Utah Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Needs Assessment 2020

October 1, 2020

This Report was produced by the University of Utah Division of Public Health

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Division of Family Health, Office of Early Childhood, Home Visiting Program

(formerly, Utah Department of Health, Division of Family Health and Preparedness, Bureau of Maternal and Child Health, Office of Home Visiting)

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ACKNOWLEDGEMENTS

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To the over 3,000 people who participated in the survey and those who gave their time for a face to face interview, your contributions are important and appreciated. You help give voice to women, children, and families across Utah

- Parents and Caregivers
- Health Services Professionals
- Community Organizations
- Public Health Professionals
- Mental Health Professionals
- Stakeholders and Partners

LIST OF ACRONYMS

ACF:	Administration for Children and Families
ASQ:	Ages and Stages Questionnaire
BBA:	Bipartisan Budget Act
CAPTA:	Child Abuse Prevention and Treatment Act
CBCAP:	Community-Based Child Abuse Prevention
CPS:	Child Protective Services
CSHCN:	Children with Special Health Care Needs
ECCS:	Early Childhood Comprehensive Services
ED:	Emergency Department
EHS:	Early Head Start
FFPSA:	Family First Prevention Services Act
FG:	Focus Group
FY:	Fiscal Year
HPSA:	Health Professional Shortage Area
HRSA:	Health Resources and Services Administration
HV:	Home Visiting
IPV:	Intimate Partner Violence
LIA:	Local Implementing Agency
MCH:	Maternal Child Health
MIECHV:	Maternal, Infant, Early Childhood Home Visiting Program
OHV:	Office of Home Visiting
SUD:	Substance Use Disorder
TANF:	Temporary Assistance for Needy Families
TCM:	Targeted Case Management (Medicaid)
UCA:	Utah Community Action
UDOH:	Utah Department of Health
WIC:	The Special Supplemental Nutrition Program for Women, Infants and Children

LIST OF TABLES

LIST OF FIGURES

[1] Data referenced for 2019 is the most recent data provided by HRSA in January of 2019. This data includes data collected in 2017.
[2] Data referenced for 2012-2016 indicator data utilized HRSA data provided. This data includes data collected between 2012 and 2016.

Table of Contents

I. Summary of the MIECHV Program and Goals

Overview. The national Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV Program) was established in 2010 and is administered by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF). MIECHV grants are made to states and tribal communities to "*deliver effective evidence-based early childhood home visiting programs to pregnant women, expectant fathers, and parents and primary caregivers of young children birth to kindergarten entry in communities identified through statewide needs assessments as being at risk*"[3]. For the purposes of this report "home visiting" is defined as: An evidence-based program designed to meet the needs of pregnant women and families with children under six years of age by improving maternal mental and physical health, supporting positive parenting, preventing child abuse and neglect, and promoting child health, development, and school readiness. By 2018, the MIECHV Program was provided in all 50 states, the District of Columbia, and five U.S. territories[4].

Each awardee has the flexibility to tailor their program to serve the diverse needs of children and families in targeted communities. The program is steered by data obtained through a statewide needs assessment conducted every five years where awardees identify target populations and select home visiting interventions and service models that best meet state, regional, and local level needs.

Utah's Home-Visiting program particularly serves a high-risk population, including ethnic minorities and American Indian and Alaska Native families. According to 2018 data, of the families served by Utah's MIECHV Program:

- 61.2% of households are low income (≥ 185% below the federal poverty level; For a family of four in Utah, the average annual income in 2018 would need to fall below $31,361);
- 38.6% of families have a child identified as having low academic achievement; &
- 18.5% of families have a child with developmental delays or disabilities[4].

Many of the families supported by home visiting are teen or young adult mothers (66% of which are single mothers), many of whom receive some type of public benefits. Home visits are free, last one to one and a half hours, and are conducted at least twice monthly by a 'home visitor' (i.e., a nurse, or health or social service professionals). Home visiting interventions often focus on families who could benefit from additional parenting knowledge, skills, and support. Continuous home visiting promotes the health, mental health, safety, and well-being of children by encouraging the development of parenting capacity, and understanding of the developmental needs of the child. Often, home visitors step in to help address multiple risk factors which may include: familial substance use disorders, child abuse and/or neglect, social isolation and depression, housing and food insecurities, low educational attainment, and unhealthy family

[3] The Maternal, Infant, and Early Childhood Home Visiting Program: Partnering with Parents to Help Children Succeed.
https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf
[4] https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview

relationships. The home visitor serves as a resource to families by identifying community resources helpful to their clientele[5].

Home visiting exists in many forms throughout the state of Utah. The Office of Home Visiting through the Utah Department of Health currently manages both MIECHV and state funding. However, there is not a comprehensive statewide system of home visiting currently, resulting in home visiting programs with other funding sources across the state. Between state and MIECHV funding, the Office of Home Visiting oversaw nine home visiting programs in the 19-20 fiscal year, five of which were funded by MIECHV. The majority of these programs utilize the Parents as Teachers model for evidence-based home visiting, although one state site utilizes the Nurse Family Partnership model. The fragmented home visiting system throughout the state means there is limited data available for programs operated outside of the state system. Programs managed by the state are listed below.

Table 1. Current Programs Operated Through the Office of Home Visiting (FY19-20)

Program Name	Funding Type	Evidence Based Home Visiting Model Used
San Juan County Public Health Department	State	Parents as Teachers
Prevent Child Abuse Utah	MIECHV	Parents as Teachers
Central Utah Public Health Department	State	Parents as Teachers
Salt Lake County Health Department	State	Nurse Family Partnership
Salt Lake County Health Department	MIECHV	Parents as Teachers
Utah Navajo Health Systems	State	Parents as Teachers
Wasatch County Health Department	MIECHV	Parents as Teachers
Utah County Health Department	MIECHV	Parents as Teachers
Southeast Utah Health Department	MIECHV	Parents as Teachers

The Primary Goals of the MIECHV Program. The MIECHV Program documents progress made on a number of goals for children and families living in communities of need including:

1. Improvements in prenatal, newborn, early childhood, and maternal health and mental health;
2. Monitoring of child health and child developmental milestones;
3. Improvements in parenting skills, and the prevention of child injuries and maltreatment;
4. Achieving preschool and elementary school readiness;
5. Completed referrals to existing resources and resulting provision of community services and supports; and
6. Lowering incidence of domestic violence, and criminal behavior.

[5] http://homevisiting.utah.gov/

Nationally, the MIECHV seeks to: 1) strengthen and improve the programs and activities carried out under Title V of the Social Security Act[6]; 2) improve coordination of service provision for identified, at-risk communities; and 3) identify and provide comprehensive services to improve outcomes for eligible families residing in at-risk communities.

The Measurable Objectives of the Utah MIECHV Program. There are numerous measurable outcomes being tracked. These include:

1. Decrease the percent of infants born preterm (before 37 weeks);
2. Increase the percent of that infants breastfed for any amount at six months of age;
3. Screen all primary caregivers enrolled in the program for depression within three months of delivery or within three months after enrollment;
4. Increase the percent of parents who adhere to recommended pediatric wellness visits for infants and children based on the American Academy of Pediatrics criteria;
5. Increase the percent of mothers enrolled during the prenatal time period who later received a postpartum wellness visit with a healthcare provider within 8 weeks after birth of the child;
6. Increase the percent of caregivers enrolled for 3 months who used tobacco or cigarettes at enrollment and were not receiving cessation services are referred to tobacco cessation services;
7. Increase the percent of infants enrolled in the home visiting program who are always positioned to sleep on their backs, without bed-sharing or use of 'soft-bedding' materials;
8. Decrease the percent of children who have parent-reported nonfatal injury-related visits to the ED post enrollment in the home visiting program;
9. Decrease the percent of children enrolled in the home visiting program with at least 1 investigated case of maltreatment since enrollment in the home visiting program;
10. Increase the percent of caregivers enrolled in home visiting who receive an observation of caregiver-child interaction by the home visitor using a validated tool within the child's first program year and annually thereafter;
11. Increase the percent of parent(s) enrolled who reported that during a typical week, s/he read, told stories, and/or sang songs with their child daily, every day;
12. Increase the percent of children enrolled in home visiting who receive a timely screening for developmental delays (using the ASQ-3 Screening Tool);
13. Decrease the percent of visits where primary caregivers enrolled in home visiting report having concerns regarding their child's development, behavior, or learning;
14. Increase the percent of primary child caregivers enrolled in home visiting who are screened for intimate partner violence (IPV);
15. Increase the percent of primary caregivers who enrolled without obtainment of a high school degree (or equivalent) who subsequently enrolled in, maintained continuous enrollment in, or completed high school or the equivalent while receiving home visiting services;
16. Increase the percent of enrolled families who have continuous insurance coverage;
17. For those caregivers who screen positive for depression, increase the percent of caregivers referred to mental health services;

[6] https://www.ssa.gov/OP_Home/ssact/title05/0500.htm

18. Increase the percent of children enrolled in home visiting who receive appropriate services in a timely manner in those who have had positive screens for developmental delays; and
19. Increase percent of primary caregivers enrolled in home visiting who receive referral information to IPV services when there is a positive screen for IPV.

What Happens During a Home Visit? Home-visiting sessions are about an hour-long, held twice per month and are scheduled at the convenience of mothers and family members. Agendas in these visits are typically flexible and can often begin with a status update from the mother before moving into the content planned for the day. The remaining time is then used for a variety of activities such as asking/answering questions, goal-setting and education, child health and development skills, as well as parental empowerment and feedback. Participants in the HV Program were in agreement that the sessions focused heavily on parenting education and provided opportunities about how to find support and navigate the system to obtain available community resources.

Outside of the meetings, participants expressed ability to easily communicate with their home-visitor through phone calls and text messaging. Some participants expressed having weekly contact with their home visitor while others stated preference to wait until their scheduled meetings. Many participants initiated conversations with their home visitor by texting questions or leaving voice mail questions, and would receive same day or next day responses from the home visitor staff. Participants also said it was common for home visitors to initiate communication by occasionally checking in on them, or providing text reminders of events taking place, or reminders of upcoming appointments. Some participants expressed how they relied on the home visitor for weekly emotional support, and how they felt their home visitor was more of a family member than professional staff.

Home visitors were viewed as gatekeepers in connecting HV participants to needed community resources. Some participants expressed being given resources to help find financial aid for education, referrals to help address housing and food insecurities, mental health services, and Medicaid. Many participants reported being given information for community health fairs in their area and were encouraged to attend. Participants also mentioned they were given information about 'Parent Connections', an opportunity to connect with other parents as a source of social support, typically held once monthly. Many of the resources provided to HV participants were through text messaging with internet links while others reported receiving flyers/pamphlets.

For several participants, the sense of friendship and trust in their home-visitor was a highly valued aspect of their experience. Participants described their home visitors as a non-judgmental resource who provided education and support for them for a variety of subjects important in life. Participants talked about the home visits as being a highlight in their week, and visits were viewed as something they looked forward to. For many, the home visits reduced feelings of being lost and overwhelmed. Many participants stressed the importance of their personal connection with their home visitor as one of the most important aspects of their experience. Home visitors were seen as using a holistic approach while making the emotional/mental health

connection and overall wellness was routinely assessed. Participants valued how the HV Program also welcomed other family members including the child's father as part of the process.

Table 2. Quotes from Home Visiting Program Participants About What Happens During a Home Visit
"They kind of have the same pattern. As soon as she comes in, she asks how we are and how we've been doing since we've last seen each other. And then we always start off with a book so we can read together. It's always a different kind of book, kind of like topics that we were going to do that day. For example, one of them we were focusing on different textures so she brought a texture book that he can feel, that he can have fun with."
"I would have to agree as well with receiving a lot of support. I already have enough support from my mom and my sister, but home visitor is an extra support too. When I have any questions and my mom doesn't know, she (home visitor) always gives me links as well or brings me papers. When she comes to visit, she'll ask how I'm feeling. She's very caring. She cares for my daughter, too. A few weeks back, she brought her little toys, like cups to play with. I liked that."
"I would have to agree with support and resources. I can mention something and say, "Hey, I'm having trouble with FAFSA, I'm having trouble with Medicaid," and she'll get down to the bottom of this and say, "Hey, this is why you've been having trouble", or things like that, and again, sending links, sending YouTube videos, anything on just a simple question – it's a lot of information, not just a simple answer. It's a whole list of things you can try."
"I was like, sometimes it's hard to keep up on myself or housework, but I knew my home visitor was going to come over so I was like, I'm going to get ready, we're going to get the house picked up. And then, it was just something to look forward to, to fill the time before the kids went down for a nap."

II. Purpose of the Statewide Needs Assessment

Requirements. The Bipartisan Budget Act (BBA) of 2018 extended federal funding for the Maternal Infant Early Childhood Home Visiting Program through FY 2022 and requires all states to conduct a "statewide needs assessment." The Legislation mandates this needs assessment update as a condition of receiving Title V Maternal and Child Health (MCH) Block Grant funding. This MIECHV needs assessment is required once every five years.

Within this assessment, federal statutory requirements identify at-risk communities (at the county-level) using the following indicators:

1. premature birth;
2. low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;
3. poverty rates;
4. crime rates;
5. domestic violence rates;
6. rates of high-school drop-outs;
7. substance abuse rates;
8. unemployment; and
9. child maltreatment[7].

[7] A Guide to Conducting the Maternal, Infant, and Early Childhood Home Visiting Program Statewide Needs Assessment Update.

Other requirements include assessments of services quality and capacity of existing services, including such services as: home visiting programs and substance use disorder abuse treatment and counseling services. The needs assessment should incorporate findings from the Title V MCH Block Grant assessments, Head Start assessments, and Child Abuse Prevention and Treatment Act (CAPTA) recent needs assessments. HRSA recommends grantees use a methodology of using nationally available data so that cross-state comparisons can be made.

Methodology. Utah's method employs a 'simplified method' based on indices of risk in five domain areas. This statewide needs assessment update examines population trends, identifies areas of increasing or decreasing risk, and outlines resources to support families in high need communities. Based on the data collected, this update should guide strategic decision making among MIECHV awardees and their key stakeholders and identify opportunities for inter-organizational collaboration to strengthen and expand services for at-risk families.

The needs assessment is required to identify high risk communities (i.e., counties) based on an epidemiologic profile in the five domain areas: low socioeconomic status, adverse perinatal outcomes, child maltreatment, crime, and substance use disorder, based on nationally available county-level data. Indicators in each of these five domain areas align with the characteristics described in federal statute, Social Security Act, Title V §511(b)(1)(A) to identify communities with concentrations of risk.

Purpose of the Needs Assessment. Beyond the statutory mandate, the overall purpose of our MIECHV statewide needs assessment is to determine the extent to which service needs are met, or unmet, and to identify programmatic strengths and weaknesses. Our assessment findings provide evidence on met and unmet needs. Our recommendations provide guidance to ensure the Office of Home Visiting can set forth its five- year strategic plan to most effectively meet the identified needs of parents, children, and families within priority high risk communities serviced by future MIECHV funding.

This update provides guidance to plan for the following:

1. To identify existing service quality and capacity, population trends, and projected needed services within at-risk communities for the time period of 2020-2025;
2. To provide recommendations and guidance to support statewide planning for a continuum of services;
3. To inform stakeholders about unmet needs for home visiting and other services and resources needed in high risk communities;
4. To identify opportunities for inter-organizational collaboration with state & local partners for the purposes of strengthen coordination of referral networks, community resources, and early childhood service systems; and
5. To provide the evidence needed so that the Utah Office of Home Visiting can make informed, data driven strategic decision-making including funding allocations for counties in need.

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https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/needs-assessment-guide.pdf

Various qualitative methodologies were used (i.e., key informant interviews; in person and teleconferenced focus groups; regional stakeholder meetings) to determine:

1. Perceptions of stakeholders (i.e. professional staff and program participants) about met and unmet needs of their high-risk communities;
2. Assessments of the quality and capacity of evidence-based services for high-risk families, and based on this assessment, identify new promising approaches needed (if any);
3. Perceptions of current and changing trends in needed programs and services;
4. Identify types of increasing/decreasing risk behaviors within at-risk communities;
5. Provide the data to inform public and private stakeholders about top priority areas, quality of existing services, capacity, met and unmet need for the purposes of informed strategic decision-making and planning for the next five years; and
6. Identify pathways for inter-organizational collaboration to enhance home visiting service delivery and improve referral networks and coordination of services and resources within at-risk communities.

III. Methods

A. Analyses of the Quantitative Datasets.

The results of the update should provide data findings to inform strategic decision making for the MIECHV program and our stakeholders, assess opportunities for collaboration, and to strengthen and expand services for at-risk families. Per HRSA guidance, this update should be used as guidance, and not be construed as justification for moving MIECHV-funded home visiting programs, or defunding or disrupting programs within lower need counties. HRSA recognizes the need for flexibility for states to identify at-risk communities through a variety of methods. HRSA identifies the following indicators to be included in the analyses:

Table 3. HRSA Identified Indicators

Indicator	Measurement
Unemployment	percent during 2017
High school dropout	percent of 16-19 year olds with no high school diploma in 2017, and within the last five years (2013-2017)
Income inequality	measured by a Gini index[8] that expresses inequality in county-level median annual income across all counties
Preterm birth	percent of live births < 37 weeks gestation during 2013-2017
Low birth weight	percent of live births < 2,500 grams during 2013-2017
Alcohol abuse	prevalence rate in 2012-2014 of self-reported binge use in past month
Marijuana use	prevalence rate in 2014-2016 of self-reported use in past month
Pain relievers	prevalence rate of 2012-2014 self-reported nonmedical use of pain medication in past year

[8] Gini index is a measure of statistical dispersion intended to represent income inequality or wealth inequality.

Crime reports	ratio of number of reported crimes per 1,000 residents in county
Juvenile arrests	ratio of number of arrests in minors per 100,000 minors living in county during 2016
Child maltreatment	rate of minor victims per 1,000 child (ages < 18) residents in county during 2016)

Simplified Method. When using the HRSA-developed "simplified method", the values for the above risk indicators are converted into standardized indicator values (Z scores) for each county in Utah. Typically, a Z score is considered to be significantly different when the given indicator value (i.e., percent; rate) is at least two standard deviations above the average value of that indicator for all counties in the state. However, HRSA recommends counties to be assessed as "at risk" when the indicator value is greater than one standard deviation different (i.e., lowest 16%) in relation to the overall statewide mean. Tallies are conducted for each 'at risk' value for each county. Counties that have two or more indicators that fall into the 'at risk' classification are considered counties at highest risk. The raw data tables, and Z score calculations can be found in Appendix A, respectively.

B. Qualitative Approaches to Primary Data Collection

The MIECHV program seeks to mitigate familial risk factors and improve outcomes for prenatal, maternal, newborn, and early childhood health (up until age 6) for families living in high risk communities. The qualitative component of this needs assessment had multiple goals:

1. To determine the impact, the home visiting program had on participant's lives;
2. To determine how they learned about the HV Program;
3. The frequency of face to face home visits, and other forms of contacts participants had with their home visitor;
4. What HV participants' perceptions were regarding strengths of the Home Visiting Program (i.e., Parents as Teachers; Nurse Family Partnership);
5. What HV participants' perceptions were regarding weaknesses of the Home Visiting Program; and
6. What recommendations do HV participants have to improve the Home Visiting Program.

Participants and Recruitment. Participants were recruited through two OHV-funded local implementing agencies. Individuals enrolled in these programs were invited to participate in the focus groups (FG). An initial email was sent with follow-up reminder emails that provided participants the FG information (i.e., location, time, purpose) with an attached consent form to be completed and brought to the FG meetings. Consent forms were also made available at the FG location in cases where the consent form was not completed by participants at home. Participants were informed of a $20 gift card for participating, and had the choice of three different types of stores. Gift cards were given to participants during the initial moments of the FG. Participants agreed to keeping all information shared in the FG confidential. Parents were allowed to bring their children to the FG and had the option of accessing on-site child care, or bringing their child to the FG. The majority of parents opted for child-care of their toddlers, and brought their infants to the FG.

Focus Group Procedures. There were two focus groups held: one in Salt Lake City (Salt Lake County) in person and one virtually, in Ogden (Weber County) Due to the COVID-19 pandemic

restrictions, the Ogden FG was held as a teleconference meeting using the Skype platform, and through phone interviews. Initially, participants and facilitators engaged in an ice breaker about "something their child does really well". A FG process guide with the six questions to be asked (see Appendix B) was used by the FG facilitator to accomplish the qualitative goals stated above. It is important to note that the first two questions were added to the Ogden FG to gather additional information from participants on initial program awareness, and the amount of and types of services participants were receiving from their home visitor. Key questions covered perceptions of HV program strengths, weaknesses, and recommendations. Participants were also asked how their lives would be different if they were not enrolled in the HV program.

The Participants. A total of 12 participants provided information in the focus groups. The Salt Lake City FG consisted of eight participants while the Ogden FG consisted of four participants. There were some technical difficulties participants had with attending the scheduled Skype call for the Ogden focus group. As a result, two of the four participants provided their information in the Skype teleconference call, while the remaining two participants participated individually in a phone-based interview. All participants received the same questions. All FG participants were currently enrolled in the HV Program.

Audio Recording. After consent forms were collected, the audio recording was started and was maintained for the duration of the FG. While the facilitator and fellow participants called each other by their first names throughout the FG, all identifying information was removed from the audio transcription. The recordings were transcribed into Microsoft Word. Once transcribed, these Microsoft Word transcripts were uploaded into a qualitative analytic software 'Dedoose' for coding and data analyses.

Data Analyses. Thematic Analysis (TA) was used to analyze the qualitative data collected in the interviews. TA provides accessible and systematic procedures for generating codes and themes from qualitative data. The primary purpose of TA are to summarize the qualitative content, with a focus on examining themes or patterns of meaning within data. This method emphasizes both organization and rich description of the data set with a theoretically informed interpretation of meaning. Thematic analysis goes beyond simply counting phrases or words in a text (common in content analysis) by exploring explicit and implicit meanings within the data. Coding is the primary process for developing themes by identifying items of analytic interest in the data and tagging these with a coding label[9]. In the TA approach, the research question is not fixed and can evolve based on coding and theme development throughout. A coding scheme was developed in a manner for which the specific themes, ideas, and issues relevant to the questions presented in the FG. A hierarchical approach to grouping these specific codes into broader sub-themes and themes was undertaken jointly by the authors.

Limitations of the Needs Assessment Study. There were some limitations with this needs assessment. With the COVID-19 pandemic, in-person focus groups were shifted to a video-conferencing approach resulting in lower interest in participation. Given the limited number of HV program participants who were able to attend the teleconference (Skype) based format, we had a small sample size with only 12 participants. For those who wished to participate, about half

[9] Clarke, V., & Braun, V. (2017). Thematic analysis. *Journal of Positive Psychology*, *12*(3), 297–298. https://doi.org/10.1080/17439760.2016.1262613

experienced technical difficulties in attempting to enter the meeting. As a consequence, eight HV participants expressed interest, with only two completing the virtual Ogden focus group and another two opting for separate telephone interviews.

Anonymity of participants is important to maintain when conducting quantitative and qualitative research. Given the small sample, providing additional demographic information of the focus group members could potentially indirectly identify participants. Thus, cross tabulations with the qualitative themes by demographic characteristics was not possible.

IV. Results

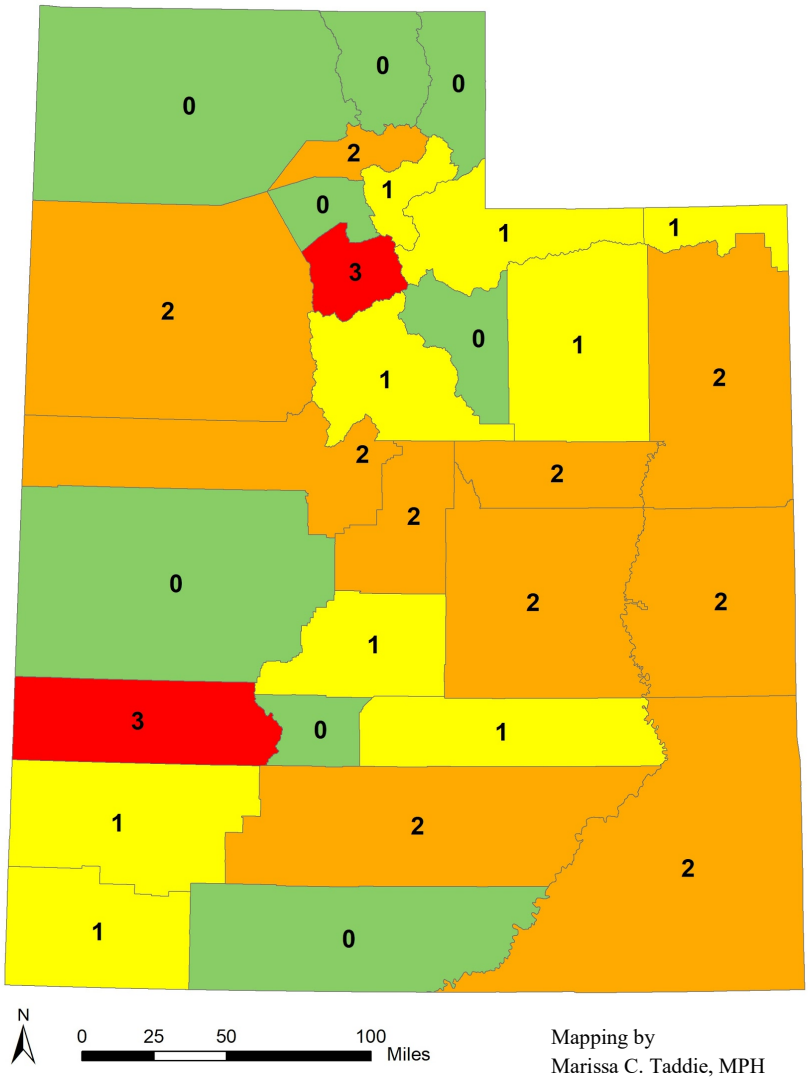
A. Counties with Concentrations of Risk.

At risk communities are identified in the following heat map. The heat map[10] identifies counties in the lowest 16% of z-score calculations (see Appendix A) based on the following risk factors:

1. Premature birth
2. Low birth-weight (infants)
3. Infant mortality
4. Poverty
5. Income inequality
6. Crime
7. Domestic Violence
8. High rates of high school dropouts
9. Substance use
10. Unemployment
11. Child maltreatment

Figure 1

Number of HRSA At Risk Domains Across Multiple Years (2014-2019)



[10] The indicator numbers on the heat map are an average (i.e., 2.5 = 3) of the two HRSA county indicator data sets (2012-2016 and 2019). Given, Utah is the 4th fastest growing state (in terms of population, and some of our counties are in the top 10 nationally in terms of population growth), the 2019 (most recent) data is equally weighted to the 2012-2016 (4 to 8-year-old data). This average takes into account the ongoing risk factors, but also factors in the most recent risk factor data of 2019.

B. Quality and Capacity of Utah's Early Childhood Home Visiting Program

Home Visiting Personnel. Home visiting programs hire personnel based on needs specific to the program implemented. Some home visiting models require that all home visiting personnel be registered nurses, while other models require a high school degree, or have no restrictions on prior education or experience. Programs will often require a minimum of a bachelor's degree or experience in social work or nursing, as a requirement to assist with retention of staff.

Personnel are sometimes restricted based on funding requirements, such as the funding appropriated by the Utah State Legislature, mandating that funds be utilized for Nurse Home Visiting programs.

Home visitor attrition rates are limited to data for programs supported by the Office of Home Visiting. Data available was limited and attrition rates were calculated based on vacant versus filled positions annually. Attrition rates averaged between 22% and 25% during the 2016 and 2017 program years. However, these rates were impacted by program closures due to loss of funding. Attrition rates during the 2019-2020 program year were 14%, which were impacted by staff reducing hours or leaving their jobs due to COVID-19.

Upon hiring, staff are required by each home visiting model to complete specific training. However, this training ranges from program to program, and model to model. Once hired, many programs focus on a combination of reflective supervision and professional development opportunities to assist with personnel retention. Professional development opportunities range from state-wide training, model-trainings, national trainings, and primarily focus on free opportunities for staff.

Utah's unemployment rates have been on a steady decline since the 2010 recession, when it hit a high of 8.0% unemployment rate[11]. In July 2019, unemployment rates in Utah dropped to a 12-year low of 2.8%, compared to a 3.7% national rate, the fifth lowest unemployment rate in the country. Utah's unemployment rate had dropped to 2.5% in February 2020, prior to COVID-19 impacting jobs. Unemployment rates in Utah rates reached a high of 10.4% in April 2020 in the height of the COVID-19 pandemic. By July 2020, Utah's unemployment rate had dropped back down to 4.5%[12], compared to 10.2% nationally[13].

Program Information. Utah currently has over 30 broad-range home visiting programs, ranging from evidence-based high-touch programs to lighter-touch programs that target specific-needs for families. Utah does not have a universal home visiting program, resulting in silos and various types of programs throughout the state. Due to a lack of infrastructure, detailed information on the number and level of participation in individual programs is limited. Programs include: Early Head Start, Family Spirit, Healthy Families America, Nurse Family Partnership, Parents as Teachers, Welcome Baby, Targeted Case Management (Medicaid), and other individually developed models such as a Family Mentoring model.

[11] https://www.bls.gov/news.release/laus.htm
[12] https://www.bls.gov/eag/eag.ut.htm
[13] State Employment and Unemployment- August 2020. https://www.bls.gov/news.release/pdf/laus.pdf

Implementation of home visiting models range from short-visits targeting specific individualized supports to continued supports with weekly to monthly visits for a period of several months or years. Implementation of programs also varies from programs that adhere to model-fidelity requirements and implement an evidence-based home visiting model such as Parents as Teachers or Nurse Family Partnership, to those who implement components of models or develop individualized models for their communities.

The Office of Home Visiting has limited access to numbers served outside of home visiting programs funded through the Office of Home Visiting. Between 2013 and 2019, there were over 3,900 families served by home visiting programs supported by OHV - with numbers served ranging between 418 and over 1,184 families per program year, with an average of 653 families served annually. This variance was due to increases and decreases in funding availability for evidence-based home visiting programs in Utah. Currently, OHV has the capacity to serve 670 families annually among all HV programs. These programs are supported with federal (86%) and state (14%) funds.

Coordination. Utah has a developing early-childhood system, as shown by the establishment of the Governor's Early Childhood Commission during the 2019 Utah legislative session. The purpose of the Early Childhood Commission is to: 1) Support Utah parents and families by providing comprehensive and accurate information regarding the availability of services for children ages six and younger; 2) Facilitate improved coordination between state agencies and community partners that provide early childhood service; 3) Share and analyze information regarding early childhood issues in the state; 4) Develop and coordinate a comprehensive delivery system of services in the areas of family support and safety; health and development; early learning; and economic development; and 5) Identify opportunities for, and barriers to, the alignment of standards, rules, policies, and procedures across programs and agencies that support children in early childhood.

The Governor's Early Childhood Commission is supported by the Early Childhood Advisory Council, composed of members from private and public early childhood agencies and programs throughout the state of Utah. The Early Childhood Advisory Council makes recommendations to the Early Childhood Commission on how to develop and support early childhood systems in Utah. Home Visiting program administrators, such as the Utah Office of Home Visiting, Head Start, and the Division of Children and Family Services, as well as some non-profit home visiting service providers, such as The Children's Service Society, act as voting members on the Early Childhood Advisory Council. These program administrators represent a voice for home visiting at the state level in early childhood coordinated systems.

Additional public and legislative support for evidence-based home visiting was demonstrated by the Utah State legislature during the 2018 legislative session when $520,000 in ongoing state funds were designated to support evidence-based early childhood home visiting programs. These funds were originally restricted in a pay-for-outcomes legislation that was amended in 2019 to allow for funds to be utilized for direct-services for home visiting in Utah.

Utah Demographics. As of 2019, Utah has 3,205,958 residents. Utah has the youngest median age (31.0) of all states in the US, with 8% of residents being under the age of five years.

Regarding race, Utahns are 85.7% White, 2.4% Asian, 1.3% Black/African American, 1.1% American Indian/Alaska Native, and 0.9% Native Hawaiian/Pacific Islander. Another 8.6% report as being an 'other race', or 'two or more races'. Of these races reported, 14.2% of those living in Utah identified as Hispanic or Latino. Utah counties with the highest percentage of Hispanic or Latino residents include Salt Lake (18.8%) and Weber (18.7%) Counties. San Juan County has the highest percentage American Indian/Alaska Native residents (49.0%) followed by Uintah County (7.9%).

During the last five years (2015-2019), Utahns without health insurance has ranged from a high of 10.5% (in 2015) to a low of 8.8% (in 2016). Utah is a well-educated state, with 92.5% of residents having received a high school diploma or higher. A little over one-third of adults (over 25 years of age) (34.8%) have obtained a Bachelor's degree, or graduate/professional degree. Utah's median annual household income is relatively high at $71,414; however, household median income in rural counties, such as San Juan ($44,680), Wayne ($44,694), Piute ($39,440), and Iron Counties ($46,809) are substantially lower. Overall, the Utahn poverty rate (9.5%) for children under 18 years of age is lower than the average poverty rate for the US (18.0%). Utah counties with the highest poverty rates are San Juan (22.6%), Piute (18.6%), and Sanpete (14.6%) counties[14].

Family Demographics. The MIECHV home visiting programs serve a diverse population throughout the state of Utah. Family demographic information was obtained for MIECHV-funded participants through July 2020 for the 19-20 fiscal year. The total number of MIECHV-funded families served in this time frame was 575. However, the number of families may vary between different measures due to missing data. The majority of caregivers were women between ages 25-29, and the majority of children served were between ages 0-2 years old. Of the 624 children served through July of 2020, 78.2% were White and 50% of children served were Hispanic or Latinx. MIECHV tracks a multitude of priority characteristics of families, to ensure that services are being provided to those with the greatest need. Priority characteristics include: low income, a mother who is younger than 21 years old, children who are experiencing abuse or neglect, substance use, tobacco use, not achieving a high school diploma or equivalency, having a child with a disability, and military families. The majority of families served through July of the 19-20 fiscal year had between zero and two risk factors as determined by intake evaluations. Often, when a family is showing zero risk factors in data reports it is due to missing data, meaning that many of these families are likely experiencing more risk factors than

Table 4. Home Visiting Home Visiting Households Sorted by Number of Priority Characteristics[15]

# of Priority Characteristics	# of Households	% of Households
0	163	28.3%
1	181	31.5%
2	144	25.0%
3	60	10.4%
4	17	3.0%
5	n<10	-
6	n<10	-
Total	575	100%

[14] https://www.census.gov/quickfacts/fact/table/UT/PST045219

[15] N<10 was used in cases where the number of households was too small to include

demonstrated here. A greater breakdown on the number of households sorted by priority characteristics can be found in Table 4.

Program Recruitment and Waiting Lists. MIECHV and state-funded home visiting programs have a handful of strategies to recruit families to participate in home visiting services, the most common strategy being a close partnership with WIC clinics. While the need for home visiting is great, outreach and marketing strategies to reach families who could benefit from home visiting services are still in development. COVID-19 poses a unique challenge for recruitment, which home visiting programs are still navigating.

Program eligibility requirements, based on funding and program requirements, dictate the number of families enrolled in home visiting programs. When funding for home visiting was consistent and programs were well established, programs maintained waiting lists with dozens of families. Programs prioritized enrollment of new families based on federally established priority requirements. However, with changes in funding and implementing agencies, waiting lists for OHV-supported programs have shifted. Currently, programs are still building capacity and do not have waiting lists. One factor that impacts waiting lists and enrollment numbers is lack of knowledge of the home visiting program in the community.

Cultural and Language Needs of Families. The majority of households in MIECHV home visiting programs speak English (59.1%), with Spanish being the next most popular language (32.9%). 8% of families served in the MIECHV home visiting programs speak a variety of other languages. These findings are summarized in Table 5.

Table 5. Languages spoken by household in MIECHV programs

Language	Number of Households	% of Households
English	340	59.1%
Spanish	189	32.9%
Other	46	8%
Total	575	100%

Enrollment in Alternative Early Childhood Programs. Home Visiting programs supported by the Office of Home Visiting collaborate locally with other early childhood programs, such as Help Me Grow Utah and Baby Watch Early Intervention. Home visitors will often refer to alternative early childhood programs to address specific needs of families or as they transition out of the home visiting program. Alternative early childhood programs that help address alternative or continuing needs for families is essential to the success of the program and the families enrolled. However, some programs have wait lists, do not provide services in needed areas, or are not accessible to all families.

Family Attrition Rates. As of July of 2020, the attrition rate among families (% of families exited the program before completion) served by MIECHV home visiting programs was 13.9%. MIECHV-funded family engagement by household for the 2019-2020 fiscal year is listed below (Table 6).

Table 6. Family Engagement Status by Household[16]		
Engagement Type	**# of Households**	**% of Households**
Currently Receiving Services	430	74.8%
Completed Program	36	6.3%
Stopped Services Before Completion	80	13.9%
Other	29	5.0%
Total	575	100.0%

Addressing Indicators of High Need. MIECHV funded home visiting programs in Utah currently use the Parents as Teachers model in delivering high quality home visiting services to families. Research results from the Parents as Teachers model show:

1. Children's developmental delays and health problems are detected early
2. Children enter kindergarten ready to learn and the achievement gap is narrowed
3. Children achieve school success into the elementary grades
4. Parents improve their parenting knowledge and skills
5. Parents are more involved in their children's schooling
6. Families are more likely to promote children's language and literacy
7. Child abuse and neglect is prevented

Education from the model along with the early childhood systems of care focus on assessments for children and help to improve outcomes for families at-risk. Each home visiting site recruits and enrolls families using specific criteria of high risk set forth by the grant funder. In using specific criteria to enroll families that have high risk factors and using a model that has shown to improve families' outcomes using an evidenced based model are ways that home visiting is improving the lives of at-risk children and caregivers in Utah.

Non-MIECHV funded home visiting programs in Utah utilize indicators of high need that are specific to the evidence-based model utilized by the program. These follow the guidelines of the various programs, and include many of the same factors as the MIECHV funded home visiting programs.

Gaps in Early Childhood Home Visitation in Utah. Gaps in early childhood home visitation in Utah were identified primarily through focus groups conducted. Gaps in home visiting primarily stemmed from lack of or non-sustainable funding and awareness of the home visiting program.

Decreasing Funding. With the award of a competitive federal MIECHV grant, Utah saw an influx of funding in 2014, which led to several new sites awarded contracts to provide home visiting services throughout the state of Utah. In addition, federal Temporary Assistance for Needy Families (TANF) funds were dedicated to provide home visiting services, passed-through the Office of Home Visiting. When both TANF and competitive MIECHV funds were no longer

[16] "Other" refers to families that are missing data or did not fall into one of the other categories.

available, many home visiting sites lost funding and had to shut down programs. While programs continue to be supported by programs such as MIECHV, Early Childhood Comprehensive Services (ECCS), and Community-Based Child Abuse Prevention (CBCAP), federal funds for home visiting have been limited and may be in jeopardy in the future. Additional funds, such as the Family First Prevention Services Act (FFPSA) provide funding for evidence-based home visiting models. In Utah, OHV has been working closely with the state Division of Child and Family Services to identify how to braid federal funds and utilize FFPSA funding for home visits. As of this report, these funds have not yet been utilized for home visiting services.

In addition to fluctuations in federal funding, Utah has limited state funds dedicated to evidence-based home visiting programs. During the 2018 legislative session, Utah passed Senate Bill 161, dedicating $520,000 in state funds to evidence-based nurse home visiting. These funds were dedicated to a pay-for-outcomes program in 2018, and were re-allocated to direct evidence-based home visiting services during the 2019 legislative session.

Awareness and Perceptions of Home Visiting. During the initial stages of becoming aware of the HV Program, FG participants had mixed perceptions and concerns about the HV Program. Some were more trusting, and thought it would be nice to have extra help. Others had significant reservations, and upon reflecting back, could have easily rejected participation due their concerns. Some participants thought the HV Program involved very formal visits that only addressed the needs of the child. Some also thought it would be more health focused and not a program with comprehensive services. Most participants did not understand the full details of the HV Program, and often filled-in their gaps of understanding with their own ideas of what they thought the program was.

One participant discussed how she was told the program was a community-based non-profit with a hidden agenda to help reduce negative feelings people had toward the government. Other participants were concerned their home visitor would judge them and/or serve as a spy for the government. A common theme was fears about having their child taken away due to poor parenting, and beliefs that the program was similar to Child Protective Services (CPS). For some, initial

Table 7. Quotes from HV Focus Group Program Participants About Initial Perceptions of the HV Program

"So, they told me about it – I think it was because I was a teen mom, just telling me if I needed any other resources, anyone – I could have someone come into my house and visit me, and just ask any questions, make sure everything's okay. And so, I just took that as extra help, and when they told me about it, I was like, "Yeah, sign me up. I need all the help I can get."
"At first, when I started coming over, I would be kind of scared. "Oh my goodness, if I say this, will she call CPS? Will they get my kid taken away?" But, I realized if I told her something that I was really scared about or something, she would guide me in the right way and tell me what to do. So then, I realized it wasn't anything like that."
"I would say the only reason why I would have said no is probably because it – I would have just said, "No, I just don't have time" before knowing about the flexibility. So, if it was presented that it would run on my time, I would have said yes, but if not, I would have been like, "No…. just no time."
"But it was like I was skeptical just for a little bit because I was like, "I don't want to sign up for something extra," or I didn't know if I was going to have to pay. Or just as a shy person, I was like, "I don't know. I'm not really into reaching out to people." I was just skeptical at first."

concerns included fear/anxiety about their child being taken away due to their citizenship status. Participants were also concerned about how much time commitment the program would require, and didn't understand the degree of program flexibility. There was a lack of clarity about program costs. Some participants also felt like the program was probably unnecessary for them given they had support from their friends and family in raising their child. Others felt intimidated, shy, and were ambivalent about reaching out for help.

Table 8. Quotes from HV Program Participants About How They were Referred to the HV Program
"We found out through WIC. They asked us if we wanted to be part of a program and they explained it a little to us, and they put us in contact with the coordinator person."
"I think I got a paper, like a little flyer, and then I think I had a call screening, and then set up a day she could come to my house, and then she came to my house, and we set up a nurse and stuff. But, yeah, it was - I think it was really organized for the way I found out".
"My friend. She goes to them, too. So that's how"
" *think just how you - are advertising the program - I feel maybe expanding that a little bit more, and not just through WIC, because I feel like a lot of people don't do WIC because they think people will judge them at the store when they go get the things they need for their baby, so maybe at a community clinics, like when there's either a teen mom or young mom, or just any mom, having flyers there, offering a flyer - "Hey , if you're interested, here's a little bit of information on this program."*
"You get so many solicited sales calls, like business programs that people are trying to sign you up for. It's like, you need a good way to cut through that so they realize that this is something real, and part of that was I'd never heard of anything like that before."

Sources of Referral to the HV Program. Most participants found out about the MIECHV-funded HV program through staff from the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). For these participants, they were completely unaware of the HV program and what it had to offer. Some indicated they found out about the HV program through flyers given to them at a hospital or health clinic. 'Word of mouth' was a common theme, with participants indicating friends, family members and neighbors being the referral source.

Participants recommended that the HV program be more effectively advertised and explained in more detail not only by WIC staff but also by staff at community clinics and alternative schools. Participants had many recommendations addressing how the recruitment process could be more effective, and how to improve perceptions and understanding about what the HV program was about and how to go about enrolling.

Barriers to Home Visiting

Barriers to Access. Utahns' access to the various home visiting programs in the state is marked by two main issues that came up amongst the key informant interviews – cultural competency for non-English speaking families and the issue of families not knowing the eligibility requirements of the programs.

As reported by one home visitor interviewee, approximately two to five percent of their program's home visiting population are refugee clients, notably Nepali refugees, but it would be helpful to also include families from Africa, the Middle East, and Eastern Europe. Additionally, the Spanish-speaking population in Utah has been identified as an important demographic to

reach. Despite the variation in cultures, the need from these two specific populations is the same – culturally competent and appropriate home visiting resources.

When asked about the needs of Spanish-speaking families in home visiting programs, one interviewee said, "…we do serve them, but they're usually not programs that translate well. We have a few native speakers in Spanish that are in our programs. Culturally, I think we've looked at adding some, more diverse home visitors since they're more diverse populations."

The accessibility of home visiting is dramatically affected by the lack of knowledge among families of the eligibility requirements and how to enroll in the service. Several interviewees mention the difficulty reaching the highest risk individuals and families and the result of "sorely" lacking in attracting those people. "…we only see a tiny fraction of what we could see in Salt Lake County," said one interviewee. "Probably less than 10% of eligible clients, even at the poverty rate."

Funding Stability Barriers. By far, the most cited need in all of the key informant interviews in regard to home visiting programs is the amount, duration, and stability of funding. While this is no surprise and is difficult, if not impossible to solve, there are two main areas related to funding that can be addressed in the future of home visiting. First, many interviewees cited the devastation of having funding for the Nurse Family Partnership program and then seeing the funding disappear after only a couple of years. While federal funding is indeed volatile, the lesson that can be gleaned is to prioritize long-term funding. One interviewee said that the closure of the home visiting program caused confusion and mistrust of the program and the organization.

However, perhaps the best issue to consider in regard to the funding of home visiting programs is how to most effectively use the limited budget. For that, researchers looked into the other thematic areas that are cited among the key informants. Because the need for cultural competence and bilingual home visitors was cited multiple times, perhaps the focus of future funding would be wisely spent on acquiring culturally competent visitors or training those who are already involved. Additionally, reaching out to rural areas where specific issues including mental health and maternal smoking are more common and are under-addressed.

Coordination of Care and Services Barriers. Home visiting programs are most often described as a linkage resource for families to other programs and resources including: WIC, Welcome Baby, Catholic Community Services, Department of Workforce Services, DDI (Discover, Develop, Impact) Vantage, YMCA, Head Start, and others. One home visitor said in regard to the ability to link families to resources, "The research is behind the value of home visits and what it can mean for the trajectory of a child if you can identify some things early and help them, get them to resources."

Another interviewee discussed the link that home visiting programs can provide to empower families and help them understand the value in taking ownership of their lives. She mentions the benefit of helping these families understand what resources they and their children need and how to seek answers to the questions that they have. Additionally, they mention the need for continuing assessment in this domain and the need to have "more conversations with our

providers, more conversations with parents to understand what are the gaps that we… still aren't seeing."

Parenting and Reproductive Health Barriers. Home visiting is arguably one of the most valuable resources for expecting and new parents in Utah. "There's a lot of baby making going on," says one interviewee, "but I don't know if everybody knows what's healthy and what's not… We get to talk about those things as home visitors." Some informants mentioned the state's restrictive laws on sexual education and family planning, citing home visiting as one way to reach the lowest income families and educate them on those topics as well as maternal health.

Starting from conception, one interviewee would like to reach expecting mothers to educate them on how to keep themselves and their fetuses healthy for the best outcomes. "Prenatal care all the way through adolescence is how to help them, and I think the [home] visiting goes along with that. I think we need to do a better job of creating that link." The need for ensuring the continuum of care for expecting and new mothers is a common theme among interviewees who want to provide resources to health care as well as education for the evolving stages of a child's life.

Social Determinants of Health Barriers. One of the benefits of the intrinsic nature of home visiting programs as a linkage resource is that it works at the source of the social determinants of health and intergenerational poverty. Both of these have been identified across the board as the major contributors to poor health outcomes in Utah and nationally.

Cost of Services and Funding Reductions. Utah is categorized into three different areas: urban, rural, and frontier. Costs of home visiting services in Utah vary depending on the region they are located and whether the home visitor is a registered nurse or a certified home visitor. Urban counties have the largest population in Utah and account for 90% of Utah's population, rural counties make up 8.7% of Utah's population and frontier counties make up 1.3% of Utah's population. The average cost of home visiting increases the farther away you live from the urban areas.

The Office of Home Visiting has determined home visiting costs for families living in urban, rural, and frontier average $4,800, $8,000, and $9,800 per family per year respectively. Home visiting staff in the rural and frontier regions are registered nurses and staff in the urban regions are a mixture of registered nurses and certified home visitors.

Since the last MIECHV needs assessment in 2013, the Office of Home Visiting has had various types of funding. Awarded grants vary in amount and time period the grant funding can be used. Currently less than 600 households are being served by MIECHV-funded home visiting services in Utah. 90.4% of those are located in the urban areas.

Strengths and Weaknesses of Home Visiting. One of the pillars of the HV program utilized in Utah are resource connections - focused on increasing service utilization for families enrolled in home visiting. Part of the model requires families enrolled to have multiple assessments to be completed for both children and caregivers. Data from assessments are used to determine if a family could benefit from a community referral. Families not only gain education from their

assigned home visitor, but are given referrals and are connected to other services in the community depending on their needs. Outcome data plays a vital role in ensuring families are connected to resources they may need.

According to FG participants, the HV program was well received, and home-visitors were considered to be a trustworthy support system where participants formed a personal, meaningful connection. Home visitors connected not only with mothers, but also fathers and their other children. Home visitors provide guidance to participants and help connect parents to community resources and programs without judgment.

The program provides flexibility for the parents to have the home visitor meetings occur when convenient. Home-visitors were also available outside of normally scheduled visits to answer questions through phone calls or text messages. Participants emphasized the importance of HV programs occurring in the home where their home visitors could observe interactions they had with their child. During visits, parents learned appropriate learning activities they could to do with their children as well as explore new ways for families' members to have fun together. The visits were seen as being very family-oriented and all-inclusive for others living in the home. Participants expressed they could discuss any thoughts they had with their home visitors who could then provide them with problem solving, feedback, and suggestions about what they could do. Also, home visitors were seen as a valuable gatekeeper to various resources available in the community, and most helpful in navigating the health and social service system.

The HV programs have proved that the trust built between families and the program can help the families navigate through life. These frameworks for home visiting are focused on strength-based practices and try to address the needs of the family from pregnancy to a child's age of six.

Table 9. Quotes from HV Focus Group Program Participants About HV Program Strengths
"It's like having an ally, having someone there, someone is coming to me, I don't have to pack up the kids. Did the morning routine with home visitor once, I like feeling that personal connection I have with her."
The home visitor sees my needs and tries to meet needs, I'm a first-time mom, so having the resources I need helps. I appreciate the home visits for the child development perspective I get."
"I was stuck in a rut, so, I looked forward to have someone come over, she's such a helpful person and program. There's reach out with text with events and she checks-in. I could text her if I needed to or if I had a question. Since COVID-19, we had one video call" (note: quote from March, 2020).
"It's the support that I get. I was a teen mom –still am, really am, but I was 15 at the time, and she just had so much support. I felt like at the time, it was really hard for me to tell people that I was pregnant, with her telling me, "You know that happens… It's been happening for years and years. You're not the first; you're not gonna be the last." If I need help, she'll encourage me. But, it's definitely the support, too."

Weaknesses exist within areas of service utilization and outcome data. Due to high demand for certain services and resources needed by families, not all resources are available at times when families might need them. The data that is used for this program is owned by the model and not

by OHV. This can sometimes cause challenges when multiple sites are trying to pull data that is needed.

One of the weaknesses commonly expressed about the HV program has been that it only reaches a small portion of individuals who are in need of these services. By and far, the largest weaknesses participants discussed were concerns with how the HV program was marketed, and how participants are recruited into the program. Participants mostly found out about the HV program through interactions with WIC staff, but felt there were many other community programs that should know about the program. Participants felt that cold calls on their cell phones were less effective, as these unknown callers can be perceived as a telemarketer calling. They also expressed limited knowledge about the HV program, and it was difficult to ascertain whether the persons they had initial conversations were indeed affiliated with the HV program versus it being a scam, or an identity theft effort.

Table 10. Quotes from HV Program Participants About HV Program Weaknesses

"As a shy person, I don't like to reach out to people. I was skeptical. I never heard about anything like this program before, so I thought during my first contact, my home visitor was a business or solicitor wanting to sell me something."
"I was cold-called by a parent educator, and was very defensive at first. I didn't quite know what to expect. They should send more information through a brochure or an email. I thought during the first visit the person (home visitor) was going to sell me something."
"She's super sweet, super nice, and was just like, 'Hey, we have this really awesome program where a nurse can come visit you once or twice a month.' I thought it was just for my kid to make sure that she was good. I didn't know that it was more gonna be about personal life, resources, and things like that, so at the beginning, I think it was kind of – I wouldn't say confusing in a bad way, but I didn't know what to expect. So, I would say that was a weakness, but as soon as it started, it was great, but at the very beginning, it was like, 'What's going on? When did I sign up for this?'"
(Mother translating for her father) "He's saying that a lot of Latinos don't do this program because of being scared that they're gonna take their kids away because they don't have papers."

During the early stages of deciding to enroll, participants expressed a lack of understanding of what to expect from the HV program. It was unclear if they had to pay for the program. Initial concerns included whether there was any flexibility regarding when home visits would occur. A significant barrier to enrollment was the perception that the home visitor would assess their parenting as poor, resulting in their child, or children being removed from their custody. While the program is marketed to expecting mothers, or mothers and their children under six years of age, it was unclear to participants as to whether fathers could be included in the home visits.

The program participants wished there were more bilingual staff. While participants spoke English, some of their family members (i.e., grandparent(s)) were not proficient in English. As such, these family members were less willing to participate. Given the current political climate in the United States, participants were very concerned about whether HV program staff would identify them or other family members as illegal immigrants who would be deported.

Once enrolled, some participants wished their home visitor could stay for longer visits. Others had concerns about what happens next once they reach the two-year threshold after enrollment. There is a lack of clarity about how participants will transition out of the program and what alternative services are available once they transition out.

County Level Data. County level data includes data gathered by OHV, based on publicly available information. As Utah lacks a comprehensive statewide home visiting program, this data may not be all-inclusive. Programs include potential evidence-based home visiting programs identified, including Early Head Start programs (some of which may be site-based programs and may not be eligible for MIECHV funds), CBCAP-funded programs, and OHV-funded programs, including MIECHV and state funded sites.

Estimated number of eligible families were determined using HRSA established criteria of:

- Number of families with children under the age of 6 living below 100% of the poverty line + Number of families in poverty with a child under the age of 1 and no other children under the age of 6 AND
- Belongs to one or more of the following at-risk sub-populations: Mothers with low education (high school diploma or less); Young mothers under the age of 21; and Families with an infant (child under the age of 2).

County level data summarizing the following:

Table 11. At Risk Communities (HRSA required "Table 7")

County	Program Name	Fully or Partially Served?	Evidence-Based and Eligible for Implementation by MIECHV	Funded by MIECHV	Estimated # of Families Served[17]	Estimated # of Eligible Families
Beaver	Unknown	No	Not Sure	No	Not Sure	29
Box Elder	Bear River EHS- Various Programs	Not Sure	Not Sure	No	Not Sure	384
Cache	Bear River EHS- Nest/ KOOP Program- Various Programs	Not Sure	Not Sure	No	Not Sure	742
Carbon	Southeast Utah Health Department PAT, Carbon County EHS, Carbon County Family Support Center PAT Program	Yes	Yes	Yes	29	186

[17] Estimated number of families served could only be included for programs funded through the Office of Home Visiting as there is not a universal home visiting model in Utah. Data was pulled as the number of families served through July 2020 during the 19-20 fiscal year.

County	Program Name	Fully or Partially Served?	Evidence-Based and Eligible for Implementation by MIECHV	Funded by MIECHV	Estimated # of Families Served	Estimated # of Eligible Families
Daggett	Unknown	No	Not Sure	No	Not Sure	11
Davis	Davis School District EHS Programs	Yes	No	No	Not Sure	571
Duchesne	Unknown	No	Not Sure	No	Not Sure	186
Emery	Southeast Utah Health Department PAT, Huntington EHS	Yes	Yes	Yes	11	93
Garfield	Unknown	No	Not Sure	No	Not Sure	22
Grand	Southeast Utah PAT, Rural Utah Child Development EHS	Yes	Yes	Yes	2	88
Iron	Southwestern Family Support Center	Not Sure	Not Sure	No	Not Sure	220
Juab	Centro de la Familia de Utah EHS	Not Sure	Not Sure	No	Not Sure	49
Kane	Unknown	No	Not Sure	No	Not Sure	32
Millard	Centro de la Familia de Utah EHS	Not Sure	Not Sure	No	Not Sure	56
Morgan	Davis School District EHS	Not Sure	Not Sure	No	Not Sure	69
Piute	Rural Utah Child Development EHS	Not Sure	Not Sure	No	Not Sure	6
Rich	Bear River EHS Program	Not Sure	Not Sure	No	Not Sure	14
Salt Lake	Multiple EHS Programs, NFP, Multiple PAT Programs, Family Support Center of SLCo	Yes	Yes	Yes	280	3,854

County	Program Name	Fully or Partially Served?	Evidence-Based and Eligible for Implementation by MIECHV	Funded by MIECHV	Estimated # of Families Served	Estimated # of Eligible Families
San Juan	San Juan Public Health Department PAT, Aneth Community School FACE Program, Blanding EHS	Yes	Yes	No	16	154
Sanpete	Central Utah Public Health Department PAT, Centro de la Familia de Utah EHS	Yes	Yes	No	16	130
Sevier	Central Utah Public Health Department PAT, Sevier EHS	Yes	Yes	No	9	93
Summit	Holy Cross Ministries PAT Program, Davis School District EHS	Not Sure	Yes	No	Not Sure	244
Tooele	EHS Tooele Program, The Kids Park at Overlake Program	Not Sure	Not Sure	No	Not Sure	469
Uintah	Ashley Valley EHS	Not Sure	Not Sure	No	Not Sure	332
Utah	Kids on the Move EHS Program, PAT Program	Yes	Yes	Yes	124	3,430
Wasatch	Wasatch County Health Department PAT, Holy Cross Ministries PAT	Yes	Yes	Yes	10	279
Washington	Multiple EHS Programs, Root For Kids PAT Program	Yes	Yes	No	Not Sure	1,219
Wayne	Rural Utah Child Development EHS	Not Sure	Not Sure	No	Not Sure	12
Weber	Prevent Child Abuse Utah PAT	Yes	Yes	Yes	196	901

V. Utah's Substance Use Disorders and Capacity to Address Substance Use Treatment and Counseling Service Needs

Drug Overdose Deaths. In Utah, the 2018 age-adjusted death rate for all drug overdoses was 21.2 per 100,000, which was similar to the U.S. rate (20.7 per 100,000). The death rate due to opioid overdose has remained stable during a 10-year span (14.0 per 100,000 in 2008 vs. 14.8 per 100,000 in 2018). The current age-adjusted death rate mirrors that of the national rate of 14.6 per 100,000. In 2018, there were 437 opioid overdose deaths in Utah, which accounted for 70.0% of all drug overdose deaths in the state[19]. Opioid overdose death rates are highest in rural counties located in the Southeast region of Utah[20].

Opioid overdose death rates are highest in rural counties located in the Southeast region of Utah. Two of these counties are Carbon and Grand, which are members of the Southeast Health District.

Table 12. Counties of Focus Opioid Age Adjusted Death Rate per 100,000 by Counties of Focus in 2018[18]

County	Rate
Carbon (a)	43.2
Emery (a)	43.2
Garfield (b)	23.1
Grand (a)	43.2
Salt Lake	23.2
Tooele	21.4
Uintah (c)	21.6
Weber/Morgan	25.4
All of Utah	21.2

Opioid Age Adjusted Death Rate per 100,000 population in 2018 by Counties of Focus. In 2018, Utah healthcare providers wrote 57.1 opioid prescriptions for every 100 Utah residents, which is higher when compared to the average U.S. rate of 51.4 prescriptions[21]. Of those Utahns receiving services for opioid addiction, 70% were introduced to opioids through prescriptions provided by their health care providers. Since 2013, the Senate Bill 214 in Utah has required healthcare providers to participate in continuing education related to controlled substances prescriptions as a requisite for license renewal.

Substance Use Disorder Treatment Services. The Public Health Indicator Based Information System (IBIS) provides a repository of information regarding substance use services in Utah[22]. Consistent with other findings in this needs assessment, substance abuse services, like other specialty services, tend to be centrally located in Utah's urban areas. While residents in rural and frontier counties are in need of intensive outpatient services, residential treatment, and detoxification, the majority of these services are only located in urban areas many hours away.

[18] (a)This county is a member of the Southeast Health District, and the rate is an average for multiple counties; (b)This county is a member of the Southwest Health District, and the rate is an average for multiple counties; (c)This county is a member of the Tricounty Health District, and rate is an average for multiple counties.

[19] https://www.kff.org/other/state-indicator/drug-overdose-death-rate-per-100000-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[20] https://www.kff.org/other/state-indicator/opioid-overdose-deaths/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[21] Centers for Disease Control and Prevention. U.S. Opioid Prescribing Rate Maps. Retrieved from https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html

[22] https://findtreatment.samhsa.gov/locator

Table 13. Substance Abuse Treatment Services by Focus Counties in 2019[23]					
County	**Clients Served**	**Outpatient %**	**Intensive Outpatient %**	**Residential %**	**Detox %**
Carbon (a)	Unknown	-	-	-	-
Garfield (b)	624	48	28	24	0
Grand (a)	Unknown	-	-	-	-
Salt Lake	8,013	25	14	18	43
Tooele	549	64	35	1	0
Uintah (c)	Unknown	-	-	-	-
Weber/Morgan	1,695	72	19	10	0
All of Utah	16,950	40	16	15	29

Substance Abuse Treatment Gap Analysis. The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Behavioral Health Statistics and Quality maintains a database of treatment facilities for each county in the US which serve those with substance use disorders. The criteria for inclusion in this database are as follows: 1) Facilities funded by the state; 2) Facilities administered by the Veterans Affairs (VA) system; 3) Private for profit, and non-profit organizations licensed in the state to provide Substance Use Disorder (SUD) treatment, or organizations which are accredited by a national organization (i.e., Joint Commission, National Committee for Quality Assurance, Commission on Accreditation of Rehabilitation Facilities, to name a few); 4) Staff hold professional credentials to treat SUD; and 5) Organizations are authorized to bill third-party payers for SUD.

The majority of substance abuse services are located in urban Salt Lake and Weber Counties. Rural counties, such as Carbon, Garfield, Grand, Tooele, and Uintah have very few specialty services such as detoxification, residential treatment, SUD services for pregnant/ postpartum women, transitional housing, and Spanish speaking services. Utah's SUD services are three times more likely to be private, for profit organizations, than public, and only about 40% of organizations that offer SUD services in Utah offer its residents services based on a sliding scale where service fees are based on client's income and ability to pay.

[23] https://ibis.health.utah.gov/ibisphview/indicator/view/PoiDth.LHD.html

Table 14[24]. Number of Substance Use Disorder Facilities Within Each County[22]								
Service Type or Specialty	**All of Utah**	**Carbon**	**Garfield**	**Grand**	**Salt Lake**	**Tooele**	**Uintah**	**Weber**
Adolescents	81	2	0	1	23	1	2	4
Alcohol Detoxification	88	1	0	0	35	0	0	4
Case management	244	3	1	1	114	2	2	14
Detoxification	86	2	0	1	44	0	0	4
Hospital inpatient detoxification	9	0	0	1	5	0	0	1
Hospital inpatient treatment	8	0	0	1	5	0	0	1
Intensive outpatient treatment	162	2	0	1	73	2	1	10
Long-term residential	82	0	0	0	33	0	0	4
Medicaid	95	1	1	1	46	2	1	5
Medicare	169	1	1	1	81	2	1	10
Methadone Maintenance	14	1	0	0	6	0	0	1
Methamphetamines detoxification	62	0	0	0	34	0	0	1
Opioid Detoxification	52	2	0	0	43	0	0	4
Outpatient day treatment or partial hospitalization	86	0	0	0	41	0	0	4
Outpatient detoxification	52	2	0	0	31	0	0	2
Outpatient Services	230	3	1	1	38	0	0	3
Persons with co-occurring mental and substance use disorders	213	3	0	1	64	2	2	9
Pregnant/postpartum women	85	2	0	0	39	2	0	3
Private for-profit organization	202	1	0	0	92	0	1	15
Private non-profit organization	65	2	0	1	40	2	0	1

[24] Facilities listed may overlap (i.e. a single facility in Carbon County may provide multiple services).

Service Type or Specialty	All of Utah	Carbon	Garfield	Grand	Salt Lake	Tooele	Uintah	Weber
Relapse prevention with naltrexone	127	2	0	0	67	2	0	7
Residential	97	0	0	0	44	0	0	5
Residential detoxification	42	0	0	0	20	0	0	1
Screening for substance use	279	3	1	1	130	2	3	17
Short-term residential	71	0	0	0	38	0	0	3
Sliding fee scale (fee is based on income and other factors)	89	2	0	1	49	0	1	4
Spanish Speaking Services	90	1	0	0	44	2	1	3
State Substance Abuse agency	214	3	1	1	108	2	1	11
Substance use treatment	287	3	1	1	133	2	3	17
Transitional housing, halfway house, or sober home	49	0	0	0	25	1	0	0

Barriers to Receipt of Substance Use Disorder Resources. In Utah, there is a scarcity of mental health providers, such that every county is considered a Health Professional Shortage Area (HPSA). HPSA is a designation used by HRSA to identify areas and population groups within a geographic area (typically, a county) which are experiencing a shortage of health professionals. There are three categories of HPSA designation based on the health discipline that is experiencing a shortage: 1) primary medical; 2) dental; and 3) mental health. This shortage also extends to service providers who treat substance use disorders (SUD).

Utah's largest barrier to receipt for services is a shortage of service availability. Due to this shortage, those who are in need of or seeking services are often faced with long waiting lists, financial barriers, or transportation limitations to services with many communities, particularly rural communities, completely lacking services.

Collaboration with State and Local Partners. The Office of Home Visiting partners with many state and local early childhood partners, such as Help Me Grow Utah, the Division of Child and Family Services, the Office of Childcare, the Maternal Mental Health Program, WIC, and Baby Watch Early Intervention. Collaboration with the Division of Child and Family Services in particular has expanded in the last year with a focus on integrating Family First Prevention Services Act (FFPSA) funding, as well as aligning family-centered funds and programming throughout Utah.

OHV also participates in community councils and collaborative groups focused on early childhood and maternal outcomes in the state of Utah. However, due to a lack of universal home visiting in the state, collaboration amongst home visiting programs is limited.

In addition to collaboration at the state level, local implementing agencies of home visiting programs collaborate with community partners and agencies within their individual communities. These collaborations between programs, for the purposes of referrals, as well as continuity of care are essential to the success of home visiting programs.

VI. Coordination with the Title V MCH Block Grant, Head Start and CAPTA Needs Assessments

The Office of Home Visiting collaborated with and utilized data from the Title V MCH Block Grant and Utah Community Action (the organization housing Head Start) Needs Assessments. OHV coordinates with the CAPTA program, but did not collaborate with the CAPTA Needs Assessment, as a formal Needs Assessment was not being conducted by CAPTA at the time of this report. Housed in the same Bureau, the MIECHV and Title V MCH Block Grant Needs Assessments were conducted in close partnership with one another and data and content from the Title V needs assessment informed the MIECHV needs assessment.

Title V Needs Assessment. The Statewide Maternal and Child Health Needs Assessment for Utah was conducted for the HRSA Title V Block Grant. In Utah, the MCH Block Grant program focuses its activities in five domain areas: 1) Women/Maternal Health, 2) Perinatal/Infant Health, 3) Child Health, 4) Children with Special Healthcare Needs, and 5) Adolescent Health.

The primary concerns from the Title V Block Grant needs assessment, in no particular order, were as follows:

1. *Mental Health* – Mental health, including perinatal depression, depression, anxiety, and suicide were top concerns in all domain areas with the exception of the infant domain. According to the 2019 Utah Department of Health (UDOH) Maternal, Infant & Child Health Indicators in Utah Report:
    - 14.7% of women report postpartum depression
    - 17.1% of adolescents reported making a plan about how they would attempt suicide
2. *Violence/Abuse/Neglect* – Violence, primarily family violence, was a priority concern in all five domains. Types of violence include intimate partner violence, child abuse and neglect, lack of parental involvement, and bullying of children and adolescents. According to the 2019 Utah Indicator Report:
    - 19.4% of adolescents reported being bullied on school property
3. *Access to Care/Health Insurance* – Access to care related to affordability, including affordable health insurance, was a key issue for women, infants, and CSHCN domains. It was not noted as a priority for children and adolescents, but was a particular concern of parents with CSHCN. According to the 2019 Maternal, Infant & Child Health Indicators in Utah Report:
    - 14.7% of women of reproductive age reported being uninsured

- 38.9 % of children and adolescents are not continuously and adequately insured

4. *Access to Care/Limited care* – A variety of types of care were described as very limited and sometimes non-existent. This was the top concern for the CSHCN domain, where specialty medical care is extremely limited, especially in rural areas, and developmental screening is not comprehensive. Mental health and behavioral health services were described as very limited and as a system that is not nearly robust enough to meet the needs. Other programs and services that are wanted and needed, but limited in scope and availability include family planning, sexual health education for youth, quality and affordable childcare and afterschool care, school nursing, dental care, and training for parents/parenting skills.
    - 44.9% of children ages 6-9 have received dental sealants in one or more of their permanent molar teeth
    - 16.4% of children in Utah have special healthcare needs
    - 18.4% of CSHCN ages 0 – 17 have a medical home

The Title V Needs Assessment included interviews with several key informants that commented on Home Visiting services. Three major themes were identified: 1) home visiting's value in addressing social determinants of health, 2) funding issues, and 3) the need for expansion, including innovations for reaching rural Utah such as telehealth and community events. Key informants repeatedly discussed the value of home visiting.

Dedicated staff discussed the inconsistencies in funding streams which not only negatively impacted families they served, but also impacted the ability of agencies to attract and maintain staffing which stabilized the longevity of ongoing home visits. In rural Utah, distances traveled to conduct home visits remains a potent barrier in fully optimizing the value of home visiting. While face to face meetings were considered invaluable, staff discussed the potential role of tele-health and video conferencing as an adjunctive method to maintain regular contact with families. Staffing vacancies were a commonly identified problem, with many key informants indicating they have recognized the value of hiring staff from various professional backgrounds to fill the vacant case manager positions.

Impact of Home Visiting Services. Key informants described the benefits of the program as helping engage participants in various 'life skills building' and problem solving. Topics such as finances, budgeting, and building family stability and self-sufficiency, including developing a plan for the future, are discussed during home visits. For younger families, home visitors problem solve with parents about improving their educational attainment such as getting their GED, or taking advantage of funding opportunities to pursue trade school or to go to college. For some families, there is a lack of awareness of what resources are available; for other families, the case manager becomes the organizing effort to help stabilize a chaotic home environment so parents can focus on higher level and longer-term goals such as educational attainment.

Many of the home visiting staff reported many success stories, and various themes of success from effective parenting, improved mental health, access to services, completing school, and/or attaining employment. Many discussed how home visits are indeed labor intensive and expensive, but through repeated visits in the home, improvement in a number of areas can be seen. Staff talked about a sense of pride in seeing families improve, and are convinced their

efforts lead to improved outcomes related to the social determinants of health, thereby improving physical and mental health outcomes.

Table 15: Quotes from HV Program Participants about HV Program Successes
"As far as human capital, where you're gonna get the most return on your investment is prenatal to three, right? If you invest your money there, you're gonna get more return on your investment than anything that you do past that point, as far as prevention goes. So, I just think these are valuable programs for people."
"We had a study done by the University of Utah people… if they participated (in home visiting), they decreased their rate of premature birth, low birth weight. The kids had higher immunization rates and more well child checks. So, there were some positive things with that.... and we do reduce intimate partner violence. I can't remember the exact amount, but it decreased smoking during pregnancy by about 50%."
"We often have teenagers that we help with them get their GED and maybe take advantage of some programs that can help them with going on to college. A lot of it is just believing. Having somebody that believes that they can do that kinda thing, right?"

Inconsistencies in Funding Streams Which Negatively Impact Families. A common barrier identified by key informants is the instability of funding. Staff discussed how funding can change significantly from one grant to the next. In cases where the funding is cut with the arrival of a new grant, staff are left to address multiple needs despite having less staffing to meet the needs of these families. The inability of staff to meet the identified needs of these families only contributes to the stress and trauma experienced by parents, thereby negatively impacting their young children. Even in districts that have lost Temporary Assistance for Needy Families (TANF) or MIECHV funding, they seem to continue to implement some form of home visiting because they want to serve families, and it is too disruptive to end a program so valued by the community.

".... we only see a tiny fraction of what who we could see in [the] County; probably less than 10% of eligible clients, even at the poverty rate. So, our services are pretty limited, because we're pretty full. So, we have a tendency to focus more on lowest-income clientele...."
"With home visiting, the biggest challenge has been the ebb and flow of federal dollars. I mean, we'll have $400,000 one year, and they'll slash it to $250,000 the next year. And that's been a real challenge."

Home Visiting Barriers in Rural Utah. Staff report that the funding formulas are based on seeing a certain number of families within their homes per day, week, and month. These funding formulas are reasonable for urban areas where families are located within 3 to 15 miles of one another. Rural Utah staff report spending one-half of their work day traveling to meet with families, with a successful day being able to meet with 3-4 families. Unfortunately, for some scheduled visits, the key family members may not be present, and a home visitor can lose hours of a given day traveling, having only conducted only a few successful home visits. Despite the cost, the need is there nonetheless.

"You could be working eight hours a day full-time, but when half of that is driving, you're just not gonna be as effective as somebody in Salt Lake City who can reach all their families and they're all within a half hour of each other… It's just not even the same playing field..."

In order to address challenges to home visiting in rural Utah, telehealth and remote communication was discussed as viable options. This, however, would require changes to what constitutes a home visit.

Key informants located in rural Utah were quite clear that face to face home visits are extremely valuable. However, they also reported that electronic visits, such as video conferencing can be an important method for having more frequent contacts with family members, and through this approach, effectively address urgent needs. These innovative technology approaches are not systemic in rural Utah. Only a few locations have ventured into using electronic video conferencing, and strategies such as this are highly dependent on families having the technology available to participate in this approach.

Table 16: Quotes from Healthcare and Public Health Professionals on Home Visiting
[What is Home Visiting] ***"****What it is, is that once the mother is noted to be pregnant, then we have health workers go and visit her to start preparing her. And they can start as early as six weeks into the pregnancy, when the pregnancy test was positive. And then, they follow them, teaching them about child care, about stress management, about financial management, about the difficulties of being a single parent, or difficulty of adding a new addition to the family when they're already stressed. It's a standard curriculum that is used. And our public health nurse and the public health department do that. And so, once there's a test that is positive here, we ask all the providers to make the referral to the group to contact them.* *And of course, it's voluntary. If they don't want anybody to come, we don't force ourselves on them. But we haven't had very many refusals. But what they do is visit them, getting them prepared to do breastfeeding. Pushing breastfeeding. And teaching them how they would do it if they've never had any babies, etc. And then, after the delivery, continue to visit them for a three-year period. So, it's a four year into the life setting there."*
[What is the impact of Home Visiting?] ***"****It's a very positive impact because the interaction is not just with the mom and baby, it's with the partner or the husband, and sometimes the families involved in that. And I think, a lot of times, what I've seen the positive impact is not just that it has been that the child's been well taken care of, which is sometimes the main focus of everything, but that the mother who's 16 went back to school. That the father who was unemployed found work. It's that type of thing that we don't really record, but you see the impact there because you got nine months to prepare. Which isn't a lot, in many cases. But it is some time."*

Head Start Needs Assessment[25]. In 2019, Utah Community Action (UCA) conducted a statewide needs assessment. UCA oversees six comprehensive programs in Utah. These are: 1) Adult Education; 2) Case Management and Housing; 3) Head Start and Early Head Start; 4) HEAT (utility crisis assistance); 5) Nutrition Assistance; and 6) Home Weatherization.

A summary of each of these services are as follows:

1. *Adult Education.* Programs focus on providing adults skills and education to bolster economic security and achieve long-term self-sufficiency. Classes include English as a Second Language, GED preparation, vocational preparation, certification for childhood education (CDA), culinary training, and awareness/referral to post-secondary degree programs. Additional services include resume and job finding skills to reduce and remove barriers to employment and increase wage-earning potential.

[25] Utah Community Action: 2019 Community Needs Assessment. https://www.utahca.org/wp-content/uploads/2020/02/2019-Community-Needs-Assessment.pdf

2. *Case Management & Housing.* Programs problem solve and assist with the most vulnerable, and multiple generation poverty families in obtaining and maintaining safe, stable and affordable housing. Services include diversion, case management, housing location and stabilization, deposit and emergency rental assistance, landlord mediation, and financial education.

3. *Head Start and Early Head Start.* These comprehensive programs assist low income children and their parents with early childhood education, while also providing supports needed for accessing health services, and community resources to improve family self-sufficiency. Head Start programs also seek to improve nutrition literacy. Home-based and prenatal services are also available.

4. *HEAT.* This program provides utility crisis utility assistance to income-eligible households in Salt Lake and Tooele counties. Participants in this program also receive energy conservation education, budget/finances counseling, and referrals to community resources.

5. *Nutrition Assistance.* This program addresses food insecurities for families with infants through those with elderly. The program provides meals for Head Start and Early Head Start classrooms, as well as for agencies serving children ages 0-18. Examples include the Summer Food Program for youth, the Sauté culinary training program for adults (i.e., the Evergreen Café at Millcreek Senior Center). UCA provides an average of over 5,000 meals daily from our Central Kitchen.

6. *Weatherization.* This program provides safe, energy-efficient upgrades to homes of income-eligible members of the community who live in apartments, manufactured homes, and single-family residences. Services include improvements in insulation, air sealing, installation of high-efficiency furnaces, energy-efficient lighting and appliances and more. In all, weatherized homes improve the health and safety of low-income families while providing an average energy efficiency increase of 30%.

Methods to Incorporate Data and Information. The Bureau of Maternal and Child Health now oversees the Home Visiting Program, which includes the MIECHV Grant Program. While home visiting is not a main focus of the MCH Needs Assessment, home visiting services are not mutually exclusive from maternal and child health services, in fact, there is significant overlap. Several Utah communities identified as having the highest need for home visiting were used to recruit key informants for the MCH Needs Assessment and inform decisions about MCH in the state of Utah moving forward. The reciprocal nature of the two needs assessments highlights the important role home visiting plays for the health and well-being of mothers and children.

The 2019 Utah Community Action Needs Assessment was created through the collection and analysis of quantitative data from the American Community Survey of the U.S. Census Bureau, and qualitative data collected from: 1) interviews (conducted with key informants from the Utah Office of Child Care, Utah Office of Education, the Community Service Block Grant, Church of Jesus Christ of Latter-Day Saints, Salt Lake County Department of Human Services, and the Salt Lake County Health Department); focus groups with UCA staff; focus groups with UCA clients;

focus groups with staff from UCA partner organizations. In addition, results were compiled from 216 completed online surveys from agency staff and clientele.

Service Gaps. The need for expanded mental health and substance use services across the lifespan and across the state was cited several times in the MCH Statewide Needs Assessment. Additionally, common themes of low availability of most types of care emerged. Pediatricians, psychologists, OB/GYNs counselors and specialized health services are referenced as particularly difficult to access in rural communities. Some respondents felt telehealth was a good option for rural communities, however even those services need more provider participation, particularly in specialized fields.

Duplication of Services. The scope of home visiting services in Utah are limited and dispersed throughout the state, reducing the potential for duplication of home visiting services, meaning the risk of a family enrolling in the same program under different agencies is unlikely to happen. In the urban areas, such as Salt Lake County, the potential for duplication of services exists among home visiting programs due to geographic proximity. However, in most instances, a family receiving home visiting services from more than one agency would likely be receiving services from two very different programs providing very different services, such as Welcome Baby and Parents as Teachers (PAT).

Utah's MIECHV-funded programs do not cover enough of the eligible population to have duplication of services. Additionally, programs funded by the Office of Home Visiting have protocols in place to identify families enrolled in other similar programs to identify and prevent potential duplication of services.

Challenges and Barriers. Participants of the MCH Needs Assessment cited a desire for increased visibility of insurance programs and important MCH programs such as home visiting, WIC and the Children's Health Insurance Program. Even when services exist, certain barriers keep some families from participating in much needed services. Some of the barriers cited in the MCH Needs Assessment were; stringent qualification requirements, fear of accessing services, long wait lists for services, or services are not covered by their insurance. Barriers and challenges are further addressed in the summary of this report.

Opportunities. The MCH Needs Assessment revealed beliefs that home visiting is a good example of care coordination, but that there could still be improvement in this area. A common theme revealed in the MCH Needs Assessment was also a need for a more concerted effort to educate and inform the public of existing MCH programs. Health departments did not typically have budgets or strategies for increasing program visibility, however the needs assessment findings suggest that efforts in this area could improve program utilization.

Summary of the Specific Findings Related to Maternal and Child Health. Consistent with the findings in this report, low income families continue to struggle with obtaining affordable housing, access to early childhood education, access to transportation, and obtaining employment that can produce livable income. In consequence, these families are confronted with housing and food insecurities, along with low access to affordable health and social services. Language barriers stood out as an unmet need related to access to needed services. As a consequence, staff

and clients perceive these stressors negatively influencing mental health of family members, resulting in maladaptive coping, including substance abuse, and suicide. Additional themes consistent with our findings included: the high volume of work within social service agencies, staff burnout, and high staff turnover. Coupled with a chronic lack of adequate funding, staff reported a pattern of ebbs and flow in obtaining effective staffing and ability to meet client needs. Also consistent with our findings is the lack of community awareness of the programs available to families. While clientele expressed high satisfaction with UCA services, they also reported community awareness of these programs is lacking. UCA expressed concern about the current cycles of under-funded programs and the increasing threat of inadequate resources resulting in being unable to address increasing community need.

Convening Stakeholders. The Office of Home Visiting is housed in the same Bureau as the Title V and ECCS grant recipients in the state of Utah, leading to regular collaboration between the programs. OHV staff work particularly closely with the ECCS grantees, participating in ECCS statewide meetings on a monthly basis.

Sharing Data. OHV staff work with other early childhood stakeholders by participating in the Early Childhood Advisory Council and subcommittees, focused on Parent and Family Engagement, Data, and Health. Through the information learned in this needs assessment, OHV staff can share findings and help inform future decisions.

Additionally, OHV works closely with the Early Childhood Integrated Data System development and has begun integration of home visiting data into the integrated database system. This will allow for home visiting data to be integrated with other early childhood data, informing wrap-around and full-service care for families and children in Utah.

VII. Summary of the Findings

Summary of the Qualitative Findings for MIECHV Home Visiting Program. Using the simplified method, the following counties were identified as counties at risk: 1) Carbon (adverse parental outcomes; child maltreatment); 2) Garfield (low SES; adverse parental outcomes); 3) Grand (crime; child maltreatment); 4) Salt Lake (substance use; crime); 5) Tooele (adverse parental outcomes; crime); 6) Uintah (crime; child maltreatment) and Weber (substance abuse; crime).

Additional Z score calculations were conducted on 2019 indicator data. These data included the following risk indicators: 1) Poverty; 2) Unemployment; 3) High School Dropout; 4) Income Inequity; 5) Preterm Births; 6) Low Birth Weight; 7) Binge Alcohol Abuse; 8) Marijuana Use; 9) Illicit Drug Use; 10) Pain Reliever Use; 11) Crime Reports; 12) Juvenile Arrests; and 13) Child Maltreatment. The findings of these Z score calculations can be found in Appendix A.

Table 17: Utah Counties Identified at Risk Based on Z Score Calculations of 2019 Indicator Data

Indicators	Counties Significantly Worse (Z= +/- 1.96)	Counties in lowest 16% (Simplified Method, with Z= +/- 1.0)
Poverty	San Juan	San Juan; Piute
Unemployment	Garfield; Grand Carbon; Beaver	Garfield; Grand; Carbon; Beaver; Washington; Tooele
HS Dropout	Emery	Emery; Grand
Income Inequality	Juab; Beaver	Juab; Beaver
Premature Birth	Daggett; Duchesne; Rich	Daggett; Duchesne; Rich
Low Birth Rate	Utah	Utah, Carbon, Juab
Alcohol Binge Use	Salt Lake Co	Salt Lake Co., Garfield; Sanpete
Marijuana_2016	Salt Lake Co.	Salt Lake Co.
Illicit Drugs	Garfield; Sanpete	Garfield; Sanpete
Pain Relievers	Garfield; Sanpete; Iron	Garfield; Sanpete; Iron
Crime Reports	Salt Lake Co.	Salt Lake Co.; Tooele; Rich; Sanpete
Juvenile Arrests	Tooele	Tooele; Washington; Wayne; Morgan
Child Maltreatment	Weber	Weber; Wayne; Washington; Wasatch; Utah

Table 18: Counties Identified At-Risk Using the Simplified Method (2012-2016 indicator data)	
County	**Number of At Risk Domains**
Carbon County	2
Garfield County	2
Grand County	2
Salt Lake County	2
Tooele County	2
Uintah County	2
Weber County	2
Beaver County	1
Daggett County	1
Duchesne County	1
Morgan County	1
San Juan County	1
Sanpete County	1
Sevier County	1
Summit County	1
Washington County	1
Wayne County	1
Box Elder County	0
Cache County	0
Davis County	0
Emery County	0
Iron County	0
Juab County	0
Kane County	0
Millard County	0
Piute County	0
Rich County	0
Utah County	0
Wasatch County	0

Table 19: Counties Identified At-Risk Using the Simplified Method (2019 indicator data)	
County	**Number of At Risk Domains**
Garfield County	4
Salt Lake County	3
Sanpete County	3
Washington County	3
Carbon County	2
Grand County	2
Tooele County	2
Beaver County	2
Wayne County	2
Weber County	1
Daggett County	1
Duchesne County	1
Morgan County	1
San Juan County	1
Emery County	1
Iron County	1
Juab County	1
Piute County	1
Utah County	1
Wasatch County	1
Uintah County	0
Sevier County	0
Summit County	0
Box Elder County	0
Cache County	0
Davis County	0
Kane County	0
Millard County	0
Rich County	0

The at-risk counties identified in this needs assessment are based on the following:

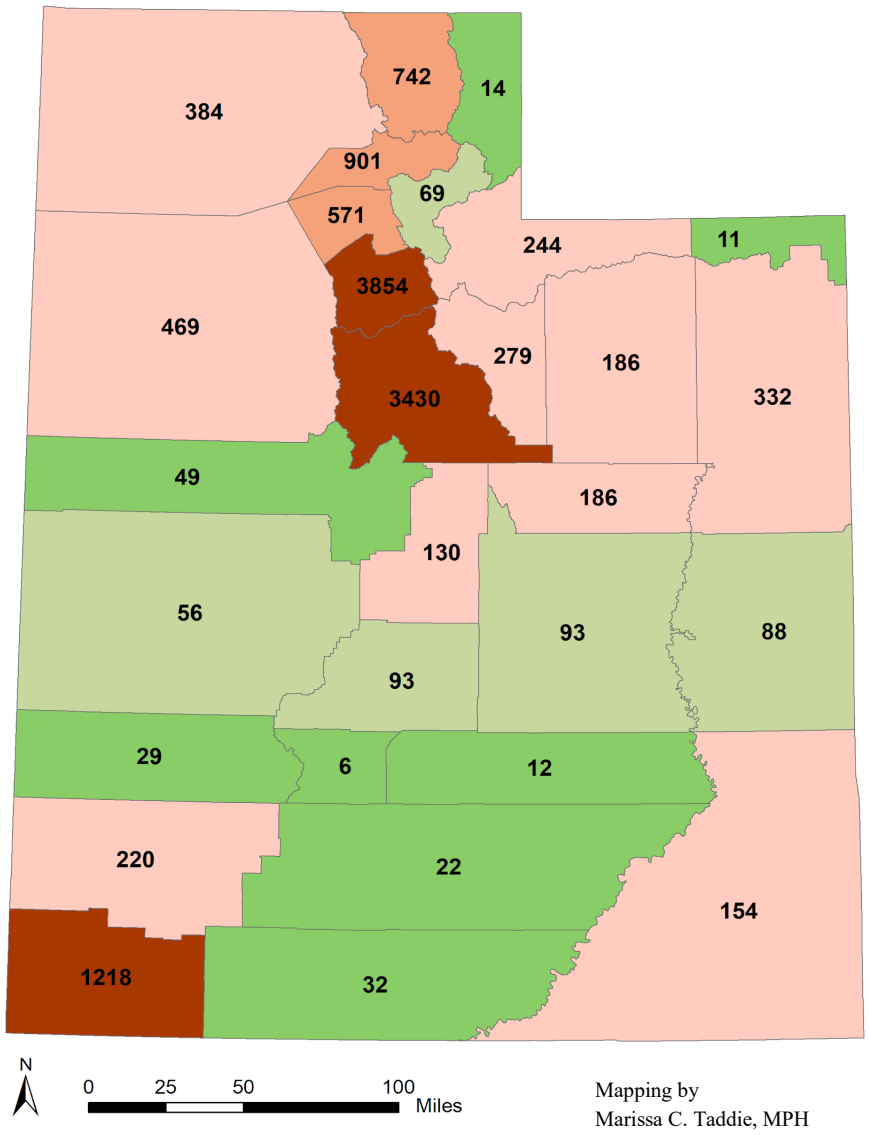
- Counties that have an average of at least 0.5 at-risk domains using 2019 data; and
- Estimated number of families in need of home visiting services (counties with over 500 estimated families or under 50 families were adjusted for).

Using the HRSA formula to identify the "number of families in need of home visiting services", urban counties such as Davis, Salt Lake, Utah, Washington, Weber, and Cache counties ranked in the top regarding HV need, each with over 500 families estimated in need of services. The

state of Utah ranks 4th in the country in percent population growth, with Wasatch County (45% increase in last 10 years) witnessing the 3rd highest growth since 2010 for counties in the U.S. Other Utah Counties that have witnessed substantial 10 year increases in population include Washington (30%) and Utah (26%) counties. As such, we have experienced a significant increase in recent years in the number of families residing in these counties in need of home visiting services.

Figure 2

Families in Need of Home Visiting Services by Utah County



In reviewing the HRSA indicator data, the Utah counties which consistently had two or more indicators across multiple years were: Carbon, Garfield, Grand, Salt Lake, and Tooele Counties. The next tier of counties at risk were: Beaver, Uintah, Washington, Wayne, and Weber Counties.

Utah has specific factors that impact individual counties that may have several or few at-risk domains. While Garfield County appears high on the list of counties identified as at-risk, Garfield County, due to their aging population, ranked 5th lowest in need of home visiting services with 22 families in need.

Additionally, Utah has many rural and frontier communities throughout the state. Of these, Beaver, Daggett, Juab, Piute, Sanpete, and Wayne Counties each have less than 50 families in need of home visiting services. With low numbers of families in need of services, the Office of Home Visiting has found that it is not feasible to run a successful evidence-based home visiting program in these areas without significant additional administrative costs and supports, making these communities difficult to support with limited MIECHV funds.

Table 20. At-Risk Counties				
Ranking	**County**	**Number of At-Risk Indicators (2019)**	**Estimated Number of Families in Need of HV Services**	**Adjustments[26]**
N/A	Beaver	2	29	HR, A
15	Cache	0	742	LR, N
4	Carbon	2	186	HR
N/A	Daggett	1	11	HR, A
16	Davis	0	571	LR, N
8	Duchesne	1	186	HR
14	Emery	1	93	HR
N/A	Garfield	4	22	HR, A
6	Grand	2	88	HR
13	Iron	1	220	HR
N/A	Juab	1	49	HR, A
10	Morgan	1	69	HR
N/A	Piute	1	6	HR, A
1	Salt Lake	3	3,854	HR, HN
9	San Juan	1	154	HR
5	Sanpete	3	130	HR
3	Tooele	2	469	HR
11	Utah	1	3,430	HR, HN
12	Wasatch	1	279	HR
2	Washington	3	1,219	HR, HN
N/A	Wayne	2	12	HR, A
7	Weber	2	901	HR, HN

[26] A: administratively burdensome (under 50 estimated families in need; HR: high-risk population based on at-risk indicators; LR: low-risk population based on at-risk indicators; HN: high-need (over 500 families estimated families in need)

Recommendations to Improve the Home Visiting Program

Improvements in breadth and strategies regarding recruitment into the HV program is essential. It was suggested the program is marketed to many other social and health service programs besides WIC. Participants suggested reaching out to community health clinics, alternative schools, and many other social service programs would be beneficial. Marketing materials that do exist fall short of clearly conveying all program components, including the breadth of services, social support, which family members can participate in, all at no cost. Providing clarification as to whether U.S. citizenship is required would be helpful. Advertising in more commonly spoken languages (i.e., Spanish) will also improve reach in the recruitment efforts. Participants stated existing program advertisements are directed at mothers, and it was recommended that these materials clearly state fathers and other family members in the home can be included.

A barrier to potential enrollment in the HV program is how initial contact is made with those mothers who have expressed interest. Initial calls made by HV program staff are viewed as potential telemarketers, or spam calls. At best, potential participants of the HV program have little, if any, awareness or understanding of the components of the program. While providing brochures or fliers, emphasis should be placed on providing pictures, key program components, costs, and participant testimonies. One participant believed a brief 3 to 5-minute video showing examples of the HV program in action would be very effective. Having an open-house or orientation meeting, where potential participants could attend and listen to HV program staff describe the program, along with current or past participants disclosing their successes achieved due to the program would be helpful. Creating an opportunity for prospective participants to talk to current participants who are considering HV program enrollment would be beneficial.

Given the scarcity of information available, numerous participants had misconceptions about the scope of services within the HV program. Furthermore, they hesitated about participation due to fears of family members being deported after a home visit took place. Another concern was over the perceived consequences should the home visitor view the mother as being a less effective parent. Participants fear their child(ren) will be taken away from them. Program advertising addressing these concerns would be most helpful.

Participants often had entirely different ideas about what would happen in a given home visit. Participants thought visits would be much more formal, medical in focus, and performed by a nurse or healthcare provider. Providing more clarity about what home visits typically look like would be helpful.

There were some suggestions regarding allowing changes in the length of a given visit. In situations where a parent needs to address child behavioral issues, a lengthier session would be more beneficial in addressing this problem.

Participants in the home visiting program required several visits prior to understanding the program and the services offered by the home visiting program. If home visiting providers addressed the gap related to 'marketing' or educating providers and the public (stakeholders) about home visiting components, more parents would pursue participation.

While some HV program staff are bi-lingual, English speaking staff are assigned to participants who state proficiency in English. In turn, HV program staff are unable to speak to other Spanish speaking family members who live in the same residence with the enrolled participant. Participants also wanted to see bilingual opportunities for visits so that all family members could participate in visits.

Many participants requested greater clarity about what happens after the two-year enrollment period, or what are the next steps when their child reaches age five. Providing information about what options are available when transitioning out of the program would help address anxiety about the HV program ending.

Participants would like to see the program be expanded. Participants see the need and value of the HV program and feel fortunate they enrolled. Many feel lucky to have found the HV program, and wish others in their high-risk communities could also benefit.

To focus on improving MIECHV-related performance measures, additional Community Needs Assessment profiles (Appendix C) were developed for existing MIECHV-funded programs. These profiles were developed with public and home-visiting data to help highlight community need for LIAs. These will be utilized by LIAs to identify areas of focus for individualized CQI projects and improve outcomes for families.

Table 21. Quotes from HV Program Participants About HV Program Recommendations
"Get some participant testimony, and improve recruitment to the program. This program helps a lot of people and reaching out to make people aware."
"Up visibility and understanding of the program. Use emails, or a virtual brochure before calling them. Tell us about what you can expect during the visits. The Parent Connection is too late in the evening, maybe more 'mom n' me' day-time activities, or library story time could be done."
"It's a valuable program, very helpful. But, not enough visibility. Expand home visiting programs!"
"The idea of virtual visit happened with me before the COVID-19 stay at home initiative. She dropped off toys, then called in to me and spoke and I played with my children during the home visit."
"It would definitely be the program including the fathers as well as the moms. It was the same as her (participant gave reference to another mother wanting the father to participate). My baby's dad was –he's not as far along and close to my home visitor as I am just because he didn't know he could be there –'He said, Is it okay for me to be there? I didn't know I could ask her.' But, we're at a point now where we're good at conversation."
"Maybe more languages, if that makes sense. I feel like my dad is just dying to be part of this right now (Participant attended with her father). At home, my home visitor knows a little bit of Spanish, so they kind of communicate. With his level of English and her level of Spanish, they find a way to connect, but if there was someone more fluent, my dad could be like –when she was newborn, he had so many questions. He always wanted to see if this and this was okay, but he would always just tell me before the meeting, and then I would ask her during, and then he would go, 'Okay.' I'd tell him the answer, but I feel like he wishes he could be more involved, and there's just that barrier of language."

Results from the Focus Groups and Interviews. There were four common themes discussed throughout the focus groups which were identified. These included:

1. *Awareness and perceptions*
    - Apprehensions of HV being like Child Protective Services (CPS)
    - Concerns about time commitment
    - Assuming it cost money to participate
    - Are these services really needed?
    - Contemplation about contacting the program.

2. *Recruitment into the program*
    - WIC Staff
    - Medical Providers
    - HV Program Flyer
    - Counselor/Therapist
    - Word of mouth from family members, friends, and neighbor

3. *What happens during home visiting?*
    - What will it be like?
        - The HV staff is highly flexible
        - Normally 2 home visits per month
    - What was offered?
        - Useful resource beyond the 2 HV with text support outside of visits
        - Parenting Skills
        - Child Development/Stages
        - Child Health
        - Life Skills/ Problem Solving
        - Setting Goals
        - Feedback about Decisions
        - Resource/Service Referrals
        - Social Support
        - Trusting Friend
        - Navigating System
        - Assistance in Applying for Services
        - FAFSA
        - Counseling
        - Medicaid

4. *Transitioning out of the program*
    - Worried about loss of this important resource once their child becomes 5 years old.

Opportunities: There are opportunities for program expansion. Since the program is still only available in specific counties and reaching a small percentage of potential participants, it would be a great opportunity to expand the program. Although, this would rely on grants and additional funding.

There is also the opportunity for additional services after participants transition out of the home visiting program, such as a transitional program or service helping participants adjust to reduced visits or providing different types of visits during the transition. This could also provide the

opportunity to keep communication lines open with visitors after transitioning out of the HV program including the texting and calling opportunities.

Threats: The biggest threat to the program is funding. The MIECHV program has been funded through 2022. Funding still varies from year to year on how much UDOH will receive. For 2019, UDOH received $3,223,566. Since each year's funding varies, it could jeopardize the current processes in place.

Transitioning Out of the Program. Participants discussed their apprehension of transitioning out of the MIECHV program after two years' time. The biggest fear for HV program members was the expected loss of having their questions answered. The parents were concerned about losing the helpful interactions they had with the parent educators and having them as a resource. The participants are not aware of any community programs they could access after transitioning out of MIECHV. The participants indicated they needed resources and continued support from the parent educators, even if that connection was just continued texting with their home visitor.

Table 22. Quotes from HV Program Participants About Transitioning Out of the Program

"Even I know my dad and my home visitor have created a bond helping with the baby, I'm gonna miss her. I know her. It's been more attachment as well, so when it's over, it's gonna be like, 'So, now what? Who's gonna help me with all these questions?'"
"Yeah, I'd be like, 'What am I gonna do afterward?' I know she did tell me about a different program that does the same, but we didn't really get too much into it yet."

VIII. Conclusion

This Needs Assessment has identified areas of focus for the Office of Home Visiting moving into the next five years of implementation of evidence-based home visiting programs in Utah. OHV will utilize the results of this Needs Assessment to 1) focus statewide efforts on sustainable funding for expansion and increased services throughout the state in high-need areas, 2) identify potential locations for expansion of evidence-based home visiting, if funding allows, 3) assist current local implementing agencies implementing evidence-based home visiting in identifying resources to address community-specific needs, 4) utilize data to focus OHV and LIA efforts on strategic decision making to maximize impact of home visiting in high-need counties in Utah, and 5) address identified barriers and implement data-driven changes to increase quality and breadth of evidence-based home visiting services in Utah.

Dissemination of Results. In order to ensure that evidence-based home visiting in Utah is maximized, this statewide needs assessment will be disseminated to stakeholders through multiple methods, including:

1. Publication on the Office of Home Visiting website,
2. Press release from UDOH with a release of the Title V MCH Block Grant Needs Assessment and the MIECHV Needs Assessment in conjunction,
3. Dissemination of Community Needs Profiles to current MIECHV implementing agencies, and
4. Release of needs assessment to the MIECHV Community Advisory Board.