

Maternal Infant and Early Childhood Home Visiting (MIECHV) Needs Assessment for Washington DC

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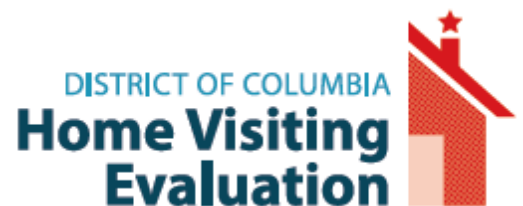


Table of Contents

Executive Summary.....	4
Introduction.....	6
Purpose of the Needs Assessment.....	7
Current Context in Washington DC.....	7
Communities with Concentrations of Risk.....	9
DC-Specific Additions to the Simplified Method.....	9
Identified Communities.....	13
Summary and Recommendations.....	15
The Home Visiting Landscape in DC.....	16
Methodology.....	16
Capacity and Quality.....	17
Current Strengths, Gaps and Barriers of the DC Home Visiting System.....	22
Outreach to Potentially Eligible Families.....	22
Referral to Home Visiting Programs.....	23
Enrolling in Home Visiting Services.....	23
Family Participation and Engagement.....	23
Staff Retention and Turnover.....	24
Infrastructure: Strengths and Gaps in the Home Visiting System.....	25
Substance Use Disorder Treatment and Counseling Services in DC.....	28
Methodology.....	29
Capacity and Quality.....	30
Current Strengths, Gaps and Barriers of the SUD/MH System.....	30
Coordination with Other Needs Assessments.....	32
Strengths and Limitations of the MIECHV Needs Assessment.....	35
Synthesis and Recommendations.....	36
References.....	38

List of Figures and Tables

Table 1. Health Planning Neighborhoods Identified “At-Risk” Using Final Version of the HRSA/UIC Formulas.....	11
Figure 1. The Number of “At-Risk” Domains Designated by the HRSA/UIC Formula for Four Risk Domains	12
Figure 2. The Child Opportunity Index for the Health Planning Neighborhoods within the DC Metropolitan Area	14
Table 2. Selected Characteristics of Home Visiting Programs in Washington DC	18
Figure 3. Total Number of Families Enrolled in MIECHV-funded Home Visiting Programs	21
Figure 4. Percentage of MIECHV-Funded Enrolled Families that Withdrew from Home Visiting Services on or Before 365 Days of Enrollment	21
Figure 5. Essential Elements of a Home Visiting System of Care.....	22
Table 3. Summary of Key Findings from the Home Visiting Capacity Assessment.....	27
Figure 6. Essential Elements of a HV, SUD, and MH System of Care.....	28
Figure 7. Number of Women of Childbearing Age who Reported Using Specific Substances.....	29
Table 4. Recent DC Reports Reviewed for the MIECHV Needs Assessment.....	32

Executive Summary

In 2010, the Patient Protection and Affordable Care Act (ACA) created the federal Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). States are entitled to formula grants administered by the Health Resources and Services Administration (HRSA) to support the adoption and expansion of one of more than 18 home visiting models that have been designated as “evidence-based” through rigorous scientific review. The Social Security Act, Title V, amended by the Bipartisan Budget Act of 2018, required all MIECHV awardees to review and update a statewide needs assessment. HRSA provided states with guidance on what needed to be included in the needs assessment, and this was published in a Supplemental Information Request (SIR) on January 3, 2019 (Human Resources Services Administration, 2019). The DC Department of Health (DC Health) has been the MIECHV awardee for Washington, DC since the inception of the program. DC Health funded the Georgetown University’s Center for Child and Human Development (GUCCHD), to plan, coordinate, analyze, and synthesize data for this 2019-2020 needs assessment.

This document reports the key findings from the updated MIECHV needs assessment in Washington, D.C. (DC). The report has three main components: descriptions of the methods and results of activities designed to (1) identify at-risk communities, (2) understand the current capacity for home visiting services, and (3) identify the current services available for pregnant women and families with young children who may benefit from substance use disorder (SUD) treatment and/or counseling services.

With a population estimated around 705,749, DC has a highly diverse population, larger than the states of Vermont and Wyoming (US Census Bureau, 2019). DC is divided into eight Wards for administrative and political purposes. Ward-level analysis is the most common reporting format for understanding data collected for DC residents. However, each Ward is made up of unique and diverse neighborhoods. The DC Department of Health identified statistical neighborhoods in the Health Equity Report (DC Health, 2018) to help planners and policy makers connect data on social determinants of health and population health outcomes. These 51 smaller units of analysis disaggregated data into Health Planning Neighborhoods, which help elevate proximal causes of health disparities which continue to persist in DC.

Defining “At-Risk Communities”

To ensure that there would be uniformity and availability of data for the MIECHV needs assessment, HRSA worked with a team at the University of Illinois-Chicago (UIC) to identify a core set of indicators across six domains to capture the populations of women and children that Congress intended be served. The domains were: socioeconomic status; adverse perinatal outcomes; substance abuse; crime; child maltreatment; and mental health. Awardees could adopt what was referred to as the simplified method or propose an independent method. DC opted for the simplified method, with some DC-specific changes to reflect a greater focus on maternal and child health populations. Analyses relied on data from 2016 (the most current full-year of data available across indicators); and data were analyzed at the Ward and Health Planning Neighborhood levels. Supplemental analyses using Census-level indicators for the Child Opportunity Index 2.0 were conducted to provide additional data on the impact of social determinants of health on the lives of District children and their families.

- At the conclusion of the HRSA-defined calculations, Wards 7 and 8 were identified as areas for focused recruitment for MIECHV-funded services.
- Using the Health Planning Neighborhoods, and adjusting for outliers in the data due to small cell sizes, 16 HPNs in Wards 5, 7, and 8 were identified as areas where a high concentration of eligible families lived.
- Similar mapping of the Children's Opportunity Index 2.0, using data from the prior year, resulted in an expanded catchment area that included all of Wards 5, 7, and 8 as well as six additional neighborhoods in Ward 4.
- As a result of the additional information provided by the neighborhood level data as well as the Children's Opportunity Index, the DC MIECHV program will focus recruitment for home visiting services in Wards 4, 5, 7 and 8.

Current Home Visiting Capacity

In collaboration with the DC Home Visiting Council, GUCCHD conducted a web-based survey to gather data on the current capacity of home visiting programs. To supplement the survey results, in-depth interviews were conducted with the majority of the programs. Interview data were analyzed and survey data were reconciled through follow-up conversations led by the DC Home Visiting Council.

In calendar year 2019, 14 organizations were implementing 18 home visiting programs in DC. Data were gathered from 13 organizations implementing 16 home visiting programs in DC. These programs reported the capacity to serve 1,347 children and families across all eight Wards; in alignment with the earlier findings about concentrated areas of need in the District, more than half of the programs reported that the majority of their families resided in Ward 8. In the data provided by HRSA in a supplemental report, there were an estimated 1,781 families living in Wards 7 and 8 that were likely to be eligible for home visiting services. If Ward 5 figures are added in, the gap in the number of potentially eligible families would be 811 families.

Substance Use Disorder Treatment and Counseling Services

A survey with follow-up interviews was also used by GUCCHD to gather data on the capacity of the substance use disorders (SUD) treatment services available to MIECHV-eligible women in DC. The analysis identified several strengths and many gaps and barriers to treatment. Many of the agencies that were interviewed provided services throughout the District and offered SUD as well as mental health (MH) treatment. There were a range of special populations that were served by specific agencies. Several respondents highlighted the Access HelpLine, operated by the Department of Behavioral Health (DBH) as a strength of the behavioral health system. On the other hand, despite the appearance of widespread availability of services, respondents reported there were limited inpatient slots and barriers to women with young children successfully engaging in outpatient SUD treatment. Other challenges facing MIECHV-eligible women who seek treatment for SUD and MH problems are common to all residents in DC seeking services. For example, homelessness and housing insecurity create barriers to enrolling in treatment, as Medicaid is the primary payer for behavioral health services in the public system.

The report concludes with a brief description of the strengths and weaknesses of the needs assessment methodology and a list of recommendations for strengthening the home visiting

system in DC. These include improving the coordination between state agencies as well as across local implementing agencies to ensure families are connected to home visiting programs that are the best fit for their needs and preferences.

Introduction

In 2010, the Patient Protection and Affordable Care Act (ACA) created the federal Maternal, Infant and Early Childhood Home Visiting Program (MIECHV). The MIECHV program is a collaboration between the federal Maternal and Child Health Bureau (MCHB) and the Administration for Children and Families (ACF). The ACA initially committed \$1.5 billion in new grants to states, territories and tribes to scale up evidence-based home visiting models across the US. States are entitled to formula grants administered by the Health Resources and Services Administration (HRSA) to support the adoption and expansion of one of more than 18 home visiting models that have been designated as “evidence-based” through rigorous scientific review. These models are listed on the HomVee website, and new models are added annually as they meet the criteria for inclusion (Office of Planning, Research and Evaluation, 2014).

The DC Department of Health (DC Health) has been the MIECHV awardee for Washington, DC since the inception of the program, serving an increasing and changing population over the years. With a population estimated around 705,749, DC has a highly diverse population, larger than the states of Vermont and Wyoming (US Census Bureau, 2019). DC has historically been a minority-majority city with 45.5% of residents self-identifying as Black/African American alone and 42.2% as White alone in the 2018 American Community Survey (ACS) estimates (US Census Bureau, 2018). However, as the city has gentrified, the 2019 ACS estimated that an equal number of White alone and Black alone people lived in DC (46%, respectively; US Census Bureau, 2019). There was a small increase in the percent of residents who self-identifies as Asian alone from 2018 to 2019 in the ACS from 3.9% to 4.5%; and the percentage of DC residents that were Hispanic or Latino remained stable at 11.3%. Of note, 13.9% of the population was foreign born and 16.9% spoke a language other than English at home (US Census Bureau, 2018). DC is also a highly educated area, with 90.6% of its residents 25 and older having at least graduated with a high school degree and 57.6% had a bachelor’s degree or higher (US Census Bureau 2019). The median income of households in DC was \$82,604 placing it well above the national median which was \$60,293 (US Census Bureau, 2019). Alongside this affluence, 16.1% of people living in DC were in poverty and an estimated 23.1% of children under 18 were below the poverty level (US Census Bureau, 2019; 2018).

DC is divided into eight Wards for administrative and political purposes. Ward-level analysis is the most common reporting format for understanding data collected for DC residents. However, each Ward is made up of unique and diverse neighborhoods. In order to understand and reflect data at a more granular level, the DC Office of Planning had determined boundaries to define 44 neighborhood “clusters.” This neighborhood cluster level-data, uses zip codes and census tract information to create customized geographic areas that align with neighborhood boundaries. Organizations are using this small-level analysis throughout DC to better inform policy makers and programmatic decisions about risk and resiliency within communities. More recently, the DC Department of Health identified statistical neighborhoods in the Health Equity Report (DC Health, 2018) to help planners and policy makers connect data on social determinants of health and population health outcomes (p. 13). Formerly referred to as “proximal neighborhood groups,” these smaller units of analysis disaggregated data into 51-areas within the District. Recently renamed “health planning neighborhoods,” these areas help elevate proximal causes of health disparities which continue to persist in DC. For example, data from 2011-2015 show a 21-year gap in life expectancy for residents in Woodley Park as compared to St. Elizabeth’s (89.4 versus 68.4; DC Health, 2018). These inequities serve as a stark reminder of the need for strategies, such as evidence-based home visiting, that might help close the gap by identifying populations that can benefit from services during pregnancy and in the early years.

Purpose of the Needs Assessment

At the federal level, MIECHV funding was renewed in 2018 for an additional 5 years. The Social Security Act, Title V, amended by the Bipartisan Budget Act of 2018, required all MIECHV awardees to review and update a statewide needs assessment. This is an essential element to ensure that states and territories are understanding and building capacity to address the numerous needs of families living in what HRSA calls “at-risk” communities. The federal MCHB worked with other federal and state partners to develop and disseminate detailed guidance on how the updated needs assessment should be conducted, and this was published in a Supplemental Information Request (SIR) on January 3, 2019 (Human Resources Services Administration, 2019).

To address this requirement, the DC Health funded the Georgetown University’s Center for Child and Human Development (GUCCHD), to plan, coordinate, analyze, and synthesize data for this 2019-2020 needs assessment. GUCCHD also serves as the external evaluation partner for the MIECHV program in DC. In preparation for the release of the SIR, DC Health supported an interim home visiting needs assessment in 2016 that was completed by GUCCHD. This work piloted a mixed methods approach, using neighborhood-level data and qualitative data collected from key stakeholders that served to inform the methodology for the current needs assessment (Georgetown University, 2016).

This document reports the key findings from the updated MIECHV needs assessment in Washington, D.C. (DC). The report has three main components, as outlined by the Supplemental Information Request: descriptions of the methods and results of activities designed to (1) identify at-risk communities, (2) understand the current capacity for home visiting services throughout the District, and (3) identify the current services available for pregnant women and families with young children who may benefit from substance use disorder (SUD) treatment and/or counseling services. The report begins with a brief overview of the current context for perinatal, infant and early childhood health and well-being in DC. The next three sections present the key findings from the core requirements in the SIR. The report concludes with a brief description of the strengths and weaknesses of the needs assessment methodology and a list of recommendations for strengthening the home visiting system in DC.

Current Context in Washington DC

There are significant and long-standing racial/ethnic, geographic, and income disparities evident in nearly every indicator of maternal and child health for residents of Washington DC. DC Health published an important report on perinatal health outcomes several years ago (DC Health, 2018). During the 2015-16 time period—which were the most recent years available for analysis—half of the city’s nearly 20,000 live births were delivered to non-Hispanic Black women (DC Department of Health, 2018). Black women continue to be more likely to deliver a pre-term and/or low birth weight baby when compared to White women. On these indicators, Wards 5, 7, and 8 have significantly elevated rates compared to other areas of the city. Data from this report also underscores that DC continues to have an infant mortality rate well above the national average, at nearly 8 per 1,000 live births. And these rates differ significantly across different Wards, with the infant mortality rate for babies in Ward 8 seven times as high those in Wards 2 and 3 (14.57 versus 2.22 and 2.27, respectively). Similar to preterm births, infant deaths differ across racial and ethnic groups. The infant mortality rate for non-Hispanic Black

women was 11.49, 5.33 for Hispanic women, and 2.55 for non-Hispanic White women (Asian/Pacific Islander data not available).

Despite these persistent problems, there is a robust array of cross-sector perinatal, infant and early childhood initiatives that support service delivery District-wide. Led by the Office of the State Superintendent for Education (OSSE), Washington DC is the nation's leader in rates of enrollment in public Pre-Kindergarten for children ages 3 and 4 (OSSE, 2017). In addition, the Mayor recently created a city-wide initiative, Thrive by Five, that is leading efforts to address the perinatal and infant disparities cited above. The DC Department of Behavioral Health is leading an early childhood system of care grant, funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), known as DC SEED. This initiative focuses on scaling up several evidence based mental health treatments for families with children under age 6 who need intensive interventions. Co-led by the Children's National Medical System and the Georgetown University Department of Psychiatry/MedStar, the Early Childhood Innovation Network (ECIN) is also developing, testing, and scaling up evidence-based and evidence-informed multi-generational programs for pregnant women and children under age 5. Working with a strong racial equity lens and commitment to community co-creation, one of ECIN's programs is a DC-specific version of Healthy Steps (ECIN, 2020). This initiative integrates behavioral health screening, brief intervention, and referrals into pediatric primary care. Very recently, Children's National Medical Systems and MedStar were the recipients of several large philanthropic investments by the Clark Foundation, focused on the perinatal and early childhood period. And the District was also one of 11 sites to receive a three-year grant from the JB Pritzker Foundation. All of these efforts underscore the cross-sector partnerships in place in which the DC MIECHV program is a part.

Home visiting in DC is also impacted by the changing demographic trends that accompany Washington's status as one of the most quickly gentrifying cities in the US. As central city neighborhoods are rebuilt, long-standing residents whose families have been in DC for generations are getting displaced. The city's population is getting more White and more affluent, and affordable housing remains out of reach for many of the city's residents. Homelessness impacted approximately 815 families in 2019 (United States Interagency Council on Homelessness, n.d.); and it was only a few years ago that the troubled family homeless shelter at the former DC General Hospital was closed. To date several of the promised community-based homeless shelters have been opened. But housing insecurity and displacement of residents through gentrification has been eroding neighborhood resilience for the past decade.

Amidst the backdrop of these persistent maternal and child health disparities, historic investments and record-setting gentrification, the COVID-19 pandemic has exacerbated the consequences of income inequality for low-income DC residents' health and well-being. A stark reminder of how these chronic gaps in wealth lead to significant difference in life expectancy for DC families living east of the Anacostia River. Both rates of COVID infections as well as deaths from COVID are higher in communities of color east of the river; and these trends will only worsen the life expectancy disparities reported in the Health Equity Report (DC Health, 2018). The COVID-19 pandemic also changed the way that home visiting services were delivered. With the city under stay at home orders starting on March 30, 2020, home visiting programs quickly adjusted to providing "virtual" visits by telephone, computer or smartphones. This is the complex context in which the DC MIECHV program is being implemented and the needs assessment was being completed.

Communities with Concentrations of Risk

To ensure that there would be uniformity and availability of data for the MIEHCV needs assessments, HRSA worked with a team at the University of Illinois-Chicago (UIC) to identify a core set of indicators to capture the populations of women and children that Congress intended be served. Data were compiled by HRSA/UIC for each MIEHCV awardee using a standard methodology, using nationally available data, to standardized across states (appendix #1a). Awardees could adopt what was referred to as the simplified method or propose an independent method. For the simplified method, the five HRSA-defined domains and indicators would be used, relying on the data compiled by UIC. Using the simplified method, awardees could add indicators, domains of risk, and/or drill down to smaller geographical areas to further refine their definitions of at-risk communities. Data were provided to states at the county level; for DC, HRSA/UIC provided data at the Ward level. The five domains were: socioeconomic status; adverse perinatal outcomes; substance use disorder; crime; and child maltreatment. The HRSA/UIC data were drawn from a variety of years from 2012-2018.

Through conversations with DC Health, the decision was made to use the simplified method. The initial analysis yielded an expected outcome: based solely on the data supplied by HRSA, Wards 7 and 8 were identified as communities with the highest concentration of risk. Paradoxically, Ward 2 was flagged as the only other area in the city with one of the HRSA-defined domains considered at-risk¹. Given that this area of the city is home to the National Mall as well as affluent neighborhoods such as Georgetown and Foggy Bottom, and that Ward 5 was identified as a focus for MIECHV funding in prior years, reinforced the team's decision to modify indicators as well as conduct analyses at a more granular level. Relying solely on data aggregated at the Ward-level, obscures neighborhoods in Wards (other than 7 & 8) where families who could benefit from home visiting services may be living.

DC-Specific Additions to the Simplified Method

To address the concerns raised above, and following the successful analytic approach used by GUCCHD in the Phase 1 (interim) Needs Assessment (GUCCHD, 2016), the team worked with DC Health to select the unit of analysis for this project. In recent years, a number of methodologies have emerged to represent DC neighborhoods as the unit of analysis. For the Phase 1 report, GUCCHD used the *neighborhood clusters* identified by the DC Office of Planning. Since that time, DC Health published a landmark Health Equity Report (2018), which defined *proximal neighborhood groups* based upon a methodology that relied on CDC life expectancy data. As the MIECHV needs assessment work began, DC Health was refining the definition of proximal neighborhood groups which were renamed Health Planning Neighborhoods (HPN) and selected as the unit of analysis (see appendix #1b for a list of HPN numbers, names and Wards).

In addition, the GUCCHD and DC Health team sought to address another concern that emerged in the initial analysis of the HRSA-defined indicators. As mentioned above, there was a concern that the initial definitions of indicators may have been too broad to capture the needs of pregnant women and families with young children. Therefore we sought to focus the population

¹ When the data were analyzed more closely, the domain that was elevated for Ward 2 was crime levels. And the team believed that these figures might have reflected rates of crimes that involved tourists or other visitors to the city, rather than levels of community-violence that impact vulnerable families in other areas of the city.

data on maternal and child health populations and added several indicators that better aligned with the home visiting populations in Washington DC. As seen on the Ward and HPN level tables in appendix #1c and #1d, the indicator definitions are now more specific to pregnant women, women with young children and women of child-bearing age². Mental health was added as a sixth domain to reflect the needs of the DC MIECHV families served. Finally, given the changing demographics related to gentrification, the team placed a high premium on having all of the data to be analyzed come from the same calendar year, whenever possible. To achieve that goal, calendar year 2016 was the point in time for which the most complete data were available at the time of the analysis across indicators and domains.

Publicly available data for all six domains and selected indicators were obtained from the American Community Survey, DC Health reports, and the DC Metropolitan Police Department. The GUCCHD team then collaborated with DC Department of Behavioral Health (DBH), the Center for Policy, Planning and Evaluation, State Center for Health Statistics within DC Health, and the DC Child and Family Services Agency (CFSA) to obtain sensitive data for other indicators that were not available to the general public.

While awaiting data from the other agencies, the GUCCHD team contracted with the MedStar Health Research Institute (MHRI) who had partnered with us for the Phase 1 Needs Assessment (2016). A list of 10 indicators of socioeconomic status that were available in the American Community Survey of the U.S. Census had been identified which aligned with the Congressional definitions of eligible families for MIECHV. In addition two population-level variables were identified to anchor the analysis: total population and number of children under the age of 5 years old. Several indicators focused on the poverty rate as well as income inequality were selected, as well as indicators of female employment and educational attainment. These 12 indicators were analyzed and mapped at the Ward and Health Planning Neighborhood level; and tables were created that ranked all of the HPNs to allow for a more granular analysis of variability³. These interim findings were also shared with the Title V team at DC Health as they worked on their needs assessment. Through this analysis, the team was able to make decisions about which of these specific indicators would be incorporated into and retained for the revised simplified method. Appendix #1e illustrates the selected definitions for each indicator used in the final analyses.

Following the simplified method in the HRSA-defined Excel spreadsheets, the team input the Ward and HPN raw data necessary to compute means and standard deviation (SD) for each indicator as well as other types of descriptive statistics (i.e., median, interquartile range, minimum, and maximum). These indicator values were then standardized for each Ward and HPN, creating a z-score based on the mean and standard deviation⁴. At this point of the process however, extreme outliers were revealed. Some outliers had a z-score of 13 SD above the mean. To mitigate this, the team computed modified z-scores based on the median⁵. The team then

² At the Ward Level, data for six domains were available (the 5 defined by HRSA, plus Mental Health); at the HPN-level, data for 4 domains were analyzed (Mental Health and Crime were not available at the HPN level).

³ These interim findings are available upon request from DC Health as a standalone, internal report and also included as Appendix 4 to this report. This report includes maps of each indicator by Ward and also at the HPN-level which can be referenced for readers unfamiliar with the location of the eight Wards.

⁴ The HRSA/UIC instructions specify “county” as the unit of analysis, but in DC we used Ward: compute z-score for each county so that all indicators have a mean of 0 and a SD of 1. $Z\text{-score} = (\text{county value} - \text{mean})/\text{SD}$.

⁵ Modified z-scores based on median were calculated by obtaining the Median Absolute Deviation (MAD), instead of the standard deviation. MAD is a robust statistical measure calculated by identifying the deviation of each data

calculated the proportion of indicators within each domain for which that Ward’s (or neighborhood’s) modified z-score was greater than 1 absolute deviation above the median. If at least half of the indicators within a domain had a modified z-score greater than or equal to one absolute deviation above the median, then that Ward or neighborhood was considered “at-risk” in that domain. Wards or neighborhoods were considered communities with high concentration of risk, if they had two or more “at-risk” domains.

The result of the (modified) simplified method of analysis resulted in Wards 7 and 8 as the “counties” within DC with the highest concentration of residents who could benefit from home visiting services. These two Wards had all six domains indicating the highest level of need. Additionally, Ward 2 and Ward 5, each had one domain where risk was elevated. As mentioned earlier, Ward 2 showed high levels of risk for the Crime domain; and Ward 5 showed high levels of risk in the Substance Use Disorder domain. Interestingly, Ward 5 also showed some elevated risk in the socio-economic and adverse perinatal outcomes domains, but not enough for it to be considered “high risk” as defined by HRSA (i.e., it was less than .5 in the proportion).

Mirroring and expanding on the Ward-level analysis, there were a number of HPNs that had elevated concentrations of need and most of these were in Wards 7 and 8 (see Figure 1 next page). Working with the DC Health team, GUCCHD produced a table that arrayed the results of various calculations using the mean versus median and excluding outliers in the aggregated results (see appendix #1f). Through an iterative process, the final solution focused on a single indicator for several of the sub-domains (e.g., poverty, unemployment, education, and income inequality); and 16 Health Planning Neighborhoods (with their corresponding numbers in brackets as assigned for these analyses) were identified as areas of the District where the most eligible families likely resided. (See Table 1 below).

Table 1. Health Planning Neighborhoods Identified “At-Risk” Using the Final Version of the HRSA/UIC Formula

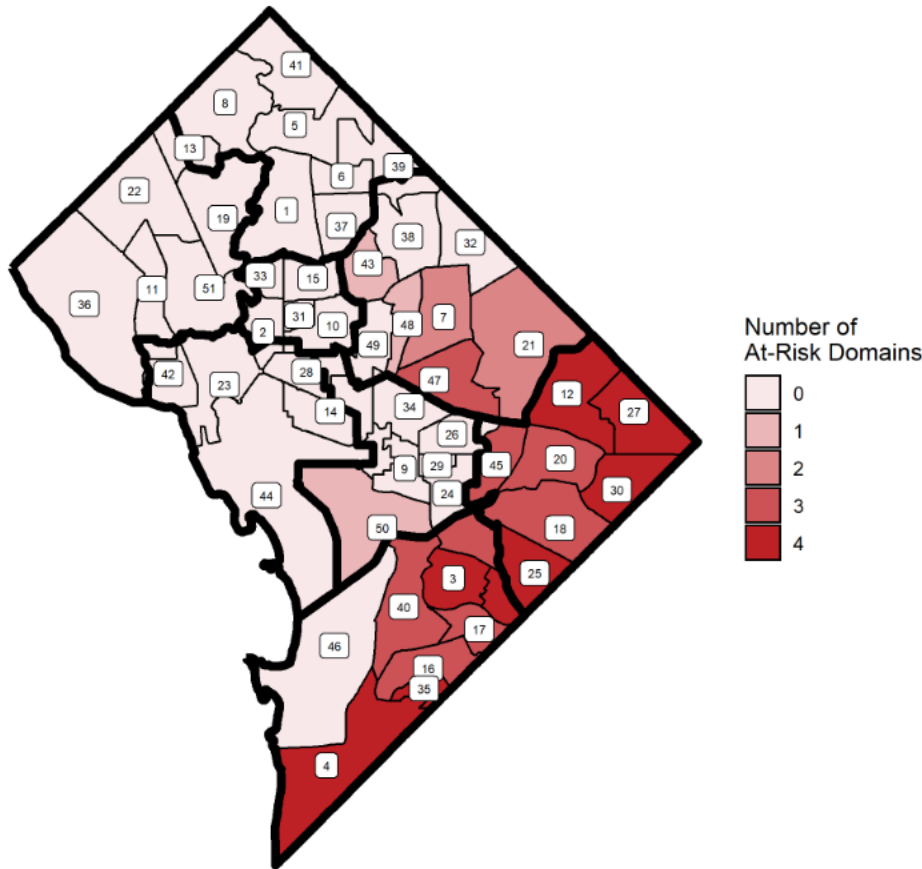
Ward 5	Ward 7	Ward 8
Brentwood (7)	Eastland Gardens (12)	Historic Anacostia (3)
Fort Lincoln/Gateway (21)	Twining (18)*	Bellevue (4)
Trinidad (47)	Fort Dupont (20)	Congress Heights/Shipleigh (16)
	Naylor/Hillcrest (25)	Douglass (17)
	Lincoln Heights (27)	Washington Highlands (35)
	Marshall Heights (30)	Saint Elizabeth’s (40)
	Stadium Armory (45)	

*Twining crosses into Ward 8 as well; numbers in brackets correspond to the HPNs as depicted in Figure 1 on the next page

point from the median, totaling up all of the deviations from the dataset, and dividing the total for all of the deviations by the number of observations. The modified z-score is then calculated by taking the value and subtracting the mean, this is then multiplied by the constant (0.645) and it is all divided by the MAD.

$$M_i = 0.6745(\text{value} - \text{median}) / \text{MAD}$$

Figure 1. The Number of “At-Risk” Domains Designated by the HRSA/UIC Formula for Four Risk Domains: Socioeconomic Status; Adverse Perinatal Outcomes; Substance Use Disorder; Child Maltreatment⁶



HRSA At Risk Limited Definitions

As can be seen in Figure 1, the eight wards of the city are demarcated by bold lines and the Health Planning Neighborhoods were each assigned a number by arraying the HPNs in alphabetical order (see Appendix 1b for a complete list of HPNs by name, Ward and Number). There were seven HPNs where data all four HRSA-defined domains showed elevated risk: Historic Anacostia, Bellevue, Eastland Gardens, Naylor/Hillcrest, Lincoln Heights, Marshall Heights, and Washington Highlands. An additional seven HPNs had data that met the threshold for risk in three out of the four domains: Congress Heights, Douglass, Twining, Fort Dupont, Saint Elizabeth’s, Stadium Armory, and Trinidad. Finally, two more HPNs had two domains that showed higher risk: Brentwood and Fort Lincoln/Gateway. All of these neighborhoods with concentration of risk were located in Wards 5, 7, and 8, consistent with the Ward level findings.

⁶ The data mapped here were derived from the final solution which relied on Median Z-scores, without Outliers, and using single indicators for domains.

Identified Communities

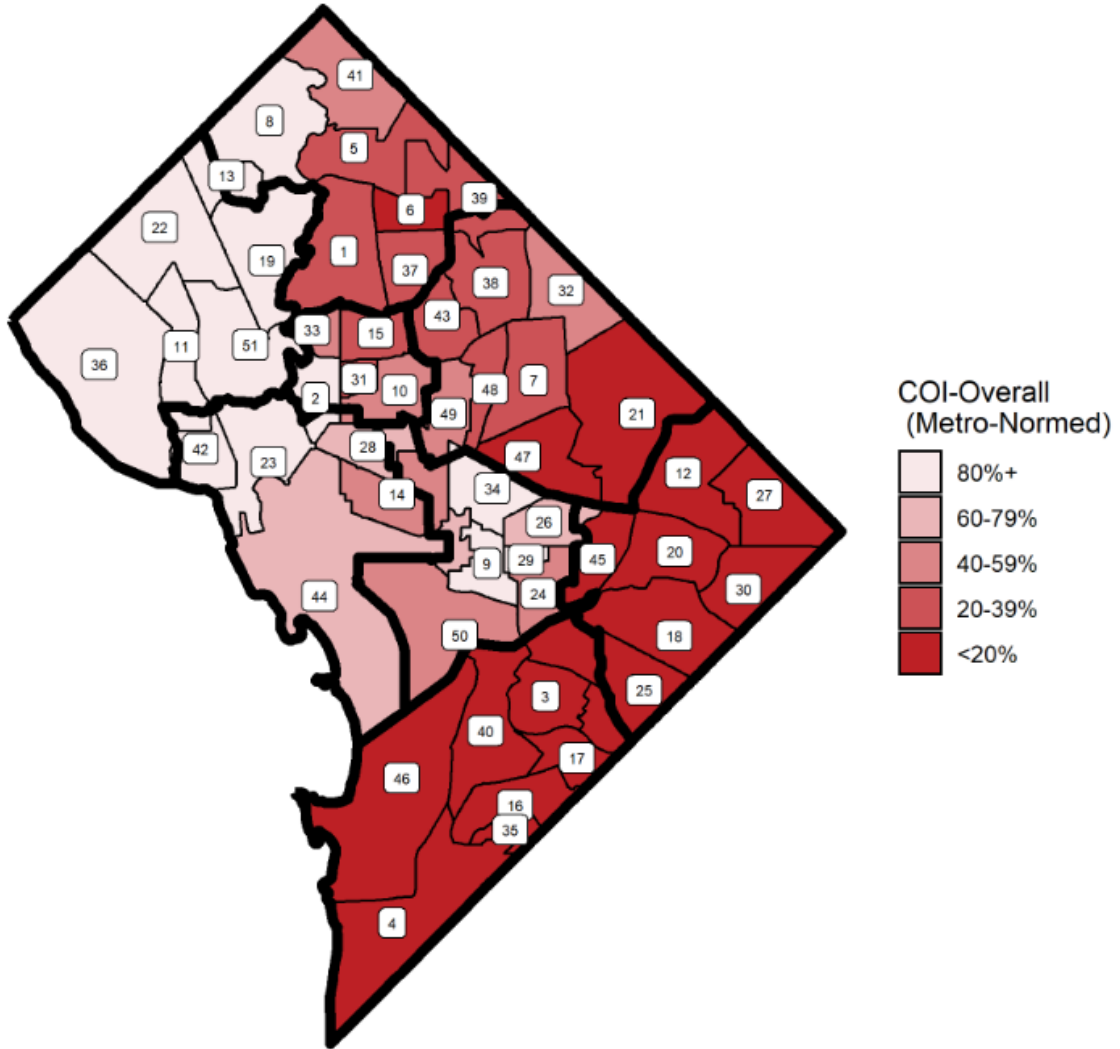
To supplement the findings from the HRSA-defined simplified methodology, the GUCCHD team undertook an extensive review of the extant literature to identify other methods for defining communities that could benefit from home visiting services under MIECHV. The team uncovered the work of Nancy Huntington and Mikyung Baek (2019), who defined and calculated the Children's Opportunity Index (COI). The COI is an innovative, researched based method to quantify the impact of children's neighborhoods on their outcomes. This index aggregates data from 29 indicators that are publicly available at the Census tract level across 3 domains: (1) education; (2) health and environment; and (3) social and economic (for a full listing, see appendix #1g). While several of the specific indicators—especially those that come from the American Community Survey—are similar to the indicators used in the HRSA-defined domains, the COI includes a broader array of things that are predictive of children's health and well-being⁷. Of note, this index included a number of indicators that the GUCCHD team sought to obtain locally at the Census tract level. For example, in the area of health and environment, the COI included measures of access to healthy food, access to green space and neighborhood walkability. In the educational domain, the COI mapped third grade reading and math proficiency as well as the number of high quality early care and education centers.

Figure 2 shows the COI as mapped by MHRI for each of the 51 Health Planning Neighborhoods in DC. A few important things to note when comparing the results in Figures 1 and 2. The COI 2.0 updated their findings using 2015 data; the data in Figure 1 relied on data from 2016 for the HRSA-defined domains of risk. In addition, the unit of analysis differs between the two figures: as required by HRSA, Figure 1 reports on the total number of domains that were elevated for risk varying from 0-4); the COI is a continuous measure of child opportunity, scored to indicate higher levels of opportunity as scores approach 100%. The data were graphed to highlight the lowest 20% as somewhat analogous to the definition of risk that HRSA offered.

The COI results suggest that many more neighborhoods likely contain families that could benefit from MIECHV services, but are also quite consistent with the findings from the HRSA-defined methodology. Specifically, all of Wards 7 and 8 are in the less than 20% (highest risk) category, as are several neighborhoods in Ward 5 (i.e., Trinidad and Fort Lincoln/Gateway). Also in the highest risk group for the COI is one neighborhood in Ward 4 (i.e., Brightwood Park). The rest of Ward 5, and much Ward 4 (with the exception of Chevy Chase and Barnaby Woods) falls into the next tier of risk on the COI (i.e., below 40%). This expanded area reflects the fact that the COI contains data on a more diverse range of indicators relevant for the well-being of pregnant women and families with young children.

⁷ The COI uses a methodology similar to the HRSA/UIC methodology, in that each indicator is converted to a z-score and then the z-scores are averaged within and then across domains. In version 2.0, they added weights to account for the strength of the relationship between specific indicators and four outcomes (i.e., 2 measures of intergenerational mobility and 2 health indicators). Indicators were selected based upon a strong research base and their proximal impact on the daily lived experiences of children in their neighborhoods.

Figure 2. The Child Opportunity Index for the Health Planning Neighborhoods within the DC Metropolitan Area (Data from 2015; provided by <http://data.diversitydatakids.org>)⁸



COI Index Data: r_COI_met (Census Tract averaged across the HPN)

⁸ The COI is rated from 0-100 with more positive scores indicating higher levels of opportunity for children who reside in those neighborhoods.

Summary and Recommendations

The GUCCHD team supplemented the simplified method for identifying “at-risk” communities by customizing the definitions for the indicators, adding a few additional indicators within the HRSA-defined domains, and standardizing the year (2016) for data to be included in the analyses.

- At the conclusion of the HRSA-defined calculation, Wards 7 and 8 were identified as areas for focused recruitment for MIECHV-funded services.
- Using the Health Planning Neighborhoods, and adjusting for outliers in the data due to small cell sizes, 16 HPNs in Wards 5, 7 and 8 were identified as areas where a high concentration of eligible families lived.
- Similar mapping of the Children’s Opportunity Index 2.0, using data from the prior year, resulted in an expanded catchment area that included all of Wards 5, 7 and 8 as well as six additional neighborhoods in Ward 4.

Given that the data used for these analyses were from 4 years ago, and the city continues to gentrify rapidly, these figures should be considered illustrative of the neighborhoods that could benefit from home visiting services. Based upon the strong evidence-based for the COI 2.0 methodology, DC Health has decided to designate a more expansive catchment area for inclusion in MIECHV services. Specifically, DC MIECHV recruitment will focus on Wards 4, 5, 7 and 8.

The Home Visiting Landscape in DC

There is a long history of home visiting services provided to DC families which predates the MIEHCV program. A wide array of community-based organizations offer home visiting as one of many services they provide to pregnant and postpartum mothers and families with young children. A fixture of this landscape has been the DC Home Visiting Council which has been meeting regularly (often monthly) for more than 20 years. In order to meet the SIR requirements in this section of the needs assessment, GUCCHD undertook a systematic review of relevant reports and literature on evidence-based home visiting services, with a focus on DC. A mixed methods approach to primary data collection was selected to gather data on current capacity, quality and gaps to inform MIECHV implementation.

Methodology

The GUCCHD team collected both quantitative and qualitative data to understand the current capacity, quality, and gaps of home visiting programs offered in DC. After completing the survey, stakeholders were invited to participate in a follow-up interview to explore issues concerning family retention, staff retention, and family outcomes within their home visiting programs. Information gathered through these methods was then synthesized and organized using a framework that provided a holistic description of DC home visiting continuum.

Working with the DC Home Visiting Council, led by DC Action for Children, GUCCHD drafted questions for the web-based survey. The questions focused on foundational information about each home visiting program serving pregnant women and families with young children, such as funding, enrollment capacity, areas served, and number of cases who received services in the last program year among others. A copy of the survey is included in appendix #2a. The survey was developed in Qualtrics, a data collection and analytic software program, and was distributed to 18 different home visiting programs in DC in coordination with the DC Home Visiting Council.

Data were collected from October to December 2019 and 15 out of the 18 programs responded, yielding an 83% response rate. Based on these survey data an initial draft of the HRSA-required table titled “Inventory of Existing Home Visiting Programs” (appendix #2b) was completed. This table was then reconciled with publicly available data (i.e., information on the national home visiting models’ websites) as well as data collected directly from DC programs by the DC Action for Children team. Thirteen organizations reported providing home visiting services consistent with the recently agreed upon definition being promulgated by the HV Council.

Of the 15 programs who replied to the survey, the GUCCHD was able to complete interviews with 9 of them. Individuals were contacted by a member of the GUCCHD team to share more detailed information about the programs they support. Interview questions explored the current structure and operations of programs (i.e., education of various staff, reasons for staff turnover, and perceived benefits of home visiting model to the community) as well as strategies the program uses for family engagement, family and staff retention, and measuring child/family outcomes. A version of the final questions can be referenced in appendix #2c⁹.

⁹ As the interviews progressed, the COVID-19 pandemic forced all home visiting programs to shift to virtual visits; as a result, interviewers informally checked in with respondents about how their programs were adjusting.

In addition to the primary data gathered from the survey and interviews, the team reviewed and synthesized the findings from several seminal reports on home visiting in DC (Auditors' report and the HV Council Annual Report 2018). These reports provided an important historical context in which to place the current needs assessment data. Other literature and federally produced reports about home visiting services were also analyzed to help place the DC MIECHV program in a national context. Together, this information tells the story of the current capacity, quality, gaps, and barriers that home visiting programs in the District—including MIECHV-funded models—possess and face.

Capacity and Quality

In calendar year 2019, 14 organizations were implementing 18 home visiting programs in DC. Out of these data were gathered from 13 organizations implementing 16 home visiting programs in DC. (One program's data were added after the survey period closed.) Together, these programs reported the capacity to serve 1,347 children and families across all eight Wards; in alignment with the earlier findings about concentrated areas of need in the District, more than half of the programs reported that the majority of their families resided in Ward 8. In the data provided by HRSA in a supplemental report, there were an estimated 1,781 families living in Wards 7 and 8 that were likely to be eligible for home visiting services¹⁰. If Ward 5 figures are added in, the gap in the number of potentially eligible families would be 811 families.

¹⁰ "Data Source: ACS 2017 1-Yr PUMS Data: Ward 4=265; Ward 5=377; Ward 7=924; Ward 8=924

Number of families likely to be eligible for MIECHV services based on the below criteria

- # of families with children under the age of 6 living below 100% of the poverty line + # of 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 that would also be eligible for MIECHV services).

AND

- Belongs to one or more of the following at-risk sub-populations:
 - o Mothers with low education (high school diploma or less)
 - o Young mothers under the age of 21
 - o Families with an infant (child under the age of 1)

Analysis includes primary families and unrelated sub-families living in the same household.

The method to define need is the number of families who are in poverty and meet one additional risk factor. Our analysis begins by identifying all families (primary families and unrelated sub-families) with children under the age of six, living below 100% of the poverty line. We then identify families facing other risk factors that relate to the statutory definition or risk and are available in CPS data (mothers with low education – a proxy for poor education outcomes, young mothers under the age of 21, and families with an infant). The populations (e.g., low income, low maternal education, and young mothers) were chosen because they are linked with negative maternal and child health outcomes such as low birth weight, child injury, child maltreatment, school readiness disparities, etc."

Table 2. Selected Characteristics of Home Visiting Programs in Washington DC (2019)¹¹

Organization	Program	Capacity	Target Population	Funding Sources
Bright Beginnings	Early Head Start-Home-Based Option	64 children at a time	Families experiencing homelessness with children under age three	Federal Head Start funding
CentroNía	Early Head Start-Home-Based Option	72 children and families annually	Servicing pregnant women with low incomes or families of children up to the age three	Federal Head Start funding
Community of Hope	Healthy Families America	40 families at a time	Women experiencing high-risk pregnancies and families with children under age three who are residents of Wards 5, 7, or 8	Federal Healthy Start funding, local DC Health funding, and private funding
	Parents as Teachers	60 families at a time		
Community Family Life Services	Nurturing Skills for Families	75 families annually	Families with low incomes and mothers who are incarcerated or returning home to their children after a period of incarceration.	Local public funding from CFSA and private funding
The Family Place	Home Instruction for Parents of Preschool Youngsters	20 families at a time	Families in Wards 1, 4, and 5 with children under age five, primarily living in Spanish-speaking households	Local public funding from the DC Mayor's Office for Latino Affairs and CFSA, and private funding
Georgetown University Center for Child and Human Development	Parenting Support Program	40 families at a time	Parents with intellectual and developmental disabilities	Local funding from DC Health
Generation Hope	Parents as Teachers	30 families annually	Adolescent mothers and families with children age 5 and under	Private funding

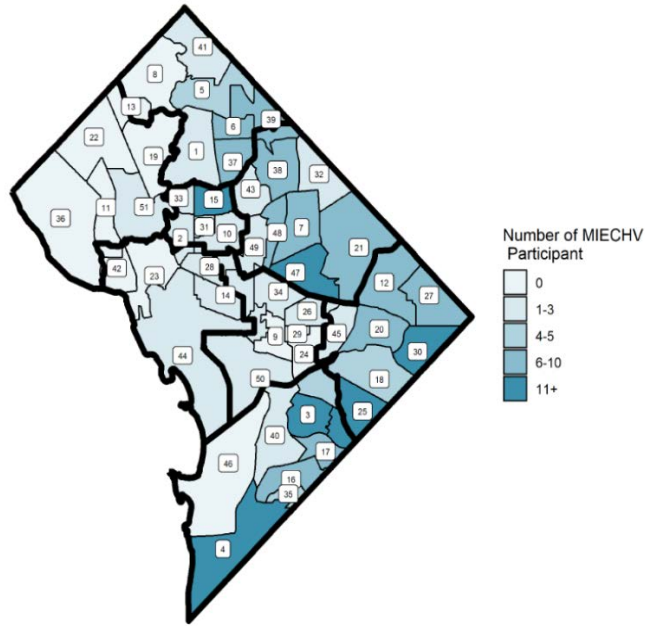
¹¹ The complete version of the HRSA-required table appears in Appendix 2b. This table was used by permission from DC Action for Children; 2019 Annual Report of the DC Home Visiting Council.
https://www.dchomevisiting.org/uploads/1/1/9/0/119003017/2019_home_visiting_council_annual_report.pdf

Organization	Program	Capacity	Target Population	Funding Sources
Healthy Babies Project, Inc	Healthy Families America / Growing Great Kids	52 children at a time	Adolescent mothers and families with children under age three	United Planning Organization - Early Head Start Subgrantee
Mamatoto Village	Mothers Rising Home Visiting	300 families annually	Medicaid-eligible pregnant people with moderate to high risk pregnancies, primarily from Ward 5, 7, and 8	Local funding from DC Health, DCHF, MCO contracts; and private funding
Martha's Table	Family Visiting (Early Head Start/Parents as Teachers)	55 families home-based at a time	Families with children under age three, primarily in Wards 7 and 8	Federal Head Start funding and private funding
Mary's Center	Father-Child Attachment Program	50 families at a time	Soon-to-be fathers and fathers with children under age five	Local funding from CFSA
	Parents as Teachers	160 families at a time	Pregnant women, including those experiencing high-risk pregnancies, and families with children under age five, including families experiencing homelessness, immigrant families, and families in which children are currently in foster care	Federal MIECHV funding and local funding from DC Health
	Healthy Families America	180 families at a time	Pregnant women and families with children under the age of 5 residing in all wards of DC and identified as high social and/or medical risk.	Federal MIECHV funding from DC Health
Rosemount Center	Early Head Start-Home-Based Option	77 families and children at a time	Pregnant women with low incomes and families with children under age three	Federal Head Start and private funding
United Planning Organization	Early Head Start	72 children annually	Families with low incomes who have children under age three	Federal Head Start funding

Across the District, there are four evidence-based home visiting models¹² being implemented as well as several “home grown” or promising practice programs. The four evidence-based models offered in DC are: Parents as Teachers (PAT), Healthy Families America (HFA), Early Head Start (EHS), and Home Instruction for Parents of Preschool Youngsters (HIPPI). It is important to note that while several programs reported using the Parents as Teachers curriculum as part of the implementation of another evidence-based model (i.e., Early Head Start), Table 2 lists the home visiting programs’ name in the second column. In addition, in triangulating these data with the national models’ websites, the inventory in appendix#2b distinguishing those agencies who have paid for and are designated as “affiliates” of the national office (i.e., HFA and PAT). In 2019, the home grown programs being implemented in the District were: (1) the Father Child Attachment program implemented by Mary’s Center; (2) the Mothers Rising program implemented by Mamatoto Village; (3) Nurturing Skills for Families implemented by Community Family Life Services; and, (4) the Parenting Support Program implemented by GUCCHD.

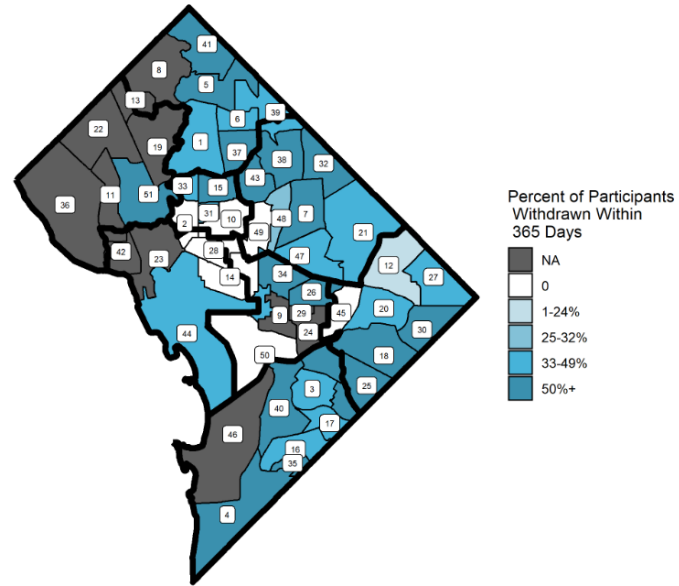
One important measure of home visiting quality is the extent to which families are able to derive the benefits promised by evidence-based home visiting. Most of the programs interviewed had family feedback surveys and mechanisms in place to determine family satisfaction. The Early Head Start programs also have a Parent Policy Council in place as part of their programs’ infrastructure, which allows for ongoing substantive involvement of families in decision-making as well as required measures of child and family outcomes. The MIECHV program currently funds Parents as Teachers and Healthy Families America at the Mary’s Center. Both programs enroll families during the perinatal period, most often during pregnancy; and both models offer services up to kindergarten enrollment. An analysis of the enrollment and early withdrawal data from the MIECHV-funded programs offer a glimpse into the challenges of maintaining families with complex needs into long-term home visiting services (see Figures 3 and 4 below).

¹² To be considered evidence-based under MIECHV, a home visiting must meet criteria established by the Office of Planning, Research, and Evaluation (OPRE) (OPRE, 2014) and be listed on the HomVEE website.



MIECHV Participant Data; Families were Served from May 2016-2020

Figure 3. Total Number of Families Enrolled in MIECHV-funded Home Visiting Programs (n=230)



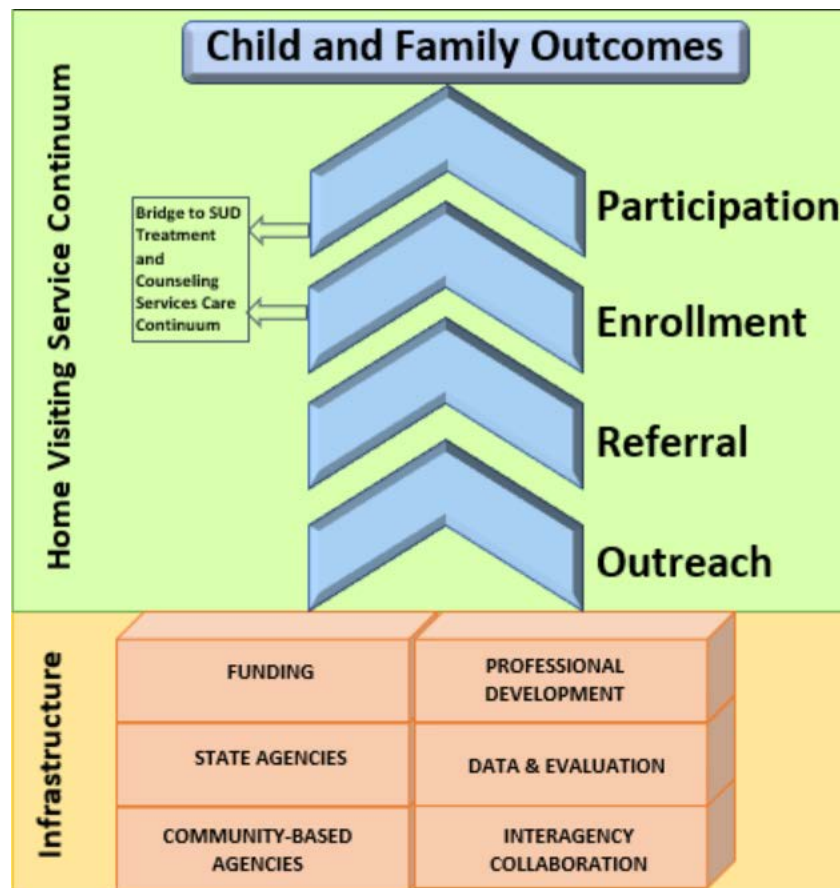
MIECHV Participant Data; Families were Served from May 2016-2020

Figure 4. Percentage of MIECHV-Funded Enrolled Families that Withdrew from Home Visiting Services on or Before 365 Days of Enrollment (n=111)

Current Strengths, Gaps and Barriers of the DC Home Visiting System

In order to synthesize the data across multiple sources, the GUCCHD team organized the results into a framework that captured the infrastructure needed to support a home visiting continuum as well as strategies to ensure families are enrolled in and served by home visiting programs. This framework is represented in Figure 5 (below).

Figure 5. Framework for Essential Elements of a Home Visiting System of Care



Outreach to Potentially Eligible Families

Throughout the interviews, respondents highlighted a variety of strategies that their programs used to let potentially eligible families know about their programs. Many emphasized the power of word of mouth to help clients connect to their agencies and services. Others stressed their long-standing ties to the community from years of service as well as their location in communities with high concentrations of eligible families. The two MIECHV-funded programs recently crafted a joint recruitment plan, thus streamlining some of their strategies to reach families who might be interested in HFA or PAT. This is particularly useful given that HFA has a smaller recruitment window for perinatal women than PAT; so women who have older infants can still enroll in PAT, if interested.

There are a number of gaps in the ability of programs to successfully outreach to potentially eligible families as well. Several programs mentioned that the term “home visiting” was unfamiliar to families and could be a barrier to enrollment. Other respondents stressed that the families that are eligible for home visiting may not have the bandwidth to engage in weekly visits focused on child development in the face of housing and food insecurity. Finally, programs that seek to enroll immigrants emphasized the challenges inherent in getting families enrolled during a time when word on the street has it that accessing “government” services may put you at risk for deportation or other problems with establishing citizenship.

Referral to Home Visiting Programs

In addition to outreach directly to potentially eligible families, programs need strategies to get referrals to their programs on an ongoing basis to ensure their slots are full. Most agencies are offering home visiting services through one of many programs their agency is implementing. This means that they can connect with eligible families through internal referrals within their agencies. In addition, many respondents mentioned formal and informal relationships they had with other community-based organizations—especially when recruiting families in areas of the city where they did not have a physical presence. At least one home visiting program highlighted the referrals that they received from Medicaid managed care organizations, which was also mentioned as a gap for other home visiting programs.

There were also a number of barriers that emerged through the interviews which undermined a more integrated system of home visiting services for eligible families in DC. One of the surprising findings was the existence of language in the Head Start performance standards that may have the unintended consequence of keeping Early Head Start programs from referring eligible families to other home visiting programs with similar eligibility criteria. In the regulations, programs are encouraged to maintain a wait list so that they can quickly fill slots if a vacancy emerges during the course of the program year. The waitlist is designed to ensure that the families with the highest levels of need are prioritized when EHS slots become available. However, the way the guidance is written supports an EHS program from referring an eligible family for services elsewhere, even if there are vacancies at the time the family is being added to the waitlist. This and other specific barriers that were mentioned continue to undermine efforts to streamline a centralized intake process and ensure that families are matched with the home visiting programs that would best meet their needs and interests.

Enrolling in Home Visiting Services

The steps in enrolling families in the various home visiting programs in the District vary from agency to agency and program to program. Most respondents were able to clearly articulate the process and expectations and described strategies in place to support families in gathering the necessary paperwork. However, more often, the enrollment process was seen as a barrier to families—requiring multiple steps, the completion of baseline intake and assessment tools, which were perceived as burdensome to families who were already coping with a lot of demands on their time and energy.

Family Participation and Engagement

As mentioned above, in voluntary home visiting programs, an ongoing challenge is maintaining high levels of participation and engagement in services—especially in the face of housing and

food insecurity which were raised by many respondents as ongoing needs for their home visiting clients. While the MIECHV programs have actual data on who drops out and when, other programs were not able to be as specific about their challenges in family retention. Successful parent engagement (and retention) depended on the ability of home visiting programs to be flexible and to customize their approach to service delivery. Respondents highlighted the need to be flexible both in what content they delivered as well as the frequency of the visit schedule. It is important to note that while the national models do allow for significant flexibility in how local sites operationalize their implementation, there are still fidelity standards that affiliates must adhere to. At times, these may be at odds with the need to customize content and timing for visits. Programs all emphasized the importance of a two-generational approach—which is the bedrock of home visiting; and one program stressed the need to implement a “three-generational approach: in black communities, what grandma or auntie says... is the golden truth.”

Other barriers that were highlighted in the interviews were the perception that being in families' homes is “intrusive” and that there were families for whom services in the community would be a better fit than in their homes. This barrier could apply to homeless families, those doubles-up due to housing insecurity, as well as for immigrant families' whose legal status might be a special concern. The data displayed in Figures 3 and 4 above underscore two points: that early withdrawal is a widespread phenomenon for MIECHV-funded programs; and that there does not seem to be differential attrition in neighborhoods across the District.

Staff Retention and Turnover

The challenges with family retention are mirrored at the national level with MIECHV as are issues related to the retention of home visitors. Staff turnover is ubiquitous, with more than half of the programs who were interviewed reporting they had lost at least one staff member in the last 12 months—and many had lost several. Among the most common reasons offered by programs for staff leaving were: returning to school (n=3); lateral move outside of the organization (n=3); internal promotion and relocation were also mentioned for specific staff who had transitioned within the past year. Of note, only 1 program singled out burn out as the reason for staff leaving their positions.

Because staff turnover is such a pervasive issue facing local organizations implementing home visiting in the US and in DC, it has served as the focus of several years of MIECHV-funded evaluations both through the formula grant as well as the Innovation award. An early qualitative finding in a DC MIECHV study suggested that family attrition might be linked with staff turnover. While many others in the field have explored the relationship between staff turnover and family retention, local data from the DC MIECHV evaluations have underscored that most families have experienced multiple changes in home visitors and remain engaged in the program. These findings, while initially paradoxical, led the team to document what best practices in transitioning families to a new home visitor following a staff resignation; qualitative interviews with MIECHV-funded home visiting staff identified several specific strategies that the programs implemented to help retain families during a transition between home visitors. These included a warm hand-off (including family notification) and preparing a transition summary for the inheriting home visitor. Recently, the GUCCHD team¹³ was able to establish links between these best practices in managing staff turnover and family retention in home visiting at

¹³ Working with an expert in a special type of mathematical methods for small sample sizes referred to as configurational comparative methods, which include Qualitative Comparative Analysis and Coincidence Analysis.

3 and 6 months following a change in home visitors. Importantly, strategies that help clients to form a relationship with the home visiting program and the local implementing agency rather than emphasizing the personal relationship with an individual home visitor were mentioned often in the interviews for this needs assessment as all agencies navigated turnover of staff.

Of note, many programs emphasized the positives of staff turnover, as agencies have sought to create more intentional career paths for people working in the home visiting and human services field. They argued that staff (who are often recent college graduates) who serve as home visitors for a few years and then go on to graduate school in nursing, social work, or other clinical fields have found their passion to serve low-income families as a career. Others who are promoted to supervisor roles within the home visiting program or in the local agency are also seen as examples of a career ladder that the field has been cultivating over the past decade.

The downside of staff turnover is that it can take time before a well-qualified replacement is found and several months until that person is trained and ready to start seeing clients. This delay in having newly hired home visitors trained in the home visiting approach is particularly challenging for programs that are implementing evidence-based models; and this is especially difficult if local capacity to conduct training in the model (and/or curriculum) has not been established. For example, home visitors who are implementing PAT need to attend out-of-state trainings in both the basic model as well as 1-2 additional trainings in the curriculum. These trainings are scheduled throughout the year, however, they are often full and may not align with the hiring dates and local needs for newly hired staff in DC agencies. Other issues raised in the interviews were the challenges in hiring and retaining bilingual staff; and the difficulty in finding training available to English as a second language speakers, who also need to deliver content to their families in their native language.

Infrastructure: Strengths and Gaps in the Home Visiting System

As the team integrated the survey results, analysis of the interviews with home visiting programs, and the recent findings from other District-wide reports on home visiting and early childhood systems, a number of themes emerged. These themes were organized into six areas of relevance to policymakers, funders and program managers and summarized in Table 3 below. The key takeaways from these analysis are:

- DC has a broad continuum of evidence-based and home grown programs being implemented across the city to families who meet the eligibility criteria for MIECHV services.
- There is strong interagency cooperation evident in the DC Home Visiting Council; but more formal interagency collaboration is needed to support centralized intake, coordination of referrals between local implementing agencies and data collection and reporting.
- Training and professional development opportunities are being offered, and core competencies were developed and agreed to in the past, but there is no centralized place to locate relevant training for home visitors, track professional development, and certify that individuals are meeting core competencies.

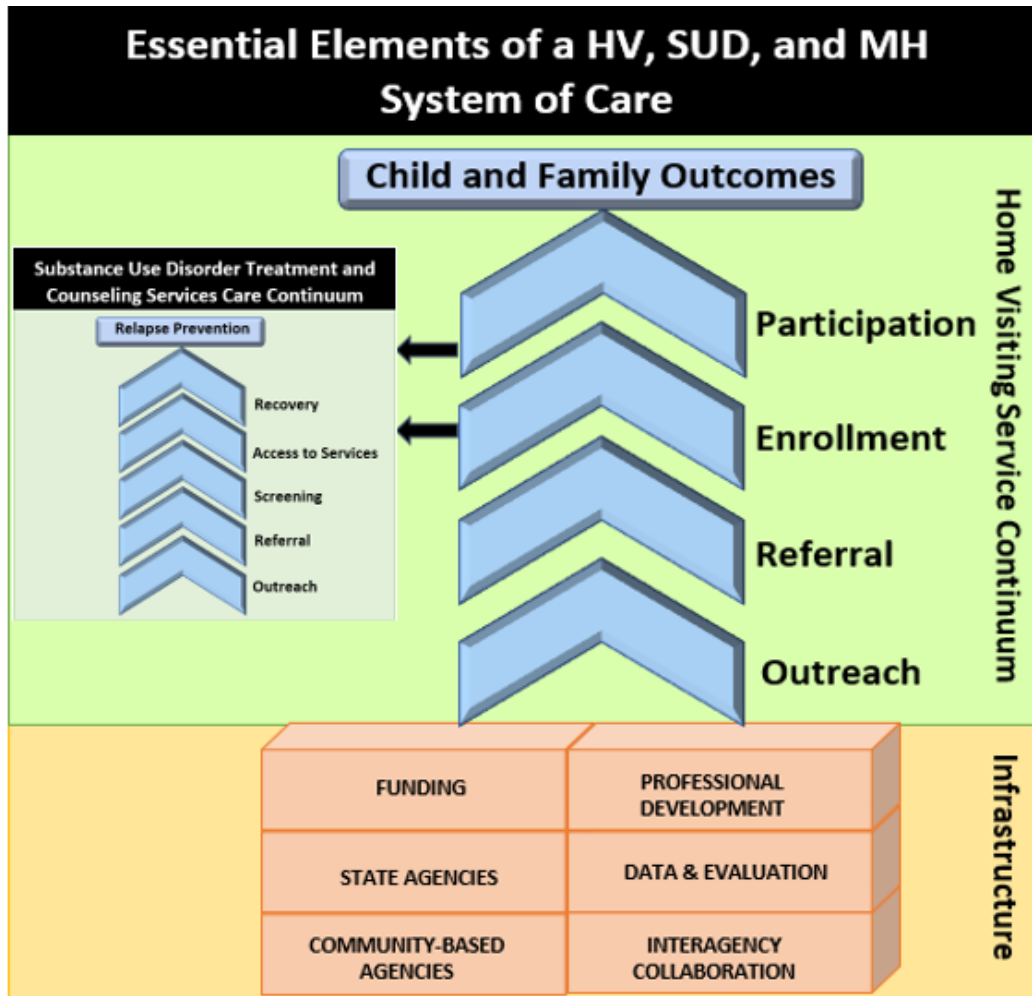
Table 3. Summary of Key Findings about Infrastructure for Home Visiting Systems of Care

Infrastructure Domain	Strengths	Gaps
Data & Evaluation	<ul style="list-style-type: none"> ▪ DC Health has created and maintains a strong data management system for MIECHV, the Data Collection and Reporting System (DCRS). ▪ Several local home grown programs have an evaluation component to help them build the evidence base for their programs' effectiveness. 	<ul style="list-style-type: none"> ▪ There is a lack of system-level consensus on home visiting indicators and outcomes; there are no commonly agreed ways to report even the most basic data on the number of individuals served. ▪ Despite implementing 4 evidence-based models, there is limited data on fidelity and quality of home visiting services.
Interagency Collaboration	<ul style="list-style-type: none"> ▪ The DC Home Visiting Council has been in operation for 20 years and continues to meet regularly; there is broad representation of key stakeholders as active members of the Council. ▪ DC Action for Children recently assumed management for the operations of the HV Council, bringing with it dedicated staff time and organizational capacity to use data to advance systems' improvement. 	<ul style="list-style-type: none"> ▪ There are no formal interagency agreements in place at the state agency or local level to refer clients to other programs if slots are not available. ▪ There is no funded entity to provide technical assistance and build local capacity to collect data, assess fidelity of implementation and monitor and report on short and long term outcomes.
Funding	<ul style="list-style-type: none"> ▪ The DC home visiting system is built upon a broad mix of public and private (federal and local) funding streams; many are multi-year grants providing stability in funding support. ▪ Many programs reported a mix of funding streams were supporting local programs. 	<ul style="list-style-type: none"> ▪ Many funding streams come with specific requirements and priority populations, which can limit interagency collaboration and referrals. ▪ Reliance on a single funding stream can leave programs vulnerable to shifting agency priorities.
Professional Development	<ul style="list-style-type: none"> ▪ Programs reported consistent support for staff participation in locally available and out-of-town trainings. ▪ DC Health has invested in several different on-line foundational training modules, including recently for DCRS. 	<ul style="list-style-type: none"> ▪ There is no centralized place where home visiting programs and staff can learn about and sign up for training. ▪ Core competencies, developed years ago, are not well-known nor influencing professional development offerings.
Role of State Agencies	<ul style="list-style-type: none"> ▪ There is a mix of state agencies currently supporting home visiting programs, including DC Health, OSSE and CFSA. 	<ul style="list-style-type: none"> ▪ The role of other DC state agencies in supporting home visiting is unknown (i.e., DHS, DBH and DDS).

	<ul style="list-style-type: none"> Health Care Finance has been a long-standing and active member of the HV Council, which could open the door for a potential role for Medicaid funding for a nurse-led model, if there is local funding and the political will. 	
Community-Based Agencies	<ul style="list-style-type: none"> Thirteen different community-based agencies reported delivering home visiting services to families in all 8 Wards of the city. Many of these local implementing agencies have long-standing commitments to marginalized groups and offer an array of services to support families in need. 	<ul style="list-style-type: none"> Some agencies may benefit from additional support to adopt and sustain evidence-based home visiting models under MIECHV. There is limited understanding about the differences between evidence-based models versus curricula and the infrastructure to support fidelity monitoring.

One of the emerging issues from the interviews with home visiting programs was a lack of knowledge about where to connect women who may have substance use disorders with community-based treatment. Given that home visiting programs are invested in supporting positive birth outcomes and development for young children and families, they may be uniquely situated to screen and provide referrals for mental health and substance use services to pregnant women and women with young children (Home Visiting Council, 2018; OPRE, 2020). Creating a collaborative system between home visiting, substance use, and mental health programs that targets several entry points on the treatment service trajectory (screening, referral, support with treatment access), may help support multiple areas of maternal health and well-being and in turn children’s healthy development. Figure 6 (below) depicts the bridges that could be built between home visiting and substance abuse and counseling services in DC.

Figure 6. The Linkages Between Home Visiting Systems of Care and Substance Use Disorders and Mental Health Treatment Services



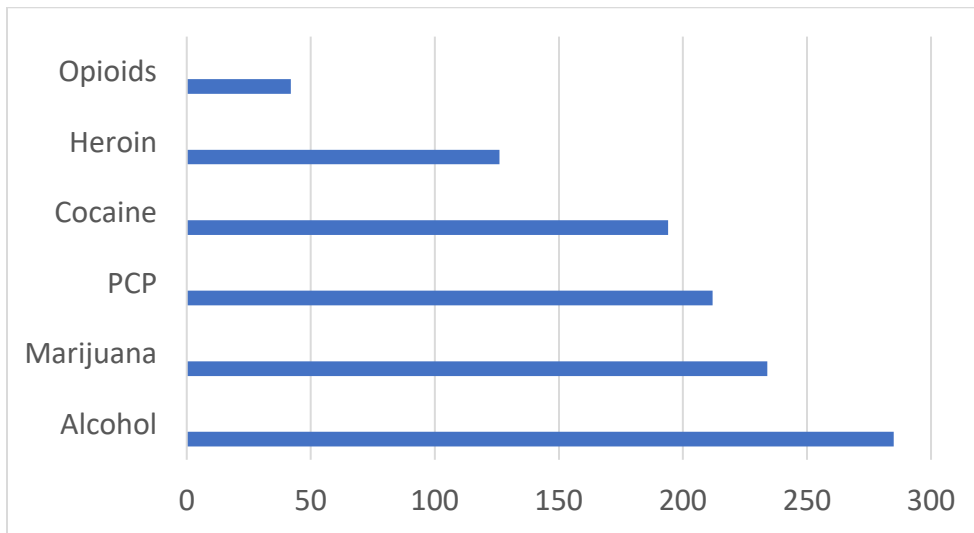
Substance Use Disorder Treatment and Counseling Services in DC

In December of 2018, Mayor Muriel Bowser released the “Live Long DC” strategic plan for combating the opioid crisis in DC. Through that plan, a Mayor’s Task Force on Opioids was established. This plan stated that 78% of opioid overdose deaths, during 2014-2016, were adult males (DC Mayor’s Office [DC-MO], DC Department of Behavioral Health [DBH], 2019). Since then, the death rate due to opioids has gone down by 31%. Additional positive steps in fighting the opioid crisis in DC have included: extending legislation for the legality of testing kits, and enacting provisions in the revised Synthetics Abatement and Full Enforcement Drug Control Amendment Act of 2017 (SAFE DC Act¹⁴) (DC-MO, DBH, 2019).

¹⁴ The SAFE DC Act This law criminalizes synthetic drugs based on the class of the chemical compound, including variants of fentanyl.

Because pregnant women and families with young children are the populations eligible for MIECHV services, the GUCCHD team sought data to determine which substances were used most often by child-bearing women in the District. As mentioned in an earlier section of this report, the GUCCHD team requested data from DBH to help identify communities with high concentrations of risk. Aligned with other available data, the team requested SUD data from 2016, and DBH provided these data in February 2020. They pulled the information from the Web Infrastructure for Treatment Services (WITS¹⁵) treatment data system that are displayed in Figure 7. Based on this 2016 data, 26% of DC women, 18 to 44 years, reported using heroin or other opiates and synthetics. In comparison, 44% reported abusing alcohol, 36% reported Marijuana, Hashish, and THC use, and 33% reported using Phenylcyclohexyl piperidine (PCP). During this time, there were even more women using cocaine (30%) than there were those using opiates.

Figure 7. Number of Women of Childbearing Age who Reported Using Specific Substances



Methodology

To better understand the SUD treatment services available to perinatal and women with young children, the GUCCHD team worked with DBH, the Single State Authority (SSA) in DC. The team sought information from the agencies who are approved by DBH to provide treatment services. To narrow down the pool to those agencies that serve those who identify as women, pregnant women, and families with young children, the team designed a short survey asking, among other questions, what populations these agencies serve (appendix #3a). The survey was designed September to October 2019 in collaboration with DBH and DC Health. Once the questions were finalized, the survey was distributed on October 23, 2019 through Qualtrics. Not all of the 160+ agencies had accurate contact information, therefore 114 surveys were delivered. By the end of December, when the initial data collection period ended, only 11 agencies had responded to the survey. Out of these responses, one agency indicated that they only treat adult

¹⁵ WITS was developed by the Substance Abuse and Mental Health Services Administration (SAMHSA). It collects and tracks client treatment data. DBH specifically looked at claims paid by females 18-44 years served in FY2016, admission records and intake transactions. They additionally unduplicated count of clients for particular substance and Ward.

males in their program consequently removing them from the pool of respondents the team hoped to interview.

With a 10% response rate, the GUCCHD team decided to redistribute the survey in February 2020. An additional 16 agencies responded to the survey, all stating that they serve MIECHV specific populations. With a 24% response rate, the team created a summary table of the information that was gathered from these agencies (appendix #3b). In an effort to provide targeted information on the services offered to women, pregnant women, and families with young children, the team reached out to the 26 agencies that indicated serving these populations for permission to conduct an in-depth interview. Interviews took place from March 2020 until April 2020 with a 58% completion rate. The interviews provided a window into some of the current issues that impact the capacity and quality of SUD services. The interview guide that the team used is included in appendix #3c.

Capacity and Quality

Out of the 27 agencies that replied, Volunteers for America was the only one to indicate that they only served adult males. Due to the focus of this needs assessment and to better speak on the services available for the specific MIECHV populations, this agency was not included in the data analyzed for this report. The remaining 26 agencies indicated that in addition to serving adult males, nearly all also served adult females; 58% indicated that pregnant women received services, and 46% also served women with children zero to five years. Depending on the agency, specific populations, such as the deaf, HIV/AIDS patients, homeless, LGBTQI+, and youth, were also mentioned. Services were provided in English only in 65% of the agencies; 23% offered services in English and Spanish, while an additional 8% added interpretation services were available for other languages. One agency mentioned their capacity to provide services in American Sign Language.

In 2019, the 38% of the agencies indicated that they have more than one site/location across the District. While all 26 indicated serving people across the District to include the homeless, 73% indicated they primarily serve residents of Ward 8. Agencies also indicated that residents of Ward 5 and 7 received substance use disorder treatment and counseling services, consistent with patterns in the service use data reported by DBH and the location of the communities with high concentration of risk identified earlier in this report. Nearly one-third of respondents said their agency provided both substance use disorder treatment and mental health services. There were more agencies that only provided mental health services in DC over those who only provided substance use disorder treatment services. While Whitman Walker provides both of these services, they self-identified as providing primary medical services.

Current Strengths, Gaps and Barriers of the SUD/MH System

Throughout the interviews and an analysis of the surveys, themes emerged in the facilitators as well as barriers to MIECHV-eligible women accessing substance use disorder and mental health treatment services. As mentioned above, many of the agencies that were interviewed provided services throughout the District and offered SUD as well as MH treatment. There were a range of special populations that were served by specific agencies. Several respondents highlighted the Access HelpLine, operated by the DBH as a strength of the behavioral health system. The Access Helpline operates 24 hours per day/365 days a year as a centralized intake system. Callers are connected to service agencies that can best meet their needs, with the DBH team making 3-way calls to ensure a warm hand-off. Often, clients can see someone within 7 days of calling to get follow-up assessments. Families can choose which agency they would like to go to,

or be connected with an agency, if they have no preference. In the interviews, respondents also mentioned that these agencies often have housing liaisons and other support teams to help with related issues that clients might be facing as they seek treatment.

On the other hand, the public behavioral health system in DC is quite complex, and there is a lot of specific terminology that can feel unfamiliar to folks as they enter and try to access services (Children’s Law Center, Children’s National Health System, & District of Columbia Behavioral Health Association, 2019). This complexity was mirrored in the interviews conducted for this needs assessment. Despite the appearance of widespread availability of services, respondents reported there were limited inpatient slots and barriers to women with young children successfully engaging in outpatient SUD treatment. There was only 1 inpatient program at Samaritan’s Inn that catered to pregnant women and mothers with young children. While this program permitted women to bring up to 2 of her children, many impacted families have more than 2 children in the home. Samaritan’s Inn also arranged for child care for the younger children and enrollment in a local elementary school for the older children while women were in treatment—which addresses a key barrier to many women entering inpatient care.

Other challenges facing MIECHV-eligible women who seek treatment for SUD and MH problems are common to all residents in DC seeking services. Homelessness and housing insecurity create barriers to enrolling in treatment, as Medicaid is the primary payer for behavioral health services in the public system. Respondents described challenges in recertifying clients for Medicaid, a process that requires an address and an in person visit if their Medicaid expires. One respondent described a specific issue, where the agency staff could only check on the current status of Medicaid eligibility for up to 3 clients during a single phone call. During this call, they were not able to get the expiration date for the clients’ Medicaid—only if they were currently covered. Other barriers mentioned by a different respondent included the limited times and dates that the DBH Assessment and Referral system was open (i.e., 7:30 am – 2:30 pm Monday through Friday). If clients did not arrive first thing in the morning, slots would get filled up and they would need to return another day. As one respondent said, all of these tasks are difficult to navigate if you are well, but “folks who are active drug users aren’t always making the most sound decisions.”

Coordination with Other Needs Assessments

The GUCCHD team met with a team of DC Health representatives that were overseeing a variety of needs assessments, including but not limited to the Title V Needs Assessment. This broader team met a variety of times over the course of more than one year to ensure that there was coordination across these project and efforts. Specific examples of how this coordination manifest were:

- a common data request was submitted to the Center for Policy, Planning and Evaluation, State Center for Health Statistics within DC Health to align requests for perinatal and infant health indicators for the Title V and MIECHV Needs Assessments;
- establishing and sharing data and documents in a HIPPA-compliant folder in Box;
- GUCCHD provided the 12 Ward and 12 Health Planning Neighborhood maps and ranked tables for the American Community Survey 2016 indicators that were foundational in the identification of neighborhoods that would benefit from MIECHV-funded services;
- Title V provided early drafts of their needs assessment findings to the GUCCHD team for review and coordination.

In addition, the GUCCHD team also coordinated with the broader interagency team focused on the birth to five systems efforts as part of DC’s Preschool Development Grant, co-led by OSSE and DC Health. This close working relationship provided access to a range of documents and data that were used for their needs assessment in 2019, including a large parent survey of more than 2,000 families in DC.

DC Health also facilitated a series of phone/zoom calls with other DC agencies to ensure access to a range of documents, including: OSSE for the Head Start community needs assessment; and CFSA for their Family First and CBCAP plans.

Table 4: Recent DC Reports Reviewed for the MIECHV Needs Assessment

Agency	Published Year	Report Name and Citation
Child and Family Services Agency (CFSA)	2020	Child and Family Services Agency (CFSA). (2020). <i>Community-Based Child Abuse Prevention (CBCAP) Grant: June 2020 Application for Funding</i> .
Child and Family Services Agency (CFSA)	2019	District of Columbia Government Child and Family Services Agency. (2019). FY 2021 Needs Assessment. Retrieved from https://cfsadashboard.dc.gov/sites/default/files/dc/sites/cfsadashboard/publication/attachments/Final_for_posting_FY21%20NA_.pdf
Child and Family Services Agency (CFSA)	2019	Child and Family Services Agency (CFSA). (2019). Putting Families First in DC. Retrieved from https://cfsa.dc.gov/sites/default/files/dc/sites/cfsa/publication/attachments/DC_CFSA_Family_First_Prevention_Plan_2019_Final.pdf
District of Columbia Home Visiting Council	2019	District of Columbia Home Visiting Council (2019). <i>2018 Annual Report of The District of Columbia Home Visiting Council</i> . https://www.dchomevisiting.org/uploads/1/1/9/0/119003017/hv_council_annual_report.pdf

Children’s Law Center Children’s National Health System District of Columbia Behavioral Health Association	2019	Children’s Law Center, Children’s National Health System, & District of Columbia Behavioral Health Association. (2019). <i>Behavioral Health in the District of Columbia for Children, Youth & Families: Understanding the Current System</i> . https://www.childrenslawcenter.org/sites/default/files/Children%27s%20Behavioral%20Health%20in%20DC%20Current%20System%20FINAL%20DRAFT%20max%20edit%202.14.19_1.pdf
DC Department of Behavioral Health (DBH)	2019	DC Department of Behavioral Health. (2019). <i>Live. Long. DC.: Washington, DC's strategic plan to reduce opioid use, misuse, and related deaths</i> . Retrieved from https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/LIVE.%20LONG.%20DC-%20Washington%20DC%27s%20Opioid%20Strategic%20Plan.pdf
Department of Health (DC Health)	2019	DC Department of Health, Office of Health Equity. (2019). <i>Health equity report: District of Columbia 2018</i> (Social determinants of health in Washington DC). Retrieved from https://app.box.com/s/yspij8v81cxqyeb17gj3uifjumb7ufsw
Department of Health (DC Health)	2018	Government of the District of Columbia Department of Health & Government of the District of Columbia Muriel Bowser, Mayor. (2018). <i>Primary Care Needs Assessment</i> . Retrieved from https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/DC%20Primary%20Care%20Needs%20Assessment%202018.pdf
Department of Health (DC Health)	2018	DC Department of Health. (2018). <i>Perinatal health and infant mortality report</i> . Retrieved from https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/Perinatal%20Health%20Report%202018_FINAL.pdf
DC Healthy Communities Collaborative	2016	Cottrell, L., Merrill, C., Searcy, K., DC Healthy Communities Collaborative. (2016). <i>District of Columbia Community Health Needs Assessment</i> . Retrieved from http://www.dchealthmatters.org/content/sites/washingtondc/2016_DC_CHNA_062416_FINAL.pdf
Office of the District of Columbia Auditor	2017	Office of the District of Columbia Auditor (ODCA). (2017). <i>Status Report on Home Visiting in the District of Columbia</i> . Retrieved from http://dcauditor.org/report/status-report-on-home-visiting-in-the-district-of-columbia/
The Community Partnership for the Prevention of Homelessness; Policy & Programs Team	2018	The Community Partnership for the Prevention of Homelessness; Policy & Programs Team. (2018). <i>2018 Point-in-time count for the District of Columbia continuum of care</i> [PDF document of PowerPoint Slides]. Retrieved from http://www.community-partnership.org/LiteratureRetrieve.aspx?ID=139205

Washington Area Women's Foundation/GW Milken Institute School of Public Health	2018	Vyas, A. N., Wood, S. F., Landry, M. M., Masselink, L. E., Mead, H. K., Ku, L., George Washington University Milken Institute School of Public Health. (2018). <i>District of Columbia Family Planning Community Needs Assessment</i> : for the DC family planning project (DCFPP). Retrieved from https://media.thewomensfoundation.org/wp-content/uploads/2018/09/10202208/WAWF_Report_FamilyPlanning-Assessment_Final_Web.pdf
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In addition, GUCCHD is actively working with DC Health and DBH on several related projects including: a perinatal needs assessment that was funded by the DC City Council to explore the role that racism may play in where and when Black women from Wards 5, 7 & 8 seek prenatal and postpartum care; the implementation and evaluation of one of DC Health’s place-based initiatives (i.e., Resilient Communities, DC or RCDC) as well as the DC SEED evaluation. In addition, the GUCCHD team worked closely to align the data collection for the home visiting system with DC Action for Children and the C-Intake subcommittee of the HV Council to reduce burden on local implementing agencies.

Strengths and Limitations of the MIECHV Needs Assessment

The GUCCHD team led the MIECHV needs assessment in close collaboration with the team at DC Health that oversees the MIECHV program. The plan for the needs assessment was developed based upon experiences the teams had in 2016 piloting the mixed methods approach that was used to collect and analyze the data for this report. The methodology provided by HRSA/UIC formed the foundation for the approach to the identification of communities that could benefit from MIECHV services; and the team was able to capitalize on extant local data as well as a new method for analyzing neighborhood level data to generate a list of areas to focus MIECHV recruitment in. We also believe the addition of the data from the Child Opportunity Index added valuable information that helped to expand our understanding of where eligible families live. The addition of in-depth qualitative data collected from both home visiting programs as well as SUD/MH agencies provided rich contextual data to better understand the DC landscape in which MIECHV is implemented.

As with many aspects of life in 2020, the COVID-19 epidemic disrupted the ability of the GUCCHD team to engage with stakeholders in a meaningful way as planned. The stay-at-home orders required us to cancel planned activities in the selected communities to determine if home visiting was going to be acceptable to eligible families. We also believe that our response rates to the interviews were impacted by the increased needs of impacted communities during the height of the outbreak in DC, which coincided with our recruitment period. While our selection of a common year for the data analysis for the neighborhood identification was a strength, the fact that the most recent year that all dataset could be obtained was 2016 represents a limitation. This is particularly true in light of the rate of gentrification that DC is experiencing.

Despite these limitations, we believe that the data collected and analyzed for this report represent a strong foundation upon which to consider the next five years of MIECHV implementation in DC. And, we offer the following recommendations for consideration by DC Health and the DC home visiting community.

Synthesis and Recommendations

The DC MIECHV program is part of a well-developed home visiting system in Washington DC, which includes a mix of evidence-based and promising practice programs.

- Given the diversity of models and programs, there is a need for a more systematic way to match families' needs and priorities to specific programs. Building on work currently underway, the Help Me Grow program could serve as a centralized intake point for families seeking home visiting services.
- There is also a need for increased guidance, technical assistance and support for programs seeking to scale up evidence-based models as well as build the evidence base for home grown initiatives. This could be an area where the strong partnership with philanthropy could be expanded.

DC MIECHV programs are reaching the intended populations of families with high needs, but home visiting services cannot address all of their issues.

- At the state agency and local program levels, there is a need for more intentional coordination between early education, child welfare, behavioral health and primary care systems. Managed care organizations could provide and/or pay for wraparound case management services to supplement what home visiting programs can offer.
- There is also a need for more coordination and direct referrals from the perinatal care providers and managed care organizations to ensure that women are connected with home visiting services as early as possible.
- Substance abuse and mental health treatment services as well as domestic violence services are often needed by families receiving home visiting services. Formal mechanisms to make referrals and get feedback on participants' connection to those services are needed.

Home visiting programs are in a unique position to help support clients with substance use disorders to get connected with treatment services. Unfortunately, formal screening for current use of legal and illicit substances is not being done, due to current laws in DC about penalties for using substances prenatally as well as stigma and fear of CFSA involvement.

- There is a need to assess the current statutes and regulations to determine how best to support women who may seek SUD treatment while pregnant. If possible, home visiting programs should add a valid SUD screen to their protocols and build partnerships with CSAs who serve perinatal populations.

DC MIECHV, as well as other home visiting programs in DC, continues to see staff turnover and families withdrawing before the programs' end.

- There is a need for a centralized place for professional development and training for home visitors to be organized. With additional funding and support, the DC Home Visiting Council is well positioned to take on this role.
- DC Health should consider the addition of shorter-term home visiting models to the array of MIECHV-funded programs to increase likelihood of program completion. Given turnover, any new models should allow for local capacity-building for training of trainers.

Each home visiting program is reporting data in inconsistent ways, making aggregation difficult. There is no consensus on how to assess quality nor how to measure outcomes.

- The Data subcommittee of the Home Visiting Council should help programs develop systems to report the total number of children and families served (point in time and annually) as well as common metrics for quality and outcomes.

There is a need for additional data on the extent to which families want people in their homes, and whether evidence-based home visiting is what eligible families want and need.

- There is a need for more exploration with “eligible” families that are not currently enrolled in home visiting about the match between their needs and what evidence-based models can offer.
- After COVID-19, there is a need to consider the reach and impact of virtual visits through evidence-based and home grown programs.

As the COVID-19 epidemic continues to impact families across the District, persistent racial and economic disparities continue to undermine the health and well-being of the populations that MIECHV seeks to serve. The challenges faced by the home visiting community are large, but there are strong partnerships and political will to meet these challenges with innovation and action. This needs assessment provides some guidance as DC Health leverages their federal home visiting dollars to help support a continuum of evidence-based services for eligible families.

Dissemination

DC Health will work with GUCCHD to disseminate the key findings through a variety of mechanisms: the evaluation team will do presentations for a variety of stakeholders including, but not limited to the DC Home Visiting Council, where a broad group of cross-sector stakeholders regularly meet to discuss home visiting policy and practice. An expanded executive summary with figures will be distributed widely, and posted on the DC HV Council’s website; in addition, GUCCHD will post the full report and appendices on GUCCHD website. The results will be used to inform the development of the RFA that will distribute the MIECHV funding for October 2021 and will be shared internally within DC Health (e.g., with the Title V team).

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