Georgia Maternal, Infant, Early Childhood Home Visiting Program

2020 Needs Assessment

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I. INTRODUCTION

Overview

The Georgia Department of Public Health (GA DPH) is a state grantee for the Maternal, Child, and Infant Early Childhood Home Visiting (MIECHV) program, a federal initiative administered by the Health Resources and Services Administration (HRSA). GA DPH implements home visiting as a prevention strategy used to support at-risk families, promote infant and child health, foster educational development, school readiness, and prevent child abuse and neglect. The Georgia Home Visiting Program (GHVP) within the GA DPH Maternal and Child Health (MCH) Section in the Division of Health Promotion is responsible for managing the program and has consistently achieved the overall goals to improve child and family outcomes by implementing Evidence-Based Home Visiting (EBHV). The specific goals achieved through EBHV include promoting program quality and effectiveness; utilizing the data and information to guide decision-making, improving coordination of services, and providing technical assistance that assists counties in monitoring performance and continuous quality improvement.

The 2020 MIECHV Needs Assessment allows GA DPH an opportunity to reassess the needs of the state, community readiness for EBHV, identify at-risk counties, and analyze the professional development needs of the existing home visiting workforce. Key stakeholders helped to identify priorities of need, potential data indicators, and sources for the assessment. Surveys were distributed to stakeholders and leaders throughout Georgia to understand their level of knowledge and the need for home visiting services in their communities. Also, two baseline Needs Assessments were completed in 2018 to address the home visiting workforce gaps and challenges. The first assessment included a comprehensive survey of the skills knowledge and training needs of home visitors (HVs). This information helped to shape and identify the appropriate professional development training needed to ensure a skilled workforce. A second assessment conducted in 2018 served as a follow up to identify changes in professional development and the needs of the workforce resulting from a series of training that were informed by the baseline assessment.

The GA DPH contracted with the Emory University Rollins School of Public Health (RSPH) to assist with completing the 2020 Needs Assessment including conducting focus groups and synthesizing data. Rollins School of Public Health is a leading institution in public health research, ranked No.5 for public health programs nationally, and has a proven track record of guiding systematic processes for determining and addressing the needs of states and communities.

This comprehensive report will provide a guide for future planning of sustaining and expanding home visiting throughout the state to communities most in need of supportive services and EBHV to improve the well-being of mothers, babies, and families.

Evidence-Based Home Visiting (EBHV)

MIECHV is dedicated to the expansion of access to evidence-based home visiting in the United States. This program builds upon decades of scientific research showing that home visits by a nurse, social worker, early childhood educator, or other trained professional during pregnancy and in the first years of a child's life improve the wellbeing of children and families by preventing child abuse and neglect, supporting positive parenting, improving maternal and child health, and promoting child development and school readiness. Home visiting services address a wide range of needs by focusing on facilitating education and answering questions around child development and developmental milestone; reinforcing engaged and positive parenting practices; providing screenings for developmental delays, maternal depression, and intimate partner violence; linking families to additional community resources through referrals; encouraging utilization of healthcare resources, including perinatal and well-child visits; and, supporting parents' educational and employment goals.

Through these interventions, home visiting is designed to (1) increase healthy pregnancies; (2) improve parenting confidence and competence; (3) improve child health, development, and readiness; and, (4) increase family connectedness to community and social support.

The Georgia Home Visiting Program (GHVP)

The overall goal of the GHVP is to improve outcomes for children and families by implementing high-quality EBHV as a major service strategy. The GHVP has designed and implemented a comprehensive early childhood system that includes recruitment and outreach through the First Steps program. First Steps provides screening and referral services for expectant parents, primary caregivers, and children from age birth to five and their families. The overarching mission of First Steps Georgia is to ensure a great start for children by linking families to resources that support the healthy development of children. Referrals are made based on screenings include various community resources (e.g., childcare options, housing supports, health care assistance, pediatrician suggestions). When more ongoing support is needed referrals are made to a home visiting program. The GHVP is designed to assist new parents who need consistent, ongoing support during the first years of their child's life. The early years of parenting are very demanding, and many conditions can make it even more difficult to ensure the safety and well-being of an infant and a young child. These risk factors may include one or more of the following for parents or primary caregivers:

Low income	First-time parent	Under 21 years of age
Unemployed	Unstable housing	Low educational attainment
Late or no prenatal care	Survivor of child abuse or neglect	History/current substance abuse
History/current special education services	History/current depression or other mental health conditions	Has children with developmental delays or disabilities
Families with individuals who are serving or formerly serving in the US military		

Staffing

The GHVP staff is comprised of professionals with over 30 years of combined experience in home visiting. The program staff includes the Deputy Director of Community Supports, Senior Home Visiting Manager, Community Relations Manager, Home Visiting Program Coordinator, and Fatherhood Involvement State Lead. Below are descriptions of each position and organizational chart (Figure1).

Deputy Director (DD). The DD is responsible for the oversight and management of MIECHV, including contractual agreements, monitoring home visiting fidelity, data collection, and quality and reporting. The DD conducts critical analysis research, develops policy and strategic plans, and implements, evaluates, and administers MIECHV funded strategies. Plans, develops, implements, and maintains a system designed to coordinate and provide continuous and systematic evaluations for programs and initiatives.

Senior Program Manager (PM). The PM is considered the Team's subject matter expert. The PM manages the day-to-day operations of the Georgia Home Visiting network; establishes partnerships with internal and external partners; focuses on sustainability; strengthening home visiting in the state and ensure home

visitors and supervisors received the support and training necessary to provide effective and efficient services to families.

Community Relations Manager (CRM). The CRM provides technical assistance and helps to integrate public health tools within the home visiting LIA as well as coordinates professional development opportunities statewide. The CRM provides sub-contract monitoring to Local Implementing Agencies (LIAs) that ensure they meet deliverables and understand the allowable and non-allowable costs. The CRM acts as the liaison between the state department and LIAs to maintain direct communication which is valuable to program success.

Program Coordinator (PC). The PC provides technical assistance to the home visiting program, manages the contracts including the technical assistance partner, University of Georgia Center for Family Research, and additional tasks to ensure the GHVP meets deliverables, provides accurate and timely reporting, and seeks opportunities to sustain and diversify funding.

Fatherhood Initiative Team Lead (FITL). The FITL is responsible for convening a cross-sector of partners and developing strategic plans to intentionally include fathers in Maternal and Child Health programs. Also, the FITL leads the way to GA DPH becoming the anchor to intra- and inter-agency partners through the development of a "Father Friendly" linkage and referral system and statewide resource guide.

Georgia Department of Public Health Home Visiting Project Organizational Chart

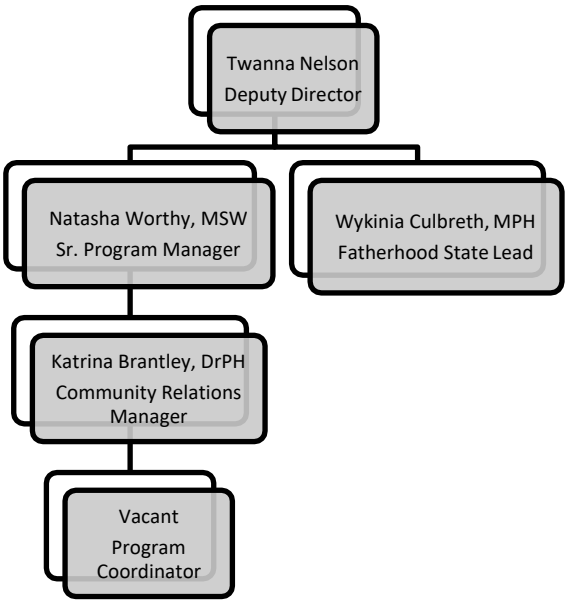


Figure 1. GA-DPH GHVP Organizational Chart

Home Visiting Models

The Georgia MIECHV program funds support four evidenced-based models:

1. Nurse Family Partnership (NFP)
2. Parents As Teachers (PAT)
3. Healthy Families Georgia (HFG)
4. Early Head Start-Home-Based Option (EHS-HBO).

These models are proven to improve outcomes in several domains including (1) maternal and child health, (2) positive parenting practices, (3) child development and school readiness, (4) reductions in child maltreatment, (5) family economic self-sufficiency, and (7) linkages and referrals to community resources and supports. Table 1 reflects the counties implementing each model.

Early Head Start-Home-Based Option (EHS-HBO)

EHS HBO aims to promote healthy prenatal outcomes and support infant and toddler development while strengthening families. Eligibility requirements for EHS-HBO include low-income pregnant women and families with a child from birth to three years of age. Program participation includes weekly 90-minute home visits and two socialization activities per month for the entire family.

Healthy Families Georgia (HFG)

HFG focuses on enhancing early, nurturing relationships between children and their primary caregivers as the foundation for life-long, healthy development. Eligibility requirements include low-income households, and parents facing challenges, such as a history of abuse, substance use, mental health issues, or domestic violence. Program participation includes 60-minute home visits every other week throughout pregnancy and weekly from birth to age 6 months. Subsequent visit frequency depends on families' needs and progress over time.

Nurse Family Partnership (NFP)

NFP aims to promote healthy pregnancies for low-income, first-time mothers. Mothers are enrolled before their 28th week of pregnancy, with services continuing until the child reaches two years of age. Trained nurses promote mothers' self-efficacy and personal growth and encourage attachment and healthy parenting choices. Program participation includes 60 to 75-minute home visits weekly in the first month of enrollment and for six weeks following birth, every other week from six weeks until the child reaches 20 months of age, and monthly thereafter.

Parents as Teachers (PAT)

PAT focuses on enhancing parenting knowledge, attitudes, and behaviors, and promoting family well-being to positively impact children's developmental trajectories. Eligibility requirements include low-income families, children with special needs, families at risk for child abuse and neglect, first-time parents, immigrant families, and parents with mental health or substance use issues. Families may enroll throughout pregnancy up until their child's 3rd birthday, with services continuing until the child reaches kindergarten entry. Participation includes 60-minute home visits conducted every other week and monthly group connection meetings for parents.

Table 1: Georgia Counties Implementing Home Visiting Models; statewide capacity: 1, 287

County	Name of LIA	EBHV Model	Funding Source	Capacity
Bartow	Advocates for Children	PAT	MIECHV	40
Bibb	United Way of Central Georgia	PAT	Title V	80
Catoosa	Communities in Schools of Catoosa County	PAT	CANP	18
Chatham/Liberty	Lutheran Services of Georgia	HFG	MIECHV	120
Clarke	Prevent Child Abuse Athens	HFG	MIECHV	100
Crisp/Dooly	Cordele Housing Authority	HFG	MIECHV	60
DeKalb	New American Pathways	PAT	MIECHV	58
DeKalb	Community Development Institute	EHS-HV	MIECHV	24
DeKalb	Scottdale Early Learning Center	PAT	MIECHV	65
Fulton	Fulton County Board of Health	PAT	DPH	40
Glynn	Coastal Coalition for Children	HFG	MIECHV CANP	100 40
Gordon	Family Resource Center Gordon	PAT	Title V	45
Houston	Rainbow House	HFG	MIECHV	80
Houston	Houston County Health Department	NFP	MIECHV	100
Lowndes	Lowndes Commission on Children and Youth	PAT	Title V	80
Lowndes	South Health District	PAT	DPH	30
Muscogee	University of Georgia	HFG	MIECHV	110
Muscogee	University of Georgia	PAT	MIECHV	90
Richmond	Augusta Partnership for Children	PAT	MIECHV	120
Rockdale	Rockdale County Schools	PAT	MIECHV	80
Whitfield	Family Support Council	PAT	MIECHV	70
Whitfield	Family Support Council	PAT	MIECHV	70

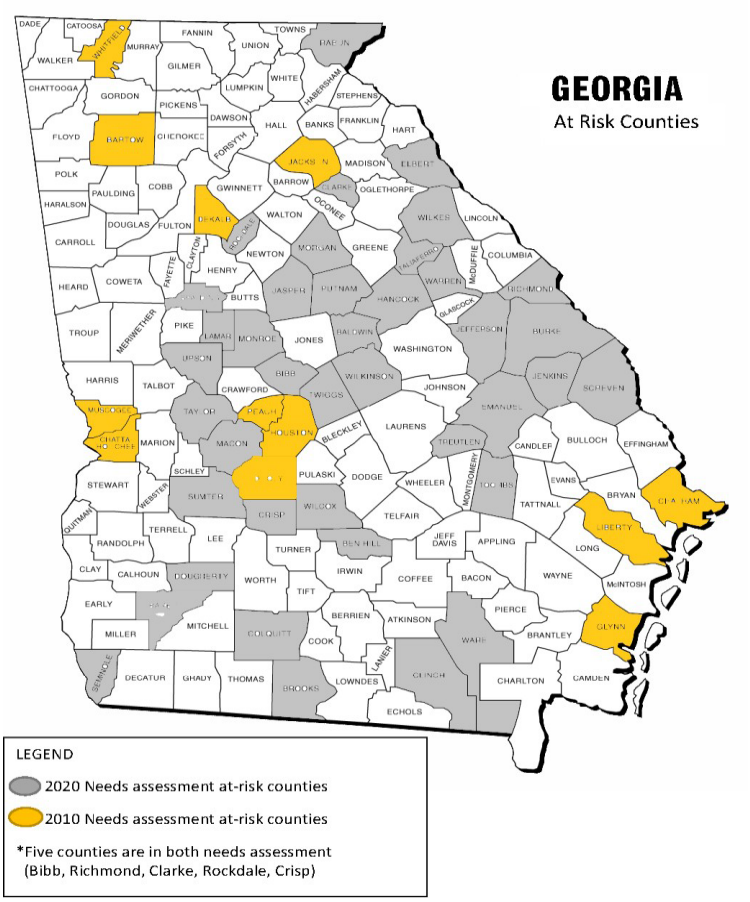


Figure 2: At-Risk Counties in Georgia 2010 and 2020

Methodology

In the FY2010 Title V Needs Assessment, there were 64 counties identified as at-risk based upon the measures used. The updated needs assessment simplified method and Phase Two indicated 52 at-risk counties.

This needs assessment process affords the state of Georgia the opportunity to:

- Conduct a thorough analysis of existing data.
- Collect additional information from stakeholders statewide.
  complement the existing quantitative data and identify any emerging trends
- Identify any data gaps and incomplete data sets.
- Establish baselines for future home visiting activities in Georgia.

This needs assessment was conducted in three parts:

1. **Community Risk Assessment** - Of the methods to identify communities with concentrations of risks, Georgia chose the Simplified Method. The simplified method is "an approach developed by HRSA based on generating indices of risk in five domains—low socioeconomic status, adverse perinatal outcomes, child maltreatment, crime, and substance use disorder—using nationally available county-level data. Indicators within each domain align with the characteristics described in the MIECHV-authorizing statute to identify communities with concentrations of risk. This method identifies a county as at-risk if at least half the indicators within at least two of the domains had z-scores greater than or equal to one standard deviation higher than the mean of all counties in the state." Data provided by HRSA was used to identify the top 40 at-risk communities in Georgia.

2. **MIECHV Focus Groups** – Using guidance from the HRSA Community Readiness Toolkit, focus groups were conducted with staff of five MIECHV-funded home visiting programs. These programs were selected based on the variability in their geographic location and communities served. One focus group was held in north Georgia, two in metropolitan Atlanta, and two in southeast Georgia. There was a total of 21 focus group participants across the five MIECHV staff focus groups, with a range of 3 to 11 participants in each focus group. Staff represented home visitors as well as program supervisors and managers. A focus group moderator's guide was developed to address several aspects of community readiness of the MIECVH programs. These topics included: 1) client population; 2) community needs/unmet needs; 3) organizational relationships and family supports; 4) program strengths; 5) opportunities for program improvements; 6) recommendations. Emory University Rollins School of Public Health researchers were contracted by DPH to conduct each focus group and to analyze and synthesize the focus group data.

3. **Community Readiness Surveys** – Using guidance from the HRSA Community Readiness Toolkit, Community Readiness Surveys were developed using questions from the toolkit for the following populations: Community Service Providers, Community Leadership, Other MIECHV Stakeholders. Surveys were distributed to the current 11 MIECHV LIA to have their managers, and supervisors complete the MIECHV *Community Service Providers Survey*. Each LIA was instructed to have the MIECHV *Community Leadership Survey* be completed by their agency CEO/Directors and local collaborative partners such as United Way and Division of Family and Community Services (DFACS). LIAs also had other community stakeholders such as parents, local childcare facilities, and community agencies complete the MIECHV *Other Stakeholders Survey*. Each survey was distributed electronically with a link to SurveyMonkey.

   The surveys were disseminated to the following groups:

   MIECHV Community Service Providers (agencies that serve new and expectant parents, families, young children, and youth):

   - Early Childcare Agencies
   - Substance Abuse Agencies
   - Mental Health Agencies
   - Community Centers
   - DFCS Caseworkers
   - Health Department (WIC, Women's Health (PCM Nurse), Pediatrician)
   - Private Providers

- Fatherhood Agencies
- School Social Workers
- Family Connection Birth to Five Advisory Groups

MIECHV Home Visiting Program Staff including program managers, supervisors, and home visitors who were able to provide information specific to the home visiting program and programs within the community:

- LIA Program Managers and Supervisors
- Home Visitors/Health Educators

MIECHV Community Leaders (Those agency leaders who could offer a broader scope of programming and maintain an influential role in decision making to ensure that new and expectant parents and their young children receive needed services (e.g., local councils/community action networks/advisory boards, home visiting champions, local funders, funders who support other programs in the community). The GA DPH partnered with the state's Children's First Program and the Women's Health Department to administer the MIECHV Community Leadership Survey. The Children's First Coordinators and the District Nursing Directors in the at-risk counties that did not have a MIECHV program completed the MIECHV Community Leadership Survey.

- LIA Board Members
- Community Service Providers Directors or Presidents or VP
- United Way Leadership
- DFCS Administrators/Funders
- Health Director
- LIA CEO

MIECHV Other Stakeholders (Parents, families who are eligible for or recipients of home visiting services, early childhood experts, academics, business owners, clergy or religious institutions, or other engaged community members/agencies that support or provide information about the community or its programming.):

- Parents
- Community Residents
- Churches
- Colleges/Universities
- Businesses
- State Legislative
- Legal Assistant
- Civic and Volunteer Groups

II. Georgia Community Risk Assessment

As part of the 2020 MIECHV Statewide Needs Assessment Update, the Health Resources and Service Administration (HRSA) required the state of Georgia to identify communities with concentrations of risks that include, but are not limited to, the following:

- Premature birth, low birth infants, infant mortality, including death due to neglect or other indicators of at-risk prenatal, maternal, newborn, or child health
- Poverty
- Crime
- Domestic Violence
- High Rates of High-School Dropouts
- Substance Abuse
- Unemployment
- Child maltreatment

Risk Assessment Method: Simplified Method

Indicators were selected in collaboration with HRSA/MCHB to match as closely as possible the statutorily defined criteria for identifying target communities for home visiting programs. Consideration was given to issues such as data availability and reliability of indicators at the county level when selecting the final indicator list. After selecting indicators, they were grouped according to five domains (Socioeconomic Status, Adverse Perinatal Outcomes, Substance Use Disorder, Crime, and Child Maltreatment). The algorithm for identifying at-risk counties is as follows:

1. Obtain raw, county-level data for each indicator from the listed data source as defined in Table 2 of the Appendix.
2. Compute mean of counties and standard deviation (SD) for each indicator as well as other descriptive statistics (number of missing, range, etc.) (Tab 3. Descriptive Statistics, in Appendix).
3. Standardize indicator values (compute z-score) for each county so that all indicators have a mean of 0 and an SD of 1. Z-score = (county value - mean)/SD. (Tab 5. Standardized Indicators, in Appendix).
4. Using the resulting z-scores for each county, calculate the proportion of indicators within each domain for which that county's z-score was greater than 1, that is, the proportion of indicators for which a given county is in the 'worst' 16% of all counties in the state (16% is the percentage of values greater than 1 SD above the mean in the standard normal distribution). If at least half of the indicators within a domain have z-scores greater or equal to 1 SD higher than the mean, then a county is considered at-risk on that domain. The total number of domains at-risk (out of 5) is summed to capture the counties at the highest risk across domains.

Counties with 2 or more at-risk domains are identified as "at-risk." (Tab 6. At-risk Domains, Appendix)

Not included are indicators for infant mortality and domestic violence. Infant mortality was excluded from the Adverse Perinatal Outcomes domain because the level of suppression at the county level for 5-year aggregate data was too high for meaningful inclusion (all but 13 states have >50% of counties with suppressed data). Preterm and low birth weight births together are the second largest cause of infant mortality. Given that the other two indicators in the domain are direct precursors of infant mortality, we evaluated the extent to which similar counties were identified when the infant mortality rate was included or excluded (among counties with non-suppressed data). The level of suppression for preterm birth and low birth weight was also substantial for individual year data. Thus, we compiled 3-yr and 5-yr aggregated

data to obtain reliable estimates for smaller counties. Domestic violence was excluded from the calculation because there are no national sources available with county-level data for domestic violence.

Summary of 2018 At-risk Community Information

At-risk Communities Served with MIECHV Funding

According to the 2018 Baseline Needs Assessment, the Georgia MIECHV program served 11 LIAs. Of the 16 counties served by these programs, four counties were considered at-risk, as defined by two or more risk domains in the 2020 Needs Assessment. An additional at-risk county, Bibb, is funded with Title V funds.

Table 2: 2018 At-risk Communities Served by Home Visiting Program

County	At-risk domain score	Name of LIA	EBHV Model	Capacity
Bibb*	3	United Way of Central Georgia	PAT	80
Clarke	2	Prevent Child Abuse Athens	HFG	100
Crisp	4	Cordele Housing Authority	HFG	60
Richmond	2	Augusta Partnership for Children	PAT	120
Rockdale	2	Rockdale County Schools	PAT	80
Total				**440**

***Bibb County is funded by Title V funding source**

Communities with Concentrations of Risk- FY2019

A county was identified as at-risk if it was in the 'worst' 16% of all counties in the state (16% is the percentage of values greater than 1 SD above the mean in the standard normal distribution). If at least half of the indicators within a domain have z-scores greater or equal to 1 SD higher than the mean, then a county is considered at-risk on that domain. The total number of domains at-risk (out of 5) is summed to capture the counties at the highest risk across domains. Counties with 2 or more at-risk domains are identified as "at-risk." See Appendix for the results and rankings for each risk assessment method and overall risk rankings. Table 4 (below) highlights the 40 at-risk counties and their overall Risk Scores.
Out of Georgia's 159 counties, 40 (25%) counties met the formal definition of at-risk communities (2 or more risk domains) (see Table 3)

Table 3: Counties with At-risk Domain Counts of 2 or more

At-risk domain count	Number of counties	% of Counties	% of the Georgia population (2017 estimates)
4	3	1.89%	.8%
3	10	6.29%	3.53%
2	27	16.98%	9.28%
Subtotal	40	25.16%	13.61%

Of the remaining 119, 65 had one risk domain, and 54 had no risk domains. Of the 40 counties meeting the at-risk definition, three counties have four risk domains, 10 have three risk domains, and 27 have two risk domains (see Table 2 for At-risk counties with MIECHV-funded home visitors and Table 4 for all counties). See Appendix for additional details on the methodology.

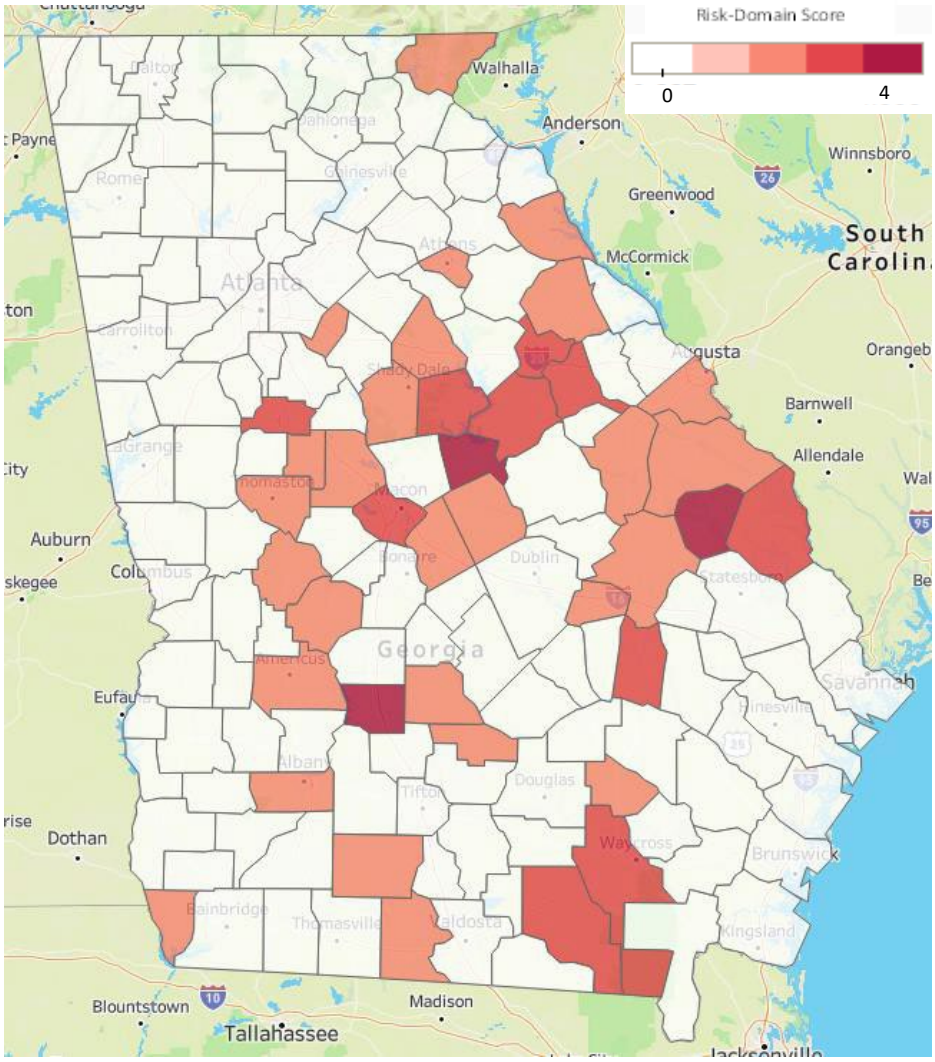


Figure 3: At-Risk Counties in Georgia

Table 4: At-risk Communities in Georgia (Simplified Method)							
County	**Number of At-risk Domains**	**County**	**Number of At-risk Domains 2**	**County**	**Number of At-risk Domains**	**County**	**Number of At-risk Domains**
Baldwin County	4	Toombs County	3	Elbert County	2	Rockdale County	2
Crisp County	4	Ware County	3	Emanuel County	2	Seminole County	2
Jenkins County	4	Warren County	3	Jasper County	2	Sumter County	2
Bibb County	3	Bacon County	2	Jefferson County	2	Taylor County	2
Clinch County	3	Ben Hill County	2	Lamar County	2	Treutlen County	2
Hancock County	3	Brooks County	2	Macon County	2	Twiggs County	2
Putnam County	3	Burke County	2	Monroe County	2	Upson County	2
Screven County	3	Colquitt County	2	Morgan County	2	Wilcox County	2
Spalding County	3	Clarke County	2	Rabun County	2	Wilkes County	2
Taliaferro County	3	Dougherty County	2	Richmond County	2	Wilkinson County	2
		Dooly County	2				

* Counties in green denote current GHVP funded LIAs

At-risk Communities Served with MIECHV Funding

According to the 2019 Georgia Home Visiting Program Annual Report, the GA Home Visiting program was expanded to 11 LIAs serving 17 counties. Of those, five areas were identified in the 2020 Needs Assessment as being at-risk communities, as defined by having two or more risk domains. One GHVP LIA is in a County with a total Risk-domain score of 4 (Crisp), and three in counties with a score of 2 (Clark, Richmond, Rockdale), reflecting the focus of the MIECHV on vulnerable and at-risk communities.

Comparison of At-risk Counties with Overall Risk Level in State

On average, all Georgia counties have one at-risk domain. In comparison, the mean at-risk domain value for all at-risk counties was 1.5 times higher than the average Georgia County. The average at-risk domain score for counties served by the MIECHV/HVP program is slightly higher than the average Georgia County. The at-risk domain score for at-risk counties served by MIECHV/HVP is higher than all of Georgia's at-risk counties. About 14% of Georgia's population lives in at-risk communities, 5.67% live in counties that are at-risk, and have a MIECHV/HVP program. Child treatment rates in MIECHV/HVP were (statistically significantly lower) than in at-risk counties with no MIECHV/HVP LIAs, reflecting the positive effect of MIECHV/HVP programs on maltreatment reports seen in the 2018 MIECHV Home Visiting Annual Report (see Table 5).

Table 5: Comparison of at-risk counties with Overall Risk Level in State						
	Summary of At-risk Domain Score	**SES**	**Adverse Perinatal Outcomes**	**Substance Use Disorder**	**Crime**	**Child Maltreatment**
GA counties (n=159)	**1.01**	**.15**	**.15**	**.17**	**.15**	**.16**
GA at-risk Counties (n=40)	**2.4**	**.29**	**.36**	**.36**	**.337**	**.37***
MIECHV/HVP counties (2019; n=17)	**1.11**	**.14**	**.24**	**.16**	**.26**	**.11**
MIECHV/HVP + at-risk counties (2019; n=5)	**2.6**	**.26**	**.4**	**.35**	**.5**	**.2**

*F=9.4; p<0.01

Presence of MIECHV/HVP LIAs in At-risk Communities by Risk Domain

Socio-Economic Status (SES)

The SES Risk Domain was calculated from the following indicators: Poverty (2017 Census Small Area Income and Poverty Estimates), Unemployment (2017 Department of Labor Statistics), High school Dropout rates (2017 American Community Survey), and Income Inequality (2017 Income Inequality). MICHV staff and service recipients all reported that low socioeconomic status, poverty, and unemployment were significant barriers to improving the health and communities. This result is reflected in the Risk-score data (see Table 6). Three out of the five MIECHV/HVP LIAs are in counties with SES-risk domain scores of 0.5 or higher (Crisp, Bibb, and Clarke).

Table 6: SES indicators in Georgia Counties				
	Families in poverty (%)	**Unemployment (%)**	**High school dropout rates**	**Income Inequality**
GA counties (n=159)	16.13	3.9	6.94	.46
GA At-risk Counties (n=40)	18.72	4.28	9.94	.49
MIECHV/HVP counties (2019; n=17)	15.52	3.7	6.0	.5
MIECHV/HVP + At-risk counties (2019; n=5)	18.94	3.94	5.68	.5

SES Indicators Details

Percent of Families living in poverty

As reflected in the SES and unemployment data, the family and provider focus groups, lack of financial resources are considered a central barrier for improving the health of families and communities. Close to 20% of families in at-risk counties served by MIECHV LIAs are considered living in poverty (see Table 7). Two of the MIECHV LIAs (Crisp and Bibb) operate in counties with high poverty rates, with 25% of the families in Crisp County living in poverty. Also, the 2018 MIECHV Home Visiting annual report states that 73% of all the families being served live below 100% of the Poverty Line. Furthermore, in both the 2018-baseline needs assessment of Georgia's MIECHV-funded home visitors and the 2019 follow-up needs assessment, "breaking the cycle of poverty and culture of poverty" were indicated to be significant priorities for the providers.

Table 7: Percent of Families Living in Poverty in Georgia

	GA counties (n=159)	GA At-risk Counties (n=40)	MIECHV/HVP counties (2019; n=17)	MIECHV/HVP + At-risk counties (2019; n=5)
Families in poverty (%)	16.13	18.72	**15.52**	18.94

Unemployment

Compared with other areas of the country, the Georgia unemployment rate in general and in at-risk communities ranged around 4% (see Table 8). Consequently, all five MIECHV LIAs are in counties with low unemployment rates. While this may look promising, it was clear, based on the focus groups, that women frequently did not seek employment (and thus did not show up in the unemployment rolls) because of the lack of options for safe and affordable childcare. See the MIECHV focus group data for more details.

Table 8: Mean Unemployment Rate

	GA counties (n=159)	**GA At-risk Counties (n=40)**	**MIECHV/HVP counties (2019; n=17)**	**MIECHV/HVP + At-risk counties (2019; n=5)**
Unemployment (%)	3.9	4.28	**3.7**	3.94

High-school Dropout Rate for Population 16-19 years

While the high school dropout rate is about 10% for Georgia at-risk communities, the counties with MIECHV-funded home visitors report a high school dropout rate of 6% (See Table 9). Nonetheless, given the poverty and low resource concerns that are evident in the families being served, MIECHV-funded home visitors have been actively working on enrolling the primary family providers into either a GED or equivalent educational programs: In 2018, the program was able to able to enroll 27% of primary caregivers without a high school degree or GED in an education program (2018 MIECHV Home Visiting Program).

Table 9: High school Dropout Rate, %

	GA counties (n=159)	GA At-risk Counties (n=40)	MIECHV/HVP counties (2019; n=17)	MIECHV/HVP + At-risk counties (2019; n=5)
High school dropout rate (%)	**6.94**	9.94	**6.0**	5.68

Income Inequality

The index is based on the Gini coefficient, a statistical dispersion measurement that ranks income distribution on a scale between 0 and 1. Low numbers represent greater equality; numbers around the mid-point represent complete inequality (50% of the population has nothing). The US Gini coefficient is estimated to be around .47, indicating high-income inequality. Georgia's GINI index indicates high-income inequality on average, as does the index of the at-risk counties (see Table 10). Four of the MIECHV LIAs that are in at-risk counties have GINI indexes of .50 or higher (Crisp, Bibb, Clarke, and Richmond).

Table 10: Income Inequality in Georgia

	GA counties (n=159)	GA At-risk Counties (n=40)	MIECHV/HVP counties (2019; n=17)	MIECHV/HVP + At-risk counties (2019; n=5)
Income Inequality (GINI index)	.46	.5	.5	.5

Rockdale has an index of .42.

Adverse Perinatal Outcomes

Adverse Perinatal Health Outcomes were calculated based on Preterm Birth and Low Birth Weight data from the 2013-2017 NVSS Raw Natality File. Two out of five MIECHV/HVP LIAs are in counties with Adverse Perinatal Health (APH) scores of 0.5 (Crisp and Rockdale) and one County with a score of one (Bibb). Georgia's at-risk communities have a mean APH score that is twice as high as GA (Table 11).

Table 11: Adverse Perinatal Outcomes Domain Score (mean)

	GA counties (n=159)	GA At-risk Counties (n=40)	MIECHV/HVP counties (2019; n=17)	MIECHV/HVP + At-risk counties (2019; n=5)
Adverse Perinatal Outcomes Domain score (mean)	.15	.36	**.24**	.4

Substance Use Disorder

The Substance Use Disorder Risk score data were calculated from the 2014-2016 SAMHSA - National Survey of Drug Use and Health. Three out of the five GHVP LIAs are in counties with Substance Use Disorder risk domain scores of 0.5 (Clarke, Richmond, Bibb), one in a County with a risk score of .25 (Rockdale), and one that is in a County with a risk score of zero, but adjacent to two at-risk communities (Crisp). Georgia's at-risk communities have domain risk scores twice as high as non-Risk Georgia counties (See. For more details on the community needs and capacity for substance use disorder, please see Section IV.

Crime

The Risk Domain Crime score was calculated using the data on Crime Reports and Juvenile Arrests from the 2016 Institute for Social Research - National Archive of Criminal Justice Data.

Table 12: Crime Risk Score Mean

	GA counties (n=159)	GA At-risk Counties (n=40)	MIECHV/HVP counties (2019; n=17)	MIECHV/HVP + At-risk counties (2019; n=5)
Crime Rate Score	.15	.337	**.26**	.5

All five MIECHV/HVP LIAs are in counties with a Crime risk score of 0.5. Georgia's at-risk counties have an indicator risk score that is at least twice as high as the average Georgia County; higher in at-risk communities with MIECHV LIAs (see Table 12). The impact of crime on the community became evident when talking to providers in a County known to be a significant pass-through for illegal drugs and accompanying crime. In this community, drug-related police raids are a considerable barrier for accessing women in the program and had significant effects on women and providers feeling safe in their community.

Child Maltreatment

The Child Maltreatment Indicator was calculated from the 2016 Administration for Children and Families (ACF) database. One of the MIECHV/HVP LIAs is in a County with a Child Maltreatment score of one (Crisp). Child treatment rates in MIECHV/HVP were (statistically significantly lower) than in at-risk counties with no MIECHV/HVP LIAs, reflecting the positive effect of MIECHV/HVP programs on maltreatment reports seen in the 2018 MIECHV Home Visiting annual report.

Table 13: Mean Child Maltreatment Indicator Score

	GA counties (n=159)	GA At-risk Counties (n=40)	MIECHV/HVP counties (2019; n=17)	MIECHV/HVP + At-risk counties (2019; n=5)
Mean Child Maltreatment Score	.16	37*	**.11**	.2

Additional Characteristics of At-risk Counties

Summary

To create a more holistic picture of the at-risk status of Georgia counties, additional characteristics were calculated for this report, including rurality, the proportion of people who are uninsured, segregation score, and domestic violence.

Fatality rate

At-risk counties that are being served by MIECHV/HVP programs are concentrated in mostly small metro counties, which may be reflective of the lack of resources in Georgia's rural (noncore) counties. Almost twenty % of families living in these counties are living in poverty, have an uninsured rate of 15%, but relatively low unemployment numbers and high school dropout rates. In terms of segregation, all Georgia counties score average into a score in the "highly segregated" range; however, the scores have a wide range, depending on location.

Rurality

The rurality status of the counties was calculated using data from the 2014-2018 U.S. Census American Community Survey (ACS), which uses the National Center for Health Statistics Rural Classification Scheme for Counties.

Two of the MIECHV-funded home visiting LIAs are located in small metro areas (Clarke and Bibb), one in a large fringe metro county (Rockdale), one in a medium metro county (Richmond), and one in a micropolitan community (Crisp; and Table 14). None located in rural (noncore) communities, which may be reflective of the lack of resources in Georgia's rural counties. The lack of rural resources was also a significant theme in the MIECHV focus group, where low resources, transportation issues, and few employment opportunities constituted significant barriers to the health of families.

Table 14: Metro Status of Georgia Counties

	GA counties (n=159)	GA At-risk Counties (n=40)	MIECHV/HVP counties (2019; n=17)	MIECHV/HVP + At-risk counties (2019; n=5)
Metro Status*	Large central metro 1 Large fringe metro 28 Medium metro 15 Micropolitan 28 Small metro 30 Noncore 57	Large central metro 0 Large fringe metro 5 Medium metro 2 Micropolitan 9 Small metro 6 Noncore 18	Large central metro 1 Large fringe metro 3 Medium metro 3 Micropolitan 2 Small metro 7 Noncore 1	Large central metro 0 Large fringe metro 1 Medium metro 1 Micropolitan 1 Small metro 2 Noncore 0

* Metropolitan counties: Large central metro counties in MSA of 1 million population that: 1) contain the entire population of the largest principal city of the MSA, or 2) are completely contained within the largest principal city of the MSA, or 3) contain at least 250,000 residents of any principal city in the MSA. Large fringe metro counties in MSA of 1 million or more population that do not qualify as large central Medium metro counties in MSA of 250,000-999,999 population. Small metro counties are counties in MSAs of less than 250,000 population. Nonmetropolitan counties: Micropolitan counties in the micropolitan statistical area. Noncore counties not in micropolitan statistical areas.

Percent of County with Uninsured Populations

The uninsured rate was calculated using the 2014-2018 U.S. Census American Community Survey (ACS) data. Georgia is a non-Medicaid expanding state, and thus, uninsured rates of about 15% are consistent across most counties (see Table 15). However, the lack of insurance during the inter-conception period is a barrier to maternal health and primary care for women throughout the state. It is thus a measure of success that the 2018 MIECHV Home Visiting annual report was able to indicate that 65% of primary caregivers had continuous health insurance coverage for at least six months of the year.

Table 15: Percent uninsured in Georgia counties, mean %

	GA counties (n=159)	GA At-risk Counties (n=40)	MIECHV/HVP counties (2019; n=17)	MIECHV/HVP + At-risk counties (2019; n=5)
Uninsured (%)	15	15	14.46	14.29

Segregation Score

The segregation score was calculated using the Theil Index. Data used in the calculation of this index were derived from the U.S. Census Bureau's 2010 Decennial Census. The Theil index is an index ranging from 0 to 1 that displays information about racial segregation. Lower index values below .20 suggest less segregation, and higher index values above .40 suggest more segregation. The Theil index is a measure of how evenly members of racial and ethnic groups are distributed within a region, calculated by comparing the diversity of all sub-regions (Census blocks) to the region. Patterns of racial segregation can emerge because of systemic barriers and opportunities or localized individual preferences. For example, highly segregated areas may be indicative of discriminatory housing practices or other related obstacles.

On average, Georgia counties score in the "more segregation" range of the score (see Table 16). While three of the LIAs (Richmond, Rockdale, and Clarke) have moderate segregation scores, one community (Bibb) has a high segregation score (.4). In contrast, Crips County, which has the highest at-risk score of all the served counties, has the highest segregation score of .6. The effects of racism on a community's health were also expressed in several focus groups around the state. Besides, both the 2018 Baseline Needs Assessment and the 2019 follow-up indicate that MIECHV-funded home visitors would like more training on the effects of racism and discrimination on families.

Table 16: Segregation score, mean

	GA counties (n=159)	GA At-risk Counties (n=40)	MIECHV/HVP counties (2019; n=17)	MIECHV/HVP + At-risk counties (2019; n=5)
Segregation Score	.41	.45	.39	.38

Domestic Violence Fatality Rates of At-risk Counties

While there is no federal database that is collecting domestic violence-related data, we were able to obtain domestic violence death data from the 2018 report of The Georgia Domestic Violence Fatality Review Project (http://georgiafatalityreview.com/reports/), normalized to the 2017 data. The quantitative analysis of the domestic violence fatality rate confirmed the presence of this thread, with MIECHV LIAs serving counties with comparatively high fatality rates, about 8 in 100,000. In the staff focus groups, domestic violence was talked about as an underlying thread of the lives of the women they were serving, and it was considered one of the areas that required more training and resources. This request for more training on this topic was also reflected in both the 2018 Baseline Needs Assessment, and the 2019 follow-up indicate that MIECHV-funded home visitors.

The training received has shown great success in that MIECHV Home Visitors are aware of the importance of the topic and report that 88% of primary caregivers were screened for intimate partner violence within six months of enrollment. Furthermore, 79% of primary caregivers who screened positive for intimate partner violence received referral information to appropriate community resources.

Phase Two Approach

Georgia optionally added the following counties to the list of at-risk counties utilizing the *Phase Two* approach: Bartow, Chatham, Liberty, Glynn, DeKalb, Whitfield, Muscogee, Houston, and Peach. The Georgia Department Health internal evaluators have provided relevant data points that provide support for the Phase Two approach associated with Sudden Infant Death (SIDS) which a priority set by the department and a MIECHV Performance Measure. Also, infant mortality has become a major priority for the GA DPH with the

establishment of an infant mortality program and the infant mortality workgroup focused on improving birth outcomes which is consistent with many of the MIECHV benchmarks. These counties display a need for continued home visiting services based upon the following:

Bartow County
Challenges related to birth outcomes, teen births, sudden infant death (SIDS), and violent crime. First, the percentage of uninsured children is 2% higher than the state average at 7%. The teen birth rate is 32 compared to the Georgia rate of 26, and the rate of babies born to mothers with less than 12 years of education is 17.8 vs 12.6 for the state. The violent crime rate is 468 compared to 388 for the state of Georgia. Bartow has experienced 7 deaths for children under the age of 1 since 2015 from SIDS and additional 2 children died from suffocation in 2019.

Chatham County
Chatham County has several concerns related to birth outcomes. The rate of preterm birth is 12.9 compared to the state average of 11.6. The infant mortality is 7.4 compared to 7.0. The late or no prenatal care is 11.8 compared to a state rate of 9.5. The children deaths reported from SIDS were 10 children under the age of 1 since 2015.

Liberty County
Liberty County is home to Fort Stewart, Georgia, a large military base near Savannah. The percentage of children in poverty is 23% compared to 21% in Georgia. The infant mortality rate is high at 7.6, compared to 7.0 for the state. The child maltreatment rate is 15.1 compared to 12.0 for the state of Georgia. The teen birth rate is 56, compared to 26 for the state. Civilians deliver their babies in Savannah (Chatham County), but there is a birthing hospital on the military base.

Glynn
The percent of children living in poverty is 27% compared to a state average of 21%. The rate of low birth weight babies is 12.0 compared to 10.0 for the state of Georgia. Preterm birth is higher than the state average by 2.1 higher. (13.7 vs 11.6). Four times the number of late to no prenatal care has been reported 40.6 compared to 9.5 for the state. Glynn county consists ofrural areas, but the population mostly resides in urban areas.

DeKalb
The established EBHV in DeKalb county is serving South DeKalb and a large population of immigrants in the state of Georgia through the New American Pathways program. The north Dekalb area is flanked by a thriving part of Metropolitan Atlanta made up of Brookhaven, Tucker, Chamblee, Stonecrest, and Doraville while the south DeKalb is home to a lower-income base and social-economic status. The EBHV is serving the most at-risk high-need population of this county however the north DeKalb data is influencing the data more positively. There are six times more white residents in north Decatur almost 66% vs 11% in south Decatur and four times more black residents in south Decatur (85% vs 18.9% in south Decatur. This is one example of a city in DeKalb county. The poverty for children in DeKalb county is 23.0% compared to the state of 21%. The infant mortality is 8.0 compared to 7.0 for the state. Lastly, the rate of late to no prenatal care was 11.8 compared to 9.5 in the state in 2019. This number would be even higher for the immigrant population being served by the DeKalb EBHV program New American Pathways. This county would benefit from continued funding to support the south DeKalb population and immigrant population in the state of Georgia.

Whitfield
The Hispanic/Latino percent is 36.3% according to the 2019 census. The teen birth rate is 39 compared to 26 for the state of Georgia. The uninsured percent is high at 23% compared to 16% for the state. The

teen birth rate is 39 compared to the 26 for the state of Georgia. The EBHV that serves Whitfield has a large Latino population many undocumented. This county has a large rate of mothers with less than 12 years of education 29.4 compared to 12.6 for the state. The EBHV Family Support Dalton has many trained home visitors with experience working with the Hispanic/Latino population.

Muscogee
The teen birth rate is 41 compared to 26 for the State of Georgia. A larger portion of children is living in poverty compared to the state of Georgia 28% compared to 21%. The low birth weight is 2% higher in this county compared to the state at 12% vs 10%. Another birth outcome that continues to be a challenge in Muscogee is the preterm birth rate is 14.4 compared to the state rate of 11.6. The infant mortality is 10.9 compared to 7.0 for the state of Georgia.

Houston/Peach
These counties are both located in the central portion of the state and are served by two EBHV (Nurse Family Partnership and Rainbow House) that serve families. The infant mortality rate documented in Houston County rate is 11.8 compared to the state average of 7. Both EBHV programs could continue serving those clients on their current caseload and close them out while increasing the caseload in the surrounding areas in greater need. Both Nurse Family Partnership and Rainbow House are serving Peach county. The preterm birth in Peach is 18.6 compared to the state average of 11.6. the percent of children in poverty in Peach is 33% compared to the state average of 21%.

It is our concern that removing home visiting supports to these communities would be detrimental to the families and the communities. Although these counties have improved in some defined risk factors, they are still considered at-risk based upon the constructs indicated above. Removal of these programs would only send these counties back to the top of the at-risk list with more negative circumstances facing families in those areas. The MIECHV programs serving the current area have improved the well-being of families and support key initiatives of safe sleep and infant mortality set by the GA DPH.

III. QUALITY AND CAPACITY OF EXISTING PROGRAMS

In this section, we identify the quality and capacity of existing programs for early childhood home visiting in Georgia. Information is provided regarding the number and types of home visiting programs as well as the number of individuals and families who receive services under such programs. Also contained in this report is information about how well programs are meeting the needs of families and gaps in the childhood home visitation in Georgia. To do so, data was reviewed from survey data gathered from the 2018 baseline assessment, survey data collected from key stakeholders, and focus group data collected from the five MIECHV programs.

Local Implementing Agencies (LIAs)
The GHVP supports a network of robust LIAs that continue to provide distinct and systematic approaches for supporting and improving the well-being of families. GHVP helps to coordinate necessary services within and outside of home visiting programs to provide support and technical assistance to the LIA staff to address the needs of participants, which may include: mental health, primary care, dental health, children with special needs, substance use, childhood injury prevention, child abuse/neglect/maltreatment, school readiness, employment training, and adult education programs. Throughout these 16 counties, there are 11 individual home visiting programs and 67 home visitors (HVs) funded by MIECHV. The total capacity of MIECHV funded home visiting programs is 1, 287 families, while the total GHVP statewide capacity of individual home visiting programs ranges from 24 to 120 families.

Total Families Served through Home Visiting

Table 17 provides details regarding the number of families served with MIECHV funding and funding from all sources of home visiting funding. MIECHV funds were used to serve a total of 1,457 families, 272 pregnant women, 1,185 primary caregivers, and 1,365 children. Home visiting funds were used to serve 2, 066 total families, 355 pregnant women, 1,711 primary caregivers, and 1, 927 children.

Table 17: Total Families Served

Program Funding	Total Families	Families Completing Program	Families Stopped Services Before Completion	Pregnant Women	Primary Caregivers	Children
MIECHV	**1, 457**	**96**	**425**	**272**	**1, 185**	**1, 365**
Home Visiting	**2,066**	**130**	**64**	**355**	**1,711**	**1,927**

Demographics

Georgia reports the key demographics of the families served with MIECHV and GHVP funding. Additional information about the characteristics of participants can be found in the 2019 Georgia Home Visiting Program Annual Report.

Household Income

As indicated in Table 1, most families served through MIECHV and GHVP are below 100% of the federal poverty level (FPL). Of these, most families live at or below 50% FPL, indicating that both programs serve low-income families in need.

Table 18 Household Income about Federal Poverty Guidelines

	All households	50% and under	51 to 100%	101 to 133%	134 to 200%	201 to 300%	>300%	Unknown/ Did not report
MIECHV								
All households	1,457	499	492	226	162	49	25	4
GHVP								
All households	2,066	778	674	285	224	67	32	6

Race

Table19 provides details about the race of participants served through both MIECHV and GHVP. The data indicate that Black or African Americans represent most pregnant women, female and male caregivers, female and male children served by MIECHV. These findings hold true also for participants served by GHVP.

Table 19: Participants by Race

Program Funding	Total	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Other Pacific Islander	White	More than One Race	Unknown or Did Not Report
MIECHV								
Pregnant women	**272**	**0**	**5**	**197**	**0**	**61**	**3**	**6**
Female caregivers	**1,167**	**0**	**82**	**562**	**1**	**486**	**22**	**14**
Male caregivers	**18**	**0**	**0**	**9**	**0**	**9**	**0**	**0**
All Adults	***1,457***	***0***	***87***	***768***	***1***	***556***	***25***	***20***
Female index children	**694**	**26**	**43**	**330**	**0**	**265**	**22**	**8**
Male index children	**671**	**11**	**48**	**333**	**0**	**238**	**32**	**9**
All index children	**1,365**	**37**	**91**	**663**	**0**	**503**	**54**	**17**
GHVP								
Pregnant women	**355**	**0**	**5**	**257**	**0**	**81**	**4**	**8**
Female caregivers	**1,680**	**0**	**83**	**849**	**22**	**701**	**24**	**21**
Male caregivers	**31**	**0**	**0**	**17**	**0**	**14**	**0**	**0**
All Adults	***2,066***	***0***	***88***	***1,123***	***2***	***796***	***28***	***29***
Female index children	**967**	**34**	**44**	**483**	**1**	**364**	**31**	**10**
Male index children	**960**	**22**	**48**	**476**	**0**	**364**	**38**	**12**
All index children	**1,927**	**56**	**92**	**959**	**1**	**728**	**69**	**22**

Ethnicity

Table 20 provides details about the ethnicity of participants served through both MIECHV and GHVP. The data indicate that most participants served through both MIECHV and GHVP are not Hispanic or Latino. However, both programs do serve many Hispanic or Latino participants, including female caregivers, and female and male children.

Table 20: Participants by Ethnicity				
Program Funding	**Total**	**Hispanic or Latino**	**Not Hispanic or Latino**	**Unknown or Did not Report**
MIECHV				
Pregnant women	**272**	**33**	**238**	**1**
Female caregivers	**1,167**	**332**	**831**	**4**
Male caregivers	**18**	**6**	**12**	**0**
All Adults	**1,457**	**371**	**1,081**	**5**
Female index children	**694**	**193**	**494**	**7**
Male index children	**671**	**175**	**491**	**5**
All index children	**1,365**	**368**	**985**	**12**
GHVP				
Pregnant women	**355**	**46**	**308**	**1**
Female caregivers	**1,680**	**459**	**1,215**	**6**
Male caregivers	**31**	**7**	**1,547**	**7**
All Adults	**2,066**	**512**	**1,547**	**7**
Female index children	**967**	**261**	**694**	**12**
Male index children	**960**	**253**	**702**	**5**
All index children	**1,927**	**514**	**1,396**	**17**

Staffing

Table 21 reflects the number and type of home visiting staff employed by each of the four program models. These data are displayed according to staff funded by MIECHV or Georgia Home Visiting program (GHVP) funding. There was a total of 24 Supervisors, 66 Home Visitors, and 11 Other Home Visiting Staff employed with MIECHV funding. There was a total of 29 Supervisors, 83 Home Visitors, and 15 Other Home Visiting Staff employed with Georgia Home Visiting Program funding.

Table 21: Home Visiting Staff by Program Model, October 1, 2018-September 30, 2019			
HV Model	**Supervisors[1]**	**Home Visitors**	**Other Home Visiting Staff[2]**
MIECHV Funded Staff			
Early Head Start HV	1	2	0
Healthy Families Georgia	14	32	7
Nurse-Family Partnership	1	4	1
Parents as Teachers	8	28	3
Total	**24**	**66**	**11**
GVPH Funded Staff			
Early Head Start HV	1	2	0
Healthy Families Georgia[3]	14	33	7
Nurse-Family Partnership	1	4	1
Parents as Teachers	13	44	7
Total[4]	**29**	**83**	**15**

[1] Includes Supervisors, Program Managers, and Clinical Supervisors. [2] Includes other First Steps Georgia staff and Family Assessment Workers (FAWs). First Steps Georgia is a community-based service that connects families to community resources appropriate for expectant parents and children from birth to five years of age. FAW is an HGF position, with the main responsibility of completing a more in-depth screening called the Parent Survey. Usually, the FAW and First Steps roles are completed by one person. [3] Healthy Families Georgia is the name used for Healthy Families America programs in Georgia. [4] Not included in the total are three First Steps Georgia staff, which each serve more than one program in the following counties: Dekalb, Muscogee, and Whitfield.

Strengths of Home Visiting

In this section, the data presented reflects the strengths of the program as well as information about the capacity of home visiting programs to serve families in need. Overall, home visiting staff and community stakeholders report strong support and a great capacity for implementing home visiting services in Georgia. Also, program data suggest that there has been a success in promoting key maternal and child health outcomes for families served through the MIECHV and GHVP.

Impact of Home Visiting Services

Table 21 below reflects these positive outcomes by the source of home visiting funding (MIECHV or all home visiting funding). These findings indicate that many women who received home visiting services were breastfeeding at 6 months (31%) and completed a postpartum visit (97% - MIECHV and 82%- all HV funding). Most clients reported practicing safe sleep with their infants (83%) and had almost no reports of child maltreatment (99%). Also, many mothers were screed for depression (91%-MIECHV; 85%-all HV funding). Caregivers also largely reported reading, telling stories, or singing songs to their children (96%), and being screened for intimate partner violence (92-MIECHV; 85%-all HV funding).

Table 21: Impact of Home Visiting Services							
Funding Source	**Breastfeeding at 6 months**	**Completed Postpartum Visit**	**Practicing Safe Sleep**	**No Child Maltreatment**	**Mothers screened for depression**	**Caregiver Read, Told Stories, Sing Songs**	**Caregivers Screened for IPV**
MIECHV	**31%**	**97%**	**83%**	**99%**	**91%**	**96%**	**92%**
All HV	**31%**	**82%**	**83%**	**99%**	**85%**	**96%**	**85%**

Support for Home Visiting in the Community

There is strong support for home visiting services in most communities in Georgia. Home visiting staff ranked community support as high (mean of 7.9 on a scale of 1 to 10) and indicated in the focus groups that have a wide range of partners is crucial to the success of home visiting programs. As one MIECHV staff member explained, strong collaboration with community resources has helped make home visiting services successful in her program. *"A successful resource for me would be Children 1st and programs like Babies Can't Wait. We are doing, both programs are doing ASQs evaluations, right? And oftentimes if there's an area that is in the gray or the black, we make the referral to Children 1st and I've just seen really good collaboration between them and the mom and us on helping that baby get the needs, or getting the needs met. So that has been successful."*

Qualitative data from the stakeholder surveys also denote strong community support for home visiting services. Select quotes from these stakeholders are provided below.

Community Service Providers: *"*Our community members are more than willing to do whatever it takes for the betterment of children & their families*."*

Community Leaders: "Very good support from the community, they are financially supported by the United Way and Dalton Public Schools. The hospital gives support by giving access to the First Steps program to complete assessments of new mothers. The business community provides direct support by providing for families at Christmas*."*

Home Visiting Staff: "Community members support home visiting in numerous ways: serving on the program's advisory committee, allocating space for the program to use the group activities for program participants; donating items needed by program participants (e.g. furniture, clothing, diapers, etc.) and sponsoring families for Christmas*."*

Professional Development and Job Satisfaction

Another major strength of the home visiting program is the opportunity for professional development for home visitors. Stakeholders highly ranked the opportunities in their communities for training and professional development for home visitors. On a scale of 1 to 10, with 10 being very high, community leaders had a mean rank of 7.5, community service providers had a mean rank of 6.9 and other stakeholders had a rank of 7.5.ranked professional development opportunities (mean of 7.5. On a scale of 1 to 10, community leaders ranked professional development. When asked if the community can provide ongoing professional development through formal, informal, or online training opportunities for home visitors, survey respondents reported favorably (yes by 100% of the community service providers, and yes by 92% of community leaders).

Data gathered from the 2018 baseline workforce assessment and 2019 MIECHV focus groups indicate that home visitors have high job satisfaction. Home visitors reported being very satisfied with their work, supervision, and their coworkers. They also reported that certain professional development opportunities were especially helpful, including training regarding communication, mental health, motivational interviewing, self-care, facilitation of visits, Certified Lactation Counselor, self-defense, and the Home Visiting Institute. In one MIECHV staff focus group, a participant explained how important it has been to have training on maternal mental health issues. "I feel like we've gotten good training over the years about maternal depression, but we have moms with bipolar disorder dissociative identity disorder, schizophrenia. I mean you can never have enough training about how to accomplish what you need to accomplish with those families, within the context of a mom who is battling that type of mental illness."

Gaps and Challenges

In this section, we discuss the gaps and challenges in the delivery of early childhood home visiting services in Georgia. Findings reflect gaps in the types of services offered, challenges experienced by home visiting staff in delivering such services, and home visiting workforce and training challenges. Data were gathered from our baseline assessment reports, stakeholder surveys, and qualitative focus group data.

Delivery of Home Visiting Services

Findings from the stakeholder surveys indicate that there are challenges to home visiting services in some communities. About 77% of home visitors and 93% of community leaders felt that there are challenges to starting or expanding home visiting services in their communities. Other stakeholders identified the lack of phones or computers as major barriers to delivering home visiting services to clients.

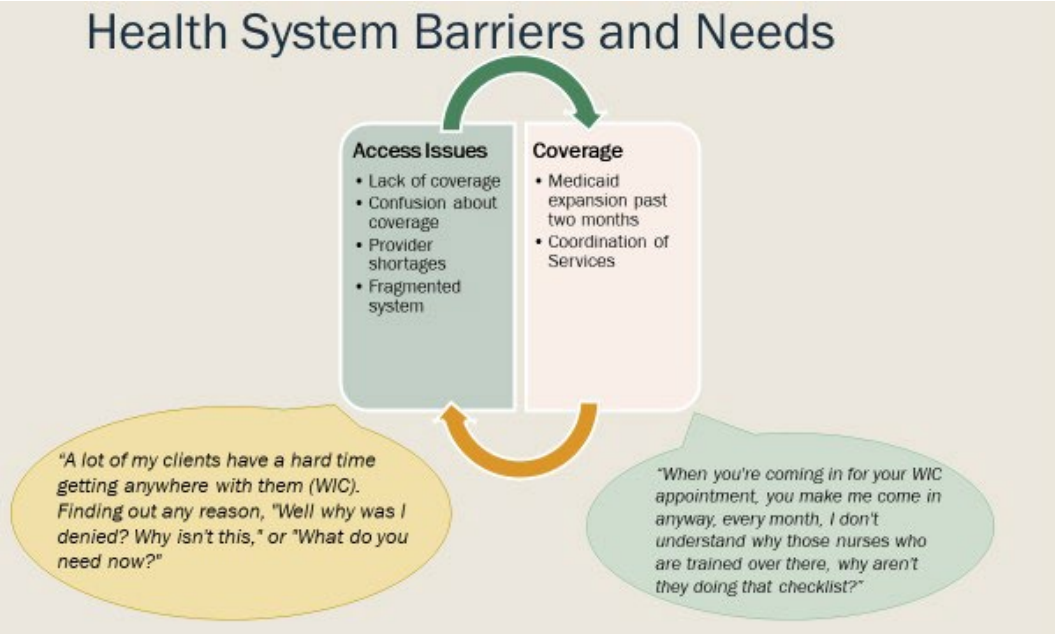
About 92% of community leaders and 96% of community service providers indicated that there are recent or adverse events that have impacted the delivery of home visiting or other services in the community. A majority of respondents in the "other stakeholders" category (84.5%) reported that the COVID-19 pandemic was the most serious challenge to starting or expanding services in their community. Also, about 77% of these respondents indicated that there are community members who may oppose implementing or expanding home visiting services for expectant mothers, new parents, or young children.

Qualitative data from these surveys provide more details about how and why these challenges exist. As one community leader indicated, the challenge of starting a new home visiting program is because *"a lot of programs duplicate services and often the perception is that programs are re-created without truly finding out what exists. Also, questions arise as to why funds were not put into existing programs with the experience and knowledge to expand their services, instead of implementing a new program."*

Concerning recent or adverse events, several survey participants indicated that the COVID-19 pandemic has affected the delivery of home visiting services. One stakeholder explained, *"the home visits are virtually now. I know that a lot of moms have declined services because they have no phone or laptop to connect them with the visitors."* GA DPH is planning a specific assessment of the impact of the COVID-19 pandemic on home visiting programs in Georgia. In partnership with the Rollins School of Public Health, this assessment will document the emerging needs of home visiting clients and the strategies that home visiting programs have implemented to meet these needs since the start of the COVID-19 pandemic.

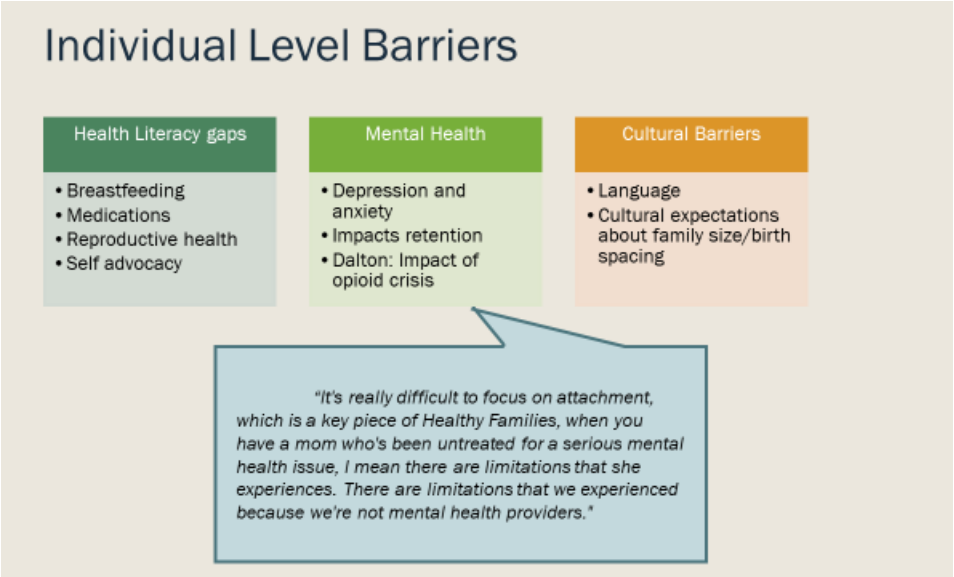
Health System Barriers and Needs

Findings from the MIECHV focus groups indicate that there are other barriers to the delivery of home visiting services that relate to health systems issues. Home visitors indicated that many of their clients lack health care coverage or are confused about their coverage and thus do not seek health care for themselves or their families. Staff explained that because Medicaid does not provide coverage after two months postpartum, many moms forgo services. This also makes coordination of care very difficult when families are no longer eligible for services.



Individual Barriers and Needs

Several individual-level client barriers and needs were identified through the stakeholder surveys and focus groups. In terms of barriers, data indicate that home visiting families have health literacy gaps, specific to breastfeeding, medication adherence, reproductive health, and self-advocacy. Mental health is a specific barrier mentioned by almost all informants. MIECHV staff indicated that many of their clients suffer from depression and anxiety, and as such, affects retention in the program. The opioid crisis has fueled some of these mental health crises in certain parts of the state. Informants also indicated that numerous cultural and language barriers prevented some families from participating in the home visiting programs.



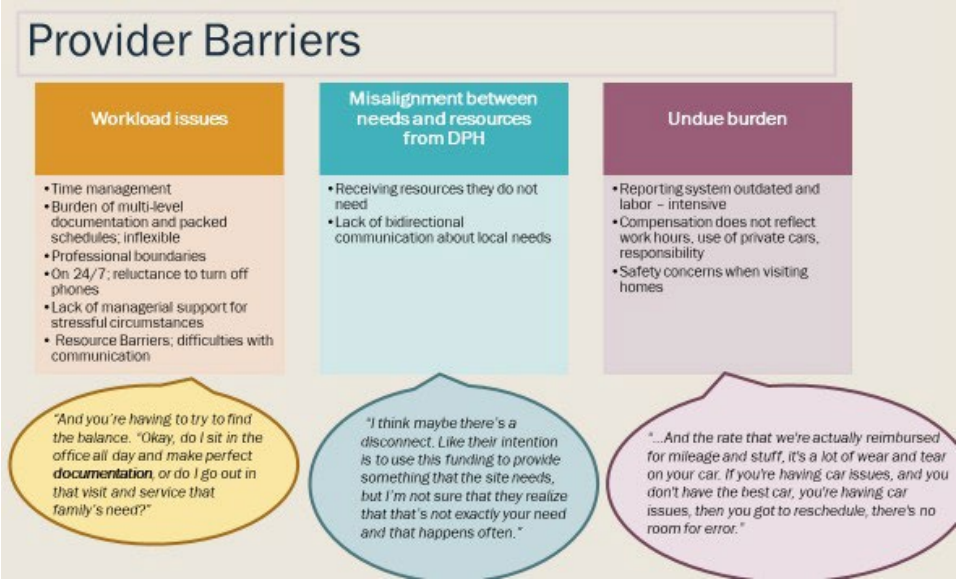
Stakeholders and home visitors identified common themes about the individual needs of home visiting clients. This includes the need for quality mental health care that would reduce the stigma many families face or believe regarding mental health. Families need resources to meet basic needs (employment, childcare, housing), as well as reliable social support (from fathers, family members, or peer support groups). Finally, families need more support and education about child development and wellbeing, as well as help with navigating the health care and social service systems.

Community Barriers and Needs

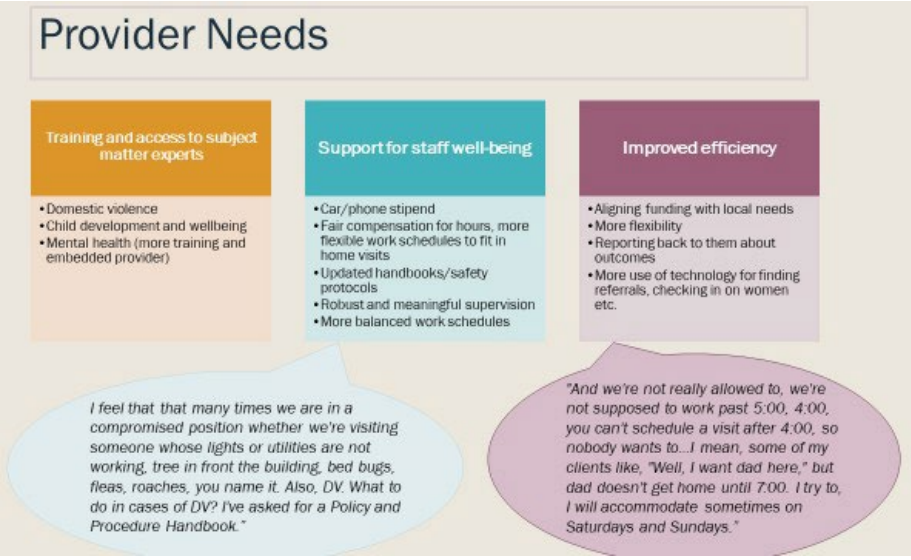
Home visitors often identified specific barriers and needs of their community that served as challenges to delivery home visiting services. They indicated that their clients often do not have transportation to seek health care appointments or to seek employment. The transportation barriers are especially difficult for families that live in rural areas and do not have public transportation options. Home visitors also discussed the distance they must travel to serve some families who live in rural areas of the state. Often, there is no cellular phone service in these areas and roads are difficult to navigate. Additionally, it takes more time for home visitors to travel to serve these families. Families often do not have safe housing or live in areas with high crime, lack of food security, and quality childcare.

Provider Barriers and Needs

Findings from the MIECHV focus groups yielded important insight into the barriers and needs of home visiting staff. Several common themes emerged regarding provider barriers, including workforce issues, needs and resources from DPH, and undue burden. First, home visitors reported having difficulty with managing their time, of having a heavy workload burden that included multi-level documentation and inflexible work schedules. They also commented that they felt they worked 24/7 and were reluctant to turn off their phones, in case their families needed to reach them. They also expressed challenges with working in stressful environments without a lot of managerial support. Finally, some home visiting staff reported limited resources to complete their duties and had difficulties with communication in their teams. Home visiting staff reported that the data system they work with for documentation is too labor-intensive.



Provider needs were identified through the MIECHV focus groups. First, home visitors requested more training on specific topics related to domestic violence, child development and wellbeing, and mental health. Additionally, support services were requested for staff well-being, such as having financial support for cell phones, fair compensation, updated safety protocols, additional robust and meaningful supervision, and assistance with having a more balanced work schedule.



IV. Capacity for Providing Substance Abuse Treatment and Counseling Services

GA DPH collaborates with the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) to provide substance use disorder treatment and counseling services to families who present with substance abuse challenges. Georgia has an aggressive state's substance use disorder prevention, early identification, treatment, and recovery support systems described below.

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) and its network of community providers offer treatment and support services to help people with behavioral health challenges achieve recovery by focusing on their strengths. DBHDD is the state agency responsible for the administration, coordination, planning, regulation, and monitoring of all components of the state public behavioral health and intellectual and developmental disability systems. DBHDD operates state hospitals and provides for community-based services across the state through contracted providers. As Georgia's public safety net, the department's primary responsibility is to serve uninsured people, individuals on Medicaid, and others with few resources or options are also served.

Division of Behavioral Health (DBH) is responsible for providing leadership for all behavioral health services for children and adolescents, emerging adults, and adults. There are nine offices within this Division: Addictive Diseases; Prevention Services; Adult Mental Health; Children, Young Adults, and Families; Deaf Services; Recovery Transformation; Field Operations; Crisis Services and Federal Grant Programs and Special Initiatives. DBH is the authority for behavioral health programs, services, and support statewide.

DBH has developed the following goal*: Build a recovery-oriented community-based system of care, with the capacity to provide timely access to quality behavioral health treatment and support services.*

Office of Addictive Diseases (OAD) provides leadership for adult and adolescent substance use disorder treatment services. The responsibilities include: program oversight, grants management; ensuring compliance with federal and state funding requirements; maintaining collaborative relationships with advocacy groups and other stakeholders; providing data and information at the regional and local levels to impact policy decisions; statewide technical assistance to providers and the six DBHDD Field Offices; developing and maintaining collaboration among private and public sector providers and stakeholders;

providing training and information on best practices for substance use disorder treatment; coordinating collaborative efforts in increasing best practices models; assisting community and faith-based groups in developing capacity and training; overseeing HIV Early Intervention Services among substance users and their families and significant others; overseeing men's residential treatment services throughout Georgia and the Women's Treatment and Recovery Services program; and carrying out gambling prevention activities.

The Office of Addictive Diseases and the Office of Adult Mental Health coordinate treatment and training issues regarding service delivery to those with co-occurring substance use and mental health disorders. By contract, all state providers of services must be co-occurring capable. Georgia has spent several years providing statewide training to ensure competency in assessing and treating both mental illness and substance use disorders. Both offices share the same service definitions in the state Provider Manual and work in harmony to ensure that adults, children, and adolescents have an integrated system of care.

The Office of Behavioral Health Prevention (OBHP) is the state agency charged with providing prevention leadership, strategic planning, and services to improve the mental/emotional well-being of communities, families, and individuals in Georgia. The OBHP develops and contracts for prevention services across the state specifically designed to reduce the risks and increase protective factors linked to substance use related problem behaviors, suicide, and mental health promotion. The office uses a public health approach (population-based) and the Strategic Prevention Framework Model (Assessment, Capacity, Planning, Implementation, and Evaluation). A more in-depth description of the OBHP is provided later in this document in the Office of Behavioral Health Prevention Services and Programs section.

Delivery of Behavioral Health Services Including Addictive Diseases

DBHDD is responsible for the delivery of services for adults with severe and persistent mental illness, substance use disorders, or a combination of any of these, and children with serious emotional disturbances as well as for people with intellectual and developmental disabilities. The service delivery system and the process for developing and contracting with providers are comprehensive in scope and focused on the value of consumer choice. Community-based services are delivered by a network of private and public providers with whom DBHDD contracts or have letters of agreement. Currently, there are over 250 behavioral health providers for DBHDD with 25 of them being Comprehensive Community Providers, the department's public safety net providers.

Women's Treatment and Recovery Support

DBHDD contracts with providers in all six DBHDD regions of the state to provide various levels of treatment services for women with substance use disorders. Currently, there are 21 residential programs, 13 outpatient programs, and 13 transitional programs providing gender-specific treatment. There are 425 residential treatment slots and 395 outpatient slots. The Women's Treatment and Recovery Services (WTRS) are designed to view recovery as an ongoing process to improve health and wellness and live satisfying self-directed lives for pregnant and parenting women. Providers use evidenced-based practices that address risk factors for relapse and empower individuals to achieve identified goals with a flexible range of options for treatment. WTRS helps to identify barriers to employment, education, housing, family roles and responsibilities, and to identify unique strengths, preferences, and natural supports in the community. The target population is women with substance use disorders who are pregnant and/or parenting children under the age of 13 years. WTRS programs also provide services for women who are at high risk for relapse, are sufficiently medically stable to participate in intensive outpatient and residential treatment, and who may have one or more of the following risk factors:

• Highest priority is given to women who meet the needy family's definition

- Pregnant women will be given priority status
- Involvement with the criminal justice system
- History of relapse, or secondary medical or psychiatric disorder that can be safely managed in a substance use treatment environment
- Women with an open child protected service case

With levels of care ranging from outpatient, residential, and transitional housing options, WTRS providers work with individuals who are at high risk for relapse, are pregnant, have Child Protective Services or Family Support Involvement, criminal justice involvement, psychiatric disorders, and are sufficiently medically stable to participate in treatment. Services for women include but are not limited to: ongoing assessment and screening, psychiatric and nursing care, group and individual interventions that address issues of relationships, cognitive distortions, sexual and physical abuse, trauma, parenting, anger management, symptom management, and therapeutic child care. Therapeutic interventions for children in the custody of women in treatment address developmental needs and issues of sexual and physical abuse and neglect. Case management and transportation are provided to ensure that women and their children have access to services. Vocational assistance includes job training, job matching, educational resources, and other supports to allow individuals to gain experience and ability in the community. The average length of stay is three to six months.

DBHDD's services for pregnant and postpartum women are enhanced through the State Pilot Grant Program for Treatment for Pregnant and Postpartum Women (PPW-PLT). PPW-PLT, known as Georgia Strong – Standing Together in Recovery to Overcome and Nurture Growth, targets women with substance use disorders, including opioid use disorders, who are pregnant and/or parenting children under the age of two years and who are at high risk for setbacks, have Child Protective Services or Family Services involvement, criminal justice involvement, and/or co-occurring mental health challenges. In its first year, the program, which continues to grow, has served over 25 women and their families, providing a family-centered, integrated approach to treatment for pregnant and post-partum women. There are approximately 12,800 pregnant women estimated to need treatment for substance use disorder. Of these, 4, 250 are currently in treatment. There are approximately 8,250 women with dependent children estimated to need treatment (a 15% increase since 2019). Of these, 6,300 are currently in treatment.

Another DBHDD partnership has also supported services for mothers and their infants. With support from DBHDD, the Georgia Council on Substance Abuse (GCSA) is working in partnership with the Northeast (NE) Georgia Medical Center (NGMC) to provide peer recovery support services and recovery coaching to mothers with infants with Neonatal Abstinence Syndrome (NAS) in two of NGMC's Neonatal Intensive Care Units (NICU) located in Gainesville and Braselton. The program currently employs four recovery coaches, known as Certified Addiction Recovery Empowerment Specialist (CARES) NICU coaches. CARES-NICU coaches listen and are present to answer questions parents and families may have about recovery supports or treatment options. CARES-NICU coaches maintain contact with individuals after discharge to continue providing additional recovery support.

Services, which are provided through a collaborative relationship with the NICU department and supportive relationships with NGMC's Mother/Baby Unit, Labor and Delivery Unit, and the Pediatrics Department, include intentional peer support through initial encounters and contact with family members to help build natural supports. The peer recovery support services and recovery coaching help fill a gap in services between delivery and discharge from the hospital to the first checkup/follow up with the mother and/or her infant. In year 2 of this program, FY 19 data shows that recovery coaches have met with 69 peers for initial encounters; followed in person 132 times with peers and family members; followed up by making contact by phone/social media 132 times with peers; and left messages by telephone or text message for peers or family members 191 times.

Collaborating with Local Entities

DBHDD acknowledges the gravity of the work to reduce the number of overdose deaths, provide access to those needing treatment, and increase the availability of recovery support in communities throughout Georgia that cannot be accomplished by one agency. The department has partnered with the following organizations to address OUD and overdose collaboratively:

- Department of Corrections/Community Supervision – to advise of addiction as a brain disease, how to provide support to those with OUD returning to communities, and to help them feel empowered with information and resources to assist those in their program.
- Accountability Court Judges – teaches on addiction as a brain disease, why treatment cannot be limited to one medication, and the challenges and triumphs of having a MAT program within an accountability court.
- Department of Family and Children Services – teaching on addiction as a brain disease, the challenges of providing support to a parent with OUD, and the resources available to assist individuals that may need treatment or connection to a recovery support center.
- Department of Public Health – providing strong support in the development of a state strategic plan on the opioid epidemic, sharing information regarding training throughout the state and gaps in coverage, and education on ways to collaborate to reduce overdose deaths and provide greater recovery support.
- Physicians at various hospitals – provide the required three CME's through education on the risks and known benefits of treating pains with opioids, addiction as a brain disease, and identifying and educating patients at greater risk for addiction.
- Provider network – provide training on improved communication around substance use disorder. to increase appropriate language awareness and reduce stigma.
- Partnered with Georgia Council on Substance Abuse to launch a statewide project titled"Georgia Recovers". This project will consist of billboards and videos of people that have recovered from substance use disorder sharing their stories.

Gaps in Current Level of Substance Use Disorder Treatment and Counseling Services

There are several gaps in the current level of substance use disorder treatment and counseling services in meeting the needs of pregnant women and families with young children. We highlight these gaps below. These gaps include:

- Collaborative relationships with private OBGYN
- Revision of policy and inclusion of effective Plan of Safe Care Development and Coordination with Child Welfare
- Transportation
- Housing
- Family/Social Supports

Lack of Substance Use Treatment Resources

Findings from our MIECHV surveys indicate a strong need for substance use treatment services for women, during and after pregnancy, as well as their families. As one community leader explained, home visiting services could assist women with connecting with "services during postpartum for substance abuse and mental health." Another community leader described substance use treatment as "difficult to come by for parents, yet these interventions are critical for the social-emotional health of children."

Barriers to Receipt of Substance Use Disorder Treatment and Counseling Services
We have identified several barriers to the receipt of treatment and counseling services among pregnant women and families with young children. These barriers were identified through several sources of data, including MIECHV home visiting staff and Title V client focus groups, as well as stakeholder and staff surveys. These findings are summarized below.

Screening Barriers
Both the 2018 and 2019 Georgia Home Visiting Program (GHVP) Annual Reports identify substance use as a main area of support offered to families through the evidence-based models. Healthy Families and Parents as Teachers include substance abuse as one eligibility requirement for the programs. History of substance abuse is one of the 10 domains of family functioning used to measure the level of risk.

Stigma
Stigma was identified as a major barrier to seeking treatment for substance use disorder. The stigma of substance use disorder prevented many pregnant and postpartum women from seeing care for their addiction. Due to the stigma surrounding the topic, families likely need to be specifically asked about drug use to gain an understanding of the existence and nature of the issue. Future focus groups with home visitors should also include specific questions about substance abuse in families and communities served.

Opioid Crisis
In Georgia, the opioid crisis has been particularly challenging for rural communities. In one northern town, home visiting staff explained that the reason given for the high rates of opioid use in mothers was for stimulation to keep them going through long shifts at work and taking care of their families.

Lack of Training
Home visitors sometimes suspect there is drug use in the home, but the families often do not talk to them about drug use in the home. In the 2018 Baseline Needs Assessment, one LIA identified the need for training on "recognizing signs of drug use." In MIECHV home visitor focus groups one location discussed not having a protocol of what to do when they find themselves in a potentially unsafe situation with drugs. Home visitors in another location asked for more training for cases with opioid use.

Unsafe Environments due to drug use
Home visiting staff reported that they are often prevented from completing their home visits due to the unsafe environments of their clients. Both home visitors and community leaders emphasized the need to be aware of personal safety when entering communities to complete home visits. One home visiting staff member discussed frequent drug busts and police raids in her community as a major barrier. The 2019 MIECHV Innovation Follow-Up identified drug activity as a safety barrier for home visitors in three counties.

Opportunities for Collaboration with State and Local Partners
There are opportunities for collaboration with state and local partners to address gaps and barriers to care for pregnant women and families with young children affected by substance use disorder. Collaboration with partners at all

Opportunities for collaboration include the following:
- Cross-system training for improved understanding of each agency's role
- Training on state referral processes and ways to improve referrals
- Education on retaining custody that can keep family in-tact and deter from foster care placement

- Implementation of prevention, treatment, and recovery supports within the public/private systems as well as the community.
  Examples of partners that can assist with addressing the gaps and barriers along with GA DPH are United Way, DCFS, Family Support Council, Promoting Safe and Stable Families (PSSF), Department of Behavioral Health and Developmental Disabilities, Community Service Boards, drug treatment courts, faith-based institutions, and community-based organizations.

Current Activities to Strengthen Systems of care for Addressing Substance Use Disorder Among Pregnant Women and Families with Young Children

Current activities to strengthen systems of care for addressing substance use disorder among pregnant women and families with young children are fostered by the GA DPH Opioid and Substance Misuse Response Program, Georgia Pregnancy Risk Assessment Monitoring System (PRAMS), and Douglas County Family Treatment Court.

GA DPH Opioid and Substance Misuse Response Program

GA DPH Opioid and Substance Misuse Response Program convened a multidisciplinary workgroup team to focus on ongoing work for developing a state plan to address maternal substance use to discover best practices and develop unified cross-cutting strategies. The workgroup has developed a plan that includes methods to educate women of childbearing age, their partners, and their health care providers on substance misuse, prevention, interventions, treatment, the opioid epidemic, and Neonatal Abstinence Syndrome (NAS).

Georgia Pregnancy Risk Assessment Monitoring System (PRAMS)

The Georgia Pregnancy Risk Assessment Monitoring System (PRAMS) is a Georgia Department of Public Health surveillance project funded by the Centers for Disease Control and Prevention. PRAMS collect state-specific population-based data on maternal knowledge, attitudes, behaviors, and experiences before, during, and shortly after pregnancy. The PRAMS team provides information on substance abuse among Georgia moms that is used to guide programs serving families.

Substance use before and during pregnancy smoke and alcohol exposure during pregnancy can be harmful to mother and baby, causing a range of adverse birth outcomes and developmental/behavioral problems including miscarriage, preterm birth, low birth weight, birth defects, and intellectual disabilities. Vital Record data helps GA DPH identify the rate of preterm birth; however, PRAMS provides additional information about potential contributing factors, for instance, smoke and alcohol use during pregnancy. The Georgia PRAMS Substance Use Fact Sheet has been useful to GHVP planning activities to serve families facing challenges with substance use disorder. The PRAMS report provided recommendations to community-based programs on a variety of topics including creating a safe place for mom to talk about substance use; offering empathy and understanding that encourages help-seeking behavior, building much-needed trust in heeding medical advice by refraining from accusing or shaming mom, and providing accurate information on risk to mom and baby due to alcohol use.

Douglasville County Family Treatment Court

The Quality Improvement Court Collaborative lead by the Douglasville Family Treatment Court is a partnership among the Juvenile Court, Division of Family and Children Services, Court Appointed Special Advocates (CASA), Law Enforcement, Georgia Department of Public Health, community treatment service agencies, and local birthing hospital. This partnership provides Georgia participants with treatment for their substance abuse as well as a relationship with these agencies to promote reunification and early intervention services for the children. There are current efforts to explore options to sustain the Quality Improvement Court Collaborative and expand to other communities.

V. Coordination with Other Needs Assessments

Coordinating with Title V, Head Start, and CAPTA Needs Assessment

Georgia Title V

GA DPH coordinated both the MIECHV and Title V Block Grant needs assessment. Key components of the assessments were aligned to gather data necessary to meet the needs of women, infants, and children in Georgia. Because both the MIECHV and the Title V Block Grants are managed at the state level by the Department of Public Health Maternal and Child Health Program communication between programs was easy to coordinate and strategies developed to avoid duplication of efforts and strength of the assessments. The GHVP worked closely with the Title V program to address the common strengths and weaknesses of each program and to gain early input from stakeholders about the development of the surveys and focus groups. GHVP sought to understand the recommendations from multiple perspectives about strategies for improving program services and for engaging with the community to leverage additional resources and support for home visiting services. GA DPH contracted with Emory University Rollins School of Public Health to conduct focus groups for both MIECHV participants and Title V home visiting staff. RDPH also assisted with synthesizing data and preparation of the MIECHV needs assessment.

During this process GA DPH assembled the Georgia MCH Advisory Council to provide support and guidance to the Title V program to promote and improve maternal and child health in Georgia. The Council consists of over sixty members from cross-sector organizations and groups with a broad range of expertise to address and improve health outcomes for women, infants, children, and families. The Council serves as a conduit for the exchange of information and advises on progress, facilitates private and public sector support for improving health outcomes and helps focus efforts among partners, recommends collaborative initiatives, and reviews existing and proposed Title V projects. Council members include representatives from state, local, non-profit, academic, health care, and professional family practice, child protection, family development, district, and state health departments, and a parent/family member representative. organizations that have expertise in areas related to MCH, such as nursing, nutrition, parenting, and pediatrics. The advisory council provided input on the MIECHV Needs Assessment and members of the completed surveys and assisted with identifying other partners to participate.

CAPTA Needs Assessment

The Georgia Division of Family and Children Services (DFCS) administers programs funded under Title IV-B of the Social Security Act. The Division provides a wide range of human services that are designed to promote services and self-sufficiency, independence, safety, and well-being of Georgians including child welfare services and public assistance programs. Georgia child welfare service delivery is state-supervised, county-administered, and responsible for implementing services under the Child Abuse Prevention and Treatment Act (CAPTA). GA DPH coordinated with the DFCS administrators and those responsible for completing the CAPTA Needs Assessment. Local DFACS departments were included in the community readiness surveys conducted in those areas that do not currently have home visiting programs. The determination was made to coordinate with DFCS because these centers are located throughout the 159 Georgia counties. GA DPH home visiting program staff met with the
DFCS Prevention and Community Support Section Director for discussion regarding home visiting and contribution to the plan to support families. The CAPTA Needs Assessment included voluntary, in-home services to support positive parent-child relationships, child health, and neglect. DFCS will release a Statement of Need (SoN) to solicit proposals from state government agencies, non-profits, and public entities to provide an allocation to support services for vulnerable children. GA DPH will provide the results of the MIECHV needs assessment to assist DFCS in making the award that will support the most at-risk counties. GA DPH will maintain regular meetings with DFCS to share results and collaborate.

Head Start
Bright from the Start: Georgia Department of Early Care and Learning (DCAL)is responsible for meeting the childcare and early education needs of Georgia's children and their families. It administers the nationally recognized Georgia's Pre-K Program, licenses childcare centers and home-based childcare, administers Georgia's Childcare and Parent Services (CAPS) program, federal nutrition programs, and manages Quality Rated, Georgia's community-powered childcare rating system. The department also houses the Head Start State Collaboration Office, distributes federal funding to enhance the quality and availability of child care, and works collaboratively with Georgia child care resource and referral agencies and organizations throughout the state to enhance early care and education.

DECAL identified GA DPH home visiting as a key partner in this work. GA DPH home visiting collaborated with DECAL by providing available data about children birth-to-five and their families, participating in overview webinars, completing surveys regarding population and service data specific to GA DPH home visiting and focus groups.

Efforts to Convene Stakeholders to Review and Contextualize Results
The Needs Assessment Workgroup (NAW) was established to ensure an effective community assessment and a comprehensive perspective. The group, under the leadership of the Title V Director and Deputy Director, consisted of directors and managers from all MCH programs, MCH Epidemiology, Program Evaluation, and Performance Improvement, Adolescent Health, Chronic Disease, Office of Sexually Transmitted Disease (STD), and Injury Prevention.

NAW Workgroup Members

Jeannine Galloway, MCH Director	Adam Barefoot, Director, Oral Health Program
Paige Jones, Deputy Director, Title V	Diane Durrence, Director, Women's Health
Linda Tran, Analyst, Title V	Melanie Durley, Director, Program Evaluation and Performance Improvement
Sherry Richardson, Team Lead, Title V	Michael Bryan, Director of Maternal and Child Health Epidemiology
Twanna Nelson, Deputy Director, Family and Community Supports	Jerusha Barton, Manager, Infant Epidemiology
Lisa Pennington, Deputy Director, Early Intervention	Tonia Ruddock, Manager, Perinatal Health Epidemiologist
Judith Kerr, Deputy Director, Child Health Services	Lisa Dawson, Director, Injury Prevention
Sharifa Peart, Program Director, Children, and Youth with Special Health Care Needs	Latasha Terry, STD Director
Frederick Dobard, Senior Manager, Planning and Partnerships	Jimmie Smith, Sr. Deputy of Health Science, Chronic Disease Prevention Section
Phillip Oliver, Adolescent Health and Youth Development Program Manager	Natasha Worthy, Sr. Program Manager

The Georgia MCH Advisory Council and NAW will continue ongoing meetings to share the findings and data to guide the systems providing services that improve family wellbeing. The groups are scheduled to meet quarterly and consistent communication with group members has been instituted.

Summary of Joint Findings

There are three major common themes among the MIECHV and Title V data. These relate to access to care, community awareness and support of program services, and mental health and substance abuse disorder health care needs.

First, access to care was a common topic mentioned among stakeholders who serve both Title V and MIECHV clients. In many communities in Georgia, the cost of health care is prohibitive for many families, who also often lack access to health insurance. For low-income women, they are often disconnected from health care after two months of delivering their infant. This results in a lack of interconception, family planning, and support services.

Additionally, there was very strong support for both Title V and MIECHV services among communities that serve low-income women and their families. Additional resources would help both programs maintain efforts to promote their programs, to address health literacy issues among their clients, and to help families navigate between different programs.

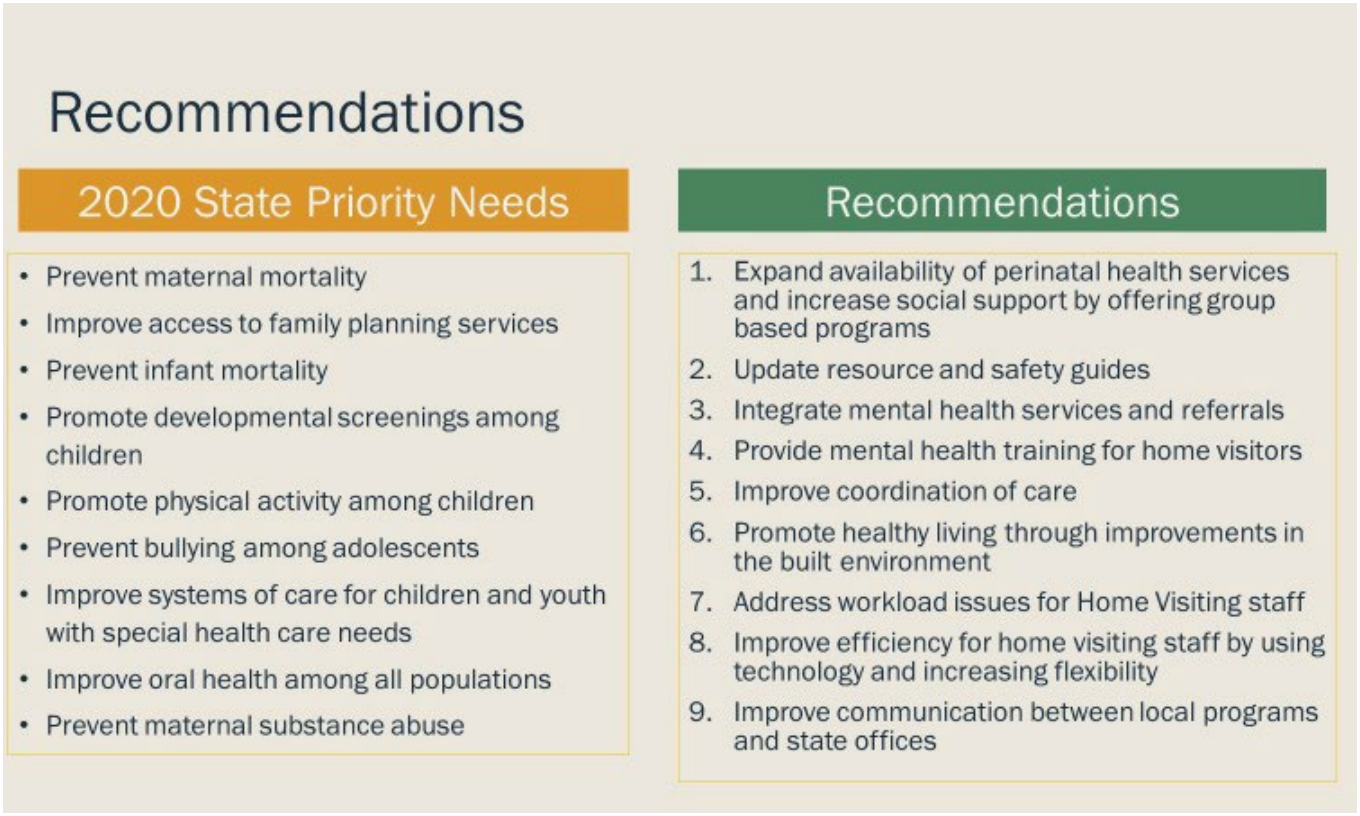
Data across programs highlight the need for more funding and awareness on the topics of mental health and substance abuse. Data collected across all sources suggest that families are struggling with mental health and substance abuse issues. Pregnant women are facing challenges with maternal mental health care issues. Informants uniformly agreed that many Title V and MIECHV families lack access to care for these health issues, due to the lack of available and affordable health care providers in their communities.

I. CONCLUSION

Summary of Major Findings

Findings from the 2020 MIECHV Needs Assessment suggest there are several strategies for enhancing and expanding home visiting services in Georgia. These recommendations are aligned with the state GA DPH 2020 Title V Block Grant priority needs (see below). It is important to expand the availability of perinatal health services and increase social support by offering group-based programs. This may include group-based prenatal education as well as postpartum group support and fatherhood support. Also, it is critical to strengthen statewide and community-specific to expand the availability of resources for use by home visiting staff. To meet the mental health needs of clients, our findings suggest that we need to integrate mental health services and referrals into home visiting services and provide mental health training for home visitors. Also, since many families experience barriers caused by difficulties in the built environment, it is important to promote healthy living through improvements in the built environment (including increasing access to transportation particularly in rural areas of Georgia). It is also critical to address the workforce issues identified by home visiting staff, such as workplace flexibility and improving the efficiency for home visiting staff to use technology. Finally, GA DPH is committed to improving communication between local home visiting programs and the state office.

This Needs Assessment update identified 52 at-risk counties with only four of the current MIECHV funded counties being indicated as having 2 or more risk factors utilizing the simplified method. There are at least two main reasons for this dramatic shift in the ten years. One is that the current counties have truly befitted from the implementation of evidence-based home visiting in the area which is indicated by the reduction in risk factors. Also, another reason for the change is that the other counties have increased because of the need for such supports. The GA DPH recognizes the importance of providing support to those areas most at risk but also understands the importance of maintaining the presence in those areas that impact has been proven to be beneficial. In many of those currently funded areas, the MIECHV funded program is the backbone for supportive services to families. We believe that removing such impactful programs would be detrimental to the community severed. Based upon this realization, the GA DPH utilized the *Phase Two Approach* to add the existing programs to the at-risk list. GA DPH is eager to progress with utilizing the updated needs assessment to strengthen programs and services under the guidance of HRSA.



Dissemination Plans

GA DPH acknowledges the importance of this data and will work to utilize traditional and innovative strategies of dissemination. GA DPH looks forward to sharing the results of the needs assessment broadly to community organizations, physicians and nurses, state agencies, universities, colleges, and GA DPH district and state staff.

GA DPH will disseminate this report in various ways including but not limited to the following:

External Dissemination

- Post the report on the Georgia Home Visiting Program web page located on the GA DPH official website
- Send email blasts to partners with an overview of the report and a link to download the report
- Present findings to the MCH Advisory Council (comprised of key stakeholders that provide input on MCH activities and program planning)
- Present at various committees and coalitions throughout the state that are focused on improving maternal and infant wellness.
- Promote the report in partner newsletters such as Georgia American Academy of Pediatrics, Georgia Family Physicians, and Prevent Child Abuse Georgia
- Present the findings at local and national conferences

Internal Dissemination

- Present at the GA DPH Health Promotion division and Maternal and Child Health section meetings
- Send virtual desk drops to staff promoting the availability of the report
- Post report on internal SharePoint LIA for GA DPH staff to download and review

Appendix B: FY25 Needs Assessment Updated Narrative

FY 2025 Needs Assessment Updated Narrative
Phase III Approach

1. Identify communities with concentrations of risk, based on factors including: premature birth, 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; poverty; crime; domestic violence; high rates of high-school drop-outs; substance abuse; unemployment; or child maltreatment.

With expansion from Phase II to the Phase III approach, Georgia has added the following counties: Crawford, Dooly, Jones, Peach, Pike, Pulaski, and Washington. The Georgia Department of Public Health evaluators have provided relevant data points that provide support for the Phase Three approach associated with 13 indicators for areas of need. The indicators of measurement include; Percentage of low birth weight, Percent Premature Births, % Births to Females <12th Grade Education, % Births with Late or no Prenatal Care, Percent of Births admitted to NICU(NICU level >=2) (2018-2022), Infant Deaths, Unemployment, Percent of Children living in poverty in Georgia, Percent of Teens who are high-school dropouts, ages 16 to 19 in Georgia, Children with a substantiated incident of child abuse and/or neglect (per 1,000), % Excessive Alcohol Consumption, % Food Insecurities, % Rural. These indicators support MIECHV Performance Measures and display a continued need for home visiting services.

Crawford County

Crawford County has several areas of concerns with percentages higher than the state of Georgia in 11 of the 13 measurement areas. The percentage of low birth weight for Crawford County is 14.90% in comparison to the state average of 10.20%. The percentage of Premature Births in Crawford County was 15.70% in comparison to the state average of 11.80%. The percentage Births to Females <12th Grade Education was 14.90% in comparison to the state average of 10.90%. Percent of Births admitted to NICU(NICU level >=2) (2018-2022) was 15.8% in comparison to the state of Georgia 13.5%. The state of Georigia recorded 884 Infant Deaths in 2023, one of those deaths occurring in Crawford County. Crawford county also matches the state average of unemployment at 3.20%, with 24.7% of children living in poverty in comparison to the state average of 18.80%. Children with a substantiated incident of child abuse and/or neglect (per 1,000) is a huge area of concern in Crawford County, as it more than doubles the state average at 13.2% in comparison to 4.5%. 17% of the population in the county has Excessive Alcohol Consumption in comparison to 16.2 at the state average. Food insecurities also average higher than the state level at 13% versus 10.90%. Crawford County is stated to be 100% rural.

Dooly County

Dooly County has several areas of concern with percentages higher than the state of Georgia in 11 out the 13 measurements. The percentage of low birth weight for Dooly County is 18% in comparison to the state average of 10.20%. The percentage of Premature Births in Dooly County doubles the state average at 23% in comparison to the state average of 11.80%. The percentage Births to Females <12th Grade Education also doubles the state average at 20% in comparison to the state average of 10.90%. The high school dropout rate in Dooly County is also higher at 10.3% in comparison to 4.80% state average. The percentage of Births with Late or no Prenatal Care in Dooly County was 10%, higher than the state average of 9.4%. The state of Georigia recorded 884 Infant Deaths in 2023, three of those deaths occurring in Dooly County. Dooly county also averages higher in unemployment at 3.80% with the state average of unemployment at 3.20%, with 31.60% of children living in

poverty in comparison to the state average of 18.80%. Children with a substantiated incident of child abuse and/or neglect (per 1,000) is five times the state average at 22.5% in comparison to 4.5%. Food insecurities also averaged higher than the state level at 14.40% versus 10.90%. Dooly County is stated to be 53.7% rural in comparison to the state average of 24.93%.

Jones County

Jones County has percentages higher than the state of Georgia in 5 of the13 measurements, with 4 additional measurements ranging close to the state average. The high school dropout rate in Jones County is 4.00% in comparison to 4.80% state average. The Percent of Births admitted to NICU(NICU level >=2) (2018-2022) was 15.80% in comparison to the state average of 13.50%. The state of Georigia recorded 884 Infant Deaths in 2023, two of those deaths occurring in Jones County. In terms of unemployment Jones County is at 3.10% in comparison to the state average of unemployment at 3.20%, with 17.80% of children living in poverty in comparison to the state average of 18.80%. Children with a substantiated incident of child abuse and/or neglect (per 1,000) is 6.80% in comparison to 4.5%. Food insecurities averaged close to the state average at 9.40% in comparison to the state average of 10.90%. Jones County is stated to be 67.70% rural in comparison to the state average of 24.93%.

Peach County

Peach County has several areas of concern with percentages higher than the state of Georgia in 10 out the 13 measurements. The percentage of low birth weight for Peach County is 11.3% in comparison to the state average of 10.20%. The percentage of Premature Births in Peach County is 13.40% in comparison to the state average of 11.80%. The percentage of Births to Females <12th Grade Education is 12% in comparison to the state average of 10.90%. The percentage of births admitted to NICU is 19.70%, averaging higher than the state of Georgia at 13.50%. The state of Georigia recorded 884 Infant Deaths in 2023, two of those deaths occurring in Peach County. Peach county also averages higher in unemployment at 3.80% with the state average of unemployment at 3.20%, with 25.30% of children living in poverty in comparison to the state average of 18.80%. Children with a substantiated incident of child abuse and/or neglect (per 1,000) is 8.1%, higher than the state average of 4.5%. Food insecurities also averaged higher than the state level at 13.70% compared to the state average of 10.90%. Peach County is stated to be 38.20% rural in comparison to the state average of 24.93%.

Pike County

Pike County has percentages higher than the state of Georgia in 5 of the13 measurements, with 1 additional measurement ranging close to the state average. The Percent of Births admitted to NICU(NICU level >=2) (2018-2022) was 18.60% in comparison to the state average of 13.50%. The state of Georigia recorded 884 Infant Deaths in 2023, one of those deaths occurring in Pike County. In terms of unemployment Pike County is at 2.70% in comparison to the state average of unemployment at 3.20%, with 12.40% of children living in poverty in comparison to the state average of 18.80%. Food insecurities averaged close to the state average at 9.0% in comparison to the state average of 10.90%. Substance use is an area of concern, as excessive alcohol consumption in Pike County is 19.00%, averaging higher than the state average of 16.20%. Pike County is stated to be 99% rural in comparison to the state average of 24.93%.

Pulaski County

Pulaski County has several areas of concern with percentages higher than the state of Georgia in 10 out the 13 measurements, and one additional measurement close to the state's average. The percentage of low birth weight for Pulaski County is 11.0% in comparison to the state average of 10.20%. The percentage of Births to Females

<12th Grade Education is 11% in comparison to the state average of 10.90%. The percentage of births admitted to NICU is 13.60%, averaging higher than the state of Georgia at 13.50%. The percentage of late to no prenatal care in Pulaski County is 12%, averaging higher than the state average of 9.40%. The state of Georigia recorded 884 Infant Deaths in 2023, one of those deaths occurring in Pulaski County. Pulaski county also averages higher in unemployment at 3.50% with the state average of unemployment at 3.20%, with 31.90% of children living in poverty in comparison to the state average of 18.80%. Children with a substantiated incident of child abuse and/or neglect (per 1,000) is 5%, averaging higher than the state average of 4.5%. Food insecurities also averaged higher than the state level at 14.40% compared to the state average of 10.90%. Substance abuse issues related to excessive alcohol consumption is 16% averaging close to the state average of 16.20%. Pulaski County is stated to be 66.7% rural in comparison to the state average of 24.93%.

Washington County

Washington County has several areas of concern with percentages higher than the state of Georgia in 9 of the13 measurements, with two additional measurements close to the state's average. The percentage of low birth weight for Washington County is higher at 10.5% in comparison to the state average of 10.20%. The percentage of premature births are at 11.20%, nearing the state average of 11.80%. The percentage of Births to Females <12th Grade Education is 9.20% in comparison to the state average of 10.90%. The percentage of births admitted to NICU is 15.50%, averaging higher than the state of Georgia at 13.50%. The percentage of late to no prenatal care in Washington County is 9.90%, averaging higher than the state average of 9.40%. Washington county also averages higher in unemployment at 4.20% with the state average of unemployment at 3.20%, with 29.50% of children living in poverty in comparison to the state average of 18.80%. Children with a substantiated incident of child abuse and/or neglect (per 1,000) is 10.70%, doubling the state average at 4.5%. Food insecurities also averaged higher than the state level at 14.00% compared to the state average of 10.90%. Washington County is stated to be 65.60% rural in comparison to the state average of 24.93%.

2. To the extent feasible, identify the quality and capacity of existing programs or initiatives for early childhood home visiting in the state. Please include:

a. The number and types of programs and the numbers of individuals and families who are receiving services under such programs or initiatives;

In FY2024 (October 1, 2023- September 30, 2024) the following LIA served the following numbers of households and children with the following EBHV models:

County	Local Implementing Agency	County(ies)Served	EBHV Model(s)	# of Households	# of Index Children
Bartow	Advocates for Bartow's Children	Bartow	PAT	55	55
Chatham/Liberty	Coastal Coalition for Children	Chatham, Liberty	HFG	148	136
Clarke	Brightpaths	Clarke	HFG	155	154
Crisp	Housing Authority of Cordele	Crisp, Sumter	HFG	79	76
DeKalb	DeKalb County Government - NAP	DeKalb	PAT	98	101
DeKalb	DeKalb County Government - SD	DeKalb	PAT	144	153
Glynn	Coastal Coalition for Children	Glynn	HFG	110	105
Houston	Houston Board of Health	Houston, Macon, Twiggs	NFP	154	111
Houston	Rainbow House	Houston, Twiggs	HFG	123	123
Muscogee	University of Georgia	Muscogee	HFG	81	83
Muscogee	University of Georgia	Muscogee	PAT	70	73
Muscogee	West Central Health District	Muscogee	PAT	18	14
Richmond	Augusta Partnership for Children	Richmond, Burke	PAT	104	102
Rockdale	Rockdale County Schools	Rockdale	PAT	125	122
Whitfield	Family Support Council	Whitfield	HFG	93	93
Whitfield	Family Support Council	Whitfield	PAT	65	66
				1622	**1567**

b. the gaps in early childhood home visitation in the state; and

Gaps and challenges still exist in the delivery of early childhood home visiting services in Georgia. The Georgia 2020 Needs Assessment reported findings that reflect gaps in the types of services offered, challenges experienced by home visiting staff in delivering such services, and home visiting workforce and training challenges.

Delivery of Home Visiting Services
There are challenges to home visiting services in some communities. Many communities feel that there are challenges to starting or expanding home visiting services in their communities because some programs duplicate services and often the perception that programs are re-created without truly finding out what already exists. Others identified the lack of phones of computers as major barriers to service delivery.

Health System Barriers and Needs
Other barriers to service delivery relate to health systems issues. Many home visiting families lack health care coverage or are confused about their coverage and thus do not seek health care for themselves. When moms have to forgo services due to loss of Medicaid, it makes coordination of care very difficult.

Individual Barriers and Needs
In terms of barriers, home visiting families have health literacy gaps, specific to breastfeeding, medication adherence, reproductive health, and self-advocacy. Mental health is a specific barrier mentioned by almost all informants. Home visitors reported that many of their clients suffer from depression and anxiety, and as such, affects retention in the program. The opioid crisis has fueled some of these mental health crises in certain parts of the state. Also, numerous cultural and language barriers prevented some families from participating in the home visiting programs.

Community Barriers and Needs
Community barriers include lack of transportation to seek health care appointments or seek employment. Transportation barriers are especially difficult for families that live in rural areas and do not have public transportation options. Home visitors often have to travel long distances to serve some families who live in rural parts of the state and this takes more time. These families often do not have safe housing or live in areas with high crime, lack of food security and quality childcare.

Provider Barriers and Needs
Provider barriers including workforce issues, needs and resources from the awardee, and undue burden. Time management for home visitors can be a challenge, given they have a heavy workload burden that includes multi-level documentation and inflexible work schedules. Home visitors often are reluctant to turn off their phones, in case their families needed to reach them. They also can work in stressful environments without a lot of managerial support. Finally, there are limited resources to complete their duties and had difficulties with communication in their teams.

c. The extent to which such programs or initiatives are meeting the needs of eligible families.
Since the onset of MIECHV, data reflects the strengths of home visiting programs that serve families in need. Overall, home visiting staff report strong support and a great capacity for implementing home visiting services in Georgia. Also, program data suggest that there has been a success in promoting key maternal and child health

outcomes for families.

The table below reflects positive outcomes by MIECHV funded home visiting in FY2024. These findings indicate that many women who received home visiting services were breastfeeding at 6 months and completed a postpartum visit. Most clients reported practicing safe sleep with their infants and almost no reports of child maltreatment. Also, many mothers were screened for depression. Caregivers also largely reported reading, telling stories or singing songs to their children and being screened for intimate partner violence.

10% of women enrolled prenatally delivered preterm.
39% of infants were breastfed at six months of age.
93% of primary caregivers were screened for depression.
80% of children received their last well child visit.
90% of mothers received a postpartum visit within 8 weeks of delivery.
81% of primary caregivers who used tobacco products at enrollment received a referral to cessation services.
% of primary caregivers consistently practiced safe sleep methods with their infants.
0.2% of enrolled children had an injury related emergency department visit.
0.6% of children had an investigated case of maltreatment following enrollment.
92% of primary caregivers were specifically assessed for their parent-child interactions.
98% of children had someone who read or sang to them daily.
87% of children received an on-time screening for developmental delays.
100% of visits included asking primary caregivers if they had any concerns about their child's development, behavior, or learning.
96% of primary caregivers were screened for intimate partner violence within 6 months of enrollment.
21% of primary caregivers who enrolled without a high school degree or GED subsequently enrolled in an educational program.
72% of primary caregivers had continuous health insurance coverage for at least 6 months of the year.
100% of primary caregivers referred due to a positive screen for depression received mental health services.
100% of children referred due to a positive screen for developmental delays received services in a timely manner.
100% of primary caregivers who screened positive for intimate partner violence received referral information to appropriate community resources.

3. To the extent feasible, update the needs assessment narrative to reflect the capacity for providing substance abuse treatment and counseling services.
Information remains relevant from the 2020 Needs Assessment

4. To the extent feasible, describe how information from any of these needs assessments (Title V MCH Block Grant, Head Start, and CAPTA) supported your identification of additional at-risk counties.
Information remains consistent with the 2020 Needs Assessment