



**NEW YORK STATE  
HOME VISITING COORDINATION  
INITIATIVE  
(HVCI)**

**FINAL REPORT  
JULY 2020**

**COMPLETED BY:  
PREVENT CHILD ABUSE NEW YORK**

# ACKNOWLEDGMENTS

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Amanda O'Brien  
Home Visiting Coordinator (former)  
Home Visiting Coordination Initiative, Prevent Child Abuse NY

Jenn O'Connor  
Director of Policy and Advocacy and Home Visiting Coordination Initiative  
Prevent Child Abuse NY

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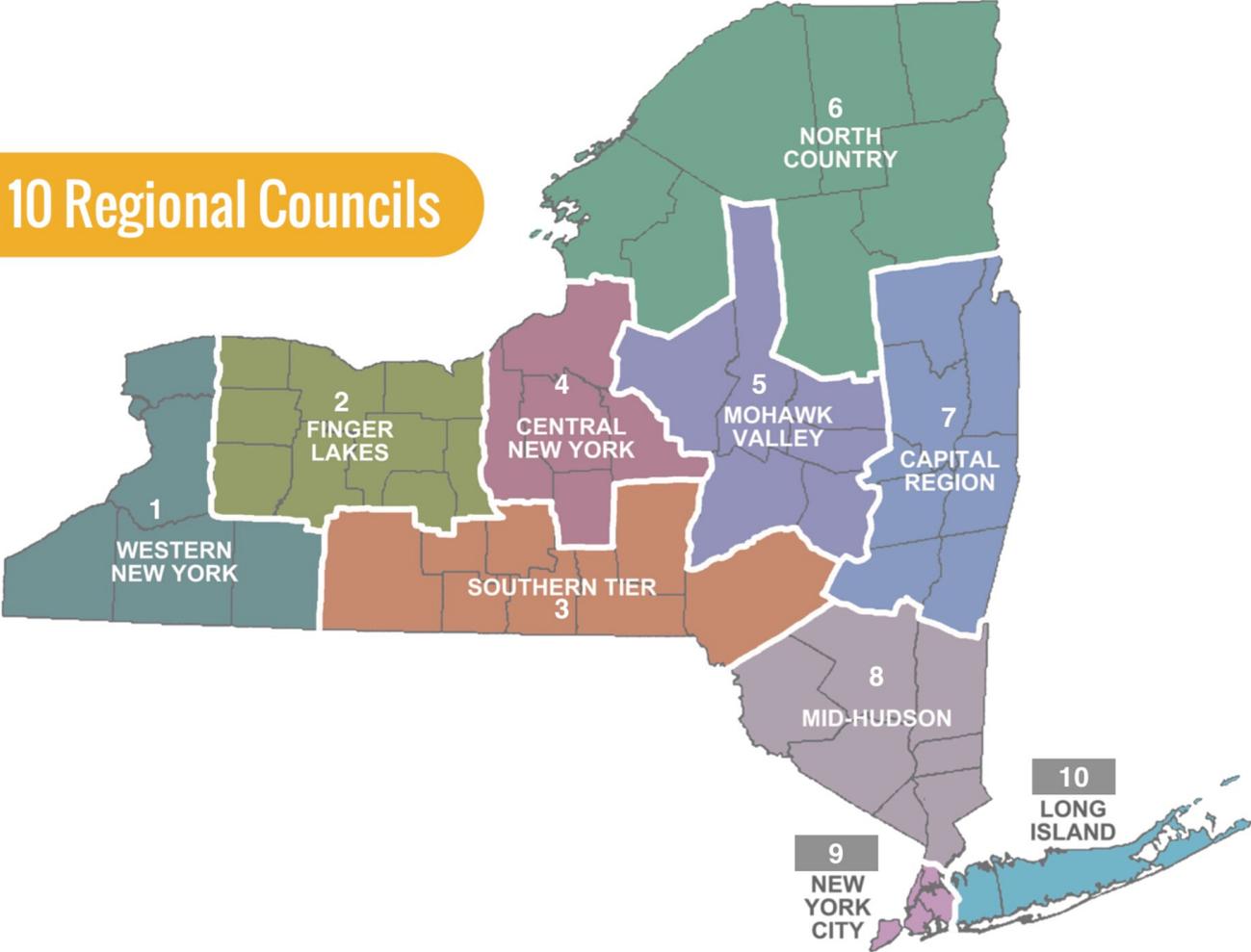
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# NEW YORK STATE ECONOMIC DEVELOPMENT REGIONS

10 Regional Councils



# EXECUTIVE SUMMARY

Voluntary home visiting programs provide support, education, and referrals to families of young children in their homes. Direct services can include everything from parent coaching on cognitive and emotional development to assistance with breast feeding to help accessing employment/educational opportunities. Home visitors-- a mix of paraprofessionals, nurses, and community health workers depending on the model in use-- form nurturing, trusted relationships with families. Research shows that home visiting decreases child abuse and neglect, increases school readiness, and improves health outcomes.

In October 2018, Prevent Child Abuse New York (PCANY) launched the NYS Home Visiting Coordination Initiative (HVCI). The HVCI is committed to supporting a continuum of services and supports from preconception through the earliest years of a child's life by working in partnership across programs. The goals of the HVCI are to promote partnership among home visiting programs in NYS, share resources, increase the number of families receiving home visiting services, refer families to supportive services and ensure the provision of high quality and comprehensive services that are most responsive to families.

In 2019, a total of 25 Regional Summits were conducted throughout the State to gather input from providers, practitioners, and parents about how to work together to support families through home visiting. This is the first report of its kind. It is the culmination of six months of research, data collection, on-site and virtual meetings, and interviews with a range of interested parties, as well as years of discussions with State partners, policymakers, and nonprofit organizations.

In Spring 2020, the COVID-19 pandemic changed the way New Yorkers live day-to-day. Home visiting became more important than ever, especially to families in the highest risk communities and to essential workers raising young children. While the people stayed home, services continued. Programs began providing supports virtually, and the workforce rose to the challenge. The HVCI's overarching recommendation--universal prenatal home visiting--is prescient and timely.

The work product of the HVCI includes this final report and ten Regional Home Visiting Development Plans included as appendices. The plans also include regional- and county-specific priority areas. Overall themes were identified from the Regional Summits and include the following overarching recommendation for the State to consider, as well as three strategies to achieve it:

- **Develop a plan for statewide implementation of prenatal home visiting**
  - **Institute a workforce development plan**
  - **Implement coordinated intake and a referral data system to support collaboration**
  - **Create a statewide public education campaign**

# OVERVIEW

NYS has long supported home visiting as a two-generation strategy to improve birth outcomes, increase school readiness, and decrease child abuse and neglect. Voluntary programs help strengthen the bond and interaction between child and caregiver; educate families about child development; connect families to supports such as the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Supplemental Nutrition Assistance Program (SNAP), and the NYS Early Intervention Program (EIP); and refer families to services such as substance abuse and mental health counseling. Home visiting is foundational to the early childhood continuum and the start of a successful parenting experience, helping to support home environments in which young children can thrive. Multiple evidence-based or evidence-generating programs operate in NYS. A description of programs can be found on the Home Visiting Coordination Initiative website at [www.nyshomevisitcoord.com](http://www.nyshomevisitcoord.com) (see Appendix 11). These include Early Head Start, Family Connects, Healthy Families New York, Nurse-Family Partnership, Parents as Teachers, ParentChild+, Power of Two, and the NYS Department of Health (DOH) Community Health Worker Program, in addition to more regional- specific, community-responsive programs. Although cost-benefit analyses show that high-quality programs offer returns on investment ranging from \$1.75 to \$5.70 for every dollar spent, due to reduced costs of child protection, K-12 special education and grade retention, and criminal justice expenses, these programs only serve a small fraction of children in NYS.<sup>1</sup> Programs are scattered across the State and, where more than one model is available, there is sometimes a lack of service coordination. There is a great need for programs to coordinate in order to serve more families.

The HVCI initially aimed to provide a model-neutral space for home visitors, supervisors, and administrators to discuss opportunities and challenges at the community and State level, and to provide learning opportunities for providers to expand their skill sets in the most current and pressing topic areas needed to best support families' success. The HVCI launched with monthly webinars on issues such as central intake; trauma-informed practice; maternal depression; infant mental health; working with immigrant families; and diversity and inclusion. The HVCI also brought national experts from the Ounce of Prevention to NYS to facilitate cross-agency/cross-program discussions on collaboration.

In Spring 2019, with funding from the federal Preschool Development Grant Birth through Five (PDGB5), HVCI's work expanded to include regional input. The NYS Council on Children and Families, via the HVCI, enlisted 10 backbone organizations (BBOs) in each of the 10 Regional Economic Development Council (REDC) regions to pull together stakeholders (including parents), complete a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis, and host 25 facilitated Summits (at least two per region) between August and November 2019.<sup>2</sup> The HVCI also held multiple conference calls and developed a parent questionnaire for parents in home visiting programs. Much time was spent on building partnerships and collecting information, including timely data,<sup>3</sup> that would inform both State and local priorities. The broader intent was to coordinate services locally, increase enrollment, increase retention, and improve outcomes for children and families. This input from regions became even more important when the pandemic hit in 2020, causing families to require additional supports and programs to become more flexible in delivering those services.

# PARENT PERSPECTIVE

Over the course of the Summits, more than 200 parents who are currently participating in or who had previously participated in home visiting shared their experiences and insights. Statewide themes emerged.

- **Focus on trust.** This is imperative to increase retention of families participating in programs. Since establishing trust takes time, it is critical that home visiting programs work to decrease staff turnover. Families will not continue to participate in programs where they must cycle through staff. Moreover, parents want the flexibility to choose their home visitor so they can find the right fit for their family.
- **Redefine “home”.** While model fidelity may predicate visits in actual homes, some parents expressed trepidation with that aspect. Families may be uncomfortable with strangers in their home, or may be balancing other pressures with their desire for services. Families also encouraged programs to be more flexible around the location and hours of visits. Working parents, or those who are in school, may need evening or weekend visits. Throughout the pandemic, home visitors continue to do their jobs, albeit virtually. Tele-home visiting may be a necessary accepted practice going forward. Costs historically associated with travel might be re-purposed to ensure access to tele-home visiting.
- **Redefine “dosage”.** Again, this speaks to model fidelity. Programs require a certain number of visits over a distinct period of time; yet families may be hesitant to commit to a long-term program.
- **Address gender issues.** Parents expressed both that: 1) male home visitors are sometimes unwelcome because of discomfort or distrust and 2) there is a rise in single fathers and a growing need for male visitors. Programs should hire based on community need and this may include hiring male staff as home visitors.
- **Be aware of community resources.** Families need a one-stop-shop and they rely on the trusted home visitor to have knowledge of and connect them to a wide range of services. They also sometimes require a warm hand off as opposed to a quick referral.
- **Address implicit bias.** Families expressed a need for not only increased cultural competency but for staff to look at their own views and reflect on what ideas they bring to the table. Staff must meet the parent where they are without judgment and respect their personal rules, values, and norms. This means understanding broader issues like religion and subtler differences like power dynamics.
- **Be intentionally strengths-based.** While all programs strive to achieve this, families reported they are not always successful. Some parents felt disrespected or judged, which shut down their ability to connect and participate fully in the program. Additional staff training would address this issue.

# FINDINGS

Each region is distinct, yet several common themes emerged. All regions expressed concerns around the home visiting workforce. This included workforce recruitment, retention, burnout, characteristics, qualifications and wages. This directly impacts family retention and needs improvement. Home visitors need a career path, streamlined training, and increased compensation and must be recruited from the communities they serve. Frequent staff turnover negatively impacts programs, wastes money, and erodes a trusted relationship between home visitor and parent that ultimately leads to families leaving programs.

The HVCI work also found that families don't understand what home visiting is or the benefits of participating. Families are also under-utilizing services because they are nervous about participating. A recent poll by Raising NY/Global Strategy Group suggested that people need more information about home visiting in order to make informed decisions regarding its benefits. Input on this project demonstrated that parents sometimes erroneously believed that involvement with a home visiting program would lead to involvement with Child Protective Services (CPS). Others were hesitant due to immigration concerns. Overall, the general consensus was that, in order to truly be successful, home visiting must be destigmatized, parent perception transformed, and the public well educated about its many benefits.



Across the State, universal home visiting emerged as the ideal. Providing at least one visit to all expectant parents would normalize the services. The prenatal period is critically important to healthy development and home visits during that time could help improve birth outcomes, including reducing low birth weight and incidences of neonatal abstinence syndrome (in babies born addicted to opiates). Higher risk families would then be referred to longer-term programs.

Coordinated intake connects families to home visiting programs that support their needs and connects them to wrap-around services within their community. It is a vehicle to streamline intake and referrals, as well as a way to collect data, incorporate it into a larger early childhood coordinated system-building effort, and utilize it to make informed policy and funding decisions. Also included in regions' top priorities were the need for:

- Creative ways to connect families to services and supports (including to each other), such as tele-home visiting, text messaging, and social media (some organizations that hold home visiting contracts may have policies that impact how home visitors creatively outreach to families such as texting policies)
- Trauma-informed services (including training for staff and assistance addressing vicarious trauma in staff) and father-focused services
- Substance abuse supports, stable housing and services for families in shelters

## Immigration

Immigration concerns were included in top priorities for many regions. Many expressed a desire to be more responsive to immigrant and refugee populations. While summit participants often mentioned language challenges and the need for translation and interpreter services, they also spoke about how fear of deportation has hindered the willingness of all immigrants to participate in programs. Participants noted that the federal government "Public Charge" proposals, targeting people who are or may become dependent on public assistance, negatively impacts families in need of home visiting services. Program administrators and staff admitted feeling helpless in the current political environment but were adamant that they would do all they could to make families feel safe.

# RECOMMENDATIONS

After a comprehensive review of home visiting programs across the State, the following are recommendations for the State to consider to help support children and families:

- Develop a plan for statewide implementation of prenatal home visiting
  - Institute a workforce development plan
  - Implement coordinated intake and a referral data system to support collaboration
  - Create a statewide public education campaign

## **Develop a Plan for Statewide Implementation of Prenatal Home Visiting**

This year, Oregon became the first state to begin implementation of universal newborn home visiting (Family Connects). Oregon will phase-in the program over a six-year period and intends to support the initiative with an insurance mandate. The State has created a rate setting model for commercial plans and will launch in January 2021. While Oregon's plan is truly transformative, it misses an opportunity to impact birth outcomes, as well as some maternal health outcomes.

Moreover, due to the opioid epidemic, it is estimated that annually more than 10,000 babies born across the country are born addicted to opioids. In NYS in 2019, over 2,000 babies were born with neonatal abstinence syndrome (NAS) and/or affected by maternal use of drugs. According to the U.S. Surgeon General, babies born addicted to opiates stayed in the hospital for an average of 16.9 days, eight times higher the number of days non-addicted babies stay. Care for infants born with NAS costs hospitals \$1.5 billion nationally. In addition, according to the most recent data, only 73.7% of pregnant women received prenatal care in the first trimester; nearly 19,000 births were low- birthweight; and more than 10% of all babies were born premature.<sup>4</sup> Finally, one in seven women experience some form of maternal depression, including prenatally.<sup>5</sup>

Under NYS's Medicaid program, all women are already presumptively eligible for prenatal or additional postpartum visits based on individual patient need. This is important because families covered by Medicaid have a higher rate of emergency room visits in the first year of a child's life; "light touch" home visiting, shown to reduce emergency room visits in that first year and to have a return on investment of \$3 saved for every \$1 invested, could help reduce costs and provide families with essential supports.

New York State's Medicaid Redesign Team II recently approved a home visiting recommendation to provide "light touch" or universal home visiting based on that data. Because the minimum wage rate change has resulted in some working families no longer meeting existing financial thresholds for home visiting services, a more comprehensive plan to implement prenatal home visiting would help reach most women, not only those who are Medicaid-eligible or considered low-income.

Even though it is critical that programs adhere to strict model-specific requirements to implement with fidelity, discussions should occur to prevent families from falling between the cracks. For example, if a family does not meet certain eligibility requirements, they will not receive services. Discussions should include strategies to close these gaps so necessary supports and services are provided to families in need.

Home visiting programs have been proven to decrease child abuse and neglect, improve health outcomes, and increase school success. With these benefits in mind, the development of these strategies should be a targeted approach with existing programs to increase access to additional families. There must be home visiting programs available to take referrals. This plan would look across all regions to determine need, paying particular attention to catchment areas that have been hard hit by the pandemic, have high incidence of drug addiction, maternal depression, or other risk factors; or that have seen a recent influx of immigrants/refugees.

The following three strategies will help NYS achieve and successfully implement this plan (see below):

# RECOMMENDATIONS (continued)

## Institute a Workforce Development Plan

Home visitors have a wide range of education and experience. Qualifications vary by program. Not unlike other “helping” professions, many barely make a living wage and are eligible for social services themselves. Currently, there is no clear path to become a home visitor and no career pathway that would encourage people to stay in the field. For these reasons and more, instituting a cohesive workforce development plan is critical to the effectiveness of the home visiting programs and, ultimately, the success of children and families. Strategies to consider are as follows:

- Conduct a study of the workforce, with recommendations for addressing recruitment and retention. The study would collect information on staff and administrator education attainment across all programs, compensation and turnover. Initial research shows that the cost of delivering services are not commensurate with current program funding, that wages are not competitive, and that turnover is high. In order to make informed recommendations for a comprehensive approach, more data and research is necessary.
- Award more Home Visitor CDA (Child Development Associate) Credentials. Established in 1984 and updated in 2016, the Home Visitor CDA National Credentialing Program defines, evaluates, and recognizes the competence of more than 400,000 home visitors and early childhood professionals in 50 states and three territories. According to the Council for Professional Recognition, only 96 home visitors in NYS hold a Home Visitor CDA; all are Early Head Start/Head Start staff for whom such a credential meets program requirements. The target audience for this CDA would be additional Early Head Start/Head Start staff, community members (especially in the migrant community), and former home visiting clients/parents without a college degree who are interested in a career ladder. NYS should amend the Educational Incentive Program (EIP) to apply to home visiting providers, as well as to child care.
- Link the Home Visitor CDA to The Aspire Registry (NYS early childhood professional development registry). Aspire aims to professionalize the early childhood field, of which home visitors are an important but often neglected part. The Aspire Registry provides consultation and assistance in the creation of a free online professional portfolio; serves as a clearinghouse for trainings and professional development opportunities; and, as of December 2019, collects data on the workforce to influence policy and practice.
- Develop model-neutral shared training opportunities across programs and models. NYS agencies and home visiting programs should review existing skill-based opportunities to provide standardized trainings decreasing duplication of effort and cutting costs. NYS has a skilled, compassionate workforce with established community connections and relationships with families; this workforce should be strengthened by deepening the level of training and equipping home visitors with additional skills (commensurate with adequate salaries). All home visitors should have a consistent baseline on which to build; as well as training on timely topics such as immigration concerns and the opioid crisis.

# RECOMMENDATIONS (continued)

There are also opportunities to build a stronger relationship between home visiting and the rest of the early childhood continuum. For example, by incorporating the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood into home visiting programs, translating the Pyramid Model for Supporting the Social and Emotional Competence of Infants and Young Children for use in a home-based environment, and sharing home-visiting curriculum with family child care providers.

## **Implement Coordinated Intake and a Referral Data System**

Coordinated or centralized intake for families helps to determine the best fit for families and enrolls them in a program that supports their needs, maximizes impact, and streamlines services. It also decreases competition between programs and increases collaboration. A centralized access point with a common data system would decrease duplication, increase efficiency, and increase statewide reach. Ideally, such a system would not only improve the coordination of home visiting programs, but would improve coordination within the larger early childhood system. New York City's proposed Coordinated Intake & Referral (CI&R) Home Visiting system paves the way for statewide implementation. The new system will utilize a standardized risk assessment tool to match families with a home visiting program that best meets their needs; create system efficiencies by centralizing client/family intake and minimizing duplication of services; and provide data and information to help build and expand a greater evidence base to support the effectiveness of home visiting.

Regions 1, 4, and 10 are poised to participate in coordinated intake, since they were early adapters of Help Me Grow, a comprehensive approach to early identification of developmental concerns and connection to needed services. Help Me Grow in NYS has a plan to merge (by 2021) its three affiliate screening and client management systems in order to share data; create a common platform for tracking referrals; begin data analysis; build a data platform; and ensure that new affiliates are seamlessly integrated into the Help Me Grow data and technology hub. In addition, pilot programs in Regions 2, 3, and 8 are taking initial steps towards coordination. Statewide implementation of coordinated intake could connect regional efforts.

## **Create a Statewide Public Education Campaign**

NYS has a history of producing cutting edge public awareness and information campaigns—from smoking cessation to traffic safety. A campaign aimed at all expectant and new parents, regardless of socio-economic status or identified risk factors, would help normalize home visiting and turn it from an unknown into a benefit that families seek out and normalize. Such an initiative would also increase awareness of the importance of the first 1,000 days (three years) of life.

The majority of parents interviewed via the HVCI reported that they heard about home visiting from a friend. Programs expressed frustration that physicians did not refer for services, and felt that they spent an inordinate amount of time on community outreach with limited success.. Launched with a phase-in of universal prenatal home visiting, a campaign could increase referrals and overall participation.

# CONCLUSION

The authors assumed this project with a few hypotheses based on years of discussions at the State level, that had rarely included regional, county, or even provider/family input. After 25 Summits were held throughout NYS, the authors heard similar stories from programs, partner organizations, and parents. The ten accompanying Home Visiting Development Plans (appendices) echo several of the same sentiments including county- and/or region-specific challenges and recommendations.

The work of the HVCI resulted in new and strengthened partnerships across the State, as well as the formulation of recommendations included in this Final Report, and in the regional Development Plans. Implementation of the identified priorities will take time, but the authors are hopeful that this will ultimately result in more families in NYS receiving home visiting services, positively impacting communities and supporting all families.

## QUOTES FROM PARENTS AND PROVIDERS ABOUT THE PROCESS

- "I want to be part of a community." -- Parent, Region 4
- "As a dad, I have not had an opportunity to participate without mom." -- Parent, Region 2
- "My home visitor - they are like a family member now. They helped me within 10 minutes of me calling when I was in a domestic violence crisis – brought totes to pack up my stuff, put me and child/children into a hotel for weeks, supplied food also. Checked in regularly-- even on the weekends." -- Parent, Region 2
- "What are they offering? What do you have for me?" -- Parent, Region 7
- "I don't want home visiting here to be seen as punitive or reactive. To me, it feels that way when often home visiting in some instances is a result of a mandate, rather than a choice for children. The stigma has to change to meet the unmet need on Long Island and across New York, but we have to change the message. We need to redefine home visiting as proactive in helping our kids in improving their education and health outcomes."-- Parent, Region 10
- "Families need to feel they are partners and the programs are a staple; a part of their home." - Parent, Region 10
- "Help is for everyone."-- Participant, Region 3
- "Wish I knew about home visiting before the baby was born." -- Parent, Region 6
- "I want to see more marketing about the program in my community. I am proud to be in this program." -- Parent, Region 6
- "Programs tripping on each other." -- Provider, Region 7
- "All I want and wish for, is better for my community" -- Parent, Region 9
- "It was a very positive personal experience that I would recommend to other women and families. It was educational; the CHW linked me to various resources within the community. The CHW was a great advocate who advocated for me and helped empower me. She also helped me write up my own personal life plan, which has and continues to help me throughout life."-- Parent, Region 8

## Endnotes

1 <https://www.ncsl.org/research/human-services/home-visiting-improving-outcomes-for-children635399078.aspx>

2 For the purpose of this report, "parent" connotes all caregivers, including kin, foster, and adoptive.

3 Kids' Well-being Indicators Clearinghouse (KWIC) data; NYS Council on Children and Families; 2012-14.

4 "Addressing the Opioid Crisis through Home Visiting"; Education Development Center; April 2019.

5 As of Summer 2019, NYS Department of Health regulation requires insurers to cover maternal depression screenings and referrals to specialists.

## APPENDIX 1

**REGION 1** - Western NY: Allegheny, Cattaraugus, Chautauqua, Erie, and Niagara Counties

### SUMMIT DETAILS

**Backbone Organization (BBO):** Help Me Grow Western NY (HMG-WNY), a free resource connecting families in Erie and Niagara counties to community resources and child development information.

**Number of Participants:** Approximately 30.

**SWOT Results:** Each BBO in this project conducted an initial SWOT Analysis and a compilation of the Region's strengths and challenges. This was used as the basis for the first Summit, wherein attendees revised and ranked issues accordingly.

**Strengths:** Family-led goal setting; individualization of services, strong Early Intervention program; several active coalitions.

**Weaknesses:** Funding for research; inadequate salaries; need for male home visitors.

**Opportunities:** Not captured.

**Threats:** Funding streams for children 0-5; high poverty rates; high mental health/substance abuse rates; inequality for indigenous women (especially in court).



**ACKNOWLEDGEMENT:** The authors wish to thank Help Me Grow Western NY for its partnership, and Glenda Cadwallader for facilitation. This report would not be possible without input from providers, parents and other nonprofits in Region 1. We thank everyone who participated!

## LANDSCAPE AND DATA SYNOPSIS

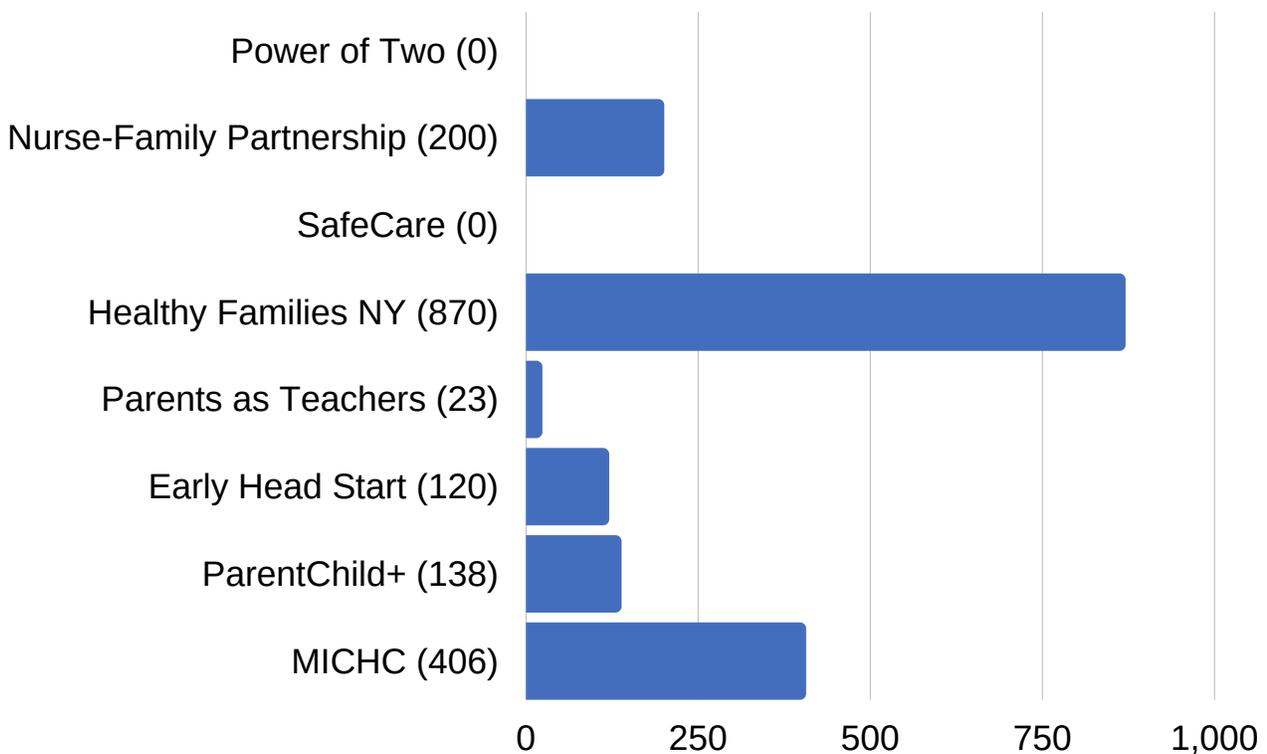
The following bullets give a sense of the percentage of families with young children who may have been eligible for home visiting services based on income level.

- 11% of children under age six with parents who are unemployed<sup>1</sup>
- 25% of young children (under age six) living in poverty (under 100% FPL)<sup>2</sup>
- 13% of young children (under age six) living in deep poverty (under 50% FPL)<sup>3</sup>

The total number of births in this Region during the three-year period 2014-2016 was 44,944.<sup>4</sup>

The funded capacity of evidence-based and evidence-generated home visiting programs (see chart) is significantly lower. Note that these programs are not active in every county in the Region.

### Region 1: Western NY Funded Capacity of Home Visiting Programs



**Total Funded Capacity of Home Visiting Programs: 1,757**

## **PARENT PERSPECTIVE**

Throughout the State parents expressed similar sentiments. In this Region, parents also focused on: the critically important nature of the relationship with their home visitor and the complications that losing a home visitor caused. Parents stated that with high staff turnover, they have to start from scratch, tell their story all over again, and re-establish a trusting relationship.

## **RECOMMENDATIONS**

### **Enhance community collaboration, coordination, and communication.**

Form a regional home visiting council that meets quarterly to offer opportunities for home visiting providers to share resources, training opportunities, and outcome data. It is the Region's hope that, through this council, there can be shared programming and potential collaborative funding requests. The council could report out to local and State policymakers on the importance of home visiting and the experiences of the families in their constituency. This council would lead to more appropriate referrals and help avoid duplication of services.

**Strengthen workforce development.** The regional home visiting council would share, discuss, and prioritize resources to address training needs on topics such as cultural humility, trauma-informed strategies, and available community supports. In addition, there is a need for investment in the workforce in the form of salary and career pathways to reduce turnover and increase retention. Low pay rates make it difficult to hire quality candidates and often leave home visiting programs competing with less stressful employment opportunities. High turnover results in an inability to respond to community requests for partnering opportunities to expand services, loss of families due to the loss of a trusted provider, loss of organizational and community wisdom, and an inability to leverage opportunities with home visiting programs and a value-based payment funding system.

**Collect and use outcome data.** Through the regional home visiting council, develop and make available repositories for all members to use in gathering data and statistics regarding items such as: expected birth-rates, return on investment projections, developmental screening results, poverty rates, adverse childhood experience (ACEs) rates, the impact of home visiting on preventive health appointments (well visits), developmental screening/early intervention services, and home visiting program outcomes associated with social determinants of health.

1 Data courtesy of the Schuyler Center for Analysis and Advocacy

2 IBID

3 IBID

4 [https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county\\_list.htm](https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county_list.htm)

## APPENDIX 2

**REGION 2** - Finger Lakes: Genesee, Livingston, Monroe, Ontario, Orleans, Seneca, Wayne, Wyoming, and Yates Counties (Region 2 chose to hold a separate Summit for Monroe County)

### SUMMIT DETAILS

**Backbone Organization (BBO):** The Children’s Agenda (TCA), an organization that advocates for effective policies and drives evidence-based solutions for the health, education and success of children. TCA is especially committed to children who are vulnerable because of poverty, racism, health disparities and trauma.

**Number of Participants:** Approximately 30.

**SWOT Results:** Each BBO in this project conducted an initial SWOT Analysis and a compilation of the Region's strengths and challenges. This was used as the basis for the first Summit, wherein attendees revised and ranked issues accordingly.

**Strengths:** Staff that are reflective of the population; decades of early childhood collaboration.

**Weaknesses:** No formal coordination; inadequate capacity; lack of funding; lack of community/program resources.

**Opportunities:** Moving to a competency-based workforce; neutral coordinated intake through centralized entity.

**Threats:** High prevalence of trauma; stigma; reallocation of government funding.



The authors wish to thank The Children’s Agenda (TCA) for its partnership, and Twylla Dillon for facilitation. This report would not be possible without input from providers, parents and other nonprofits in Region 2. We thank everyone who participated!

## LANDSCAPE AND DATA SYNOPSIS

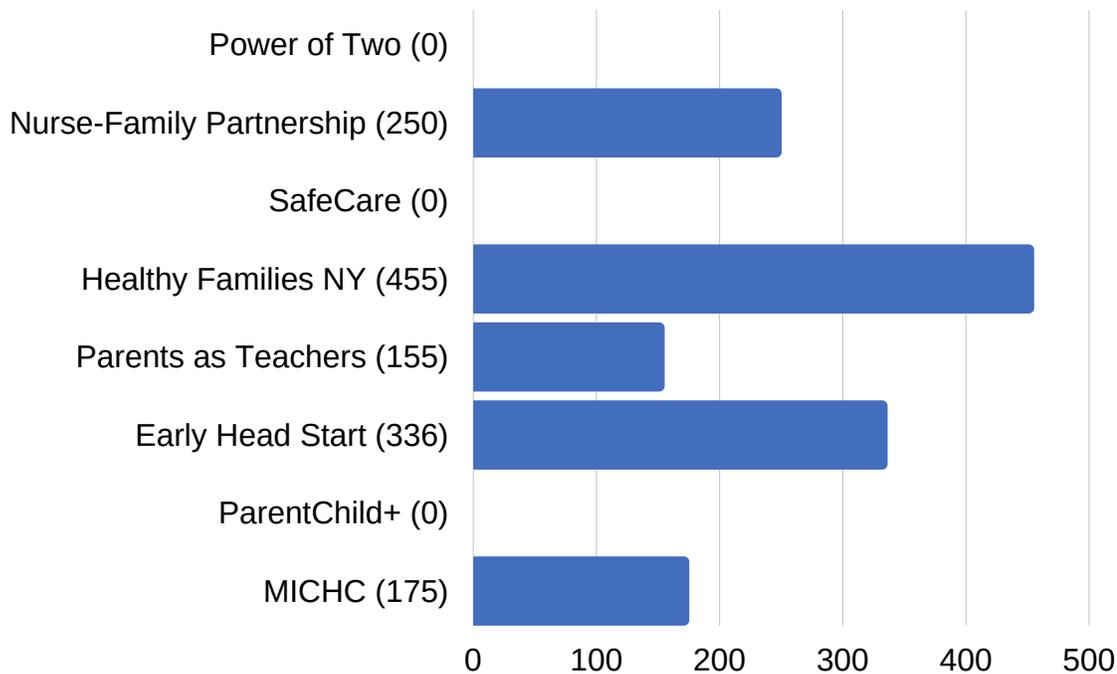
The following bullets give a sense of the percentage of families with young children who may have been eligible for home visiting services based on income level.

- 10% of children under age six with parents who are unemployed <sup>1</sup>
- 23% of young children (under age six) living in poverty (under 100% FPL) <sup>2</sup>
- 11% of young children (under age six) living in deep poverty (under 50% FPL) <sup>3</sup>

The total number of births in the Region during the three-year period 2014-2016 was 38,295.<sup>4</sup>

The funded capacity of evidence-based and evidence-generated home visiting programs (see chart) is significantly lower. Note that these programs are not active in every county in the Region. In addition, community-based programs exist that provide services that can enhance home visiting programs, but are not necessarily meant to supplant them. For example, Genesee County has UMMC MOMS Program, while Livingston County has Catholic Charities and Noyes First Steps and Monroe has Baby Love.

## Region 2: Finger Lakes Funded Capacity of Home Visiting Programs



**Total Funded Capacity of Home Visiting Programs: 1,371**

## PARENT PERSPECTIVE

Throughout the State parents expressed similar sentiments. In this Region, parents also focused on: dread in anticipation of their child aging out of the home visiting program (a continuum of care might help alleviate this issue by providing transition assistance to another supportive program); not having restrictive time limits on program length; appreciation of the services they received (wish that more people knew how valuable they are and that it is not because parents are “bad”); and the importance of including fathers and asking for the father’s perspective.

## RECOMMENDATIONS

**Convene Quarterly Gathering.** Implement quarterly United Way Greater Rochester home visiting gatherings to network and better coordinate services across the diverse region. All local agencies with and without United Way funding will be invited. Gatherings would allow for creative funding and reimbursement discussions to ensue.

**Implement Coordinated Referrals.** Implement coordinated referrals through the Community Information and Referral Services Call Center, 211. Create and share a living document that provides information on requirements for participation with all home visiting programs. In addition, meet with clinical providers to explain the programs and best practices for referral. Begin participating in the Monroe County Systems Integration Project as a means of improving integration of data between programs and clinicians. This data will allow providers to address and serve families’ needs more efficiently.

**Launch Universal Home Visiting.** Implement universal home visiting across the Region in order to reduce stigma and allow all families to receive a baseline level of support.

**Increase Workforce Development Opportunities.** Analyze cost of living and increase pay for home visitors. In addition, invest in staff vehicles to eliminate personal vehicle wear and tear.

1 Data courtesy of the Schuyler Center for Analysis and Advocacy

2 IBID

3 IBID

4 [https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county\\_list.htm](https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county_list.htm)

## APPENDIX 3

**REGION 3** - Southern Tier: Eastern: Broome, Chemung, Delaware and Tioga Counties. Western: Chenango, Schuyler, Steuben, and Tompkins Counties.

### Summit Details

**Backbone Organization (BBO):** Mothers and Babies, an organization that works to improve pregnancy and birth outcomes and to support the health and development of all individuals and families. Mothers and Babies educates the communities; connects individuals and families to health and other services; advocates for system improvements; and partners with other agencies, government, and providers to strengthen families.

**Number of Participants:** Approximately 15 in East Region and 15 in West Region.

**SWOT Results:** Each BBO in this project conducted an initial SWOT Analysis and a compilation of the Region's strengths and challenges. This was used as the basis for the first Summit, wherein attendees revised and ranked issues accordingly.

**Strengths:** Program capacity; programs working to reduce/eliminate barriers to services.

**Weaknesses:** Rural areas have a lack of transportation and fewer resources; low salaries; inconsistent referrals from community providers, such as primary care.

**Opportunities:** Initiatives to include fathers; increased funding to serve older youth.

**Threats:** Limited sources of funding; evaluation requirements that do not always reflect the work done with clients.



The authors wish to thank Mothers and Babies for its partnership, and Mary Haust for facilitation. This report would not be possible without input from providers, parents and other nonprofits in Region 3. We thank everyone who participated!

## LANDSCAPE AND DATA SYNOPSIS

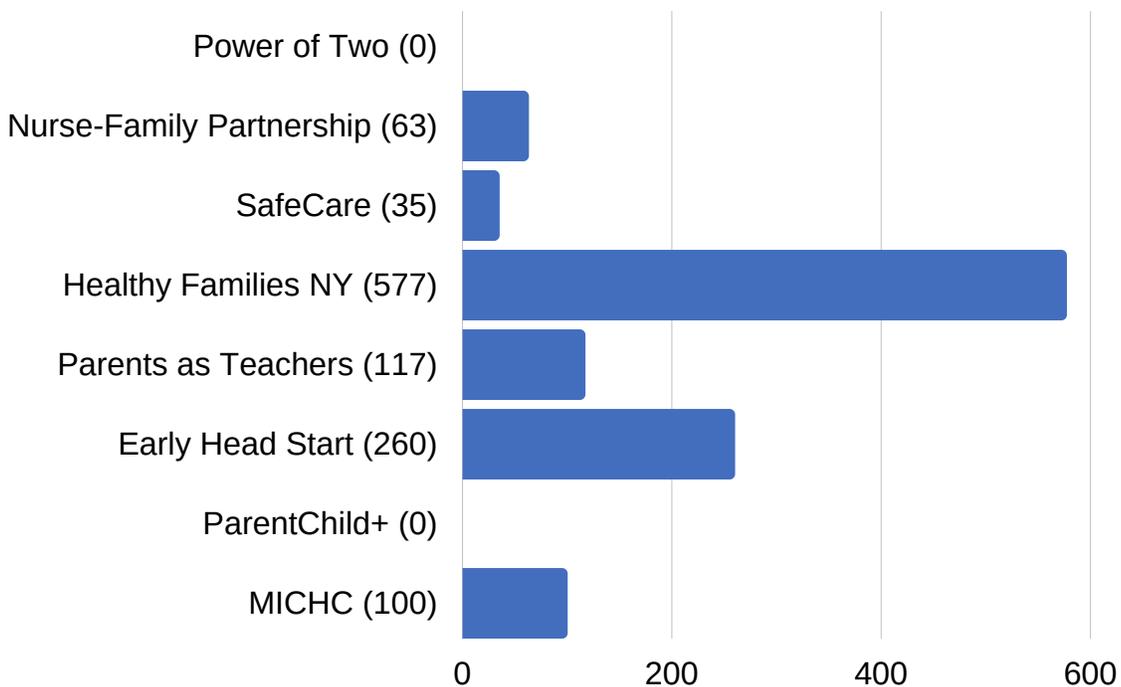
The following bullets give a sense of the percentage of families with young children who may have been eligible for home visiting services based on income.

- 9% of children under age six have parents who are unemployed <sup>1</sup>
- 26% of young children (under age six) living in poverty (under 100% FPL) <sup>2</sup>
- 13% of young children (under age six) living in deep poverty (under 50% FPL) <sup>3</sup>

The total number of births in this Region during the three-year period 2014-2016 was 18,806.<sup>4</sup>

The funded capacity of evidence-based and evidence-generated home visiting programs (see chart) was significantly lower. Note that these programs are not active in every county in the Region. In addition, community-based programs exist that provide services that can enhance home visiting programs, but are not necessarily meant to supplant them. For example, Broome County has Binghamton PACT, Chemung County has the School Readiness Project, and Tompkins County's Public Health Department hosts SafeCare and the MOMS Program.

### Region 3: Southern Tier Funded Capacity of Home Visiting Programs



**Total Funded Capacity of Home Visiting Programs: 1,152**

## PARENT PERSPECTIVE

Throughout the State parents expressed similar sentiments. In this Region, parents also focused on: trepidation about home visitors being mandated child abuse and neglect reporters, and families feeling judged (particularly their living situations); time restrictions on visits; wanting services tailored to fathers; and the fact that many parents don't know about home visiting programs and their many benefits.

## RECOMMENDATIONS

**Create a media campaign to destigmatize home visiting and highlight the importance of the early years and the advantage of utilizing home visiting.** During the parenting listening sessions, parents stated they were not aware that home visiting programs existed before entering them nor were they aware of the benefits to utilizing such programs. Once they became aware of program benefits they hoped to spread the information to other parents. If home visiting were marketed to all families as a well-deserved support mechanism for parents it would no longer be viewed as a negative intervention for poor parenting.

**Formalize a collaborative referral system for all relevant home visiting programs and services within each county.** Home visiting programs often have to rely on referrals from obstetricians and pediatricians who may refer based on their own biases. If a collaborative referral system existed, all families could undergo screening and be directed to the services that best meet their individual needs.

**Create and fund the development of universal home visiting models using both evidence-based and evidence-generated home visiting programs so that all parents of children birth to age five can access a base-level of service.**

**Formalize a regional/county level meeting schedule where all relevant programs can discuss challenges and creative solutions around the goal of expanding home visiting capacity.** During the Summit, home visiting programs shared information regarding open spots in their programs that proved useful to others in the room. There was a strong desire to continue meeting on behalf of the programs and families served to discuss implementation of recommendations and to further discuss challenges in the field.

1 Data courtesy of the Schuyler Center for Analysis and Advocacy

2 IBID

3 IBID

4 [https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county\\_list.htm](https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county_list.htm)

## APPENDIX 4

**REGION 4** - Central NY: Cayuga, Cortland, Madison, Onondaga and Oswego Counties

### Summit Details

**Backbone Organization (BBO):** Early Childhood Alliance (ECA), a diverse cross-section of community stakeholders that impact the early childhood system in Onondaga County. The ECA was launched in January 2015 and works within the larger community to develop a coordinated and strategic early childhood system.

**Number of Participants:** Approximately 25.

**SWOT Results:** Each BBO in this project conducted an initial SWOT Analysis and a compilation of the Region's strengths and challenges. This was used as the basis for the first Summit, wherein attendees revised and ranked issues accordingly.

**Strengths:** Head Start, WIC, and Early Intervention programs across counties; strong networks.

**Weaknesses:** Funding; long wait lists; staff retention/compensation; shortage of nurses.

**Opportunities:** Education campaign; expansion of ParentChild+; trauma-informed program expansion.

**Threats:** Loss of workers; community conditions, including violence, mental health/substance abuse needs.



ACKNOWLEDGEMENT: The authors wish to thank Early Childhood Alliance for its partnership, and Lisa Fasolo Frishman for facilitation. This report would not be possible without input from providers, parents and other nonprofits in Region 4. We thank everyone who participated!

## LANDSCAPE AND DATA SYNOPSIS

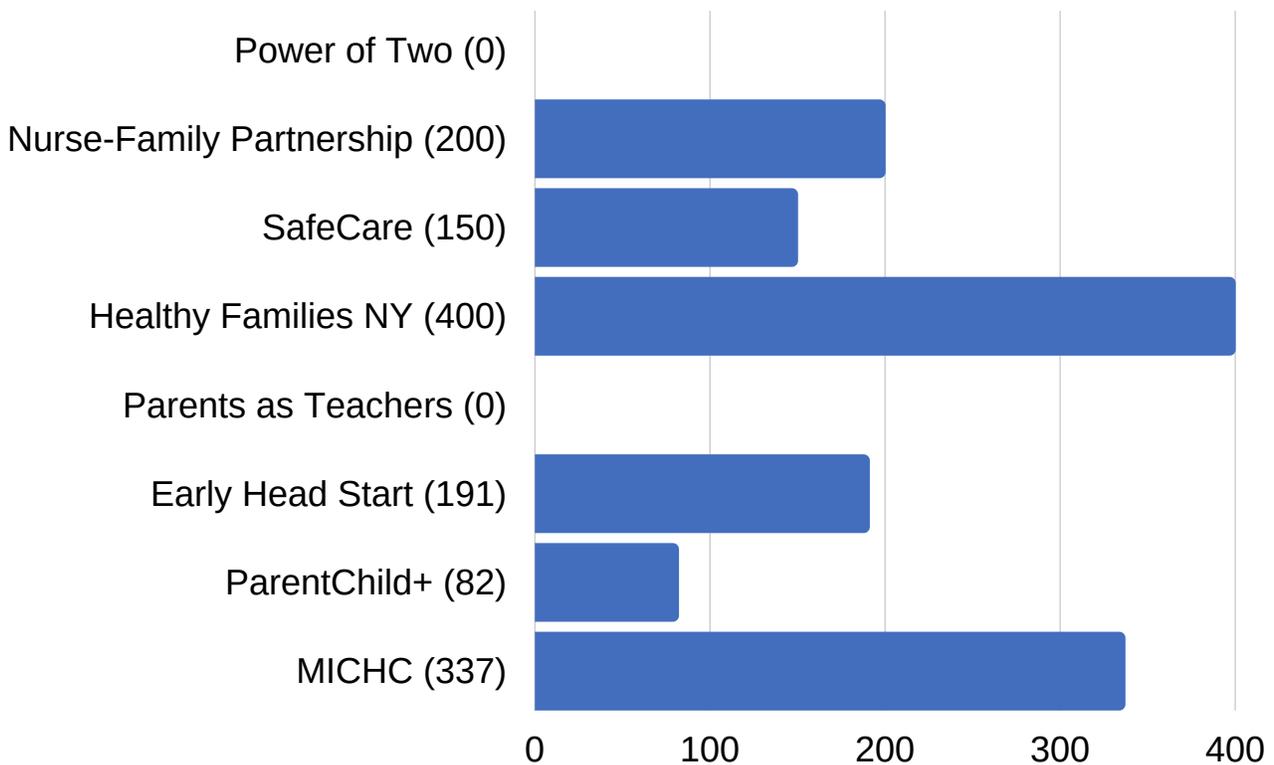
The following bullets give a sense of the percentage of families with young children who may have been eligible for home visiting services based on income.

- 10% of children under age six who have parents who are unemployed <sup>1</sup>
- 25% of young children (under age six) living in poverty (under 100% FPL) <sup>2</sup>
- 13% of young children (under age six) living in deep poverty (under 50% FPL) <sup>3</sup>

The total number of births in this Region during the three-year period 2014-16 was 25,329 <sup>4</sup>

The funded capacity of evidence-based and evidence-generated home visiting programs (see chart below) is significantly lower. Note that these programs are not active in every county in the Region. In addition, community-based programs exist that provide services that can enhance home visiting programs, but are not meant to supplant them. For example, Cayuga County has doula, lactation, and kinship programs, while Onondaga has Better Beginnings and Lullabye League, and Oswego has Catholic Charities.

### Region 4: Central NY Funded Capacity of Home Visiting Programs



**Total Funded Capacity of Home Visiting Programs: 1,360**

## PARENT PERSPECTIVE

Throughout the State parents expressed similar sentiments. In this Region, parents also focused on: the need for increased training for staff on cultural competency and implicit bias; more flexible program hours; and assistance with concrete supports (housing, food, clothing, child care).

## RECOMMENDATIONS

**Attract, develop, and support an empowered workforce.** Without an empowered workforce, families suffer. They deserve and need consistency, trust, respect, and support. Some parents reported leaving programs early due to the loss of a trusted, knowledgeable provider. Programs are navigating this negative consequence of high staff turnover, as well as increased workloads, stress, and overall confusion. They are also faced with the high costs of hiring and training (and then losing staff they've invested in), as well as the issue of families on waiting lists who remain there because of a lack of program capacity. Some parents also felt “driven away” by staff who lacked sufficient training and were not aware of their biases. Empowering staff through more specialized training would help create a productive, compassionate workplace with home visitors who feel confident in their abilities and, consequently, are more likely to remain in their job.

**Enhance existing programs by tailoring sessions to fit the needs of the family.** A one-size-fits-all approach is problematic. Take a comprehensive look at the home visiting system to see how it works, who participates, what issues it addresses, how communities should talk about it, and how counties should implement it. Ideas for enhancements include longer visits, weekend and evening visits, and tele-home visiting. Improvements could also include increasing connections among families to decrease the social isolation many parents experience.

**Increase peer and community connections.** Many families reported that home visiting provides a connection to someone they can talk to about parenting concerns. The gaps here include programming for fathers, connections to support groups, and free parenting classes with on-site child care.

**Provide more wrap-around services.** Families expressed the need for warm hand-offs to housing, public assistance, and food/clothing supports. They need assistance finding affordable child care and employment. Programs also reported a desire to be able to provide more concrete support, such as diapers, formula, car seats, strollers, and transportation.

**Create an education and awareness campaign around the importance of home visiting to destigmatize it and allow all parents to take advantage of the services being offered.** Many families view home visiting as a negative occurrence rather than a strengths-based support mechanism. It is misunderstood and undervalued. If home visiting were described as every parent’s right to support and education during the prenatal and early childhood period, this view would drastically change.

**Create a regional contact list to increase information sharing across counties.** Region 4 Summit participants expressed a desire to continue conversations about program design and management, as well as local needs. Program staff hoped to be able to come together in the future for inspiration, ideas, and resource sharing.

1 Data courtesy of the Schuyler Center for Analysis and Advocacy

2 IBID

3 IBID

4 [https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county\\_list.htm](https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county_list.htm)

## APPENDIX 5

**REGION 5** - Mohawk Valley: Fulton, Herkimer, Montgomery, Oneida, Otsego and Schoharie Counties.

### Summit Details

**Backbone Organization (BBO):** Cornell Cooperative Extension of Oneida County, an educational organization that enables people to improve their lives and communities through partnerships that put experience and research knowledge to work.

**Number of Participants:** Approximately 25.

**SWOT Results:** Each BBO in this project conducted an initial SWOT Analysis and a compilation of the Region's strengths and challenges. This was used as the basis for the first Summit, wherein attendees revised and ranked issues accordingly.

**Strengths:** Program slots are full and utilized; affiliation with Cornell.

**Weaknesses:** Staff burnout; poor communication across programs.

**Opportunities:** Parent education.

**Threats:** Funding cuts.



ACKNOWLEDGMENT: The authors wish to thank Cornell Cooperative Extension of Oneida County for its partnership, and Eric Williams for facilitation. This report would not be possible without input from providers, parents and other nonprofits in Region 5. We thank everyone who participated!

## LANDSCAPE AND DATA SYNOPSIS

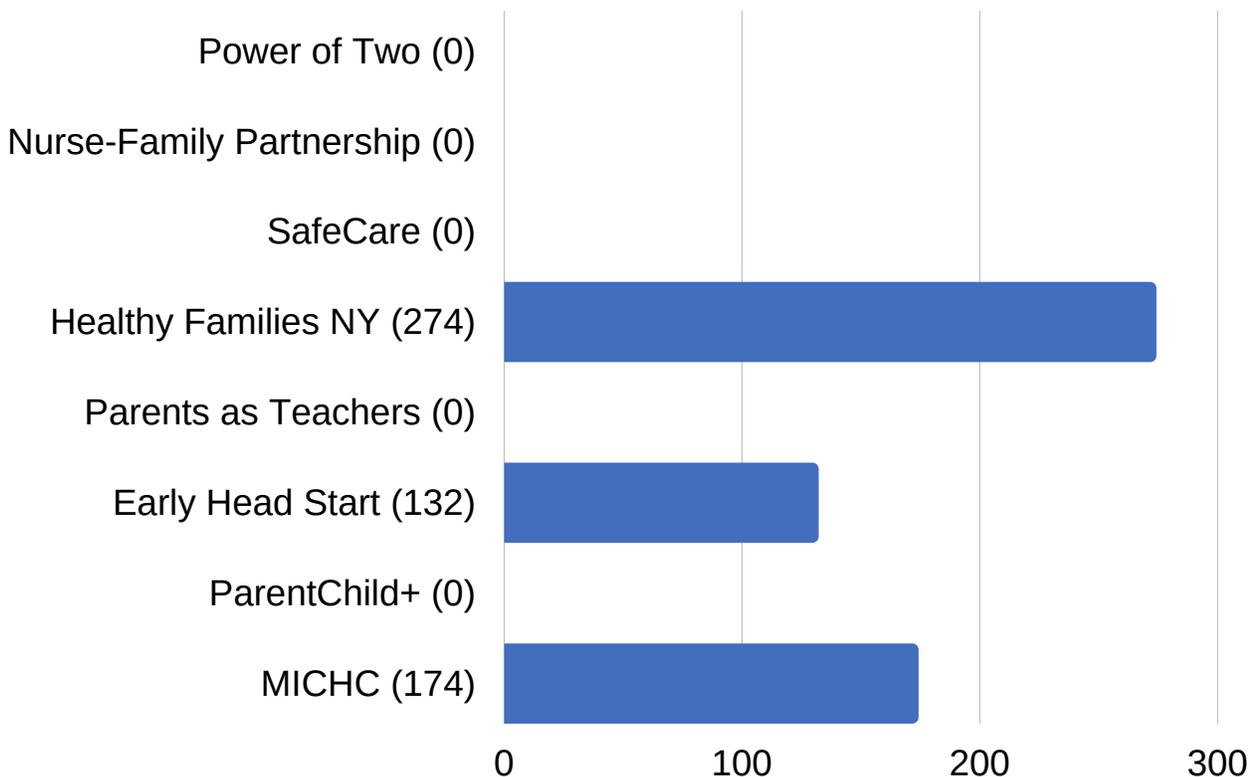
The following bullets give a sense of the percentage of families with young children who may have been eligible for home visiting services based on income.

- 13% of children under age six who have parents who are unemployed <sup>1</sup>
- 29% of young children (under age six) living in poverty (under 100% FPL) <sup>2</sup>
- 15% of young children (under age six) living in deep poverty (under 50% FPL) <sup>3</sup>

The total number of births in this Region during the three-year period 2014-16 was 15,063 <sup>4</sup>

The funded capacity of evidence-based and evidence-generated home visiting programs (see chart) is significantly lower. Note that these programs are not active in every county in the Region. In addition, community-based programs exist that provide services that can enhance home visiting programs, but are not necessarily meant to supplant them. For example, all of the counties have Catholic Charities.

### Region 5: Mohawk Valley Funded Capacity of Home Visiting Programs



**Total Funded Capacity of Home Visiting Programs: 580**

## **PARENT PERSPECTIVE**

Throughout the State parents expressed similar sentiments. In this Region, parents also focused on: the need for sufficient money and resources like food and housing to raise their children without struggling; education to help parents raise happy and healthy children; socialization and trips for both parents and children; peer and community support systems; and universal eligibility and accessibility to parents of all incomes.

## **RECOMMENDATIONS**

**Centralize provider agencies, services, and programs for ease of family access as a one-stop- shop supporting parents of young children.** A family community hub featured prominently in discussions during both Summits, seeking to address the hurdles that home visiting programs see for the families they serve in accessing education and support services spread across the (predominantly rural) county. This can be achieved by establishing a Family Resource Center 5 (FRC) that houses multiple agencies or agency representatives, or as a mobile van/bus that coordinates wrap-around services for families served. A central location could provide needed space for programming, opportunities to train staff and facilitate warm referral hand-offs, and promote intake partnerships. As a benefit to agencies, economies of scale was cited as a benefit for providing additional services like food, drop-in child care, and opportunities for research/ data collection. This recommendation is primarily aligned for county-level or region-level action but can be supported through statewide efforts.

**Facilitate partnerships around intake and referrals with hospitals and delivery centers.** Hospitals and birthing/ delivery facilities are ideal partners to refer parents to home visiting services and new parent education but rarely do. Home visiting programs can build relationships and trust with hospital staff by being present at the hospital, involving them in local coalitions, and providing education about home visiting successes. The ultimate goal is to identify the right processes and points of intervention that can be integrated to ensure that new parents receive the correct information and have opportunities to participate in home visiting programs. Hospital administrators, department directors, and organizational executive directors will likely be needed to make this coordination sustainable. What is needed is a clear understanding of how referrals should be made and an alignment of incentives for busy hospital and delivery personnel. Barriers involving HIPAA and institutional resistance to changes may make these partnerships a challenge to implement. This recommendation is mainly on a region-by- region or hospital-by-hospital basis but can be aided through prioritization by State government agencies, partners, and hospital system decision makers.

**Address staffing and retention challenges by supporting manager and administrative training.** Burnout and turnover are challenges to program continuity, as is keeping families engaged in programs with a trusted point of contact and ensuring that staff who want to stay are not overburdened. As such, a recommendation was put forward to establish stronger training and support for managers and administrators. A key component of this is mandatory reflective supervision between home visiting staff and managers to discuss workload, challenges, and wellness to ensure that reasonable and realistic goals are set. On the regulatory and structural side

## **RECOMMENDATIONS (continued)**

this may include setting more manageable caps on caseloads for home visiting staff and mechanisms for adding additional staff capacity when those limits are exceeded. Additionally, programs could create mechanisms to allow for using staff time more flexibly to adapt to evening or weekend visits. The staffing pipeline is also a challenge with a few recommendations focused on mentoring opportunities for early-career home visiting staff, opportunities to engage graduate and participant families to fill staffing needs, and revisiting the educational requirements versus pay scale for those thinking about entering the field. Many of these suggestions rely on the buy-in of State agencies and the adaptation of funding mechanisms at the State level. This may also include the allocation of additional funds set aside for training.

**Family Resource Centers (FRCS) are voluntary programs that, while diverse in their offerings, “all promote the strengthening of families through developing social support, increasing knowledge of effective parenting, fostering child development, and enhancing family functioning.”** Services include parent education classes, concrete services such as food pantries, and information and referral services. FRCs receive State funding through the NYS Office of Children and Family Services/Hoyt Memorial Children and Family Trust Fund.

**Create a central database of resources, programs, and referrals for all programs serving parents of children aged 0-5.** This database should include all agencies serving children ages 0-5 and their parents and will enable involved agencies to make more effective referrals to the scope of support a family may need. This can include local public and provider events, program eligibility, geographic scope, and program areas of expertise. Implementation can be done at the county level to start, but a unified database could be built at the State level with advantages to economies of scale. Staff time will be needed to maintain the database and ensure that contacts and programs remain updated regularly. As a means of collaboration, this can also include establishing monthly meetings between regional providers and facilitating information sharing.

**Change the culture and normalize home visiting to reduce stigma and promote the usage of home visiting services.** Reducing the stigma of home visiting and normalizing parent education could be done at multiple levels. At the State level, State agencies can build relationships with health providers, hospitals, and medical systems to include their perspective as important parts of the ecosystem of care for families. At the regional level, this can be achieved by a unified community outreach effort that leverages program participants, staff, and graduates in reaching out to other peer groups about the available services or a mobile unit participating at local events. A social media strategy is a key component, and an app could house resources for parent education and online questionnaires for new parents to assess their needs. Social media outreach could also include stories promoting family success stories.

1 Data courtesy of the Schuyler Center for Analysis and Advocacy

2 IBID

3 IBID

4 [https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county\\_list.htm](https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county_list.htm)

## APPENDIX 6

**REGION 6** - North Country: Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis and St. Lawrence Counties, including the Saint Regis Mohawk Reservation.

### Summit Details

**Backbone Organization (BBO):** Adirondack Birth to Three Alliance (BT3), an organization whose vision is that all young children are healthy, learning, and thriving in families that are supported by a full complement of services and resources essential for successful development.

**Number of Participants:** Approximately 25.

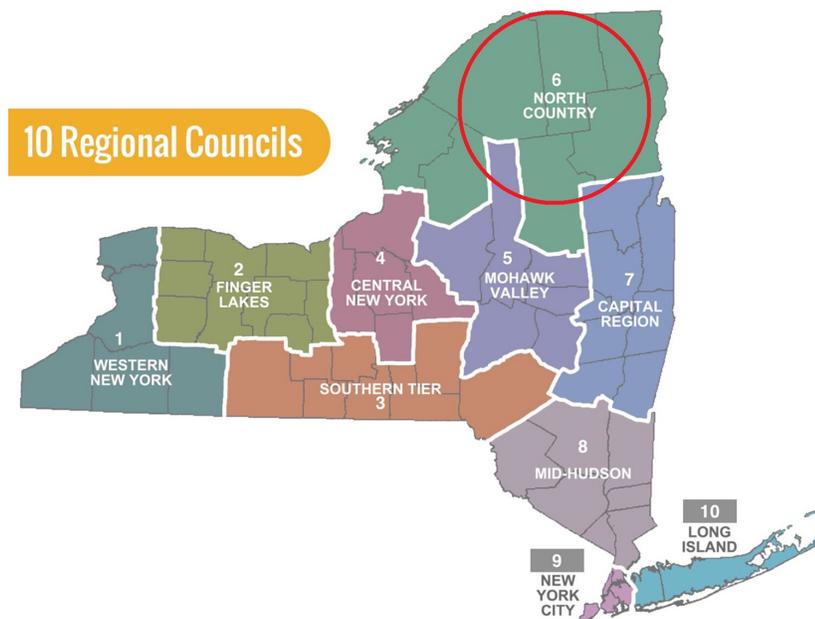
**SWOT Results:** Each BBO in this project conducted an initial SWOT Analysis and a compilation of the Region's strengths and challenges. This was used as the basis for the first Summit, where attendees revised and ranked issues accordingly.

**Strengths:** Supported a successful HFNY expansion into Franklin County, as well as the transition of Head Start slots into Early Head Start slots; developing "New Parent Kits" to connect parents to services.

**Weaknesses:** Challenges of rural demographics; need to continue to develop better connections with medical providers.

**Opportunities:** Light touch programs to de-stigmatize/normalize home visiting.

**Threats:** Funding; inadequate salaries.



ACKNOWLEDGMENT: The authors wish to thank Adirondack Birth to Three Alliance (BT3) for its partnership, and Lisa Fasolo Frishman for her facilitation. This report would not be possible without input from providers, parents, and other nonprofits in Region 6. We thank everyone who participated!

## LANDSCAPE AND DATA SYNOPSIS

The following bullets give a sense of the percentage of families with young children who may have been eligible for home visiting services by income level.

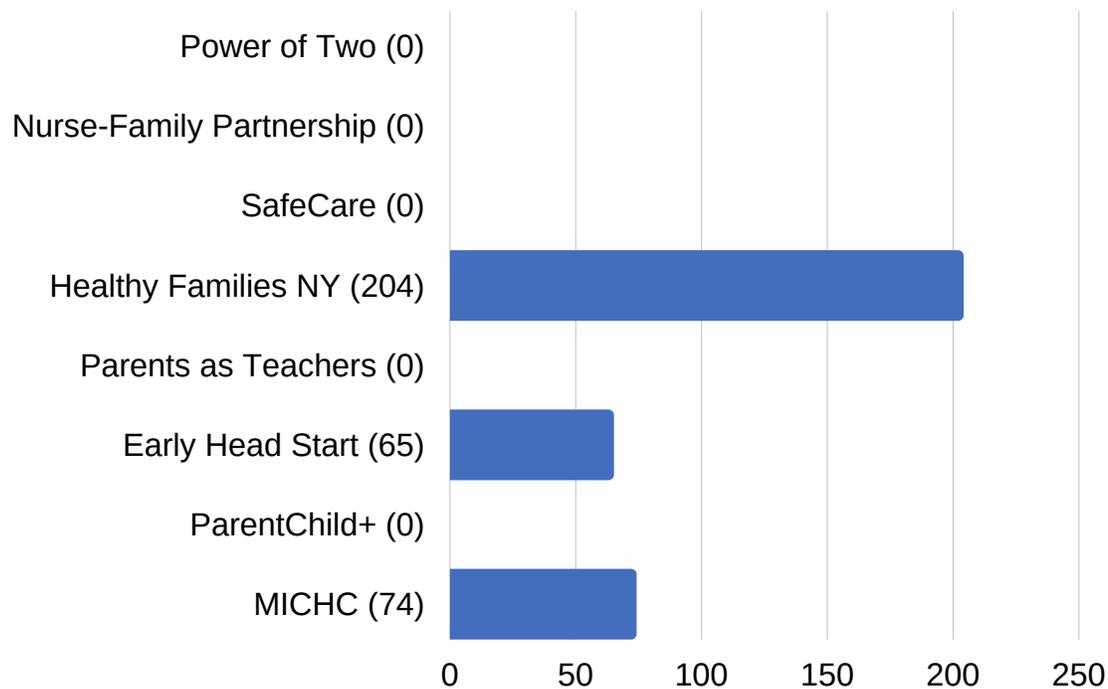
- 12% of children under age six have parents who are unemployed <sup>1</sup>
- 27% of young children (under age six) living in poverty (under 100% FPL) <sup>2</sup>
- 14% of young children (under age six) living in deep poverty (under 50% FPL) <sup>3</sup>

The total number of births in this Region during the three-year period 2014-16 was 14,614 <sup>4</sup>

The funded capacity of evidence-based and evidence-generated home visiting programs (see chart) is significantly lower. Note that these programs are not active in every county in the Region.

In addition, community-based programs exist that provide services that can enhance home visiting programs, but are not necessarily meant to supplant them. For example, Fort Drum in Jefferson County hosts a New Parent Support Group.

### Region 6: North Country Funded Capacity of Home Visiting Programs



**Total Funded Capacity of Home Visiting Programs: 343**

## PARENT PERSPECTIVE

Throughout the State parents expressed similar sentiments. In this Region, parents also focused on: greater flexibility from programs (access beyond working hours, including on weekends and holidays; allowing staff to meet with other caregivers; allowing staff to accompany families to other appointments); transportation support; increased mental health services; and greater connections to other parents and to parenting information and group activities.

## RECOMMENDATIONS

**Through community engagement and collaboration, focus on marketing home visiting programs to the larger community.** By destigmatizing home visiting and increasing awareness of the great resources home visiting provides, referrals would be increased. Parents in this Region claimed that they wish they knew about home visiting before their child was born. They also wished that all families knew about and had access to home visiting and insisted that all obstetricians/gynecologists and other physicians' offices should promote home visiting for all clients. Many parents expressed being proud to be in the program and wanting to share their success with others. Home visiting programs at the Summit described a need for funding to begin marketing their services. Through marketing, the reputation of home visiting could be improved and could attract a larger more diverse workforce.

**Create media campaign to destigmatize home visiting and highlight the importance of the early years with the advantage of utilizing home visiting.** Many families view home visiting as a negative occurrence rather than a strengths-based support mechanism. It is misunderstood and undervalued. If home visiting were described as every parent's right to support and education during the prenatal and early childhood period, this view would drastically change. In addition, home visiting is not fully understood by policymakers; this marketing campaign would seek to inform everyone of the importance of intervening early by means of home visiting.

1 Data courtesy of the Schuyler Center for Analysis and Advocacy

2 IBID

3 IBID

4 [https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county\\_list.htm](https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county_list.htm)

## APPENDIX 7

**REGION 7:** Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Warren and Washington counties.

### Summit Details

**Backbone Organization (BBO):** Brightside Up (formerly the Capital District Child Care Coordinating Council), a child care resource and referral agency that invests in collaborative relationships that enhance the development of children.

**Number of Participants:** Approximately 20.

**SWOT Results:** Each BBO in this project conducted an initial SWOT Analysis, a compilation of the region's strengths and challenges. This was used as the basis for the first Summit, wherein attendees revised and ranked issues accordingly.

**Strengths:** Strong Early Intervention model; Early Head Start model is a good example of program excellence.

**Weaknesses:** Lack of funding to implement full-scale programs; no formalized referral system other than Early Intervention.

**Opportunities:** Work with community colleges and training programs to offer workforce development training; connect to maternal mortality.

**Threats:** Family turnover and lack of a comprehensive multidisciplinary team to support family retention; stigma.



ACKNOWLEDGMENT: The authors wish to thank Brightside Up for its partnership, and Pamela Icochea Calenzani for her facilitation. This report would not be possible without input from providers, parents, and other nonprofits in Region 7. We thank everyone who participated!

## LANDSCAPE AND DATA SYNOPSIS

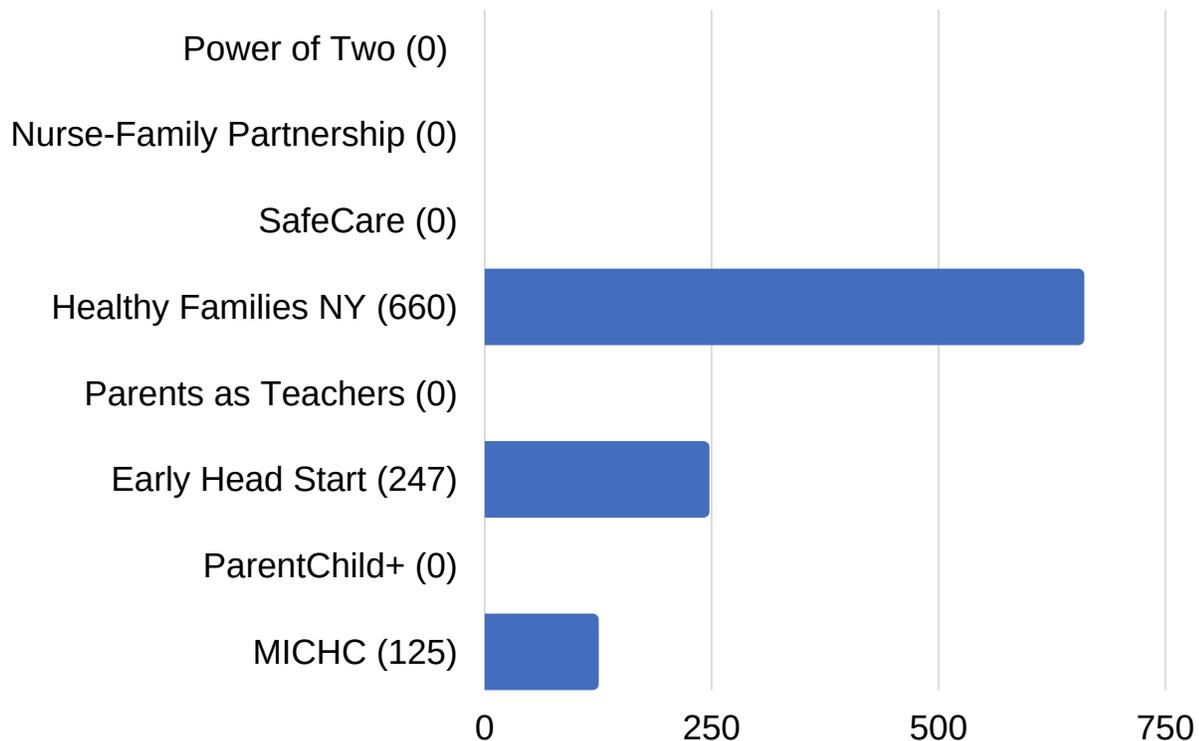
The following bullets give a sense of the percentage of families with young children who may be eligible for home visiting services by income level.

- 4% of children under age six have parents who are unemployed<sup>1</sup>
- 17% of young children (under age six) living in poverty (under 100% FPL)<sup>2</sup>
- 8% of young children (under age six) living in deep poverty (under 50% FPL)<sup>3</sup>

The total number of births in this Region during the three-year period 2014-16 was 31,927<sup>4</sup>

The funded capacity of evidence-based and evidence-generated home visiting programs (see chart) is significantly lower. Note that these programs are not active in every county in the Region. In addition, community-based programs exist that provide services that can enhance home visiting programs, but are not necessarily meant to supplant them. For example, Columbia County has a locally-funded Healthy Families America program. Greene County has no programs.

### Region 7: Capital Region Funded Capacity of Home Visiting Programs



**Total Funded Capacity of Home Visiting Programs: 1,032**

## PARENT PERSPECTIVE

Throughout the State parents expressed similar sentiments. In this Region, parents also focused on: increased training for staff on cultural competency and implicit bias (meet the family where they are); tailoring services to individual families, including allowing more flexible program hours; adequate staff training/certification; and community-informed staff.

## RECOMMENDATIONS

**Enhance systems development in order to increase referrals (usage) as well as promote interagency relationships and communication.** During the Summit, participants reported a need for strengthening interagency relationships as well as intra-organizational leadership development. They discussed having a single point of entry, as well as the need for service coordination to cut down on competition between programs. These changes would allow for appropriate referrals of parents to home visiting programs as well as increase opportunities for home visitors to connect parents to all the services they need. Some of the activities proposed during the Summit were: interagency training opportunities to promote networking; understanding of goals and missions and identification of ways to strengthen interagency relationships and trust; and allowing data/information sharing between programs and agencies. Participants noted that, in Schenectady County, Early Head Start and Healthy Families New York have been co-located for years and coordinate intake/referrals successfully; other counties could look to Schenectady as a model of a trusting relationship.

**Increase workforce development and sustainability.** Increase the number of home visitors, promote competencies that are reflective of the community's needs, and promote individual professional development. The following proposed activities aim to increase retention of staff and to promote job satisfaction: engage parents as potential home visitors and create a career pathway for them to follow; identify, define, and encourage baseline job competencies; and invest in staff self-care training in order to address vicarious trauma. Lastly, a partnership between home visiting programs and the SUNY/CUNY system would provide an opportunity for home visitors to further their education (such as pursuit of a CDA).

1 Data courtesy of the Schuyler Center for Analysis and Advocacy

2 IBID

3 IBID

4 [https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county\\_list.htm](https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county_list.htm)

## APPENDIX 8

**REGION 8** - Mid-Hudson: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, and Westchester Counties.

### Summit Details

**Backbone Organization (BBO):** Westchester Children’s Association (WCA), an organization that stands for the principle that all young people deserve a strong start in life. As the leading voice for the children and youth of Westchester, WCA works to improve the status quo for all young people – from newborns to young adults.

**Number of Participants:** Approximately 20.

**SWOT Results:** Each BBO in this project conducted an initial SWOT Analysis and a compilation of the Region’s strengths and challenges. This was used as the basis for the first Summit, wherein attendees revised and ranked issues accordingly.

**Strengths:** WCA convenes Westchester County advocates, home visiting and early childhood professionals; Healthy Families NY is present in the majority of counties.

**Weaknesses:** Unmet need is great; Funding.

**Opportunities:** Pilot program in Yonkers to facilitate coordinated intake.

**Threats:** Access to funding (finding buy-in from the private sector/foundations).



ACKNOWLEDGMENT: The authors wish to thank Westchester Children’s Association (WCA) for its partnership, and Eric Williams for his facilitation. This report would not be possible without input from providers, parents, and other nonprofits in Region 8. We thank everyone who participated!

## LANDSCAPE AND DATA SYNOPSIS

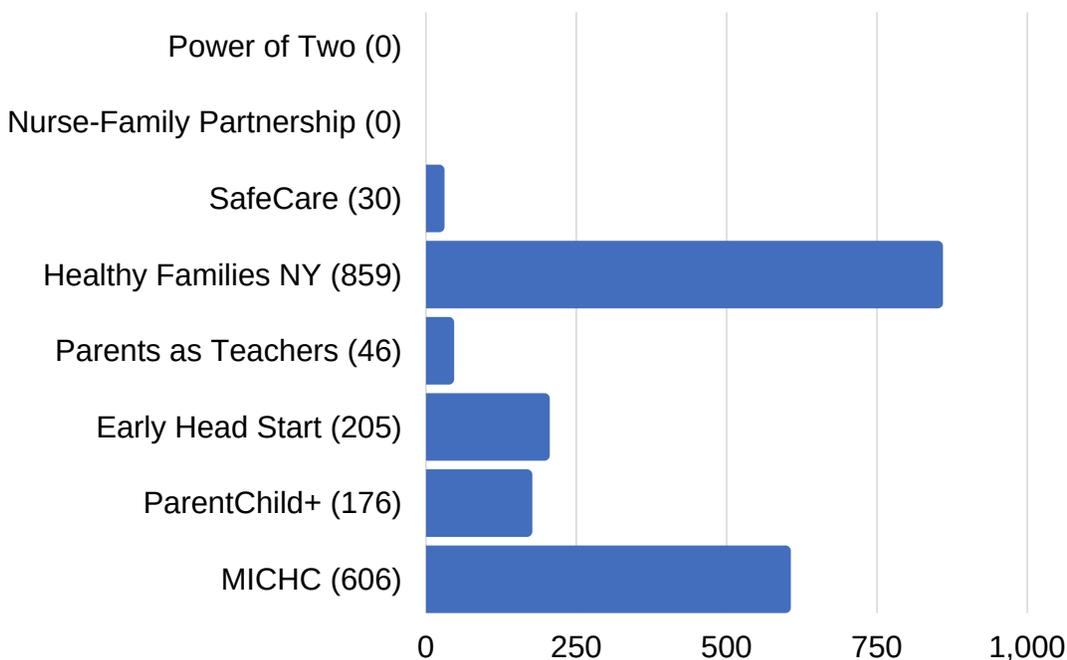
The following bullets give a sense of the percentage of families with young children who may have been eligible for home visiting services based on income level.

- 4% of children under age six have parents who are unemployed <sup>1</sup>
- 18% of young children (under age six) living in poverty (under 100% FPL) <sup>2</sup>
- 8% of young children (under age six) living in deep poverty (under 50% FPL) <sup>3</sup>

The total number of births in this Region during the three-year period 2014-16 was 78,537 <sup>4</sup>

The funded capacity of evidence-based and evidence-generated home visiting programs (see chart) is significantly lower. Note that these programs are not active in every county in the Region. In addition, community-based programs exist that provide services that can enhance home visiting programs, but are not necessarily meant to supplant them. For example, Westchester County has Babies Step Forward, Early Head Start/Head Start, It's About You Maternal Infant Community Health Collaborative (MICHC), Nurse-Family Partnership, Westchester Jewish Community Services ParentChild+; and Andrus/Healthy Families New York serving Yonkers Zip Codes 10701 and 10705, while Putnam County is limited to Early Head Start (and only in certain parts of the county).

### Region 8: Mid-Hudson Funded Capacity of Home Visiting Programs



**Total Funded Capacity of Home Visiting Programs: 1,922**

## **PARENT PERSPECTIVE**

Throughout the State parents expressed similar sentiments. In this Region, parents also focused on: the desire for increased access to helpful programs like Maternal Infant Community Health Collaborative (MICHC) and Community Health Workers (CHWs); and the need to feel more comfortable accessing education and support services to help them raise their children. In addition, county-specific issues centered around supporting the immigrant population. In Sullivan County, African immigrants have diverse language needs. In Ulster County, refugee populations with various language needs and limited translation ability is a challenge. The county is fostering language collectives to support local K'iche populations.

## **RECOMMENDATIONS**

**Create a regional working group to establish data standards, tracking systems, and research that can inform smarter decision making.** Define the needs and opportunities to standardize data across the area, understand how this data can best be used to tell stories, validate local needs, and articulate the quantitative and qualitative aspects of the work. Such a system would be used to improve program outcomes, ease reporting and tracking burdens, and allow for a more robust understanding of community impact. While agencies collect a great deal of data including demographics, medical information, and referrals, much of it goes unused or underused. Healthy Families New York data is used effectively for some aspects, while the group considered Early Head Start data to be less effective. There are no core data collection systems for MICHC.

This recommendation could begin at a county-wide or regional level as an unfunded pilot project to outline the key elements. This process will need to have key players at the table, including home visiting services, healthcare providers, schools, and potential partners such as Healthy Families New York, MICHC, Nurse Family Partnership, Department of Health, medical systems, and State level funders. Economies of scale and necessary resources are likely to result at the State level in the longer term. Hurdles to implementation include staff time needed to establish and train others around the new data systems, likely necessitating additional funding. Program requirements may need to be redefined to fit into standardized systems. Institutional inertia and resistance to change could also be a hurdle.

**Increase inter-program collaboration around funding, intake, referrals, and requirements (coordinated intake).** The group recommends establishing a full-time coordinator to do intake across programs and recommend referrals to all relevant agencies, along with easing the rules to allow parents to participate in multiple programs, if necessary. The intention is to provide a one-stop-shop for families to connect with the resources they

## **RECOMMENDATIONS (continued)**

need, along with a philosophy that there is no wrong door to get into the system by connecting initially with individual agencies.

This recommendation will help staff focus more time on the delivery of services and enhance credibility with families by fitting them into programs based on their individual needs. Families will get to choose the right program for themselves based on their life situation and alignment with the models. Agencies will be able to further specialize in their own areas of expertise rather than needing to be a one-size-fits-all provider while presenting a stronger opportunity to use marketing and branding to normalize home visiting overall. The Region suggests examining other state models, like New Jersey, for answers on the best way to coordinate central intake (New Jersey utilizes county point people).

Some of the underlying issues this recommendation seeks to address are mistrust and competition between programs, boosting enrollments and participation, and being able to address a fuller extent of needs within and outside of current scopes. This recommendation can, in part, be implemented at the county or regional level because it relies on the connections between local agencies. Some of the funding challenges will have to be handled at the State level. Hurdles include entrenched government agencies and funders who are set in their structures, as well as building trust and cooperation among agencies that compete for funds.

1 Data courtesy of the Schuyler Center for Analysis and Advocacy

2 IBID

3 IBID

4 [https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county\\_list.htm](https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county_list.htm)

## APPENDIX 9

**REGION 9** - New York City: Boroughs of Brooklyn (Kings County), Bronx (Bronx County), Manhattan (New York County), Queens (Queens County), and Staten Island (Richmond County).

### Summit Details

**Backbone Organization (BBO):** Public Health Solutions, a nonprofit working to improve health outcomes in New York City by providing services directly to the most vulnerable neighborhoods and supporting community-based health organizations who share in its mission to improve public health.

**Number of Participants:** Approximately 50 across all boroughs.

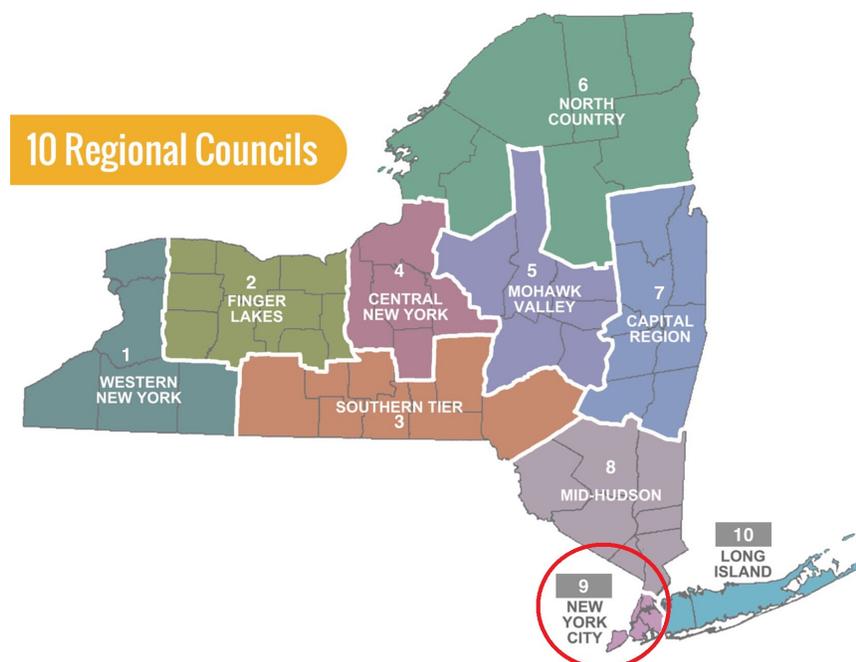
**SWOT RESULTS:** Each BBO in this project conducted an initial SWOT Analysis and a compilation of the Region's strengths and challenges. This was used as the basis for the first Summit, wherein attendees revised and ranked issues accordingly.

**Strengths:** All of the NYS MIECHV models in operation; four of five boroughs have participated in the NYS Coordinated Intake Pilot; NYS DOHMH has held three annual home visiting summits.

**Weaknesses:** Staff turnover due to non-competitive salaries; shorter-term programs do not consistently refer to longer term programs.

**Opportunities:** Reimbursement/payment for home visiting or insurance-covered universal; evaluation of impact.

**Threats:** Limited coordination between NYS- and NYC-funded programs; limited cross-program training; public charge.



**ACKNOWLEDGMENT:** The authors wish to thank Public Health Solutions for its partnership, and Rachel Schwartz for her facilitation. This report would not be possible without input from providers, parents, and other nonprofits in Region 9. We thank everyone who participated!

## LANDSCAPE AND DATA SYNOPSIS

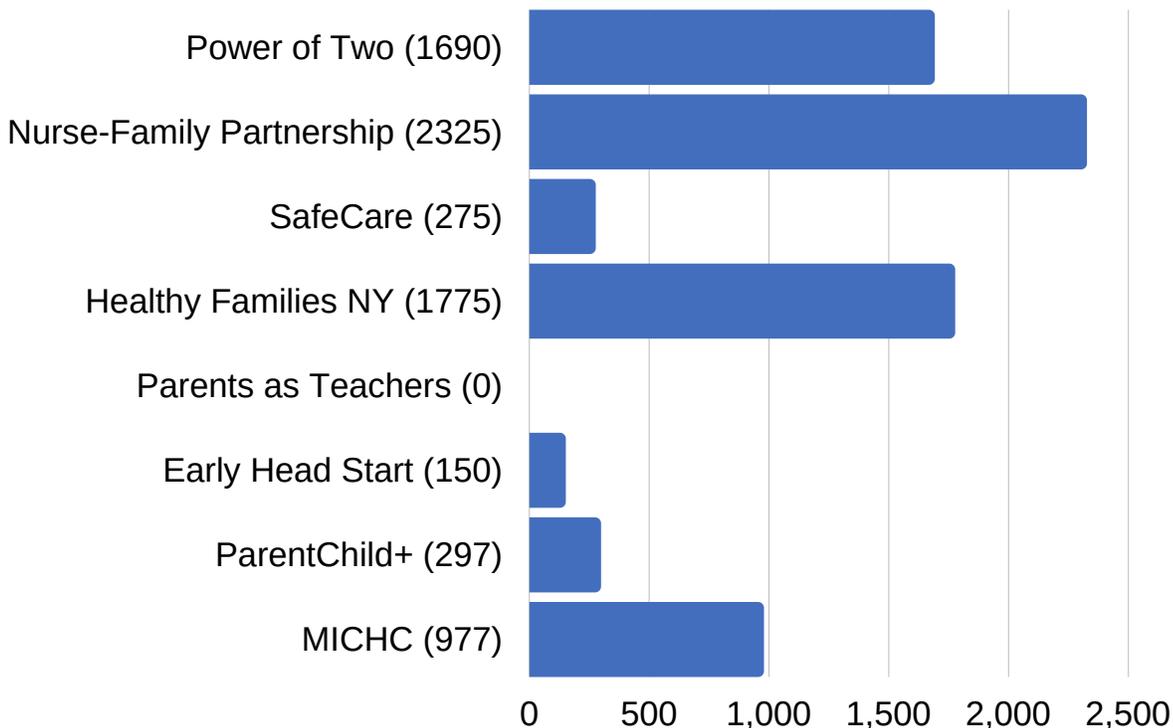
The following bullets give a sense of the percentage of families with young children who may have been eligible for home visiting services based on income level.

- 11% of children under age six have parents who are unemployed<sup>1</sup>
- 27% of young children (under age six) living in poverty (under 100% FPL)<sup>2</sup>
- 12% of young children (under age six) living in deep poverty (under 50% FPL)<sup>3</sup>

The total number of births in this Region during the three-year period 2014-16 was 346,993<sup>4</sup>

The funded capacity of evidence-based and evidence-generated home visiting programs (see chart) is significantly lower. Note that these programs are not active in every county in the Region. In addition, community-based programs exist that provide services that can enhance home visiting programs, but are not necessarily meant to supplant them. For example, Brooklyn, Bronx, Manhattan, and Queens have the Newborn Home Visiting Program, with Bronx also home to the national model of HIPPIY (Home Instruction for Parents of Preschool Youngsters).

### Region 9: New York City Funded Capacity of Home Visiting Programs



**Total Funded Capacity of Home Visiting Programs: 7,489**

## PARENT RECOMMENDATIONS

Throughout the State parents expressed similar sentiments. In this Region, parents also focused on: concern about the quality and safety of their own living environments and its impact on raising children; challenges of accessing good healthcare and food in their community; and interest in participating in more listening sessions, workshops, and community-building events, as well as in increasing opportunities for fathers.

NYC often seems like a world away from the rest of NYS. What the authors found in working with Region 9 was that there were many similarities in terms of both strengths and challenges. One significant challenge is a structure (both real and perceived) that keeps NYC separate from the rest of the State; while this is sometimes necessary, there should be enhanced opportunities for collaboration. Providers have worked hard to create trusting relationships in Region 9 and have started collaborating in more formalized ways that puts them ahead of other regions, and places them in a position where their experiences can be helpful to others.

## RECOMMENDATIONS

**Develop a borough, NYC and NYC Housing Authority (NYCHA) screening and referral process and use a coordinated intake approach to make this process as streamlined for NYCHA as possible.** The same process should be implemented with NYC Health + Hospitals, NYC Administration for Children's Services (ACS), and PATH. These systems should screen for ALL programs, not just Nurse-Family Partnership.

**Develop a system to serve high-need participants regardless of zip code.** Multiple programs have identified that otherwise eligible pregnant or postpartum women are not eligible for their program because of zip code eligibility. Due to gentrification, as well as new placement of shelters, high-need women are increasingly not eligible (aside from Nurse-Family Partnership's City-wide access) due to their zip code. This is actually a statewide issue.

**Increase collaboration between medical providers and home visiting programs for referrals.** Facilitate co- location or embedding of home visiting outreach staff at healthcare sites.

**Coordinate between State- and City-level funders and agencies in order to develop effective collaboration.** There is relatively little coordination between the NYS Department of Health (DOH)/NYS Office of Children and Family Services (OCFS) and the NYC Department of Health and Mental Hygiene (DOHMH). This helps lead to a split in collaboration amongst State-funded and City-funded programs/models, in addition to federally-funded programs.

## **RECOMMENDATIONS (continued)**

Salary increases for home visitors are a priority and a necessity, yet many programs are flat funded. This is not a sustainable model for staff retention. Disparities among cost of living in boroughs (and across regions) makes it more difficult for higher cost areas to function at the same level of funding.

### **Adequately fund Coordinated Intake and Referral (CI&R), in order to provide staffing to handle the flow of referrals that an effective system would process.**

CI&R can also include coordinated outreach, alleviating the need for local programs to each do their own outreach. Funding for the outreach function is essential.

**Make programs fiscally 'whole' before expansion.** Increase diversified funding sources and opportunities, such as value- and performance-based payments for optimal maternal child health outcomes.

**Provide model-neutral and/or model-specific training with State funding.** This can help to alleviate some of the limited budgets that programs have, potentially creating space for COLAs and incentive bonuses.

**Provide a home visitor credential.** It is difficult to find qualified staff; a baseline credential/certification would help augment the playing field.

**Create program financial incentives for maintaining full capacity.** Make it allowable for small pieces of program budgets to be put toward direct financial incentives (such as unrestricted funds for a program being at capacity at the end of a quarter) or for tangible goods (like diapers, books for families, etc.)

**Implement a statewide public education campaign about home visiting to spread awareness and decrease stigma.**

1 Data courtesy of the Schuyler Center for Analysis and Advocacy

2 IBID

3 IBID

4 [https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county\\_list.htm](https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county_list.htm)

## APPENDIX 10

**REGION 10** - Long Island: Nassau and Suffolk Counties.

### Summit Details

**Backbone Organization (BBO):** Choice For All, whose approach focuses on building leadership, promoting learning, and collaborating across sectors to ensure wellness in health and wealth with those they we serve.

**NUMBER OF PARTICIPANTS:** Approximately 12

**SWOT RESULTS:** Each BBO in this project conducted an initial SWOT Analysis and a compilation of the region's strengths and challenges. This was used that as the basis for the first Summit, wherein attendees revised and ranked issues accordingly.

**Strengths:** Promising practices of home visiting in child care settings; research on early childhood needs

**Weaknesses:** Family engagement; community trust and perceptions; cultural and linguistic responsiveness

**Opportunities:** Redefining “home visiting” as a strategy instead of a program; expand link with child care programs and pre-K movement

**Threats:** Sustainability; siloed versus regional approach



ACKNOWLEDGMENT: The authors wish to thank Choice For All for its partnership, and Lynette Batts for facilitation. This report would not be possible without input from providers, parents, and other nonprofits in Region 10. We thank everyone who participated!

## LANDSCAPE AND DATA SYNOPSIS

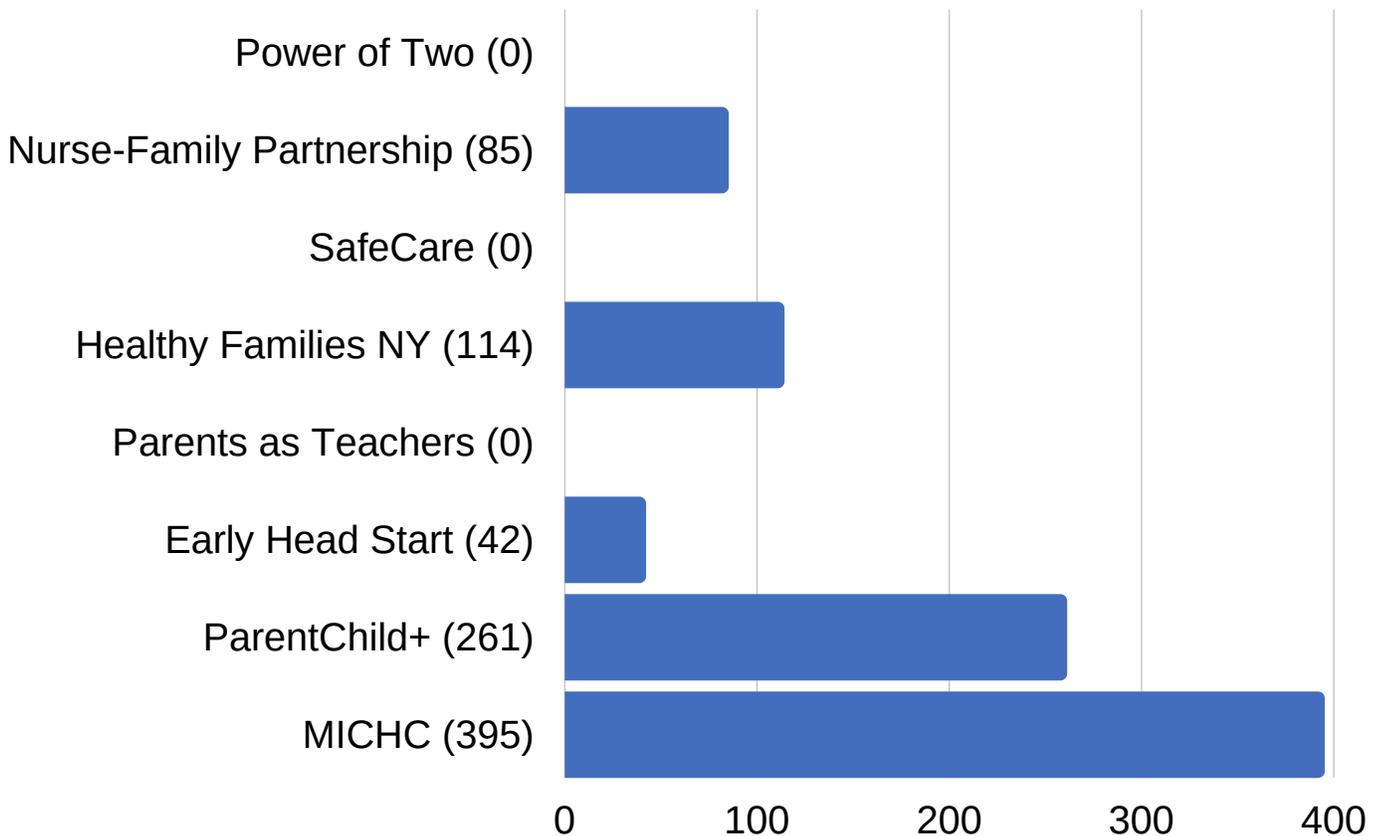
The following bullets give a sense of the percentage of families with young children who may have been eligible for home visiting services based on income level.

- 6% of children under age six have parents who are unemployed<sup>1</sup>
- 9% of young children (under age six) living in poverty (under 100% FPL)<sup>2</sup>
- 4% of young children (under age six) living in deep poverty (under 50% FPL)<sup>3</sup>

The total number of births in this Region during the three-year period 2014-16 was 89,958<sup>4</sup>

The funded capacity of evidence-based and evidence-generated home visiting programs (see chart) is significantly lower. Note that these programs are not active in every county in the Region. In addition, community-based programs exist that provide services that can enhance home visiting programs, but are not necessarily meant to supplant them.

### Region 10: Long Island Funded Capacity of Home Visiting Programs



**Total Funded Capacity of Home Visiting Programs: 897**

## PARENT PERSPECTIVE

Throughout the State parents expressed similar sentiments. In this Region, parents also focused on: creating programs that are more proactive than reactive (families felt that stigma and actual/perceived punishment sometimes plays a part in their interactions); and the desire to create safe spaces, wherein programs and providers understand and work with home dynamics instead of denying them.

## RECOMMENDATIONS

**Create universal core competencies for home visiting.** Other states, like Oregon, have key features – cultural and linguistic responsiveness, family partnerships, and more. The core competencies should be broad enough to connect within the diverse programs across the State.

**Redefine and normalize home visiting as a strategy and a foundation for parenthood.** The siloed approach and stigma related to home visiting has impacted the full potential of home visiting across Long Island. By working with existing birth to five coalitions, home visiting programs, parent leaders, schools and systems, Region 10 hopes to create a new awareness and messaging campaign about home visiting. Additionally, redefining the “home” for a parent and child is critical for success. There are home visiting models in the region where “home” is not necessarily the physical placement of a parent/ guardian, but a child care, early care center, or library in which to receive services.

**Invest in home visiting advocacy.** Increased advocacy can help to ensure home visiting is recognized for its contribution to healthy families and that it is allocated adequate resources for staff retention, data sharing, technology, and resource development across all programs.

1 Data courtesy of the Schuyler Center for Analysis and Advocacy

2 IBID

3 IBID

4 [https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county\\_list.htm](https://www.health.ny.gov/statistics/chac/perinatal/county/2014-2016/county_list.htm)

# Appendix 11



## Overview of Select Evidence-Based and Evidence-Informed Home Visiting Programs

Program	Program Description	Program Goals	Population Served	Service Delivery
<b>Early Head Start (EHS)</b>	Service provided through center-based, home-based or mixed models, with visits by trained home visitors. Focus on: prenatal outcomes, health family functioning & school readiness.	Promote healthy prenatal outcomes for pregnant women. Enhance the development of very young children. Promote healthy family functioning.	Serves families from pregnancy until child turns 3.	By trained professionals.
<b>Family Connects</b>	The Family Connects model is an evidence-based program that connects parents of newborns to the community resources they need through postpartum nurse home visits. FC also conducts rigorous research and evaluation of the model, as well as innovative research on early childhood well-being and parent-child relationships.	Improve child and family health and well-being. Create access to a continuum of community-based care to support health and success. Values: Equity; collaboration; excellence; integrity. The nurse may recommend longer-term programs, such as Early Head Start.	Home visits begin 2 to 3 weeks after birth, offering one to three home visits in total. The child may be enrolled until they are 6 months of age.	By trained & registered nurses.
<b>Healthy Families New York (HFNY)</b>	Home-based services to expectant families and new parents. Trained home visitors provide support, child development & parenting information to reduce family stress. Participants screened to identify risk factors & stressors.	Identify overburdened families needing support. Promote positive parent-child interaction. Ensure optimal prenatal care. Promote healthy growth & development. Enhance family functioning. Prevent child abuse & neglect. Promote parental self-sufficiency.	Enrolls expectant parents and parents with an infant less than 3 months old; serves until age 5.	By specially-trained family support professionals.
<b>Maternal and Infant Community Health Collaborative (MICHC)</b>	Community Health Workers (CHWs) assess individuals and families of needs, provide education and assistance, and connect individuals/families to supports within their community.	Improve maternal and infant health outcomes, while reducing racial, ethnic and economic disparities. Assess needs and barriers to accessing services. Connect to community resources. Maintain healthy behaviors and reduce or eliminate risky behaviors.	Medicaid-eligible/low-income women across the lifespan (and their families).	By trained Community Health Workers
<b>Nurse-Family Partnership (NFP)</b>	Intensive home visiting provided by an RN who uses clinical assessment skills to deliver a comprehensive, nationally-proven prevention model. Focus on: family & environmental health, maternal-child attachment, nurturing child-caregiver interactions, maternal life course development, referrals to health & human services.	Help women improve pregnancy outcomes. Help parents improve child's health & development. Help parents become economically self-sufficient.	Enrolls low-income, first-time mothers in pregnancy (first two trimesters) and serves until child turns 2.	By registered nurses.
<b>Parents as Teachers (PAT)</b>	Certified parent educators work with families through visits, child screenings, group connections, and connecting families to resources. The evidence-based model focuses on: parent-child interaction, development-centered parenting & family well-being. Organizations can replicate the model, use the curriculum independently, or blend the PAT approach into existing programming.	Increase parents' knowledge of early childhood development & improve parenting practices. Provide early detection of developmental delays & health issues. Prevent child abuse & neglect. Increase children's school readiness & success.	Serves families from pregnancy to kindergarten entry.	By trained professionals and parent educators.
<b>ParentChild+</b>	Through a research-proven model, PC+ prepares children for school success by increasing language & literacy skills, enhancing social-emotional development, and strengthening parent-child relationships. Parents become children's teachers & advocates: reading, playing, talking & learning together.	Prepare children challenged by poverty for success in school. Stimulate parent-child verbal interaction. Enable children to gain critical language and literacy skills.	Two-year program serves families with 2- and 3-year-olds (can enter as young as 16 months and stay until age 4).	By specially-trained paraprofessionals.
<b>Power of Two</b>	Power of Two is a non-profit organization operating in NYC that is scaling Attachment and Biobehavioral Catch-Up (ABC), a proven parenting program, in New York City. ABC gives children a foundation for success in school and life by fostering a strong and healthy attachment between parent and child.	With ABC, pre-school age children showed higher levels of executive functioning than their peers, are more likely than their peers to develop secure attachments to their parents, and have normalized stress hormone levels after only 10 coaching sessions in the home.	Serves families from 6 month - 2 years of age.	By parent coaches trained in ABC.

## Appendix 12

**Emerging Themes Data Chart:** Data determined by a review of SWOT analyses and issues that appeared in over half of the regions' reporting. Data does not necessarily reflect holistic discussions at Summits.

The full chart can be viewed through this [link](#).

	REGION 1	REGION 2	REGION 3	REGION 4	REGION 5	REGION 6	REGION 7	REGION 8	REGION 9	REGION 10
<b>WORKFORCE</b>	x	x	x	x	x	x	x	x	x	x
Staff Retention	x					x	x	x		
Staff Characteristics		x	x	x						x
Professional Development	x	x		x		x				
Staff Qualifications	x		x					x		
Staff Wages		x		x					x	
Staff Burnout					x			x		
Staff Recruitment						x				
<b>COLLABORATION AND COORDINATION</b>	x	x	x	x	x	x	x	x	x	
Coordinated Intake and Referral		x	x	x	x	x	x		x	
Develop Partnerships with PCPs and OB/GYNs				x		x	x			
Develop Partnerships with the Early Childhood System								x		
<b>AWARENESS AND STIGMA</b>	x	x	x	x		x	x	x	x	x
Stigma About Home Visiting	x		x							x
Absence of Education/Misinformation			x	x	x					
<b>LACK OF FUNDING</b>	x	x	x	x	x	x	x	x	x	
<b>UNIVERSAL HOME VISITING</b>		x	x		x					
<b>SOCIAL AND ECONOMIC ISSUES</b>	x	x			x		x	x	x	
Language Barriers					x			x		
High Poverty Rates					x					
Housing for Families		x					x	x	x	
Basic Needs for Families		x								
High Unemployment Rates					x					
Immigration Concerns			x					x		
Rural Access to Programs	x	x								
<b>PROGRAM STANDARDS AND REQUIREMENTS</b>		x	x	x				x	x	
Program Restrictions-Eligibility Requirements		x						x	x	
Program Restrictions-Program Capacity		x	x							
Program Restrictions-Scheduling				x				x		
<b>COMMUNITY RESOURCES</b>		x		x	x		x			
Limited Community Resources-Mental Health		x		x			x			
Limited Community Resources- Early Intervention				x			x			
Limited Community Resources-Trauma Experts		x								
Limited Community Resources-Early Childhood					x					
Limited Community Resources-Medical Providers					x					
Limited Community Resources-Home Visiting Programs					x					
Limited Community Resources-Child Care					x					
<b>INDIVIDUAL PROGRAM ISSUES</b>				x		x	x			
Worker Safety				x						
Share Vehicles						x				
No Standardized Risk Assessment/Plan Development							x			
<b>PARENT VOICE</b>		x		x			x			
Include Fathers	x						x			
Include Parent Voice	x	x		x						
<b>DATA</b>	x		x					x		
Inadequate Data/Evaluation	x		x					x		
<b>ADVOCACY</b>										x
Legislative Advocacy										x
<b>OTHER ISSUES</b>								x		x
Review Home Visiting Regulations								x		
Develop Standard Definition of Home Visiting								x		
Develop a Registry of Home Visiting Services								x		
Develop Home Visiting Core Competencies										x