VIRGINIA HOME VISITING
NEEDS ASSESSMENT

JUNE 2021

EARLY IMPACT VIRGINIA

ALLIANCE FOR EARLY CHILDHOOD HOME VISITING

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Virginia is a large and diverse state with a population of more than 8.5 million including more than 700,000 children age 0-6, including an estimated 208,000 in low-income households (with income under 200% of poverty). These children and their families reside in Virginia's 133 cities and counties, all of which have some level of need for home visiting.

This **Virginia Home Visiting Needs Assessment** is the product of a statewide collaborative effort to identify strengths and needs in Virginia's system of home visiting programs. The effort to produce this needs assessment was led by Early Impact Virginia, and informed by dozens of organizations and hundreds of individuals from across Virginia. These stakeholders shared their insights, ideas, and critiques of Virginia's home visiting system from a wide range of perspectives. This guidance is invaluable for understanding the needs, challenges, and opportunities for optimizing home visiting in Virginia.

The results of this needs assessment are intended to inform the work of multiple audiences, including public agencies, home visiting programs, and advocacy groups. In the following subsections, the Early Impact Virginia mission, members, and partners are described, along with the state and federal directives that guided the needs assessment.

A. Early Impact Virginia and the Alliance for Early Childhood Home Visiting

Early Impact Virginia, formerly the Home Visiting Consortium, advances the delivery of high quality, efficient services that improve the health, social, and educational outcomes for new and expecting parents, young children, and their families within safe homes and connected communities so that children grow up healthy and ready to learn. Early Impact Virginia:

GUIDES through coaching, professional development, and technical assistance for high quality services.

LEADS in resource development, innovation, efficiency, and advocacy to sustain and expand high quality services.

COLLABORATES and coordinates home-based services across public and private agencies for greater impact.

FACILITATES RESEARCH through data collection, analysis, and evaluation for continuous improvement and growth.

One of the primary activities of Early Impact Virginia is to convene the Alliance for Early Childhood Home Visiting. The Alliance includes members that represent eight home visiting models and eleven early childhood partners as shown in **Box 1.1**. These organizations work individually and collaboratively to strengthen home visiting services across Virginia.

Box 1.1

Alliance for Early Childhood Home Visiting

Home Visiting Models

- CHIP of Virginia
- Early Head Start
- Family Spirit
- Healthy Families
- Healthy Start/Loving Steps
- Nurse-Family Partnership
- Parents as Teachers
- Resource Mothers

Early Childhood Partners

- Early Childhood Mental Health Virginia
- Early Childhood Special Education @ Virginia Department of Education
- Early Intervention/Part C @ Virginia Department of Behavioral Health and Development Services
- Head Start Collaboration Office
- Health Education and Design Group @ James Madison University
- Project Link @ Virginia Department of Behavioral Health and Development Services
- Reach Out and Read Carolinas
- Virginia Commonwealth University
- Virginia Department of Health
- Virginia Department of Medical Assistance Services
- Virginia Department of Social Services

B. Purpose of the Needs Assessment

This report is intended to inform the work of multiple audiences concerned with home visiting in Virginia. At the federal level, the U.S. Health Resources and Services Administration (HRSA) requires a statewide needs assessment as a requirement of its Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants to states. The MIECHV needs assessment will inform the systemic and statewide needs assessment for Virginia's home visiting programs that occur once every three years and is mandated by the Governor and General Assembly, which will be conducted by Early Impact Virginia.

MIECHV Program

The MIECHV Program is authorized by Social Security Act, Title V, § 511(c) (42 U.S.C. § 711(c)) to support voluntary, evidence-based home visiting services for at-risk pregnant women and parents with young children up to kindergarten entry. The MIECHV Program is administered by the Health Resources and Services Administration (HRSA) in partnership with the Administration for Children and Families (ACF). Program awardees receive funding through the MIECHV Program to implement evidence-based home visiting programs and promising approaches.

Awardees have the flexibility to tailor their program to serve the specific needs of their communities. Through a statewide needs assessment, awardees identify target populations and select home visiting service delivery models that best meet state and local needs. By law, a needs assessment update must identify communities with concentrations of defined risk factors, assess the quality and capacity of home visiting services in the state, and assess the state's capacity for providing substance abuse treatment and counseling services. HRSA encourages states to use their needs assessment updates to:

- Understand the current needs of families and children, and at-risk communities.
- Target home visiting services to at-risk communities with evidence-based and promising approach home visiting models that meet community needs.
- Support statewide planning to develop and implement a continuum of home visiting services for eligible families and children prenatally through kindergarten entry.
- Inform public and private stakeholders about the unmet need for home visiting and other services in the state.
- Identify opportunities for collaboration with state and local partners to establish appropriate linkages and referral networks to other community resources and supports and strengthen strong early childhood systems.
- Direct technical assistance resources to enhance home visiting service delivery and improve coordination of services in at-risk communities.

Virginia's MIECHV program is committed to implementing evidence-based home visiting models. Virginia selected Healthy Families Virginia, Parents as Teachers, and Nurse-Family Partnership as the evidence-based models to be funded by the MIECHV program.

MIECHV funding currently supports three evidence-based models serving 1,300 families (2019) through 18 local programs. This represents a fraction of the overall services delivered in the state. Aligning MIECHV funding with state administered funding demonstrates a fundamental commitment to strategically addressing system-level gaps and challenges by reinforcing the existing strengths inherent in Virginia's system.

State Action

The Governor and the Virginia General Assembly have directed Early Impact Virginia to conduct multiple activities in support of home visiting. The 2018-2019 budget passed by the Virginia General Assembly and signed into law by Governor Northam states that:

> *Early Impact Virginia shall have the authority and responsibility to determine, systematically track, and report annually on the key activities and outcomes of Virginia's home visiting programs; conduct systematic and statewide needs assessments for Virginia's home visiting programs at least once every three years; and to support continuous quality improvement, training, and coordination across Virginia's home visiting programs on an ongoing basis. Early Impact Virginia shall report on its findings to the Chairmen of the House Appropriations and Senate Finance Committees by July 1, 2019 and annually thereafter.*

Multiple agencies are involved in supporting home visiting at the state level. Among these are the Virginia Department of Social Services, the Virginia Department of Education, the Department of Behavioral Health and Developmental Services, the Department of Medical Assistance Services, and the Virginia Department of Health. This needs assessment is intended to inform this vital work.

Local Action

Home visiting programs operate within a broader array of services and supports for children and families at the local level. This needs assessment is intended to inform the work of local social service agencies, community services boards, public health agencies, school districts, health care providers, local government officials, and advocacy groups.

C. Research Methods

This needs assessment was produced using multiple methods. Multiple sources of community data were used to generate community profiles of need and risk. Data on service utilization and workforce were obtained from program records. Insights from community stakeholders were generated through surveys and interviews. These sources are cited more specifically throughout the report and appendixes.

D. Organization of the Report

The main sections of the report are outlined in **Box 1.2**. Section 2 is focused on identifying communities with concentrations of risk so that Virginia can target resources toward communities with greatest need. Sections 3.1 and 3.2 describe the quality and capacity of existing programs at the state and community level. Section 4 examines Virginia's capacity for providing maternal treatment and counseling for substance use disorders. Section 5 describes how this needs assessment is coordinated with other needs assessments focused on maternal, infant, and early childhood issues. Finally, Section 6 summarizes major findings, and outlines strategy for disseminating this needs assessment report.

Box 1.2
Report Outline

1. Introduction
2. Identifying Communities with Concentrations of Risk

3.1 Quality and Capacity of Existing Programs (System Level)

3.2 Quality and Capacity of Existing Programs (Community Level)

4. Capacity for Providing Treatment and Counseling for Substance Use Disorders
5. Coordination with Other Needs Assessments
6. Conclusion

2 / Virginia Communities with Concentrations of Risk

One of HRSA's requirements for the MIECHV program's needs assessment is to identify communities with concentrations of risk. This analysis applied the Independent Method option, outlined in the Supplemental Information Request for Submission of the MIECHV Statewide Needs Assessment Update, to analyze concentrations of risk in 133 localities (cities and counties) in Virginia. This section describes:

- **A.** Methods for Assessing Concentrations of Risk
- **B.** Indicators of Risk Across Virginia Localities
- **C.** Concentrations of Risk in Virginia Localities

A. Methods for Assessing Concentrations of Risk

Virginia is a large and diverse state with wide variations in community need and community capacity for home visiting. Using the Independent Method option for identifying communities with concentrations of risk is designed to acknowledge this diversity. A five-step method outlined below was used to produce the assessment of risk. Steps 1 through 3 were completed collaboratively with the Early Impact Virginia Data Action Team. The Data Action Team includes representatives from multiple home visiting models at both the state and local program level.

Step 1. Select Indicators >> **Step 2.** Assign Weights >> **Step 3.** Assign Point Values >> **Step 4.** Generate Risk Scores >> **Step 5.** Rank Localities by Risk Scores

Step 1. Select Indicators

Virginia selected sixteen Maternal and Child Health (MCH) indicators that were identified as key proxy measures of maternal, infant, and early childhood development and health. The resulting list of indicators is shown in **Exhibit 2.1**.

Exhibit 2.1 — Selected Indicators and Assigned Weights

Weight = 0-2 Points	*Weight = 0-1 Points*	*Weight = 0-0.5 Points*
1. Children Age 0-6 in Low-Income Households	8. Live Births	12. Marijuana Abuse Prevalence Rate
2. Low Birth Weight Rate	9. Unemployment Rate	13. Alcohol Abuse Prevalence Rate
3. Late/No Prenatal Care Rate	10. Pain Reliever Abuse Prevalence Rate	14. High School Dropout Rate
4. Teen Pregnancy Rate	11. Illicit Drug Use Prevalence Rate	15. Crime Rate
5. Preterm Birth Rate		16. Juvenile Arrest Rate
6. Child Maltreatment Rate		
7. Children in Food-Insecure Homes		

Step 2. Assign Weights

As also shown in the exhibit, each of the indicators was assigned a weighting value to reflect the potential impact on infant and early childhood development and health. The seven indicators assigned a weight of 0-2 points are considered to have the greatest direct impact on infant and early childhood development and health. The nine additional indicators were assigned a weight of 0-1.0 or 0-0.5, based on assumptions about their relative influence on maternal, infant, and early child health.

Step 3. Assign Point Values

Points were assigned based on which quartile, or 25% section of data, each county's value fell in within each indicator. The specific method for assigning point values to each locality is described in **Appendix B.**

Step 4. Generate Concentration-of-Risk Scores

A concentration-of-risk score was calculated for each locality by summing the point values (assigned in Step 3) across all 16 indicators. The resulting risk score was used to produce the locality rankings as shown in **Appendix B**.

Step 5. Rank Localities by Concentration of Risk Score

The localities were then ranked within each classification according to their concentration-of-risk score. The resulting list of at-risk counties is provided in **Section C** and again in **Appendix B**.

B. Indicators of Risk across Virginia Localities

The maps in **Appendix B, Figures 1 – 16,** illustrate the variation in indicators of risk (described in **Exhibit 2.2**) across Virginia localities. The results indicate that all geographic regions in Virginia have a relatively high score on one or more of the risk indicators.[1] This includes the larger urban and suburban corridors in northern, central, and eastern Virginia, as well as the rural communities and smaller cities and towns across southern, southwest, and western Virginia. The data tables in **Appendix B** show the number of points assigned to each locality based on their quartile ranking on each indicator. **Section C** shows the overall concentration-of-risk scores for each locality.

Exhibit 2.2 — Indicators of Risk

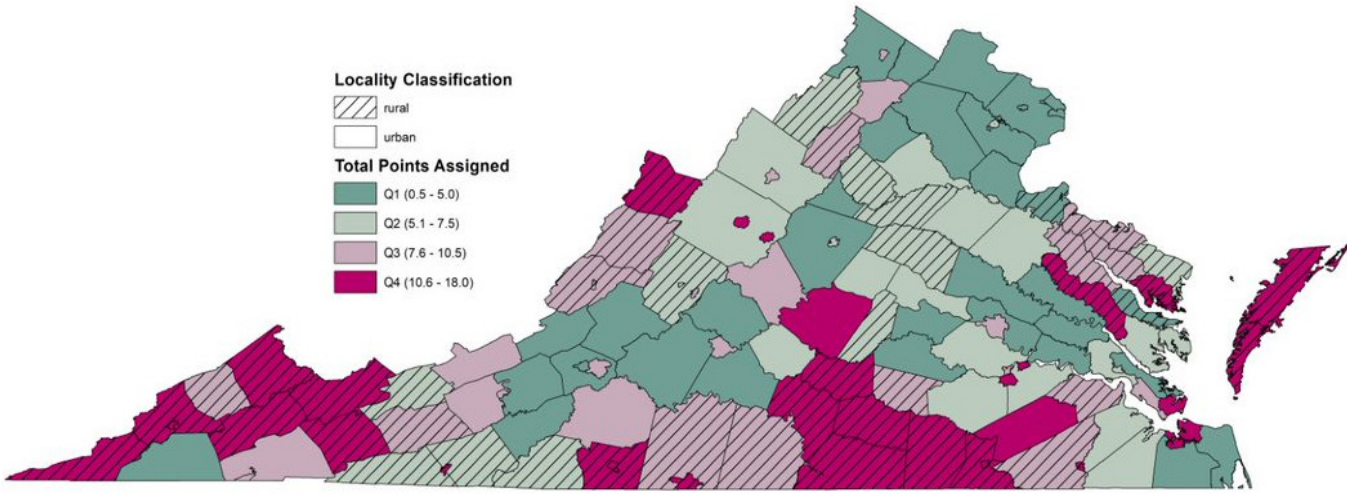
Data Point	Description
# of Live Births	Number of live births
Teen Pregnancy Rate	Pregnancy rate = (number pregnancies to females ages 15-19)/number of females in a specific age group) x 1,000
Preterm Birth Rate	Percent preterm births = (number of births to less than 37 weeks gestation/number of live births) x 100
% Low Birth Weight	Percent low weight births = (number of births less than 2,500 grams/number of live births) x 100
% Late/No Prenatal Care	Percent late or no prenatal care = (number of births to moms who had late or no prenatal care/number of live births) x 100
Unemployment Rate	Unemployed percent of the civilian labor force
High School Dropout Rate	Percent of 16-19 year olds not enrolled in school with no high school diploma — (5 year estimate)
Alcohol Abuse Prev. Rate	Prevalence rate: Binge alcohol use in past month
Marijuana Abuse Prev. Rate	Prevalence rate: Marijuana use in past month
Illicit Drug Use Prev. Rate	Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month
Pain Relievers Abuse Prev. Rate	Prevalence rate: Nonmedical use of pain medication in past year
Crime Reports	Number reported crimes/1000 residents
Juvenile Arrests	Number crime arrests ages 0-17/100,000 juveniles aged 0-17
Child Maltreatment Rate	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents
Children in Poverty	Percent children, ages 0-6, living below 200% FPL
Children in Food Insecure Homes	Percent of children identified as food insecure of the total child population

[1]Juvenile arrests could not be mapped due to missing data at the locality level.

C. Concentrations of Risk in Virginia Localities

A concentration-of-risk score was calculated for each locality by summing the point values displayed in the maps above across all 16 indicators. The resulting concentration-of-risk scores for each locality were then ranked into quartiles from highest (4th quartile) to lowest (1st quartile). The results are illustrated in **Exhibit 2.3,** and high risk counties are listed in **Exhibit 2.4**.

Exhibit 2.3 — Community Concentrations of Risk: Statewide View



Source: EIV analysis of risk indicators and concentration-of-risk scores.

As shown:

- Localities in quartile four (Q4) have the highest concentration of risk scores. The Q4 localities include rural counties and some urban pockets in the western, southwestern, southern, and eastern parts of Virginia.
- Localities in quartile 3 (Q3) are also spread across the state, including rural counties and some additional urban localities in central, eastern, and Northern Virginia.
- The table below lists each locality in Q4 and Q3 in descending order from highest to lowest risk score within that quartile.

As an additional factor for **setting priorities**, localities were categorized as urban or rural based on classifications assigned by the Virginia Department of Health. These designations are illustrated on the map with cross-hatching of rural localities and were examined when forming the final list of at-risk communities. There are a total of 40 rural localities above the median number of points, and 28 urban localities.

Appendix B includes data tables for raw indicators, weighting, estimated numbers of families and children served, and estimated need[2], for the **74 at-risk localities** to be given priority attention by the MIECHV program for resources and support. The list includes localities that rank above the median concentration-of-risk score, which was 7.5 points.

[2]Virginia has defined need for home visiting as number of children age 0-6 living under 200% of the Federal Poverty Level.

Exhibit 2.4
Community Concentrations of Risk in Quartiles 3-4: 2020 At-Risk County Ranking

Localities With Risk Scores in Q4 (11.0-18.0 pts.)		**Localities With Risk Scores in Q3** (7.5-10.5 pts.)	
Locality	**Total Points**	**Locality**	**Total Points**
Hopewell City	18	Franklin County	10.5
Danville City	16.5	Nottoway County	10.5
Petersburg City	16	Pulaski County	10.5
Accomack County	15.5	Covington City	10.5
Lee County	15.5	Roanoke City	10.5
Wise County	15.5	Winchester City	10.5
Norfolk City	15.5	Nelson County	10.5
Portsmouth City	15.5	Page County	10
Lunenburg County	15	Wythe County	10
Galax City	15	Radford City	10
Norton City	15	Surry County	10
Northampton County	14.5	Colonial Heights	9.5
Martinsville City	14	Bath County	9.5
Staunton City	14	Dickenson County	9
Charlotte County	13.5	Essex County	9
Franklin City	13.5	Washington County	9
Brunswick County	13	Bristol City	9
Buchanan County	13	Halifax County	8.5
Highland County	13	Southampton County	8.5
Prince Edward County	13	Westmoreland County	8.5
Russell County	13	Harrisonburg City	8.5
Sussex County	13	Lynchburg City	8.5
Waynesboro City	13	Alleghany County	8
Tazewell County	12.5	Giles County	8
Henry County	12	Pittsylvania County	8
Lancaster County	12	Richmond County	8
Greensville County	11.5	Warren County	8
King and Queen County	11.5	Buena Vista City	8
Mecklenburg County	11.5	Caroline County	7.5
Hampton City	11.5	Carroll County	7.5
Richmond City	11.5	Prince George County	7.5
Buckingham County	11	Spotsylvania County	7.5
Smyth County	11	Suffolk City	7.5
Emporia City	11		
Newport News City	11		

In the 2020 needs assessment:

- There are 16 new localities on the list of at-risk communities that were not identified in the prior needs assessment. Those localities are: Alleghany County, Bath County, Buena Vista City, Caroline County, Colonial Heights City, Covington City, Essex County, Highland County, King and Queen County, Nelson County, Page County, Prince George County, Spotsylvania County, Staunton City, Surry County, and Westmoreland County.
- Six (6) localities that were on the prior list of at-risk communities, and are currently funded by MIECHV in Virginia, did not make the 2020 list. They are: Campbell County, Fairfax County (partial), Frederick County, Fredericksburg City, Montgomery County, and Williamsburg City.

While the six (6) localities that came off the list did not rank in the top two quartiles of concentration of risk, each locality still demonstrates need in one or more indicators of risk. For example, Campbell was in Q3 for number of live births, percent of low-birth-weight, and percent of women with late entry into prenatal care. Fairfax was in Q4 for number of live births and Q3 for teen pregnancy rate. Frederick was in Q4 for number of live births and pain reliever abuse prevalence rates, and Q3 for preterm birth rate and illicit drug use. Montgomery was in Q4 for child maltreatment and number of live births. And lastly, Williamsburg was in Q4 — the highest category of risk — for percent of women with late entry into prenatal care, and Q3 for number of children 0-6 living in poverty and child maltreatment.

While their overall concentration of risk score did not rank in the highest quartiles, these six (6) localities continue to demonstrate need. In addition, they are currently serving families. Data in Exhibit 2.5 shows each locality's concentration of risk score, as well as the average number of families served each quarter between October 2019 and September 2020.

Exhibit 2.5 — MIECHV-Funded Localities by Concentration of Risk and Families Served

Locality	Total Points	Average Number of Families/Quarter
Campbell	4.0	12
Fairfax	1.5	113
Frederick	4.5	28
Fredericksburg	6.5	29
Montgomery	4.0	54
Williamsburg	7.0	22

Because of these risk indicators, and the fact that families are currently being served in these localities, Virginia has added these six (6) localities to the 2020 list of at-risk communities. MIECHV will work with local programs in these localities to develop strategies so that no families currently receiving home visiting will experience an interruption in services. Virginia MIECHV will also work with its advisory council to integrate the new list of 74 at-risk localities into the upcoming renewal process (Spring 2021).

Additionally, MIECHV leadership in Virginia recognizes the critical importance of sustainable, reliable funding to ensure high-quality program delivery and cultivate long-term success of local home visiting programs. Because of this, MIECHV will work in partnership with Early Impact Virginia, local programs, and model offices in Virginia to determine that best way to sustain gains made by prior MIECHV investment in at-risk localities.

3.1 / Quality and Capacity of Existing Programs — System Level

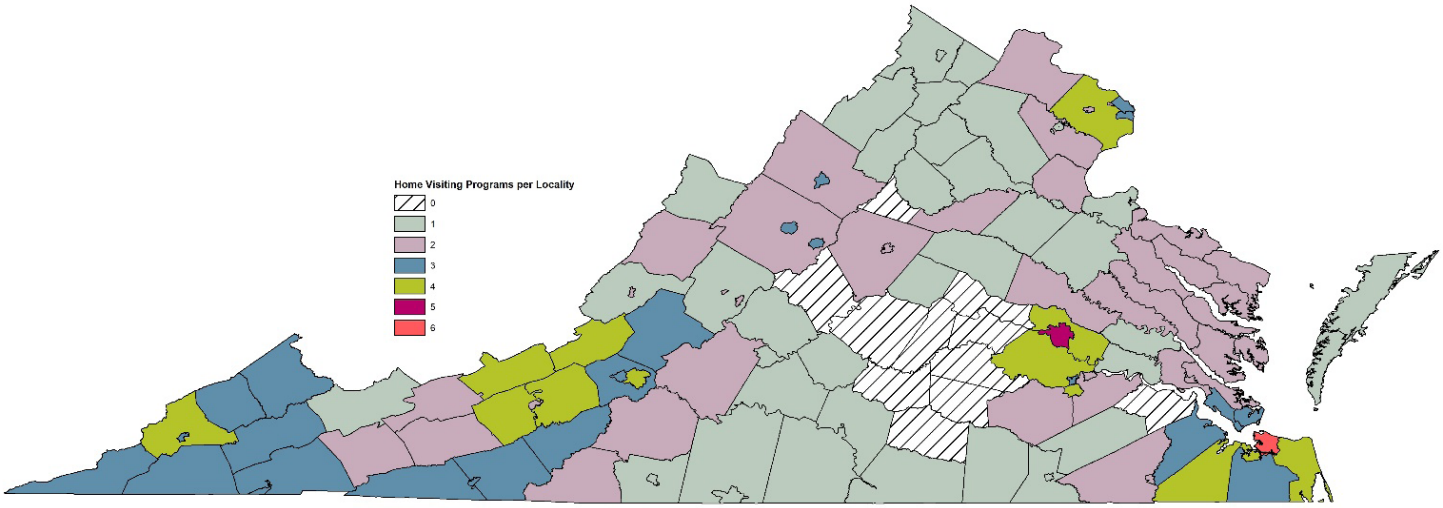
In this section we assess the quality and capacity of existing home visiting programs from a system-level perspective (see Section 3.2 for a community-level assessment). The following sections describe:

- **A.** Virginia's Eight Unique Home Visiting Models
- **B.** System-Level Strengths, Gaps, and Challenges
- **C.** Virginia's Plan for Home Visiting
- **D.** Additional System-Level Initiatives

A. Virginia's Eight Unique Home Visiting Models

Virginia has eight unique, early childhood home visiting models. As shown in **Exhibit 3.1**, as of 2020 one or more of these models were implemented in 121 Virginia localities. The localities with the highest number of programs are Norfolk (6) and Richmond (5); 119 localities have 1 to 4 programs, and 12 localities have no home visiting program in operation.

Exhibit 3.1 — Virginia Home Visiting Programs by Locality (2020)



Source: EIV analysis of home visiting program data.

3.1 / Quality and Capacity of Existing Programs — System Level

Below is a list of brief descriptions of the home visiting programs in Virginia. Those marked with an asterisk are promising practice or evidence-informed.

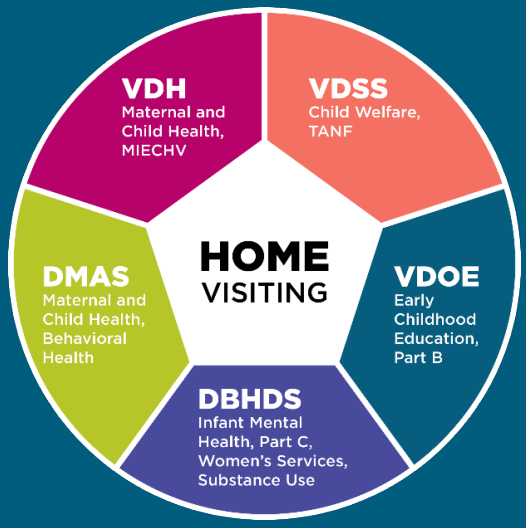
- **CHIP of Virginia*:** CHIP of Virginia changes lives two generations at a time by working with families caught in the cycle of poverty. Using proven best practices to intervene early, CHIP prepares parents to be their child's first and most important teacher.
- **Early Head Start:** Head Start is a national child development program for children from birth to age 5, which provides services to promote academic, social, and emotional development for income-eligible families. Many Head Start programs also offer home-based services to families and childcare for infants and toddlers through Early Head Start.
- **Family Spirit (new in 2021):** Family Spirit® is an evidence-based, culturally tailored home-visiting program of the Johns Hopkins Center for American Indian Health to promote optimal health and wellbeing for parents and their children. The program combines the use of paraprofessionals from the community as home visitors and a culturally focused, strengths-based curriculum as a core strategy to support young families.
- **Healthy Families Virginia:** Healthy Families Virginia is the nationally recognized home visiting model developed by Prevent Child Abuse America. The program is designed to work with overburdened families who are at-risk for adverse childhood experiences, including child maltreatment.
- **Healthy Start/Loving Steps*:** Healthy Start/Loving Steps works to eliminate disparities in perinatal health experienced by African-American women and their families to prevent infant mortality and low weight births.
- **Nurse-Family Partnership:** Nurse-Family Partnership is a maternal and early childhood health program that introduces vulnerable first-time parents to caring maternal and child health nurses. Nurses support first-time moms to have a healthy pregnancy, develop parenting skills, and provide their babies with the best possible start in life.
- **Parents as Teachers:** Parents as Teachers promotes optimal early development, learning, and health of young children by supporting and engaging their parents and caregivers. Parents as Teachers supports parents in being their child's first and most influential teachers.
- **Resource Mothers*:** Resource Mothers is designed to decrease infant mortality and low birth weight rates among Virginia's teen mothers. The program was created to improve birth outcomes for the teen and the baby.

B. System-Level Strengths, Gaps, and Challenges

At the system level, home visiting lives at the intersection of five agencies serving Virginia children and families **(Box 3.1)**. Each agency plays a significant role in all or some part of the administration, funding, and delivery of home visiting services. While this offers certain advantages for collaboration, it also creates inherent fragmentation and adds to the complexity of an already disparate system.

Box 3.1

Virginia State Agencies Involved in Home Visiting



The opportunity to strengthen the statewide home visiting system has been clearly identified by state and local leaders. In 2017 the Virginia General Assembly's Joint Legislative Audit and Review Commission (JLARC) conducted a comprehensive, statewide evaluation of Virginia's early childhood development programs. In its resulting report, JLARC noted a series of system strengths:

> *Virginia's voluntary home visiting programs demonstrate effective performance, are generally well designed, and have strong quality assurance mechanisms to ensure they are implemented as intended. Participants often have better outcomes than those who do not participate, both nationwide and in Virginia. For example, participants in Virginia's home visiting programs for pregnant women are more likely than nonparticipants to carry their pregnancies to full term, which is associated with positive developmental outcomes. Virginia's voluntary home visiting programs also feature the key components that experts generally agree are necessary to be effective.*

JLARC also identified gaps and challenges in administrative infrastructure to ensure effective coordination, evaluation, and planning across programs, stating:

> *However, these programs lack adequate administrative infrastructure to ensure effective coordination, evaluation, and planning across programs. The funding for voluntary home visiting programs in Virginia is unstable and difficult to predict each year, and this instability hinders the ability of these programs to operate in a consistent, strategic manner over time.*

To address these concerns, JLARC recommended that the state "take action to solidify and strengthen Early Impact Virginia as the lead entity for the state's voluntary home visiting programs."

Virginia leaders acted swiftly during the following legislative session to address these recommendations by including legislation to support this work. The 2018-2019 budget signed into law by Governor Northam grants Early Impact Virginia *"the authority and responsibility to determine, systematically track and report annually on the key activities and outcomes of Virginia's home visiting programs; conduct systematic and statewide needs assessments for Virginia's home visiting programs at least once every three years; and to support continuous quality improvement, training, and coordination across Virginia's home visiting programs on an ongoing basis."*

As further demonstration of the state's commitment to streamlining administration across the home visiting system, VDH entered into a unique partnership with Early Impact Virginia to support the broader system goals of the MIECHV program. Since 2012, the Alliance for Early Childhood Home Visiting has served as the Advisory Board for MIECHV. In a clear display of public-private collaboration, VDH redesigned its approach to MIECHV administration to align with the Early Impact Virginia legislative mandate. This approach creates the opportunity for full statewide alignment of legislative priorities for home visiting, including standardized workforce development, continuous quality improvement, accountability, needs assessment and strategic planning.

C. Virginia's Plan for Home Visiting

Early Impact Virginia also partnered with the Governor's office to convene a Leadership Council charged with developing the plan to guide the state's investment in home visiting that is driven by a clearly articulated vision for the Commonwealth's families with young children. Virginia's first Lady Pamela Northam convened and chaired the inaugural Leadership Council meeting in November 2018. The resulting planning framework was drafted in partnership with Leadership Council and informed by the Alliance for Early Childhood Home Visiting, which includes home visiting leaders and state funding partners, including MIECHV.

Virginia's Plan for Home Visiting: The Framework was endorsed by the Virginia Children's Cabinet in May of 2019. The framework is intended to guide the development of a comprehensive plan for coordination of home visiting program services within the early childhood system to ensure quality service delivery and sustainable growth.

D. Additional System-Level Initiatives

Virginia Department of Health: The Virginia Department of Health supports a broad range of systems-level initiatives to strengthen the home visiting workforce, enhance state-level coordination, and advance quality improvement projects and other data-driven efforts. Specific examples of initiatives led by VDH to improve the health of prenatal women and their families include: supporting online training modules at no-cost to home visitors through The Institute for Family Support Professionals; assuring home visiting program staff are represented on the Title V-funded state Maternal Mortality Review Committee; supporting state and regional coordination of developmental screening; collaborative efforts around breastfeeding with statewide Women Infant and Children (WIC) programs; continuing efforts with the Office of Family Health Services on ensuring equity in all service programs; agency representation on the Sister Agency Workgroup to form collaborative efforts around maternal infant health initiatives with various state agencies; agency representation on Family First Prevention Services Act Workgroup; collaborative efforts to promote smoking cessation through the use of the VDH "Quit Now" line; and promotion and education on safe sleep measures using the VDH Safe Sleep Virginia webpage.

Maternal and Infant Health Initiatives: Gov. Ralph Northam's budget proposal for FY 2021 and FY 2022 included a package of directives and funding to boost health care access and support for new moms and babies, as well as reduce the racial disparity in the state's maternal mortality rate. The Virginia General Assembly approved many elements of this package, including the milestone achievement of expanding access to home visiting services by making them eligible for Medicaid reimbursement.

This phenomenal "win" for home visiting in Virginia can be traced back to 5-year goal established as a part of MIECHV program sustainability planning. The budget approved in March 2020 included $12M in state funding to establish home visiting as a Medicaid funded services, with a projected federal match rate of at least $30M. However, due to COVID-19, funding for all new initiatives was frozen until the overall impact of the pandemic could be assessed.

A Special Session was held in Fall 2020, and the majority of funds to support maternal and child health, plus early childhood education initiatives, was restored. The General Assembly is in the process of finalizing the budget for the next biennium (2021-2023), and a language-only amendment to develop a Medicaid benefit for home visiting has been added.

Other efforts to support maternal and child health, and the elimination of racial disparities in health and maternal mortality, that were restored in the 2020 Special Session budget included:

- **Budget language and funding to:**
  - Support efforts by the Virginia Neonatal Perinatal Collaborative (VNPC) to decrease maternal mortality and morbidity and to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes.
  - Create a Perinatal Quality Collaborative to improve pregnancy outcomes for women and newborns by advancing evidence-based clinical practices and processes.
  - Expand Medicaid offerings for uninsured pregnant women, including extended coverage and reimbursement for support services like educational home visits.
  - Extend the length of time an uninsured expectant or new mother can be covered under the state's Medicaid program for uninsured mothers, known as FAMIS MOMS.
  - Extend Medicaid coverage from pregnancy to up to one year after delivery, including coverage for medically necessary addiction and substance abuse treatment.

- **Budget language authorizing the Department of Medical Assistance Services to require contracted Medicaid managed care organizations to:**
  - Identify and address racial disparities in maternal, reproductive and child health.
  - Provide additional care coordinators for the early intervention population.
  - Develop advisory groups for member feedback and engagement surrounding maternal, child, and women›s health.
  - Develop strategies to keep mom and baby together during residential SUD treatment.
  - Improve care coordination of the high-risk maternity program.

Family First Prevention Services Act: The Family First Prevention Services Act aims to keep children safe, strengthen families and reduce the need for foster care whenever it is safe to do so. Within Virginia, Family First services are coordinated by the Virginia Department of Social Services, and operated collaboratively with other state and local agencies. Funding is available for trauma informed, evidence-based, foster care prevention services within the following categories:

- Mental Health Prevention and Treatment Services
- Substance Use Disorder Prevention and Treatment Services
- In-Home Parent Skill-Based Programs

The implementation of Family First has been extended to January 30, 2021. Virginia Department of Social Services had several major Family First implementation activities scheduled for Spring 2020 that unfortunately have been cancelled and/or postponed due to COVID-19. These activities include training for specified providers in evidence-based practices and assisting localities in determining the needs of their communities which are critical to support the implementation of Family First. Implementing Family First remains a high priority for the Division of Family Services and implementation activities will continue with state and community partners.

Behavioral Health Redesign: Virginia is engaged in a multi-year effort to redesign behavioral health services including services for mental health, substance disorder, and intellectual disability. Significant elements of this redesign are designed to improve prevention and treatment services for children and families. See **Section 4** for additional detail.

The Children's Cabinet: In 2018 Governor Ralph Northam issued Executive Order No. 11 reestablishing the Children's Cabinet. Experiences during the early years of a child's life have a tremendous impact on development and life outcomes. This Children's Cabinet will develop solutions to address challenges that exist for children across the Commonwealth and will focus its efforts on several key priorities. Among these priorities are early childhood development and school readiness, nutrition and food security, systems of care and safety for school-aged youth. In addressing these priorities, the Children's Cabinet will work to develop goals, identify strategies, and measure impact and outcomes.

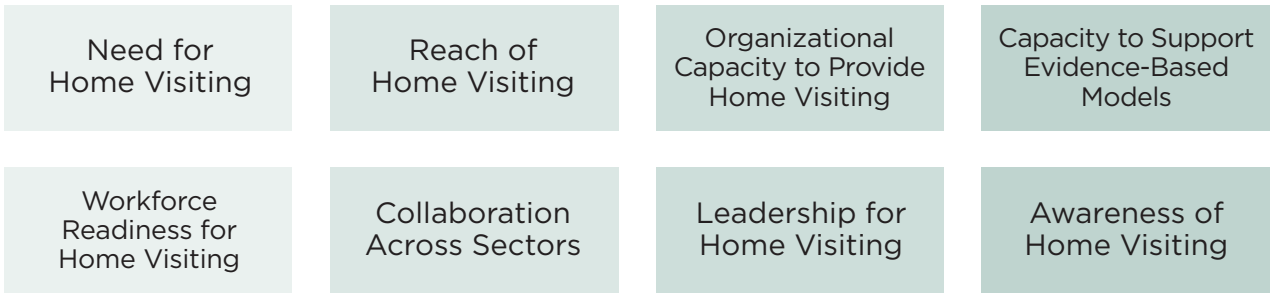
The system-level dynamics described in Section 3.1 influence the community context for home visiting programs. The following sections describe:

- **A.** A Framework for Community Readiness
- **B.** The Need for Home Visiting
- **C.** The Reach of Home Visiting Programs
- **D.** Organizational Capacity to Provide Home Visiting
- **E.** Capacity to Support Evidence-Based Models
- **F.** Workforce Readiness for Home Visiting
- **G.** Collaboration Across Sectors
- **H.** Leadership for Home Visiting
- **I.** Awareness of Home Visiting

A. A Framework for Community Readiness

Community readiness can be defined as the extent to which a community is ready, willing, and able to meet the home visiting needs of young children and their families. As shown in **Exhibit 3.2**, the framework for community readiness includes eight core elements that influence a community's ability to meet local needs. The following sections apply this framework to assess the quality and capacity of existing programs at the community level.

Exhibit 3.2 — A Framework for Community Readiness



To add richer detail and community-level context to the quantitative data analyzed for this needs assessment, the following qualitative research was also conducted: Home Visiting Workforce Focus Groups, key informant interviews, and the Virginia Home Visiting Needs Assessment survey.

Home Visiting Workforce Focus Groups were conducted from January – June 2020. These focus groups began in a face-to-face format, but with the emergence of COVID-19, shifted to virtual in April 2020. A total of 54 home visiting staff and 17 supervisors participated in focus groups, totaling 71 participants. All regions of the state were represented in the focus groups, as were eight home visiting models.

The Virginia Home Visiting Needs Assessment Survey was conducted in summer 2020 and targeted four distinct stakeholder groups: home visiting directors, community service providers, community leaders, and other stakeholders. Key informant interviews were identified via the survey and volunteers represented all four stakeholder groups.

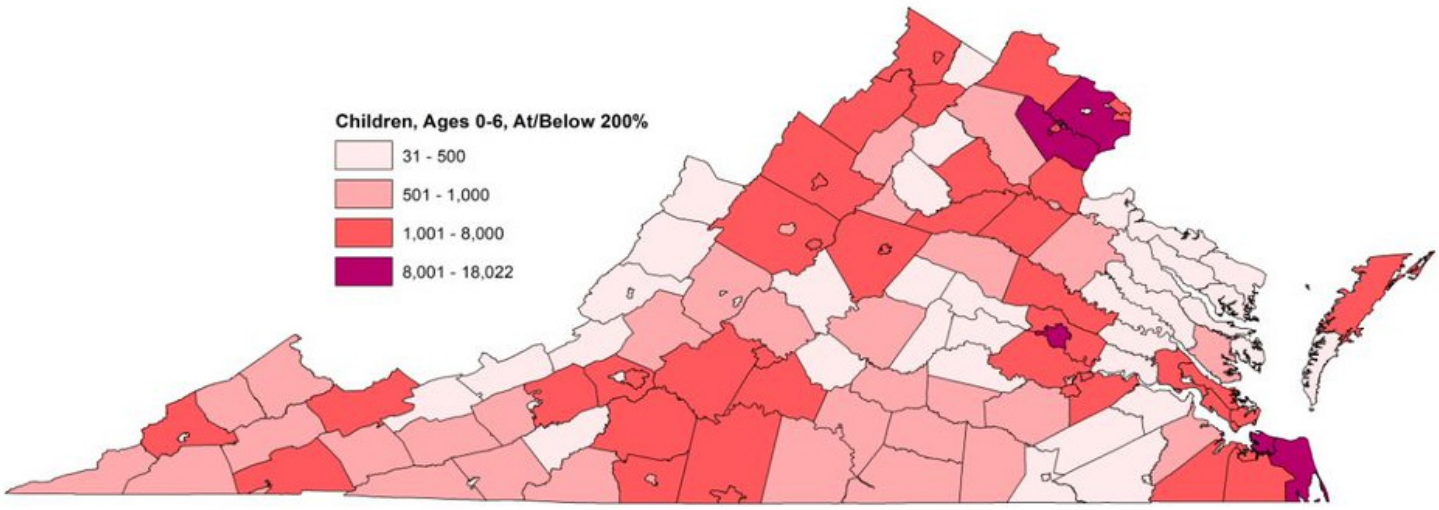
Through collaboration with other state level needs assessments, it was decided not to include parents in the Virginia Home Visiting Needs Assessment Survey as many families served by home visiting had been targeted for interviews, surveys and focus groups by both Preschool Development Grant and Title V needs assessment efforts in 2018 and 2019. Honoring and acknowledging the demand that participation in these efforts place on families was tantamount. This needs assessment will pull on parent and family voice from other concurrent needs assessments.

B. The Need for Home Visiting

This assessment defines potential community need in terms of the number of children age 0-6 with income below 200% of the federal poverty level. Although this is not the only possible indicator of need, low-income is a prominent factor in most models that predict need for home visiting services. Applying this measure for Virginia, as of 2018 there were an estimated 208,000. Virginia children age 0-6 with income below 200% of poverty. This estimate represents roughly one out of three children age 0-6 statewide.

Exhibit 3.3 provides a map of this population by city and county. Focusing on population counts, the *largest numbers* of low-income children reside in the most populous cities and counties (Fairfax County, Prince William County, and the cities of Norfolk, Virginia Beach, and Richmond). However, many rural localities have a comparatively high percentage of children age 0-6 with income below 200% of poverty. See **Appendix B** for an estimate of potential need by locality.

Exhibit 3.3 — Estimate of Children with Potential Need for Home Visiting in Virginia (2018)



Source: EIV analysis of data from the United States Census Bureau American Community Survey.

Insight from Community Stakeholders: Community stakeholders contacted for the needs assessment provided additional insight on community need. As shown in **Exhibit 3.4**, home visiting directors reported via the Virginia Home Visiting Needs Assessment Survey that they use a variety of indicators to assess community needs and target community populations, with the five most frequently identified being live births, teen pregnancy, child abuse and neglect, the poverty rate, and low weight births. These survey results further validate the indicators of risk selected by the Data Action Team to determine Concentration of Risk scores for the needs assessment.

Exhibit 3.4 — Community Need: Insights from Community Stakeholders

Use of Community Indicators: Which indicators does your program use to assess community needs and identify target populations?

Five most frequently identified:	***Home Visiting Directors (n=32)***
Number of live births	75%
Teen pregnancy rate	53%
Child abuse and neglect rate	50%
Percent of population in poverty	50%
Low birth weight rate	44%

Observed Extent of Need: Please indicate the extent to which each of the following services is needed by most expectant parents and/or families with young children in your community.

Mean rating for each service on a scale from 1 (not needed) to 5 (very needed)	***Community Service Providers (n=56)***	***Community Service Leaders (n=36)***	***Other Stakeholders (n=22)***
Home Visiting	4.6	4.6	4.9
Mental Health	4.4	4.7	4.9
Substance Use	4.5	4.5	4.6
Maternal Health	4.3	4.5	4.8
Public Transportation	4.0	4.5	4.6
Unemployment Assistance	4.3	4.4	4.5
Employment Opportunities	4.8	4.6	4.5
Child Care	3.9	4.8	4.9
Government Assistance	4.4	4.1	4.3
Affordable Healthcare	4.0	4.5	4.8
Healthcare for Undocumented Residents	4.0	3.9	4.5
Food Assistance	4.2	4.4	4.6
Culturally & Linguistically Appropriate Services	4.2	4.1	4.6

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey

Respondents to the Virginia Home Visiting Needs Assessment Survey were asked to rate the extent of need they have observed for various community services. Home visiting was rated as needed to very-needed by all three groups. The need for services is further supported by parent and family voice findings in the Title V qualitative data collection, specifically for women of reproductive age and pregnant women and mothers of young children.

Themes from women of reproductive age stated that "[m]ental health is a primary need, and common complaints relate to finding a mental health provider, long wait times to schedule an appointment, large gaps between appointments, and long-distance travel to see providers or access services." Additionally, pregnant women and mothers of young children findings indicated that "[s]upport system and service needs include financial stress and issues, access to and navigation within housing and transportation, lack of community, essential supplies for infants like diapers, breastfeeding, and mental health counseling." The high ratings of need across the board for multiple community services quantified in the survey and underscored by insight from parents and family illustrates the diverse and substantial needs of families with young children.

Home visiting directors shared their insights about capacity versus need as outlined in **Exhibit 3.5**. As shown, 47% of home visiting directors surveyed reported the need for home visiting services in their community exceeds program capacity, and 39% reported they were unable to enroll new families due to capacity issues at some point in the past year.

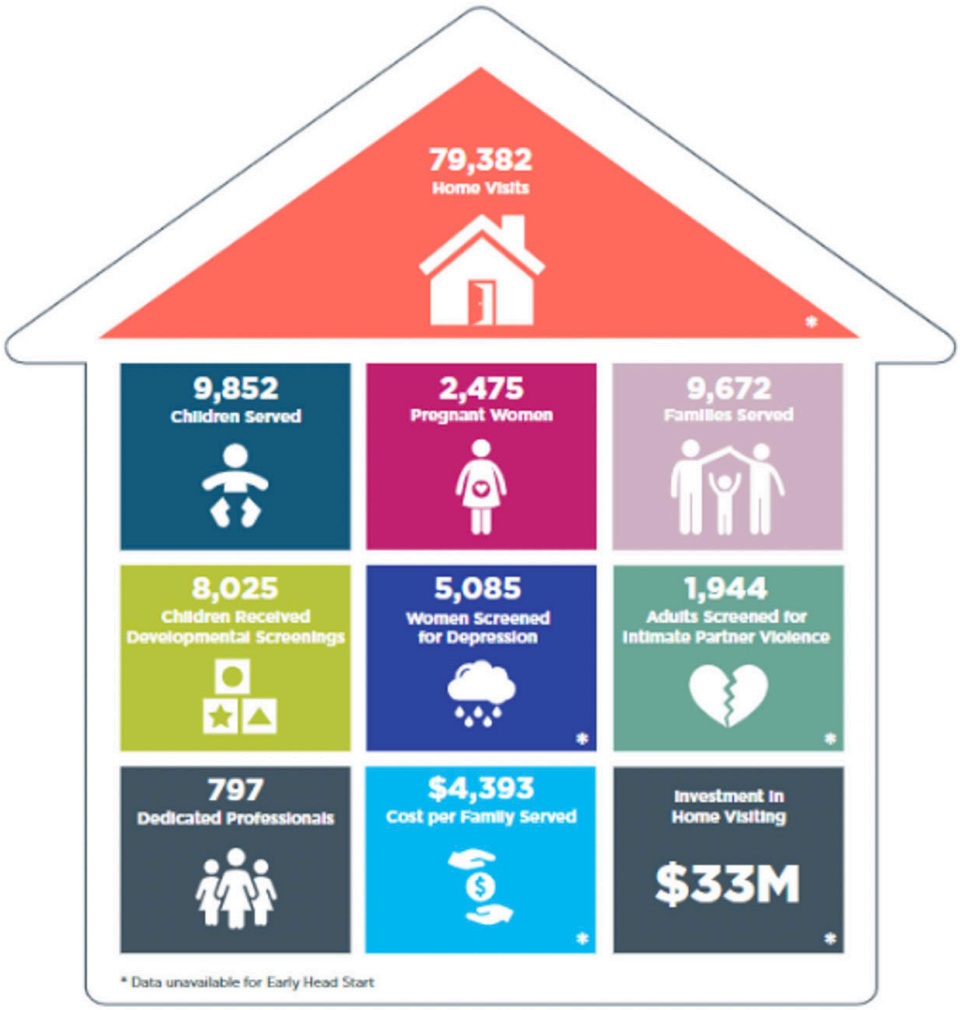
Exhibit 3.5 — Community Need: Insights from Home Visiting Directors

Concerns about Capacity Versus Need: Does the need for home visiting services in your community exceed your program's capacity?	
Response:	***Home Visiting Directors (n=32)***
Yes	47%
No	31%
Not sure	22%
Concerns about Capacity Versus Need: At any point in the last year, were you unable to enroll new families because you didn't have the staffing or capacity to provide services?	
Response:	***Home Visiting Directors (n=32)***
Yes	41%
No	59%

C. The Reach of Home Visiting Programs

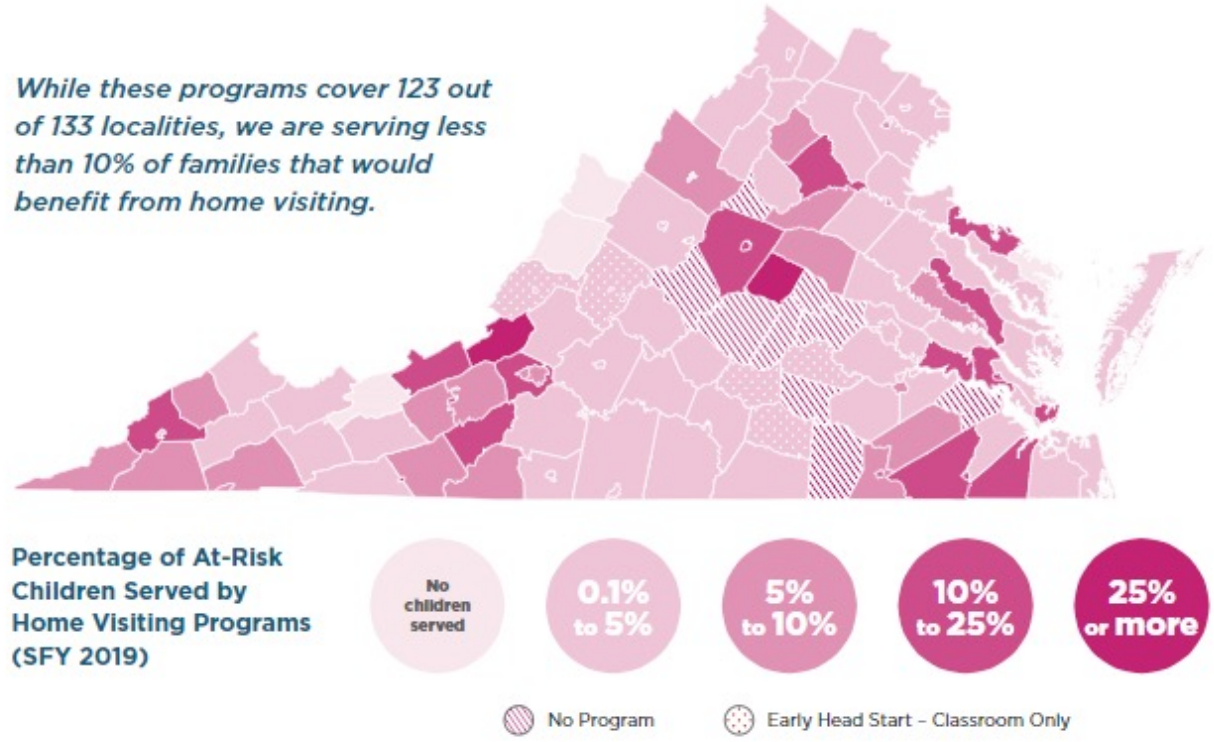
Community reach of home visiting is defined as the percent of children in need served by voluntary home visiting programs. As shown in Exhibit **3.6a-b**, in 2019 an estimated 797 professionals from **seven home visiting programs** provided **over** 79,000 home visits to more than 9,600 families. The estimated percent of children in need who were served by these programs reached 25% or more in only two localities. Although home visiting programs have expanded since 2018, there are still large pockets of unmet need in most localities.

Exhibit 3.6a — Selected Home Visiting Indicators for Virginia in 2019



Source: Home Visiting in Virginia, State Fiscal Year 2019, Early Impact Virginia

Exhibit 3.6b — Selected Home Visiting Indicators for Virginia in 2019



Source: Home Visiting in Virginia, State Fiscal Year 2019, Early Impact Virginia

Insight from Community Stakeholders: Community stakeholders contacted for the needs assessment provide additional insights about community reach. As shown in **Exhibit 3.7**, more than 40% of community service providers and community leaders surveyed reported they have observed barriers to accessing home visiting services for expectant parents or families with children. Also, between 44% and 59% of Home Visiting Directors surveyed identified one or more barriers to access.

Exhibit 3.7 — Community Reach: Insights from Community Stakeholders		
Observed Barriers to Accessing Home Visiting Services: Have you observed any barriers for expectant parents or families with children to accessing home visiting services?		
Response:	***Community Service Providers (n=54)***	***Community Leaders (n=31)***
Yes	46%	50%
No	52%	36%
Observed Barriers to Providing Home Visiting Services: What barriers do home visiting programs face in providing services in your community?		
Response:		***Home Visiting Directors (n=32)***
Developing and maintaining referral relationships		59%
Engaging working families		56%
Presence of multiple, additional high-risk factor among families		53%
Access to technology and/or reliable phone/internet services		50%
Enrolling new families		50%
Retaining families		47%
Language needs		44%

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey

The observed barriers identified in the survey results are further illuminated by insights shared in the Home Visiting Workforce Focus Groups, as shown in **Box 3.2**.

Box 3.2

Home Visitor Insights on Helping Families Address Barriers to Accessing Services

One of the primary ways home visiting serves families is by connecting them to resources in the community; however, programs vary widely in the ways in which they help bridge the structural gaps, especially in regards to transportation and providing tangible goods to families. Because they are often the service providers most familiar with a family and use a trauma-informed approach, home visitors often serve as a "lifeline" for families, aiding families beyond the scope of their job. The supportive relationships between home visitors and the family are of utmost importance, often determining whether families stick with the program. When families do disengage with home visiting, it is typically because of staff turnover, families moving to a different service area, or other significant families issue arise.

Source: Qualitative Summary Report for Virginia Home Visiting Needs Assessment

Health Disparities and Health Equity: Health disparities and health equity are critical considerations for assessing and meeting the needs of families served by home visiting programs. A recent analysis conducted by the Virginia Hospital & Healthcare Association (VHHA) indicates disparate rates of maternal morbidity, as summarized in **Box 3.3**.

In addition, as shown in **Exhibit 3.8**, within Virginia there are racial/ethnic disparities in rates of obtaining early prenatal care, low birth weight, preterm births, infant mortality, and maternal mortality.

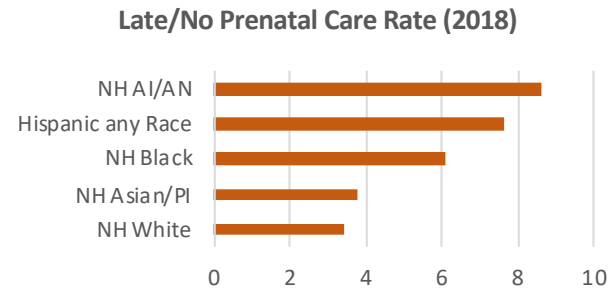
Box 3.3

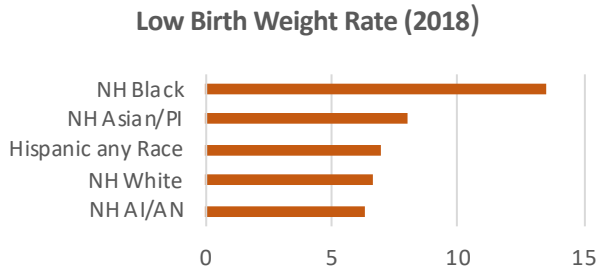
Selected Indicators of Maternal Morbidity

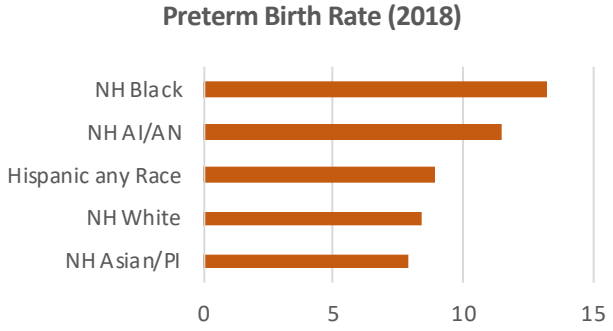
The VHHA Data Analytics team examined the records of 226,403 deliveries from 2017 through the second quarter of 2019. The analysis indicates **40 percent** of mothers in this group (n=89,562) gave birth with a chronic condition diagnosis or risk factor, with the most common conditions being anemia, obesity, asthma, tobacco use, anxiety disorders, acquired hypothyroidism, depression, drug use, and diabetes. The analysis also shows noticeable differences in prevalence when the data is stratified by race and payer class.

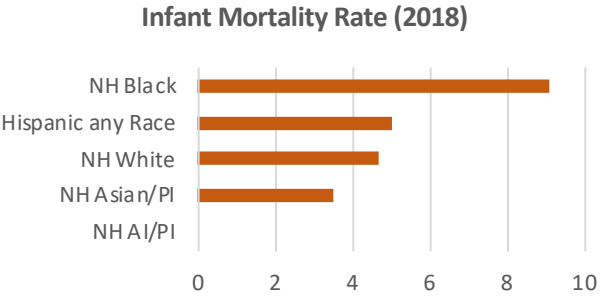
Source: Virginia Hospital & Healthcare Association.

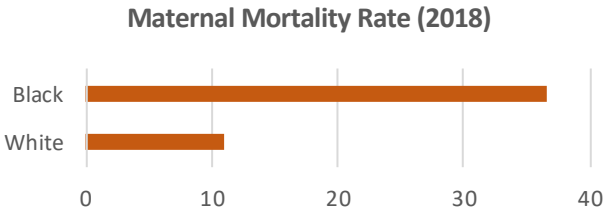
Exhibit 3.8 — Selected Indicators of Disparities in Maternal and Infant Health in Virginia











Source: EIV analysis of data from the Virginia Department of Health. Additional information on maternal and infant morbidity and mortality is available from the Virginia Department of Health at insight-editor.livestories.com.

The disparities outlined above are shaped by multiple factors including inequities in access to health care, as well as various social determinants of health. The scope and complexity of these factor are reflected in **Box 3.4** summarizing insights from home visiting professionals.

Similar insight was gathered from maternal and child health providers through the Title V needs assessment, which found that "providers demonstrate implicit bias in their practice and systems of healthcare have chronically oppressed and disenfranchised people of color, immigrants and non-native English speakers, persons of low socioeconomic status, incarcerated persons, people with disabilities, and those who identify as LGBTQ+."

The implication for community readiness is that home visiting programs should directly identify and address health disparities in program planning, service delivery, and program evaluation.

Community leaders and other stakeholders were asked to rate their own knowledge of home visiting programs and other community services. The survey respondents rated their own knowledge in the range 6.9 to 7.7 on a scale of 1 (no knowledge) to 10 (detailed knowledge). When asked how their program or agency receives information about home visiting programs and services in their community, community coalitions/alliances, community meetings, and communication from leadership were identified as the most common information sources.

D. Organizational Capacity to Provide Home Visiting

Organizational capacity for home visiting can be defined as the capability of an organization to effectively manage and implement a home visiting program. The management challenges most frequently identified by home visiting directors and community leaders included identifying/recruiting families, funding, and retention of families.

Box 3.4

Home Visitor Insights on Factors in Health Disparities and Equity

The families served are diverse. There are many races and ethnicities represented; many do not speak English as a first language; refugee and immigrant families have concerns about documentation status.

While a minority of organizations have an adequate proportion of bilingual staff, overall, there is a severe shortage across the state—both in terms of home visiting staff and health providers in the community. These clients also have notable difficulties navigating the U.S. healthcare and related systems.

In addition, although differences may be magnified in rural areas, all regions highlighted the structural barriers that impact their clients, including lack of affordable housing and childcare, lack of accessible public transportation, and few employment opportunities or workforce development resources.

Source: Qualitative Summary Report for Virginia Home Visiting Needs Assessment.

Exhibit 3.9 — Insights from Home Visiting Directors	
Management Challenges: In your opinion, what are the most challenging aspects of managing a home visiting program?	
Concerns:	***Home Visiting Directors (n=32)***
Identifying/recruiting families	78%
Funding	59%
Retention of families	56%
Access to additional community services	34%
Data collection	28%
Maintaining model fidelity	19%
Administrative/operational capacity	16%
Integrating into existing early childhood systems	16%
Other	16%
Model-specific technical assistance/quality assurance	13%
Public/political will	13%
Training/professional development	0%

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey

E. Workforce Readiness for Home Visiting

The community workforce for home visiting is defined as the supply and skill level of professionals available to meet home visiting staffing needs. In exploring challenges and opportunities for workforce development, it is important to understand the work environment for home visiting professionals. As reflected in **Box 3.5**, having a "heart" for the job, plus the ability to create and sustain positive relationships are essential. In addition, home visitors must be able to manage effectively in a complex environment that is not always structured to support delivery of what families really need.

Box 3.5

Insights from Home Visitor on their Professional Practice

Having a "heart" for the job was described as the most important qualification for home visiting. Staff are generally satisfied with the onboarding process at the local level and very satisfied with the trainings from EIV.

Many reported high job satisfaction from relationships with clients, seeing their families accomplish goals, and their work environment and colleagues. While many participants appreciated the autonomy of their jobs, others felt that their positions were more rigid and that detracted from their job satisfaction. Several participants felt the caseload expectations were not aligned with the realities of doing the job on the ground.

Similarly, participants expressed a desire for a greater understanding from supervisors of the context of their clients' lives and how those challenges impact home visiting. The low pay, lack of professional growth, and lack of appreciation for staff were the most commons reasons for staff turnover.

Source: Qualitative Summary Report for Virginia Home Visiting Needs Assessment.

Exhibit 3.10 shows additional insights about community workforce from the perspective home visiting directors. To summarize:

- Successful home visitors should ideally have good communication and personal skills, reflect the community/families they serve, have an appropriate educational level/degree, and demonstrate interest in home visiting.
- The most frequently identified hiring challenges include inability to offer a competitive salary, lack of candidates with necessary skills, and lack of candidates with bilingual skills.
- Professional development and training opportunities are generally available, although it is important to assure that these opportunities are responsive to needs and realities of home visiting practice.
- In addition, home visiting directors were asked to rate the extent to which home visiting staff and leadership reflect the community they serve in relation to race, gender, and language. On a scale of 1 (does not reflect) to 10 (is highly reflective), the average ratings were 6.6 for staff and 6.0 for leadership.

Exhibit 3.10 — Qualified Workforce: Insights from Home Visiting Directors

Most Important Qualities in a Successful Home Visitor:
What are the most important qualities in a successful home visitor?

Response:	***Home Visiting Directors (n=32)***
Communication and personal skills	88%
Relevant experience and expertise	78%
Interest in home visiting	56%
Reflect the community/families served	56%
Bilingual/language fluency	19%
Education level/degree	16%

Challenges in Hiring New Home Visitors:
What challenges have you experienced in hiring new home visitors for your program?

Response:	***Home Visiting Directors (n=32)***
Unable to offer competitive salary	72%
Lack of candidates with necessary education, skills, and experience	47%
Lack of bilingual candidates	44%
Other	16%
Lack of interest	3%

Training and Professional Development Opportunities for Home Visitors:
How would you describe the training and professional development opportunities for home visiting in the following areas?

Extent accessible at the:	***Home Visiting Directors (n=32)***		
	Not Accessible	***Moderately Accessible***	***Very Accessible***
Community Level	13%	53%	25%
Regional Level	3%	56%	34%
State Level	3%	41%	50%
National Level	3%	66%	22%

Home Visiting Workforce as a Reflection of Communities Served:
To what extent do you believe home visiting STAFF reflect the community they serve in relation to race, gender, and language?

Mean score on scale of 1 (does not reflect at all) to 10 (is highly reflective)	***Home Visiting Directors (n=32)***
	6.6

To what extent do you believe home visiting LEADERSHIP reflect the community they serve in relation to race, gender, and language?

Mean score on scale of 1 (does not reflect at all) to 10 (is highly reflective)	***Home Visiting Directors (n=32)***
	6.0

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey.

Shifting the focus to **professional development**, home visitors need to possess a complex array of knowledge and skills, as well as a unique temperament and a willingness to work in challenging environments. To support the comprehensive training needs of all home visitors, Virginia provides extensive professional development opportunities for all local providers. Access to free competency-based e-learning training is provided through the **Institute for the Advancement of Family Support Professionals.** Additionally, Early Impact Virginia provides regional classroom training to meet the advanced training and development needs of all home visiting staff members, as shown in **Box 3.6**.

All training is developed collaboratively with state and local home visiting and early childhood professionals, and designed to meet the needs of staff. In addition to required evidence-based program training to ensure model fidelity and foundational relational skills, Early Impact Virginia works together with model trainers to support the multidisciplinary knowledge and skills necessary for effective service delivery.

Box 3.6

Early Impact Virginia Workforce Development Activities (SFY'20)

66	On-line training modules on **The Institute**
1,615	Virginia Home Visitors and Early Childhood Professionals participated in Early Impact Virginia trainings
197	Hours of classroom training provided*
23	Classroom trainings provided
4,138	On-line trainings completed by Virginia professionals
28	Supervisors participating in 2-year Reflective Practice Learning Community
10	Scholarships for Virginia Infant Mental Health Endorsement
28	Local Home Visiting programs trained to implement *Mothers & Babies* curriculum

** 6 hours delivered virtually in May 2020*

F. Capacity to Implement Evidence-Based Models of Home Visiting

Virginia's home visiting programs are committed to implementing evidence-based or informed service models. These models are backed by research indicating home visiting programs can positively affect the health and well-being of children parents. All local service providers receive extensive training and support prior to engaging in service delivery with families. Virginia is fortunate to have a strong infrastructure of support for these three evidence based models. The MIECHV program partners with the program model offices to support model related technical assistance, quality assurance and training needs of local providers.

The Research Evidence: One resource for documenting the evidence for home visiting is the Home Visiting Evidence of Effectiveness (HomVEE) initiative operated by the Administration for Children and Families in the US Department of Health and Human Services.[3] HomVEE was launched in 2009 to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting program models that serve families with pregnant women and children from birth to age 5.

In its most recent review from 2019, HomVEE published a systematic review of research on 21 different home visiting models nationally. The home visiting models vary in focus and scope of services, so it is not expected that every

[3]https://homvee.acf.hhs.gov/

model should improve every relevant outcome. The results of the HomVEE review indicate that one or more of the 21 programs studied had evidence of a positive primary or secondary impact on one or more of eight defined outcome domains, as listed in **Box 3.7**.

The HomVEE research is just one of multiple published reviews that indicate home visiting can contribute to positive outcomes for children and parents. Achieving these outcomes in Virginia will require effective design and delivery of home visiting programs that are evidence-based and targeted toward families in need. The positive impact will be elevated to the extent that programs are adequately resourced and effectively coordinated with children and families at the center.

MIECHV Grant Requirements: There are additional criteria identified in statute for evidence-based models eligible for implementation under the MIECHV grant. Legislative requirements for an evidence-based model to be implemented under MIECHV are that it: "conforms to a clear consistent home visitation model that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement," among other requirements.

When selecting a model or models for a state or territory, MIECHV grantees must ensure the selection can:

- Meet the needs of the identified at-risk communities and/or any specific target populations in statute;
- Provide the best opportunity to achieve meaningful outcomes in benchmark areas and measures; and
- Be implemented effectively with fidelity to the model in the state or territory based on available resources and support from the national model developer.

The model(s) selected should also be well-matched to the needs of the state's or territory's early childhood system. States or territories may select multiple models for different communities and use a combination of models with a family, avoiding concurrent dual enrollment, to support a continuum of home visiting services that meets families' specific needs.

Implementation Challenges and Opportunities: Research and experience show that evidence-based practice requires strong capacity in terms of funding, staffing, training, and management. In this context, the challenges outlined in Section E on **service capacity** and Section F on **workforce development** can directly impact the ability of home visiting programs to deliver evidence-based service models. Building on the recent momentum for supporting home visiting services, Virginia has an opportunity to resource and manage programs in ways that are demonstrated to best support evidence-based practice.

Box 3.7

Outcomes That Can Be Affected by Home Visiting

- Child health
- Child development and school readiness
- Family economic self-sufficiency
- Linkages and referrals
- Maternal health
- Positive parenting practices
- Reductions in child maltreatment
- Reductions in juvenile delinquency, family violence, and crime.

Source: HomVEE initiative

At the ground level, matching families' needs to home visiting programs is crucial to developing relationships. Pulling from Title V insight gathered from pregnant women and mothers with young children, families shared that "parenting [support] needs include affirmation and reassurance that they are doing the right thing." This strengths-based approach is embedded in all of the home visiting models in Virginia, and enabling them to first build trust with families creates additional opportunities to identify and address each family's specific needs.

The subsequent Community Readiness Framework and Toolkit that will be released by Early Impact Virginia after the needs assessment will provide an additional tool to enable local communities to determine the best home visiting programs for their community based on data, as well as readiness of factors that are essential to implementing a successful home visiting program — such as availability of other community services, presence of referral partners, awareness of home visiting, and supportive community leadership.

G. Collaboration Across Sectors

While home visiting can create positive impact for children and families on its own, the impact is strongest when home visiting is delivered as part of a coordinated set of services tailored to meet the needs of families. The ideal approach is for service providers to work across sectors and agencies to coordinate services, with parents as partners. This requires effective collaboration, a positive community climate, and committed community leadership.

The Importance of Community Collaboration: Community collaboration is essential for delivering effective child and family serves, including home visiting services. Coordination across agencies is essential for helping families understand and navigate available services. Coordination works best in a climate where home visiting is perceived as important, and community leaders are committed to coordinating services for children and families.

Six percent (6%) of community leaders reported there was no community coalition or advisory board (other than their own) working on issues relevant to early childhood and related services, and 19% said they were not sure.

Exhibit 3.11 — Collaboration Across Sectors: Insights from Community Stakeholders

Does your community have a coalition or an advisory board (other than your own) that addresses topics relevant to early childhood development, child health, trauma-informed practices, substance abuse, or other issues relevant to home visiting?

Response:	***Community Leaders (n=29)***
Yes	56%
No	6%
Not sure	19%

H. Leadership for Home Visiting

Perceived Importance of Home Visiting: One element of a positive climate for home visiting is community members who see home visiting as important. As shown in **Exhibit 3.12**, the stakeholders surveyed reported their communities generally see home visiting as important, with ratings from 6.2 to 8.1 on a scale from 1 (not important) to 10 (very important).

Exhibit 3.12 — Importance of Home Visiting Services: Insights from Community Stakeholders

How does your community rate the importance of home visiting services?

Mean score on scale of 1 (not important) to 10 (very important)	*Home Visiting Directors (n=32)*	*Community Service Providers (n=56)*	*Community Leaders (n=36)*	*Other Stakeholders (n=22)*
	6.2	*7.4*	*7.6*	*8.1*

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey

Leadership Support for Home Visiting: Another important indicator of community climate and readiness to collaborate is community leadership support. As shown in **Exhibit 3.13**:

- The stakeholders surveyed generally view community leaders as sometimes or always ready to participate in planning, partnering to deliver necessary services, and communicating the importance of home visiting to the public/community, and facilitating development of new referral relationships.
- Home visiting directors reported generally positive, but lower levels of support for allocating resources to support home visiting and engaging in volunteer activities to support home visiting efforts.
- Community service providers and community leaders reported generally positive but lower levels of support for generating new revenue/resources for home visiting.

Exhibit 3.13 — Leadership for Home Visiting: Insights from Community Stakeholders

How often do community leaders demonstrate support for home visiting programs in the following ways?

Type of Support:	*Home Visiting Directors (n=32)*			*Community Service Providers (n=56)*			*Community Leaders (n=36)*		
	Never	*Some-times*	*Always*	*Never*	*Some-times*	*Always*	*Never*	*Some-times*	*Always*
• Participating in planning and developing home visiting efforts	13%	59%	22%	7%	73%	16%	3%	64%	14%
• Partnering to provide necessary services (healthcare, early intervention)	6%	53%	31%	4%	64%	29%	0%	44%	36%
• Allocating resources (funding, staffing, training) to support home visiting efforts	22%	47%	25%	9%	70%	18%	3%	56%	19%
• Communicating importance of home visiting to the public/ community	3%	75%	16%	11%	66%	18%	11%	56%	11%
• Facilitate development of new referral relationships	3%	75%	16%	11%	70%	14%	3%	64%	14%
• Generate new revenue/resources for home visiting	19%	59%	16%	20%	64%	7%	17%	64%	0%

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey

Support for Expanding Home Visiting: A positive community climate and committed community leadership are fundamental for program development. **Exhibit 3.14** shows insights from community stakeholders about local support for starting or expanding home visiting services.

Exhibit 3.14 — Leadership Support for Home Visiting Program Development

How strongly would community leaders support new or expanded home visiting efforts in your community?		
Mean score on scale of 1 (not at all) to 10 (very strongly)	***Community Service Providers (n=56)***	***Other Stakeholders (n=22)***
	6.5	***8.0***

Are there community members who would oppose implementing or expanding home visiting services in your community?		
Response:	***Community Leaders (n=36)***	***Other Stakeholders (n=22)***
Yes	14%	18%
No	72%	73%

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey

As shown in the exhibit:

- Community service providers and other stakeholders surveyed believe (on average) that community leaders would be supportive of expanding home visiting services, (although this type of support is not perceived in every locality).
- Also, 14% of community leaders and 18% of other stakeholders believe there are community members who would oppose expansion of home visiting.

The two primary reasons as to why community members would oppose expanding home visiting are competing priorities for funding and lack of local government buy-in.

I. Awareness of Home Visiting

Community awareness is defined as the community knowledge of family needs and home visiting efforts. Community stakeholders shared their insights about community awareness as outlined in **Exhibit 3.15**. Home visiting directors rated parental knowledge about home visiting at an average of 4.2 on a scale of 1 (no knowledge) to 10 (detailed knowledge). Focusing on information sharing for parents, home visiting directors identified brochures, program websites, and special/community events as the most common communication channels.

Exhibit 3.15 — Community Awareness: Insights from Community Stakeholders

Parent Awareness: How much do you think parents know about home visiting?	
Mean rating on a scale of 1 (no knowledge) to 10 (detailed knowledge)	***Home Visiting Directors (n=32)***
	4.2

Information Sharing for Parents: How is information about home visiting made available in the community?	
Methods:	***Home Visiting Directors (n=32)***
Brochures	94%
Program websites	84%
Special/community events	72%
Social media	66%
Posters	47%
Branded giveaways from programs	25%
Other	25%
Rack cards	22%
Printed newsletters	19%
E-newsletters	16%

In Virginia as in the nation, substance use disorder has been a growing concern for pregnant women, parents, and the children in their care. In this section we describe:

A. The consequences of parental substance use
B. Indicators of parental substance use in Virginia
C. Insights from community stakeholders
D. Virginia strategies for strengthening services
E. Opportunities and challenges for effective implementation

A. Consequences of Parental Substance Use

Prenatal and Infant Development: Research indicates parental substance use can have profound negative consequences for children, beginning before the child is born. For example:

- Maternal drug and alcohol use during pregnancy have been associated with premature birth, low birth weight, slowed growth, and a variety of physical, emotional, behavioral, and cognitive problems. (National Institute on Drug Abuse)[4]
- Research suggests powerful effects of legal drugs, such as tobacco, as well as illegal drugs on prenatal and early childhood development. (ACOG)[5]
- Fetal alcohol spectrum disorders (FASD) are a set of conditions that affect an estimated 40,000 infants born each year to mothers who drank alcohol during pregnancy, and children with FASD may experience mild to severe physical, mental, behavioral, and/or learning disabilities, some of which may have lifelong implications (e.g., brain damage, physical defects, attention deficits). (National Organization on Fetal Alcohol Syndrome)[6]
- In addition, increasing numbers of newborns are affected by neonatal abstinence syndrome (NAS), a group of problems that occur in a newborn who was exposed prenatally to addictive illegal or prescription drugs. (Virginia Department of Health)[7]

Child and Adolescent Development: The full impact of prenatal substance exposure depends on several factors. These include the frequency, timing, and type of substances used by pregnant women; co-occurring environmental deficiencies; and the extent of prenatal care. Research suggests that some of the negative outcomes of prenatal exposure can be improved by supportive home environments and positive parenting practices. (Child Welfare Information Gateway)[8]

[4]https://www.drugabuse.gov/drug-topics/health-consequences-drug-misuse/prenatal-effects

[5]https://www.acog.org/patient-resources/faqs/pregnancy/tobacco-alcohol-drugs-and-pregnancy

[6]https://www.nofas.org/about-fasd/

[7]https://www.vdh.virginia.gov/opioid-data/neonatal-abstinence-syndrome-nas/#:~:text=Neonatal%20drug%20dependency%20or%20withdrawal,trembling%2C%20and%20increased%20muscle%20tone.

[8]https://www.childwelfare.gov/pubPDFs/parentalsubabuse.pdf

The negative consequences of parental substance use continue beyond infancy. Children and youth of parents who use or abuse substances and have parenting difficulties have an increased chance of experiencing a variety of negative outcomes including:

- Poor cognitive, social, and emotional development
- Depression, anxiety, and other trauma and mental health symptoms
- Physical and health issues
- Substance use problems

Parental substance use can affect the well-being of children and youth in complex ways. For example, an infant who receives inconsistent care and nurturing from a parent engaged in addiction-related behaviors may suffer from attachment difficulties that can then interfere with the growing child's social-emotional development. Adolescent children of parents with substance use disorders, particularly those who have experienced child maltreatment and foster care, may turn to substances themselves as a coping mechanism. In addition, children of parents with substance use issues are more likely to experience trauma and its effects, which include difficulties with concentration and learning, controlling physical and emotional responses to stress, and forming trusting relationships. (Staton-Tindall et al., 2013)[9]

B. Indicators of Parental Substance Use in Virginia

Multiple indicators show parental substance use is a substantial concern across Virginia.

- As shown in **Exhibit 4.1**, NAS is a statewide issue, as reflected in the map showing the NAS rate per 1,000 live birth hospitalizations by locality in 2017. NAS rates vary remarkably across Virginia localities, with highest rates in rural areas, especially communities in southwest Virginia. (Virginia Department of Health, 2017)[10] NAS has also been increasing, as illustrated by the graphics showing trends in NAS rates and counts from 2012 to 2017.
- Separate data from the Virginia Hospital & Healthcare Association indicates that the number of NAS hospitalizations in Virginia rose from 741 in 2016 to 818 in 2017, followed by a drop to 742 in 2018. (VHHA, 2019)[11]
- Looking beyond newborns alone, in 2016 alcohol or other drug use was a contributing factor in child removal from the home in 2,223 child welfare cases, representing 29 percent of all removals in Virginia. (National Center on Substance Abuse and Child Welfare)[12]

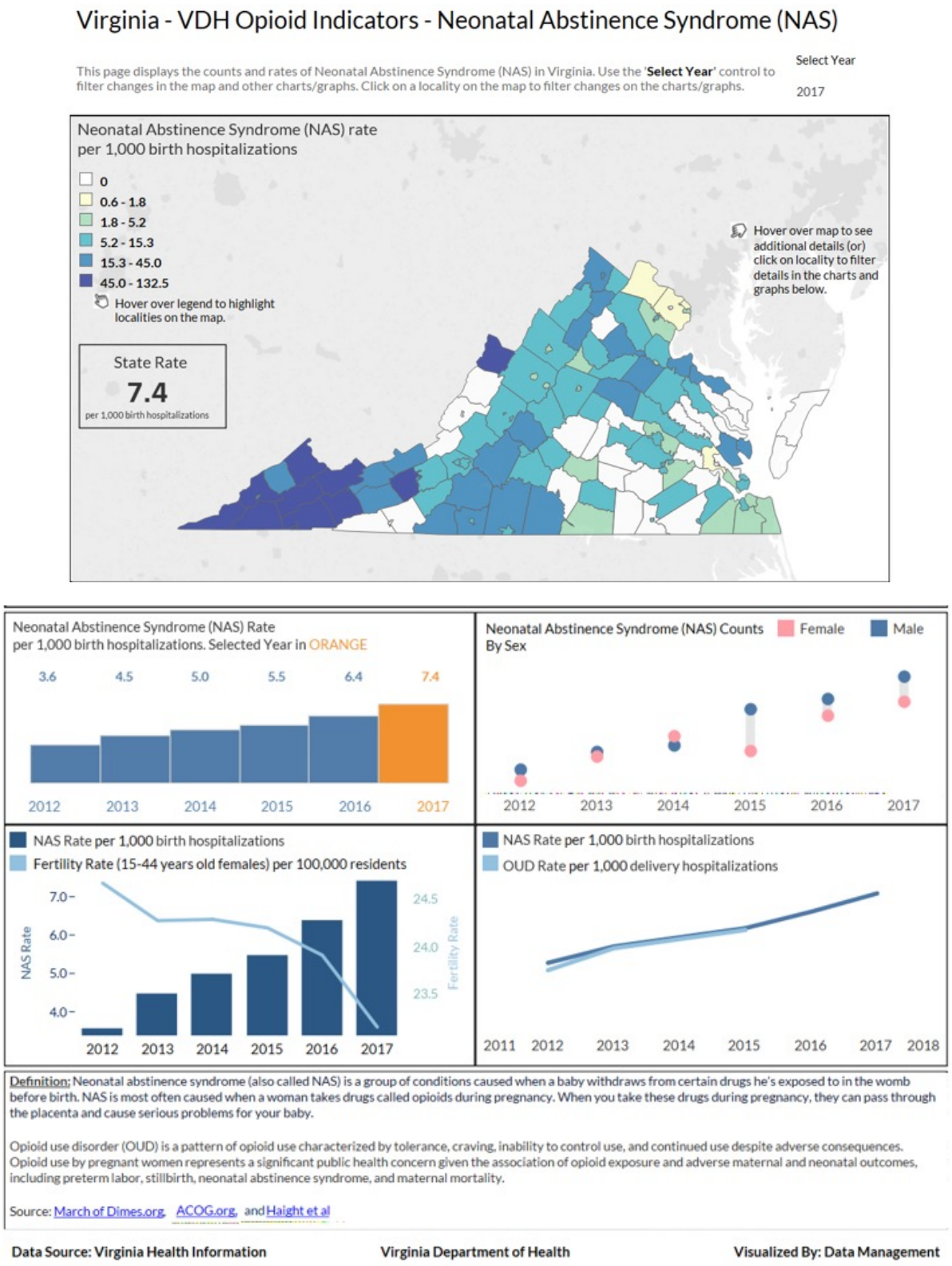
[9]Caregiver substance use and child outcomes: A systematic review. Journal of Social Work Practice in the Addictions, 13(1), 6-31.

[10]https://www.vdh.virginia.gov/opioid-data/neonatal-abstinence-syndrome-nas/

[11]https://www.vhha.com/research/2019/08/30/data-show-nas-birth-trend-largely-unchanged/

[12]https://ncsacw.samhsa.gov/research/child-welfare-and-treatment-statistics.aspx

Exhibit 4.1 — Virginia Indicators of Neonatal Abstinence Syndrome



Source: Inpatient hospitalization discharge data, Virginia Health Information; compiled by the Division of Population Health Data, Office of Family Health Services, Virginia Department of Health (2019)

C. Insights from Community Stakeholders

A significant service gap is access to residential treatment for pregnant and postpartum women. Virginia has eight dedicated residential treatment clinics in Virginia. Of those sites, not all of them will not allow a woman to bring her children with her into treatment. If they do allow this, there are many stipulations (e.g., age cut off, number of children that can be admitted with the mothers, rooms large enough to accommodate a family), that make utilizing the service difficult, if not impossible, for mothers who need it.

An additional gap is the lack of MAT providers in certain areas of the state. In southwest Virginia, there is a gap in accessing MAT services because the limited number of service providers cannot cover the large, rural catchment area in that part of the state.

Local Project Link sites also reported gaps and challenges in providing services. While the type of challenge it creates varies depending on the location of the program, lack of transportation is an issue reported across the board. One program located in rural southwest Virginia reported that "Often Project Link staff who assist with transportation have to leave the Project Link site at 6:00 AM in order to provide transportation for individuals who live further out into more mountainous areas the catchment and ensure they arrive at the office at 9:00 AM for a three hour group, three times per week."

Other challenges reported by Project Link sites include not getting referrals prior to delivery and difficulty partnering with local departments of social services/child protective services. Another Project Link site reported that, "Many of our participants have had previous open cases with CPS and/or criminal histories. They face negative prejudices by legal and social services staff. This is further complicated by the participant's lack of communication skills, knowledge of individual rights and limited social supports."

Concerns about parental substance use are further illuminated by insights from professionals in the field. As shown in **Exhibit 4.2**, community service providers, community leaders, and other stakeholders surveyed for this needs assessment observe high levels of need for substance use treatment services for expectant parents and/or families with young children. The quotes from group interviews with home visiting providers illustrate the complications that can arise when assisting parents with substance use concerns.

Exhibit 4.2 — Insights from Community Stakeholders

Observed Need for Substance Use Treatment: Please indicate the extent to which substance use treatment services are needed by expectant parents and/or families with young children in your community.

Response:	***Community Service Providers (n=56)***	***Community Leaders (n=36)***	***Other Stakeholders (n=22)***
Very needed	55%	50%	59%
Needed	34%	33%	36%
Somewhat needed	7%	3%	0%
Not needed	4%	0%	0%

Source: EIV analysis of Virginia Home Visiting Needs Assessment Survey

Insights from Group Interviews with Home Visiting Providers

- *Meth and heroin are very big in the county I would say in the last couple of years. Those numbers have shot up I would think just from what we see.*
- *Part of our job as parent educators is to talk to parents about things related to parenting, but sometimes it's hard to get there, when a family is constantly in crisis. So, it's really hard to talk to a family about getting early intervention services. If they don't have food or their lights are about to get turned off or they're facing eviction. So, it's really hard to do that aspect of my job sometimes, when…Or if they're coping with substances, for example, it's hard to really focus on parenting, in general. So, that's one of the challenges I experienced.*
- *There's a lot of drug addiction, drug use in our area and a lot of the families I work with have a criminal history a lot of times related to drugs. So that's an obstacle for them to be able to be eligible for certain services and even housing. So that's a challenge for them. So that's a pretty common challenge in our area.*

Source: Qualitative Summary Report for Virginia Home Visiting Needs Assessment

D. Virginia Strategies for Addressing Parental Substance Use

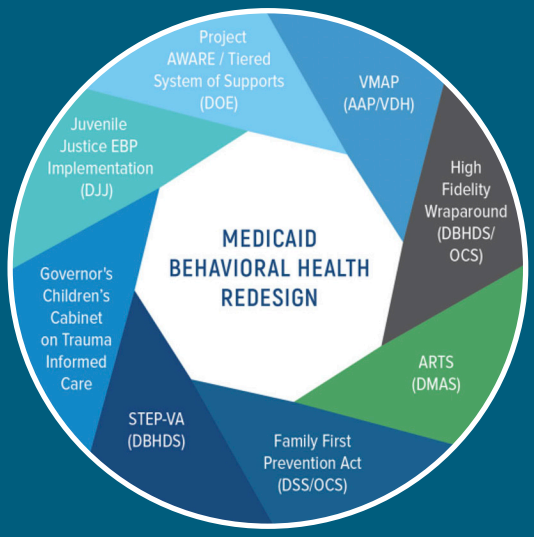
Virginia is implementing multiple coordinated strategies to help improve access to substance use treatment and counseling services for pregnant women and parents of young children. Key examples include Medicaid behavioral health redesign, Project Link, the Children's Cabinet, recent maternal and infant health initiatives, and the Family First Prevention Services Act.

Medicaid Behavioral Health Redesign: As illustrated in **Box 4.1**, multiple state agencies are collaborating to implement behavioral health redesign for Medicaid enrollees. The aims of the redesign are to:

- Keep Virginians well and thriving in their communities.
- Improve behavioral health services and outcomes for members in current and expansion populations.
- Meet people's needs in environments where they already seek support such as schools and physical health care settings.
- Invest in prevention and early intervention services that promote resiliency and buffer against the effects of adverse childhood experiences.

Box 4.1

Medicaid Behavioral Health Redesign



Source: Virginia DBHDS

Project Link: Project Link is one key component of the behavioral health redesign effort. Project Link is an interagency, community-based collaborative program designed to coordinate and enhance existing services to help meet the extensive and multiple needs of women and their children whose lives have been affected by substance use. Project Link seeks to provide a full continuum of care by integrating prevention, early intervention, and treatment services with health care and other human and supportive services.

The Department of Behavioral Health and Developmental Services (DBHDS) administers and monitors 10 Project Link programs throughout the state. Project Link provides intensive case management, linkage to MAT, primary care, pediatricians and coordinates services for women and children who have a history, current use or who are at risk of using substances. Project Link prevents gaps and barriers to treatment and is funded by the substance abuse block grant (SABG).

In a report provided by Project Link, local programs served 287 pregnant and postpartum women between 2018 and 2020. 77 of those women delivered infants while enrolled in the program.

Project Link currently partners with all 40 community services boards (CSB) in Virginia to deliver services to pregnant and parenting women. In Virginia, pregnant women are a priority population for SUD treatment services. A pregnant woman must be seen within 48 hours of a request for services with the CSB. If the woman cannot be seen within this time frame, she is provided interim services to include, but not limited to, brief counseling on pregnancy and SUD, access and coordination of OB/GYN and/or PCP, access to MAT or inpatient care, if needed. CSBs are required to contact the women's services coordinator with DBHDS when this occurs to assist with problem solving. Virginia has eight providers of inpatient treatment providing services to pregnant women and her children.

While Virginia has made strides to improve provision of substance use disorder treatment and counseling services, there are several barriers to treatment for pregnant and parenting women. Transportation is a barrier, especially for those women and families who are located in Southwest Virginia. Women need to travel farther, often well outside of their community, for services. In short, these services are not readily available in rural areas. Additionally, women continue to be fearful of receiving services due to the misunderstanding that child protective services will be involved, potentially leading to the possibility of having their children removed from their custody.

Currently, at the state level, a Maternal and Infant Health workgroup that includes DBHDS, VDH, DSS, DMAS, the Virginia Hospital and Healthcare Association, and other community partners meets monthly to focus on substance use issues. This group was designed to align the work of each state agency to meet the unique needs of this population.

Maternal and Infant Health Initiatives: Gov. Ralph Northam's budget proposal for FY 2021 and FY 2022 included a package of directives and funding to boost health care access and support for new moms and babies, as well as eliminate the racial disparity in the state's maternal mortality rate. Additionally, Virginia is completing the development of an innovative approach to improve coordination of services for families impacted by substance use disorder. *Pathways to Coordinated Care* is designed to ensure interagency collaboration and a comprehensive system of care to address the medical, mental health and social needs of families impacted by substance use disorder.

Family First Prevention Services Act: The Family First Prevention Services Act aims to keep children safe, strengthen families and reduce the need for foster care whenever it is safe to do so. Within Virginia, Family First services are coordinated by the Virginia Department of Social Services and operated collaboratively with other state and local agencies. Funding is available for trauma informed, evidence-based, foster care prevention services within the following categories:

- Mental Health Prevention and Treatment Services
- Substance Use Disorder Prevention and Treatment Services
- In-Home Parent Skill-Based Programs

The implementation of Family First has been extended to January 30, 2021. VDSS had several major Family First implementation activities scheduled for Spring 2020 that unfortunately have been cancelled and/or postponed due to COVID-19. These activities include training for specified providers in evidence-based practices and assisting localities in determining the needs of their communities which are critical to support the implementation of Family First. Implementing Family First remains a high priority for the Division of Family Services and implementation activities will continue with our state and community partners.

E. Opportunities and Challenges in Addressing Parental Substance Use

Virginia is facing both opportunities and challenges in addressing parental substance use and the related impacts on child health and well-being. The opportunity lies in collaborating across agencies at the state and community level to understand the needs of pregnant women and families, and provide coordinated services for substance use prevention, treatment, and recovery. Potential benefits of this approach include more timely screening and intervention to help families avoid or reduce the profound human and economic costs of substance use for children and parents. Home visitors can be key partners in this vital work.

Several of the challenges faced by Project Link sites are similar to that of home visiting programs in Virginia. Using the information provided for this needs assessment, Early Impact Virginia will explore ways to strengthen relationships between local home visiting programs and Project Link sites, and address shared challenges in a collaborative manner.

Several challenges also arise as communities attempt to implement more coordinated models of family supports for addressing substance use issues. Funding streams must be aligned to support coordinated supports for families at the community level. Professional roles and responsibilities must be clarified as multiple agencies and professionals from different disciplines seek to serve families as partners who are facing multiple challenges. Systems and workflows for screening, referral, and follow-up must be designed, tested, and improved over time.

These operational requirements have implications for the home visiting workforce, including competencies, training, and supports that allow them to participate as partners with a manageable level of time and effort. As voiced in surveys and interviews conducted for this needs assessment, community service providers are encountering families facing multiple challenges that require intensive supports. Home visitors and other community service providers will need operating structures and professional supports that are agile, efficient, and tailored for the local context.

5 / Coordination with Other Needs Assessments

The **Virginia Home Visiting Needs Assessment** was conducted in coordination with other needs assessment efforts in Virginia. Five of these studies are listed below and described in more detail in the following sections.

1	2	3	4	5
Title V 2021-2025 Needs Assessment	2019 PDG B-5 Needs Assessment	2020 Head Start Needs Assessment	2019 Child Abuse Prevention and Treatment Act Report	2018 Substance Use and Behavioral Health Needs Assessment

A. Virginia Title V 2021-2025 Needs Assessment

The Virginia Department of Health (VDH) Office of Family Health Services (OFHS) houses the state Title V program and complementary MCH programs. The Title V Team had the unique opportunity to leverage and align key needs assessment activities with MIECHV. Virginia's MIECHV program is housed within VDH OFHS, presenting prime opportunity to ensure combined efforts to gather the information and data required for both needs assessments. This opportunity ensured that programs avoided duplication of efforts, leveraged staff and fiscal resources, and aligned the data collected by each program. The Title V Director and the MCH Epidemiology Lead met periodically with Early Impact Virginia, a key Virginia MIECHV partner and facilitator of the state's MIECHV Needs Assessment. Data, tools, and information were shares seamlessly and utilized by both programs, and plans were discussed to ensure gap-filling efforts.

Every five years, Virginia's Title V Maternal and Child Health (MCH) Program conducts a statewide needs assessment of the health and well-being of women, children, youth, and families living in Virginia. The priority needs identified in the most recent needs assessment (for 2021-2025) are outlined below:

- **Upstream / Cross-Sector Strategic Planning:** Eliminate health inequities arising from social, political, economic, and environmental conditions through strategic, nontraditional partnerships.
- **Community, Family, & Youth Leadership:** Provide dedicated space, technical assistance, and financial resources to advance community leadership in state and local maternal and child health initiatives.
- **Mental Health:** Promote mental health across MCH populations, to include reducing suicide and substance use.
- **Finances as a Root Cause:** Increase the financial agency and well-being of MCH populations.
- **Racism:** Explore and eliminate drivers of structural and institutional racism within OFHS programs, policies, and practices to improve maternal and child health.
- **MCH Data Capacity:** Maintain and expand state MCH data capacity, to include ongoing needs assessment activities, program evaluation, and modernized data visualization and integration.
- **Reproductive Justice & Support:** Promote equitable access to choice-centered reproduction-related services, including sex education, family planning, fertility/grief support, and parenting support.
- **Strong Systems of Care for All Children:** Strengthen the continuum supporting physical/socio-emotional development (i.e. screening, assessment, referral, follow-up, coordinated community-based care).
- **Maternal and Infant Mortality Disparity:** Eliminate the racial disparity in maternal and infant mortality rates by 2025.
- **Oral Health:** Maintain and expand access to oral health services across MCH populations.

The state Title V program is in the process of increasing alignment of the goals, objectives, and metrics of various federal and state maternal and child health funding streams into a shared "Maternal and Child Health Agenda." A series of stakeholder meetings will be convened by VDH to review and contextualize the results from each needs assessment and identify opportunities for ongoing collaboration. This will leverage synergies through the collective impact approach to improve the health of women, children, and families.

B. Virginia Preschool Development Grant, Birth through Five

In 2019 the Virginia Early Childhood Foundation published a needs assessment for the *Virginia Preschool Development Grant, Birth through Five*. Findings with relevance for home visiting programs include the following:

- **Family Engagement:** Family engagement in planning and decision making is essential for positive preschool development. Parents can be engaged as partners in service planning for their own children. Parents can also be involved as key informants in parent policy councils required by federal funding.
- **Accountability and Measurement:** Shared data and clear accountability across programs and agencies can support planning, targeting services, evaluating outcomes and public investment, and advocating for resources.
- **Coordination and Communication:** Early childhood programs can create opportunities to prevent risk and minimize resources spent on remediation by identifying families and children who will benefit from support prior to, during, and after entering an early childhood program. Also, integrating elements of early care and education in policies and practices facilitates more comprehensive and seamless delivery of services and attention to quality early care and education across state agencies and programs.
- **Finance:** Increased state funding levels can support resources for more than 30% of eligible children. Focusing on home visiting programs in particular, increased public expenditures in the last decade have allowed home visiting efforts in Virginia to expand, but funding remains heavily dependent on federal allocations and a lack of stable, predictable funding from year to year limits programs' ability to develop joint strategy and administration.
- **Data and Outcomes:** Individual programmatic and integrated data can provide insight on family service use. Shared data can be used to identify what programs or combinations of programs best serve children and families, including preventive assistance that minimizes remediation and supports positive outcomes for children and families.

C. Virginia Head Start Needs Assessment

In 2019, the Virginia Head Start State Collaboration Office conducted a needs assessment of Head Start grantees within the Commonwealth of Virginia. The assessment included (a) examining the types and degree of relationships that grantees had with community partners and (b) identifying the level of difficulty associated with functioning in different areas. Key findings relevant for home visiting include:

- Head Start grantees are continuing to develop new partnerships and strengthen existing ones. Relationships with providers for children with special needs, community services, and transition providers are stronger now than at any other time in the past.
- Current challenges identified by grantees are typically in the categories of health care, childcare, and professional development. At least 25% of Head Start grantees found it was difficult or extremely difficult to:
  - Ensure parents follow through with dentists' recommendations for children's dental care
  - Get full representation/active commitment on Health Advisory Committee
  - Get involved in state level planning and policy development around welfare/child welfare issues
  - Align policies and practices with other providers

Several of Virginia's home visiting programs partner with classroom-based Head Start and Early Head Start programs at the local level. Enhancing the relationships between Early Head Start (and Head Start) home-based programs will further benefit families with young children in local communities.

D. Virginia Child Abuse Prevention and Treatment Act (CAPTA) Plan

CAPTA provides federal funding and guidance to states in support of prevention, assessment, investigation, prosecution, and treatment activities, and provides grants to public agencies and nonprofit organizations, including Indian tribes and tribal organizations, for demonstration programs and projects. Virginia's CAPTA plan is coordinated by the Virginia Department of Social Services and operated in collaboration with state agencies and local service programs:

- Virginia's CAPTA plan includes targeted efforts to assure the safety of children within their homes by improving local department staffs' ability to properly identify and assess safety and risk factors within family systems and provide protective and rehabilitative services by focusing on the development and improvement of worker training, supervision, and formal tools.
- Emphasis has been placed on working with children under the age of two, children in out-of-family settings, substance-exposed infants (including the development of plans of safe care), receiving and responding to concerns of child abuse and neglect, and children diverted from foster care.
- Additionally, Virginia's CAPTA plan focuses on enhancing local department staffs' ability to utilize a strength-based, child-centered, family-focused, and culturally competent approach when working with children and families.

Virginia's home visiting programs are part of the collaboration for CAPTA, and will continue to work with state and local partners to optimize use of CAPTA resources.

E. Virginia Statewide Substance Use and Behavioral Health Needs Assessment

In 2018 the Virginia Department of Behavioral Health and Developmental Services published the *Virginia Statewide Substance Use and Behavioral Health Needs Assessment*. Although the report is focused primarily on services provided through Virginia's state and community behavioral health system, a key theme of the report with relevance for home visiting is an emphasis on prevention and collaboration at the community level:

- **Context:** Thirty-one prevention staff members from across the Commonwealth participated in SWOT (Strengths, Weaknesses, Opportunities, Threats) discussions, in which they identified several strengths and weaknesses of the prevention workforce, funding structure, and community services board (CSB) operations. In addition, participants identified external opportunities that could facilitate prevention work in the future, as well as threats that pose challenges to prevention work and may be areas to address in future years.
- **Strengths:** Virginia strengths include strong partnerships, coalition support, and passionate staff, all of which are essential to prevention work. CSBs are already successfully incorporating these items into their work in the priority areas.
- **Weaknesses:** Both CSBs and DBHDS highlighted funding, staff resources, and workforce skills as key internal weaknesses that hinder prevention work in the priority areas.
- **Opportunities:** DBHDS's emphasis on environmental strategies requires a switch from direct service to indirect, community-wide approaches. Many voiced the desire for additional trainings, support, and resources to shift their work in this direction.
- **Threats:** Larger trends in the cultural and social acceptance of substance use, and the alignment of funding with these priority areas, are perceived as major external threats to prevention work.
- **Recommendations:** After reviewing data trends, discussing with DBHDS and the State Epidemiology Outcomes Workgroup, and receiving input from stakeholders across the Commonwealth, three key areas for potential growth and action emerged:
  - *Fund Priorities:* Strategically impact priority areas by funding strategies and outcomes that address appropriate risk and protective factors.
  - *Build Capacity:* Support the prevention workforce across Virginia with training and peer learning opportunities.
  - *Lead Initiatives:* Lead efforts for statewide messaging, advocacy, collaboration, and decision-making that facilitate effective prevention work across the Commonwealth.

A. Summary of Major Findings

The Virginia Home Visiting Needs Assessment is the product of a statewide collaborative effort to identify strengths and needs in Virginia's system of home visiting programs, with guidance from multiple advisory groups and insight from more than 150 community stakeholders. This section summarizes the major findings of the needs assessment in terms of four imperatives for home visiting in Virginia: addressing specific risk factors, collaborating to support community services, building community readiness, and listening to community stakeholders.

1. Addressing Identified Risk Factors: Section 2 of the report identifies a list of 74 (of 133) Virginia cities and counties as at-risk localities (also see **Appendix B** for details). These localities include a mix of rural and urban communities that will receive priority focus as Virginia seeks to continuously strengthen home visiting services.

Of the 12 localities with no reported home visiting program (Exhibit 3.1), three of them — Buckingham, Lunenburg, and Prince Edward — fall into the highest quartile for concentration-of-risk. Early Impact Virginia will work together with the funders through the Alliance for Early Childhood Home Visiting and Leadership Council to determine how best to integrate the new list of at-risk localities into upcoming funding processes (e.g., MIECHV).

This needs assessment will help Virginia focus its efforts on addressing the array of risk factors that influence maternal, infant, and child outcomes. A list of these risk factors is shown in **Box 6.1**. In addressing these factors, it will be imperative to consider health disparities and health equity in efforts to improve access to home visiting services and other community services.

2. Building Community Readiness: State level systems and supports are essential for supporting community home visiting programs. *Section 3.2* introduces a "framework for community readiness" as a tool for assessing family needs and strengthening home visiting services in Virginia communities. The eight elements of the community readiness framework are illustrated in **Box 6.2**. Early Impact Virginia plans to develop this framework into a practical toolkit that home visiting programs, funders, and community stakeholders can use to assess community capacity to ensure successful implementation and/or expansion of home visiting.

Box 6.1

Risk Factors in Need of Attention in Virginia

- Maternal mortality
- Infant mortality
- Maternal morbidity
- Access to prenatal care
- Low birthweight
- Preterm birth
- Teen pregnancy
- Child maltreatment
- Maternal substance use
- Neonatal abstinence syndrome
- Children with developmental delays
- Children with special health care needs
- Child maltreatment
- Food insecurity
- Economic distress

Box 6.2 A Framework for Developing Community Readiness

- Need for Home Visiting
- Reach of Home Visiting
- Organizational Capacity to Provide Home Visiting
- Capacity to Support Evidence-Based Models
- Workforce Readiness for Home Visiting
- Collaboration Across Sectors
- Leadership for Home Visiting
- Awareness of Home Visiting

3. Collaborating to Support Community Services: Home visiting is a key asset for helping children and families achieve optimal health and well-being. But no single program or sector is equipped to fully address these risk factors on its own. Opportunities to increase collaboration include improving programmatic-level partnerships and systems-level coordination.

Enhancing the relationship between other home visiting programs and Early Head Start (and Head Start) home-based programs will further benefit families with young children in local communities. Targeting Early Head Start home-based programs to engage in existing workforce supports for home visiting in Virginia will help enhance relationships between them and other home visiting programs, and enable Early Head Start programs to provide more appropriate training and professional development to their home-based staff.

As outlined in *Section 3.1*, collaboration across the public and private sectors and across levels of government will be essential for producing improvement. Each of the following agencies plays a significant role in all or some part of the administration, funding, and delivery of home visiting services: Virginia Department of Social Services, Virginia Department of Education, Department of Behavioral Health and Developmental Services, Department of Medical Assistance Services and Virginia Department of Health.

One of the many practical strategies for collaboration is to share results from various needs assessments addressing child and family needs in Virginia, as illustrated in *Section 3* and *Section 4* of this assessment.

The state Title V program is in the process of increasing alignment of the goals, objectives, and metrics of various federal and state maternal and child health funding streams into a shared "Maternal and Child Health Agenda." A series of stakeholder meetings will be convened by VDH to review and contextualize the results from each needs assessment and identify opportunities for ongoing collaboration. This will leverage synergies through the collective impact approach to improve the health of women, children and families.

4. Listening to Community Stakeholders: State and local efforts to enhance and extend home visiting should be informed by community stakeholders including home visiting professionals and the families they serve. In this needs assessment we obtained input from more than 150 community stakeholders including home visiting professionals, community leaders, and others.

As outlined in **Box 6.3**, community stakeholders provided rich insight into the complexity of family life for parents with young children, especially when the family is in economic distress or a family member is managing a health or developmental challenge. Perhaps the most important insight is that home visiting is a deeply human service that works best when home visitors have time to develop trusting relationships with families.

Box 6.3

Stakeholder Insights about Community Capacity

- Building trust and relationships is essential for effective home visiting.
- There are high levels of need for a wide range of maternal, infant, and child services.
- Many families require intensive support to help them manage complex challenges.
- Attention to disparities and equity is essential for optimizing services.
- Resources and service capacity for home visiting are concerns in many localities.
- Home visiting programs face challenges recruiting and retaining professional staff.
- Home visiting professionals have positive views of professional development opportunities, and also offer practical ideas for improving education programs.
- Community support for home visiting is generally positive, but there is room for improvement in community collaboration and coalition building.

Home visiting professionals also shared thoughtful analysis of the professional challenges they face in serving families with complex needs, along with ideas for how state and local systems can be better organized and coordinated to support their work on behalf of families. Early Impact Virginia and its collaborating partners will carefully consider these insights as they pursue multiple aims for strengthening the home visiting system.

B. Dissemination Strategy

As noted in *Section 1*, the Virginia General Assembly has given Early Impact Virginia the authority and responsibility to determine, systematically track, and report annually on the key activities and outcomes of Virginia's home visiting programs; conduct systematic and statewide needs assessments for Virginia's home visiting programs at least once every three years; and to support continuous quality improvement, training, and coordination across Virginia's home visiting programs on an ongoing basis. Early Impact Virginia will use this needs assessment to inform its reporting to the General Assembly. In addition, Early Impact Virginia will coordinate efforts to disseminate this needs assessment throughout Virginia. This needs assessment will inform efforts to develop community readiness and implementation strategies. The work will be facilitated through a statewide network of organizations involved in home visiting and other child and family services.

- In 2019, Early Impact Virginia developed *Virginia's Plan for Home Visiting*, an outline for scaling and sustaining home visiting in Virginia.
- In 2019-2020, Early Impact Virginia conducted the Virginia Home Visiting Needs Assessment, legislatively mandated by the General Assembly, and also to meet the HRSA requirement for the MIECHV program.
- To accompany the needs assessment, Early Impact is creating a Virginia-specific Community Readiness Toolkit for use by state partners and local programs to operationalize the needs assessment and its related findings.
- After the needs assessment is complete, Early Impact Virginia, the Alliance for Early Childhood Home Visiting, and the Early Impact Virginia Leadership Council will use the community readiness framework and needs assessment to develop the Strategic Growth Plan for Home Visiting in Virginia. This plan will have a special focus on strategic growth and sustainable financing that integrates Medicaid reimbursement and Family First Prevention Services Act funding streams.

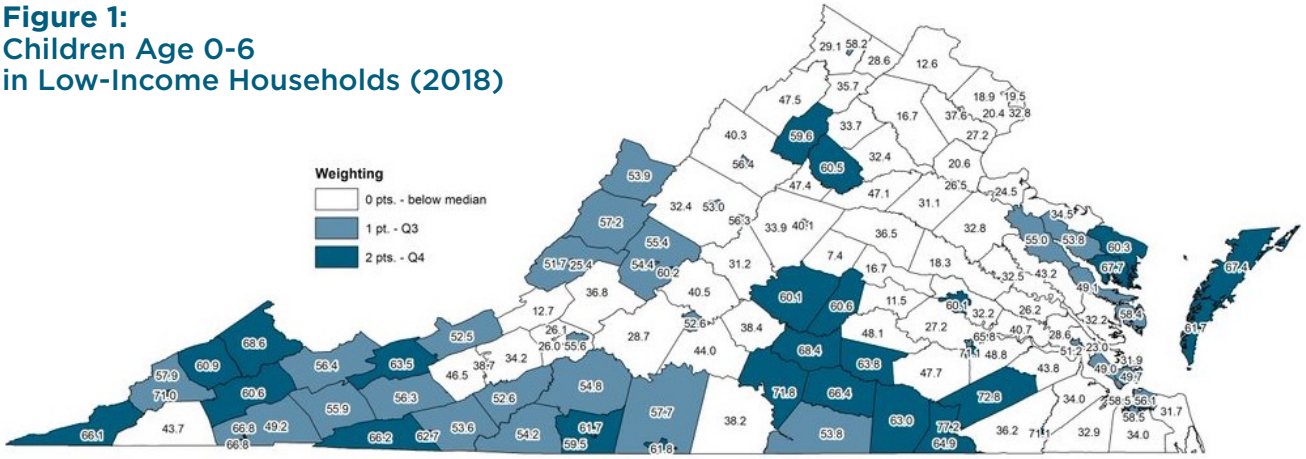
These next steps will require a collaborative effort in which state, regional, and local organizations work together to optimize services for children and families.

APPENDIX A

Mapping Indicators of Risk by Locality in Virginia

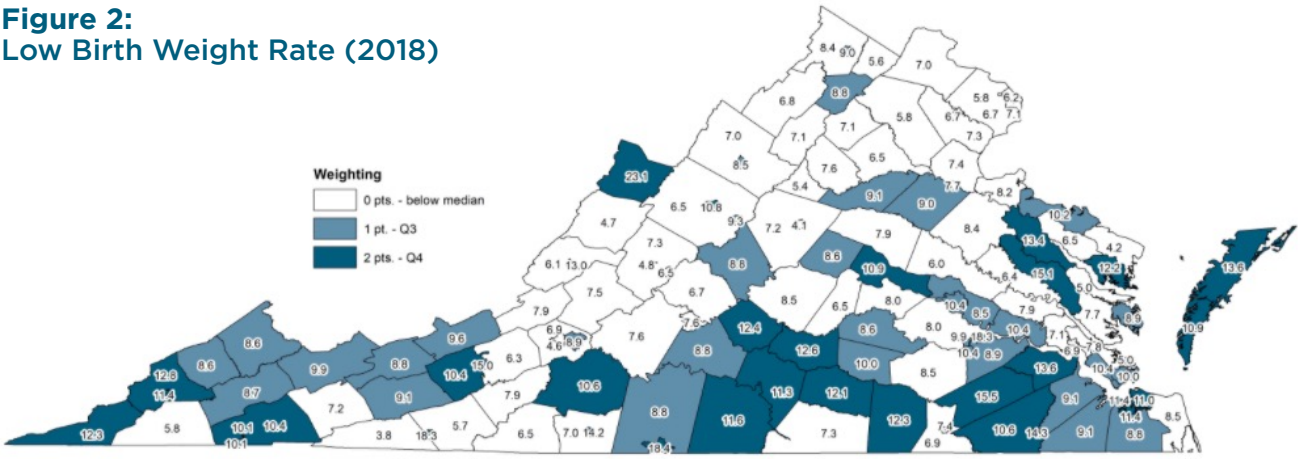
Mapping Indicators of Risk by Locality (Weight = 0-2 points)

Figure 1:
Children Age 0-6 in Low-Income Households (2018)



Source: EIV analysis of data from the United States Census Bureau American Community Survey

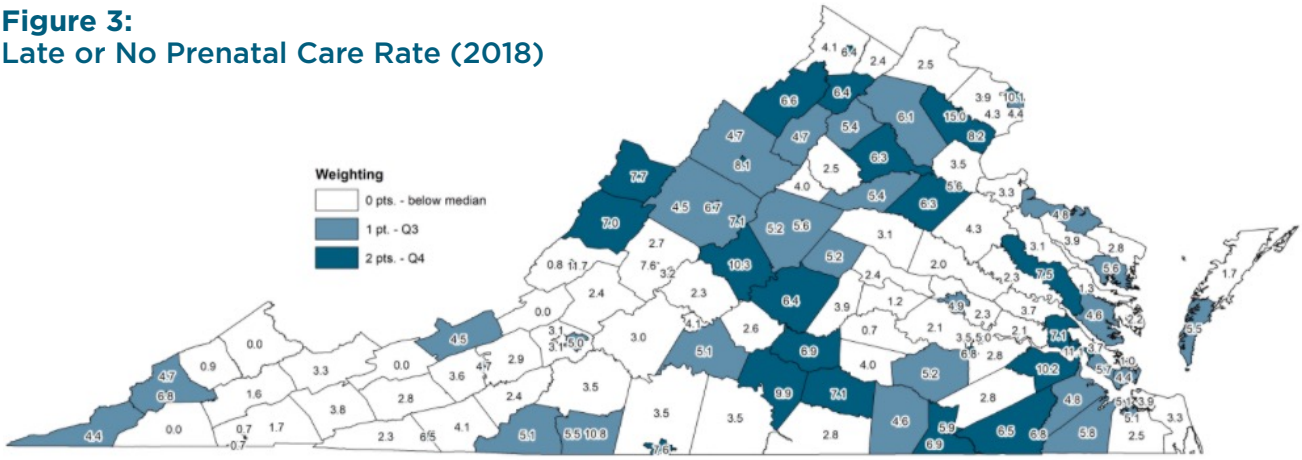
Figure 2:
Low Birth Weight Rate (2018)



Source: EIV analysis of data from the Virginia Department of Health

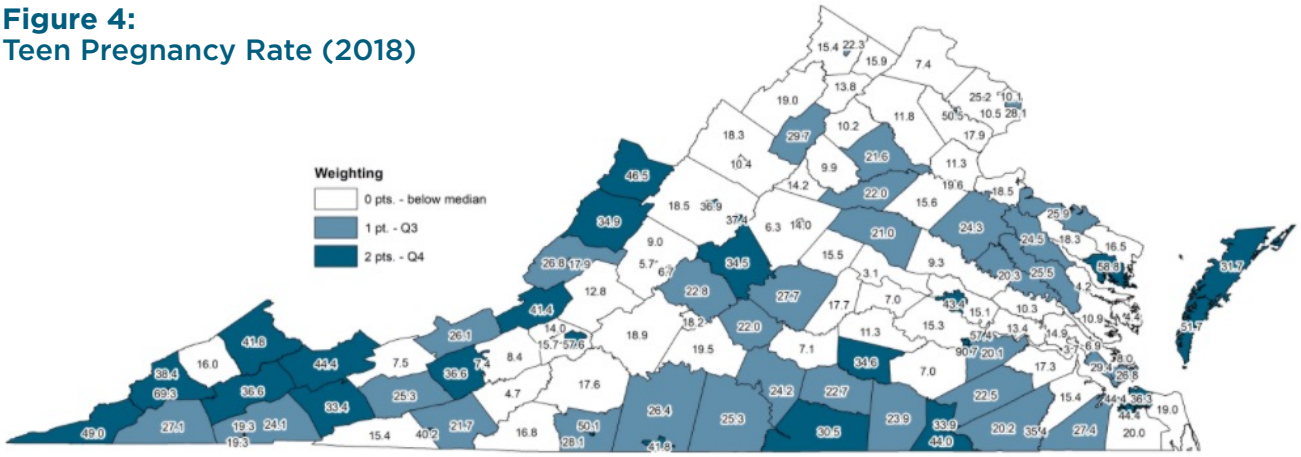
Mapping Indicators of Risk by Locality (Weight = 0-2 points)

Figure 3:
Late or No Prenatal Care Rate (2018)



Source: EIV analysis of data from the Virginia Department of Health

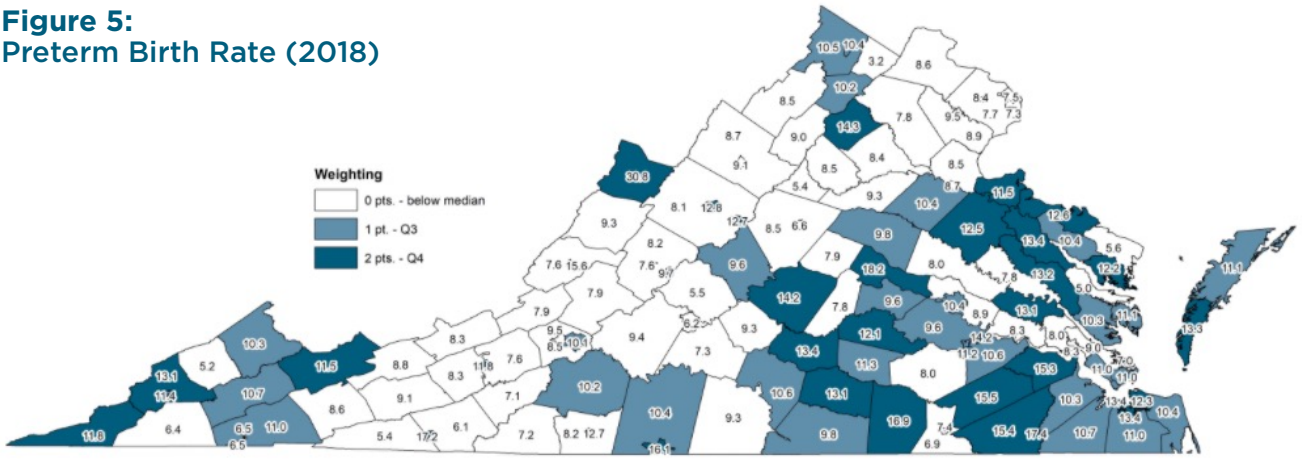
Figure 4:
Teen Pregnancy Rate (2018)



Source: EIV analysis of data from the Virginia Department of Health.

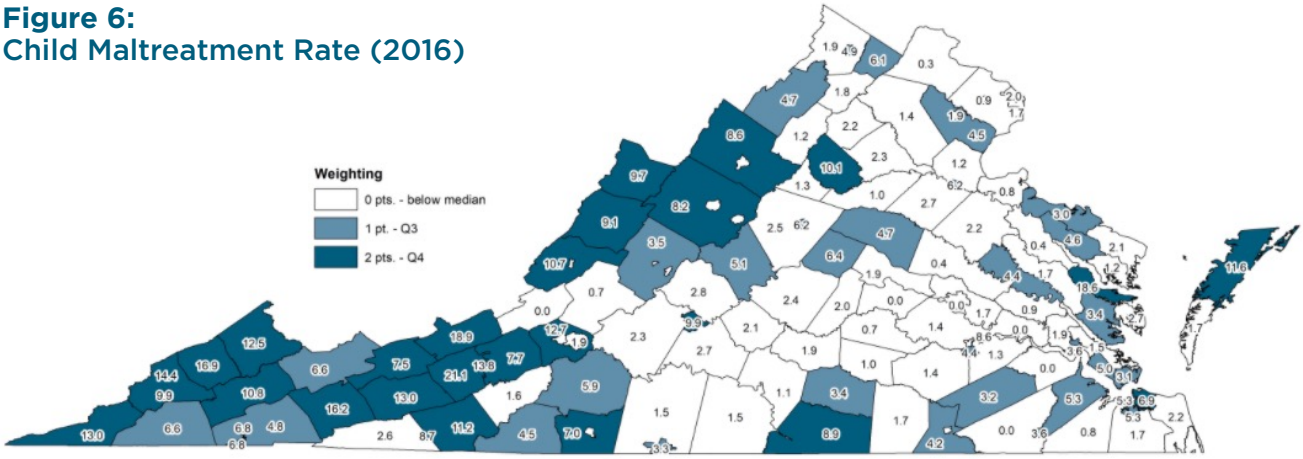
Mapping Indicators of Risk by Locality (Weight = 0-2 points)

Figure 5:
Preterm Birth Rate (2018)



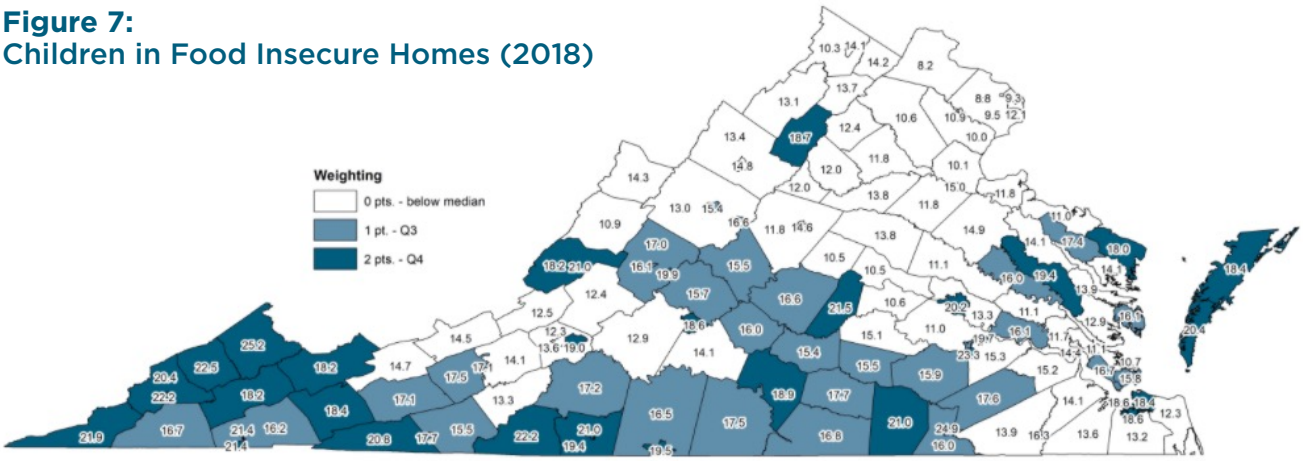
Source: EIV analysis of data from the Virginia Department of Health

Figure 6:
Child Maltreatment Rate (2016)



Source: EIV analysis of data from the Virginia Department of Social Services

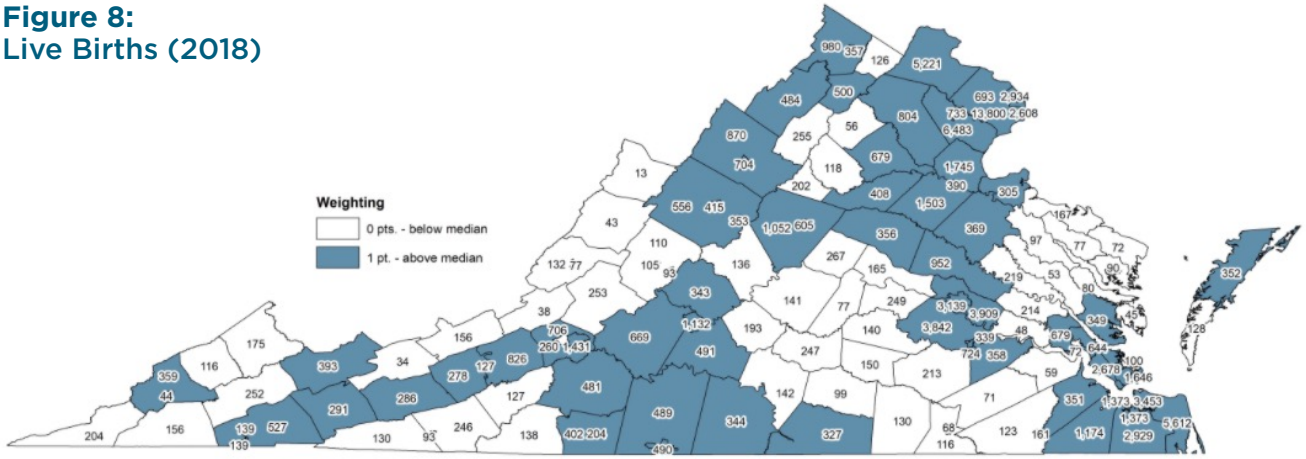
Figure 7:
Children in Food Insecure Homes (2018)



Source: EIV analysis of data from the Virginia Department of Social Services

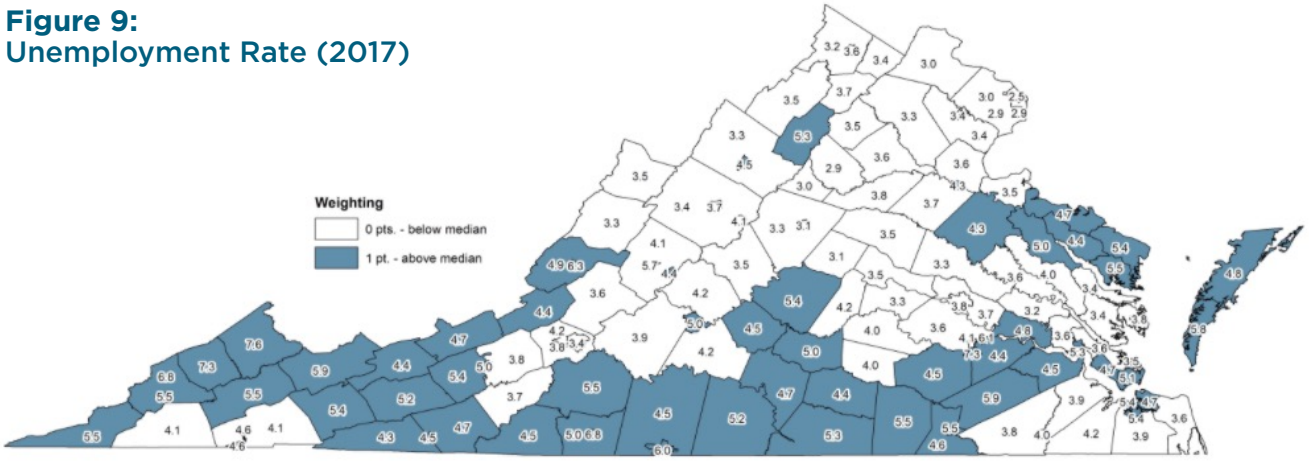
Mapping Indicators of Risk by Locality (Weight = 0-1 point)

Figure 8:
Live Births (2018)



Source: EIV analysis of data from the Virginia Department of Health

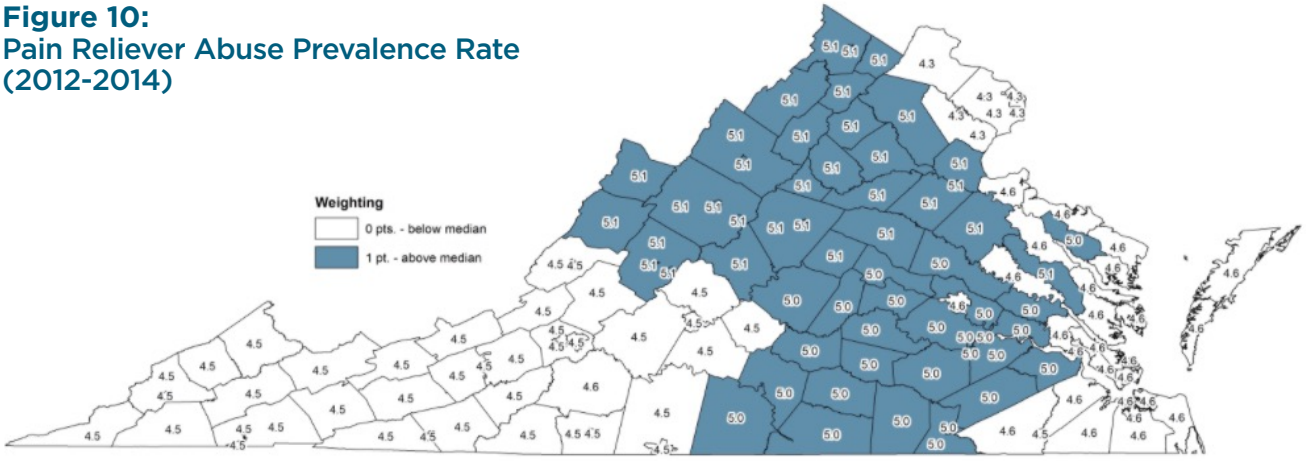
Figure 9:
Unemployment Rate (2017)



Source: EIV analysis of data from the Bureau of Labor Statistics

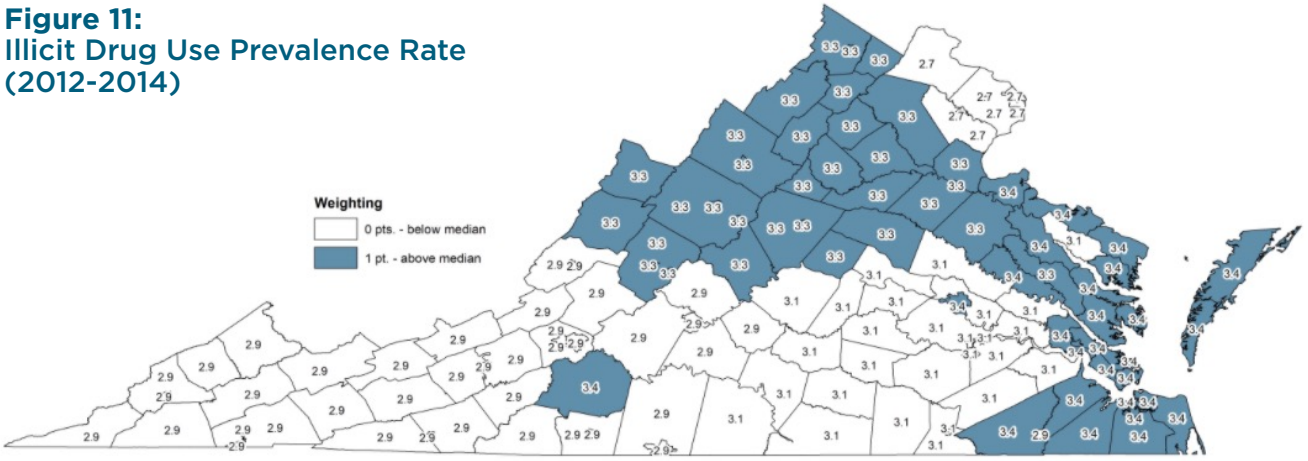
Mapping Indicators of Risk by Locality (Weight = 0-1 point)

Figure 10:
Pain Reliever Abuse Prevalence Rate (2012-2014)



Source: EIV analysis of data from the SAMHSA National Survey of Drug Use and Health

Figure 11:
Illicit Drug Use Prevalence Rate (2012-2014)



Source: EIV analysis of data from the SAMHSA National Survey of Drug Use and Health

APPENDIX B

Needs Assessment Data Summary

Description of Indicators			
Data Point	**Description**	**Year**	**Source**
# of Live Births	# of live births Live Births: A live birth is defined as the complete expulsion or extraction of a product of human conception from its mother, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. (Vital Statistics Laws of Virginia, Chapter 7, Section 32.1-249.7)	2018	Virginia Department of Health, Office of Information Management, Division of Health Statistics; compiled from birth and death certificate files by the Division of Population Health Data, Office of Family Health Services
Teen Pregnancy Rate	Pregnancy rate = (number pregnancies to females ages 15-19) / number of females in a specific age group) x 1,000	2018	Virginia Birth, Fetal Death, and Induced Termination Vital Events Records; Virginia Department of Health, Office of Information Management, Division of Health Statistics; compiled by the Division of Population Health Data, Office of Family Health Services
Preterm Birth Rate	% preterm births = (number of births to less than 37 weeks gestation / number of live births) x 100 A birth of a live born infant before 37 completed weeks of gestation.	2018	Virginia Department of Health, Office of Information Management, Division of Health Statistics; compiled from birth and death certificate files by the Division of Population Health Data, Office of Family Health Services
% Low Birth Weight	% low weight births = (number of births less than 2,500 grams / number of live births) x 100 A birth weight of less than 2,500 grams (approximately 5.5 lbs) or less	2018	Virginia Department of Health, Office of Information Management, Division of Health Statistics; compiled from birth and death certificate files by the Division of Population Health Data, Office of Family Health Services
% Late/No Prenatal Care	% late or no prenatal care = (number of births to moms who had late or no prenatal care / number of live births) x 100	2018	Virginia Department of Health, Office of Information Management, Division of Health Statistics; compiled from birth and death certificate files by the Division of Population Health Data, Office of Family Health Services
Unemployment Rate	Unemployed percent of the civilian labor force	2017	Bureau of Labor Statistics
High School Dropout Rate	% of 16-19 year olds not enrolled in school with no high school diploma - 5 Yr Estimate	2017	American Community Survey
Alcohol Abuse Prev. Rate	Prevalence rate: Binge alcohol use in past month	2012-2014	SAMHSA - National Survey of Drug Use and Health
Marijuana Abuse Prev. Rate	Prevalence rate: Marijuana use in past month	2014-2016	SAMHSA - National Survey of Drug Use and Health
Illicit Drug Use Prev. Rate	Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month	2012-2014	SAMHSA - National Survey of Drug Use and Health
Pain Relievers Abuse Prev. Rate	Prevalence rate: Nonmedical use of pain medication in past year	2012-2014	SAMHSA - National Survey of Drug Use and Health
Crime Reports	# reported crimes/1000 residents	2016	Institute for Social Research - National Archive of Criminal Justice Data

(Continued on next page)

Description of Indicators			
Data Point	**Description**	**Year**	**Source**
Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17	2016	Institute for Social Research - National Archive of Criminal Justice Data
Child Maltreatment Rate	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	2016	Administration for Children & Families (ACF)
Children in Poverty	% children, ages 0-6, living below 200% FPL	2018	American Community Survey
Children in Food Insecure Homes	% of children identified as food insecure of the total child population Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Percentage reflects number of children identified as food insecure of the total child population.	2018	Map the Meal Gap: Food Insecurity and Child Food Insecurity Estimates at the County Level. Feeding America.

Descriptive Statistics											
Data Point	**Description**	**Year**	**Missing (n)**	**Missing (%)**	**Mean of Counties**	**SD**	**Median**	**IQR**	**Min**	**Max**	**State Estimate**
# of Live Births	# of live births Live Births: A live birth is defined as the complete expulsion or extraction of a product of human conception from its mother, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. (Vital Statistics Laws of Virginia, Chapter 7, Section 32.1-249.7)"	2018	0.0	0.0	750.3	1575.1	267.0	517.0	13.0	13800.0	99792
Teen Pregnancy Rate	Pregnancy rate = (number pregnancies to females ages 15-19) / number of females in a specific age group) x 1,000	2018	0.0	0.0	23.3	14.7	20.0	15.8	1.8	90.7	19.2
Preterm Birth Rate	% preterm births = (number of births to less than 37 weeks gestation / number of live births) x 100 A birth of a live born infant before 37 completed weeks of gestation.	2018	0.0	0.0	10.1	3.3	9.5	3.4	3.2	30.8	9.4
% Low Birth Weight	% low weight births = (number of births less than 2,500 grams / number of live births) x 100 A birth weight of less than 2,500 grams (approximately 5.5 lbs) or less	2018	0.0	0.0	8.9	3.1	8.5	3.5	3.8	23.1	8.2
% Late/No Prenatal Care	% late or no prenatal care = (number of births to moms who had late or no prenatal care / number of live births) x 100	2018	0.0	0.0	4.7	2.8	4.3	3.3	0.0	18.8	4.6
Unemployment Rate	Unemployed percent of the civilian labor force	2017	0.0	0.0	4.3	1.0	4.2	1.5	2.5	7.6	3.8
High School Dropout Rate	% of 16-19 year olds not enrolled in school with no high school diploma - 5 Yr Estimate	2017	0.0	0.0	3.5	4.5	2.2	3.7	0.0	26.2	2.6
Alcohol Abuse Prev. Rate	Prevalence rate: Binge alcohol use in past month	2012-2014	0.0	0.0	22.5	0.5	22.3	0.9	21.8	23.1	22.3
Marijuana Abuse Prev. Rate	Prevalence rate: Marijuana use in past month	2014-2016	0.0	0.0	6.9	0.6	6.8	0.8	5.2	7.5	6.6
Illicit Drug Use Prev. Rate	Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month	2012-2014	0.0	0.0	3.1	0.2	3.1	0.3	2.7	3.4	3.1
Pain Relievers Abuse Prev. Rate	Prevalence rate: Nonmedical use of pain medication in past year	2012-2014	0.0	0.0	4.7	0.3	4.6	0.5	4.3	5.1	4.6
Crime Reports	# reported crimes/1000 residents	2016	0.0	0.0	18.4	11.3	14.7	11.4	3.8	65.2	20.9

(Continued on next page)

Descriptive Statistics											
Data Point	**Description**	**Year**	**Missing (n)**	**Missing (%)**	**Mean of Counties**	**SD**	**Median**	**IQR**	**Min**	**Max**	**State Estimate**
Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17	2016	38.0	28.6	763.3	691.4	566.4	844.7	0.0	3719.4	862.3
Child Maltreatment Rate	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	2016	13.0	9.8	4.8	4.6	2.9	5.2	0.0	21.1	3.2
Children in Poverty	% children, ages 0-6, living below 200% FPL	2018	0.0	0.0	45.6	16.4	48.8	26.0	7.4	77.2	34.6
Children in Food Insecure Homes	% of children identified as food insecure of the total child population Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods. Percentage reflects number of children identified as food insecure of the total child population.	2018	0.0	0.0	15.4	3.6	15.3	5.2	7.8	25.2	13.2

Raw Data																
Locality	# of Live Births	Teen Pregnancy Rate	Preterm Birth Rate	% Low Birth Weight	% Late/ No Prenatal Care	Unemployment Rate	High School Dropout Rate	Alcohol Abuse Prev. Rate	Marijuana Abuse Prev. Rate	Illicit Drug Use Prev. Rate	Pain Relievers Abuse Prev. Rate	Crime Reports	Juvenile Arrests	Child Maltreatment Rate	Children in Poverty	Children in Food Insecure Homes
Accomack County	352	31.75	11.08	13.64	1.70	4.8	23.1	21.8	7.4	3.4	4.6	17.8	456.1	11.6	67.4	18.4
Albemarle County	1,052	6.29	8.46	7.22	5.23	3.3	0.2	22.3	6.7	3.3	5.1	14.9	1422.8	2.5	33.9	11.8
Alleghany County	132	26.76	7.58	6.06	0.76	4.9	9.8	23.1	6.8	2.9	4.5	11.0	372.8	10.7	51.7	18.2
Amelia County	140	11.27	12.14	8.57	0.71	4.0	1.7	22.4	7.5	3.1	5.0	11.6	405.8	0.7	48.1	15.1
Amherst County	343	22.75	5.54	6.71	2.33	4.2	3.3	23.1	6.8	2.9	4.5	10.6	414.7	2.8	40.5	15.7
Appomattox County	193	22.03	9.33	12.44	2.59	4.5	1.1	23.1	6.8	2.9	4.5	9.9	355.0	2.1	38.4	16.0
Arlington County	2,934	10.08	7.53	6.17	10.09	2.5	6.0	22.2	5.2	2.7	4.3	17.6	733.1	2.0	19.5	9.3
Augusta County	556	18.51	8.09	6.47	4.50	3.4	4.3	22.3	6.7	3.3	5.1	11.0	143.4	8.2	32.4	13.0
Bath County	43	34.88	9.30	4.65	6.98	3.3	0.0	22.3	6.7	3.3	5.1	6.6	0.0	9.1	57.2	10.9
Bedford County	669	18.93	9.42	7.62	2.99	3.9	3.8	23.1	6.8	2.9	4.5	10.7	630.1	2.3	28.7	12.9
Bland County	34	7.46	8.82	8.82	0.00	4.4	0.0	23.1	6.8	2.9	4.5	9.4	0.0	7.5	63.5	14.7
Botetourt County	253	12.78	7.91	7.51	2.37	3.6	2.1	23.1	6.8	2.9	4.5	8.3	2032.0	0.7	36.8	12.4
Brunswick County	130	23.87	16.92	12.31	4.62	5.5	1.1	22.4	7.5	3.1	5.0	7.1	502.5	1.7	63.0	21.0
Buchanan County	175	41.83	10.29	8.57	0.00	7.6	4.1	23.1	6.8	2.9	4.5	18.5	635.3	12.5	68.6	25.2
Buckingham County	141	27.70	14.18	8.51	6.38	5.4	1.0	22.4	7.5	3.1	5.0	9.9	378.3	2.4	60.1	16.6
Campbell County	491	19.49	7.33	8.76	5.09	4.2	2.1	23.1	6.8	2.9	4.5	15.9	100.7	2.7	44.0	14.1
Caroline County	369	24.27	12.47	8.40	4.34	4.3	6.9	22.3	6.7	3.3	5.1	12.3	297.2	2.2	32.8	14.9
Carroll County	246	21.68	6.10	5.69	4.07	4.7	3.8	23.1	6.8	2.9	4.5	15.8	160.7	11.2	53.6	15.5
Charles City County	48	13.42	8.33	10.42	2.08	4.8	3.8	22.4	7.5	3.1	5.0	7.2	636.9	0.0	40.7	16.1
Charlotte County	142	24.17	10.56	11.27	9.86	4.7	5.7	22.4	7.5	3.1	5.0	11.3	228.7	1.1	71.8	18.9
Chesterfield County	3,842	15.32	9.58	7.96	2.11	3.6	2.8	22.4	7.5	3.1	5.0	21.1	2926.0	1.4	27.2	11.0
Clarke County	126	15.91	3.17	5.56	2.38	3.4	0.0	22.3	6.7	3.3	5.1	10.9	934.0	6.1	28.6	14.2
Craig County	38	41.38	7.89	7.89	0.00	4.4	0.0	23.1	6.8	2.9	4.5	5.2	0.0	0.0	12.7	12.5
Culpeper County	679	21.62	8.39	6.48	6.33	3.6	4.0	22.3	6.7	3.3	5.1	12.0	1084.1	2.3	32.4	11.8
Cumberland County	77	17.67	7.79	6.49	3.90	4.2	0.0	22.4	7.5	3.1	5.0	9.2	51.8	2.0	60.6	21.5
Dickenson County	116	16.00	5.17	8.62	0.86	7.3	4.7	23.1	6.8	2.9	4.5	12.7	370.0	16.9	60.9	22.5
Dinwiddie County	213	6.98	7.98	8.45	5.16	4.5	8.7	22.4	7.5	3.1	5.0	14.0	850.6	1.4	47.7	15.9
Essex County	97	24.47	13.40	13.40	3.09	5.0	1.2	21.8	7.4	3.4	4.6	15.1	318.9	0.4	55.0	14.1
Fairfax County	13,800	10.54	7.75	6.69	4.29	2.9	1.9	22.2	5.2	2.7	4.3	18.2			20.4	9.5

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Raw Data																
Locality	# of Live Births	Teen Pregnancy Rate	Preterm Birth Rate	% Low Birth Weight	% Late/ No Prenatal Care	Unemployment Rate	High School Dropout Rate	Alcohol Abuse Prev. Rate	Marijuana Abuse Prev. Rate	Illicit Drug Use Prev. Rate	Pain Relievers Abuse Prev. Rate	Crime Reports	Juvenile Arrests	Child Maltreatment Rate	Children in Poverty	Children in Food Insecure Homes
Fauquier County	804	11.83	7.84	5.85	6.09	3.3	1.8	22.3	6.7	3.3	5.1	10.3	339.6	1.4	16.7	10.6
Floyd County	127	4.68	7.09	7.87	2.36	3.7	0.0	23.1	6.8	2.9	4.5	8.6	2110.9	1.6	52.6	13.3
Fluvanna County	267	15.54	7.87	8.61	5.24	3.1	7.9	22.3	6.7	3.3	5.1	8.5	92.7	6.4	7.4	10.5
Franklin County	481	17.58	10.19	10.60	3.53	5.5	4.8	21.8	7.4	3.4	4.6	40.0		5.9	54.8	17.2
Frederick County	980	15.44	10.51	8.37	4.08	3.2	1.5	22.3	6.7	3.3	5.1	13.8	1288.7	1.9	29.1	10.3
Giles County	156	26.10	8.33	9.62	4.49	4.7	4.1	23.1	6.8	2.9	4.5	13.6	485.7	18.9	52.5	14.5
Gloucester County	349	10.89	10.32	7.74	4.58	3.4	0.6	21.8	7.4	3.4	4.6	15.0	1027.3	3.4	32.2	12.9
Goochland County	165	3.10	18.18	10.91	2.42	3.5	3.8	22.4	7.5	3.1	5.0	8.9	23.6	1.9	16.7	10.5
Grayson County	130	15.39	5.38	3.85	2.31	4.3	1.3	23.1	6.8	2.9	4.5	11.7	72.9	2.6	66.2	20.8
Greene County	202	14.24	5.45	5.45	3.96	3.0	3.0	22.3	6.7	3.3	5.1	10.9	1287.6	1.3	47.4	12.0
Greensville County	116	44.00	6.90	6.90	6.90	4.6	0.8	22.4	7.5	3.1	5.0	9.4	768.0	4.2	64.9	16.0
Halifax County	344	25.32	9.30	11.63	3.49	5.2	8.5	22.4	7.5	3.1	5.0	13.1	376.1	1.5	38.2	17.5
Hanover County	952	9.31	7.98	5.99	2.00	3.3	0.5	22.4	7.5	3.1	5.0	13.7	1342.3	0.4	18.3	11.1
Henrico County	3,909	15.05	8.93	8.52	2.33	3.7	0.3	22.4	7.5	3.1	5.0	27.2	1688.8	1.7	32.2	13.3
Henry County	402	28.07	8.21	6.97	5.47	5.0	3.0	23.1	6.8	2.9	4.5	28.0	830.1	7.0	59.5	19.4
Highland County	13	46.51	30.77	23.08	7.69	3.5	0.0	22.3	6.7	3.3	5.1	12.8	0.0	9.7	53.9	14.3
Isle of Wight County	351	15.37	10.26	9.12	4.84	3.9	4.9	21.8	7.4	3.4	4.6	14.7	506.2	5.3	34.0	14.1
James City County	679	14.94	7.95	7.07	7.07	3.6	3.4	21.8	7.4	3.4	4.6	16.8	2626.2	1.9	28.6	11.7
King and Queen County	53	25.48	13.21	15.09	7.55	4.0	3.6	22.3	6.7	3.3	5.1	11.1	196.8	1.7	43.2	19.4
King George County	305	18.52	11.48	8.20	3.28	3.5	1.6	21.8	7.4	3.4	4.6	7.1	820.3	0.8	24.5	11.8
King William County	219	20.28	7.76	6.39	2.28	3.6	0.0	21.8	7.4	3.4	4.6	9.9	1055.0	4.4	32.5	16.0
Lancaster County	90	58.82	12.22	12.22	5.56	5.5	0.0	21.8	7.4	3.4	4.6	15.2	485.4	1.2	67.7	14.1
Lee County	204	48.99	11.76	12.25	4.41	5.5	3.7	23.1	6.8	2.9	4.5	15.2	22.1	13.0	66.1	21.9
Loudoun County	5,221	7.44	8.60	7.05	2.53	3.0	1.3	22.2	5.2	2.7	4.3	10.6	409.5	0.3	12.6	8.2
Louisa County	356	21.01	9.83	7.87	3.09	3.5	6.1	22.3	6.7	3.3	5.1	14.1	96.0	4.7	36.5	13.8
Lunenburg County	99	22.73	13.13	12.12	7.07	4.4	2.9	22.4	7.5	3.1	5.0	8.1	1354.3	3.4	66.4	17.7
Madison County	118	9.85	8.47	7.63	2.54	2.9	10.0	22.3	6.7	3.3	5.1	8.8	301.9	10.1	60.5	12.0
Mathews County	45	4.39	11.11	8.89	2.22	3.8	23.1	21.8	7.4	3.4	4.6	9.0	851.1	2.7	58.4	16.1
Mecklenburg County	327	30.53	9.79	7.34	2.75	5.3	1.5	22.4	7.5	3.1	5.0	15.7	274.1	8.9	53.8	16.8

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Raw Data																
Locality	# of Live Births	Teen Pregnancy Rate	Preterm Birth Rate	% Low Birth Weight	% Late/ No Prenatal Care	Unemployment Rate	High School Dropout Rate	Alcohol Abuse Prev. Rate	Marijuana Abuse Prev. Rate	Illicit Drug Use Prev. Rate	Pain Relievers Abuse Prev. Rate	Crime Reports	Juvenile Arrests	Child Maltreatment Rate	Children in Poverty	Children in Food Insecure Homes
Middlesex County	80	4.17	5.00	5.00	1.25	3.4	3.0	21.8	7.4	3.4	4.6	13.5	234.7	18.6	49.1	13.9
Montgomery County	826	8.40	7.63	6.30	2.91	3.8	0.5	23.1	6.8	2.9	4.5	16.6	335.0	7.7	34.2	14.1
Nelson County	136	34.48	9.56	8.82	10.29	3.5	0.0	22.3	6.7	3.3	5.1	13.8	107.0	5.1	31.2	15.5
New Kent County	214	10.27	13.08	7.94	3.74	3.2	0.2	22.4	7.5	3.1	5.0	14.8	1219.5	0.9	26.2	11.1
Northampton County	128	51.66	13.28	10.94	5.47	5.8	8.0	21.8	7.4	3.4	4.6	11.0	1262.7	1.7	61.7	20.4
Northumberland County	72	16.46	5.56	4.17	2.78	5.4	0.0	21.8	7.4	3.4	4.6	11.1	430.8	2.1	60.3	18.0
Nottoway County	150	34.57	11.33	10.00	4.00	4.0	9.0	22.4	7.5	3.1	5.0	17.2	888.5	1.0	63.8	15.5
Orange County	408	21.97	9.31	9.07	5.39	3.8	7.3	22.3	6.7	3.3	5.1	10.0	287.6	1.0	47.1	13.8
Page County	255	29.65	9.02	7.06	4.71	5.3	3.3	22.3	6.7	3.3	5.1	17.1	487.6	1.2	59.6	18.7
Patrick County	138	16.79	7.25	6.52	5.07	4.5	2.6	23.1	6.8	2.9	4.5	14.6	31.4	4.5	54.2	22.2
Pittsylvania County	489	26.36	10.43	8.79	3.48	4.5	5.1	23.1	6.8	2.9	4.5	7.7	108.1	1.5	57.7	16.5
Powhatan County	249	6.96	9.64	8.03	1.20	3.3	3.7	22.4	7.5	3.1	5.0	8.4	1050.5	0.0	11.5	10.6
Prince Edward County	247	7.13	13.36	12.55	6.88	5.0	1.9	22.4	7.5	3.1	5.0	16.8	589.8	1.9	68.4	15.4
Prince George County	358	20.13	10.61	8.94	2.79	4.4	0.9	22.4	7.5	3.1	5.0	12.4	1228.3	1.3	48.8	15.3
Prince William County	6,483	17.95	8.92	7.31	8.21	3.4	1.4	22.2	5.2	2.7	4.3	13.7	1552.5	4.5	27.2	10.0
Pulaski County	278	36.59	8.27	10.43	3.60	5.4	1.7	23.1	6.8	2.9	4.5	29.3	902.5	21.1	46.5	17.5
Rappahannock County	56	10.15	14.29	7.14	5.36	3.5	0.0	22.3	6.7	3.3	5.1	3.8	153.0	2.2	33.7	12.4
Richmond County	77	18.35	10.39	6.49	3.90	4.4	4.1	22.4	7.5	3.1	5.0	45.7		4.6	53.8	17.4
Roanoke County	706	13.99	9.49	6.94	3.12	4.2	3.9	23.1	6.8	2.9	4.5	46.7		12.7	26.1	12.3
Rockbridge County	110	9.04	8.18	7.27	2.73	4.1	15.7	22.3	6.7	3.3	5.1	13.4	1118.7	3.5	55.4	17.0
Rockingham County	870	18.35	8.74	7.01	4.71	3.3	3.6	22.3	6.7	3.3	5.1	10.2	571.9	8.6	40.3	13.4
Russell County	252	36.62	10.71	8.73	1.59	5.5	5.3	23.1	6.8	2.9	4.5	15.8	979.1	10.8	60.6	18.2
Scott County	156	27.13	6.41	5.77	0.00	4.1	0.0	23.1	6.8	2.9	4.5	12.3	3719.4	6.6	43.7	16.7
Shenandoah County	484	18.96	8.47	6.82	6.61	3.5	0.3	22.3	6.7	3.3	5.1	13.3	1761.3	4.7	47.5	13.1
Smyth County	291	33.45	8.59	7.22	3.78	5.4	3.3	23.1	6.8	2.9	4.5	21.5	989.0	16.2	55.9	18.4
Southampton County	123	20.20	15.45	10.57	6.50	3.8	0.0	21.8	7.4	3.4	4.6	11.7	86.1	0.0	36.2	13.9
Spotsylvania County	1,503	15.61	10.45	9.05	6.25	3.7	2.3	22.3	6.7	3.3	5.1	14.7	132.3	2.7	31.1	11.8
Stafford County	1,745	11.34	8.54	7.39	3.50	3.6	3.5	22.3	6.7	3.3	5.1	14.9	272.5	1.2	20.6	10.1
Surry County	59	17.34	15.25	13.56	10.17	4.5	0.3	22.4	7.5	3.1	5.0	10.8	608.2	0.0	43.8	15.2

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Raw Data																
Locality	# of Live Births	Teen Pregnancy Rate	Preterm Birth Rate	% Low Birth Weight	% Late/ No Prenatal Care	Unemployment Rate	High School Dropout Rate	Alcohol Abuse Prev. Rate	Marijuana Abuse Prev. Rate	Illicit Drug Use Prev. Rate	Pain Relievers Abuse Prev. Rate	Crime Reports	Juvenile Arrests	Child Maltreatment Rate	Children in Poverty	Children in Food Insecure Homes
Sussex County	71	22.52	15.49	15.49	2.82	5.9	8.6	22.4	7.5	3.1	5.0	11.2	976.7	3.2	72.8	17.6
Tazewell County	393	44.44	11.45	9.92	3.31	5.9	1.8	23.1	6.8	2.9	4.5	22.7	1183.1	6.6	56.4	18.2
Warren County	500	13.82	10.20	8.80	6.40	3.7	1.1	22.3	6.7	3.3	5.1	15.9	1249.9	1.8	35.7	13.7
Washington County	527	24.13	11.01	10.44	1.71	4.1	1.9	23.1	6.8	2.9	4.5	19.6	566.4	4.8	49.2	16.2
Westmoreland County	167	25.94	12.57	10.18	4.79	4.7	0.0	21.8	7.4	3.4	4.6	12.0	392.5	3.0	34.5	11.0
Wise County	359	38.43	13.09	12.81	4.74	6.8	1.7	23.1	6.8	2.9	4.5	17.5	1653.7	14.4	57.9	20.4
Wythe County	286	25.28	9.09	9.09	2.80	5.2	4.9	23.1	6.8	2.9	4.5	15.2	1076.4	13.0	56.3	17.1
York County	644	6.95	9.01	7.76	3.73	3.6	1.7	21.8	7.4	3.4	4.6	20.7	2302.9	1.5	23.0	11.1
Alexandria City	2,608	28.07	7.29	7.09	4.41	2.9	7.2	22.2	5.2	2.7	4.3	20.2		1.7	32.8	12.1
Bristol City	139	19.32	6.47	10.07	0.72	4.6	2.0	23.1	6.8	2.9	4.5	28.0		6.8	66.8	21.4
Buena Vista City	93	6.73	9.68	6.45	3.23	4.4	0.0	22.3	6.7	3.3	5.1	9.1			60.2	19.9
Charlottesville City	605	14.03	6.61	4.13	5.62	3.1	4.1	22.3	6.7	3.3	5.1	31.5		6.2	40.1	14.6
Chesapeake City	2,929	20.05	10.96	8.77	2.46	3.9	1.6	21.8	7.4	3.4	4.6	29.8		1.7	34.0	13.2
Colonial Heights	282	37.18	10.28	9.93	3.55	4.1	1.7	22.4	7.5	3.1	5.0	49.6			55.3	15.8
Covington City	77	17.86	15.58	12.99	11.69	6.3	26.2	23.1	6.8	2.9	4.5	25.5			25.4	21.0
Danville City	490	41.78	16.12	18.37	7.55	6.0	3.1	23.1	6.8	2.9	4.5	45.2		3.3	61.8	19.5
Emporia City	68	33.90	7.35	7.35	5.88	5.5	18.8	22.4	7.5	3.1	5.0	55.0			77.2	24.9
Fairfax City	693	25.16	8.37	5.77	3.90	3.0	1.9	22.2	5.2	2.7	4.3	14.4	1758.9	0.9	18.9	8.8
Falls Church City	188	4.53	6.38	4.26	3.72	2.7	0.0	22.2	5.2	2.7	4.3	17.4			7.5	7.8
Franklin City	161	35.40	17.39	14.29	6.83	4.0	4.3	23.1	6.8	2.9	4.5	14.7	1455.4	3.6	71.1	16.3
Fredericksburg City	390	19.62	8.72	7.69	5.64	4.3	0.0	22.3	6.7	3.3	5.1	40.3		6.2	26.5	15.0
Galax City	93	40.20	17.20	18.28	6.45	4.5	0.0	23.1	6.8	2.9	4.5	35.3		8.7	62.7	17.7
Hampton City	1,646	26.84	11.00	10.02	4.44	5.1	2.7	21.8	7.4	3.4	4.6	38.3		3.1	49.7	15.8
Harrisonburg City	704	10.44	9.09	8.52	8.10	4.5	0.3	22.3	6.7	3.3	5.1	23.2			56.4	14.8
Hopewell City	339	57.36	14.16	18.29	5.01	6.1	6.0	22.4	7.5	3.1	5.0	33.8		8.6	65.8	19.7
Lexington City	105	5.65	7.62	4.76	7.62	5.7	0.0	22.3	6.7	3.3	5.1	12.0			54.4	16.1
Lynchburg City	1,132	18.19	6.18	7.60	4.06	5.0	2.2	23.1	6.8	2.9	4.5	26.5		9.9	52.6	18.6
Manassas City	733	50.48	9.55	6.68	15.01	3.4	9.2	22.2	5.2	2.7	4.3	11.5		1.9	37.6	10.9
Manassas Park City	16	1.84	6.25	6.25	18.75	3.4	2.2	22.2	5.2	2.7	4.3	22.5		1.0	42.8	11.4

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Raw Data																
Locality	**# of Live Births**	**Teen Pregnancy Rate**	**Preterm Birth Rate**	**% Low Birth Weight**	**% Late/ No Prenatal Care**	**Unemployment Rate**	**High School Dropout Rate**	**Alcohol Abuse Prev. Rate**	**Marijuana Abuse Prev. Rate**	**Illicit Drug Use Prev. Rate**	**Pain Relievers Abuse Prev. Rate**	**Crime Reports**	**Juvenile Arrests**	**Child Maltreatment Rate**	**Children in Poverty**	**Children in Food Insecure Homes**
Martinsville City	204	50.15	12.75	14.22	10.78	6.8	0.0	23.1	6.8	2.9	4.5	29.2			61.7	21.0
Newport News City	2,678	29.39	11.02	10.42	5.71	4.7	1.5	21.8	7.4	3.4	4.6	36.4		5.0	49.0	16.7
Norfolk City	3,453	36.27	12.31	11.00	3.85	4.7	2.9	21.8	7.4	3.4	4.6	48.4		6.9	56.1	18.4
Norton City	44	69.31	11.36	11.36	6.82	5.5	0.0	23.1	6.8	2.9	4.5	41.9		9.9	71.0	22.2
Petersburg City	724	90.66	11.19	10.36	6.77	7.3	6.9	22.4	7.5	3.1	5.0	43.4		4.4	71.1	23.3
Poquoson City	100	7.96	7.00	5.00	1.00	3.5	6.1	21.8	7.4	3.4	4.6	15.9			31.9	10.7
Portsmouth City	1,373	44.38	13.40	11.36	5.10	5.4	4.8	21.8	7.4	3.4	4.6	65.2		5.3	58.5	18.6
Radford City	127	7.44	11.81	14.96	4.72	5.0	1.2	23.1	6.8	2.9	4.5	27.5		13.8	38.7	17.1
Richmond City	3,139	43.44	10.45	10.42	4.94	3.8	0.0	21.8	7.4	3.4	4.6	7.4	472.7	0.0	60.1	20.2
Roanoke City	1,431	57.64	10.06	8.87	5.03	3.4	1.2	23.1	6.8	2.9	4.5	16.9	1143.0	1.9	55.6	19.0
Salem City	260	15.72	8.46	4.62	3.08	3.8	0.2	23.1	6.8	2.9	4.5	22.0			26.0	13.6
Staunton City	415	36.88	12.77	10.84	6.75	3.7	4.8	22.3	6.7	3.3	5.1	23.9			53.0	15.4
Suffolk City	1,174	27.42	10.73	9.11	5.79	4.2	2.8	21.8	7.4	3.4	4.6	27.3		0.8	32.9	13.6
Virginia Beach City	5,612	19.04	10.41	8.46	3.28	3.6	2.0	21.8	7.4	3.4	4.6	23.6		2.2	31.7	12.3
Waynesboro City	353	37.43	12.75	9.35	7.08	4.1	11.1	22.3	6.7	3.3	5.1	25.1			56.3	16.6
Williamsburg City	72	3.72	8.33	6.94	11.11	5.3	0.0	21.8	7.4	3.4	4.6	26.3		3.6	51.3	14.4
Winchester City	357	22.31	10.36	8.96	6.44	3.6	0.0	22.3	6.7	3.3	5.1	31.0		4.9	58.2	14.1

Weighting (Points Assigned)																	
Points Assigned Based On:																	
Locality	Total Points	# of Live Births	Teen Pregnancy Rate	Preterm Birth Rate	% Low Birth Weight	% Late/ No Prenatal Care	Unemployment Rate	High School Dropout Rate	Alcohol Abuse Prev. Rate	Marijuana Abuse Prev. Rate	Illicit Drug Use Prev. Rate	Pain Relievers Abuse Prev. Rate	Crime Reports	Juvenile Arrests	Child Maltreament Rate	Children in Poverty	Children in Food Insecure Homes
Accomack County	15.5	1	2	1	2	0	1	0.5	0	0.5	1	0	0.5	0	2	2	2
Albemarle County	5	1	0	0	0	1	0	0	0	0	1	1	0.5	0.5	0	0	0
Alleghany County	8	0	1	0	0	0	1	0.5	0.5	0	0	0	0	0	2	1	2
Amelia County	5	0	0	2	1	0	0	0	0.5	0.5	0	1	0	0	0	0	0
Amherst County	4	1	1	0	0	0	0	0.5	0.5	0	0	0	0	0	0	0	1
Appomattox County	5.5	0	1	0	2	0	1	0	0.5	0	0	0	0	0	0	0	1
Arlington County	4.5	1	0	0	0	2	0	0.5	0	0	0	0	0.5	0.5	0	0	0
Augusta County	6.5	1	0	0	0	1	0	0.5	0	0	1	1	0	0	2	0	0
Bath County	9	0	2	0	0	2	0	0	0	0	1	1	0	0	2	1	0
Bedford County	2.5	1	0	0	0	0	0	0.5	0.5	0	0	0	0	0.5	0	0	0
Bland County	6.5	0	0	0	1	0	1	0	0.5	0	0	0	0	0	2	2	0
Botetourt County	1	0	0	0	0	0	0	0	0.5	0	0	0	0	0.5	0	0	0
Brunswick County	13	0	1	2	2	1	1	0	0.5	0.5	0	1	0	0	0	2	2
Buchanan County	13	0	2	1	1	0	1	0.5	0.5	0	0	0	0.5	0.5	2	2	2
Buckingham County	11	0	1	2	0	2	1	0	0.5	0.5	0	1	0	0	0	2	1
Campbell County	4	1	0	0	1	1	0	0	0.5	0	0	0	0.5	0	0	0	0
Caroline County	7.5	1	1	2	0	0	1	0.5	0	0	1	1	0	0	0	0	0
Carroll County	7.5	0	1	0	0	0	1	0.5	0.5	0	0	0	0.5	0	2	1	1
Charles City County	6	0	0	0	1	0	1	0.5	0.5	0.5	0	1	0	0.5	0	0	1
Charlotte County	13.5	0	1	1	2	2	1	0.5	0.5	0.5	0	1	0	0	0	2	2
Chesterfield County	5.5	1	0	1	0	0	0	0.5	0.5	0.5	0	1	0.5	0.5	0	0	0
Clarke County	3.5	0	0	0	0	0	0	0	0	0	1	1	0	0.5	1	0	0
Craig County	3.5	0	2	0	0	0	1	0	0.5	0	0	0	0	0	0	0	0
Culpeper County	7	1	1	0	0	2	0	0.5	0	0	1	1	0	0.5	0	0	0
Cumberland County	6	0	0	0	0	0	0	0	0.5	0.5	0	1	0	0	0	2	2
Dickenson County	9	0	0	0	1	0	1	0.5	0.5	0	0	0	0	0	2	2	2
Dinwiddie County	6	0	0	0	0	1	1	0.5	0.5	0.5	0	1	0	0.5	0	0	1
Essex County	9	0	1	2	2	0	1	0	0	0.5	1	0	0.5	0	0	1	0
Fairfax County	1.5	1	0	0	0	0	0	0	0	0	0	0	0.5	0	0	0	0
Fauquier County	4	1	0	0	0	1	0	0	0	0	1	1	0	0	0	0	0

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Weighting (Points Assigned)																	
Points Assigned Based On:																	
Locality	Total Points	# of Live Births	Teen Pregnancy Rate	Preterm Birth Rate	% Low Birth Weight	% Late/ No Prenatal Care	Unemployment Rate	High School Dropout Rate	Alcohol Abuse Prev. Rate	Marijuana Abuse Prev. Rate	Illicit Drug Use Prev. Rate	Pain Relievers Abuse Prev. Rate	Crime Reports	Juvenile Arrests	Child Maltreament Rate	Children in Poverty	Children in Food Insecure Homes
Floyd County	2	0	0	0	0	0	0	0	0.5	0	0	0	0	0.5	0	1	0
Fluvanna County	5.5	0	0	0	1	1	0	0.5	0	0	1	1	0	0	1	0	0
Franklin County	10.5	1	0	1	2	0	1	0.5	0	0.5	1	0	0.5	0	1	1	1
Frederick County	4.5	1	0	1	0	0	0	0	0	0	1	1	0	0.5	0	0	0
Giles County	8	0	1	0	1	1	1	0.5	0.5	0	0	0	0	0	2	1	0
Gloucester County	6.5	1	0	1	0	1	0	0	0	0.5	1	0	0.5	0.5	1	0	0
Goochland County	6.5	0	0	2	2	0	0	0.5	0.5	0.5	0	1	0	0	0	0	0
Grayson County	5.5	0	0	0	0	0	1	0	0.5	0	0	0	0	0	0	2	2
Greene County	3	0	0	0	0	0	0	0.5	0	0	1	1	0	0.5	0	0	0
Greensville County	11.5	0	2	0	0	2	1	0	0.5	0.5	0	1	0	0.5	1	2	1
Halifax County	8.5	1	1	0	2	0	1	0.5	0.5	0.5	0	1	0	0	0	0	1
Hanover County	3.5	1	0	0	0	0	0	0	0.5	0.5	0	1	0	0.5	0	0	0
Henrico County	5	1	0	0	1	0	0	0	0.5	0.5	0	1	0.5	0.5	0	0	0
Henry County	12	1	1	0	0	1	1	0.5	0.5	0	0	0	0.5	0.5	2	2	2
Highland County	13	0	2	2	2	2	0	0	0	0	1	1	0	0	2	1	0
Isle of Wight County	7	1	0	1	1	1	0	0.5	0	0.5	1	0	0	0	1	0	0
James City County	6	1	0	0	0	2	0	0.5	0	0.5	1	0	0.5	0.5	0	0	0
King and Queen County	11.5	0	1	2	2	2	0	0.5	0	0	1	1	0	0	0	0	2
King George County	5	1	0	2	0	0	0	0	0	0.5	1	0	0	0.5	0	0	0
King William County	5	0	1	0	0	0	0	0	0	0.5	1	0	0	0.5	1	0	1
Lancaster County	12	0	2	2	2	1	1	0	0	0.5	1	0	0.5	0	0	2	0
Lee County	15.5	0	2	2	2	1	1	0.5	0.5	0	0	0	0.5	0	2	2	2
Loudoun County	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Louisa County	6.5	1	1	1	0	0	0	0.5	0	0	1	1	0	0	1	0	0
Lunenburg County	15	0	1	2	2	2	1	0.5	0.5	0.5	0	1	0	0.5	1	2	1
Madison County	6.5	0	0	0	0	0	0	0.5	0	0	1	1	0	0	2	2	0
Mathews County	6.5	0	0	1	1	0	0	0.5	0	0.5	1	0	0	0.5	0	1	1

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Weighting (Points Assigned)																	
Points Assigned Based On:																	
Locality	Total Points	# of Live Births	Teen Pregnancy Rate	Preterm Birth Rate	% Low Birth Weight	% Late/ No Prenatal Care	Unemployment Rate	High School Dropout Rate	Alcohol Abuse Prev. Rate	Marijuana Abuse Prev. Rate	Illicit Drug Use Prev. Rate	Pain Relievers Abuse Prev. Rate	Crime Reports	Juvenile Arrests	Child Maltreament Rate	Children in Poverty	Children in Food Insecure Homes
Mecklenburg County	11.5	1	2	1	0	0	1	0	0.5	0.5	0	1	0.5	0	2	1	1
Middlesex County	5	0	0	0	0	0	0	0.5	0	0.5	1	0	0	0	2	1	0
Montgomery County	4	1	0	0	0	0	0	0	0.5	0	0	0	0.5	0	2	0	0
Nelson County	10	0	2	1	1	2	0	0	0	0	1	1	0	0	1	0	1
New Kent County	5	0	0	2	0	0	0	0	0.5	0.5	0	1	0.5	0.5	0	0	0
Northampton County	14.5	0	2	2	2	1	1	0.5	0	0.5	1	0	0	0.5	0	2	2
Northumberland County	6.5	0	0	0	0	0	1	0	0	0.5	1	0	0	0	0	2	2
Nottoway County	10.5	0	2	1	1	0	0	0.5	0.5	0.5	0	1	0.5	0.5	0	2	1
Orange County	6.5	1	1	0	1	1	0	0.5	0	0	1	1	0	0	0	0	0
Page County	10	0	1	0	0	1	1	0.5	0	0	1	1	0.5	0	0	2	2
Patrick County	7	0	0	0	0	1	1	0.5	0.5	0	0	0	0	0	1	1	2
Pittsylvania County	8	1	1	1	1	0	1	0.5	0.5	0	0	0	0	0	0	1	1
Powhatan County	4	0	0	1	0	0	0	0.5	0.5	0.5	0	1	0	0.5	0	0	0
Prince Edward County	13	0	0	2	2	2	1	0	0.5	0.5	0	1	0.5	0.5	0	2	1
Prince George County	7.5	1	1	1	1	0	1	0	0.5	0.5	0	1	0	0.5	0	0	0
Prince William County	4.5	1	0	0	0	2	0	0	0	0	0	0	0	0.5	1	0	0
Pulaski County	10.5	1	2	0	2	0	1	0	0.5	0	0	0	0.5	0.5	2	0	1
Rappahannock County	5	0	0	2	0	1	0	0	0	0	1	1	0	0	0	0	0
Richmond County	8	0	0	1	0	0	1	0.5	0.5	0.5	0	1	0.5	0	1	1	1
Roanoke County	4.5	1	0	0	0	0	0	0.5	0.5	0	0	0	0.5	0	2	0	0
Rockbridge County	6	0	0	0	0	0	0	0.5	0	0	1	1	0	0.5	1	1	1
Rockingham County	7	1	0	0	0	1	0	0.5	0	0	1	1	0	0.5	2	0	0
Russell County	13	0	2	1	1	0	1	0.5	0.5	0	0	0	0.5	0.5	2	2	2
Scott County	4	0	1	0	0	0	0	0	0.5	0	0	0	0	0.5	1	0	1

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Weighting (Points Assigned)																	
Points Assigned Based On:																	
Locality	Total Points	# of Live Births	Teen Pregnancy Rate	Preterm Birth Rate	% Low Birth Weight	% Late/ No Prenatal Care	Unemployment Rate	High School Dropout Rate	Alcohol Abuse Prev. Rate	Marijuana Abuse Prev. Rate	Illicit Drug Use Prev. Rate	Pain Relievers Abuse Prev. Rate	Crime Reports	Juvenile Arrests	Child Maltreament Rate	Children in Poverty	Children in Food Insecure Homes
Shenandoah County	6.5	1	0	0	0	2	0	0	0	0	1	1	0	0.5	1	0	0
Smyth County	11	1	2	0	0	0	1	0.5	0.5	0	0	0	0.5	0.5	2	1	2
Southampton County	8.5	0	1	2	2	2	0	0	0	0.5	1	0	0	0	0	0	0
Spotsylvania County	7.5	1	0	1	1	2	0	0.5	0	0	1	1	0	0	0	0	0
Stafford County	4	1	0	0	0	0	0	0.5	0	0	1	1	0.5	0	0	0	0
Surry County	9.5	0	0	2	2	2	1	0	0.5	0.5	0	1	0	0.5	0	0	0
Sussex County	13	0	1	2	2	0	1	0.5	0.5	0.5	0	1	0	0.5	1	2	1
Tazewell County	12.5	1	2	2	1	0	1	0	0.5	0	0	0	0.5	0.5	1	1	2
Warren County	8	1	0	1	1	2	0	0	0	0	1	1	0.5	0.5	0	0	0
Washington County	9	1	1	1	2	0	0	0	0.5	0	0	0	0.5	0	1	1	1
Westmoreland County	8.5	0	1	2	1	1	1	0	0	0.5	1	0	0	0	1	0	0
Wise County	15.5	1	2	2	2	1	1	0	0.5	0	0	0	0.5	0.5	2	1	2
Wythe County	10	1	1	0	1	0	1	0.5	0.5	0	0	0	0.5	0.5	2	1	1
York County	3.5	1	0	0	0	0	0	0	0	0.5	1	0	0.5	0.5	0	0	0
Alexandria City	4	1	1	0	0	1	0	0.5	0	0	0	0	0.5	0	0	0	0
Bristol City	9	0	0	0	1	0	1	0	0.5	0	0	0	0.5	0	2	2	2
Buena Vista City	8	0	0	1	0	0	1	0	0	0	1	1	0	0	0	2	2
Charlottesville City	6	1	0	0	0	1	0	0.5	0	0	1	1	0.5	0	1	0	0
Chesapeake City	5	1	0	1	1	0	0	0	0	0.5	1	0	0.5	0	0	0	0
Colonial Heights City	9.5	1	2	1	1	0	0	0	0.5	0.5	0	1	0.5	0	0	1	1
Covington City	10.5	0	0	2	2	2	1	0.5	0.5	0	0	0	0.5	0	0	0	2
Danville City	16.5	1	2	2	2	2	1	0.5	0.5	0	0	0	0.5	0	1	2	2
Emporia City	11	0	2	0	0	1	1	0.5	0.5	0.5	0	1	0.5	0	0	2	2
Fairfax City	2.5	1	1	0	0	0	0	0	0	0	0	0	0	0.5	0	0	0
Falls Church City	0.5	0	0	0	0	0	0	0	0	0	0	0	0.5	0	0	0	0
Franklin City	13.5	0	2	2	2	2	0	0.5	0.5	0	0	0	0	0.5	1	2	1

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Weighting (Points Assigned)																	
Points Assigned Based On:																	
Locality	Total Points	# of Live Births	Teen Pregnancy Rate	Preterm Birth Rate	% Low Birth Weight	% Late/ No Prenatal Care	Unemployment Rate	High School Dropout Rate	Alcohol Abuse Prev. Rate	Marijuana Abuse Prev. Rate	Illicit Drug Use Prev. Rate	Pain Relievers Abuse Prev. Rate	Crime Reports	Juvenile Arrests	Child Maltreament Rate	Children in Poverty	Children in Food Insecure Homes
Fredericksburg City	6.5	1	0	0	0	1	1	0	0	0	1	1	0.5	0	1	0	0
Galax City	15	0	2	2	2	2	1	0	0.5	0	0	0	0.5	0	2	2	1
Hampton City	11.5	1	1	1	1	1	1	0.5	0	0.5	1	0	0.5	0	1	1	1
Harrisonburg City	8.5	1	0	0	1	2	1	0	0	0	1	1	0.5	0	0	1	0
Hopewell City	18	1	2	2	2	1	1	0.5	0.5	0.5	0	1	0.5	0	2	2	2
Lexington City	7	0	0	0	0	2	1	0	0	0	1	1	0	0	0	1	1
Lynchburg City	8.5	1	0	0	0	0	1	0.5	0.5	0	0	0	0.5	0	2	1	2
Manassas City	5.5	1	2	0	0	2	0	0.5	0	0	0	0	0	0	0	0	0
Manassas Park City	3	0	0	0	0	2	0	0.5	0	0	0	0	0.5	0	0	0	0
Martinsville City	14	0	2	2	2	2	1	0	0.5	0	0	0	0.5	0	0	2	2
Newport News City	11	1	1	1	1	1	1	0	0	0.5	1	0	0.5	0	1	1	1
Norfolk City	15.5	1	2	2	2	0	1	0.5	0	0.5	1	0	0.5	0	2	1	2
Norton City	15	0	2	1	2	2	1	0	0.5	0	0	0	0.5	0	2	2	2
Petersburg City	16	1	2	1	1	2	1	0.5	0.5	0.5	0	1	0.5	0	1	2	2
Poquoson City	2.5	0	0	0	0	0	0	0.5	0	0.5	1	0	0.5	0	0	0	0
Portsmouth City	15.5	1	2	2	2	1	1	0.5	0	0.5	1	0	0.5	0	1	1	2
Radford City	10	0	0	2	2	1	1	0	0.5	0	0	0	0.5	0	2	0	1
Richmond City	11.5	1	2	1	1	1	0	0	0	0.5	1	0	0	0	0	2	2
Roanoke City	10.5	1	2	1	1	1	0	0	0.5	0	0	0	0.5	0.5	0	1	2
Salem City	1	0	0	0	0	0	0	0	0.5	0	0	0	0.5	0	0	0	0
Staunton City	14	1	2	2	2	2	0	0.5	0	0	1	1	0.5	0	0	1	1
Suffolk City	7.5	1	1	1	1	1	0	0.5	0	0.5	1	0	0.5	0	0	0	0
Virginia Beach City	4	1	0	1	0	0	0	0	0	0.5	1	0	0.5	0	0	0	0
Waynesboro City	13	1	2	2	1	2	0	0.5	0	0	1	1	0.5	0	0	1	1
Williamsburg City	7	0	0	0	0	2	1	0	0	0.5	1	0	0.5	0	1	1	0

At-Risk Counties							
Locality	**County Is Served by at Least One HV Program**	**County Is Served by at Least One MIECHV-Eligible HV Program**	**County Is Served by HV Program Funded by MIECHV**	**Estimated Number of Families Served**	**Estimated Number of Children Served[a]**	**HRSA-Provided Estimate of Need[b]**	**Alternate Estimate of Need[c]**
Accomack County	Yes	Yes	Yes	35	35	139	1514
Alleghany County	Yes	No	No	0	8	83	417
Bath County	Yes	Yes	No	0	0	1	111
Bristol City	Yes	Yes	Yes	35	71	55	761
Brunswick County	Yes	Yes	Yes	0	0	111	619
Buchanan County	Yes	Yes	No	3	23	159	704
Buckingham County	No	No	No	0	0	116	512
Buena Vista City	Yes	Yes	No	0	0	2	210
Campbell County	Yes	Yes	Yes	26	20	210	1463
Caroline County	Yes	Yes	No	16	12	67	936
Carroll County	Yes	Yes	No	15	55	95	926
Charlotte County	Yes	Yes	Yes	0	19	83	540
Colonial Heights	Yes	Yes	No	3	5	188	722
Covington City	Yes	Yes	No	0	38	29	72
Danville City	Yes	Yes	Yes	47	40	306	1864
Dickenson County	Yes	Yes	Yes	36	55	107	539
Emporia City	Yes	Yes	Yes	31	31	57	241
Essex County	Yes	Yes	No	12	12	47	390
Fairfax County	Yes	Yes	Yes	1575	834	4166	18022
Franklin City	Yes	Yes	No	54	79	61	349
Franklin County	Yes	Yes	No	25	80	300	1833
Frederick County	Yes	Yes	Yes	60	60	133	1791
Fredericksburg City	Yes	Yes	Yes	76	62	40	620
Galax City	Yes	Yes	No	23	76	22	215
Giles County	Yes	Yes	Yes	45	81	134	498
Greensville County	Yes	Yes	Yes	33	35	124	382
Halifax County	Yes	Yes	Yes	28	22	238	747
Hampton City	Yes	Yes	Yes	880	765	740	4702

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At-Risk Counties							
Locality	**County Is Served by at Least One HV Program**	**County Is Served by at Least One MIECHV-Eligible HV Program**	**County Is Served by HV Program Funded by MIECHV**	**Estimated Number of Families Served**	**Estimated Number of Children Served[a]**	**HRSA-Provided Estimate of Need[b]**	**Alternate Estimate of Need[c]**
Harrisonburg City	Yes	Yes	No	48	0	586	1828
Henry County	Yes	Yes	No	13	11	376	7508
Highland County	Yes	Yes	No	0	0	1	48
Hopewell City	Yes	Yes	No	23	49	242	1184
King and Queen County	Yes	Yes	No	7	31	30	164
Lancaster County	Yes	Yes	No	14	14	46	359
Lee County	Yes	Yes	No	59	53	173	877
Lunenburg County	No	No	No	0	7	83	501
Lynchburg City	Yes	Yes	Yes	132	102	305	2845
Martinsville City	Yes	Yes	No	8	7	98	734
Mecklenburg County	Yes	Yes	No	6	4	210	880
Montgomery County	Yes	Yes	Yes	100	133	785	1679
Nelson County	No	No	No	0	0	5	231
Newport News City	Yes	Yes	Yes	310	371	1089	7652
Norfolk City	Yes	Yes	Yes	248	401	2124	10669
Northampton County	Yes	Yes	Yes	8	19	51	463
Norton City	Yes	Yes	Yes	11	11	28	233
Nottoway County	No	No	No	0	0	106	603
Page County	Yes	Yes	No	41	38	136	822
Petersburg City	Yes	Yes	Yes	52	118	340	1785
Pittsylvania County	Yes	Yes	Yes	6	6	451	1893
Portsmouth City	Yes	Yes	Yes	130	200	808	4764
Prince Edward County	No	No	No	0	21	157	822
Prince George County	Yes	Yes	No	16	23	402	1182
Pulaski County	Yes	Yes	Yes	52	86	272	844
Radford City	Yes	Yes	Yes	26	38	140	206
Richmond City	Yes	Yes	Yes	357	400	1586	9463

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At-Risk Counties							
Locality	**County Is Served by at Least One HV Program**	**County Is Served by at Least One MIECHV-Eligible HV Program**	**County Is Served by HV Program Funded by MIECHV**	**Estimated Number of Families Served**	**Estimated Number of Children Served[a]**	**HRSA-Provided Estimate of Need[b]**	**Alternate Estimate of Need[c]**
Richmond County	Yes	Yes	No	3	3	37	169
Roanoke City	Yes	Yes	Yes	376	761	527	4527
Russell County	Yes	Yes	No	12	28	197	890
Smyth County	Yes	No	No	36	36	100	973
Southampton County	Yes	Yes	Yes	30	55	133	381
Spotsylvania County	Yes	Yes	No	81	55	293	3044
Staunton City	Yes	Yes	No	2	2	8	907
Suffolk City	Yes	Yes	Yes	189	271	654	2309
Surry County	No	No	No	0	0	70	153
Sussex County	Yes	Yes	Yes	31	31	122	380
Tazewell County	Yes	Yes	No	0	42	302	1470
Warren County	Yes	Yes	Yes	26	26	225	1022
Washington County	Yes	Yes	Yes	33	102	176	1361
Waynesboro City	Yes	Yes	No	4	20	7	1011
Westmoreland County	Yes	Yes	No	17	48	74	367
Williamsburg City	Yes	Yes	Yes	24	27	26	287
Winchester City	Yes	Yes	Yes	53	53	43	1183
Wise County	Yes	Yes	Yes	79	191	281	1325
Wythe County	Yes	No	No	8	8	94	784

a. Number of children served to provide context to alternate estimate of need by county

b. HRSA estimate of need defined as families with children under 6 years old that were living in poverty and met two additional risk factors (families in which the mother has low educational attainment (high school education or less); families with pregnant women (a child less than 1 year in the past year); or families with young mothers (aged under 21)).

c. Alternate estimate of need by county provided; operationalized as the number of children, up to age 6, at/below 200% FPL

EARLY IMPACT VIRGINIA

ALLIANCE FOR EARLY CHILDHOOD HOME VISITING

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