income, low maternal education, and young mothers) were chosen by HRSA because they are linked with negative maternal and child health outcomes such as low birth weight, child injury, child maltreatment, school readiness disparities, etc. PUMS data is not available at the county level. The smallest geography available is the Public Use Microdata Area (PUMA) which corresponds to areas with 100,000+ populations that are nested within states and re-defined after every census based on census tracts and counties. Using the Missouri Census Data Center's MABLE database, counties can be matched to PUMAs weighted by an estimate of the 2014 population to determine the amount of intersection between county and PUMA. With this matching method, HRSA used the MABLE database to generate county estimates for the number of families likely to be eligible for MIECHV services (county estimate). A key assumption is that the at-risk population is evenly distributed

across the PUMA. However, our analysis found that PUMA grouped counties and areas with mixed levels of risks and needs. Therefore, we decided to present the Washington-specific estimated need of eligible families in each county, which will be discussed in detail.

Washington has used various approaches to assess unmet need for home visiting over the years, all of which present limitations in quantifying the unmet need for home visiting in communities across our state. In the most recent 2017 needs assessment and 2019 report to the Washington State Legislature of Considerations and Options for Expansion of Home Visiting Services in Washington State, the methods produced wider to narrower possible populations. There is continued effort to modify techniques in order to get a more nuanced picture at county- and locale- levels.

For the 2020 MIECHV needs assessment, Washington estimated need of eligible families using the following method. First, low-income births were identified using Medicaid and Women, Infants, and Children Program [WIC] variables from 2016-2018 Birth Certificate data, similarly to how need was estimated in the 2017 needs assessment. This represents low-income children ages 0-2 and their pregnant mothers. Second, the number of children were restricted if their mothers belonged to one or more of the following at-risk populations: 1) mothers with low education (high school diploma or less); or 2) young mothers under the age of 20. Finally, to estimate the number of families in need of services (instead of the number of children in need of services), we multiplied the number of children in need of services in each county by a factor of 0.7. This factor was chosen by comparing the household size and number of children <5 in poverty, using 2014-2018 American Community Survey data. We chose this method because it is similar to HRSA's method in defining subpopulation (mothers with low education and young mothers under the age of 20 during pregnancy). This method also aligns with the 2017 statewide needs assessment by using the same data source and using Medicaid and WIC to define low-income population, which aligns more closely with the priorities of the HVSA. HVSA prioritizes services to families in poverty (<100%FPL) and in extreme poverty (<50% FPL), low-income families well as (<200%FPL) who have identified needs. According to the HRSA estimate, the estimated need of home visiting services in the 31 at-risk counties is 32,333 families. Washington's estimated need of home visiting services is 44,329 families. The two types of estimated need of at-risk counties were compared against the estimated number of families served by a home visiting program located in the county in the most recently completed program fiscal year to examine met and unmet need. Washington understands that the estimated need of home visiting services is not synonymous with the number of families who may choose to participate in home visiting. This is further complicated by home visiting models with differing approaches for determining possible eligible population and those likely to participate in jurisdictions considering implementing their model.

The Scan provides a statewide view of the capacity of early childhood home visiting services. We used the Scan data to estimate the number of families served by a home visiting program located in the at-risk counties, and compared against the estimated need of home visiting services using the two methods. The Scan data showed that the existing services are offered in 27 of the 31 at-risk counties and were serving 9,419 families. The Scan estimated to meet only 21% of the need identified by Washington and 29% of the need estimated by HRSA (see Data Summary, table 7).

The data suggest considerable unmet need for home visiting among Washington families, with an estimated 79% of eligible families across 31 of the 39 counties unserved. Variability of services by county ranges from 0-54% of estimated need met, with four rural, sparsely populated counties

offering no home visiting services while counties along the I-5 corridor from the Canada border to Portland, Oregon serving 6,044 families or meeting approximately 24% of the need. Home visiting programs in the five most populous counties (King, Pierce, Snohomish, Spokane and Yakima) cover 62% of the estimated eligible families, yet serve very different clients. In the densely populated Puget Sound region (King, Snohomish, Pierce) we find extreme wealth inequalities given the rise in high-tech companies in King County. This has contributed to an affordable-housing crisis, which adversely affects the population most in need of home visiting services. Lack of affordable housing means families are moving out further from their place of employment, facing transportation barriers and potentially differing educational opportunities for themselves and their families. In central (Yakima) and eastern (Spokane) counties, we find more agrarian economies with concentrations of migratory populations dependent on seasonal labor opportunities. These agriculture-based enterprises have been particularly hard hit by the COVID-19 pandemic with multiple employment-based outbreaks expanding to community-wide transmission in many counties. The devastation to the economy and the physical and mental health of these communities is further exacerbated by the lack of health and social services available. In large, rural communities, families often are required to travel great distances to seek services and too often those services may not fit their cultural or linguistic needs.

Despite this overwhelming need, Washington has seen some successes with thoughtful, participatory expansion of services over the past few years including increased state funds over the last four years. With these funds, Washington has been able to expand home visiting services across 12 counties to serve an additional 400+ families including three tribal communities. These state funds have also allowed for flexibility to fund promising practice home visiting models.

In order to meet diverse community needs, the HVSA has prioritized a portfolio approach, investing in a range of models and programs. In planning for home visiting expansion, stakeholders emphasized the importance of matching communities with the right model to ensure that the unique needs of vulnerable populations are met. Through recent expansion efforts, 25% of funds have been awarded to promising practice models, who are often serving those furthest from opportunity and many of the racial and ethnic populations we have identified priority recipients of services. Through each expansion procurement, Washington used the 2017 Needs Assessment to identify priority populations based on need and risk. Applicants were required to describe the community need and risk context within which they were proposing home visiting expansion.

There continues to be interest in building out more coordinated approaches to building the early childhood systems, including interest in models such as Help Me Grow and Family Connects. Planning for the development of continued high quality implementation or expansion of home visiting services is also reliant on connection and coordination with systems serving similar populations. Washington's Preschool Development Grant provides an opportunity to continue development of a coordinated early childhood system that includes home visiting. Insights from the Preschool Development Grant Needs Assessment are highlighted in Section V.

3. Quality of home visiting services to meet the needs of families in Washington State

Working in concert with DCYF, Ounce Washington supports new and established home visiting programs through coaching, consultation, training and general professional development to ensure the highest-quality services to families. Ounce Washington's home visiting team is composed of a

team of subject matter experts in the MIECHV funded home visiting models, home visiting, family engagement, program implementation and community service coordination. Quality implementation is supported at all stages of program design, implementation, and growth. Through individual and group technical assistance, as well as peer learning opportunities, Ounce Washington promotes model fidelity, best practices, and innovation.

Identify the Quality and Capacity of Current Home Visiting Programs using Self-Reflection Tools

Ounce Washington's Home Visiting Implementation Hub ("the Hub") supports model fidelity and quality implementation of home visiting services. Home visiting programs funded through the HVSA receive individual technical assistance, consisting of mentoring, coaching, consultation, and facilitation of peer-to-peer learning. While supports are tailored to the unique needs and strengths of each individual program, all Hub technical assistance is grounded in the key drivers[15] identified by Implementation Science research conducted by the National Implementation Research Network (NIRN). The Hub provides supports based on the home visiting program's stage of implementation (implementation stages and drivers are described in more detail below). [16]

On a quarterly basis, each HVSA-funded home visiting programs receive individualized support from Hub technical assistance (TA) providers. The lead TA provider briefs Hub members on program updates, strengths and challenges, strategies that the program has used to solve challenges, and how that TA provider has been supporting them. The Hub also houses expertise in Continuous Quality Improvement (CQI) processes and provides support to all HVSA-funded home visiting programs around implementing improvement cycles to improve practice and address barriers in program implementation.

On an annual basis, the Hub works with 42 HVSA-funded local implementing agencies (LIAs) to complete the Self-Reflection Tool (SRT) to evaluate and reflect on the current state of program implementation, as well as assess training and technical assistance needs. The SRT is based on Implementation Science and asks programs to self-identify the program's current stage of implementation and identify key Drivers for success as follows.

Exploration – examine the fit, feasibility, and readiness to implement home visiting (see below for more detailed discussion of the Exploration stage)

Installing – Programs have just received funding (generally in the past 3-6 months) and are putting the pieces together to be able to begin serving families.

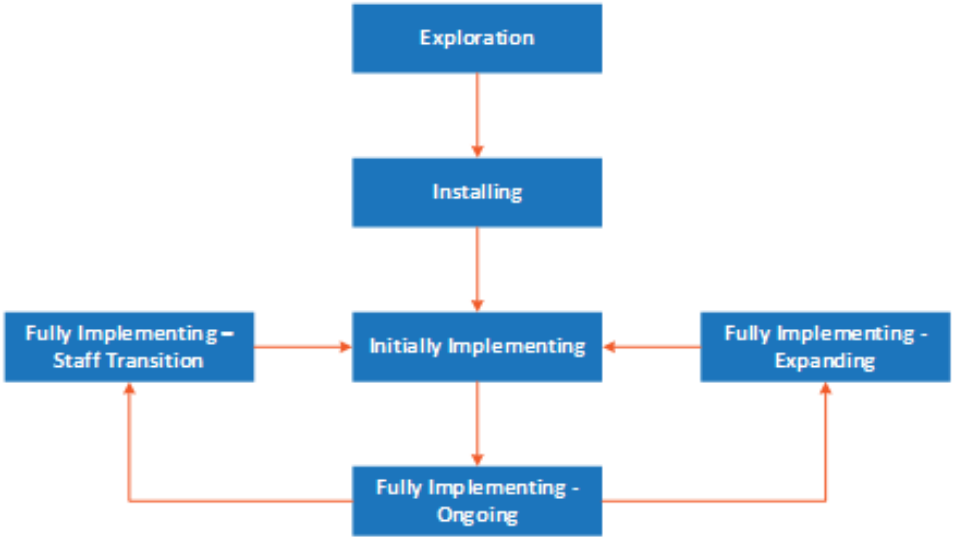
Initially Implementing – Programs who have just (generally within the last 6-12 month) started implementing a home visiting model are in this stage. They are still getting acclimated to model fidelity and the core components of serving families through their new program. This is a period of rapid problem solving.

[15] https://nirn.fpg.unc.edu/learn-implementation/implementation-drivers
[16] https://nirn.fpg.unc.edu/learn-implementation/implementation-stages

Fully Implementing - Programs are confident with model fidelity, problem solving as needed, and engaged in refining practice. Fully Implementing programs are not stagnant and are themselves constantly evolving. Three subsets within this group are:

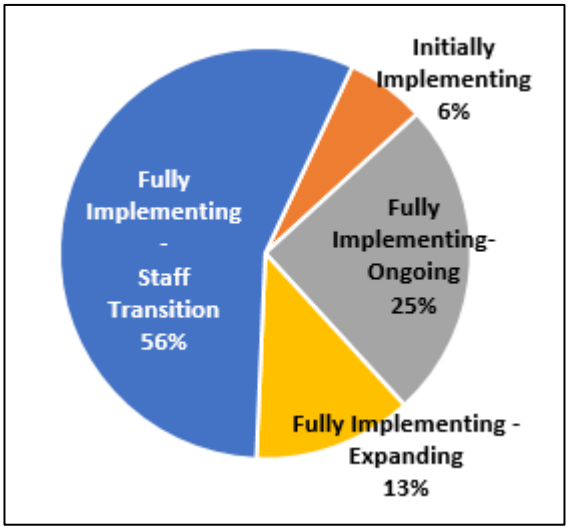
- **Fully Implementing-Ongoing** – maintaining full implementation
- **Fully Implementing-Expanding** – adapting to growth or expansion, installing some additional program elements associated with serving additional families
- **Fully Implementing-Staff Transition** - adjusting to staff transition and revisiting some activities associated with initial implementation (staff selection, training, leadership development, relationship with community partners, etc.)

Figure 6. Stages of Implementation



Based on SRTs completed by HVSA-funded programs in State Fiscal Year 2021 (July 1, 2020 – June 30, 2021), 94% of the programs considered themselves "Fully Implementing", with half of those experiencing staff transition (Figure 7).

Figure 7. Self-Identification of Stage of Implementation, SRT SFY21



Implementation Science has also helped us understand that **key drivers** affect implementation of evidence-based or research-based home visiting programs and the likelihood of reaching desired outcomes. Through completing the SRT, programs reflect on their capacity across key implementation drivers, including: Team Drivers, Program Leadership Drivers, Organizational Drivers, Connection to Community, and CQI (**Figure 8**). Within each category programs reflect on current capacity and practice/systems in place.

Figure 8. Key Drivers for Program

When reflecting on capacity across drivers of implementation, programs identified their greatest strengths within the Program Leadership and Team drivers, with 69% of responses and 68% of responses (respectively) designated as "Very" or "Extremely" – indicating these are drivers or processes are well-established. Alternatively, Connection to Community and CQI emerged as the areas with the most opportunity for improvement, with only 57% and 55% of responses (respectively) identified as "Very" or "Extremely". Within Connection to Community, program respondents selected "Not at all" or "Slightly" for 18% of drivers.

Table V. Areas of Reflection by programs, State Fiscal Year (SFY) 2021*

Areas of Reflection	**% Responses "Very" or "Extremely"**
Leadership	69%
Team	68%
Organizational	67%
Connection to Community	57%
Continuous Quality Improvement	55%

*July 1, 2020 through June 30, 2021

The SRT provides a valuable source of data that directly reflects the perspective of programs funded through the HVSA. The results are used to develop individually tailored Training and Technical Assistance Plan for the coming year. Based on the findings of the SFY21 SRT it is evident that programs perceive a gap in their ability to effectively connect with community partners, specifically entities connected to state systems such as child welfare, supported by DCYF, and Community Service Organizations (CSOs) supported by DSHS. We also see a critical need to better support access to reflective supervision for program supervisors, as well as support programs to better and more effectively engage families in leadership and elevate family voice in decision-making.

CQI remains a priority and area for capacity building at all levels of the state home visiting system. Likewise, CQI will continue to be an important approach to achieving improvement across implementation drivers. While programs reported high capacity and strengths related to Team Drivers (including team culture, systems for training and professional development, and staff retention), we also learned that 56% of programs identified experiencing some form of staff transition, which raises concerns for family engagement and quality of services. We might expect this level of staff transition to impact Team Drivers, however programs may associate high staff transition rates with external factors beyond their control. Given trends of high turnover across the home visiting field it is important that as a state system we continue to examine the reasons for staff turnover and strengthen systems to support and grow the home visiting workforce.

These gaps that programs have identified (effectively connecting with community partners, applying concepts of CQI, and integrating family voice and leadership) are critical as we consider how best to meet the needs of eligible families. Improving how programs connect with community partners will strengthen referral pathways and create more opportunities for successful warm handoffs so that families receive the services they need. By continuing to build capacity in CQI,

programs will be better equipped to address other barriers and gaps in practice and service delivery, including connecting with eligible families. And finally, as a state system, we recognize that meaningful inclusion of family voice and leadership is essential to ensuring high quality, effective home visiting services.

4. Gaps in staffing, community resources, and other requirements for delivering evidence-based home visiting services

Washington's Workforce

In 2019, the HVSA, along with regional MIECHV partners, published findings from the Region X MIECHV Innovation Grant's Home Visiting Workforce Study (University of Denver, 2019). Recognizing the importance of the home visiting workforce to effective service delivery and improved child and family outcomes, the study sought to identify the current strengths, gaps, and unmet needs in the home visitor workforce in Region X. In particular, it was designed to help inform workforce recruitment, retention, and professional development needs to help ensure the well-being and effectiveness of home visitors in the region. More than 250 home visitors and supervisors in Washington state participated, providing a rich body of work that described the current makeup of the home visiting workforce: from demographics and professional background - to professional development opportunities - to reasons behind the intent to leave or stay in current positions.

The Washington State home visiting field brings many strengths to their work, as the Workforce Study showed. In addition to the deep value the field receives knowing that they are making a difference in the lives of vulnerable children and families, home visiting staff are receiving support and reflective supervision from their supervisors, which is a predictor of workplace wellbeing and job retention. They carry an average caseload of 16, work overtime (one-third of home visitors, one-half of supervisors) and report an average of close to 10 hours per week spent on required paperwork. Significantly too, they report strong learning cultures and opportunities for peer-to-peer connections. These are all factors that have been shown to lead to organizational wellbeing and worker retention.

That said, attrition of home visitors is an issue that affects the quality of home visiting. Evidence shows staff retention is highly associated with family retention. The Workforce Study showed a home visiting workforce attrition rate of 20% to 23% over a three-year period. A scan of recent HVSA quarterly data, shows a 6-8% open positions rate for home visitors and a slightly smaller range for supervisors. Family attrition in Washington over a one-year period is 27%.

The Workforce Study found that a third of home visitors and almost a quarter of supervisors have been in the home visiting profession less than two years. Survey responses show that staff are leaving the workforce due to lack of promotional opportunities, low pay and an aging workforce. The absence of an established career pipeline points to a greater need for professional development upon entering the field and opportunities for growth within the field. Home visitors' low wages result in close to a quarter of the home visitors relying on two or more public assistance benefits in order to make ends meet. Importantly, being a home visiting professional of color was predictive of -$1.35 hourly pay, and was also a predictor of a higher intent to stay in the job. The

Study showed that 40% of supervisors and 25% of home visitors in Washington approach retirement age within 10 years. There is an imminent need to explore new ways to recruit and retain a new workforce.

Another issue mentioned by the Workforce Study and echoed by programs in Washington is the cultural and linguistic match of the home visitors and families. Families are more engaged in home visiting when there is a cultural and linguistic match with the home visitor. Fewer than half of home visitors shared common racial, ethnic, or cultural traits with the families they served. As one HVAC member mentioned, there is also an opportunity to recruit more diverse workforce in the next 10 years.

Workforce Retention encompasses recruitment, professional development and retention of a robust home visiting workforce. As the HVSA continues to expand the number of families it's able to serve, Washington sees workforce retention as one of the most critical strategies to improving family engagement outcomes, including enrollment, visit dosage, and retention and overall participation in home visiting services. Washington State's workforce development continues to identify racial and cultural equity as a priority.

Community Response and Resources

Traditionally, home visiting services provide a lifeline to many families, offering in-home support as well as connections to community resources. The COVID-19 pandemic has disrupted our way of doing business and continues to impact our communities. The home visiting workforce and families receiving home visiting services are heavily impacted. Programs and families made rapid changes to transition to virtual and phone visits, outdoor visits (in some counties), and sometimes connected through text messages, emailing, or a quick "hello" at the door while dropping off developmental activities for children or basic goods, such as diapers, formula, or food. Many home visitors had to adapt to a remote working environment while also caring for young children or school aged children at home. NFP nurses in our state, who mostly work in local health jurisdictions, have often been redirected to COVID-19 response and have had to operate at reduced capacity. Despite COVID deployment, NFP programs continue to connect with families and provide virtual home visits.

Further, the pandemic intensified unmet needs facing families in our state, particularly in behavioral health and economic well-being. There are limited culturally appropriate community resources to address the socioeconomic and behavioral health needs of families, especially for immigrants and people experiencing homelessness. These issues and gaps (particularly in rural communities), existed long-before the pandemic and home visitors lacked a sufficient supply of appropriate referrals to respond to increasing family needs in these areas.

5. Washington State's Home Visiting Infrastructure

Washington has built a strong home visiting program with MIECHV funding over the last several years, yet resource constraints continue to limit full implementation and support for the depth of services envisioned for the families in Washington. The expansion of services has continued to rise over the years with increased local and state funds; however, the internal infrastructure, for the HVSA and the LIAs, to support and maintain these services has not kept pace. Increasing the infrastructure around home visiting in services was a priority for Washington. With the rise of the

COVID-19 pandemic and impacts on the economy, we anticipate there will be state-wide budget adjustments. Advocates and community members continue to advocate for and build understanding of the critical impact and importance of home visiting, especially during these uncertain times. Prior to COVID-19, there was interest in expanding the TANF home visiting partnership work to expand access to services. Additionally, DCYF continues to work with the HCA to determine pathways for financing home visiting with Medicaid funds. Despite the work done over the last several years to diversify funding for home visiting, COVID-19 will have long-term effects on the sustainability of current and future programming which in turn may affect the capacity and infrastructure of the state team as well as potential stability of funding for programming throughout the State. As such, Washington continues to explore various funding streams to maintain the status quo as much as possible during this uncertain time.

One example of statewide infrastructure needing support is the HVSA data system. Accurate, reliable data are essential to the functioning of Washington's home visiting system. Information about who receives home visiting, the types of services they receive and where they are referred to, and goals and outcomes achieved all affect financial planning, eligibility for funding, service provision, quality improvement, and almost every aspect of program management and service delivery. Currently, there is variation in data collection strategies and tools across models and LIAs, because each model has specific requirements. For example, some of the more established models require that all LIAs use a national data system; for others, the LIA may (or may not) develop its own practices around collecting and maintaining data. Some models have established fidelity standards, and some do not. Non-MIECHV funded LIAs using promising practices models have less-structured data collection requirements and thus less-structured data management systems, though still collecting data for all of the aligned performance measures required by the HVSA. To create greater data standardization and quality, the HVSA has worked to integrate data from the various systems across models into a single database using SQL Server. To date, more than 80 percent of LIAs are using systems that allow integration into the SQL Server database system, while work is continuing with the remaining 20 percent to streamline their data reporting. This structure allows the LIAs to continue to use the model or a locally developed data system (avoiding duplicate data entry) and uses raw data from transfers and transformation/standardization from each system's data. Washington has begun a long-term data system planning process to guide development of the next stages of expansion and necessary data management. Some of this work will now be on-hold as we consider more immediate family and LIA needs in the course of the pandemic.

At the local level, need for infrastructure support is also growing. Costs to implement and maintain different models in communities across the state varies, but across the board, LIAs are facing increased costs of doing business yet flat funding levels. This translates into limitations on training and staff development, no or minimal cost of living increases, and generally doing more with less. Despite these challenges, Washington's portfolio model approach reflects our commitment to offering services that match the different needs across diverse communities. Supporting community exploration and matching communities with relevant models is one of the key strengths of Washington's program.

6. Assessing Community Readiness

Ounce Washington's Hub has proven experience leading communities through a structured community planning process to assess readiness and fit for starting up a new home visiting program. During this process, Hub staff facilitate and provide administrative support for a series of structured planning meetings with local community providers and stakeholders. Through these meetings, community members:

- learn more about home visiting as an intervention,
- assess service gaps and opportunities within the community,
- select a home visiting model that will best support desired outcomes,
- select a lead implementing agency for the new home visiting program, and
- confirm referral relationships and community support for the home visiting program

This planning process allows communities to thoughtfully and collectively assess how home visiting fits into their community's existing network of services, improving community coordination around resource allocation and service provision. As this is an exploratory process in nature, communities may at any point determine that home visiting is not a good fit.

This process is rooted in Implementation Science and the stages of implementation noted above (**Figure 6**) that serve to support quality, effective, and sustainable implementation of a new program. Implementation Science research has demonstrated that the "Exploration Stage" of implementing an intervention – evaluating whether an intervention is a good fit for the community and assessing readiness to implement it – is crucial for program success, saving significant time and financial resources in the long-term.

Community planning is highly collaborative, led primarily by a committed group made up of a diverse array of stakeholders, including parents and local service providers that support the health and development of families and young children. Though structured to follow an intentional flow to support decision-making, the process is flexible and tailored to meet the needs of individual communities. The Hub designed two self-assessments completed by community planning participants. These assessments are intended to support decision-making and reflect on readiness and fit for implementing home visiting. The two self-assessment ask communities to reflect on the following elements:

Community Readiness Assessment:

- Knowledge of Family Experience: Assess community awareness and general knowledge of the experience of families and young children and existing efforts to support families
- Leadership: Assess engagement and commitment of community leaders to actively support the startup of a new home visiting program
- Climate/attitude: Assess the climate and prevailing attitude within the community to support and work for the successful implementation of a new home visiting program

Community Fit Assessment:

- Eligible Families: Sufficient numbers of eligible potential program participants within the geographic area identified (eligibility dependent on selected home visiting model)
- Community Networks: Broad community support for one or more home visiting models, specifically support within the priority population
- Home Visiting Model Selection: Community agreement that selected home visiting model is a good fit with community and family priorities

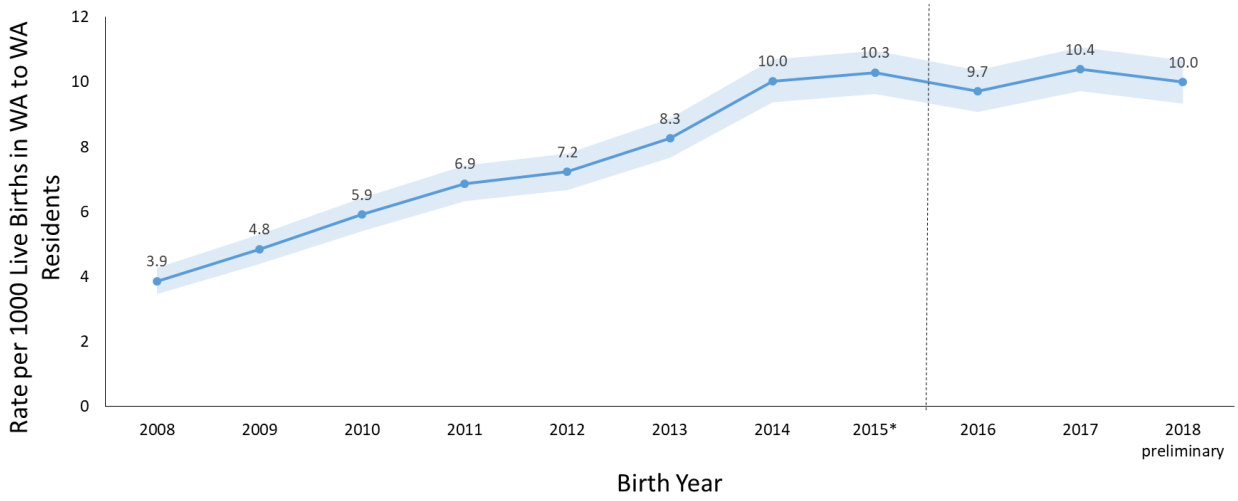
Since 2013, eleven communities have taken part in community planning supported by the Hub, resulting in funding of five new programs through Washington state and federal funding opportunities. In 2013 and 2015 the HVSA focused on providing community planning supports to rural and frontier communities with limited or no existing home visiting services. These efforts were directly connected to known funding opportunities, enabling installation and implementation of the home visiting program to take place shortly following the completion of community planning. Most recently, in 2017, community planning supports were again offered, this time expanding beyond only rural communities to include urban/suburban communities, this resulted in funding one home visiting program.

As the home visiting landscape grows and diversifies across the state, Ounce Washington and DCYF continue to evaluate, refine, and adapt the community planning process. In planning for future community exploration work Ounce Washington is critically examining the existing process to center equity and ensure family voice is amplified in decision making. We are also considering other uses of data beyond geographic locales to identify communities or populations that could most benefit from expansion of home visiting services.

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

Opioid and other substance use crisis has affected Washington residents, including pregnant women and families with young children. Between 2008 and 2018, when substance use disorder (SUD) was increasing among the general population, neonatal abstinence syndrome (NAS) incidence also increased by 150% (**Figure 9**). Today, about 1% of babies born in Washington State are diagnosed with NAS at birth. Substance use can lead to parenting challenges as well as compromise the nurturing parent-child relationships and safe environments that are essential for children to thrive.[17] The Title V Maternal and Child Block Grant (MCHBG) needs assessment revealed that stakeholders, key informants, and the general public described SUD as a direct threat to the health and wellness of women, children, and families. Fifteen local health jurisdictions serving 25 counties identified at least one form of SUD as a significant issue affecting their communities (Asotin, Benton, Chelan, Clark, Douglas, Ferry, Franklin, Garfield, Grays Harbor, Jefferson, Kitsap, Klickitat, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whatcom, and Yakima). Approximately 30% of families served by HVSA have familial history or current experience with substance use, including tobacco.

Figure 9. Incidence of Neonatal Abstinence Syndrome in Washington State, 2008-2018



Source: Washington DOH Comprehensive Hospital Abstract Reporting System. *transition year from ICD-9 to ICD-10
Note: 1. NAS cases are determined using Tier 2 CSTE recommendations; 2. Due to recent changes in treatment guidelines for Neonatal Abstinence Syndrome, there is variability in how birthing hospitals care for babies who could exhibit symptoms of withdrawal. Babies treated with older guidelines may be more likely to be given an NAS diagnosis. There is also variability in how and when clinicians and birthing hospitals screen for substance use and NAS, so some mothers and babies may be more likely to be screened & diagnosed than others; 3. Babies diagnosed with NAS may be born to mothers who are taking prescribed opiates, in treatment for Opioid Use Disorder, or for misusing substances.

[17] HRSA's Home Visiting Program: Supporting Families Impacted by Opioid Use and Neonatal Abstinence Syndrome. A Resource for MIECHV Awardees. October 2018. Available at https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/MIECHV-Opioid-NAS-Resource.pdf

To examine the capacity for providing SUD treatment and counseling services, information was gathered mainly through key informant interviews. Key informants were subject matter experts from DOH, DCYF, HCA, the Women Services Coordinator representing Washington State for Women Services Network (WSN), a director from a LIA, and epidemiologists from DOH.

1. Describe the range of treatment and counseling services

Various types of SUD treatment and counseling services exist in Washington State for pregnant women and families with young children. A listing of federal, state, local government, and private facilities that provide SUD treatment services is available in the National Directory of Drug and Alcohol Abuse Treatment Facilities, published by SAMHSA. This directory includes information such as the location of the facility, service settings (e.g., outpatient, inpatient, residential, telehealth), gender and age groups accepted, types of treatment and counseling services, language services, types of payment/insurance/funding accepted (including Medicaid).

Outpatient treatment services of some form for the general population exist in all counties, according to SAMHSA's Behavioral Health Treatment Locator. They include Federally Qualified Health Centers, private treatment centers, methadone treatment centers, and wraparound programs for Tribal members. The Medicaid Transformation[18] innovation allowed Washington State to integrate federal care services with primary care services. Some maternal care clinics offer both medical care (prenatal care) and substance use treatment and counseling services, but not all of them do. Some Federally Qualified Health Centers have behavioral health outreach workers, who do outreach work on the street and in the woods to locate people (including pregnant women and parents with young children) experiencing SUD and homelessness and connect then to services.

Inpatient treatment services are provided typically in hospital settings, usually in the acute phase, which may include detoxification, medical treatment, counseling, and rehabilitation services. There is a program that specifically targets pregnant and parenting women in Washington State. The Chemical-Using Pregnant (CUP) Women Program is an inpatient, up to 26-day, hospital-based program for adult or adolescent individuals who are pregnant, have a medical need, have a substance use history and are screened as at risk, and are currently enrolled in or are eligible (pending application) for Medicaid. The purpose of the CUP Women program is to reduce harm to a birthing parent and their unborn baby who need medical stabilization for complications often present in chemically-dependent pregnant individual and to provide all of the following services in a hospital setting to improve the health of the pregnant individual and the unborn baby: immediate access to care; medical detoxification and stabilization; medical treatment; and substance use treatment and referral. There are currently four CUP Women providers: Harbor Crest Behavioral Health (Grays Harbor Community Hospital) in Aberdeen (Grays Harbor County), Providence Recovery Program (Providence Regional Medical Center Everett) in Everett (Snohomish County),

[18] The Medicaid Transformation is an agreement with the federal government, which allows Washington State to test innovative approached to providing health coverage and care. See: https://www.hca.wa.gov/about-hca/healthier-washington/medicaid-transformation

Swedish Medical Center (Ballard Community Hospital) in Seattle (King County), and Evergreen Health Monroe Recovery Center in Monroe (Snohomish County).[19]

After inpatient treatment, patients are transferred to residential treatment services if they are eligible and the services are available. The program typically lasts for six months. These facilities allow mothers to stay with their infants and young children (See Appendix C). As of April 2020, there were nine Pregnant and Parenting Women Residential Treatment facilities in six counties (Clark, Cowlitz, Snohomish, Spokane, Thurston, and Yakima) in Washington State. Together, the nine facilities can hold a client capacity of 150 and child capacity of 127. The majority of residential clients are eligible for Medicaid.

First Steps (maternity support services and infant case management) is a Medicaid program for pregnant individuals and their infants in Washington State that covers a variety of services. First Steps services include medical (e.g., prenatal care, delivery, post pregnancy follow-up, one year of full medical for newborns), enhanced (added Maternity Support Services and Infant Case Management), drug and alcohol (alcohol and drug assessment and treatment) and other services (e.g., outreach, transportation, interpreter services). Maternity Support Services (MSS) are preventive health and education services to help an individual have a healthy pregnancy and a healthy baby. MSS include screening for pregnancy risk factors, brief solution-based counseling for identified risk factors, and referral to community resources. Services are provided by a team that includes a nurse, a nutritionist, a behavioral health specialist, and a community health worker (in some locations). Services are provided in a clinic or office, a home setting, or a community setting. Infant Case Management (ICM) may start any time after MSS ends (usually when the baby is about 3 months old) and can continue up to the last day of the month of the baby's first birthday. ICM helps families learn about, and how to use, needed medical, social, educational, and other resources in the community. First Steps providers are currently in 27 counties. Some providers only provide either MSS or ICM, not both. MSS is provided in 26 counties as of August, 2020 (Adams, Benton, Chelan, Clallam, Clark, Cowlitz, Franklin, Grant, Grays Harbor, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, and Yakima). Medicaid clients are allowed to receive services from any provider. [20]

Clients with SUD are often referred to PCAP from Medicaid providers or MSS. PCAP is a home visiting case-management model for pregnant and parenting women with substance use disorders. The PCAP model was developed in the 1990's by researchers from University of Washington. The goals of PCAP are to help mothers build healthy families and prevent future births of children exposed prenatally to alcohol and drugs. Trained case managers meet with clients twice monthly in clients' homes when possible to assist clients in obtaining alcohol/drug treatment, staying in recovery, addressing housing, domestic abuse, child custody issues, connecting with community services, and resolving system service barriers.[21] Currently, 15 PCAP agencies serve clients in 19

[19] Washington State Health Care Authority. Chemical-Using Pregnant Women. Available at: https://www.hca.wa.gov/health-care-services-supports/apple-health-medicaid-coverage/chemical-using-pregnant-women

[20] First Steps provider directory. Available at: https://www.hca.wa.gov/health-care-services-and-supports/apple-health-medicaid-coverage/first-steps-provider-directory

[21] Parent-Child Assistance Program. Available at: https://depts.washington.edu/pcapuw/

counties (**Table VI**). A majority (93%) of PCAP clients are on or eligible for Medicaid. PCAP home visitors/case managers call themselves "PCAP advocates", and often advocate for the clients when the clients have legal and/or custody issues and need to appear in drug or LIFT (therapeutic) courts.

PCAP's intensive case management provide wrap-around services such as accessing mental health services and finding housing. It is a three-year program for pregnant or parenting women at any stage. The goals of the program are to prevent subsequent substance use and to get mothers to be involved in different services. At discharge, the program prepares with the client for housing and a plan of action, including mental health services, counseling services, and AA (Alcoholics Anonymous) and NA (Narcotics Anonymous) meetings. However, as mentioned earlier, PCAP programs often have a hard time finding adequate and affordable housing for clients.

Table VI. Parent-Child Assistance Program (PCAP) locations in Washington State

County	PCAP Agency
King	Evergreen Recovery Centers
Pierce	Evergreen Recovery Centers
Yakima	Triumph Treatment Services
Spokane	New Horizons Care Centers
Cowlitz	Family Health Center
Skagit	Brigid Collins Family Support Center*
Clallam	First Step Family Support Center*
Kitsap	Agape Unlimited
Clark	Community Services Northwest
Grays Harbor/Pacific	Connections, A Center for Healthy Families
Thurston/Mason/Lewis	Family Education and Support Services
Whatcom	Brigid Collins Family Support Center*
Snohomish	Pacific Treatment Alternatives
Benton/Franklin	Elijah Family Homes
Chelan	Pathways to Enlightened Parenting

*Currently HVSA-funded organization/program

There are other programs and resources for the general population experiencing SUD. Washington Recovery Help Line offers an anonymous, confidential 24-hour help line for Washington State residents experiencing SUD and/or mental health issues. It refers clients to a variety of services. (http://www.warecoveryhelpline.org/) Medications for Opioid Use Disorder (MOUD) Locator can be used to find local clinics and programs that use evidence-based treatments to treat opioid user disorder. (http://www.warecoveryhelpline.org/moud-locator/)

There are other general behavioral health resources that are providing support virtually during the COVID-19 pandemic:

- Virtual recovery resources for substance use and mental illness: During COVID-19 pandemic, when social distancing and self-quarantine are needed to limit and control the spread of the disease, virtual resources can and should be used so people with SUD can continue to be socially connected and maintain recovery. SAMHSA's tip sheet describes resources that can be used to virtually support recovery from SUDs. It also provides resources to help local recovery programs create virtual meetings. https://www.samhsa.gov/sites/default/files/virtual-recovery-resources.pdf

- Faces & Voices of Recovery: The Association of Recovering Community Organizations (ARCO) at Faces & Voices of Recovery unites and supports the growing network of local, regional, and statewide recovering community organizations (RCOs). Currently there are two ARCO members in Washington State (Recovery Café in Seattle and Trilogy Recovery Community in Walla Walla) and are providing virtual peer support. https://facesandvoicesofrecovery.org/resources/covid-19-resources/
- Shatterproof – Stay supported, connected, and healthy during COVID-19: Shatterproof is a national nonprofit organization that provides addiction resources during the COVID-19 pandemic. https://www.shatterproof.org/COVID19
- We Are Peer For You!: The Washington State University College of Nursing, Peer Workforce Alliance, has set up community forums so people with mental health and/or substance use challenges who are missing their regular meetings and groups can check in with like-minded, recovery-oriented individuals in daily webinars. They have Certified Peer Counselors, Recovery Coaches, Mental Health Professionals and Nurses available by appointment. https://www.peerworkforcealliance.org/covidwebinarsaccess

2. Gaps in treatment and counseling services for home visiting service populations

While the needs for substance use treatment and counseling services increased during the past decade (**Figure 9**), it is not being met by an increase in access or availability in treatment. The main gap in current level of treatment and counseling services is the availability of services in all locales, especially the community-based treatment options. The geographic gaps in services are especially severe in rural areas, particularly in Central and Eastern Washington. The inpatient CUP women's services where women can enter treatment with their children are only available in three counties in Western Washington (Grays Harbor, Snohomish, and King County). Pregnant and Parenting Women Residential Treatment facilities are only in six counties, of which, four (Clark, Cowlitz, Thurston, Snohomish) are in Western Washington and two (Spokane and Yakima) are in Eastern Washington. PCAP programs (home visiting and case management program) are also mostly in Western Washington. PCAP programs serve 14 out of 19 counties in Western Washington while the programs serve only five out of 20 counties in Eastern Washington (**Table VI**). As a result, pregnant and parenting mothers need to travel long distances for treatment and counseling services, making transportation a barrier to care. Not having integrated services is also a problem. Some people need to go to different places for prenatal care and for substance use treatment and counseling services. There are not enough providers that can manage SUD and also prescribe medications. In some rural areas, there is even a shortage of maternal care services as well as a lack of mental health services for the home visiting population.

Even when SUD treatment and counseling services are available in the area, chronic shortages of personnel, including mental health professionals who can treat individuals experiencing SUD, lead to service delays. Long wait-times for outpatient, inpatient, and residential services are the norm, with wait time for residential services typically two to four weeks, and up to eight weeks (**Appendix C**). Given there are workforce retention challenges in both home visiting and SUD treatment, it is very likely these challenges impede families accessing needed services when they are ready to receive them,

especially in rural areas. Layer on top the needs for culturally and linguistically appropriate care, especially for Spanish-speaking individuals, and the gap in services is notable.

SUD treatment penetration among parents whose children and youth (age 0 to 17) enrolled in Medicaid is known to be low in Washington State. A preliminary analysis conducted by DSHS RDA Division showed that only 27% of parents of Medicaid-enrolled children and youth (age 0 to 17) were receiving any needed treatment (i.e., had an identified diagnosis and a treatment or service code) in state fiscal year 2015 and 2016. The penetration rate differed by county of residence, ranging from 17% to 43%. There was no difference in the penetration rate for mothers and fathers in this population. However, we do not know the penetration rates by pregnancy status of the mother or among parents with younger children (age <6) who would be eligible for MIECHV home visiting program. It is possible that mothers have better access to care during pregnancy and while the child is young compared to fathers or mothers with older children. It is conceivable that access becomes limited once women become ineligible for Medicaid (during the postpartum period) or as the child grows older. More analysis in this area is needed to truly understand the unmet needs for these services among pregnant women and families with young children, who are the target population for MIECHV services.

As mentioned earlier, there are limited culturally appropriate community resources to address the behavioral health needs of families, especially for immigrants and people experiencing homelessness. These issues and gaps existed before the COVID-19 pandemic, but have likely exacerbated with the pandemic. The influence of the pandemic on unmet needs of SUD treatment and counseling services among pregnant women and families with young children also needs to be examined.

3. Barriers to receipt of substance use disorder treatment and counseling services

Barriers to receipt of treatment and counseling services include fear of stigma, fear of losing their children, and unwillingness to seek care until pregnancy. Medication Assisted Treatment (MAT) providers can work with pregnant women, but pregnant women are afraid to receive services because of fear they would be reported to CPS. Home visitors often mention that families are not willing to talk about or reveal a substance use problem until long into the program, and only after relationships have been built between the home visitor and the family.

Another barrier to receipt of SUD treatment and counseling is related to gaps in appropriate services for pregnant and parenting women. Because either services do not exist in the area for pregnant and parenting women that allow children to be present or culturally and linguistically appropriate services are not available in the area, families need to travel long distances, often crossing multiple county borders, which is a significant barrier to treatment. In addition, there is a challenge when pregnant and parenting women move to different areas of the State for family, employment, or other reasons, and there are no services when they move. This creates a significant barrier to continuing treatment.

One barrier that was mentioned by a subject matter expert and echoed by a community member is the availability of affordable housing for pregnant and parenting individuals experiencing SUD. Without stability in housing, their sobriety and recovery are at risk. While some programs try to address the issues of housing (e.g., PCAP), it remains one area that is hard to address solely by a

substance use service provider, a case manager, or a home visitor, yet has a tremendous effect on the success of treatment and counseling services.

4. Opportunities for collaboration with state and local partners

In Washington State, a state workgroup has formed, coordinated by a staff lead in DCYF child welfare, to look at re-imagining the Plan of Safe Care to more effectively eliminate stigma associated with substance for pregnant and parenting women and define CPS involvement for this population. Plans of Safe Care involve an interdisciplinary approach to providing support at birth and post-partum to mothers and their babies who are at risk of substance use and substance exposure. This model is designed to be highly collaborative, proactive and preventative to keep families together and healthy. In Washington, the leadership team for this work crosses multiple agencies including members from DCYF, DOH, HCA, Mulitcare Health Systems and the PCAP program. In addition to the leadership team, a workgroup has been established that consists of health care providers, child welfare staff, substance use disorder treatment/medication assisted treatment experts, home visitors, tribal partners and early intervention providers.

Currently, in Washington, a Plan of Safe Care is provided to infants who fall into one of the following categories: 1. Identified as substance affected by a medical practitioner, 2. Identified as having withdrawal symptoms resulting from prenatal drug and alcohol exposure and 3. Born to a dependent youth. Plans of Safe Care are only used with families involved with DCYF caseworkers (those who have been screened in through CPS) and not used with families who are screened out for services as defined by DCYF.

In addition to the Plan of Safe Care, DCYF has worked with the Harvard Government Performance Lab (HGPL) to design on some innovative pilot approaches to support and engage pregnant and parenting women who have been screened out of services by DCYF definitions (i.e. currently CPS cannot intervene until the child is born) and therefore don't meet the threshold for enacting a Plan of Safe Care. As part of one of the innovative pilots, DCYF is examining the feasibility of creating automated referrals to voluntary community providers when screened out for the following reasons:

1. Infants exposed to legally prescribed medications, taken as prescribed, with no other risk factors,
2. Infants experiencing withdrawal from legally prescribed medications, taken as prescribed, with no other risk factors and
3. Infants exposed to marijuana only, with no other risk factors.

DCYF is pursuing pilot projects in two regions in Washington State beginning in early September 2020 to explore a community-based referral pathway approach to supporting substance using pregnant and parenting women. In one region, the partnership is being piloted with PCAP and in another, the partnership piloted with Help Me Grow. The pilots are taking an intentional look at centering black and indigenous voices, proposing distinct pathways for tribes in the pilot regions and additional efforts for Black communities. Initial findings and recommendations from the pilots are anticipated in Spring of 2021 with the hope that by taking this public health approach, supporting pregnant and parenting women through a community-based lens and intentionally centering women of color, we will see more families and children thrive.

In addition to the Plan of Safe Care and pilots, there are various other partnerships DCYF and the MIECHV program leverage and support, including the Washington State Department of Corrections Community Parenting alternative sentencing program. DCYF supports the implementation of this program in various ways, which supports incarcerated people to release early into the community to focus on parenting their children. Additionally, DCYF has strong partnerships across partners with the TANF program, Washington State Coalition Against Domestic Violence and internal programming implemented through the Community-Based Child Abuse Program, such as a statewide pilot on building capacity for women experiencing or at-risk for perinatal mood and anxiety disorders.

5. Additional activities to strengthen the system of care for addressing substance use disorder

In 2008, in response to the opioid overdose epidemic in Washington State, DOH first convened an Unintentional Poisoning Workgroup to address overdose deaths involving prescription opioids. Several years later, DOH changed the name of the workgroup to the Opioid Response Workgroup and expanded the focus of the group to include overdose deaths related to any type of opioid. In 2016, Governor Jay Inslee signed Executive Order 16-09, *Addressing the Opioid Use Public Health Crisis*, formally directing state agencies to implement key elements of the Washington State Opioid Response Plan.[22] The four priority goals of the Washington State Opioid Response Plan are to: 1) prevent opioid misuse and abuse; 2) identify and treat opioid use disorder; 3) reduce morbidity and mortality from opioid use disorder; and 4) use data and information to detect opioid misuse/abuse, monitor morbidity and mortality, and evaluate interventions. The executive sponsors for this plan, who oversee the implementation of the plan, include officials from DOH, HCA, HCA/Division of Behavioral Health and Recovery (DBHR), and a partner from University of Washington, Alcohol and Drug Abuse Institute. The executive sponsors established six workgroups to coordinate actions under each of the four goals, which included: Prevention Workgroup (Goal 1), Treatment Group (Goal 2), Criminal Justice Opioid Workgroup (Goal 2), Pregnant and Parenting Workgroup (Goal 2), Morbidity and Mortality Workgroup (Goal 3), and Data Workgroup (Goal 4). The Pregnant and Parenting Workgroup brings together DOH, HCA DBHR, DCYF, and partners from Washington State Hospital Association (WSHA) to work on topics related to pregnant and parenting women, such as educating maternity care providers to identify and treat women with substance use disorder, reducing clinician biases, linking pregnant and post-partum women to appropriate services including PCAP and NFP, and determining breastfeeding guidelines and best practices for mothers with substance use disorder (See **Table VII**).

Table VII. Opioid Response Plan – Pregnant and Parenting Women Workgroup (Goal 2)

2.3	STRATEGY 3: Identify, treat and support pregnant and parenting women with opioid use disorder. Improve management of infants born with neonatal abstinence syndrome.	Lead Party
2.3.1	Expand access to family planning services in syringe service programs or improve linkages between syringe service programs and family planning services.	DOH

[22] Department of Health: 2018 Washington State Opioid Response Plan. July 2018. Available at: https://www.doh.wa.gov/Portals/1/Documents/1000/140-182-StateOpioidResponsePlan.pdf

2.3.2	Educate maternity care providers to identify and treat (or rapidly refer) women with substance use disorder including opioid use disorder who are pregnant or parenting. • Provide Screening, Brief Intervention, Referral to Treatment training to obstetric and primary care clinicians. • Disseminate the Substance Use during Pregnancy: Guidelines for Screening and Management and SAMHSA Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants best practice guide. • Host a SAMSHA training conference. • Build regional expertise around treating pregnant women with opioid use disorder within each Hub.	DOH, HCA DBHR, WSHA
2.3.3	Pilot and evaluate group prenatal care for women with substance use disorder.	HCA, DOH
2.3.4	Reduce clinician biases by implementing quality improvement projects and hosting local and statewide conferences with women who are in recovery.	DOH
2.3.5	Conduct a gap analysis on the supply and demand for treatment services for pregnant women with opioid use disorder.	
2.3.6	Link pregnant and post-partum women to appropriate services (e.g., Parent and Child Assistance Program, Maternity Support Services, Behavioral Health Organizations, Nurse Family Partnership).	HCA DBHR, HCA, DOH
2.3.7	Expand wrap around services for pregnant and parenting women that address the social determinants of health (housing, employment, food security, etc.).	
2.3.8	Develop and implement hospital policies that support mothers rooming in with neonatal abstinence syndrome babies.	HCA, DCYF, WSHA, DOH
2.3.9	Partner with Department of Children Youth and Families child welfare division to increase consistency in child removal practices, including working to strengthen connections between child welfare social workers and community resources at the local level.	DOH, DCYF
2.3.10	Determine breastfeeding guidelines and best practices for mothers with substance use disorder. Educate clinicians on these guidelines and best practices.	DOH, HCA, WSHA

Source: Department of Health: 2018 Washington State Opioid Response Plan. July 2018.
Note: DOH=Department of Health; HCA=Health Care Authority; DBHR= Division of Behavioral Health and Recovery; WSHA= Washington State Hospital Association; SAMHSA= Substance Abuse and Mental Health Services Administration; DCYF= Department of Children, Youth & Families.

V. Coordination with complementary Washington Needs Assessments

1. The Title V Maternal and Child Health Block Grant (MCHBG) Needs Assessment

Both the Washington State Title V MCHBG Program awardee and Home Visiting Unit of DOH sit within the Office of Family & Community Improvement (OFCHI) at DOH. The OFCHI is dedicated to enhancing the health and well-being of individuals, families, and communities. The OFCHI works with Local Health Jurisdictions (LHJs), tribes, community based organizations, health systems, and healthcare providers across the state to promote health at every stage of life through policies, systems, and environmental changes with emphasis on health equity, life course theory, social determinants of health, and community-clinical linkages.

For the Title V MCHBG Needs Assessment, the MCHBG Coordinator, MCH epidemiologists, and a qualitative data analyst collected qualitative data between the fall of 2018 and the fall of 2019 using four primary methods: 1) facilitated discussions with the DOH and program partners, which emphasized the needs, gaps, and strengths of state-funded programming available for maternal and

child health; 2) LHJ needs assessment reports, which catalogued LHJ and community needs and capacity to work with populations served by the MCHBG, as well as a qualitative summary of local needs; 3) key informant interviews of state and community leaders representing specific populations, interests, and geography; and 4) "Discovery Survey" responses from the public. This survey asked two open-ended questions to establish the needs of women, children, and families.

Home visiting epidemiologists, working on the MIECHV needs assessment, had multiple meetings with the MCHBG Coordinator and MCH epidemiologists to share data, processes, results, and insights of both needs assessments. In the early stage, MCH epidemiologists provided inputs on the data sources and methods for identifying at-risk communities. Home visiting epidemiologists were invited to participate in the facilitated discussions with stakeholders for the MCHBG needs assessment. The MIECHV awardee DCYF, staff from Ounce Washington, and members of HVAC participated in a facilitated discussion lead by the MCHBG Coordinator and the Home Visiting Epidemiologist. Finally, the Home Visiting Epidemiologist was invited to participate in the prioritization process for the MCHBG needs assessment.

A consistent theme across all MCHBG data collection, pre-COVID, was that families across the state are struggling with the cost of living and this struggle is negatively affecting their health and wellness. Housing, childcare, transportation, and food security topped the list of essentials needed to ensure women, children and families could live their healthiest lives. Cultural humility and serving marginalized populations was prominent across all data sources. Participants expressed a need for services that respect diversity, acknowledge and train for cultural awareness, have adequate language services, are non-discriminatory, and have a culturally representative workforce. Disparities among tribal communities, women and children of color, LGBTQ+ community, people who are differently-abled, and rural vs urban communities were of concern for participants. Access to both health and social services is a challenge for families. This challenge is made worse by the prohibitive cost of healthcare for both under and uninsured families. Shortages in providers, inadequate reimbursement for practitioners/services, parenting education needs, and need for home visiting services were all mentioned. Home visiting was viewed as viable intervention strategy that has an impact on social determinants of health and resilience. However, some viewed home visiting as too limited or underfunded and fragmented.

2. The Child Abuse Prevention and Treatment Act (CAPTA) Needs Assessment

The Strengthening Families Washington Team, within DCYF, houses both the MIECHV awardee and Community Based Child Abuse Prevention (CBCAP) awardee. These two teams work collaboratively to ensure families in Washington have access to prevention supports and resources. The primary strategy of the CBCAP work is to fund local prevention programs in order to improve outcomes for children and families and strengthen child abuse and neglect prevention policies, programs, and practices. The CBCAP funds support up to 16 diverse prevention strategies including parent education programs and local communities working on perinatal mental health initiatives ranging from evidence-based programs to promising practices.

Through the application process, CBCAP staff have identified community need well-beyond the available funding for local, group-based, prevention programming to support families and young children. The home visiting and CBCAP teams work together to leverage the community supports, available trainings and webinars, and referral pathways to create opportunity for families to have access to the resources and supports they need.

3. The Head Start Needs Assessment

Both the Washington State Head Start Collaboration Office (HSCO) and the MIECHV awardee sit within DCYF. HSCOs exist "to facilitate collaboration among Head Start agencies … and entities that carry out activities designed to benefit low-income children from birth to school entry, and their families." The methods by which HSCOs coordinate and lead efforts for diverse entities to work together include: communication, stakeholdering, and overall systems work. Washington State has 50 Head Start and Early Head Start grantees that serve 20,000 children and their families each year (prenatal to kindergarten) through Early Head Start and Head Start programs.

Staff working on the MIECHV Needs Assessment had multiple meetings with HSCO staff to discuss our respective needs assessment requirements for data collection, community engagement, and systems coordination. The HSCO provided information about funded programs in the state, where they were located, and what types of family slots they had (i.e. head start, early head start, or early head start home-based). This data is included in our HVSA Scan 2019 update and helps tell the story of the breadth and depth of home visiting services in Washington. Anecdotally, we also heard examples of discreet communities and their coordination in seeking community input, identifying need and use of available data in decisions, and applying for funding opportunities. Since funding is provided from the federal Office of Head Start (OHS) directly to community organizations, it is at the community awardee level in which the assessment and community-wide strategic planning occurs, not a statewide Head Start needs assessment.

4. The Preschool Development Grant (PDG) Needs Assessment

The Preschool Development Grant Birth through Five (PDG B-5) was awarded to DCYF in 2018. One of the requirements of the PDG B-5 was to create a state-wide needs assessment. Through both qualitative and quantitative data, the PDG B-5 Needs Assessment looks at progress made at the end of Washington States' ten-year early learning plan and provides guidance for the creation of a new early learning plan. 2010 Washington Early Learning Plan lays out a 10-year roadmap to support achieving the state's early learning vision to ensure that all kids start life with a solid foundation to be successful. Strategy #5[23] directly addresses the role of home visiting:

Make evidence-based and promising prenatal and child (birth to 5 years) home visitation services more widely available to at-risk families and caregivers.

The PDG B-5 Needs Assessment initial results and findings continue to demonstrate the need for home visiting services in Washington with 139 mentions of home visiting throughout the report. *Please note: At the time of submission for the MIECHV Needs Assessment, the PDG B-5 Needs Assessment is in its final phases of completion.*

Home visiting service providers and staff had a robust voice throughout the PDG Needs Assessment process, with two home visiting LIAs as members of the steering committee and several home visiting providers and staff participating in community engagement opportunities including workgroups and input from the Home Visiting Advisory Committee (HVAC) into the content of the PDG Needs Assessment.

[23] 2010 Washington Early Learning Plan, p.84, accessed at http://www.k12.wa.us/EarlyLearning/pubdocs/WashingtonEarlyLearningPlan.pdf

Some key finding from this report, which were echoed in stakeholder interviews and workshops conducted by the PDG B-5 staff, were similar to findings through the MIECHV Needs Assessment.

- The need for home visiting services far exceeds the current resources available statewide. Among counties with a significant number of low-income births (more than 500), none had slots available for more than 11% of low-income families, and the large majority were between 0% and 6%.
- Home visiting programs are currently operating in all but seven counties in Washington State, but only four of these counties have capacity to offer services to more than 15% of low-income families who have children of an appropriate age.
- Another key finding from both the report and outreach is the importance of creating a system of home visiting services that can incorporate community-designed models. Options that build on community experience and expertise have the potential to meet community needs in important and effective ways.
- Community planning, leadership and organizational capacity development are critical to expansion. Capacity at the local implementation level will need to grow, which means an expansion strategy must consider current challenges to workforce development.

Given that both the home visiting team and PDG are situated across two divisions under the Assistant Secretary for Children and Families within DCYF, these two teams will continue to work together to identify commonalities between the two Needs Assessments and strategize about ways to continue supporting families and children through home visiting services in Washington State.

5. Ongoing collaboration and coordination

Collaboration between various needs assessments, grants, agencies, and stakeholders has been continuous since the MIECHV Needs Assessment Supplemental Information Request (SIR) was released on January 3, 2019. This section describes some of the key meetings and activities that demonstrate the collaboration.

- June 2019: Preliminary findings from the MCHBG Needs Assessment were presented followed by a facilitated discussion with HVAC members and staff from the Trio (DCYF, DOH, and Ounce Washington).
- September 2019: Staff from the PDG grant joined the HVAC meeting to provide a PDG grant renewal overview as well as solicit feedback.
- January 2020: The timeline, purposes, methods, and processes of the Home Visiting Needs Assessment were presented to HVAC members at the quarterly HVAC meeting. PDG and FFPSA also joined and provided updates to the HVAC.
- March 2020: The HVAC met to discuss targeted universalism and community need with the services we offer.
- May 2020: HVAC members received an update on the MIECHV Needs Assessment including progress to date, updated timeline, and opportunities for additional stakeholder input and
- feedback.
- September 2020: A special webinar for HVAC members, Trio staff, stakeholders from PDG, and stakeholders from MCHBG to share methods and findings from the needs assessments for MIECHV, the MCHBG and the PDG.

The September webinar created a unique opportunity to share learnings from three concurrent needs assessments that focused on similar populations and employed a variety of data collection methods to produce complementary quantitative and qualitative findings. Small group discussion following the presentations of results, provided an opportunity to triangulate findings, layering qualitative context from the MCHGB over the geographic and demographic risk assessment work of the home visiting assessment. The groups identified gaps and raised up implications for home visiting related to policy and practice. A few themes resonated across these assessments, including but not limited to: the challenges of poverty and inability to meet basic family needs such as housing, food, childcare, and transportation; inequitable access to services and resources across the state and an overall lack of adequate resources; the breadth of health needs from maternity care to mental health and substance use disorder; and the value of prioritizing racial, cultural and economic equity in the services we provide to reach all peoples with the services that meet their needs.

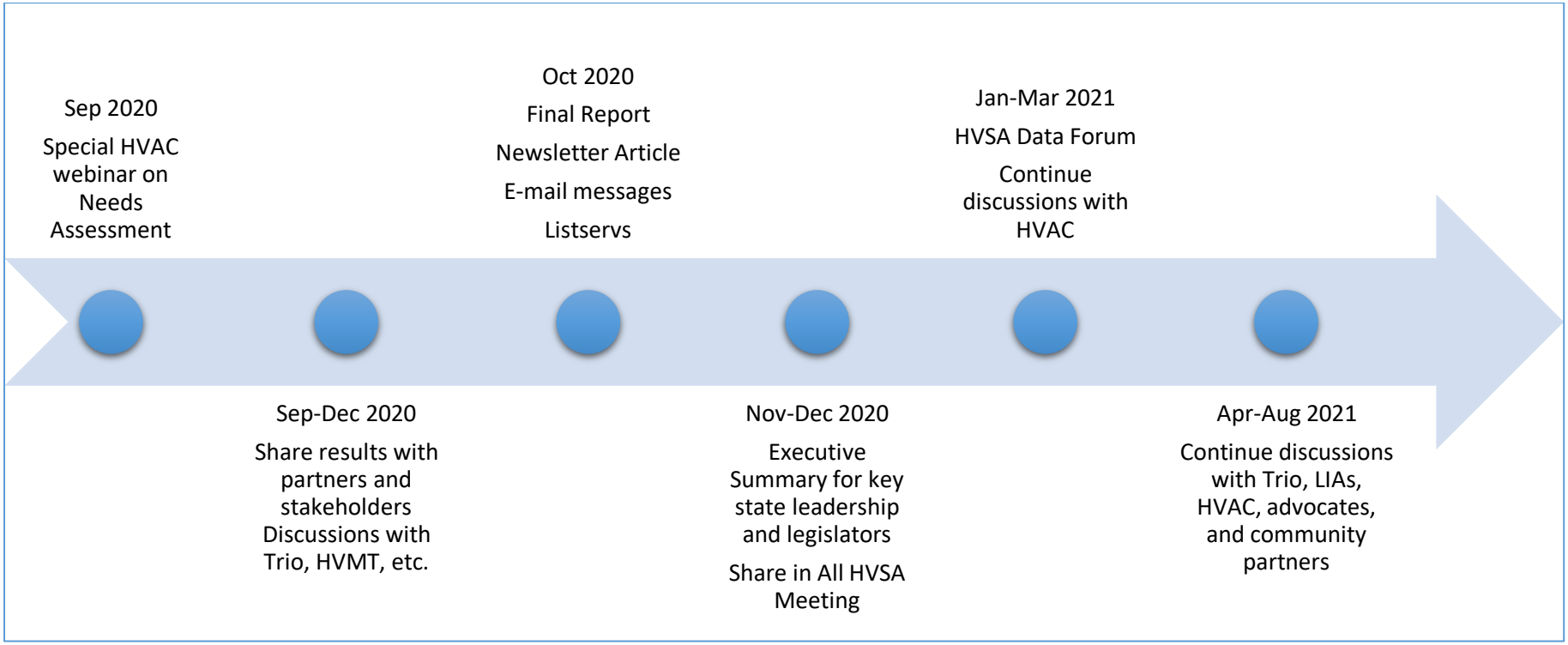
As evidenced by the strong input processes throughout the 2020 MIECHV Needs Assessment development process, collaboration and coordination are key in delivering effective home visiting programs. So much so that successful implementation of home visiting is reliant on strong community and state level partnerships. These partnerships are foundational for families and programs to experience successes. As such, the MIECHV program in Washington continues to renew or develop new partnerships, including those with required MIECHV partners such as IDEA Part C, child welfare, our state funded pre-K program among others. These partners serve as HVAC members or impact home visiting policy and implementation through the various networks that Trio team members engage in. These partnerships have and continue to inform approaches to engaging and supporting LIAs, dismantling racism, focus of data and evaluation work and response to COVID-19 for home visiting in Washington.

VI. Conclusion

The 2020 MIECHV needs assessment has provided an opportunity for the Washington HVSA to critically examine the changing needs of our communities, through both a geographic and an equity lens. Moreover, through partnerships across multiple state agencies and community stakeholders, we have started the process of sharing and triangulating our findings with other needs assessments and community experiences to deepen our understanding of the data and the context that gives us insights into families' experiences in Washington. Looking at the collective themes, we find challenges of poverty and inability to meet basic family needs, inequitable access to services and resources across the state and an overall lack of adequate resources. These barriers faced by families can, in part, be mitigated by support from home visitors. The next step in this process for Washington is to use this information to shape ongoing and expanding support for home visiting and other early childhood intervention efforts. *Understanding that the need for home visiting services estimated in this report is not synonymous with the number of families who may choose to participate in home visiting, nor does it necessarily identify those most in need. Rather the estimated need alongside resources and prioritization will help Washington focus any new resources to priority communities.* To that end, we have a number of opportunities identified over the next year for continued sharing of information and discussion with key partners.

The first kick-off was in September with the HVAC, where methods and findings were shared and validated with members. Internal discussions with the Trio, Home Visiting Management Team (HVMT), and internal leadership groups will continue with a focus on how to use the results of the needs assessment, and to direct technical assistance resources to enhance home visiting service delivery and improve the coordination of services in at-risk communities. A Final Needs Assessment Report will be published and posted on DCYF website in fall 2020 for stakeholders and the general public. A newsletter article will be published on DCYF website, and email messages through listserv will be sent to home visitors, supervisors, directors of LIAs, HVAC members, advocates, and other community partners informing them about the completion of the Final Report. An Executive Summary will be prepared and shared with key state leadership and legislators in late fall. Results will be shared in November during the Fall All HVSA virtual meeting with LIAs (home visitors, supervisors, and directors) and other community partners. Further discussions are planned for early 2021 at HVSA Data Forum (with the Trio) and in future HVAC meetings. We are planning to continue the discussions about utilizations of needs assessment results with Trio, LIAs, HVAC, advocates, and community partners through the spring and summer of 2021. (See **Figure 10**) In these communication and dissemination efforts, care will be taken to describe the limitations of the Needs Assessment in capturing the recent shifts and changes in the experiences and needs of families due to the COVID-19 pandemic and the changing methods for accessing home visiting services remotely or virtually.

Figure 10. Dissemination Timeline



Note. HVAC=Home Visiting Advisory Committee; Trio=DCYF, DOH, Ounce Washington; HVMT=home visiting management team; LIA=local implementing agency; HVSA=Home Visiting Services Account.