Maternal, Infant, and Early Childhood Home Visiting Program

2020 Statewide Needs Assessment

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The Louisiana Department of Health's Bureau of Family Health administers the Louisiana Maternal, Infant, and Early Childhood Home Visiting Family Support and Coaching Program (LA MIECHV). LA MIECHV is a no-cost, voluntary program that provides family support and coaching to improve the health and well-being of pregnant women and parenting families with young children.

About this Report

As the MIECHV awardee for Louisiana, the Louisiana Department of Health receives funding through the Federal MIECHV Program to implement evidence-based home visiting. The Bipartisan Budget Act of 2018 requires that awardees conduct a Statewide Needs Assessment Update by October 1, 2020. In this Statewide Needs Assessment Update, the awardee builds upon the 2010 State Needs Assessment to identify at-risk communities, describe needs of families, and assess quality and capacity of services in early childhood systems and services. This update also includes an analysis of the state capacity for substance use disorder (SUD) treatment services for pregnant women and families with young children. The purpose of this update is to identify recent trends in distribution of risk and resources and to ensure that areas with high risk are prioritized for MIECHV program services. The results of this needs assessment update will inform strategic decision-making and identify opportunities for collaboration to strengthen and expand service offerings for eligible families. Stakeholders, communities, and families may use this update to learn about home visiting services and identify opportunities for collaboration or strengthening of current services.

Summary of Key Findings

- All 64 Louisiana parishes are at risk using HRSA's simplified method to compare risk. Risk among parishes varies from low to severe and is more concentrated and severe in northern Louisiana parishes than southern, particularly in the state's rural northeast.
- In State Fiscal Year (FY) 2018-2019, 4,416 families were served by evidence-based home visiting.
- Although home visiting is offered in all 64 parishes through four evidence-based models, almost all evidence-based home visiting in Louisiana is administered by the MIECHV awardee, the Louisiana Department of Health's LA MIECHV program.
- LA MIECHV key program strengths include average enrollment length of over one year, equitable access to programs by race and ethnicity, a high degree of self-reported family satisfaction, and proportionally higher reach in parishes with more severe risk.
- LA MIECHV key program opportunities include strengthening referral relationships and processes and building upon community awareness and recognition to ensure greater access to home visiting services.
- Community members and leaders find LA MIECHV services to generally be valuable for their communities and believe that greater collaboration with community partners would enhance recognition and interest among eligible families.
- Substance use disorder service capacity for pregnant women and families with young children is limited in Louisiana, and families face many gaps in services and barriers to access. LA MIECHV and other stakeholders have opportunities to strengthen the systems of care for families experiencing SUD and are supported by recent legislative priorities and statewide strategy for improving access to SUD care.
- This update references findings and data from other Needs Assessments, such as Head Start, CAPTA, and Title V.

INTRODUCTION

"There is no trust more sacred than the one the world holds with children. There is no duty more important than ensuring that their rights are respected, that their welfare is protected, that their lives are free from fear and want and that they can grow up in peace." -- Kofi Annan

Early childhood is a time of exploration, skill development, and tremendous growth; what children experience at a young age shapes who they become as they grow into adulthood. Parenting and environment are moderators for early childhood that can have lasting positive or negative effects. Free and voluntary home visiting services are a tool for communities and families that can provide family-specific support and resources to support families raising young children. The positive effects of home visiting on family success are observed from before the child is born well into adolescence.

Maternal, Infant, and Early Childhood Home Visiting Overview

The Federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) program was established by the U.S. Congress in 2010 and is administered by the Health Resources Services Administration (HRSA) in collaboration with the Administration for Children and Families (ACF). The Bipartisan Budget Act of 2018 reauthorized MIECHV for a five-year period at a cost of $400 million (National Conference of State Legislatures, 2019). The Federal MIECHV program requires state awardees to dedicate funding towards the implementation of one of 18 evidence-based home visiting models. The Bipartisan Budget Act of 2018 requires that awardees conduct a Needs Assessment Update by October 1, 2020 to the 2010 State Needs Assessment.

The Louisiana Department of Health (LDH), Office of Public Health (OPH), Bureau of Family Health (BFH) has been implementing evidence-based home visiting for over twenty years, with the establishment of the first LDH-administered team implementing the Nurse-Family Partnership model in Lafayette, Louisiana in 1999. BFH has been able to significantly expand home visiting services with federal MIECHV funding, first awarded in 2010 (X02MC19418) and currently offers evidence-based home visiting services in all 64 parishes in Louisiana. The LDH was awarded $10.7 million to continue to sustain two evidence-based models, Nurse-Family Partnership (NFP) and Parents as Teachers (PAT) for Fiscal Year (FY) 2019. Both models have met the Department of Health and Human Services (HHS) criteria for evidence of model effectiveness (HHS, 2019).

The goals of evidence-based home visiting are to improve maternal and child health, prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. Priority is given to families living in at-risk communities, as identified by the Statewide Needs Assessment. Success is measured by improvement in performance measure domains including school readiness and achievement, maternal and newborn health, reduction in child injuries, abuse, and neglect, reduction in crime or domestic violence, improved family economic self-sufficiency, and improved coordination and referral for community resources and supports (HRSA, 2019). Evidence-based home visiting has been extensively studied and found to have benefits for both families and communities. The Mother and Infant Home Visiting Program Evaluation (MIHOPE) is a national randomized controlled trial that examined effects of evidence-based home visiting on families and communities. MIHOPE found that overall, home visiting produced positive effects for families. Statistically significant effects on family outcomes were generally consistent with the overarching goals of the model; PAT which focuses on positive parenting and school readiness was associated with the largest increase in parental supportiveness, and NFP which focuses on maternal and child health was associated with the greatest reduction in emergency department visits for children ("Impacts on Family Outcomes", 2019).

Home visiting can play a critical role in ensuring that parents and young children have the supports that they need, including linkage to community resources for early intervention, prenatal and early childhood programs, health assistance, and mental health services (DiLauro, 2012). Home visiting is an important part of the continuum of care for low-income young children and their families (DiLauro, 2012).

Louisiana Overview

There are challenges and strengths present in Louisiana's systems, policies, and communities that affect the health and wellbeing of the state's maternal and child population. The historical foundations of colonization, slavery, and legalized racism which have disempowered and oppressed portions of Louisiana's population for centuries still take a significant toll on communities in the state, and continue to be perpetuated through biases in institutions and systems (Title V, 2020). Disparities by race should be interpreted in light of conditions largely affected by institutional structures that create and sustain concentrated areas of disadvantage, particularly for communities of color (Title V, 2020). Economic instability, low educational attainment, and poor health outcomes are some of the challenges facing Louisianans every day. Louisiana residents earn less in income than the average American, are less likely to finish high school than other Americans, and experience more severe poor health outcomes, such as low birth weight, infant mortality, preterm birth, and maternal mortality, than the U.S. on average. Maternal mortality is increasing in Louisiana, and Black mothers are 4.1 times as likely to die as White mothers (Title V, 2020). Louisiana was ranked 49th of 50 states in America's Health Rankings 2019 on overall health (America's Health Rankings, 2019). Louisiana has the second-highest incarceration rate in the country (Prison Policy Initiative, 2020). Incarceration of a parent is recognized as an Adverse Child Outcome (ACO) and is associated with increased poverty for children of incarcerated parents (youth.gov, 2015). The opioid epidemic contributes to poor health, with the rate of drug related deaths and substance exposed newborns both on the rise (LODSS, 2020).

One key strength in Louisiana is a vast improvement in insurance coverage over the past five years. After Louisiana expanded Medicaid to all adults under 138% of the Federal Poverty Level (FPL), Louisiana experienced one of the largest reductions in the uninsured rate for any state (LDH, 2018). Medicaid and the Louisiana Children's Health Insurance Program (LaCHIP) now sustains high rates of coverage for children, with only 3% of children reported as uninsured (LDH, 2018).

Needs Assessment Overview

The Statewide Needs Assessment Update is intended as a foundational resource to help identify and understand how to best meet the needs of eligible families living in at-risk communities, reveal population trends, identify areas of concentrated risk, identify needs for additional resources to support families and community capacity to meet needs, inform strategic decision making, and identify opportunities for collaboration to strengthen evidence-based home visiting services (HRSA, 2019). The Needs Assessment comprises four main sections, as described below.

1. *Identify communities at risk:* This section will present an analysis of relative risk for each parish based on a set of indicators provided by HRSA and modified by the Louisiana State Needs Assessment team.
2. *Identify quality and capacity of home visiting programs:* This section examines the capacity of evidence-based home visiting in Louisiana, and quality of programs offered.
3. *Discuss state capacity for substance use treatment and counseling for pregnant women and families with young children*: This section analyzes current treatment availability for pregnant women and parents of young children, as well as gaps, barriers, and opportunities for home visiting programs to collaborate in prevention and treatment efforts. It includes an analysis of statewide strategy and policy for substance use disorder treatment and prevention for pregnant women and parents of young children.

IDENTIFYING PARISHES AT RISK IN LOUISIANA

LOUISIANA BACKGROUND

America's Health Rankings has ranked Louisiana 49 out of 50 states in health outcomes. Of the indicators considered, Louisiana ranks 50th in overall behaviors, 49th in low birthweight, and 46th in infant mortality (America's Health Rankings, 2020). Louisiana continues to be one of the least healthy states by health outcomes, livelihood, and socioeconomic status. Louisiana's economic development is ranked near to last in a comparison of US states with manufacturing, oil and gas, food production, and tourism as its primary economic drivers (The Pelican Institute, 2019).

Access to healthcare is an urgent concern for Louisianans, particularly disadvantaged or rural residents. Primary care and mental health shortage areas have increased across Louisiana in the past two years as the state safety net has shifted from healthcare delivery for low-income residents by Parish Health Units (PHU) to Federally Qualified Health Centers (FQHCs) (Title V, 2020). PHUs and Rural Health Clinics (RHC) perform essential services such as sexual and reproductive health, Women, Infants, and Children (WIC), and immunizations, among others.

More than one-quarter of Louisiana's 1.1 million children live in poverty, and over 200,000, or 20% of all children, live in high poverty areas (KIDS COUNT, 2018). Save The Children's 2020 US Childhood Report named Louisiana the worst state for children, with childhood severely threatened in Louisiana due to food insecurity, graduation rates, poverty, births to adolescents, and child mortality rates. Several parishes in Louisiana are noted for their extreme conditions, such as East Carroll Parish, with the highest food insecurity rate in the United States at 40% of children in food insecure households (Save the Children, 2020). Young children are particularly at risk in Louisiana; as of 2019, three-quarters of kindergarteners who entered the school system in 2018-2019 were considered "economically disadvantaged" with household incomes below 200% of the FPL ("Preschool Development Grant", 2019). Though early childhood education in Louisiana lags behind the national average for measures of positive early learning experiences, it is a current legislative priority ("State of Babies", 2020).

The wellbeing of children and families across the United States is impacted by policies and laws that determine access to sexual and reproductive health and education. The American College of Obstetricians and Gynecologists (ACOG) "recognizes that access to comprehensive reproductive health care services is essential to women's health and well-being" (ACOG, 2016). Research has demonstrated that the more restrictive sexual health policies a state enacts, such as those limiting access to contraception, the less likely the state is to have a robust structure of evidence-based supportive polices for women and children, leading to poorer outcomes in health and wellbeing (Evaluating Priorities, 2017). Louisiana has one of the greatest number of restrictions to comprehensive care in the country (Evaluating Priorities, 2017).

Louisiana is the 25th most populous state in the United States, home to 4.6 Million people in 2019 (American Community Survey, 2018). Louisiana is culturally and geographically diverse, with 64 parishes (equivalent to "county") and five distinct geographic and cultural regions. This report will reference five distinct geographic areas and the nine LDH Administrative Regions. The five geographic regions and the LDH Administrative Regions they contain are described in greater detail below. A map of Louisiana's LDH Administrative Regions is located in Appendix A.

Greater New Orleans. The Greater New Orleans area is also the LDH Administrative Region 1, including Orleans, Jefferson, Plaquemines, and St. Bernard parishes. Greater New Orleans, defined by the City of New Orleans, a historic urban center, contains about a quarter of the state's population, with 1.2 million residents (American Community Survey, 2018). The greater New Orleans area also has robust Vietnamese and Honduran communities. The

area has received significant federal and state aid to rebuild the region after the devastating effects of Hurricane Katrina in 2006.

Acadiana. The Acadiana geographic region encompasses LDH Administrative Region 5 and most of LDH Administrative Regions 3 and 4, including Lafourche, Terrebonne, St. Mary[1], Assumption, St. James, St. John, St. Charles, Pointe Coupee, West Baton Rouge, Iberville, Ascension, Cameron, Jefferson Davis, Allen, Beauregard, Calcasieu, Vermillion, Iberia, St. Martin, Lafayette, Acadia, St. Landry, Evangeline, and Avoyelles parishes. Acadiana refers to the geographic southern parishes of Louisiana, excluding the Greater New Orleans area at the extreme southeast and includes parishes that border Texas. This area is home to a historically French-speaking population who live and work on the Gulf, bayous, and lakes that are prevalent in the region. Lafayette is the largest city in the Acadiana region, and Lake Charles, an industrial manufacturing hub for the oil and gas industry, is in the southwest region. The area received significant federal and state aid to rebuild following the destruction and devastating impacts of Hurricane Rita in 2005. The Acadiana region is also home to "Cancer Alley", which refers to the corridor of the Mississippi River between New Orleans and Baton Rouge with a high concentration of petrochemical plants. Cancer Alley has some of the most toxic air quality in the United States (Baurick, Younes & Meiners, 2019).

Florida Parishes. The Florida Parishes encompass LDH Administrative Regions 2 and 9, including East Baton Rouge, East Feliciana, West Feliciana, St. Helena, Livingston, Tangipahoa, Washington, and St. Tammany parishes. The Florida Parishes is the geographic region bordering Mississippi on two sides, east of the Mississippi River and north of New Orleans, divided by Lake Pontchartrain. This area includes the State Capitol, Baton Rouge, and several smaller metro areas. The Baton Rouge area received significant federal aid following devastation from the 2016 floods.

Central Louisiana, also known as "CENLA". CENLA overlaps with LDH Administrative Region 6 and is inclusive of Rapides, Vernon, Grant, LaSalle, Catahoula, Concordia, and Winn parishes. Central Louisiana is the geographic center of the state, anchored by the small city of Alexandria. The region is known for pine forests and a foresting industry, and parts of the region are very rural. The area borders Acadiana to the North and spans the width of the state from Texas to Mississippi.

North Louisiana. North Louisiana is a large geographical region that covers the northern third of the state. The northwest portion – sometimes called "ArkLaTex" for the meeting of Arkansas, Louisiana, and Texas – encompasses LDH Administrative Region 7 and contains Shreveport, the third largest city in Louisiana (American Community Survey, 2018). LDH Administrative Region 8 is in the north-central and northeast portions of the state. Several parishes in the region lie within the lower Mississippi River Delta region, where the small city of Monroe is located. The parishes included in North Louisiana are: Sabine, Natchitoches, Red River, DeSoto, Caddo, Bossier, Webster, Claiborne, Bienville, Jackson, Lincoln, Union, Ouachita, Caldwell, Franklin, Richland, Morehouse, West Carroll, East Carroll, Madison, and Tensas.

Method

Title V of the Social Security Act, as amended by the Bipartisan Budget Act of 2018, specifies that as a part of the Statewide Needs Assessment Update, states must identify communities with concentrations of risk across various domains focused on child and family health, well-being, and ability to thrive (U.S. Social Security Administration). The Statewide Needs Assessment Update for Louisiana was conducted in partnership between BFH and LPHI. Key staff from these two agencies comprise the Louisiana Statewide Needs Assessment (LSNA) team and collaborated on selecting indicators and acquiring data for analysis. The LSNA team used a mixed methods approach to identify parishes at risk. The specific methodology is described in greater detail below.

[1] The abbreviation "St." stands for "Saint". This abbreviation is used for multiple parishes in Louisiana (Saint Mary, Saint James, Saint John the Baptist, Saint Charles, Saint Martin, Saint Landry, Saint Tammany, and Saint Helena).

PHASE ONE: "SIMPLIFIED METHOD"

The LSNA team used the "simplified method", a quantitative method for identifying parishes "at risk" developed by HRSA for this assessment. The simplified method includes standardizing parish data – and sub-county data, if necessary – for a series of domains and indicators that align with the statutorily-defined criteria for identifying at-risk communities to target for home visiting programs, and is described in detail in the *Guide to Conducting the Maternal, Infant, and Early Childhood Home Visiting Program Statewide Needs Assessment Update* [U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), 2019] (heretofore referred to as "The Guide"). The Guide also clarifies that states have permission to add data to the simplified method and to organize indicators and domains in a way that is optimal for their state.

Per the Guide's instructions, the LSNA team modified the original set of indicators and domains provided by HRSA to better reflect the variation and pervasiveness of risk across the state. Indicators and domains were identified through a collaborative process that included a review of existing early childhood and maternal health literature and assessments, as well as strategic conversations with partners across the state. This process resulted in the selection of 13 additional indicators and seven additional domains (on top of the original set of five domains and 14 indicators from HRSA). The new domains and indicators served to increase the assessment's sensitivity for detecting risk and relevance to communities across the state. With this increased sensitivity, the LSNA team sought to identify statewide risk trends across domains that impact maternal and child health as well as general community and population health, making the results more useful for program planning and policy change conversations.

Additionally, given the pervasiveness of risk within parishes and communities across Louisiana, the LSNA team developed a risk scale designed to better identify parishes at *elevated* risk. After identifying parishes at risk according to the simplified method algorithm (further described below), the LSNA team analyzed the total number of domains that were at risk for each parish. By adding data beyond the original five domains provided by HRSA, the LSNA team increased the range of the "risk scale" from a maximum of five domains to a maximum of twelve domains, ultimately creating a more robust and comprehensive investigation into levels and types of risk present across Louisiana. Results from this investigation are shared at the end of this section. It should be noted that this index does not consider interaction effects and limitations must be considered when interpreting results.

An overview of the process that the LSNA team used to carry out HRSA's "simplified method" is described in the sub-sections below (Data Sources, Statistical Analysis, and Level of Analysis).

Data Sources

The LSNA team included data from numerous sources in this analysis – either received directly from HRSA or obtained separately. HRSA organized publicly available parish-level data from nationally administered surveys and surveillance systems (e.g. U.S. Census; National Vital Statistics). As described in the next section, the LSNA team identified additional indicators to include in the simplified method and acquired these data from national publicly available data sources (e.g. County Health Rankings) and internal data systems operated by the LDH OPH. The LSNA team also collaborated with several state governmental agencies outside of OPH, such as the Louisiana Department of Child and Family Services (DCFS).

More information about the data sources for this analysis are presented in Appendix B. Data provided by HRSA are denoted with an asterisk. All other data were obtained by the LSNA team for the purpose of this analysis.

Statistical Analysis

HRSA provided a step-by-step algorithm as a part of the simplified method for organizing, standardizing, and analyzing data indicators. The rules included predefined thresholds for classifying a given indicator, domain, and parish as "at risk". In summary, the algorithm includes the following steps:

1. Obtain and organize raw, county-level data for each indicator.
2. For each indicator, compute the mean of counties and standard deviation (SD).
   Note: although not used in the algorithm, HRSA also requested that states report other descriptive statistics for each indicator (number of parishes with missing values, minimum value, maximum value, range, and interquartile range).
3. For each indicator, standardize raw values by computing a z-score for each parish. This will make all indicators have a mean of 0 and a standard deviation of 1. Z-score = (county value - mean)/SD.
4. For each indicator, identify the parishes that have a z-score greater than or equal to 1. This will identify the parishes that have a parish-level value for this indicator that is one standard deviation above the mean in a standard normal distribution.
5. Once all indicators within a given domain are standardized, identify the parishes where at least half of the indicators within the domain have a z-score greater than or equal to 1. In other words, if at least half of the indicators with a domain have z-scores greater than or equal to 1, the parish is considered "at risk" for the domain.
6. Parishes that are "at risk" for 2 or more domains are identified as "at risk" and considered a target community for home visiting services.

More information about the algorithm can be found in HRSA's *Supplemental Information Request (SIR) for Submission of the Statewide Needs Assessment Update* (HRSA, 2019).

Level of Analysis

In line with HRSA guidance, the LSNA team first analyzed indicators at the parish level. For several indicators, the LSNA team incorporated sub-county data into the simplified method to overcome the limitation of heterogeneity in parishes. If a sub-county unit within a parish met criteria for being "at risk" (e.g. at least half of the indicators within that domain have a z-score of greater than or equal to 1), the domain for the parish was counted as "at risk". The LSNA team followed the following steps, outlined by HRSA, to analyze sub-county data (*after* completing the county analysis):

1. Obtain data from the same source but at a smaller unit of analysis (e.g. zip code, census tract).
2. For each sub-county unit of interest, calculate a z-score, *using the mean and standard deviation from the county-level analysis*.
3. Like the county-level method, you must determine if at least half of the indicators within a given domain have a z-score of greater than or equal to one *for the sub-county unit.* For indicators within a domain for which you are not incorporating sub-county data, use the parish-level z-score.
4. Determine which sub-county units are "at risk" for a given domain. Like parish-level units, sub-county units are considered "at risk" if 2 or more domains are "at risk".

DATA SUMMARY

The Statewide Needs Assessment Update for Louisiana included a total of 12 domains in the simplified method, consisting of 26 indicators. Domains included 1-4 indicators, depending largely on the availability of parish-level data from a recent year (i.e. since 2014). At the onset of the Statewide Needs Assessment Update, Louisiana received parish-level data for 13 indicators, falling into 5 domains, directly from HRSA. The LSNA team added 7 domains and 13 indicators to increase the robustness and sensitivity of identifying at risk parishes in Louisiana. An overview of all indicators and domains included in this analysis can be found in Table 1.

Added Domains and Indicators

This section describes changes and additions to indicators and domains provided by HRSA. After completing additions to the simplified method, 62 of 64 Parishes were identified as having concentrations of risk.

Socioeconomic Status (SES)

Nearly 19% of Louisianans live at or below the FPL, compared to 12% nationally (American Community Survey, 2018). People living in poverty are at "increased risk for mental illness, chronic disease, higher mortality, and lower life expectancy" (Office of Disease Prevention and Health Promotion, 2020). Poverty is a multifaceted domain which goes beyond income. The SES domain includes 4 indicators: poverty, unemployment, high school dropouts, and income inequality. The LSNA team obtained these data at the parish level directly from HRSA and did not make any changes to the parish-level data. After completing the parish-level analysis, the LSNA team chose to incorporate sub-county data for a subset of parishes with known socioeconomic disparities. Sub-county data at the census tract level were obtained from Census.gov and further investigated using the method described above. Sub-county level data could only be included for the parishes of interest for 3 of the 4 indicators within the SES domain due to data availability (The Federal Bureau of Labor was the source for unemployment data and the data are not available at the sub-county level).

Table 1. Domains used to determine at risk parishes

Domains	Indicators
Socioeconomic Status (SES)	Poverty*
	Unemployment
	High School Dropout*
	Income Inequality*
Adverse Perinatal Outcomes	Preterm Birth
	Low Birth Weight
Substance Use Disorder	Alcohol
	Marijuana
	Illicit Drugs
	Pain Relievers
Crime	Crime Reports
	Juvenile Arrests
Child Maltreatment	Ages 0-17
	Ages 0-5*
Adequacy of Prenatal Care (Kotelchuck Index)Ψ	No prenatal care
	Inadequate or intermediate prenatal care utilization
Infant MortalityΨ	Infant mortality
Teen PregnancyΨ	Teen Pregnancy count
	Teen Pregnancy rate
Health InsuranceΨ	Uninsured adults
	Medicaid births
Mental HealthΨ	Mental Health Providers
	Poor Mental Health Days
Access to ResourcesΨ	Broadband Access
	Limited Access to Foods
ALICE IndexΨ	ALICE Households*

List of domains and indicators
Ψ Additional domains
* Added indicator to HRSA domain or added sub-county analysis

Child Maltreatment

Child maltreatment is the "abuse and neglect that occurs to children under age 18". Children who have experienced child maltreatment are at an increased risk for physical, mental, and behavioral health problems (WHO, 2020). In

2018, Louisiana had 9,380 victims of child abuse or neglect (Child Welfare League of America, 2020). HRSA provided data for one indicator in the 'Child Maltreatment' domain: rate of maltreatment victims ages <1-17. In a report to Congress in 2015, evaluators mentioned that a small number of states included data for substantiated abuse in their 2010 MIECHV Needs Assessments and suggested that states incorporate this indicator in future needs assessments (Michalopoulos et al., 2015).

To improve the sensitivity of this domain at identifying parishes at risk, the LSNA team requested and acquired data from DCFS on child maltreatment in Louisiana by parish. The LSNA team calculated the rate of substantiated abuse in each parish for children ages 0-5 using the count of substantiated cases by parish and the population estimates for children 0-5 from the same year. The rate of substantiated abuse (Louisiana DCFS data) differs from the rate of maltreatment victims (national ACF data) in their data definitions. Whereas the local DCFS data measured unduplicated children with a valid allegation, the national ACF data reports deduplicated children "whom the state determined at least one maltreatment was 'substantiated' or indicated." (HHS, 2020).

Adequacy of Prenatal Care Domain

Women who seek prenatal care are more likely to have positive birth outcomes, as doctors can recognize and address problems with the pregnancy (Office on Women's Health, 2020). The Kotelchuck Index classifies adequacy of prenatal care according to the number of prenatal visits compared to the expected number of visits, which is based on the American College of Obstetricians and Gynecologists prenatal care standards for uncomplicated pregnancies and is adjusted for gestational age when care began and gestational age at delivery (Utah Department of Health). Two measures from the Kotelchuck Index were included to describe the adequacy of prenatal care across parishes: 1) inadequate (<50%) and intermediate (50-79%) expected prenatal care utilization and 2) adequate (80-109%) and adequate plus (>110%) expected prenatal care utilization. Although research suggests the Kotelchuck Index is associated with low birth weight, these data are in their own domain rather than grouped with 'Adverse Perinatal Outcomes.' Inadequate prenatal care is an independent measure of access to care, whereas adverse perinatal outcomes can indicate failures of systems of cares at multiple levels, including access, maternal health, and maternal prenatal care (Association of Maternal and Child Health Programs, 2013).

Teen Pregnancy Domain

Louisiana's adolescent birth rate (34 births per 1,000 female population 15-19) is far higher than the National adolescent birth rate (23 births per 1,000 female population 15-19) (Blomme et al., 2020). Parenting during adolescence can have negative effects on both the parent and the infant, putting both at greater lifetime risk. According to Centers for Disease Control (CDC), adolescent parenting is associated with higher high school drop-out rates, and the children of teen parents are at an elevated lifetime risk for lower school achievement, incarceration, and teen parenting (CDC, 2019). Research has shown that developmental interventions in early childhood have the potential to reverse negative outcomes for the children of teen parents (Mollborn and Dennis, 2012). This analysis considered both the crude count and rate in population because they assess complementary information. Whereas rates standardize measures across different sized populations, absolute/crude counts are helpful for immediate public health planning and resource allocation (Aschengrau and Seage, 2013).

Infant Mortality Domain

Infant mortality is a measure of the number of infants who die before the age of one for every 1,000 live births. For this Statewide Needs Assessment Update, the rate of infant mortality was calculated using Vital Statistics data from LDH. The infant mortality rate (IMR) was calculated as the count of deaths per year in infants ages 0-1 divided by the count of total births per year, by parish across a 5-year timeframe (2014-2018). Data were suppressed for five parishes; these parishes were imputed with the average parish rate.

According to CDC, "the IMR is an important marker of the overall health of a society" (CDC, 2017). Infant mortality is indicative of community health status, poverty and socioeconomic status, availability and quality of health services, and medical technology (AMCHP, 2013). Beyond community health, the experience of infant death has a negative impact on individual health outcomes of family members. For instance, parents that have lost a child suffer from an increased risk of post-traumatic stress disorder, depression, and heart attacks (United Health Foundation, 2019). Infant mortality prevention initiatives frequently focus on curbing adverse birth outcomes like preterm birth and low birthweight - two outcomes that can impact child health as well as increase the risk of infant mortality (AMCHP, 2013).

The IMR in Louisiana (7.1 per 1,000 live births) exceeds the national rate (5.8 per 1,000 live births) and is the third highest in the US (America's Health Rankings in Zotero). Though preterm birth and low birthweight are associated with infant mortality, 1 in 4 infant deaths from 2014-2016 in Louisiana were related to injury (Benno and Lake, 2018), suggesting that infant mortality is not always mediated by adverse perinatal outcomes. Moreover, the Child Death Review (CDR) concludes that some of Louisiana's infant deaths in excess of the national rate are preventable, by targeting maternal health prior to conception and birth, as well as causes of injury such as unsafe sleep environments (Benno and Lake, 2018). Stress reduction, access to quality health care before, during, and after pregnancy, and management of chronic conditions are all cited by the Louisiana CDR as factors that could reduce fetal and infant mortality (Benno and Lake, 2018). Evidence-based home visiting can impact an individual family's risk of infant mortality in immediate ways, by providing support during pregnancy and birth, or providing education related to safe sleep and injury prevention. Given the unique impact that home visiting programs can have on preventing infant mortality in Louisiana and the fact that infant mortality is a distinguishable problem in the state of Louisiana, the LSNA investigated infant mortality as its own domain.

Health Insurance Domain

The LSNA team added the health insurance domain because research has demonstrated the importance of having health insurance for affording, accessing, and continuing care across personal health. The domain includes two indicators: (1) percentage of adults uninsured and (2) percent of total births in 2018 among women who were eligible for Medicaid at birth. The LSNA team acquired data regarding adults uninsured from the County Health Rankings publicly accessible download. The percent of adults who are uninsured is important because research shows that uninsured adults are less likely to receive necessary care (Tolbert et al., 2019). The percent of total births for Medicaid-eligible women was calculated using the LDH OPH Vital Statistics. The percent of women who are eligible for Medicaid during the month they give birth is indicative that women may be less likely to afford adequate and comprehensive care (Ranji et al., 2019). Among the women enrolled in Medicaid coverage during time of delivery may be likely to face challenges continuing care postpartum. For instance, a 2019 Issue Brief from the Centers for Medicare and Medicaid (CMS) states that many women covered by Medicaid lose their coverage 60 days postpartum, making this group especially vulnerable to discontinued care and at an increased risk for maternal mortality and morbidity (Ranji et al., 2019).

Access to Resources Domain

Environmental and social factors, including availability of resources and access to care, influence maternal health behaviors and health status, which affect pregnancy outcomes and infant and child health. Racial and ethnic disparities exist in infant mortality and can be partly attributed to disparities in social determinants of health (Office of Disease Prevention and Health Promotion, 2020). A high-quality environment is essential for children to achieve optimal health and development.

The LSNA team incorporated two types of resources into the present assessment: access to broadband and access to healthy foods. The Brookings Institute now calls broadband essential infrastructure with applications so wide ranging, it can deliver services that touch every social determinant of health (Tomer et al., 2020). There is also

increased interest and utilization of telehealth services to support long-distance clinical health care and health-related education, including maternal health services. One of the common challenges with telehealth is limited access to broadband, especially in rural areas (Rural Health Information Hub). The team also included percent of the population who are low-income and do not live close to a grocery store. (Rural vs. urban are defined by the 2010 census). There is strong evidence that residing in a food desert is correlated with a high prevalence of obesity and premature death, as well as associated with anxiety and depression in mothers and low self-rated health status among children (Ahern, Brown & Dukas, 2011). These effects may be particularly important given the increased nutritional requirements during pregnancy and the potential negative effects of stress and compromised nutrition on maternal and infant health (Office of Disease Prevention and Health Promotion, 2020).

Mental Health Domain

According to County Health Rankings, Number of poor mental health days is a Behavioral Risk Factor Surveillance System (BRFSS) health-related indicator of quality of life (County Health Rankings, 2020). Poor mental health days are associated with a loss in income growth and have been shown to have a more devastating impact in rural counties (Penn State, 2018). Mental Health Professional Shortage Area (HPSA) designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. These mental health indicators were included because untreated mental health conditions and poor access to mental health treatment are associated with adverse outcomes for postpartum women and infants including infant morbidity and mortality (Kendig et al., 2017) and Adverse Childhood Experiences (ACES) (Clemmer, 2019).

Asset Limited, Income Constrained Employee (ALICE) Threshold Domain

The LSNA team investigated an alternative measure of poverty as its own domain (e.g. outside of the "SES" domain). The ALICE Index is a measure spearheaded by United Way that captures households that are above the Federal Poverty Line (FPL), but still struggle with cost of living (United Way, 2018). Across Louisiana in 2016, almost half (48%) of households struggled to meet their needs, with 19% of Louisiana households living in poverty and an additional 29% of households (500,000 families) above the FPL, but still facing financial hardship and therefore considered to be an "ALICE household" (United Way, 2018). Despite the overall employment and economic gains after the 2010 recession, the recovery efforts were uneven across the state. Basic cost of living consistently outpaced wages with consistent increase in ALICE families from 2010 to 2016 across most of the state (United Way, 2018). For this Needs Assessment, one indicator was included in the ALICE Index domain: percent of households that are "ALICE Households". The LSNA team chose to investigate this indicator in its own domain because the SES domain already contains four indicators – all traditional measures of poverty. Adding another indicator to the SES domain would decrease the sensitivity of the traditional poverty measures for detecting areas of risk that are important to many governmental programs that rely on these measures for determining eligibility. The ALICE Index is a new measure for identifying a population that is left out of traditional measures of poverty and not as frequently considered for governmental services that rely on the FPL for determining eligibility. Finally, the ALICE Index is a composite measure that the United Way derives from multiple indicators, so including it is an indicator within the SES domain would dilute its true weight when identifying parishes at risk.

A Deeper Dive: Incorporating Sub-County Data

Sixteen parishes in Louisiana were not deemed as "at risk" when only considering parish-level data. All but 4 of these 16 parishes are located within Acadiana. The LSNA team hypothesized that parish-level data were masking pockets of risk within the remaining 16 parishes given that a body of national (Benzow & Fikri, 2020) and local Louisiana research (Scribner et al., 2017) demonstrates that key social factors related to health and wellbeing, like poverty and access to healthcare and resources, vary not only across counties, but also by zip code, neighborhood, and even block by block. The LSNA team was also interested in further examining these remaining 16 parishes at

the subcounty level based on qualitative findings from discussions with Nurse Supervisors, as well emerging public health issues like the COVID-19 pandemic.

Nurse Supervisors who live and work in these parishes discussed a range of socioeconomic and cultural challenges that residents face. Qualitative findings from discussions with Nurse Supervisors found that access to healthcare and transportation as key factors associated with these areas that could deepen economic inequality and maternal and child health risk factors. All the parishes in question contain rural areas that are cut off from needed resources by a lack of public transport and distance. Several of the parishes do not have any obstetric providers, a phenomenon referred to in the literature as "Maternity Care Deserts" (March of Dimes, 2018) that is associated with poor maternal and child outcomes. In addition to these barriers, COVID-19 has had an enormous impact in Louisiana, particularly in communities of color. Early data indicates that Black Louisianans are over-represented among fatalities from COVID-19 relative to White residents, and researchers hypothesize that these differences are related to elevated exposure due to socioeconomic causes (Price-Haywood et al., 2020).

According to the 2017 Distressed Communities Index (DCI), nearly one-third of the Louisiana population lives in distressed zip codes. At the parish and zip code level, these parishes all experienced a decline in ranking from 2011 to 2016 in the DCI, a composite index of complementary economic indicators such as adults without high school diploma, percent of adults not working, and poverty rate. All parishes experienced a downward trajectory in quintiles, with Acadia, Assumption, and Iberia now in the worst-performing quintile, "distressed." At the zip code level, all but one zip code with data in the DCI moved downward on the quintile scale from 2011 to 2016, and more than half were classified as distressed in 2016 (Economic Innovation Group, 2017).

Given these reasons, as well as availability and accessibility of subcounty data for simplified method indicators, the LSNA team chose to examine subcounty data for two domains, as follows:

(1) Socioeconomic Status (SES) Domain
    a. Poverty (Indicator), census tract
    b. High school dropout (Indicator), census tract
    c. Income inequality (Indicator), census tract
(2) ALICE Index Domain: ALICE Households (Indicator), zip code & sub-county divisions

Sub-county Analysis Results

Fourteen of the 16 parishes that were not deemed "at risk" with only parish-level data became "at risk" when considering sub-county data. The LSNA considered a parish as at-risk if sub-county data produced one of two scenarios. First, if the parish had one domain at risk using parish-level data and one domain at risk using sub-county data, the parish was deemed as "at risk". Alternatively, if the parish had zero domains at risk using parish level data but contained at least one sub-county unit that was at risk for each of the domains investigated at the sub-county level, then the parish was considered at risk.

Only 2 of the 16 parishes investigated at the sub-county level did not follow one of these scenarios. Those two parishes are discussed more in depth in the following section, titled 'Phase Two'.

PHASE TWO: ADDITIONAL PARISHES KNOWN TO BE AT RISK

The simplified method resulted in 62 out of 64 Louisiana classified as "at risk" using the quantitative methodology. After considering all parish and sub county-level data, two parishes, Jackson and Beauregard, had only one domain at risk and were therefore not considered "at risk" using the simplified method. However, qualitative data collected as part of the Needs Assessment Update (and further described in the forthcoming sections) indicate that both Jackson and Beauregard Parishes should both be considered "at risk"; additional detail and reasoning is further

described below. The data regarding descriptions of factors that contribute to these parishes being considered "at risk" were gathered in qualitative interviews with LA MIECHV staff who serve these parishes.

Jackson Parish

Jackson Parish is very rural and has only one small town, Jonesboro, with a few shops and restaurants and one rural hospital with an emergency room. It is widely recognized that women who live in highly rural areas within Louisiana lack access to reliable transportation (Medicaid transport is widely viewed as unreliable). Jackson Parish has very few resources for low-income parents and access to prenatal care is burdensome for low-income pregnant women and their families. Jackson is home to one pediatrician, one childcare center, no public transportation, few job opportunities, and zero OB/GYN providers. To access prenatal care, pregnant women must travel to Ruston, at least a 20 to 50-minute trip each way.

Beauregard Parish

Rural Beauregard Parish lacks reliable public transport, and Medicaid transport is largely viewed as unreliable. Beauregard Parish also lacks higher education opportunities, mental health resources that accept Medicaid, legal assistance for low-income residents, homeless shelters or women's shelters, and substance abuse treatment facilities. Local MIECHV staff share that substance abuse is on the rise in Beauregard Parish, and that there are few resources for substance abuse. Without a local inpatient facility for mental health or substance abuse, residents do not want to travel to other areas of the state for care because of a lack of transportation.

RISK FINDINGS

Parish Level Risk analysis

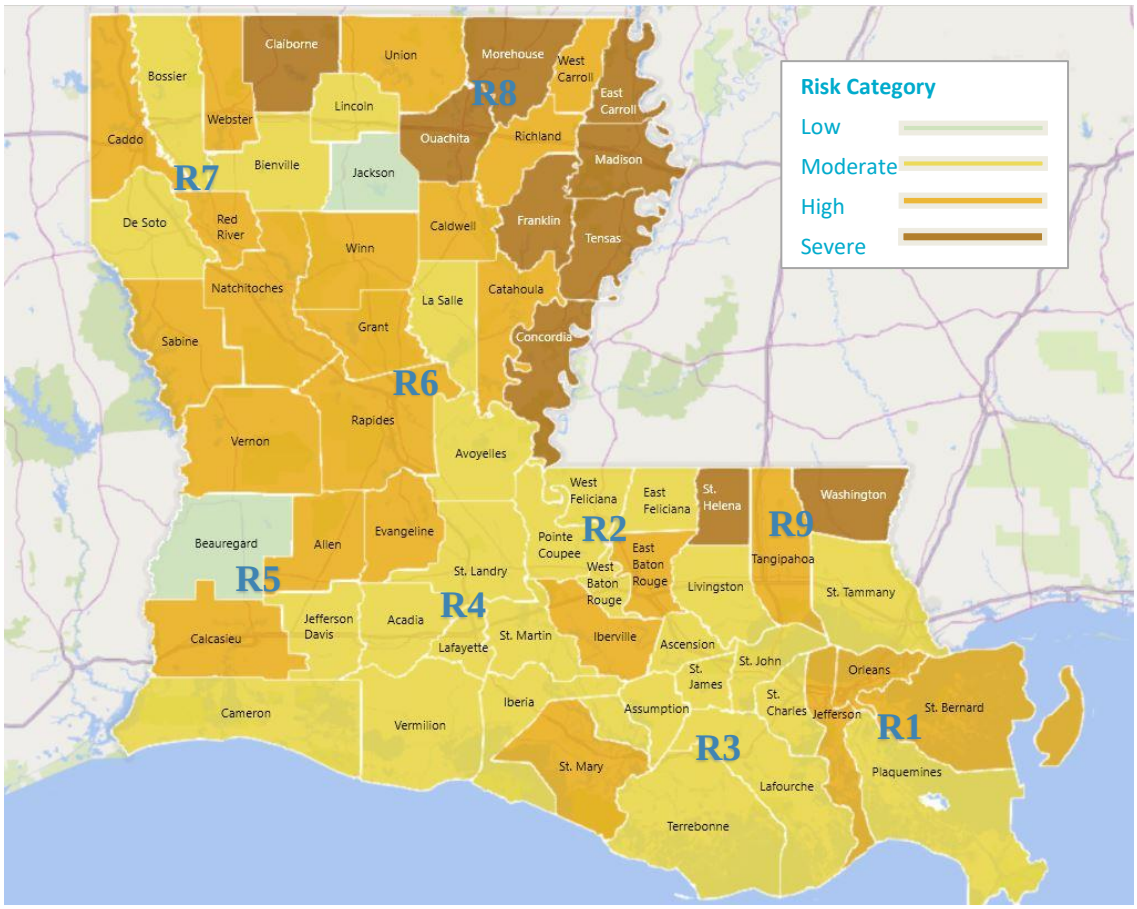
Using the simplified method overlaid with rich qualitative data collected and analyzed as part of the Needs Assessment Update, all 64 parishes in Louisiana are determined to be at risk. **Figure 1**Figure 1 presents a map of Louisiana, in which parishes are categorized into one of four "risk categories" based on the total number of domains that were "at risk" using the simplified method. The LSNA team created four categories of risk given that the *Early Childhood Risk and Reach Report* uses four categories of risk and the team was interested in comparing results between the two assessments. The LSNA team reviewed the distribution of total domains at risk across all 64 parishes to develop cut-offs for the risk categories. As previously described, the simplified method included 12 domains. Total domains at risk ranged from a minimum of 1 domain (Beauregard and Jackson) to a maximum of 9 domains (Morehouse). The distribution of total domains at risk is positively skewed, with a mean and median value of 3, a mode of 2, and a standard deviation of 1.5. Given these statistics, the LSNA team categorized risk as follows:

- Low Risk: 1 domain at risk
- Moderate Risk: 2 domains at risk
- High Risk: 3-4 domains at risk
- Severe Risk: 5-9 domains at risk

While all parishes within Louisiana are considered at risk, several trends emerge across the state. For example, parishes that are at least partially MIECHV funded generally have more elevated risk compared to parishes without MIECHV funding. Parishes in North Louisiana demonstrate more severe risk, particularly in the northeast region of the state along the Mississippi River. Aligned with other assessments of overall risk in Louisiana such as the *Louisiana Early Childhood Risk and Reach Report* and the *Save the Children 2020 US Childhood Report*, rural status within Louisiana appears to be associated with higher risk and worse outcomes for families and children. However, the association is strongest in North Louisiana, so it is difficult to assess whether rural status is predicting poor outcomes, or if it is a mediating factor for other predictors such as accessible health and mental health resources, public transportation, adequate housing, and quality education. These assessments confirm that families in urban

centers in Louisiana experience risk in different ways, such as elevated drug use, crime and violence, and teen pregnancies.

Figure 1



Domains of interest

SES risk, or elevated poverty, is highest in northern Louisiana and parts of Acadiana's southern region. Parishes with the most risk are generally those without a metro city, as well as those that are heavily rural, indicating that extreme poverty may be concentrated in parishes where most of the population lives in a rural setting. Access to resources followed a similar geographic trend, with risk concentrated in North Louisiana, Central Louisiana, and the northern Florida Parishes along the border with Mississippi. Health insurance coverage risk is geographically concentrated in northeast Louisiana along the Mississippi River, and the southernmost parishes in Acadiana and Greater New Orleans along the Gulf of Mexico. Mental health risk is concentrated along the Mississippi River region of North and Central Louisiana on the border with Mississippi.

Infant and perinatal risk factors, such as adverse perinatal outcomes, adequacy of prenatal care, and child maltreatment, are strongly concentrated in Northern and Central Louisiana. Almost all of Region 8 parishes in North Louisiana are at risk for adequacy of prenatal care, and almost all of Region 6 in Central Louisiana, and several parishes in neighboring Region 7, are at risk for child maltreatment. Adverse perinatal outcomes are most concentrated in the Region 7 area of North Louisiana and the northeast Parishes along the Mississippi river. Infant mortality does not follow a strong geographic trend, though most parishes at high risk are in North Louisiana.

Parishes with urban centers displayed higher risk in the crime and teen pregnancy domains. SUD was starkly concentrated in the southeast corner of Louisiana surrounding the Greater New Orleans and Florida Parishes regions, with almost all parishes east of the Mississippi river at elevated risk for substance use. Environmental exposure risk is clustered in the far northwest corner of Louisiana and south central and east Louisiana, throughout the Acadiana, Florida Parishes, and Greater New Orleans area. This area is home to many refineries and petrochemical plants and is sometimes known as the "chemical corridor" or "Cancer Alley" (Baurick et al., 2019).

North Louisiana has an overall higher risk level than other areas, though most domains and indicators follow geographic trends. Morehouse Parish was most at risk in this analysis, with inclusion in 10 of 12 included domains. Parishes in north central Louisiana have a similar but less concentrated risk than those along the Mississippi River to the northeast. Rapides Parish, home to the city of Alexandria, has significant risk associated with family well-being outcomes like child maltreatment, access to resources, and crime. Risk is concentrated in several other parishes that border Mississippi, such as St. Helena and Washington Parishes, which may not be entirely rural, but are located a significant distance from large cities that contain resources for low-income families. South Louisiana, including Acadiana, Greater New Orleans, and the Florida Parishes, has significant risk challenges related to substance use, health insurance access, teen pregnancy, and environmental exposure.

Emerging Trends

In analyzing both quantitative and qualitative data and assessing risk by parish, several new and emerging trends come to light. Though SUD risk was concentrated heavily in the Southeast portion of the state, staff from most if not all regions describe family drug abuse as one of the greatest emerging risks faced by the families that they serve. This risk is described as increasing rapidly in urban and rural areas of the entire state. In addition, research suggests that the data available on SUD risk may not be comprehensive in estimating current rates of drug use, abuse, and drug-related deaths throughout Louisiana (LODSS, 2018). SUD resources to address this are discussed at length later in this report.

Another emerging concern is the lack of mental health resources throughout the state, which was identified by MIECHV staff as well as community members in almost every region across Louisiana. Even if a parish or region appears to have sufficient resources, need outpaces availability in many instances, especially for underserved populations like pregnant women, patients using Medicaid, and homeless or indigent patients. This may manifest in unreasonably long wait times, full Medicaid rolls/caseloads, or extremely limited options, such as non-evidence-based counseling or a lack of prescribing psychiatrists.

Community and neighborhood factors, including safe and available housing, are largely absent from this analysis, but qualitative findings suggest that they play a large role in family well-being and economic stability. The inclusion of the ALICE framework attempts to represent challenges confronted by families who face low-wage or stagnant job prospects as well as increasingly unaffordable rates for rent/housing, childcare, and transportation. Food insecurity and access to education are similarly important indicators for child health and well-being across Louisiana and have been examined at length by the Early Childhood Risk and Reach Report (Tulane Institute of Infant and Early Childhood Mental Health et al., 2016) and Save the Children 2020 US Childhood Report (Save The Children, 2020). Though not included here, these factors can influence parish-level equity and access.

Alignment with Other Risk Assessments and Reports

The data used to determine risk in this assessment is in line with other Louisiana BFH assessments that have been completed, such as the 2016 Early Childhood Risk and Reach Report. Child outcomes such as child maltreatment follow the same geographic and regional trends in both analyses. Some variation from expected results exist. Most assessments that examine child poverty and health outcomes that were studied by the LSNA team have determined that North Louisiana is more at risk and in need of resources than the rest of the state. The focus and relative

weight of varying indicators, however, influences which specific subregions are more at risk. Data may be limited or difficult to compare across parishes, when sub-county analyses reveal that great inequality exists at the sub-county level and may mask some pockets of extreme poverty in otherwise prosperous parishes. (Benzow & Fikri, 2020). When comparing to an index created by Save the Children to measure “childhood enders'' such as food insecurity, adolescent pregnancy, and child death, the parishes along the Mississippi river in the northeast portion of the state appear to be most at risk for children. The 2020 County Health Rankings & Roadmaps rankings for Louisiana also illustrate a concentration of high risk in the northeast along the Mississippi river (Blomme, 2020). It is also important to note that Louisiana as a whole is the most “at-risk” state for children and youth, and that several of these noted parishes are within the 50 worst counties for child outcomes: Madison, Morehouse, Franklin, St. Landry, St. Helena, Concordia, and Webster (Save the Children, 2020).

QUALITY AND CAPACITY OF HOME VISITING

In this section, an analysis of quality and capacity of evidence-based home visiting services supported by MIECHV in Louisiana is presented. Data are from State Fiscal Year (SFY) 2018-2019 (July 1, 2018 – June 30, 2019) or Federal Fiscal Year (FFY) 2018 -2019 (October 1, 2018 – September 30, 2019); if representing a different period, it is noted in the table and text.

Quality and Capacity of Evidence-based Home Visiting Services in Louisiana

Factors that contribute to the ability to serve eligible families who want home visiting services can be described using two domains: capacity, and quality. For the purposes of this assessment, capacity is defined as the program’s ability to provide home visiting services to all interested and eligible families. Data that illustrate the capacity of home visiting programs includes overall number of families served, Home Visitor (HV) caseload, estimates of community reach, referrals by referral source, family enrollment rate, and referral outcomes. Families served, caseload, and estimates of community reach demonstrate the overall share of eligible families who receive services, and how that relates to the number of regional slots available for home visiting at any point in time. Family enrollment rate, referrals by program source, and overall referral outcomes demonstrate the ability to enroll new families in home visiting services.

Quality is defined as the program’s ability to effectively deliver services to enrolled families. Data that illustrates the quality of home visiting programs includes performance measures, family attrition, and family satisfaction. Performance measures and family outcomes demonstrate quality through measured benefits to families related to maternal and child health, family self-sufficiency, and access to resources. Family attrition demonstrates the degree to which families receive appropriate program dosage and speaks to their satisfaction with services. Family satisfaction data tells the story of why families enroll and what they find beneficial, demonstrating dimensions of value of home visiting services to the families they serve.

There are some points which will be discussed which can speak to both quality and capacity, such as staffing and employment and family demographics. Factors relating to staff, such as employment length and vacancies can demonstrate both the capacity to serve families (are all areas adequately staffed? Do some areas experience more staff vacancy than others?) and quality (do families experience more staff vacancies, which is associated with program attrition?). Demographics of families are a measure of capacity in demonstrating effectiveness of reach to eligible families, and a measure of quality in that it demonstrates if the population has equitable access and utilization of services.

Overview of Home Visiting in Louisiana

Louisiana's home visiting infrastructure includes four evidence-based models: NFP, PAT, Home Instruction for Parents of Preschool Youngsters (HIPPY), and Early Head Start Home Based Option (EHS-HBO), as well as the home visiting services provided by the Healthy Start Program. Though this report only focuses on the evidence-based models, it is important to acknowledge the critical role played by all home visiting services available across the state.

Although Healthy Start is not an evidence-based home visiting model, the program offers robust home visiting services and is a critical component of the home visiting landscape in Louisiana. In some states, Healthy Start sites utilize evidence-based models, but it is not a requirement (Healthy Start, 2020). Healthy Start is a national home visiting program that uses evidence-based curricula to educate care takers. Healthy Start serves communities with infant mortality rates at least 1.5 times the US national average, with maternal and infant health issues like low birth weight, pre-term delivery, and maternal morbidity and mortality, as well as communities with high rates of poverty, low education, and limited access to care (HRSA, 2016). Louisiana has 4 Healthy Start sites in major cities across Louisiana: New Orleans, Gretna, Baton Rouge, and Lafayette. These sites cover Regions 1, 2, and 4. Healthy Start enrollment numbers were unable to be obtained for this assessment. Healthy Start serves families from pregnancy until two years after the end of pregnancy.

BFH administers two of the four models available in Louisiana: NFP and PAT. Together, these models comprise LA MIECHV, and represent services accessed by 95% of families who participated in evidence-based home visiting in SFY 2018-2019. Overall capacity and eligibility of families will be discussed for all evidence-based home visiting in Louisiana, but detailed analysis about capacity and quality of evidence-based home visiting will be focused on LA MIECHV services because they are the only recipient of federal MIECHV funds in the state. Readily available and accessible data about other evidence-based home visiting programs in Louisiana is limited to what is presented here. There is one HIPPY site in Region 2 and 27 EHS-HBO sites throughout Louisiana. Service data was not accessible for the HIPPY site or the majority of EHS-HBO (Data was received from 7 sites).

Table 2. Home Visiting Model Eligibility Requirements

Model	Requirements
NFP	Medicaid, WIC, SNAP, TANF, or SSI eligible first-time mothers and families from pregnancy until the child's second birthday. Families must enroll in NFP before 29 weeks of pregnancy and must reside in the parish where services are being provided. (Bureau of Family Health, 2020)
PAT	PAT services and supports are provided to Medicaid, WIC, SNAP, TANF, or SSI-eligible expectant or parenting families with a child age 24 months or under from pregnancy until the child enters kindergarten. Families must reside in the parish where services are being provided. (Bureau of Family Health, 2020)
EHS - HBO	Expectant or parenting families with children from pregnancy to age 5 who are at or below 100% of the Federal Poverty Line.
HIPPY	Parents who have doubts or lack confidence in their ability to instruct their children and prepare them for school. Frequently, these parents did not graduate from high school or have only limited formal education, limited English proficiency, limited financial resources, or other risk factors. HIPPY serves parents with children ages 3 to 5. (HHS, 2013)

Capacity of Evidence-based Home Visiting Services

Of the 4,032 families served by LA MIECHV in SFY 2018-2019, 3,220 (80%) were enrolled in the NFP model and 807 (20%) in the PAT model. At least one LA MIECHV model is available in each of Louisiana's 64 parishes. Sixteen

parishes (25%) offer both NFP and PAT, 42 parishes (66%) offer only NFP, and 6 parishes (9%) offer only PAT. NFP is available in all 9 regions, and PAT is available in Regions 1, 7 and 8 (Table 3).

Table 3. Inventory of evidence-based home visiting programs in Louisiana. Note: This table presents count of families served for only 3 of the 4 evidence-based programs in Louisiana due to limited data availability. "NA" indicates that the model is not offered in region. ND indicates that no data is available.

Region	# Families served by LA MIECHV Program- NFP	# Families served by LA MIECHV Program- PAT	# Families served by EHS-HBO	# Families Served by HIPPY	Total Served
1	264	168	100	NA	532
2	284	NA	220	ND	504
3	280	NA	NA	NA	280
4	391	NA	NA	NA	391
5	220	NA	NA	NA	220
6	481	NA	NA	NA	481
7	610	285	40	NA	935
8	235	354	29	NA	618
9	455	NA	NA	NA	455
Overall	3220	807	389	NA	4416

The EHS-HBO program served 389 families in SFY 2018-2019. This number is an underestimate, as the LSNA team was only able to obtain enrollment information for 8 of the 17 parishes that they serve. EHS-HBO is offered in regions 1, 2, 7, and 8 (See Table 3). The LSNA team was unable to acquire funded capacity data for EHS-HBO and HIPPY. Data is limited to enrollment data (families served) in SFY 2018-2019.

Capacity of LA MIECHV Services

There are 19 home visiting teams in Louisiana supported at least in part by MIECHV funds under the LA MIECHV program; 5 teams implement PAT, and 14 implement NFP. Most LA MIECHV teams consists of HVs, one Nurse Supervisor, one Assistant Supervisors/Lead Parent Educator, one Administrative Assistant, one regional Outreach Specialist (OS), and one Infant and Early Childhood Mental Health Consultant (IECMHC). LA MIECHV team staff are supported by a Statewide Support team. Several regional OSs and IECMHCs support more than one team. OSs are responsible for developing community partnerships and recruiting eligible families. IECMHCs are responsible for providing mental health consultation to HVs. Team Nurse Supervisors report to four Regional Nurse Managers (RNMs) located throughout the state, who each support a combination teams implementing NFP and teams implementing PAT. Teams implementing NFP first began providing services in 1999 in regions 4, 5, and 8. By 2004, there was at least one team implementing NFP in each region of the state. Teams implementing PAT began providing services in 2013 with one team each in Regions 7 and 8. PAT expanded between 2016 and 2018 with the addition of three more teams, one each in Regions 1, 7, and 8. Given its different enrollment criteria, the expansion of PAT increased LA MIECHV's capacity to reach families by allowing enrollment after 29 weeks of pregnancy, enrollment for families with multiple children, and enrollment of families where the mother is not the primary caregiver.

LA MIECHV uses a braided funding model for home visiting teams. There are 1,753 family slots funded by federal MIECHV funding, and 1,304 family slots funded through a combination of state general funds, TANF funds, and Title V funds. LA MIECHV had a service capacity of 76% on January 1, 2019 (capacity is a point in time estimate, and this date was chosen to represent an estimate of capacity for 2018 – 2019).

Table 4. Family slots and actual caseload by funding source and region. Data from 1/1/2019									
	Family Slots by Funding Type			**Actual Caseload by Funding Type**			**Capacity Reached**		
Region	**MIECHV**	**Non-MIECHV**	**All Funds**	**MIECHV**	**Non-MIECHV**	**All Funds**	**MIECHV**	**Non-MIECHV**	**All Funds**
1	202	113	315	125	83	208	62%	73%	66%
2	50	148	198	47	137	184	94%	93%	93%
3	100	98	198	77	85	162	77%	87%	82%
4	175	123	298	130	95	225	74%	77%	76%
5	48	125	173	47	72	119	98%	58%	69%
6	98	246	344	92	209	301	94%	85%	88%
7	530	173	703	364	154	518	69%	89%	74%
8	377	130	507	222	103	325	59%	79%	64%
9	173	148	321	137	130	267	79%	88%	83%
Louisiana	1753	1304	3057	1241	1068	2309	71%	82%	76%

Reach of LA MIECHV Program

LA MIECHV program reach is estimated using an alternative to HRSA's suggested "estimate of need." The "estimate of need" is a measurement of number of potentially eligible and interested families in a specific region. The LSNA team elected to use births paid by Medicaid during 2018 as an alternate "estimate of need". These data were acquired from a validated birth file based on birth records and provided by BFH. The LSNA team chose to use this alternate estimate because it is from a data source that is easily accessible for later comparisons of reach, is more easily understood by stakeholders and community partners, and represents absolute rather than weighted numbers of eligible families. While this estimate is not perfectly aligned with eligibility and enrollment guidelines for NFP and PAT, the LSNA team believes it is the best estimate of need for home visiting for new parents and parents with young children in Louisiana.

Table 5. Estimate of LA MIECHV reach by region using Medicaid birth data, 2018				
Region	**Percent of eligible families served by LA MIECHV Program, 2018**	**Estimated number of eligible families in 2018**	**Families Served by LA MIECHV Program in SFY 2018-2019**	**Number of LA MIECHV HV Positions**
1	6.50%	6,694	436	9
2	5.70%	4,947	286	7
3	9.20%	3,006	281	7
4	8.30%	4,673	387	11
5	8.80%	2,512	224	6
6	20.90%	2,300	490	12
7	22.60%	3,962	690	25
8	20.40%	2,871	595	19
9	11.90%	3,798	413	11
LA	11.60%	34,763	4,032	107

As shown in Table 5, LA MIECHV serves 11.6% of eligible families in Louisiana. This estimate of reach ranges from 5.7% in Region 2 to 22.6% in Region 7. It is important to note that two of the three regions with the highest estimate of reach also have the greatest concentration of home visiting resources, Regions 7 and 8, though this does not take into account other home visiting capacity outside of LA MIECHV because number of HVs for other models and programs are not known. For instance, Region 7 includes 5 teams and 31 HVs, and Region 8 includes three teams with 24 HVs. This may demonstrate that the investment of home visiting resources in this region has resulted in the ability to serve a higher proportion of eligible families. LA MIECHV has the smallest reach in Regions 1 and 2, when compared to other regions, according to this estimate. These two regions are home to the largest cities in the state, New Orleans, and Baton Rouge. Families in both regions are also served by Healthy Start programs and EHS-HBO, and Baton Rouge families may be eligible for HIPPY.

Table 6 demonstrates the LA MIECHV program reach by risk category. This comparison shows that LA MIECHV is serving a larger proportion of eligible families in parishes in the severe risk category than in high, moderate, and low risk. LA MIECHV serves 20% of the estimated 2,688 families eligible for home visiting services who live in a parish with severe risk.

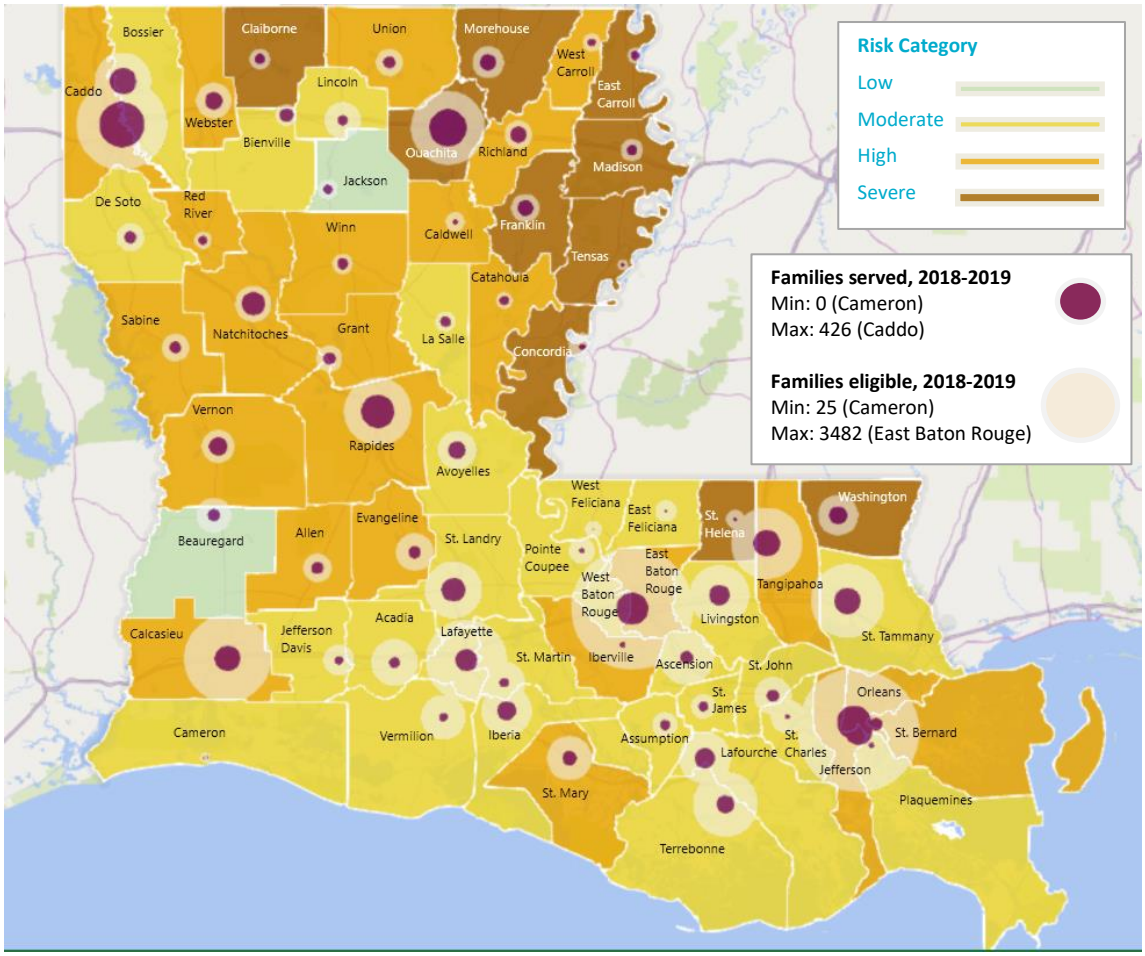
Table 6. **LA MIECHV program reach by risk category**
*Evidence based programs only, for which data were available

Risk category	Families served by LA MIECHV Program	Families served by all LA HV programs*	Estimate of families eligible for HV services	Percent of eligible families served by LA MIECHV Program	Percent of eligible families served by all LA HV programs
Severe	543	569	2688	20%	21%
High	2191	2494	19288	11%	13%
Moderate	1241	1301	12399	10%	10%
Low	51	51	388	13%	13%
All	4026	4415	34763	12%	13%

The LSNA team also combined reach data with results from the parish risk analysis discussed in the first section of this report.

Figure **2** (below) presents the risk categories shown in Figure 1, with two additional data points/layers: families served by LA MIECHV HVs in FY 2018-2019 (shown as a purple inner bubble) and an estimate of families eligible for evidence-based home visiting in FY 2018-2019 (shown as an outer gray bubble). It should be noted that these bubbles do not use the same scale. Nonetheless, this map illustrates the ratio of families served to families eligible within parishes across the state of Louisiana. The map displays several conclusions presented so far in this report. First, all families that are eligible for home visiting programs were not served in the prior fiscal year. The proportion of eligible families that were reached in the prior fiscal year is higher in northern Louisiana, albeit the parish with highest reach (Bienville) only reached 36.6% of eligible families. LA MIECHV has higher reach in the areas with highest risk. The parishes in southern Louisiana were determined to be less at risk according to the simplified method, and there is less reach of home visiting programs in these areas. Appendix E presents risk category, families served, families eligible, and percentage of eligible families served for each parish.

Figure 2



Referrals to LA MIECHV Program

Eligible families are introduced to and enrolled in LA MIECHV in several different ways. The two most common paths to enrolling in LA MIECHV are through referral by healthcare providers from the local community who interface directly with the family, and through direct face-to-face recruitment by LA MIECHV staff (i.e. "program outreach"). Both are critical means to recruiting families to enroll in LA MIECHV. "Referrals" to LA MIECHV are defined as the number of families who are referred to evidence-based home visiting from a range of referral sources. The "referral-to-enrollment rate" demonstrates the acceptance of LA MIECHV services by families who self-refer or are invited to participate and choose to enroll.

Research shows that a "…well-trained and qualified workforce and community service agencies are necessary for programs to operate at service capacity, and local leaders, program champions, and alignment with trusted community organizations bolsters participant trust and program acceptance" (HRSA, 2017). For that reason, the source of the referral is critical to evaluating referral pathways to LA MIECHV. Research also suggests that families are "twice as likely to accept services when assessed for program eligibility in person rather than by telephone", and that "universal versus targeted program enrollment improves program acceptance by removing stigma associated with program participation" (HRSA, 2017). The findings presented in this section show regional variation in LA MIECHV referral patterns, and variation in pathways from referral sources to enrollment.

Table 7. Description of percent share of all referrals and referral outcome by referral source, all LA MIECHV.

Referral Source	% Share of All Referrals	Enrolled	Eligible Unable to Serve	Refused	Unable to locate	Ineligible	Other
Community	8% (646)	13%	1%	32%	30%	10%	13%
Governmental	2% (189)	42%	1%	19%	24%	11%	3%
Healthcare provider	21% (1660)	25%	2%	30%	33%	9%	2%
Program Outreach	16% (1309)	19%	3%	23%	38%	9%	9%
School	1% (81)	43%	2%	25%	22%	6%	1%
WIC	44% (3,499)	20%	2%	38%	30%	6%	4%
Other	4% (341)	47%	2%	20%	22%	8%	1%
Total	7,974	22%	2%	31%	31%	8%	6%

Description of categories – "Community" includes pregnancy testing clinics and community events; "Governmental" includes Medicaid/health plans, the judicial system, and child welfare services; "Healthcare provider" includes pediatric providers, obstetric providers, mental health providers, hospitals, and non-OB adult providers.

As shown in Table 7, WIC is the largest source of referrals for LA MIECHV (44%), and 20% of all WIC-referred families enroll in LA MIECHV. Schools and government programs have notably higher referral-to-enrollment rates (43% and 42%, respectively), but the number of referrals from these sources is much lower. "Other" referral source, which includes self-referral, uncategorized referrals, and HV referrals, has a high referral-to-enrollment rate. However, the results pertaining to the "other" category must be interpreted with caution, as there are data quality concerns that make it an unreliable metric for program use. There is a low overall number of families who are categorized as unable to serve or ineligible, relative to other referral outcomes.

Though 22% of all families referred to LA MIECHV ultimately enrolled (see Table 8), this does not show the complete picture of program uptake. Research has shown that 8-20% of families contacted are active refusals (directly refuse) and 12-22% are passive refusals (families who initially accept services and are subsequently unavailable) (HRSA, 2017). When examining program enrollment among referred families who were successfully contacted in SFY 18-19 (e.g. the family either enrolled, refused participation, or was unable to be served), the enrollment rate is much higher. This is because a large share of families referred – almost one third - are never located in the referral follow up process. Considering only the number of families who are successfully contacted for follow up by LA MIECHV shows that 40% subsequently enroll, just over half refuse, and 4% are unable to be served (Table 8). This number includes only potential families who were reached and decided to either participate or not participate, or families that were eligible and unable to be served due to language or program capacity.

Refusal rates are notably different between both models. NFP has a slightly higher refusal rate than enrollment, where over two-thirds of potential PAT families refuse, and less than one third enroll. Assessing enrollment by restricting to families who were able to be contacted by LA MIECHV (excluding those unable to be reached), the refusal rate of 56% overall is greater than the 8-20% active refusal estimates documented in research (HRSA, 2017). Higher direct refusal rates represent an opportunity for programs to engage in quality improvement by better understanding direct refusals. Furthermore, identifying strategies for successful follow-up with all referred eligible primary caregivers may increase program reach/enrollment.

Table 8. Enrollment disposition of reached and eligible families in SFY 18-19			
Enrollment Outcome	**NFP**	**PAT**	**Overall**
Enrolled	45% (1,477)	27% (306)	40% (1,783)
Refused	52% (1,734)	68% (776)	56% (2,510)
Eligible unable to serve	3% (106)	5% (56)	4% (162)
Total	3317	1138	4455

LA MIECHV Program Enrollment

Duration of enrollment is an important measure of family engagement in home visiting services, which has implications for both quality and capacity of a home visiting program. Duration of enrollment can be influenced by a number of program factors, such as relationship between the HV and family, engagement during home visits, level of experience of HVs, and amount of supervision time for HVs (HRSA, 2017). Families with an enrollment duration of at least one year and an average of four or more visits per month are "more likely to demonstrate positive child and family outcomes" (HRSA, 2017). A national meta-analysis found that the average duration of enrollment for families in evidence-based home visiting was nine months (HRSA, 2017). Duration of enrollment was examined for all LA MIECHV families who had an exit date during SFY 2018-2019. In Louisiana, families stay enrolled in LA MIECHV services for an average of 1 year, 1 month. National studies have found that factors such as enrolling participants prenatally and program flexibility to meet individual participant needs are associated with longer enrollment length (HRSA, 2017).

Table 9. Average duration of NFP and PAT family enrollment for families with an exit date in SFY 18-19			
Region	**Model**	**# of Families**	**Average Time Enrolled (Years/Months)**
1	NFP	178	10 months
1	PAT	73	5.5 months
2	NFP	147	1 year 2 months
3	NFP	159	1 year 6 months
4	NFP	152	1 year 4 months
5	NFP	108	1 year 3 months
6	NFP	310	1 year 4 months
7	NFP	342	1 year 5 months
7	PAT	88	8.5 months
8	NFP	118	1 year 5 months
8	PAT	127	1 year 1 month
9	NFP	242	1 year 2 months
Total NFP (1-9)	NFP	1769	1 year 3 months
Total PAT (1,7,8)	PAT	338	10 months
LA MIECHV Total	NFP & PAT	2107	1 year 1 month

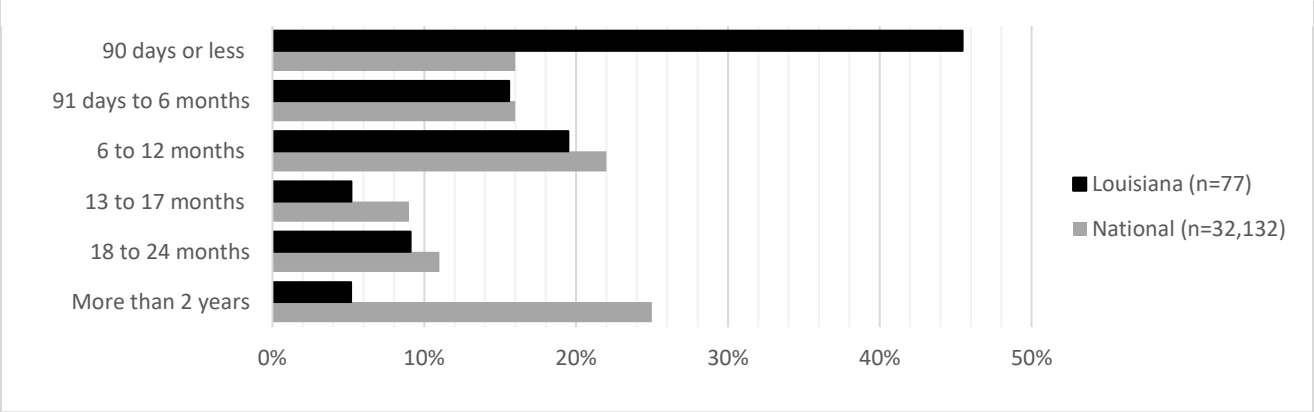
LA MIECHV Program Attrition

Family attrition is a key measure of family engagement and quality. When families exit services before the intended program completion, they may not benefit from program outcomes, such as improvements in child and family health and well-being. National studies have found that about half of families exit evidence-based home visiting

services before intended program completion, though this varies from model to model, from 20% - 80% (HRSA, 2017). LA MIECHV family exit data presented in Figures 3 and 4 is limited to the convenience sample of families who were enrolled in FY 2018-2019.

PAT evaluates family attrition at monthly intervals, with enrollment durations ranging from 90 days or less to more than two years. Nearly half (45%) of Louisiana families served by PAT leave the program within the first 3 months. This is nearly triple that of the national rate. One quarter of PAT families nationally remain in the program for over two years, compared to around five percent of Louisiana families (Figure 3). Differences in PAT attrition rates within Louisiana compared to national averages may be due to the recent introduction of PAT in Louisiana. PAT was first introduced in Louisiana in 2013 and the most recent addition of a PAT team was in 2017. Thus, there has been variability in the ability for families to remain in the program for more than two years.

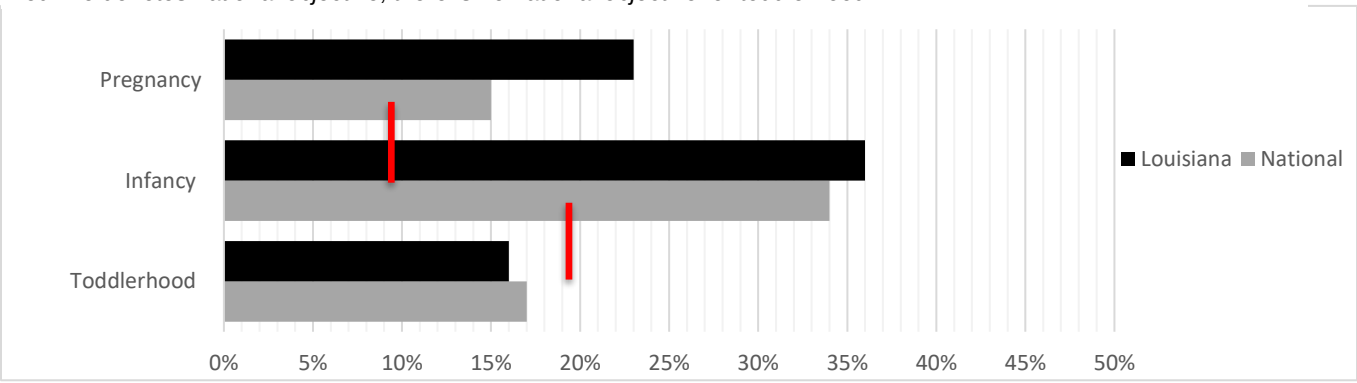
Figure 3. Louisiana PAT Time of Program Exit vs. PAT National Average



NFP evaluates family attrition at three life stages: pregnancy, infancy, and toddlerhood. Data from the inception of the LA MIECHV NFP teams to the end of 2019 shows that 23% of clients enrolled leave the program during pregnancy, which is higher than the national average of 15% during pregnancy, and the 10% or less goal set by NFP. The LA MIECHV attrition rate during infancy and toddlerhood is similar to national attrition rates (Figure 4). Research indicates that attrition is usually due to a combination of factors such as the family did not perceive a benefit to participation, they could not commit to the visit schedule, or a perceived lack of fit between their needs and the program offerings (Holland et al., 2014). Research also suggests that families may leave the program before graduation because they reach milestones or perceive that they have received enough benefit from the program sooner than the end of the prescribed two-year duration (Hernandez et al., 2019).

Figure 4. Louisiana NFP Time of Program Exit vs. NFP National Average, from inception to end of 2019

**red line denotes national objective, there is no national objective for toddlerhood.*



Reasons for Family Exit

Examining the reasons why families exit home visiting services is an important part of understanding how services or service delivery could be improved. Research shows that the following factors are predictors of service discontinuation: 1) the quality of HV-family relationships, (2) provision of cohesive and organized home visits, (3) involvement of other family or household members, (4) number of unsuccessful home visit attempts, and (5) the duration between completed home visits (HRSA, 2017). Research indicates that "Home visitors report that families with multiple children in the home and families with limited English language proficiency often struggle to consistently engage in program services" (HRSA, 2017). Knowing the factors that contribute to family exit is important for improving quality of home visiting services and maintaining caseload capacities.

During SFY 18-19, 1,644 families exited LA MIECHV services. The top three reasons for NFP family exit, cumulatively from the program's inception in Louisiana through 2019, were: graduation from NFP program, unable to locate, and moved from service area (Table 10

Table 10. NFP Program Family Exit Reasons LA vs. National, cumulative from program inception through Q4 2019

NFP Program Exit Reason	Louisiana (n=15,007)	National (n=152,846)
Unable to locate	34%	29%
Graduation	30%	34%
Moved from service area	14%	24%
Excessive missed visits	12%	12%
Client received what she needs from the program	7%	8%
Refused new nurse	7%	5%
No specific reason	7%	5%
Returned to work or school	7%	6%
Miscarried/Fetal Death	4%	4%
No visit for 180+ days	2%	2%

). LA MIECHV NFP's reasons for family exit are consistent with those reported nationally.

Table 10. NFP Program Family Exit Reasons LA vs. National, cumulative from program inception through Q4 2019

NFP Program Exit Reason	Louisiana (n=15,007)	National (n=152,846)
Unable to locate	34%	29%
Graduation	30%	34%
Moved from service area	14%	24%
Excessive missed visits	12%	12%
Client received what she needs from the program	7%	8%
Refused new nurse	7%	5%
No specific reason	7%	5%
Returned to work or school	7%	6%
Miscarried/Fetal Death	4%	4%
No visit for 180+ days	2%	2%

Nationally, the top three reasons for family exit from PAT programs were: enrolled child(ren) aged out or graduated, the family left the program for unknown reasons, and the child and/or family moved out of the service area (Parents as Teachers, 2019). In Louisiana, the top three reasons for PAT family exit were: the HV could not locate the family, the family regularly missed visits, and the family no longer wanted to receive services (Table 11). These exit reasons suggest that PAT families in Louisiana leave passively, meaning that their cases are closed because of non-participation (Janczewski et al., 2020). The strongest association with passive attrition in recent research is

inconsistent participation in home visits (Janczewski et al., 2020). More research is needed to understand patterns of visit attendance for PAT families in Louisiana.

Table 11. PAT family exit reasons LA compared to PAT National SFY 18-19		
PAT Exit Reason	**Louisiana (n=341)**	**National (n=28,176)**
Couldn't locate family	29%	13%
Regularly missed visits	27%	9%
No longer wants to receive services	18%	12%
Other	15%	16%
Moved	8%	15%
Aged out/graduated	3%	27%

Family Satisfaction and Feedback

Family feedback about the home visiting experience is one of the most important dimensions of quality. As consumers, families need to have the opportunity to share what they like about their experience, as well as what they would change, and the program must be committed to utilizing the results to make the services more family centered, responsive, and community-led. The LA MIECHV program disseminates a confidential client satisfaction survey to NFP and PAT program families each year. In SFY 18-19, 59% of families enrolled at the time of survey distribution completed the satisfaction survey. Survey results (see Table 12**Error! Reference source not found.**) indicate that overall, LA MIECHV families are satisfied with their program and would recommend it to friends and family. Families indicated that home visits occurred at a good frequency and that it was not challenging to make time for home visits. Finally, most families indicated that their home visit met their needs.

Table 12. SFY 2018-2019 Family Satisfaction Survey Response (n=1,426)			
Family Perceptions of LA MIECHV	**% NFP Families that agree**	**% PAT Families that agree**	**LA MIECHV Families that agree**
Satisfied or very satisfied with the program	99%	98%	99%
Would recommend program to friends and family	98%	95%	97%
Believe the frequency of visits is just right	85%	81%	83%
Did not find it challenging to make time for home visits	82%	71%	77%
HVs were able to meet their needs	95%	93%	94%

The LA MIECHV family survey asked about reasons that families chose to enroll. The top reason for enrollment in NFP reported by families is a desire to learn about pregnancy, whereas the top reason reported for enrollment in PAT is the motivation to benefit child health and development (Table 13

Table 13. SFY 2018-2019 Family Satisfaction Survey - family enrollment reasons (n=1,426)			
Enrollment Reason	**NFP**	**PAT**	**LA MIECHV**
Learn about pregnancy	68%	21%	45%
Learn about parenting	66%	42%	54%
Benefit child health & development	63%	73%	68%
Benefit personal health	31%	14%	23%
Other	5%	2%	4%

). Interestingly, the top reasons for enrollment in the respective programs align with the focus of each program models, as NFP provides intensive support during pregnancy and infancy and PAT curricula focus on child development.

Table 13. SFY 2018-2019 Family Satisfaction Survey - family enrollment reasons (n=1,426)

Enrollment Reason	NFP	PAT	LA MIECHV
Learn about pregnancy	68%	21%	45%
Learn about parenting	66%	42%	54%
Benefit child health & development	63%	73%	68%
Benefit personal health	31%	14%	23%
Other	5%	2%	4%

When asked to identify the best part of having a HV, NFP and PAT families selected options centered around support, child health and development, and education (Table 14). Families across both models most often selected "asking questions", "improve child health and development", and "learn about parenting." Thirty-seven percent of NFP families chose learning about pregnancy, whereas only 13% of PAT families selected the same option. This difference is notable because it indicates that PAT families find greater overall value in learning about child development than pregnancy, whereas many NFP families value learning about pregnancy. This is another example of alignment between program goals and LA MIECHV families' life stage(s) when they enroll in their program.

Table 14. SFY 2018-2019 Family Satisfaction Survey - best part of having a HV (n=1,426). The survey question was formatted as select all that apply, percentages do not add up to 100 percent.

Best Part of Having a HV	NFP	PAT	LA MIECHV
Improve child health and development	41%	49%	45%
Asking questions	58%	34%	46%
Learn about parenting	40%	29%	35%
Have someone to talk to	36%	27%	32%
Improve personal health	23%	19%	21%
Get connected to Resources	17%	17%	17%
Learn about pregnancy	37%	13%	25%
Other	4%	4%	4%

It should be noted that these results may contain selection bias because it is possible that families that are more satisfied and engaged in the program take the time to respond to the satisfaction survey, and there is not currently a mechanism to collect detailed information from exiting families about why they disengage from services.

Performance Measures – Outcomes

2019 HRSA Performance Measures are a valuable tool to assess quality because they allow for comparison across states, programs, and time points. They indicate how evidence-based home visiting programs compare to other states and national averages and can also be used to compare against past performance and set goals for performance and systems outcomes in the future. For instance, improvement from one year to the next could be an indication that the program has implemented policies or quality improvement projects to improve that measure. Several Louisiana performance measures will be reviewed here. These indicators have been chosen for review for

several reasons, including higher relative confidence in data quality as compared to other indicators, and noteworthy aspects of Louisiana performance related to national thresholds (national thresholds represent a running average of all national MIECHV programs and a measure for programs to strive toward (HRSA, 2020). See Appendix C for all performance measure data referenced here.

Performance indicators are related to HV processes and may be directly influenced by the actions and processes of the program. Performance indicators can also be a resource for families and communities; they can be used to evaluate the value, quality, and equity of home visiting programs as a tool for achieving their goals. Examples of performance indicators reviewed here are depression screening, developmental screening, and postpartum care. An important component of evidence-based home visiting is to administer caregiver and child screening at specified intervals during program enrollment. Assessing the percentage of enrolled primary caregivers who have suggested screenings is an indicator of whether the LA MIECHV program is adhering to program guidelines. Eighty-four percent of enrolled primary caregivers in LA MIECHV were screened for depression within 3 months of enrollment or delivery, as compared to 64% the prior year, and the national threshold of 80% in 2019. This value has increased and is higher than the national average, an indication that Louisiana has shown demonstrable improvement in screening for depression. Expansion of consultation for mental health and initiation of quality improvement projects such as the national HV Collaborative Innovation and Improvement Network (HV CoIIN) Maternal Depression Cohort in 2019-2020 are likely driving this significant depression screening improvement in Louisiana.

In 2019, 55.9% of children enrolled in a Louisiana home visiting program had a timely screen for developmental delay using a validated parent-completed tool, compared to 48.4% the prior year and a national threshold of 75%. This value is lower than the national threshold, indicating that Louisiana has room to improve on screening children for developmental delays. Louisiana has opportunities to improve upon this screening program through partnership with statewide initiatives supported by the BFH such as the Louisiana Developmental Screening Initiative and Learn the Signs: Act Early (LTSAE).

Like screenings, a component of the LA MIECHV program is to ensure women attend postpartum healthcare visits. In 2019, 64.6% of enrolled primary caregivers who enrolled prenatally or within 30 days of delivery had a postpartum healthcare visit within 8 weeks of delivery, compared with 53% the prior year and a national goal of 67%. Louisiana is just shy of the national threshold, indicating that performance is roughly the same as the rest of the national population.

Systems outcomes are more indicative of underlying population health and systems performance and are generally less sensitive to home visiting interventions. One example of systems outcomes measured by home visiting programs is preterm birth. In 2019, 12.6% of infants born to mothers enrolled in home visiting before 37 weeks were born preterm following enrollment, compared with 13.6% the year prior, and the national threshold of 11%. Louisiana values are similar to national thresholds for the most recent year. This indicates that the families who participate in home visiting in Louisiana have similar birth outcomes to participants in other areas of the country.

Family Demographics

While Louisiana demonstrates considerable opportunities to provide LA MIECHV services, it is also important to understand whether there is equitable access to LA MIECHV services across Louisiana. In this section, demographic characteristics of families who participate in LA MIECHV home visiting services is discussed relative to the population of families who live in Louisiana who may be eligible for services. The analysis compares the age, ethnicity, and race of the primary caregivers who were enrolled in the LA MIECHV program during 2018 with the age, ethnicity, and race of women whose 2018 birth was covered by Medicaid (the same cohort as compared earlier in an analysis of program reach). NFP data for race, age, and ethnicity of enrolled primary caregivers is limited to newly enrolled families during SFY 2018-2019 due to data system limitations.

Age. When comparing age of participants to age of mothers giving birth in 2018, the LA MIECHV participant cohort is younger than that of the cohort of women giving birth covered by Medicaid in 2018. Two-thirds of the LA MIECHV cohort was under the age of 25 at enrollment, whereas less than half of women with a Medicaid birth were under 25. This is likely attributable to NFP program enrollment requirements for nulliparity. The average age for first birth in Louisiana is 24 years old (CDC Wonder, 2018), which suggests that women eligible for NFP would be generally in their early-to-mid 20's. Research has found that "adolescent age paired with limited education are associated with higher likelihood to enroll in home visiting services" (HRSA, 2017). Additionally, some home visiting programs place an emphasis on serving mothers in perceived high-risk groups such as adolescents (Duffee et al., 2017). This investigation compared the percent of primary caregivers enrolled in LA MIECHV in the following age categories with the percent of Medicaid births in each category. Results are shown in Table 15 below. Relative to other regions, regions with PAT teams serve higher shares of women in their late twenties and thirties, which may indicate that PAT teams are serving older mothers relative to NFP teams. The data suggest that older mothers who are giving birth, perhaps to multiple order children, have limited access to home visiting, particularly in regions that only offer NFP.

Table 15. Age of LA MIECHV primary caregivers at program enrollment compared to age of mothers at Medicaid birth in 2018 in Louisiana.

	<20		20-24		25-29		30+	
Region	**LA MIECHV (n=673)**	**Births (n=3,543)**	**LA MIECHV (n=886)**	**Births (n=11,601)**	**LA MIECHV (n=456)**	**Births (n=10,541)**	**LA MIECHV (n=325)**	**Births (n=9,055)**
1	28%	7%	27%	28%	23%	32%	21%	32%
2	37%	10%	39%	32%	13%	31%	10%	28%
3	29%	10%	46%	34%	20%	31%	6%	26%
4	33%	11%	48%	36%	14%	29%	5%	24%
5	37%	12%	44%	38%	16%	28%	3%	21%
6	34%	12%	45%	33%	14%	26%	6%	28%
7	25%	11%	37%	35%	20%	32%	18%	22%
8	21%	12%	35%	36%	25%	28%	18%	24%
9	37%	10%	37%	34%	16%	31%	10%	25%
Overall	29%	10%	38%	33%	19%	30%	14%	26%

Ethnicity. Hispanic ethnicity is defined here as self-reported identification as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish origin or culture regardless of race. During 2018, 9% of all Medicaid births in Louisiana were to Hispanic women, and 7% of all LA MIECHV enrolled primary caregivers identified as Hispanic, indicating that overall LA MIECHV is serving Louisiana's Hispanic primary caregivers. It is important to note that Louisiana's Hispanic population is low (5.2% in 2017) compared to the overall US population (18%) (American Community Survey, 2018). Two Louisiana regions have a higher proportion of Medicaid births to mothers of Hispanic ethnicity: Region 1 and Region 2. In Region 1, 22% of Medicaid births in 2018 were to mothers of Hispanic ethnicity and 12% of LA MIECHV primary caregivers reported Hispanic ethnicity. This gap between the

population of women giving birth and those enrolled in home visiting services may indicate that families of Hispanic ethnicity are underserved in Region 1. In Region 2, the percentages are fairly aligned; 13% of mothers giving birth and 14% of LA MIECHV primary caregivers reported Hispanic ethnicity. An opportunity exists to examine different practices in these two regions in recruitment, referral, language offerings by bilingual staff, and retention strategies for families with different cultural or language needs through qualitative exploration.

Table 16. Ethnicity of LA MIECHV primary caregivers compared to ethnicity of mothers at Medicaid birth in 2018 in Louisiana

	% Mothers of Hispanic Ethnicity	
Region	**LA MIECHV (n=2,347)**	**Medicaid Births (n=34,775)**
1	12%	22%
2	14%	13%
3	7%	11%
4	8%	6%
5	4%	6%
6	2%	4%
7	3%	6%
8	4%	3%
9	6%	9%
Overall	7%	9%

Race. Of primary caregivers enrolled in LA MIECHV home visiting during 2018, over half were Black, and one third White (13% Other or missing). Race of mothers with a Medicaid birth in 2018 and primary caregivers served by LA MIECHV are similar. Regional disaggregation shows that variation in race of enrolled primary caregivers generally follows the variation in race of mothers with a Medicaid birth in 2018. Overall, LA MIECHV serves primary caregivers that are racially representative of the population of women with Medicaid births in 2018.

Table 17. Race of LA MIECHV primary caregivers compared to race of mothers who had a Medicaid birth in 2018 in Louisiana.

	Black		**White**		**Other**		**Missing**	
Region	**Model (n=2,269)**	**Medicaid Births (n=34,775)**	**Model (n=2,269)**	**Medicaid Births (n=34,775)**	**Model (n=2,269)**	**Medicaid Births (n=34,775)**	**Model (n=2,269)**	**Medicaid Births (n=34,775)**
1	69%	54%	18%	18%	5%	28%	8%	0%
2	76%	64%	15%	20%	3%	16%	6%	0%
3	49%	42%	41%	40%	8%	18%	3%	0%
4	57%	46%	36%	45%	4%	9%	3%	0%
5	37%	37%	54%	54%	8%	9%	1%	0%
6	45%	40%	50%	53%	4%	7%	1%	0%
7	75%	59%	20%	31%	2%	10%	2%	0%
8	66%	59%	29%	35%	3%	4%	2%	0%
9	42%	32%	52%	56%	5%	11%	1%	0%
Overall	57%	48%	35%	39%	5%	12%	3%	0%

The comparison presented in Table 17 should be interpreted as an estimate, as birth data and model data do not disaggregate by race using the same methodology, definitions, or categories. NFP data was limited to only newly enrolled families in SFY 2018-2019 because of data limitations from the NFP data system. These limitations highlight a gap in the ability to monitor racial equity at the programmatic level.

Staff Recruitment and Retention Characteristics

Staff recruitment and retention are two areas that are important to understand the quality and capacity of LA MIECHV program delivery. Staff recruitment directly impacts program capacity because the recruitment, hiring and training process requires the time of current LA MIECHV staff. Additionally, there is a relationship between staff qualifications and program quality. For instance, research shows that families served by more experienced HVs typically complete more home visits than families with less experienced HVs (HRSA, 2015). LA MIECHV has stated in HRSA grant reporting that they have difficulty finding qualified candidates, particularly in rural areas and in Region 1, where LA MIECHV competes with more plentiful job opportunities for nurses and educators.

One challenge to staff recruitment is the fact that the NFP model requires that nurses hold a BSN, whereas in Louisiana the standard for many hospitals is an Associate's degree in Nursing. This difference in accreditation standards makes it difficult to recruit nurses with Bachelor's degrees. LA MIECHV has thus requested variances from NFP to hire associate-level nurses who have relevant experience. Program leaders find that this solution has been satisfactory in recruiting new hires. Hiring for PAT presents few challenges, as the relative flexibility of PAT model requirements presents LA MIECHV with an opportunity to have a larger hiring field and thus choose candidates based on fit and local criteria.

Job satisfaction among home visiting staff is an important consideration to promote staff retention, which is a critical factor for ensuring program capacity due to adequate staffing as well as program quality due to known benefits of having long-standing, trusting relationships between enrolled families and their home visitor. In a 2018 survey of LA MIECHV home visiting staff, over 95% of staff indicated that they saw themselves staying in their job for the next year or so (LPHI, 2018). Moreover, studies in other states have demonstrated that staff turnover (e.g. minimal retention) is a factor in participant exit from home visiting programs (HRSA, 2017). For NFP, a large relative risk of program exit was found to be associated with HV attrition in national research (HRSA, 2017). LA MIECHV grant reporting indicates that LA MIECHV continues to prioritize staff well-being and job satisfaction, with a goal of promoting staff retention and preventing attrition in numerous ways. Moreover, LA MIECHV remains responsive to staff feedback by planning and providing trainings, workshops, and policy updates to support the effective provision of high-quality home visiting services throughout all 19 teams. To provide PAT HVs with clinical expertise and support, LA MIECHV placed Nurse Supervisors on all teams, including PAT. LA MIECHV prioritizes high quality reflective supervision and infant mental health consultation in response to HV concerns about families with significant mental health needs and emotional exhaustion.

Staff Attrition and Length of Employment

The average length of employment for the 19 NFP and PAT Nurse Supervisors who were employed as of April 2020 is nine years, though it is important to note that teams implementing PAT were more recently hired, and their Nurse Supervisors have correspondingly fewer years of employment. Between April 2018 through April 2020, there were seven Nurse Supervisor resignations (one a promotion and two retirement), and the average length of time that Nurse Supervisor positions remained vacant was two months. HVs and Assistant Supervisors have an average length of employment of five to eight years, respectively.

Table 18. As of April 1, 2020 – Average length of employment (in years) for each home visiting staff type and positions filled

Position	Overall	Range	Number of Positions	Number Filled
Supervisor	9	0.7 - 21	19	19
Assistant Supervisor/Lead PE	8	0.3 - 21	17	16
HV	5	0.1 - 17	115	103

Staff vacancies and turnover of HV positions can have negative implications for service capacity and retention of families. It is important to recognize where and why positions are vacant for a greater than average amount of time, or where and why multiple positions in one area may be vacant in a short period of time. Long vacancies could result in a lack of access to services for families residing in that area, particularly if the vacancy is the only position serving that area. If there is a pattern of frequent turnover and vacancy in a certain region or parish, this could lead to greater than average family attrition, lost community connections with referral sources, and community mistrust in the program due to inconsistent service capacity.

There was significant variation in number of HV resignations and average months of vacancy per team between April 2018 and April 2020. A table outlining staff vacancies is located in Appendix F. When comparing between teams, a higher number of HV resignations could indicate difficulty with staff retention, and a higher average number of months vacant per vacancy could indicate difficulty in recruiting highly qualified candidates for the position. There were three home visiting teams that experienced four resignations over two years, the highest number of resignations. Two NFP teams experienced no staff resignations during the two-year period. Two teams experienced notable turnover during this period. The Region 1 NFP team experienced 23 months total of HV vacancies, with four vacancies and an average of six months vacant per position; they also experienced two Nurse Supervisor vacancies (one resulting from promotion) with a total of eight months of vacancy in the Nurse Supervisor position. The Region 8 PAT 8A team experienced one Nurse Supervisor resignation with three months of vacancy, and 10 HV resignations, with 35 months of total vacancy and an average of six months per position. Personnel challenges contributed to the above average number of resignations on that team. Other notable findings include that several teams only experienced HV resignations when HVs were promoted to a Nurse Supervisor position as the Nurse Supervisor resigned.

Gaps in service provision and utilization

Several notable gaps in service provision and utilization of home visiting exist in Louisiana and can be drawn from data discussed in this section. Service provision gaps include families with more than one child, ease of community access to services, and staff vacancies and attrition. Gaps in service utilization include low statewide reach, higher than average family attrition rates during the first year of service, and higher than average refusal rate for eligible families.

About 80% of all families enrolled in evidence-based home visiting are served by the NFP model in Louisiana. This excludes multiparous women, and by extension, women who are older at age of birth, in all but three regions of the state. Older mothers and mothers with more than one child are underserved in Louisiana. One third of families referred to LA MIECHV services are never able to be contacted; those families may be eligible and may even have intended to enroll in services, but because they were unable to be contacted, they never were able to decide if they wanted to receive services. Staff vacancies and turnover can cause gaps in service provision, both in availability of services in specific geographic areas, and in continuity and quality of services for families already enrolled. Research has shown that staff vacancies and turnovers are associated with attrition, leading to lower caseload capacity. This would impact quality of services delivered to families and could also have an impact on referrals and enrollment when staff turnover causes loss of contact with referral sources.

Service utilization gaps are characterized by regional variation in program reach, family attrition rates, and enrollment refusal rates. Statewide reach, defined as families enrolled of those eligible, is estimated to be around 11%, but varies statewide from almost 6% - 22%. Areas with less reach, especially those with higher risk, likely contain more eligible families than service capacity or slots allow. This may not be apparent to teams with average or low service capacity due to several factors, including inability to contact referred families and a high refusal rate relative to national rates observed in research. It is not known how effective referral partners are at identifying and referring all eligible families in a service area; this will be discussed further in the next section. Family attrition rates that are higher than those observed in national research suggest there is room for improvement of both capacity and quality of services offered to families. When families opt out of the program after a short time, this suggests that they could've found that they received enough benefits (Hernandez et al., 2019), were not very interested to begin with, benefits to participation were not apparent to them, or there were other barriers to retention (such as time for visits) (Holland et al., 2014).

In addition to these broad service and utilization gaps at the state level, there are some regional gaps that should be highlighted as well. Region 1 faces several related challenges, more vacancies and turnover, lower service capacity, and shorter program duration relative to other regions in the state. The data suggest that Hispanic families may be underserved in this region as well. Detailed service capacity and utilization for EHS-HBO and Healthy Start is not available, so it is possible that these alternative models are serving families who could and would otherwise be served by LA MIECHV. Though this may explain enrollment and referral challenges, it does not explain lower relative enrollment duration. Vacancies and staff turnover suggest that hiring and retaining staff is challenging in this region, which adds to instability in capacity and quality, and could impact enrollment duration negatively. An additional factor that could influence enrollment, capacity, and quality is staff turnover in the OS position in Region 1. Anecdotal data suggest that retention has been a challenge in Region 1, with four OSs occupying the position over the last 5 years, which impact the ability of the program to stay connected to community partners, including those who refer to LA MIECHV.

Regions 7 and 8 have high relative reach compared to the state average and have the highest concentration of home visiting resources in the state, with 5 teams in Region 7 and 3 in region 8, although these areas do not have the largest absolute eligible population. These areas have a higher concentration of risk. Low service capacity in this area relative to the state is likely a function of one new PAT team, and one team undergoing significant staff turnover, which greatly impacted their caseload during this period. Reach suggests that this Region is being well served, but staff retention and family engagement should be important priorities in this region to build service capacity.

Addressing Indicators of High Need through Early Childhood Systems of Care

Home visiting programs and early childhood systems address indicators of high need through several initiatives and collaborations. Indicators of high need in at-risk parishes include factors relating to birth and the peripartum period such as adverse birth outcomes and inadequate prenatal care; factors relating to family health and wellbeing such as low SES, substance use, and poor access to mental health resources; and factors relating to child health and wellbeing such as child maltreatment and low access to publicly funded pre-k. Evidence-based home visiting services play a role in addressing the needs of the community, often through resource networks and collaboration with other agencies at the local and state level. LA MIECHV has relationships with other providers of early childhood health and social services, including DCFS, Louisiana Department of Education (LDOE), EarlySteps, WIC, Reproductive Health Program Clinics, and other services for children with special healthcare needs. Hospital systems and pediatric medical care facilities, and Medicaid Managed Care Organizations (MCOs) are coordinating with LA MIECHV to provide referrals into the program and build more cohesive partnerships. LA MIECHV is moving toward more coordinated care with a goal of connecting an information exchange with referral partners and providers to better support family needs and address gaps in care and resources.

LA MIECHV addresses indicators of high need in communities through participation in community coalitions, BFH-led initiatives, and partnerships with a broad array of community providers and networks. These coalitions, initiatives, and partnerships and how they address indicators of high need will be described below.

Community Advisory & Action Teams (CAATs), located in each LDH Administrative region and co-led by LA MIECHV Nurse Supervisors and Maternal/Child Health (MCH) Coordinators, were launched statewide in 2017 to gather community organizations and stakeholders to put solutions into action for family health in their communities. CAATs include diverse membership such as healthcare providers, business owners, parents, policymakers, and local governance and public servants. CAAT priorities vary by region, but often include infant and child safety and injury prevention, access to care and services for early childhood, and transportation. CAATs are supported by a statewide leadership team. Through CAATs, BFH is working to develop and strengthen family engagement across all programs and services. CAATs address needs at the regional level and build community connections to strengthen resource networks and community awareness of early childhood systems of care.

Child screening and intervention for developmental delay is addressed through early childhood systems of care by several initiatives: a BFH-led ECCS grant, Louisiana LAUNCH (formerly Project LAUNCH), and EarlySteps. Early Childhood Comprehensive Systems (ECCS) aims to increase three-year-old children's developmental skills within two place-based communities in Louisiana. Louisiana LAUNCH provides mental health consultation to EarlySteps providers and Primary Care/Pediatric Providers, specifically for families of very young children. ECCS and Louisiana LAUNCH work to improve access to screening and referrals at the local level; Louisiana LAUNCH also was tasked with building a coordinated system of care in the Acadiana region in which it operated. ECCS and LA MIECHV have collaborated at the local level in two parishes, Morehouse in Region 8, and Vermilion in Region 4, to share data about developmental screenings and referrals. The Individuals with Disabilities Act (IDEA) Part C program in Louisiana, EarlySteps, provides services such as therapies and service coordination. EarlySteps is overseen by the State Interagency Coordinating Council and is administered through LDH. According to publicly available data, EarlySteps served 4,775 children 0-3 years of age with an Individualized Family Service Plan (IFSP) during 2016 and 2017 (Louisiana Department of Health, 2018).

BFH has several initiatives which collaborate to improve access to mental health resources for families in at-risk counties. The LA MIECHV Infant Mental Health Team embeds an infant early childhood mental health consultant (IECMHC) within each home visiting team, providing critical support for HVs with clients impacted by maternal depression, SUD, and other mental health challenges. This systematic approach to consultation aims to increase HV competence and comfort in recognizing and supporting mental health and trauma symptoms. Consultants help HVs assess mental health concerns, better understand the issues the family is managing, and to provide psychoeducation and facilitate referrals to community mental health providers as needed. To further support families, the IECMH Team became rostered providers of Child-Parent Psychotherapy (CPP), an evidence-based intervention model for children aged 0-5 who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or behavioral problems. LA MIECHV is the first home visiting program to systematically train mental health clinicians to provide this treatment model as an adjunct to standard home visiting services for a limited number of families. Louisiana LAUNCH and Louisiana Mental Health Perinatal Partnership (LAMHPP) also provide consultation to perinatal providers and early intervention providers.

In addition to providing resource connections for families, LA MIECHV addresses child health and wellbeing through collaboration with Department of Family and Youth Services (DCFS), the Young Child Wellness Collaborative, local early childhood councils, such as the Children's Coalition in Region 8, and the state network of community early childhood providers and stakeholders. Some LA MIECHV teams have strong collaborative relationships with local DCFS agencies, with active data sharing and collaboration at the family level. The LDOE has established "community

networks" in each parish that serve as an enrollment resource for families to sign up for birth-4 publicly funded early care and education. When families attend enrollment events, they are also offered other resources for parents, including evidence-based home visiting. A partnership between LA MIECHV and Community Networks to coordinate access to MIECHV as resource to families that engage with the local Community Networks has been in process since early 2020, kicking off with trainings so that both entities understand the purpose and processes of the other. In early 2019, after receiving nearly $8 million in funding from the Preschool Development Grant to enhance early education throughout the state, the LDOE began piloting a new phase of more collaborative networks called "Ready Start Community Networks." These Ready Start Networks were begun in seven communities in Louisiana and will be expanded statewide in the coming years (LDOE, 2019).

Public support and community buy-in for evidence-based home visiting in at-risk parishes is varied from region to region, and local teams have worked to cultivate champions for home visiting through collaborative efforts such as CAATs, cross-sector networking, and community outreach. All regions have at least one CAAT, as described in an earlier section. The CAAT in each region has the function of gathering community stakeholders to prioritize needs, coordinate, and plan regional interventions to promote the health and safety of Louisiana's families. The CAATs are at different phases, and some may be more robust than others based on their membership and how long they have been active. A goal of the CAAT network and Title V statewide is to include more parent involvement, with roles as active decisionmakers.

MIECHV has achieved significant coordination and recognition notably in the Region 4 and Region 7 areas of the state, in part due to the longevity of the outreach specialists in that region, and the strength of the connections they have built with their communities. In Region 4, there are several coalitions that engage the public and stakeholders in early childhood and child health, including Young Child Wellness Collaborative, Healthy Start, and the CAATs.

COMMUNITY READINESS

Qualitative methods were used to assess community readiness for evidence-based home visiting services. The qualitative researchers used an iterative, community-informed approach to data collection, with feedback and support from LA MIECHV home visiting staff.

Methods

Two regions were selected as focal areas for qualitative research: Region 1, Greater New Orleans, and Region 7, Northwest Louisiana including Shreveport. These areas were selected because they included teams implementing both NFP and PAT, covered areas with a large proportion of the population of Louisiana and are culturally diverse regions. Region 7 teams have historically experienced a high degree of collaboration with community members and typically have had fewer challenges with referrals or enrollment. Conversely, Region 1 teams have had fewer referrals to the program, lower overall enrollment, and shorter average length of enrollment when compared to other teams.

Convenience and snowball sampling methodologies was used to recruit individuals to participate in interviews across all non-staff categories. Regional BFH and LPHI staff developed lists of community leaders in maternal/child health and early childhood; the list included individuals who were connected to LA MIECHV as referral sources as well as individuals who did not have any connection to LA MIECHV. Community leader/key informants included advocates, community organizers, doulas, healthcare providers, parish health unit staff, leaders of community or-

ganizations, and leaders of other home visiting programs. Community members were invited to participate in interviews by community leaders as well as regional BFH staff. Former and current families were invited to participate by their HVs.

Table 19. LA MIECHV Staff Interview Descriptors				
Descriptor	**Supervisory and Outreach Staff**	**Community leader/key informants**	**Current or Former participants**	**Non-participant community members**
# of Interviews	9 (20%)	11 (24%)	13 (29%)	12 (27%)
Region				
Region 1	2 (22%)	5 (45%)	6 (46%)	5 (42%)
Region 7	7 (78%)	6 (55%)	7 (54%)	7 (58%)
Ever Heard of LA MIECHV (Y/N)				
Yes	N/A	8 (73%)	100%	1 (8%)
No	N/A	3 (27%)	N/A	11 (92%)
Ever Referred to LA MIECHV (Y/N)				
Yes	N/A	8 (73%)	N/A	N/A
No	N/A	3 (27%)	N/A	N/A

In the Spring of 2020 when qualitative research was set to begin, all planned in-person data collection activities had to be shifted to virtual data collection because of the global COVID-19 pandemic. All focus groups and interviews were virtual and were held via phone or ZOOM, and were recorded, transcribed, coded, and analyzed using Dedoose software. Interviews were conducted by a qualified interviewer familiar with the MIECHV program. Further details and an analysis of limitations of qualitative data collection are located in Appendix G.

COMMUNITY READINESS FINDINGS

There are three main research questions that the qualitative data seeks to answer.
What is the reach of evidence-based home visiting in communities in Louisiana?
What is the degree of connectedness of existing home visiting services in communities in Louisiana?
How can we characterize the need, preferences, and cultural considerations for evidence-based home visiting services in communities in Louisiana?

Reach of home visiting programs in Louisiana is limited by recognition, eligibility criteria, and discretion of referral providers. Community members and LA MIECHV staff describe a lack of knowledge about home visiting by eligible families. Eligibility criteria are seen as limiting by community members, specifically restrictions based on gestational age, parity, and income. Community members believe that many more families in Louisiana could benefit from home visiting services than are eligible. The dominant method for enrolling eligible families is through referrals made by community providers; the largest such provider is WIC. Another method for reaching families is face-to-face enrollment by HV staff located in WIC clinics or other community provider settings. Both methods of enrolling potential families have benefits and drawbacks. Community referrals are less time intensive for HV staff, but both HVs and community leaders/key informants who refer explained that they do not consistently provide referrals, nor do they refer every eligible family - often they have their own, more limiting, criteria for referral, such as high-risk pregnancy or parenting adolescents. Face-to-face recruitment and enrollment are seen by HVs as more reliable and effective, but they state that it is time consuming, and time spent recruiting is competing with time spent visiting with other families. Another challenge that is caused by low community recognition is the barrier of initial

distrust or suspicion because families have never heard of home visiting services. This may contribute to low acceptance of services when families have little information to make their decision. Thus, HVs must invest time and effort to build initial relationships with eligible families. Many staff believe that with different marketing and advertising efforts, more families might recognize and trust the program, and therefore LA MIECHV staff would have less difficulty enrolling families, as they may already be aware of and interested in home visiting.

Because community providers have such an important role in reaching families, relationships with community providers should be maintained to assure mutual benefit and a robust partnership. Regular communication about families, collaboration in serving families, and frequent face-to-face contact are elements of a healthy community partnership; HV staff believe that they have had greater success creating meaningful partnerships and generating referrals with partners who serve smaller and more rural populations than with busier, more urban focused partners. HVs and community providers both described declining referrals and communication between each other in recent years but did not have any explanation or hypothesis for this. This presents an opportunity for LA MIECHV to further investigate the patterns of referrals and enrollment that are associated with their regional referring agencies. Community providers frequently discussed losing contact with HV programs, leading to fewer referrals, inaccuracies in understanding of service offerings, and even poor perceptions of home visiting services. Some community providers feel that home visiting services are not adequately connected to or serving communities, and express doubts that services are beneficial to families. Many of their perceptions are based upon inaccurate understandings of home visiting services, a probable result of losing contact with teams and feeling undervalued as a partner. More frequent contact or collaboration, more understanding of HV services and benefits, and a frequent updates of referral outcomes would be appreciated by community providers.

Most current/former participants who were interviewed were very happy with their experience, and express that they would like to continue services beyond the program enrollment period. Families cite strong supportive relationships with their HV as the most significant benefit of participation. Experienced and perceived benefits by community members are having a support person to ask questions, getting support and encouragement for child development, and connecting to resources. There are tangible benefits to participation in home visiting that were identified as community needs, such as breastfeeding support, child development support, and connection to resources. Families expressed a need for more flexible scheduling for visits to accommodate their family schedules. Families who have never participated expressed doubt and hesitation about allowing home visits to take place in their homes, and HVs described strategies to build trust with families experiencing discomfort with that aspect of services. Community providers discussed family distrust and disinterest in allowing HVs into their home, and suggested alternative locations as a solution. HVs expressed a desire to provide essential or emergency items for families in need, particularly infant and baby necessities such as diapers.

Families and key informants stated that communities in Louisiana need general parenting education and support, transportation, mental health resources, and more coordination of perinatal and early childhood systems. Community providers expressed needs for more intensive and coordinated prenatal and postpartum services, such as screening for physical and mental health conditions that could impact birth outcomes. There are opportunities for home visiting services to further integrate with community providers such as health providers, supportive services, early childhood services, and schools.

Adaptation to local and family level needs by home visiting services could address some of the challenges identified by LA MIECHV staff, families, and community providers. Community members describe families who are unable to accommodate visits in their home, but who may also be limited in their ability to travel to an outside location to meet with their HV. These families are likely the least reached by home visiting services. HVs could collaborate with community providers and healthcare services to combine visits for these families who are not receptive to or able to accommodate visits in the home.

Qualitative data highlights key differences in how NFP and PAT model characteristics and availability are perceived. The NFP model is more widespread and has been operating for longer than PAT in Louisiana. Community members had mixed feelings about the NFP model. Community members and community providers both expressed frustration with model requirements for length of service and eligibility criteria, with valid points that the model excludes a great number of parents who could greatly benefit from services. Both community members and providers also emphasized the unique offerings and importance of the clinical aspects of NFP, citing these as reasons for why home visiting was important and successful in Louisiana. Model fidelity requirements allows for little adaptation to address these contradictions. In contrast to NFP, PAT services were less widely recognized by the community members who were interviewed, but this may be because it is a newer model and is less widely offered than NFP. HV and HV staff expressed a need for PAT to be offered more widely in Louisiana, as they feel that they are missing families who could participate, because of narrow eligibility criteria for NFP, and in many parishes only NFP is currently offered.

Appendix I contains selected quotations from interviews with LA MIECHV program staff, key informants/community leaders, current/former participants, and non-participant community members. These quotations were selected to highlight some of the themes summarized in this section. Findings were coded to the following key domains: Recognition, eligibility, referrals, trust, benefits, community needs, cultural humility, and barriers to enrollment.

CAPACITY FOR PROVIDING SUBSTANCE USE DISORDER TREATMENT AND COUNSELING SERVICES

SUBSTANCE USE DISORDER AND PREGNANT WOMEN

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines Substance Use Disorder (SUD) as "a problematic pattern of using alcohol or another substance that results in impairment in daily life or noticeable distress" (DSM-5). Each specific substance is categorized as its own use disorder with diagnosis based on the same overarching set of criteria (APA, 2013). Opioid Use Disorder (OUD) will be highlighted in this section because of its emergence as a national public health epidemic, causing a significant increase in opioid-related deaths and hospitalizations across the United States (CDC, 2020).

The evidence-based standard of care for pregnant women with OUD is medication assisted treatment (MAT). According to a 2019 PEW report, "MAT, which pairs behavioral therapy, such as counseling, with U.S. Food and Drug Administration (FDA)-approved medications, is the most effective way to treat OUD." Methadone is considered the gold standard MAT for reducing opioid dependence (Stotts et al., 2009) and can only be administered at SAMHSA licensed Opioid Treatment Programs (OTPs) (SAMHSA, 2020), but two other MAT, Buprenorphine and Naltrexone, can be office-administered by a healthcare provider. "OTPs are also an important part of the care during pregnancy, as MAT with buprenorphine or methadone is the standard of care for pregnant women with OUD because of improved maternal and neonatal outcomes when combined with comprehensive prenatal care" (Pew, 2020).

Prevention and Intervention

The Louisiana Office of Behavioral Health (OBH), BFH, and the Louisiana Perinatal Quality Collaborative (PQC), an initiative of BFH, have initiated demonstration projects to study efforts to prevent Neonatal Opioid Withdrawal Syndrome (NOWS) and Neonatal Abstinence Syndrome (NAS).

These projects include OBH's Neonatal Abstinence Restoration Program and a BFH/OBH NOWS Pilot Project implemented by the PQC, which focuses on the implementation of evidence-based best practices including Screening, Brief Intervention, and Referral to Treatment (SBIRT). The Neonatal Abstinence Restoration Program added specialty beds for pregnant women and women with dependent children who receive MAT to an existing Human Services District-run TANF residential program, Reality House, located in Baton Rouge. The NOWS Pilot Project supported staff in implementing screening and referral services at four birthing hospital sites, Women's Hospital and Baton Rouge General Hospital in East Baton Rouge Parish, Our Lady of the Angels Hospital in Washington Parish, and Slidell Memorial Hospital in St. Tammany Parish. These hospital sites prioritize colocation of mother and infant, maternal access to OUD treatment, and promotion of practices that minimize harm and improve outcomes in infants, as a safe alternative to treatment in hospital-based intensive care unit settings. The PQC NOWS Pilot Project aims to create a change package and measurement strategy for comprehensive, patient-centered screening and treatment of birthing persons with SUD and newborns affected by NOWS.

Substance Use Disorder Treatment Facilities Overview

As of SAMHSA's 2019 survey of SUD service providers, 120 facilities indicated that they provide SUD treatment in Louisiana (SAMHSA, 2020). Overall, 103 (86%) of SUD treatment facilities indicated that they accept Medicaid, state insurance, or sliding scale payment. Only 27 (23%) of all SUD facilities in Louisiana facilities specified that they provide special SUD programs for pregnant women. Of facilities that provide SUD services for pregnant women, 19 (70%) accept Medicaid payments (the remaining 30% accept cash or private insurance payment only). Five SUD facilities in Louisiana focus specifically on women with dependent children and pregnant women covered by Temporary Assistance for Needy Families (TANF) funds. Each LDH Administrative region in Louisiana has at least one SUD treatment facility that accepts pregnant women with Medicaid coverage. However, most are in larger cities.

At any given moment, there are a total of 69 beds available statewide for residential SUD treatment of women with dependent children. Child bed totals vary because some facilities do not limit the number of dependent children that can be admitted with their mother. Minimum length of stay for women and their children ranges from no minimum to 6 months; maximum length of stay is one year or more. Though it is often beneficial for the treated individual to have a long or no maximum length of stay (Koenig et al., 2000), the actual number of treated women and their families may be low to accommodate longer stays. Data about utilization of TANF-funded residential facilities for women and children is unavailable.

As of 2020, Louisiana was home to 10 OTP facilities, all of which are outpatient day treatment centers. Seven OTPs (70%) indicated that they accept pregnant women, but none accept Medicaid. Although all 10 OTPs provide pregnancy tests to female clients upon beginning the program, a 2016 analysis by BFH found varying practices for caring for pregnant clients. Some OTPs placed pregnant clients with special counselors or nurse practitioners and engaged with the clients' obstetric care providers. Three OTPs provided specialized care to address obstetric needs, including "development of individualized treatment plan, monitoring of prenatal treatment, updating treatment plan after delivery" (Baca, 2016).

GAPS IN SUBSTANCE USE DISORDER TREATMENT SERVICES

Gaps in SUD treatment for pregnant women and families with young children are due to limited treatment availability, limited availability of MAT, lack of coordination across sectors, and a policy landscape that does not take into account the social determinants of health that create and exacerbate effects of SUD in vulnerable populations. Evidence-based treatment may be inaccessible to pregnant women and families with young children, particularly those who live in rural areas and use Medicaid. There is especially limited capacity for families to remain together during residential treatment. MAT is limited due to limited payment options, a relative dearth of OTP in Louisiana, and policies that deter community providers from providing MAT. Collaboration between sectors like justice, medical homes, substance use treatment centers, and child welfare is limited. Lastly, policies such as lack of access to

contraceptives and reproductive health, high incarceration rates relative to the rest of the U.S., and protocols for suspected substance-exposed newborns can contribute toward stressors and challenges that families face in seeking and gaining access to treatment for SUD.

Table 20. SABG estimate of women in need of treatment and receiving services for SUD. Source: SABG 2020-2021.

SABG Persons in need of SUD Treatment	Aggregate # Estimated in Need	Aggregate # in Treatment
Pregnant Women	20,000	193
Women with Dependent Children	67,000	1,757

Overall Gaps in Treatment of Substance Use Disorder in Louisiana

Based on an analysis of federal data conducted by the LDH in 2017, "only five percent of people needing treatment for SUDs in the state receive it" (Pew, 2019). OBH estimates that 99% of pregnant women and 97% of women with dependent children in need of treatment for SUD in Louisiana are not currently receiving the SUD services that they need (LDH, 2019).

According to Pew, "treatment capacity has not kept pace with the need for services" (Pew, 2019). One major gap is the availability of SUD treatment facilities (Pew, 2019). Although 22 SUD facilities are available statewide that serve pregnant women and accept Medicaid, only five have beds for dependent children. Moreover, facilities are limited in terms of overall capacity (only 69 beds for women available at any given time) and maximum time spent at the facility per family.

Data about the actual utilization of SUD treatment services in Louisiana is limited. According to Pew, "Louisiana…lacks complete data demonstrating the size of the state's treatment gap. For example, there is no data source that pinpoints treatment capacity, need, or utilization across the state by the level of care provided" (Pew, 2019). However, the data that is available indicates major gaps in terms of the availability and utilization of SUD services among pregnant women in Louisiana. For example, in 2018 1,006 hospitalizations were reported related to substance-exposed newborns and 1,836 newborns were validated as being a "Drug/Alcohol Affected Newborn", but only 193 pregnant women were estimated to have received SUD treatment in Louisiana (LODSS, 2018; Hussey, 2020). The Louisiana Pregnancy Risk Monitoring System (PRAMS), a national CDC survey designed to monitor maternal behaviors and experiences in the perinatal period, reported that in 2017, only one percent of pregnant women in Louisiana were using MAT and seven percent were using prescription pain relievers (Louisiana PRAMS, 2017).

Gaps in Treatment of Opioid Use Disorder in Louisiana

Gaps in available care for parents with OUD in Louisiana are even more severe. According to Pew's study of Louisiana's OUD Capacity, Louisiana "has one of the lowest numbers of OTPs per capita in the country -- 46th compared to all states and the District of Columbia" (Pew, 2019). This analysis also found that access to OTPs in Louisiana is extremely limited, especially in rural parishes. The fact that zero OTPs accept Medicaid payment further compounds these gaps, and "as a result, patients receiving care...rely on out-of-pocket payments, state and federal grants, and private insurance" (Pew, 2019). In addition to gaps in access to Methadone at OTPs, MAT provided in other settings is limited by state policies and laws. According to the FDA, everyone who seeks treatment for an OUD should be offered access to all three options as this allows providers to work with patients to select the treatment best suited to an individual's needs" (FDA, 2019).

In Louisiana, MAT availability is limited by geographic availability, as well as laws and policies that hinder use in community settings. MAT can be provided at SUD treatment facilities, OTPs, and outpatient medical office locations such as behavioral health clinics, FQHCs, or primary care medical homes. According to Pew, "of the 81 behavioral health service providers in Louisiana for which there is federal SUD treatment data, fewer than half (35) provide some form of MAT and of those, 11 provide naltrexone only" (Pew, 2019). Naltrexone may not be ideal for pregnant active opioid users, as it requires full detoxification before administration, and withdrawal is not recommended during pregnancy due to the stress it may cause for the pregnant person and fetus (ASAM, 2015). Physicians may complete federally required training requirements to become waivered by SAMHSA to prescribe Buprenorphine in their offices. Buprenorphine is an accepted treatment in pregnancy (ASAM, 2015). However, Louisiana faces a large shortage of providers who are authorized to prescribe buprenorphine and actively prescribe the medication. Per Pew, "24 parishes do not have any physician or other health-care provider who can prescribe buprenorphine." (Pew, 2019).

Louisiana faces a huge gap providing community-based OUD services to patients in rural areas. According to Pew, "more than 95 percent of the state's 452 waivered prescribers practice in urban parishes. Of those providers who treat in community based settings in Louisiana, little is known or published about their cost or ability to accept Medicaid or new patients, and "the actual problem may be more acute, since one study found that nearly half of rural physicians nationwide who obtained a waiver were not accepting new patients." (Pew, 2019). As of 2017, no waivered providers were practitioners at FQHCs. Policy regulations surrounding Buprenorphine waivers contribute to a lack of availability of the full spectrum of MAT across the state (Pew, 2019).

MAT is likely difficult to access for most Medicaid-eligible pregnant women in Louisiana. Of the five TANF-funded SUD treatment facilities specifically oriented to families and mothers with children, only one indicates that they provide MAT in the form of Buprenorphine and Naltrexone in their inpatient setting, but it is unclear if MAT is available for their pregnant patients or for non-pregnant clients only. One residential facility, Reality House, is engaged in a demonstration program to provide MAT. Of the 22 facilities that have programs for Medicaid-eligible pregnant women, 5 do not allow any use of medication in treatment. According to Pew, "many residential treatment facilities nationwide rely upon abstinence-based treatment protocols, which have higher rates of relapse in patients upon release" (Pew, 2019).

Collaboration and Patient-Centered Care

SAMHSA published the guide, "*Practice and Policy Considerations for Child Welfare, Collaborating Medical, and Service Providers*" in 2016 to guide state policy making work groups to promote collaboration, equity, cultural responsiveness, and best practices in treating pregnant women, substance-exposed newborns, and their families. According to this guide, all entities that are involved with pregnant women with SUD should be working under the same framework of evidence-based practices for the interest of the mother-infant dyad. (SAMHSA, 2016).

The only statewide publicly available guidelines are the "Louisiana Substance Use in Pregnancy Toolkit", produced by DCFS and LDH, which will be discussed later in this report. OTP providers stated in a 2016 BFH survey about reproductive health access at OTP that their concerns about treating prenatal patients were as follows; a lack of proper connections to services due to limited resources; limited funding; limited knowledge of care for infants exposed to opioids, negative stigma associated with pregnant women with SUD/OUD, lack of education and training for professionals like hospital personnel, physicians, and those working in the court system (Baca, 2016).

Policy Gaps and Response to Disparities

The topics below describe policies and systems at the state and federal level that create barriers for families impacted by SUD, perpetuate health disparities, and prioritize punishment over treatment. The American Academy of Pediatrics (AAP) recommends primary prevention for substance use in pregnancy by "preventing substance and

opioid misuse before pregnancy" (Patrick et al., 2017). As part of the public health response to the opioid crisis, the AAP recommends policies that prevent unintended pregnancy among women with OUD, along with improving broad access to contraception and reproductive health (Patrick et al., 2017). Fifty percent of mothers in Louisiana who did not intend to get pregnant were not using any form of contraception when they became pregnant (Louisiana PRAMS, 2016).

According to a 2020 Guttmacher Institute analysis, Louisiana laws consider substance use during pregnancy to be a form of child abuse. If in-utero exposure is suspected, a physician "must order a toxicology test on the newborn without the parent's consent" and it must be reported to DCFS if the test is positive or inconclusive (DCFS, 2017). In the 25 states that implemented such policies for pregnant women with SUD in response to the opioid epidemic (including Louisiana), the likelihood of a child being born with NAS was higher than in states that took treatment-oriented approaches. Researchers theorize that this is at least in part because mothers are less likely to seek medical help due to the fear of losing custody of their child (Patrick et al., 2017). Organizations such as the National Perinatal Association, March of Dimes, Amnesty International, ACOG, National Organization on Fetal Alcohol Syndrome, and the American Medical Association have expressed that non-punitive, treatment oriented approaches to SUD treatment for pregnant women are more effective than the punitive approaches (Patrick et al., 2017). Louisiana has punitive legislation surrounding substance abuse during pregnancy and has limited to no access to treatment programs specified for pregnant women, thus creating a challenging landscape for mothers with SUD.

Incarceration is a social determinant of health for both the incarcerated person and their dependents, and the children of incarcerated persons are more likely to have developmental delays, attention disorders, aggressive behaviors, and are 5 times more likely to be involved in the criminal justice system (Healthy People 2020). There is no publicly available information on implementation of the treatment program within Louisiana correctional facilities and there are no SUD programs specifically for incarcerated pregnant women. Louisiana has the second highest rate of incarcerated persons in the United States, with 1,052 incarcerated persons per 100,000 residents (Prison Policy Initiative, 2020). Five percent of incarcerated persons in Louisiana are women, 80% of whom are mothers and a primary caretaker of children prior to their arrests (Le Blanc, 2020; Human Impact Partners, 2018). In Louisiana, 1 in 12 children have been separated from a parent due to incarceration, which is 4 times the national average (Human Impact Partners, 2018). In Louisiana, black children are 9 times as likely than white children to have an incarcerated parent (Human Impact Partners, 2018). Nationally, between 58% and 63% of incarcerated persons meet the criteria for SUD, which is over 7 times the national average for non-incarcerated persons. Comparatively, the prevalence of SUD in Louisiana correctional facilities is even greater with an average of 74% of incarcerated persons diagnosed with SUD (Bureau of Justice Statistics, 2017).

Louisiana's 2020-2021 Substance Abuse Block Grant (SABG) includes a section addressing disparities in substance use treatment which indicates that OBH tracks enrollment as well as access to service and outcomes by race, ethnicity, age, gender, and sexual orientation. Louisiana has a data-driven plan to address and reduce disparities in access, service use, and outcomes, as well as a plan to identify, address, and monitor linguistic disparities and language barriers. The state does not, however, have a workforce-training plan to build the capacity of mental health and SUD providers to identify disparities in access, services, outcomes, and provide support for improving culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations, nor does the state have a budget item allocated to identify and remediating disparities in SUD treatment (Hussey, 2020). This puts diverse populations at particular risk for not receiving appropriate care and indicates that there is no current plan to train or remediate issues related to lack of access for state-identified diverse populations.

BARRIERS TO RECEIPT OF SUD TREATMENT SERVICES

HV Perspectives on Barriers to Receipt of SUD Treatment Services

LA MIECHV HVs were asked a series of questions about SUD during virtual focus groups conducted as part of this Needs Assessment (see Appendix H for questions asked). HVs were generally in agreement that enough treatment resources for pregnant women were not available, particularly evidence-based, and highly effective treatment options. Though most are not entirely aware of the resources available, the perception is that services that do exist often do not take pregnant women. Access to quality services is limited in most areas of the state, according to HVs. Actual or perceived barriers, such as waitlists, non-acceptance of Medicaid payment, lack of transportation, and lack of childcare largely prevent families from accessing services, even if they are technically available to them. In addition to these barriers, families and HVs have concerns about the adequacy of quality, and ability to meet the families' needs. Findings from these focus groups are discussed in detail in the below section.

Limited or Inadequate Treatment Resources

HVs perceive a shortage of adequate treatment resources across the state. Though many HVs were aware of participating families who successfully accessed treatment resources, the overall perception is that resources are limited and inadequate for pregnant and parenting families. Several other factors influenced availability and quality, including geographic barriers, payment/affordability barriers, and barriers related to parenting and pregnancy. Resources for pregnant women are either unavailable or little is known by HVs. As one HV explained, *"It doesn't seem to be a lot of resources for the pregnant moms that are addicted."* Several HVs explained that their rural communities offered no or limited treatment options, and that families were often unable to travel due to lack of reliable transportation. Others mentioned limited options for Medicaid patients. One HV in a rural parish explained: *"some of them don't accept Medicaid, some of them have a waiting list, and there's many places...don't accept pregnant clients when they are pregnant and using."* An important structural barrier for families is the issue of childcare during treatment - several HVs mentioned scenarios where active users were unable to seek intensive treatment because they had no or inadequate childcare, or no trusted support to keep their children during inpatient treatment. Some HVs had experienced quality issues with treatment centers, noting that families tried the options available to them, and that they were insufficient or of poor quality. One HV explained, *"She had been referred from her case worker to AA meetings and places like that which, you know, she said that's not my problem, that's not what I need. And she felt like she needed her stressors addressed and finding her therapy services was difficult. One of them was an inpatient option, and she didn't feel like she had a safe place to leave her baby at that point to be able to go inpatient."*

Resources that are insufficient or of poor quality can have significant effects on families experiencing SUD. Some HVs even spoke of experiences where parents experiencing SUD were mistreated, saying, *"I've definitely seen nurses at one hospital just treat mom with just total disrespect."* HVs described experiences with families where active users are court mandated to treatment, but it's either not the right treatment option for them, or it doesn't fully address their needs: *"She got through the initial active recovery phase one and then she was having her baby, so she didn't start with phase two, and court didn't mandate her to, so she didn't go."* The HVs are left wondering, *"Um, and so I just worry if it's not a matter of if but just when she's going to relapse."* Some HVs spoke to families who had a positive experience with their treatment center. One said, *"I have heard them talking about it and them seeking help and it being a positive experience."*

Family & Social Environment

HVs spoke at length about the challenges that pregnant women and parents in active addiction faced with regards to their family and surrounding social environment. HVs described family and community norms of drug use and abuse, unhealthy attachment and relationships, and an often-generational cycle of addiction. One HV explained, *"The people who are using usually come from families that use and it just doesn't seem like it's a problem to them."* While it is impossible to say that every participant in active addiction comes from a family with a history of drug abuse, this sentiment came up quite often with many examples of extended families and communities. The norms

of drug abuse compounded other challenges faced by parents and pregnant women experiencing SUD. HVs described participants who felt stuck and unable to break free of the influence of their surroundings. Participants who were able to seek residential inpatient treatment faced being "surrounded" by drug use; one HV worried that *"her family, it is- that is the norm in her family, she's just surrounded by it."* Another HV spoke of working with a parent who left inpatient treatment, saying *"we have to sometimes try to change what their new norm is once they get out."* Another HV described this challenge; *"even if we get them in a treatment program, it's hard to get away from the individuals that got them involved in the first place because they have no other place to go."* Facing damaging community or family norms, lack of parental support, being surrounded by negative influence are all compounding factors for pregnant women and parenting families experiencing SUD, on top of the barriers they face as someone in active addiction, like lack of treatment options, fear and stigma, and parenting challenges.

Additional Barriers Identified by HVs

Pregnant and parenting women in active addiction face additional barriers when seeking treatment for opioid addiction. Additional barriers include lack of treatment options that cater to pregnant women or parents (particularly highly effective treatment options), attachment and bonding challenges with their children, and fear of DCFS or having their children removed from their home. Many HVs expressed that pregnant women and parents in active addiction were fearful of DCFS, and by extension, entering home visiting services and trusting their HV. This distrust of outsiders came from a deep fear of having their children taken from them; as one HV explained;*"…even though you can reassure your clients that their purpose is not to remove their children, their purpose…is to help families stay together and get families the help that they need. There is a stigma that's been there a long time, so I can definitely see the fear that comes with knowing the possibility of your child to get taken away from you."*

Structural Barriers

Structural barriers exist that may play a role in why women eligible to receive care at a SUD treatment facility may not be able to. Data show that 47% of children in Louisiana live in a single-parent home, and that 20% of households are headed by women receiving child support (KIDS COUNT, 2018). Only one facility that accepts Medicaid and treats postpartum or pregnant women provides childcare. This is a significant barrier for women who want to seek intensive or residential treatment. OTPs are virtually inaccessible for Louisiana residents who do not have private insurance or the ability to pay cash; over 60% of births in 2018 were covered by Medicaid in Louisiana, so only 40% of pregnant or postpartum women would theoretically be able to afford MAT from an OTP (March of Dimes, 2018).

There is a lack of data on the number of people screened using SBIRT in obstetric and primary care in Louisiana. There are, however, efforts underway to increase SBIRT in obstetric care as a universal preventive measure, which will be described in the following section. Healthcare providers have traditionally relied on urine drug screening for suspected prenatal drug exposure. Screening based on suspicion of use rather than verbal screening results can be influenced by implicit bias, and can produce inaccurate results (Odeyomi, 2020). Lack of trust in the provider-patient relationship could be an additional barrier both to seeking prenatal care and revealing use of substances during pregnancy.

Availability and proximity of high-quality treatment services is a barrier for women and families seeking treatment for SUD. Though each region has at least one outpatient treatment facility that accepts Medicaid and pregnant women, evidence-based standard of care for providing MAT to pregnant women is not widespread. TANF residential treatment facilities that accept dependent children are mostly located near the larger urban centers and may not be readily accessible to rural residents.

OPPORTUNITIES FOR COLLABORATION

There are a number of opportunities to collaborate with state agencies, local governing entities/human service authorities (LGE/HSA), hospital systems, community organizations, and SUD treatment facilities to address gaps

and barriers in treatment for pregnant women and families with young children. At the local level, LA MIECHV staff continually seek ways to improve coordination of support to families impacted by maternal depression, SUD, and other mental health challenges and to ensure access to services, beyond just an initial referral and connection. This section describes initiatives that focus on family well-being, reduction of child abuse and neglect, and services for at-risk families who are in need of mental health or SUD treatment, and describes potential or existing partnership opportunities for LA MIECHV to collaborate with these initiatives.

BFH, in partnership with the Administrators of the Tulane Educational Fund and the Tulane Department of Psychiatry and Behavioral Science, received the Safeguarding Two Lives: Expanding Early Identification and Access to Perinatal Mental Health and Substance Abuse Screening, Treatment and Referral grant award to address perinatal depression, anxiety, and related disorders, including SUDs and interpersonal violence, primarily through use of mental health consultation. Louisiana has used the award to establish the Louisiana Mental Health Perinatal Partnership (LAMHPP), which provides consultation to perinatal providers in Regions 4 and 8. LAMHPP and LA MIECHV collaborate through psychiatric consultations, trainings, and cross-sector networking with consultants for LAMHPP, LA MIECHV, EarlySteps, and Louisiana LAUNCH (formerly Project LAUNCH). Louisiana LAUNCH provides mental health consultation to EarlySteps providers and Primary Care/Pediatric Providers in Regions 4 and 8 to support families of young children from birth to 8 years old, with mental health challenges. MIECHV and Louisiana LAUNCH continue to provide cross domain collaboration to provide resources to families of young children that may be experiencing pregnancy, substance use, other mental health conditions, as well as other environmental stressors, all while engaging the family in a supportive network of consultants, HVs, physicians, and early intervention providers, where appropriate.

Department of Children and Family Services

Child welfare agencies such as the Louisiana DCFS and community prevention agencies such as the Human Service Authorities, Substance Abuse Prevention Coalitions, and local early childhood coalitions offer an opportunity to build local support and partnerships between home visiting services and other agencies which work closely with at-risk families to address substance use disorder. LA MIECHV and DCFS collaborate on community-based initiatives such as My Community Cares and the Nurturing Parent Program.

LA MIECHV staff coordinate with DCFS on the local level via participation in DCFS' My Community Cares (MCC) Network meetings. MCC is a multitiered, multidisciplinary grassroots approach designed to empower communities to intentionally and collectively care for their children and families. With judicial leadership, the Louisiana Court Improvement Program, other legal stakeholders, and the DCFS will collaborate with local communities to build and support their capacity (Hodnett and Harris, 2019). DCFS is currently piloting MCC in four parishes (Livingston, East Baton Rouge, Rapides, and Caddo) as part of their five-part performance improvement plan. Connections have been made with local CAATs to try to prevent duplication of efforts.

Nurturing Parent Program (NPP) is a DCFS program available at each of the Family Resource Centers that serve each Administrative region. This program is a parenting program that prevents and treats child abuse and neglect, serving 328 parents statewide in 2018 with a need in their case plan. With 2019 CAPTA funding, DCFS plans to collaborate with LDH to house substance abuse counselors in each administrative region to conduct screening, assessment, and referrals to treatment. DCFS and LDH have discussed expanding home visiting programs for DCFS families of newborns affected by substances.

The Family First Prevention Services Act, signed into law in February 2018, aims to "prevent children from entering foster care by allowing federal reimbursement for mental health services, substance use treatment, and in-home parenting skill training. It also seeks to improve the well-being of children already in foster by incentivizing states to reduce placement of children in congregate care." (Torres and Mathur, 2018) This bill allows states to fund in-

home family services and SUD treatment for up to 12 months for families at risk of entering the child welfare system. DCFS is currently in the planning phase of how to best utilize the Family First Act provisions to prevent entry of children into foster care.

Louisiana Department of Health, Office of Public Health and Office of Behavioral Health

LA MIECHV has been included in the OPH Overdose Data to Action Grant as a key strategy for providing pregnant and parenting women struggling with mental health and/or addiction access to a continuum of services and supports from prevention to treatment, as well as serving to prevent SUDs by identifying and reducing risk factors, identifying and increasing protective factors. A new Training and Network Coordinator position has been created with a specific focus on building staff capacity to support families with substance and opioid use disorders via targeted training and support for HVs, IECMHCSs, and Team Supervisors.

The Region 2 NFP team has also been included in the MOM Model grant, the goal of which is to improve care for pregnant and postpartum women with OUD and their infants. The grant funds an expansion of the Guiding Recovery and Creating Empowerment (GRACE) program already in operation at Women's Hospital. The home visiting services provided by the Region 2 NFP Team are an essential part of the perinatal and postpartum continuum of care outlined in the grant.

Other Agencies and Community Organizations

Opportunities to engage health providers, particularly Obstetricians, can center on hospitals, Medicaid, and FQHCs. Because most births in Louisiana are covered by Medicaid, there is an opportunity to engage with managed care organizations (MCOs) and delivery hospitals to provide coordinated care to women in need of SUD treatment. FQHCs may have a larger role in the upcoming hub and spoke model (see next section) as an entry point into a coordinated system of care that could include MAT and other substance use treatment, as well as home visiting services for parents and pregnant women at risk.

Four delivery hospitals in Louisiana are already engaged in a quality collaborative to develop a quality improvement and measurement strategy to implement evidence-based screening and coordination for birthing persons with SUD with the BFH PQC, with plans to expand further within the PQC network of delivery hospitals. Academic research and hospital centers such as Tulane, who operates the Tulane University Project ECHO to train providers in MAT, and LSU, which is engaged in expanding SBIRT and other substance use prevention efforts around the state, could be collaborative partners in training and connecting providers with evidence-based home visiting services for at-risk mothers and families.

Several communities throughout the state received Louisiana Partnership for Success (LaPFS and LaPFS II) grants administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement substance abuse prevention programs for their communities. LaPFS focuses on preventing and reducing underage drinking and prescription drug misuse. These programs often target teens or other groups that intersect with home visiting families, which could provide an opportunity for collaboration between evidence-based home visiting and community prevention networks and coalitions. Parishes that received LaPFS II funding include Evangeline, Avoyelles, St. Landry, W. Feliciana, Jefferson Davis, Ouachita, Franklin, St. Helena, Tangipahoa, and Sabine Parishes.

STATE STRATEGIC APPROACH TO SUD RESPONSE

In an expert panel memo to the Health Secretary, Louisiana public health leaders and experts in addiction medicine recommended an investment into models of care for women and families, including screening, access to medications, and evidence-based home visiting (Dunham et al., 2018). This section describes the state strategic direction

for Louisiana's response to SUD treatment gaps and barriers for pregnant women and families with young children, led by the OBH.

The OBH, along with parent agency LDH, has led legislative efforts and federally funded grant activities to respond to SUDs among pregnant women and families with young children. LDH has unified strategies and coordination efforts through the formation of a new council, the HOPE Council. Other state entities, such as DCFS, maintain local activities that serve families with experience of abuse and neglect. DCFS, through federal legislation, is responsible for ensuring that a Plan of Safe Care is developed for all newborns reported as being affected by substances in-utero. Services provided through the Plan of Safe Care include safety planning, SUD assessments and treatment, and referrals for Early Intervention services. DCFS also provides TANF dollars to LDH to support residential SUD treatment for women and children.

The State Single Agency for Substance Abuse Services in Louisiana is the OBH. OBH administers SAMHSA grants at the state and LGE level, through statewide efforts, targeted local efforts, and Human Services Districts. The Louisiana Legislature formed the Advisory Council on Heroin and Opioid Prevention and Education (HOPE) to advise the Governor's Drug Policy Board in 2017 with the goal of creating an inter-agency coordination plan. The LDH Opioid Steering Committee published the first state-wide plan, "Louisiana's Opioid Response Plan" in September of 2019. As of 2019, LDH was receiving almost $50 million in funding to address SUD, including prevention, prescription drug monitoring, and MAT expansion. The State Targeted Response (STR) and State Opioid Response (SOR) grants from SAMHSA are the largest funding mechanisms statewide. Through SOR funds of $23 million from SAMHSA, OBH provides training and education to care providers and the community at large about OUD prevention and evidence-based treatment.

The Louisiana Opioid Response Plan details the following new cross-sector initiatives to increase access to evidence-based treatment for OUD:

- Legislation to increase the number of OTPs and allow for Medicaid coverage for Methadone at OTPs
- Paradigm shift towards evidence-based treatment for OUD, including MAT
- Requirements for residential treatment centers to offer or facilitate access to MAT for OUD
- Prevention and community education and outreach to reduce stigma for individuals with SUD, including highly stigmatized groups like pregnant women who use substances during pregnancy
- Hub and Spoke model for OUD treatment, with OTP serving as "hubs" and FQHCs as "spoke" to facilitate greater access to care, including encouraging providers waivered to prescribe MAT

There are three current legislatively mandated efforts to expand and improve substance use treatment options for pregnant women and women with dependent children; the TANF-Reality House Neonatal Abstinence Restoration Program; the PQC NOWS Pilot Project, and the Centers for Medicare and Medicaid Services (CMS) Innovation Accelerator Program (IAP) for SUD. The TANF-OBH-Capital Area Human Services District (CAHSD) Reality House pilot is a Neonatal Abstinence Restoration Program partnership that provides MAT to pregnant and postpartum women, and women with dependent children who have been diagnosed with OUD. The PQC NOWS Pilot project engages 4 delivery hospitals in a quality improvement effort to implement evidence-based best practices for screening, referral, and treatment for the birthing person and infant in the delivery hospital setting. The IAP resulted in the development of a NAS Toolkit for practitioners called "Louisiana Substance Use in Pregnancy Toolkit" jointly produced by LDH and DCFS, with representation from many agencies across the state. The goal of the toolkit was to increase early identification, referral to treatment, and engagement for mothers and babies at risk for NAS by 5% at three pilot sites (DCFS and LDH, 2018) with the goal of widespread adoption of the toolkit by member hospitals of the PQC.

The SABG includes language that requires funded programs to provide priority admission at treatment facilities for pregnant women (and highest priority for pregnant injecting drug users). When admission cannot be granted due to capacity, the grant requires the program to notify OBH, who is required to make interim services available to the client within 24 hours, including prenatal care referral. This language is reflected in "OBH RFPs, MOUs, Contracts, Accountability Implementation Plan (AIP), and Special Provisions requirements" (Hussey, 2020).

The HOPE Council was tasked with creating a subcommittee led by LDH and DCFS to coordinate heroin and opioid-specific education, prevention, and treatment services specifically for women of childbearing age, pregnant women, and women with newborn infants along with services to meet the needs of newborns impacted by the mother's Opioid use. As of this publication, this initiative is still in development.

ASSESSMENT COORDINATION

During the development of this Needs Assessment, several workgroups were convened by the joint LPHI-BFH steering team to review and coordinate efforts between ongoing assessments. The Head Start and CAPTA needs assessments were already completed and published by the time of this Needs Assessment. Louisiana does not have a centralized collection point for all the local community-based Head Start needs assessments; instead, community-wide needs assessments are completed and reported at the local level. The LSNA team received and reviewed the Louisiana Head Start State Collaboration Project Needs Assessment and the CAPTA report and discussed opportunities for data sharing with representatives from Head Start and DCFS, respectively. The Title V MCH Block grant assessment was under development at the time of this writing, and efforts were made to collaborate where it was possible to evaluate state distribution of risk, assess and share efforts to address areas of risk, and gather and share data. The LSNA team shared qualitative findings from community data collection with the Title V MCH Block Grant assessment workgroup.

The 2020 Title V Block Grant Needs Assessment is researched and written at the same time as this MIECHV Needs Assessment. Coordination has been between MIECHV and Title V strategic leads, as both grants are awarded to the same agency, BFH, and MIECHV and Title V are closely aligned in many efforts statewide. Title V Block Grant research has informed background data collection about counties at risk and services offered across the state. The Title V Block Grant Needs Assessment addresses how the state's system of care is meeting underserved and vulnerable populations; this research is included in the MIECHV need assessment. Finally, qualitative data gathered for the MIECHV needs assessment will be used to supplement the Title V Block Grant Needs Assessment findings about needs of families across Louisiana, particularly need for services for families and other auxiliary services.

The Louisiana KIDSCOUNT report released in 2020 by Agenda for Children and the Early Childhood Risk and Reach report released in 2016 by BFH are recent assessments of early childhood risk and protective factors that were used to explore risk factors and gaps in services. The LSNA team met with BFH staff to discuss methods and overlap with Risk and Reach (described in below section). Lastly the LSNA team reviewed the 2019 Preschool Development Grant Needs Assessment, which provided background on early childhood community coalitions around the state.

The LSNA team spoke to representatives from Title V, CAPTA/DCFS, and Head Start to obtain insight to help contextualize and make sure this needs assessment appropriately represented results from their needs assessments and to let them know what type of information was collected so they know what will be available to them in the future. This level of collaboration and data sharing on needs assessments cross-agency is new to these agencies; an integrated approach to each agency's development of their needs assessment was not possible given that reports were completed at different times over the 2019-2020 time period. Conversations about collaboration and

data sharing have laid the groundwork for closer collaboration and sharing cross-agency for future needs assessment and other data collection activities.

Data about initiatives to address gaps in the system of early childhood care was incorporated from the CAPTA Needs Assessment and Title V MCH Block Grant Needs Assessment. Information about pertinent background about the health and economic outlook in Louisiana was incorporated and cross-referenced from the MCH Block grant Needs Assessment. The Title V MCH Block Grant provided epidemiology capacity to analyze and report on Medicaid births by parish for this Needs Assessment. Head Start provided EHS-HBO service utilization data for several of their program sites to help inform statewide evidence-based home visiting capacity. DCFS/CAPTA provides data about child maltreatment for LA MIECHV Performance Measure data through a data sharing agreement, which was examined in this Needs Assessment as an indicator of quality of evidence-based home visiting.

Efforts were made to collaborate between the MIECHV Needs Assessment and the Early Childhood Risk and Reach Report, a publication of BFH that uses health, socioeconomic, education, and neighborhood indicators to examine distribution of risk and protective factors across the state. The Risk and Reach Report has been used by LA MIECHV as a tool to evaluate parish-level distribution of risk for children and families since the last MIECHV Needs Assessment was published in 2010. Report writers shared their indicator selection and indicator selection process map. The LSNA team shared early risk data and maps and solicited feedback for the development of risk domains and indicators. The Early Childhood Risk and Reach report writers are closely aligned with the Louisiana Advisory Panel for Young Child Wellness Collaborative at BFH, and were able to contextualize the work of the Young Child Wellness Collaborative to convene the agencies that work toward state and local early childhood collaboration, namely the LDOE, LDH, and DCFS.

Qualitative and quantitative data were collected and analyzed in an iterative process. During qualitative data collection, LSNA researchers engaged local community leaders to discuss and contextualize findings from interviews with members of their communities. This allowed LSNA researchers to explore topics that families and community members introduced more fully through interviews and discussion. During data gathering efforts for the Substance Use Disorder Treatment Capacity section, early data analysis and results were shared with OBH HOPE council to review, validate, and contextualize findings. The LSNA team also consulted the lead for the Louisiana PQC to gain insights into their work on NOWS and NAS prevention through several legislatively mandated pilot screening programs. Once the data gathering and analysis process was complete, the LSNA team engaged local academic researchers with expertise in early childhood trauma, infant mental health, and maternal health to review and contextualize quantitative and qualitative findings. These experts provided insight on the data gathered from the community, and shared recent relevant findings from their own research to help validate and contextualize the needs of the community with regards to evidence-based home visiting services.

Other opportunities for current and former collaboration exist, including sharing and dissemination through existing workgroups, collaboratives, and partnerships, such as the HEAT workgroup and the State Young Child Wellness Collaborative. The Title V MCH Block Grant convenes a Health Equity Action Team (HEAT) to address statewide challenges or barriers to receipt of services related to disparities and racial inequity. This group will utilize findings from each Needs Assessment to further coordinate action to address disparities and racial inequity in access to services across LDH. The LSNA team identified an opportunity to introduce a collaborative approach to future needs assessments through data sharing efforts already under way through the State Young Child Wellness Collaborative (SYCWC). The primary role of the SYCWC, where MIECHV representatives have a leadership role, is to drive state system change and to ensure community priorities have visibility at the state-level. The SYCWC aims to improve data sharing to benefit families across the state who have contact with multiple services such as child welfare, publicly funded early childhood programs, and MIECHV evidence-based home visiting. Through these efforts by

SYCWC, agencies will have the opportunity to further streamline data collection and sharing for future needs assessments.

CONCLUSIONS

All Louisiana parishes are at risk using the simplified method, sub-county data, and qualitative data. Additional indicators and domains were added to explore risk related to Louisiana's heavy burden of poverty and poor health and wellbeing outcomes for children and families. When risk was categorized into levels of severity, several trends emerged. Parishes with large rural populations and high poverty rates face many challenges, such as access to basic resources. Parishes in Northern Louisiana had more severe risk, and more parishes were at high or severe risk than Southern Louisiana parishes. Evidence-based home visiting is a critical piece of the early childhood system to address risk across the state. Most evidence-based home visiting services in Louisiana are administrated by BFH's LA MIECHV program. Though there are evidence-based home visiting services offered outside of LA MIECHV, there was limited data available about their services. Eighty percent of Louisianans enrolled in LA MIECHV are served by HV using the NFP model, and the remaining 20% are served by HV using the PAT model. LA MIECHV home visiting is offered in all 64 parishes.

Notable strengths of the LA MIECHV Program are highlighted by the data in this Needs Assessment Update, including regional successes in capacity and retention, length of enrollment, representative family demographics, reach relative to risk category, and family satisfaction. Several regions in the state have far exceeded state averages for capacity, enrollment, and reach, suggesting that LA MIECHV has achieved successes in reaching, enrolling, and retaining families in these areas. Families stay enrolled on average for 13 months, which exceeds the length of enrollment of one year that current research suggests is necessary for lasting positive outcomes for families (HRSA, 2017). Race and ethnicity of enrolled families are representative of eligible families at the state level, indicating that program access is largely equitable. LA MIECHV is reaching 20% of eligible families in severe (highest) risk parishes, compared to about 12% across all risk categories. This indicates that resources are allocated to eligible families residing in the highest risk parishes, as intended by HRSA guidelines for federal MIECHV funds. LA MIECHV families express a high degree of satisfaction with services. Qualitative research found that families who participate in HV services value the supportive relationship with their HV, and many express a desire to continue beyond the scope of HV model time limits. Qualitative research also found that community partners and leaders believe that HV services are valuable to families and fulfill vital needs for support and education.

Key opportunities for exploration and improvement for LA MIECHV include referral systems, regional challenges, eligibility criteria, and community awareness. Referral data suggests that the current process may leave out eligible families who could be interested in receiving services, as qualitative findings uncovered that there are gaps in how referral sources provide referrals, and referral data indicate that one third of those referred are unreachable in follow up enrollment efforts. Some regions of the state experience more challenges than others. Capacity and length of enrollment are notably lower in Region 1, a region which has also experienced higher staff attrition than most other regions. NFP eligibility criteria require families to enroll by 29 weeks of their first pregnancy, thus excluding multiparous (and older) mothers from participating. LA MIECHV also includes eligibility criteria based on income. Qualitative findings uncovered that community leaders and community members view these elements of eligibility criteria as a barrier and negative aspect of HV in Louisiana. Qualitative data also found that staff, community leaders, community members, and former participants believe that the LA MIECHV program is not well known in their community, which impacts interest in enrollment.

Data about SUD treatment for pregnant women and women with dependent children is extremely limited. Based on available information, SUD treatment, especially for women with OUD, is limited and difficult to access. Though

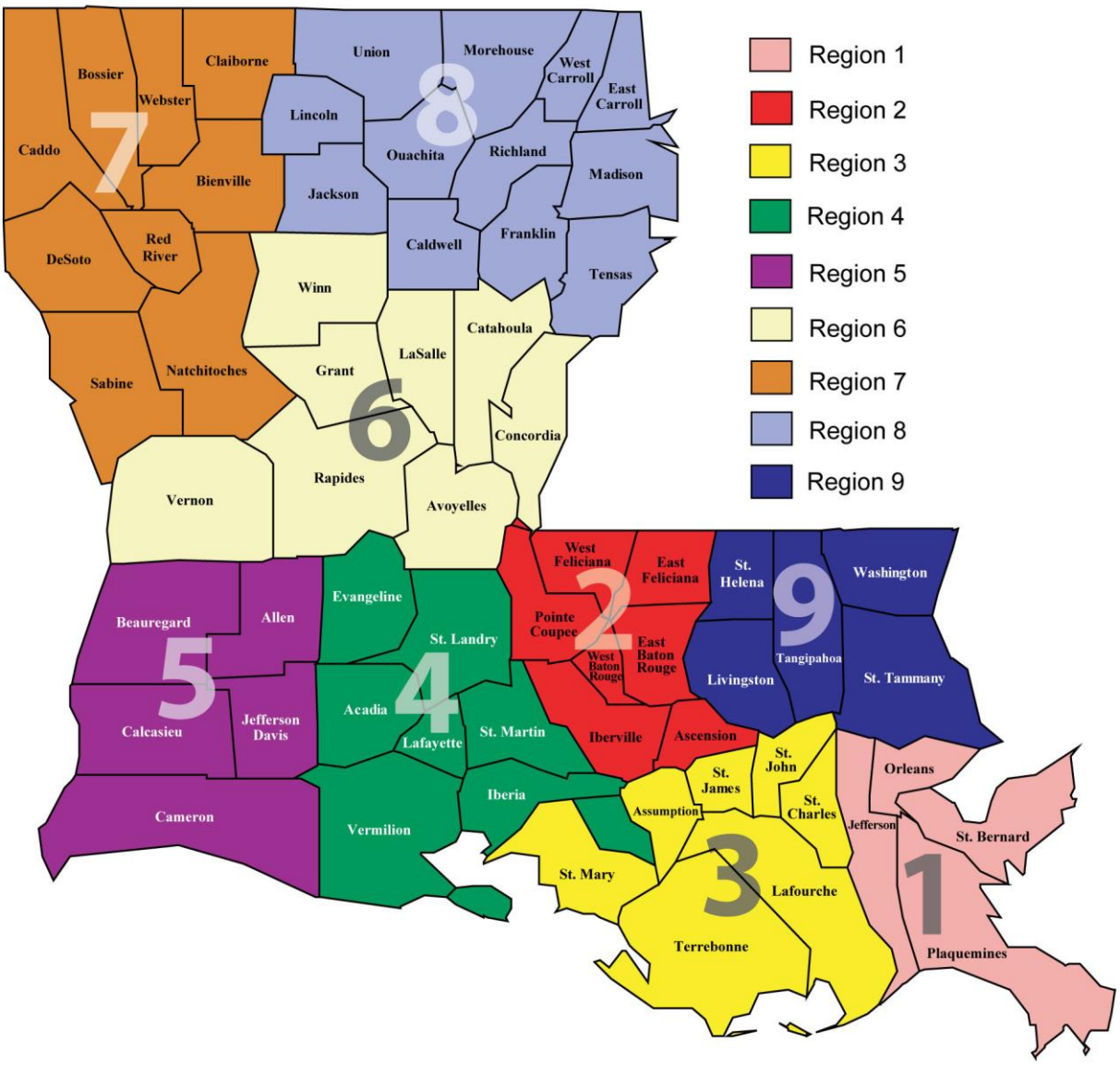
there are SUD treatment facilities in each LDH administrative region that accept pregnant women on Medicaid, few accept dependent children, and service offerings and capacity (such as waitlists and availability) are unknown. Five residential centers throughout the state accept dependent children and are funded by TANF; one of these is participating in a pilot program to provide evidence-based MAT to residents with OUD. When following evidence-based guidelines for appropriate MAT for pregnant women, MAT is currently unavailable for all pregnant women but those paying in cash or with private insurance. Qualitative research found that many barriers and gaps exist for families who experience SUD and seek treatment, including geographic barriers, lack of access to high quality and patient-centered services, fear of child welfare services, and negative social factors and attitudes. Several grant-supported innovation projects are ongoing that aim to increase access to evidence-based SUD care for pregnant women and substance-exposed newborns, however, they are currently still in pilot phases and available to a limited number of women statewide. State legislation and policies have mobilized evidence-based strategy and coordination of services for SUD treatment and prevention, especially OUD, through the newly formed HOPE Council and Opioid Steering Committee. LA MIECHV is involved in partnerships with DCFS, other BFH SUD initiatives, OBH, and other partners to address SUD and OUD in pregnant women and families with young children across the state. In coming years, these efforts will result in increasing access to MAT through Medicaid coverage, provider training, and access to evidence-based care.

Families enrolled in home visiting in Louisiana describe overwhelmingly positive experiences. Families in Louisiana face challenges related to poverty, access to resources, and maternal/child health that are significantly more severe than in other areas of the country. Home visiting services provide support and vital information to families who are doing the best they can for their children in the face of tremendous adversity. Qualitative data found that when asked how LA MIECHV could improve, many families simply wished that it could be available to all families in Louisiana.

DISSEMINATION OF NEEEDS ASSESSMENT AND FUTURE COLLABORATION

BFH MIECHV Needs Assessment representatives will proceed to share information, data, and findings both within BFH with Title V Block Grant representatives, and with the state entities that are responsible for Head Start and CAPTA assessments. Qualitative data collected for the MIECHV Needs Assessment is of particular interest to BFH because it can be used in State Performance Measure (SPM) Workgroups to gain insight into community perspectives on evidence-based home visiting and family needs for families with young children across the state as a whole. A Family Engagement Workgroup for the Title V block grant may use findings from the Needs Assessment and community data collection to inform their work with families for programs across BFH. The plan for sharing MIECHV assessment findings and convening stakeholders was altered due to the COVID-19 pandemic. Rather than in-person convenings, all communication was virtual or electronic.

APPENDIX A: LDH ADMINISTRATIVE REGIONS



APPENDIX B: SIMPLIFIED METHODS INDICATORS

Domain	Indicator	Indicator Definition	Year	Source (*denotes HRSA provided these data at parish level)
Socioeconomic Status (SES)	Poverty	% population living below %100 FPL	2017	Census Small Area Income and Poverty Estimates*
	Unemployment	Unemployed percent of the civilian labor force	2017	Bureau of Labor Statistics*
	HS Dropout	% of 16-19-year-olds not enrolled in school with no high school diploma	2017	American Community Survey*
		% of 16-19-year-olds not enrolled in school with no high school diploma	2013-2017	
		% of 16-19-year-olds not enrolled in school with no high school diploma	2013-2017 OR 2017	
	Income Inequality	Gini Coefficient - 1 Year Estimate	2017	American Community Survey*
		Gini Coefficient - 5 Year Estimate	2013-2017	
		Gini Coefficient - 1 Year or 5 Year Estimate	2013-2017 OR 2017	
Adverse Perinatal Outcomes	Preterm Birth	% live births <37 weeks	2013-2017	National Vital Statistics System - Raw Natality File*
	Low Birth Weight	% live births <2500 g	2013-2017	National Vital Statistics System - Raw Natality File*
Substance Use Disorder[2]	Alcohol	Prevalence rate: Binge alcohol use in past month	2012-2014	SAMHSA - National Survey of Drug Use and Health*
	Marijuana	Prevalence rate: Marijuana use in past month	2014-2016	SAMHSA - National Survey of Drug Use and Health*
	Illicit Drugs	Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month	2012-2014	SAMHSA - National Survey of Drug Use and Health*
	Pain Relievers	Prevalence rate: Nonmedical use of pain medication in past year	2012-2014	SAMHSA - National Survey of Drug Use and Health*
Crime	Crime Reports	# reported crimes/1000 residents	2016	Institute for Social Research - National Archive of Criminal Justice Data*
	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	Victims	Rate of maltreatment victims aged <1-17 per 1,000 children (aged <1-17) residents	2016	Administration for Children and Families*
	Substantiated abuse	% of children birth to 5 that have an investigation of abuse and neglect or alternative response	2019	State of Louisiana Department of Children & Family Services (LA DCFS)

[2] The Substance Use disorder domain includes 4 indicators; all of which were received from HRSA, compiled from the 2012-2014 National Survey on Drug Use and Health (check). HSRA distributed updated data for this domain during the Needs Assessment Update. The "newer data" were from 2014-2016 NSDUH, however 3 of the 4 indicators that were previously used were no longer available. HRSA provided similar data indicators in place of these 3. The LA Needs Assessment Team chose not to replace the substance use indicators from 2012-2014 with newer data from 2015-2016 because the older data showed more variability, which is ideal when calculating z-scores to determine risk. When reviewing the newer data (also provided by HRSA), 4 Parishes had a z-score greater than or equal to 1 for all 4 indicators: Orleans, Plaquemines, Saint Bernard, and Jefferson. The older data from 2012-2014 captured these 4 Parishes *and* an additional 12 Parishes. Because the effects of substance use disorder on the individual and community level persist over time (Office of Disease Prevention and Health Promotion, 2020), we thought it was important to retain the indicators in this domain from 2012-2014, rather than replace them with data from 2014-2016.

Adequacy of prenatal care	No prenatal care	Kotelchuck Index - % with no prenatal care utilization	2018	Louisiana Department of Health (LDH) Office of Public Health (OPH)
	Inadequate prenatal care	Kotelchuck Index - % with inadequate or intermediate prenatal care utilization	2018	Louisiana Department of Health (LDH) Office of Public Health (OPH)
Infant Mortality	Infant mortality	# infant deaths ages 0-1/1,000 live births	2014-2018	Louisiana Department of Health (LDH) Office of Public Health (OPH)
Teen Pregnancy	Teen Pregnancy (ages 15-19)	Count of births to teens ages 15-19	2018	Louisiana Department of Health (LDH) Office of Public Health (OPH)
	Teen Pregnancy (ages 15-19)	Rate (per 1000) of births to teens ages 15-19	2018	Louisiana Department of Health (LDH) Office of Public Health (OPH)
Health Insurance	Uninsured adults	Percentage of adults under 65 without health insurance	2017	Small Area Health Insurance Estimates (via 2020 County Health Rankings)
	Medicaid births	Percentage of total births born to Medicaid eligible women	2018	Louisiana Department of Health (LDH) Office of Public Health (OPH)
Mental Health	Mental Health Providers	Health professional shortage areas for mental health. Designations include geographic designations (provider ratios), low-income designations (population under 200% of FPL and providers who accept Medicaid), and high need (at least 20% of population is below 100% FPL)	2017-2019	Louisiana Department of Health
	Poor Mental Health Days	Average number of mentally unhealthy days reported in past 30 days (age-adjusted)	2017	Behavioral Risk Factors Surveillance System (via 2020 County Health Rankings)
Access to Resources	Broadband Access	Percent of Population without Fixed and Mobile Access.	2019	2019 Broadband Development Report, Federal Communications Commission
	Limited Access to Healthy Foods	Percentage of population who are low-income and do not live close to a grocery store.	2015	USDA Food Environment Atlas (via 2020 County Health Rankings)
ALICE Index	ALICE Households	% of total households that are "ALICE" (Asset Limited, Income Constrained, Employed) households	2018	United Way

APPENDIX C: NATIONAL PERFORMANCE INDICATORS

Benchmark Area	Construct	Measure Type	SFY 2019 LA MIECHV Value	SFY 2018 LA MIECHV Value	2020 National Threshold
I- Maternal & Newborn Health	1. Preterm Birth*	Systems Outcome	12.60%	13.60%	11%
I- Maternal & Newborn Health	2. Breastfeeding	Systems Outcome	15.20%	20.70%	42.70%
I- Maternal & Newborn Health	3. Depression Screening	Performance Indicator	83.80%	64.00%	80.70%
I- Maternal & Newborn Health	4. Well Child Visit	Performance Indicator	36.70%	57.80%	66.60%
I- Maternal & Newborn Health	5. Postpartum Care	Performance Indicator	64.60%	53.70%	67.50%
I- Maternal & Newborn Health	6. Tobacco Cessation Referrals	Performance Indicator	25.00%	16.70%	53.70%
II - Child Injuries, Maltreatment, and ED Visits	7. Safe Sleep	Performance Indicator	21.20%	49.60%	54.70%
II - Child Injuries, Maltreatment, and ED Visits	8. Child Injury*	Systems Outcome	0.05	0.04	0.04
II - Child Injuries, Maltreatment, and ED Visits	9. Child Maltreatment*	Systems Outcome	2.50%	2.40%	6.70%
III- School Readiness and Achievement	10. Parent-Child Interaction	Performance Indicator	65.70%	48.20%	67.40%
III- School Readiness and Achievement	11. Early Language and Literacy Activities	Performance Indicator	62.30%	60.30%	74.60%
III- School Readiness and Achievement	12. Developmental Screening	Performance Indicator	55.90%	48.40%	74.80%
III- School Readiness and Achievement	13. Behavioral Concerns	Performance Indicator	91.10%	86.90%	91.10%
IV- Crime or Domestic Violence	14. Intimate Partner Violence	Performance Indicator	86.10%	71.80%	80.80%
V- Family Economic Self-Sufficiency	15. Primary Caregiver Education	Systems Outcome	38.20%	34.80%	29.90%
V- Family Economic Self-Sufficiency	16. Continuity of Insurance Coverage	Systems Outcome	71.50%	98.50%	79.00%
VI- Coordination and Referrals	17. Completed Depression Referrals	Systems Outcome	13.60%	22.40%	41.40%
VI- Coordination and Referrals	18. Completed Developmental Referrals	Systems Outcome	66.80%	21.70%	56.80%
VI- Coordination and Referrals	19. Intimate Violence Referrals	Performance Indicator	78.30%	27.70%	55.90%

APPENDIX D: FAMILIES SERVED BY LA MIECHV

Region	Team Name	Model	Count of Parishes Served by Team	# of HVs	# Families Served
1	1 NFP A	NFP	4	4	268
2	2 NFP	NFP	7	7	286
3	3 NFP	NFP	7	7	281
4	4 NFP A	NFP	5	5	207
4	4 NFP B	NFP	4	6	180
5	5 NFP	NFP	5	6	224
6	6 NFP B	NFP	6	6	230
6	6 NFP A	NFP	3	6	260
7	7/LSUHSC A	NFP	4	6	244
7	7/LSUHSC B	NFP	2	5	161
7	7 NFP	NFP	6	4	230
8	8 NFP	NFP	6	6	241
9	9 NFP A	NFP	3	6	213
9	9 NFP B	NFP	2	5	200
NFP TOTAL		NFP	64	79	3225
1	1 PAT	PAT	4	5	168
7	7 PAT A	PAT	7	8	219
7	7 PAT B	PAT	4	2	66
8	8/PAT A	PAT	8	8	130
8	8/PAT B	PAT	3	5	224
PAT TOTAL		PAT	26	28	807

APPENDIX E: PARISHES AT RISK

Risk category	Parish	Families Served	Families Eligible	Percent of Eligible Served
Severe Risk	East Carroll Parish	17	58	29.31%
Severe Risk	Franklin Parish	53	193	27.46%
Severe Risk	Morehouse Parish	56	242	23.14%
Severe Risk	Claiborne Parish	23	102	22.55%
Severe Risk	Ouachita Parish	289	1291	22.39%
Severe Risk	Madison Parish	23	121	19.01%
Severe Risk	Washington Parish	67	387	17.31%
Severe Risk	Tensas Parish	3	28	10.71%
Severe Risk	Concordia Parish	9	184	4.89%
Severe Risk	St. Helena Parish	3	82	3.66%
High Risk	Natchitoches Parish	116	311	37.30%
High Risk	Richland Parish	56	186	30.11%
High Risk	Catahoula Parish	20	67	29.85%
High Risk	Vernon Parish	71	255	27.84%
High Risk	Winn Parish	27	99	27.27%
High Risk	Red River Parish	17	74	22.97%
High Risk	Caddo Parish	426	1943	21.92%
High Risk	Webster Parish	64	298	21.48%
High Risk	Rapides Parish	230	1080	21.30%
High Risk	Grant Parish	34	165	20.61%
High Risk	Union Parish	31	172	18.02%
High Risk	West Carroll Parish	14	78	17.95%
High Risk	Allen Parish	33	192	17.19%
High Risk	Sabine Parish	30	180	16.67%
High Risk	Tangipahoa Parish	149	1200	12.42%
High Risk	Evangeline Parish	33	335	9.85%
High Risk	St. Mary Parish	44	471	9.34%
High Risk	Orleans Parish	242	2722	8.89%
High Risk	St. Bernard Parish	33	373	8.85%
High Risk	Caldwell Parish	7	88	7.95%
High Risk	Calcasieu Parish	138	1780	7.75%
High Risk	East Baton Rouge Parish	218	3482	6.26%
High Risk	Jefferson Parish	150	3478	4.31%
High Risk	Iberville Parish	8	259	3.09%
Moderate Risk	Bienville Parish	41	112	36.61%
Moderate Risk	La Salle Parish	25	98	25.51%
Moderate Risk	Bossier Parish	147	756	19.44%
Moderate Risk	Avoyelles Parish	65	352	18.47%
Moderate Risk	De Soto Parish	31	186	16.67%
Moderate Risk	St. Landry Parish	120	768	15.63%
Moderate Risk	Assumption Parish	23	154	14.94%

Moderate Risk	St. James Parish	21	141	14.89%
Moderate Risk	Lafourche Parish	86	635	13.54%
Moderate Risk	Iberia Parish	75	606	12.38%
Moderate Risk	St. Tammany Parish	146	1280	11.41%
Moderate Risk	Livingston Parish	90	849	10.60%
Moderate Risk	St. John the Baptist Parish	33	334	9.88%
Moderate Risk	Jefferson Davis Parish	16	226	7.08%
Moderate Risk	Lincoln Parish	22	315	6.98%
Moderate Risk	Terrebonne Parish	67	997	6.72%
Moderate Risk	Lafayette Parish	101	1568	6.44%
Moderate Risk	West Baton Rouge Parish	11	177	6.21%
Moderate Risk	Plaquemines Parish	7	121	5.79%
Moderate Risk	Ascension Parish	36	687	5.24%
Moderate Risk	St. Martin Parish	20	415	4.82%
Moderate Risk	Acadia Parish	24	514	4.67%
Moderate Risk	Pointe Coupee Parish	7	162	4.32%
Moderate Risk	Vermilion Parish	17	467	3.64%
Moderate Risk	East Feliciana Parish	3	112	2.68%
Moderate Risk	St. Charles Parish	6	274	2.19%
Moderate Risk	West Feliciana Parish	1	68	1.47%
Moderate Risk	Cameron Parish	0	25	0.00%
Low Risk	Jackson Parish	18	99	18.18%
Low Risk	Beauregard Parish	33	289	11.42%

Notes:
Count of eligible families: This column presents an estimate of families eligible for home visiting services in the state of Louisiana. Data are based on preliminary 2018 Birth & Medicaid Files and limited to Louisiana residents who had a Medicaid paid birth. Date Source: (2018 Birth File- Received July 2019 / 2018 Medicaid File- Downloaded May 2020)
Percent of eligible families reached: This table presents reach of home visiting programs operated by BFH, the agency that is responsible for serving 95% of families served by home visiting programs in Louisiana. The reach of other home visiting programs in the state should be considered when using these data for resource allocation discussions. Non-BFH home visiting programs served additional families in FY18-19 in the following parishes: Bossier (40); East Baton Rouge (200); East Carroll (3); Madison (3); Orleans (100); Ouachita (20); Richland (3); West Feliciana (20).

APPENDIX F: STAFF VACANCIES

Time Vacant by Team - HVs (including still vacant position - 4/1/2018 to 4/1/2020					
Region	**Team**	**# HV Resignations**	**Average months of vacant position(s)**	**Total months with vacancy**	**# vacant HV positions as of 4/1/2020**
1	PAT	4	3	12	1
1	NFP A	4	6	23	1
2	NFP				
3	NFP	1	2	2	1
4	NFP A	1	5	5	
4	NFP B				1
5	NFP	2	8	16	
6	NFP B	2	3	7	1
6	NFP A	4	2	7	
7	NFP A	1	4	4	1
7	NFP B	4	4	15	
7	7 NFP	3	3	10	1
7	PAT A	2	2	5	1
7	PAT B	3	4	13	1
8	NFP	1	5	5	
8	PAT A	10	6	35	2
8	PAT B	5	4	20	2
9	NFP A	1	2	2	
9	NFP B	1			

APPENDIX G: QUALITATIVE METHODS

Overall, 35 members of LA MIECHV staff were interviewed about community needs and readiness for home visiting. Twenty-six HVs from across the state participated in a set of four focus groups. All HVs were invited to participate, but because participation was capped at 8 staff per focus group, not all who expressed interest were able to participate. HVs were selected into focus groups based on team and their availability. The LSNA team tried to separate HVs from the same team into separate focus groups where possible. All Supervisors and Outreach Specialists from the two focus regions were interviewed in dyads or group interviews. Two members of the LA MIECHV Statewide Team were interviewed to provide context to HV focus group findings.

All individuals interviewed who were not State employees or receiving State or Federal funds for home visiting were eligible to receive a mailed gift card as a token of appreciation for their time and expertise. Interview guides for each category of participants are included in the appendix.

There were several limitations in the methodology of qualitative data collection that may cause biases in the data. Convenience sampling was the most time and cost-effective method given severe limitations on methods caused by the COVID-19 pandemic. However, random sampling would have been more effective at creating a more representative sample for participants and non-participant community members. Non-participant sampling may not have reached community members unconnected to social services or agencies, as recruitment was done in large part by community leaders who represent social service agencies. Researchers intended to include a degree of randomization in selecting current and former participants, but because this required time and effort beyond the desired scope of the request, team-level LA MIECHV staff instead provided information to participants based on who was in frequent contact with HVs; this may have excluded participants from the research opportunity who were less engaged or less enthusiastic about services. One additional limitation regarding former and current participants is that only two families who participated in Parents as Teachers were reached, though there was an effort by team staff and researchers to contact a higher number. At the time of data collection, the Outreach Specialist position in Region 1 was vacant, which limits the perspectives from Region 1 to Supervisors.

Originally, the purpose of selecting two different regions as focal areas was to compare findings from each to be able to draw conclusions about the relationship between enrollment data and community perceptions of home visiting. After the conclusion of data collection, researchers determined that the interviewees from each region were too dissimilar to compare – in Region 7, most community leader/key informants (and thus the non-participant community members they referred for interviews) were recruited with the help of BFH staff, whereas in Region 1, most were recruited through other channels. This limits the ability to compare the two regions, as community leader/key informants were more closely related to BFH and LA MIECHV in region 7 than the community leader/key informants who participated in Region 1, and thus the differences in their perspectives cannot be attributed to their region. Unless specified, all findings should be generalized to the state level.

Reach is defined for these research purposes as the ability of eligible families to receive information about home visiting and make an informed decision about whether they would like to participate. Ideal reach conditions would allow for all eligible families to be aware of home visiting services, and for those interested to be able to access services. Elements of reach that were examined are program recognition, individual model reach, model eligibility, and an examination of referrals to home visiting programs. Connectedness to the community relates to the relationship between home visiting programs and their communities, including referral agencies, potential families, and participating and former families. Another important aspect of community connectedness is related to the relationships with agencies and partners who do not refer to LA MIECHV but may provide vital services for the community and participating families. These relationships with important partners at the community level are not

discussed in this analysis because of a limited capacity for data collection, but should be further explored by the LA MIECHV staff by giving partners an opportunity to provide feedback on their partnership with LA MIECHV at the local level. Community connectedness takes a closer look at the referral patterns discussed in reach, and further examines perceptions and behaviors of referral agencies and their relationships with home visiting programs. Community connection also examines community awareness and how the community perceives home visiting services.

Needs, preferences, and cultural considerations are defined as both the characteristics of services that meet needs and preferences of families, as well as additional unmet needs for parents and pregnant persons in the community. This section answers key elements of community readiness, such as how do home visiting programs meet family needs? What family needs exist? What elements do home visiting services have or lack that create barriers to utilization for eligible families?

APPENDIX H: QUALITATIVE INTERVIEW GUIDES

Exiting Participants

Questions:

- Tell me a little bit about yourself and your family:
- Tell me about your experience with (NFP/PAT). What do you think about it? How do you feel about it? What's your relationship like with your (NURSE/PARENT EDUCATOR)?
- How did you first hear about it when you started out with (NFP/PAT)? What made you want to join? How did you feel about it when you first started? Were you nervous or unsure about anything when you were first starting? What have been the best things about the program? Was there anything you didn't like?
- When you were pregnant, what sources of information did you use to learn about pregnancy and parenting? Do you feel like you had all the information you need?
    - Had you heard of NFP/PAT before you were asked if you wanted to join the program?
        - **PROBE**: What did you know about it?
    - What did you like best about the NFP/PAT program? What did you like the least?
      PROBE: *What made you want to stop the program?*
        - *PROBE: If you could change something about the program to continue participating, would you? What would you change?*
    - Did anything surprise you about participating in the program?
    - Did the program meet your needs?
        - **PROBE:** If no, why not?
        - **PROBE:** If yes, how?
    - What did you hope to get out of it that you did not?
        - **PROBE**: Was there anything you asked for that was not provided?
    - How could NFP/PAT get the word out to people who may want to participate in a program like this?
    - What are the trusted sources of information about pregnancy and raising a family in your area?
    - What are the greatest needs for parents in the community that you live in?
        - **PROBE:** Do you feel like NFP/PAT meets those needs?

Eligible Non-Participants

Interview Questions

- Have you heard of NFP/PAT?
    - **IF YES:** what is your impression of it?
    - **IF NO:** (briefly explain programs with program definition (outlined below); would you think of a free voluntary program to provide support to you throughout your pregnancy and/or the first few years of your child's life? What would make you want to enroll? What would be something that would make you not want to enroll?
- Would you want to join such a program if you were asked?
    - **PROBE**: Why or why not?
- How do you learn about things related to your pregnancy and raising an infant or young child?
    - **PROBE**: What sources do you trust and not trust?
    - **PROBE**: What are the trusted sources of information about pregnancy and raising a family in your area?
- What are the greatest needs for pregnant women and moms of young babies in the community that you live in?
- What should home visiting services for pregnant moms or families with young children look like?

- What should they offer?
- How often should they visit?
- What should they discuss or teach?
- What qualifications do you think the people providing the services should have?

- What other programs serve pregnant moms or families with young children?
  - **PROBE**: What do they do best?
  - **PROBE**: In what areas are they lacking?
- How could NFP/PAT get the word out to people who may want to participate in a program like this?

Key Informant Interviews

- Describe the community you serve, particularly the MIECHV population (Medicaid, WIC SNAP, TANF, and/or SSI-eligible pregnant women and families of children <5).
  - PROBE: What is your relationship like with this community?
- What do you know about the home visiting services offered in your community?
  - PROBE: What do you think of them?
- IF FAMILIAR: What do you think is the community perception of Louisiana MIECHV (NFP/PAT)?
  - PROBE: What is the perception of your clients?
  - PROBE: Do you think it's relevant to the families that you serve?
- IF FAMILIAR: What do you think is the most appealing aspect of this program? Least appealing?
  - Probe/prompt: when you discuss the program with a potential participant, how do they react? How would you encourage someone to give the program a try?
- IF UNFAMILIAR: Describe program (below) What do you think is the most appealing aspect of this program? Least appealing?
- What do you think are the greatest needs in your community for pregnant women and families with young children?
- What should a program like Louisiana MIECHV offer to pregnant moms or families with young children?
- What other programs serve pregnant moms or families with young children?
  - PROBE: What do they do best?
  - PROBE: In what areas are they lacking?
- What is something you think is unique about families with young children and pregnant women in your community relative to the state?
- Who do pregnant women trust in your community? Who do families with young children trust? Who do they NOT trust?
- IF Louisiana MIECHV were able to expand in your area, what would you think of that?
  - PROBE: How would you recommend they go about recruiting additional participants?
  - PROBE: If you don't think that would be good/don't want that, why not?
  - PROBE: What services do you think need to be more eligible in your area?

Regional LA MIECHV Staff Interviews

- What do you think is the community perception of NFP? Of PAT?
  - PROBE: What do statewide governmental programs such as WIC, Medicaid, health plans think of NFP? Of PAT?
  - PROBE: What do community organizations (faith-based, reproductive health, youth centered orgs, shelter organizations) think of NFP? Of PAT?
  - PROBE: What do health providers (OB, FQHC, clinics, etc.) think of NFP? Of PAT?

    - PROBE: What do community members think of NFP? Of PAT?
- What specifically does MIECHV provide that meets community needs? Is there a difference between NFP and PAT?
    - What services do you wish your program could provide to communities to better fit their needs?
- How do you know when a HV/family relationship is successful? What makes it successful?
- Do you think that the community connections you have for referrals into the program are adequate?
    - PROBE: Why or why not?
- Do you think the community connections you have for referrals to external services are adequate?
    - PROBE: Why or why not?
- Are there any organizations or entities in the community that you wish you could work with, but you don't currently?
- What is something you think is unique about families with young children and pregnant women in your community relative to the state?
- Who do pregnant women trust in your community? Who do families with young children trust? Who do they NOT trust?
- Describe a typical encounter with an eligible potential participant for NFP or PAT that you are hoping to enroll into the program.
    - How do you know when it's a good fit on both ends (HV and family)?
    - Are there any strategies/questions you use to help assess this?
    - How do you know when it's not a good fit?
        - Are there any strategies/questions you use to help you assess this?

Home Visitor Virtual Focus Group Guide

Domain	Question
SUD	• How common do you think substance use disorder is among your families? Particularly for pregnant women and moms? ○ PROBE: Why do you think that is? ○ PROBE: If not common, is substance use disorder present in your community?
SUD	• What treatment options or services are available for families with substance use disorder? ○ FOLLOW UP: What experiences have your families had with these services, if any?
SUD	• How are you prepared to help families with the challenges they face specific to Substance Use Disorder? ○ PROBE: what strategies do you use? ○ If not, what information or resources do you need to comfortably work with families with SUD?
SUD	• What unique challenges do families who are experiencing substance use disorder face? ○ PROBE: Are these different for pregnant women and families with young children?
SUD	• Do you have anything else you want to share with us about families and Substance Use Disorder?

Recognition	• Do you think that your regional community is aware of the home visiting services offered in your region? ○ PROBE: If no, why not?
Community Needs	• Do you think MIECHV is meeting the needs of families in your region? ○ PROBE: If no, what do you think MIECHV could change to do so?
Community needs	• What do you think your families want to get out of participation? What changes could MIECHV make to improve the program for families? ○ PROBE: Is there anything you wish you could provide to your families, but can't?

Reach	• If the Louisiana MIECHV program was able to expand in your area, what would you think of that? How would you recommend they get the word out to potential participants?
	  ○ PROBE: If you don't think that would be good/don't want that, why not?
	  ○ PROBE: What services do you think need to be more available in your area?

Reach	• What makes your region/community receptive to home visiting? (What are the strengths) What makes your community a challenging area for home visiting (What are the challenges)? ○ PROBE/CLARIFICATION: What makes your community a good fit for home visiting?
Reach	• Why do you think some eligible families choose to not enroll when they are approached? ○ PROBE: Do you think there are ways to improve this?
Retention	• Why do you think that some families choose to exit the program before completion? ○ PROBE: Do you think there are ways to improve this?
Community Needs	• What do you think are the greatest needs in your community for Medicaid eligible pregnant women and families with young children?

APPENDIX I: QUOTATIONS

LA MIECHV Quotations from LA MIECHV program staff, key informant/community leaders, current/former participants, and non-participant community members and Associated Domains		
Respondent Type	**Domain**	**Quote**
HV Staff	Recognition	"It's just people haven't heard of us. The people we talk to know about us but everyone else does not. Everyone knows about Healthy Start. They have billboards, everyone has heard of it. This is a state program, why doesn't everyone know about it? It should be like WIC or Healthy Start."
Key Informant Former Participant Key Informant	Program Eligibility	"if you got introduced to me at twenty-nine weeks, I still need your services. Why all of the sudden would you not serve me?" "A lot of people think, oh, someone with money doesn't need that kind of program… but just because you have money doesn't mean anything. We don't know what's happening in closed doors or how they really feel. So, I feel like it should be established in all areas and categories of people." "I think at any stage of being a parent you need extra support. You need somebody to check on you...This time you may have postpartum depression, last time you didn't have that."
HV Staff	Referrals	"we have built relationships with some of those in the health unit, and you know, it's on their mind when they think of that person when a potential client comes through the door, or they think of the program when a potential client comes through the door. But I think other times they are just busy with things, that they are doing their own work, and...it's not really an incentive for them to refer to our program, so it's not something that they just will take the time to do, especially if they are busy."
Key Informant	Trust	"I do think that there is some push back because people don't want you in their homes. People are private, you know, they don't want somebody intruding in their space...They have other people who live there, and it may not be up to them whether someone comes home visiting or not. So, it's just kind of a touchy thing when it comes to being in the home."
Former Participant Key Informant	Benefits	"It just makes you feel really, really good about yourself that you're doing everything that you can to assure that your child reaches their milestones on time, or if they're a little behind, it just gives hope that you have a team of people there supporting you and rooting you on." "I think that it is really nice to know when our clients have a working with NFP because it is like, otherwise if a client is just seeing an obstetrician, if there is way less follow like up afterwards, we know that is this other level of supports."
Non-Participant Community Member Key Informant	Community Needs	"Sometimes getting these services, it's not always easy. Even applying for Medicaid or food stamps or unemployment or whatever. It just seems like even when you can do things online you can't get through, it requires multiple calls, someone to encourage them, say keep trying, just call again during these hours." "with all of the health disparities that exist especially in Louisiana, I think ongoing postpartum care is really important. Especially concerning things like blood pressure checks, and access to mental health resources...the most specific thing is additional prenatal care around health screening."
Key Informant	Cultural Humility	if HVs are "not presenting information in a way that speaks to who I am as a family...if you're not able to do that, even if what you're telling me is technically good information, I'm not available to receive it."
HV Staff	Barriers to Enrollment	"when we do have to let clients go because they have returned to work or whatever the need might be that they can't do an actual home visit anymore. That definitely hinders the impact that we could have if the client still wants the program but can't fit in a visit during the Monday through Friday timeframe."

APPENDIX J: SUD TREATMENT FACILITIES

The table below provides an overview of SUD facilities in Louisiana that accept pregnant or parenting women with Medicaid and/or TANF, confirms whether MAT is provided, and indicates whether the facility provides beds or care for children. MAT treatment varies by facility in terms of whether Naltrexone and/or Buprenorphine are provided, and facility policies regarding MAT for pregnant women are unknown as of the time of this assessment. Two facilities provide beds for dependent children, and three provide childcare for clients' children.

Substance Use Treatment Center Facility Characteristics							
Facility Name	***Region***	***Facility Type***	***Accepts Medicaid***	***TANF***	***Provide MAT***	***Child Beds***	***Child Care***
DuraCARE Counseling	1	Outpatient	Yes				
ACER LLC	1	Outpatient	Yes		Yes		
Greenpath International Inc	1	Outpatient	Yes		Yes		
Woodlake Addiction Recovery Ctr	2	Residential	Yes				
Obrien House	2	Both	Yes				
Impact Group BHS	2	Outpatient	Yes		Yes		
Woodlake Addiction Recovery Ctr	2	Outpatient	Yes				Yes
LHRC - Reality House	2	Both	Yes	Yes		Yes	Yes
Fairview Treatment Center	3	Residential	Yes				
Claire House	3	Residential	*MIS	Yes		Yes	Yes
Acadiana Area HSD	4	Outpatient	Yes				
Keys for Sober Living LLC	4	Outpatient	Yes		Yes		
Woodlake Addiction Recovery Ctr	4	Residential	Yes				
New Beginnings at Lake Charles LLC	5	Both	Yes		Yes		
Edgefield Recovery Center	6	Residential	Yes		Yes		
CENLA Phase II for Women	6	Residential	*MIS	Yes		Yes	Yes
North Louisiana Human Services	7	Outpatient	Yes		Yes		
CADA	7	Residential	Yes	Yes	Yes	Yes	Yes
Brentwood Hospital	7	Both	Yes				
Rays of Sonshine	8	Residential	Yes	Yes		Yes	Yes
Rays of Sonshine	8	Outpatient	Yes				Yes
ACER LLC	9	Outpatient	Yes		Yes		

APPENDIX K: REFERENCES

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