Texas Maternal, Infant, and Early Childhood Home Visiting Needs Assessment

Prepared for Prevention and Early Intervention Division at
Department of Family & Protective Services

— by —

University of Texas Health Science Center at Tyler &
Population Health at University of Texas System

Executive Summary

The following document serves as the five-year Needs Assessment for home visiting programs in Texas funded through the Maternal, Infant, and Early Childhood Home Visiting block grant from Health Services Resource Administration. This assessment is a combination of risk modeling and qualitative investigations conducted in collaboration between the University of Texas Health Science Center at Tyler and the Prevention and Early Intervention Division at the Department of Family & Protective Services.

Through this process, 54 high-risk counties in the state have been identified as being priorities for home visiting programs. These analyses emphasize the need to assess risk profiles regionally and locally to determine how best to respond to families and build programs that address the needs in the communities. However, it is also clear that there are three major statewide needs that must be addressed through state-level multi-agency coordination.

Prenatal Substance Use Disorder

High rate of prenatal substance use disorder is found in most high-risk areas in the state. In our highest-risk ZIP Codes, between 3% and 6% of babies are born with signs of prenatal substance use exposure. These rates in Texas are rising. Texas has strong substance use treatment programs for pregnant women but does not have the capacity to meet the needs in the state. The Department of Family & Protective Services and the Texas Health and Human Services Commission are working together to coordinate services and help mothers that suffer from substance use disorder.

Mental Health Disorders

The risk modeling and interviews with home visiting staff make it clear that mental health disorders are a major issue that is negatively impacting the health and well-being of families in Texas. This factor is a major community-level risk for maltreatment and has been identified by home visitors as a difficult need to meet. Texas has substantially increased its investment in child mental health services, and several statewide groups are working together to assess how to increase capacity and training to address mental health needs among pregnant and postpartum women.

Family Service Coordination

All needs of a family cannot be met by one organization or home visiting model. The multiple needs that are seen in a community reflect the multiple needs experienced by a family. Therefore, home visiting programs must have strong social service coordination capacity. This strong capacity has been shown to be difficult to maintain and achieve by programs. A collaboration between the Department of State Health Services and the Department of Family & Protective Services is aiming to increase and sustain that capacity by supporting communities' use of proven frameworks to increase referral coordination across social services.

The needs identified in this assessment cannot be addressed through state-level action alone. Communities must use these data and turn them into action. Thus, these data and technical assistance on how to interpret a community's profile have been provided to over 300 individuals in the state. By incorporating these data into local needs assessments, using the data for program improvements, and continuing to present to local and state organizations, the results of this Needs Assessment will be used to improve the health and well-being of young children and families in the state.

1 CONTENTS

Texas Maternal, Infant, and Early Childhood Home Visiting Needs Assessment

2 INTRODUCTION

Texas is home to one out of every ten children in the United States. Every year, between 380,000 and 410,000 babies are born in the state, a number second only to California. To see measurable improvement in the nation's health, the health in Texas must improve. The purpose of this Needs Assessment is to identify and describe the needs of high-risk areas in the state where early childhood home visiting programs can positively impact Texas' youngest children.

Overall, Texas has a relatively low infant mortality rate with a rate below the Healthy People 2020 targets for over 8 years. While this is to be celebrated, this statistic is tempered by the fact that 1% of infants born to a black mothers die before turning one year old; a rate nearly twice that of white and Hispanic mothers[1]. Further, on-time prenatal care rates are well below Healthy People 2020 targets with only 65.6% of women accessing care in the first trimester of pregnancy[2]. These low rates of on-time care are also coupled with the state having a relatively high low birth-weight rate and a high rate of preterm birth. High rates of these factors mean that Texas' kids are at risk to be behind in school readiness and other markers of education and social function. These risks are seen in the data.

Home visiting programs are part of a range of services that can help mitigate the developmental consequences of many risks during early childhood[3]. It is vital to understand how risk is distributed to understand the needs of our communities and where home visiting models can have an impact to improve the trajectories of families in the state.

3 AT-RISK COMMUNITIES AND CONCENTRATION OF RISK

3.1 METHOD FOR IDENTIFICATION OF AT-RISK COMMUNITIES

Texas used the independent method to identify high risk communities. The methodology used in Texas was part of a larger effort in Texas to understand early childhood risk as a way to inform a wide variety of maltreatment prevention efforts statewide[4].

For Texas, counties still represent a large area and, in some cases, a very diverse population. Therefore, analysis of risk at that level can average over substantial variation in a county. The approach for this Needs Assessment was to assess risk at the level of the ZIP Code and then analyze how high-risk communities cluster within a county. This approach provides an ability to assess the characteristics of high need communities that are in counties that are low risk, on average.

Data were taken from Texas Child Protective Services (CPS) investigations records for 2016, American Community Survey (ACS) 5-year estimates (2012-2016), all-payer hospital inpatient and outpatient data

for 2016[5], and birth and death records from 2015. The years covered in these analyses corresponds to the years of data that HRSA provides to states for the Needs Assessment.

3.1.1 Primary Assessment of Risk

The approach taken to assess risk was to first select a wide variety of metrics that could represent risk in a community. These metrics roughly corresponded to measures of economic prosperity/poverty, family composition, housing availability and affordability, education utilization and attainment, violent crime, child safety, maternal health, health care utilization, and social program utilization. In order for a metric to be selected, it had to be from a consistent data source that was updated annually, be reported statewide, have enough granularity to be reported or aggregated to the ZIP Code, and be available publicly. The initial metric selection resulted in 84 measures that were vetted through state agency partners, stakeholders, and other researchers.

All metrics were calculated at the level of the ZIP Code (or ZCTA for ACS data), then converted to z-scores to center metrics on the state average. These data were reduced to measures that showed a moderate correlation with maltreatment exposure in the community. Metrics that had a bivariate correlation at the |0.30| level or higher were retained. These variables were then included in an Exploratory Factor Analysis (EFA) to produce uncorrelated latent constructs. Variables were eliminated from the EFA if they did not load onto the chosen factors, showed poor uniqueness values, or were the only variable loaded on a factor at |0.4| or higher. The final EFA resulted in five uncorrelated factors and included 30 variables (Table 1). These factors were *Family Poverty, Health & Disability, Child Safety & Health, Low Income*, and *Low Education*. Factor scores for each ZIP Code were computed using a standard weighted regression technique, which takes into consideration the loading for all variables.

Table 1. *Final loading for factors included to determine risk*

	Family poverty	**Child Safety**	**Low Education**	**Health & Disability**	**Low-income**
Variables	*Factor1*	*Factor2*	*Factor3*	*Factor4*	*Factor5*
Education level, older than 18 years: (high school only)			-0.79		
Education level, older than 18 years: (less that high school)			0.74		
Education level, older than 25 (some college or more)	-0.74		-0.52		
Education level, older than 25 (less than high school)	0.89				
Education level, older than 25 years (high school only)			0.60	0.43	0.48
Education level of new mothers: (high school or less)	0.76		0.43		
Employment in managerial positions	-0.68		-0.47		-0.44
Employment in service sector	0.55				0.53
Labor force participation; males 20-64 years old				-0.52	
Children in poverty	0.91				
Female headed households in poverty	0.71				
SNAP use; families with children	0.87				

SNAP use; female headed households	0.72			
Percent of births with no WIC	-0.82			
Disability benefits; 35-64 years old	0.45		0.55	
Health insurance; 35-44 years old	-0.84			
Health insurance; 24-34 years old	-0.80			
Median home value	-0.46			-0.53
Vacant units			0.61	
Number of vehicles per unit	0.70			
Father named on Birth Certificate	-0.65		-0.42	
Percent of births to teen mother	0.64			
Baby breastfed in hospital			-0.54	
Smoking during pregnancy			0.60	
Emergency department visits by infants		0.57		
Transportation related injuries, children		0.64		
Injuries due to falls; children		0.92		
Non-abuse injuries; children		0.92		

Metrics eliminated from the EFA were included in an Ordinary Least-Square (OLS) regression to assess its independent relation with maltreatment exposure after controlling for the effects of the factors. Metrics were eliminated from the final model if they were not significantly related to maltreatment exposure. Three-year infant mortality rate, enrollment in school for 3- and 4-year-old children, enrollment in school for 17- and 18-year-old youth, assaults (15 to 45 year-old) requiring medical attention, and percent of rental units costing more than 35% of household income were retained in the final OLS models.

The final step of the modeling was to apply a spatial correction to the final OLS models. ZIP Codes are not independent of other ZIP Codes, especially neighboring ones. The definition of neighboring, however, is different based on whether the zip is in an urban or rural area. Neighboring zips in urban areas are relatively close in terms of one or two miles. In rural areas, these zips can be upwards of 30 miles apart. Therefore, urban and rural areas were spatial corrected separately as the distance ban to determine neighboring ZIP codes is different for dense urban areas than sparse rural areas.

Urbanicity was defined by each ZCTA's Rural-Urban Commuting Area (RUCA) code[6]. Those areas identified as urban outlying to urban center were spatial corrected with the urban distance ban (n=708). All other ZCTA's were defined as non-urban (n=126) and spatially corrected with the rural distance ban. These spatially corrected regressions were used to produce a risk score for every ZIP Code in the state with a population greater than 400 children between the ages of 0 and 4 years old.

3.1.2 Secondary Assessment of Risk

While the risk modeling assessment approach that was used has strong predictive properties, it is acknowledged that it does not capture risk well for some Texas communities. In particular, risk in border and west Texas communities are not captured well. Texas' border communities are commonly low risk for a variety of outcomes that are tracked such as maltreatment and infant mortality. These communities are majority Mexican-Hispanic, bilingual, and tend to live near family, even if that family is in Mexico. West Texas communities, in addition to being border communities, tend to have risks that are not seen in residential data sources because of a large transient population that works in the gas and oil industries. Service needs and strains on the community tend to be hard to identify in administrative data in these communities because service users tend to have their official residence outside of the community.

These communities tend to have high teen pregnancy rates and high rates of low-birth weight babies[2]. Therefore, the percent of births to a teen mother (younger than 18 years old) in 2016 was also included as a secondary of risk, independent of its inclusion in the risk modelling.

4 DATA SUMMARY

4.1 IDENTIFYING AT-RISK COMMUNITIES

The predicted risk scores for each community were aggregated into county. ZIP Codes were assigned to a primary county based on residential density. The mean predicted risk z-score for each county was calculated to include all ZIP Codes with available data and weighted based on the child population for the ZIP Code. Therefore, ZIP Codes with large child populations had a bigger influence on the county's overall risk score than ZIP Codes with small child populations.

Risk was ranked for counties with populations greater than 2,000 children between 0 and 4-year old. This population size cutoff was made because counties with smaller populations tend not to have the infrastructure necessary to support home visiting programs. If the county had a risk score greater than 0.50 for either infants or 1 to 4-year old children, it was determined to be high risk. Further if a county had more than 15% of its child population or more than 3,000 children living in a high-risk ZIP Code, it was determined to be high risk. Finally, if a county had more than 7% of its births attributed to teen mothers, it was determined to be high risk. This resulted in 54 counties being identified as high-risk. Risk was ranked by the total 0 to 4 population in the county that lived in a high-risk ZIP Code (see Table 2).

Table 2: *Communities At-Risk*

County	Risk Rank	County	Risk Rank	County	Risk Rank
Bexar	1	Johnson	19	Howard	37
Tarrant	2	Smith	20	Jim Wells	38
Harris	3	Webb	21	Ellis	39
Dallas	4	Grayson	22	Liberty	40
Travis	5	Harrison	23	Hardin	41
El Paso	6	Victoria	24	Lamar	42
Jefferson	7	Montgomery	25	Jasper	43
Nueces	8	Hunt	26	Atascosa	44
Galveston	9	Bowie	27	San Patricio	45
Potter	10	Henderson	28	Bastrop	46
Wichita	11	Brazos	29	Nacogdoches	47
Lubbock	12	Hood	30	Angelina	48
Bell	13	Cherokee	31	Wise	49
Orange	14	Kaufman	32	Walker	50
McLennan	15	Anderson	33	Caldwell	51
Cameron	16	Parker	34	Ector	52
Taylor	17	Tom Green	35	Maverick	53
Gregg	18	Navarro	36	Starr	54

In Texas in 2016, there were 1,850,374 children (0-17 years old) that lived in a high-risk ZIP Code and 321,230 children between 0- and 4-years old lived in these areas. Risk and needs will be discussed for each of the different service regions in Texas based on the risk profiles seen in the region. To further facilitate the meaning of the profiles, the components will be explained.

Health & Disability: This factor is defined by a high percentage of women smoking during pregnancy and low rates of infants being breastfed in the hospital. Both of these measures are indicative of the broader health behaviors in the community. This factor also includes a high proportion of babies being born without the father named on the birth certificate. This risk factor also includes lower rates of workforce participation among men between the ages of 24 and 64 and a relatively high rate of adults between the ages of 35 and 64 receiving disability benefits. Through our discussions with stakeholders, it has become clear that disability in this age range is indicative of larger mental health and substance use disorders in the community. Another important aspect of this risk factor is that it is not characterized by child poverty. However, this factor does have measures associated with low-income or struggling families. This risk factor has a high percentage of vacant housing units and low levels of educational attainment.

Families in Poverty: This factor is defined by our families living at or below the federal poverty level and high utilization of safety net services. In Texas, this risk factor is also defined by low percentages of adults with health insurance, relatively high percentages of teen births, and low levels of educational attainment. This risk factor includes high rates of employment in sales and service sector jobs, which are often associated with lower pay. Importantly, it also includes a high percentage of infants being born without a father named on the birth certificate.

Child Safety & Health: There are two major components to this factor: (1) hospitalization due to non-abuse injury among children; and (2) emergency department visits among infants. While minor injuries and children are an inevitable combination, a high rate of injuries serious enough to have a child seen in the emergency department or admitted to the hospital reflects general safety concerns in the community. The rate of emergency department visits for infants has been a metric used in a variety of studies and evaluations as an indicator of health care access, insurance status, and parental education about health of infants.

Low Income: As with the *Health & Disability* factor, the *Low-Income* factor is not characterized by high rates of child poverty. However, this risk factor is associated with measures that suggest that families are low-income or struggling. These communities have low median home values and high rates of employment in service sector jobs. We believe that many families in these communities have income high enough to make them ineligible for social services and safety net support.

Low Education: Overall low educational attainment within the community is also associated with risk. This factor is not characterized by income levels in the community or its general health.

Assaults Needing Medical Attention: Crime rates have been linked to maltreatment risk in several studies. However, it is very tricky to measure and difficult to obtain crime data for small areas like ZIP codes or over very large areas like the entire state. The crime proxy used in these analyses was emergency department or hospital encounters due to assault for those between the ages of 15 and 44- years old. These assaults are both victims and perpetrators. Unlike other crime data, these data also reflect where the person receiving care lived, not where the assault took place.

Infant Mortality Rate: Infant mortality, like child maltreatment, is a multifaceted problem. There are individual factors, as well as medical and community factors that contribute to this rate. A community's infant mortality rate is associated with infant maltreatment risk. Many will think of this relationship and

immediately think this relationship exists because poverty is a risk for both. However, the relation that we have found between these two indicators is independent of poverty and other socioeconomic risk factors in the community.

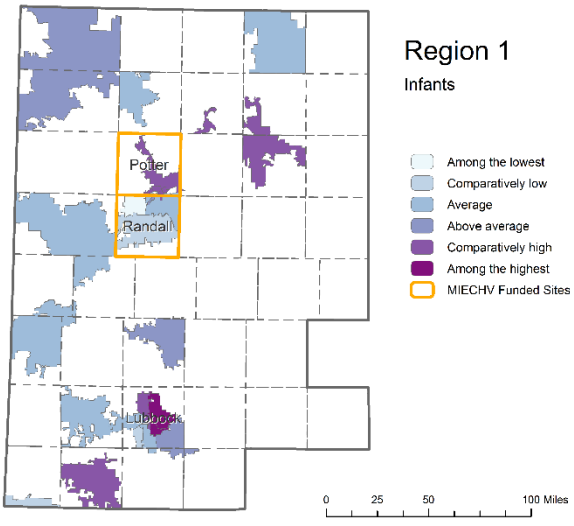
School Enrollment: There are two age ranges where enrollment in school or other formal education setting differentiates a community's maltreatment risk. One of these ages is the 3- to 4-year-old age range. This age range corresponds to when children can be enrolled in a formal preschool setting or a pre-K program. The other important school enrollment age range is the 18- to 19-year-old age range. This age range represents the transition from high school to higher education and should be a mix of high school and college enrollment. These two metrics are protective in our modelling and represent resources within the community.

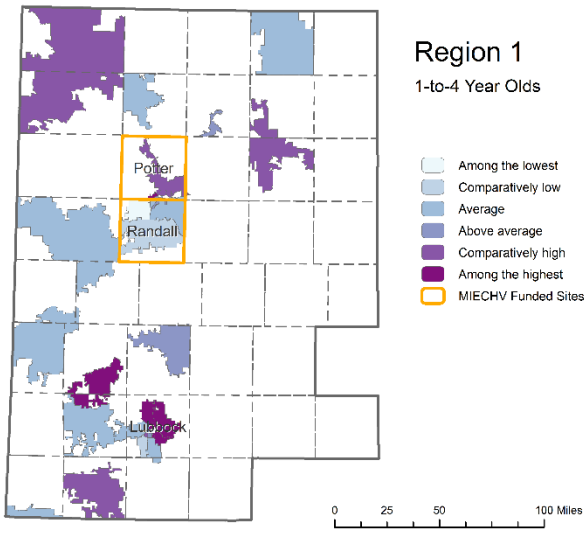
Affordable Rental Housing: Texas has a booming economy that has not been spread evenly through its population. As such there are areas of the state that are becoming too expensive for most families to live in, even those families well above the federal poverty level. This strain can be seen in the lack of affordable housing. We are measuring affordable housing by the percent of rental units that are costing families more than 30% of their income.

Of note, while prenatal drug exposure rates were not included in the modeling, it will be included in discussions of the risk profiles and needs in communities. This data point is helpful for disambiguating mental health and substance use needs in our counties.

4.2 Communities That Are At-Risk

4.2.1 Region 1. The Texas Panhandle





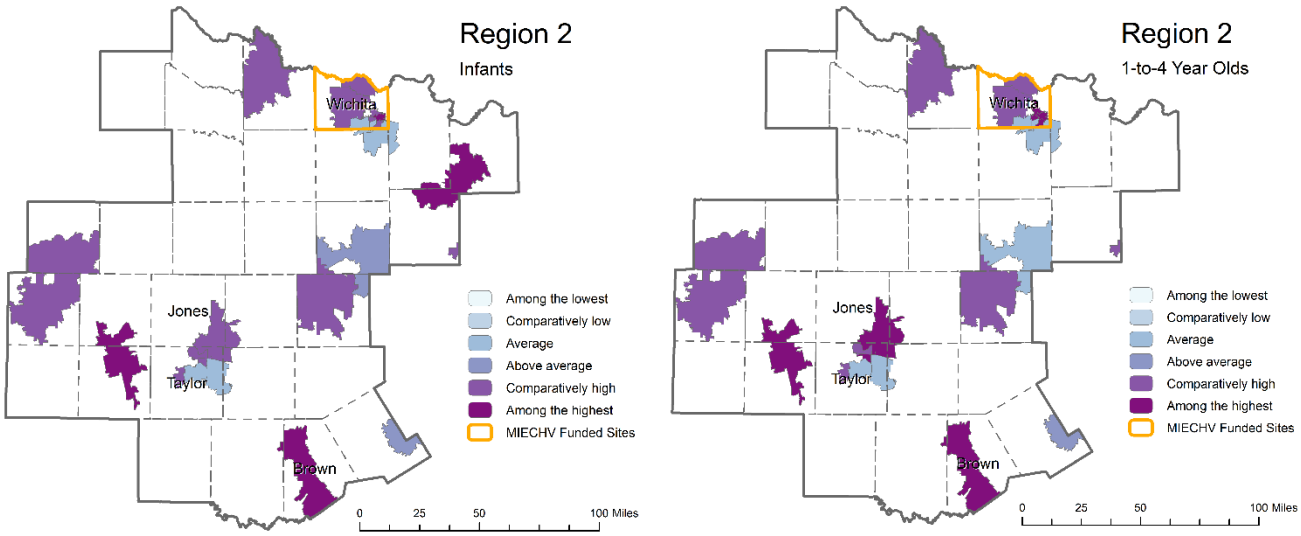
The Panhandle region of Texas has 41 counties and two major cities, Amarillo and Lubbock. Amarillo is in both Potter and Randall Counties. Lubbock is mostly in Lubbock County. Lubbock is home to Texas Tech University, which has an established medical school that serves the entire panhandle. This area of Texas is a predominantly ranching and farming community.

Across this region, the rate of *Assaults Needing Medical Attention* is high. This region is almost a half of a standard deviation higher than the rest of the state on this metric. Additionally, factor scores on *Child Safety & Health* and *Health & Disability* are elevated in this region. These higher scores point to a

general need for safety education in the area. Further, the elevated scores on *Health & Disability* in this area is reflective of relatively high concentration of adults who are receiving disability benefits, which is not surprising given the high proportion of manual labor jobs in the region. But we are also finding that this factor is closely tracking with needs for mental health services and drug treatment services throughout the state. That close coupling is also found in the Panhandle. Lubbock and Amarillo have two of the highest rates of prenatal drug exposure in the state. Potter County (Amarillo) has a prenatal drug exposure rate of 22.9 per 1,000 births and Lubbock County has a rate of 23.7 per 1,000 births. These rates are more than twice the rate for the state as a whole. In this region, the most common drug of use is methamphetamine. Fewer than 10% of infants with prenatal drug exposure have been exposed to opioids.

Potter County (Amarillo) has 73% of its 0 to 4 population living in a high-risk ZIP code. In contrast, Lubbock has 33% of its 0 to 4 population living in a high-risk ZIP code. This also translates into a greater number of children-at-risk in Potter county (7,028) than in Lubbock (5,984), leading them to be ranked 10 and 12 in the state for need.

4.2.2 Region 2. North Texas

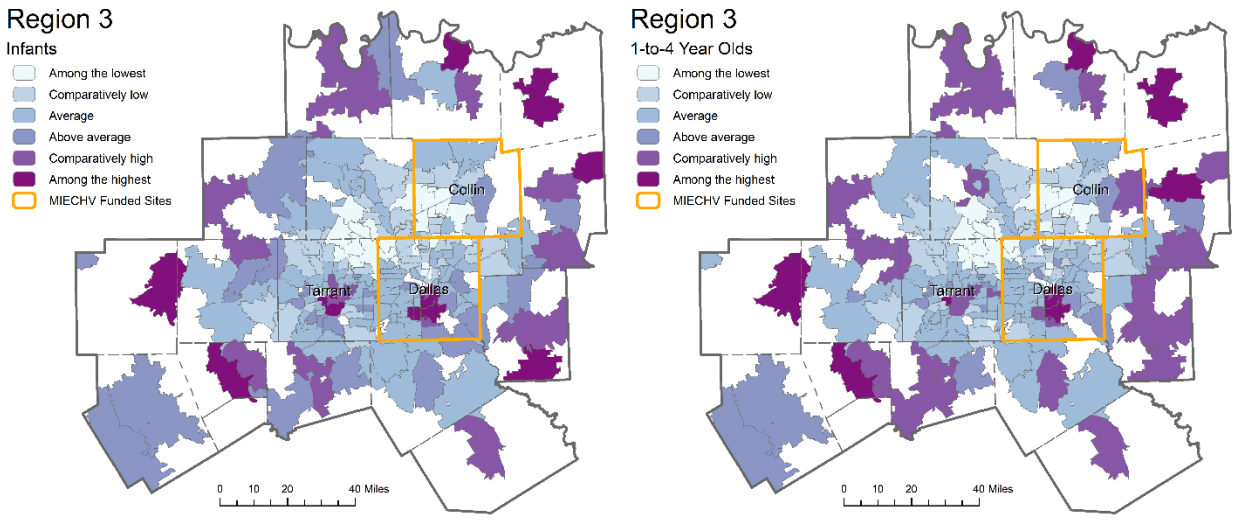


The North Texas region fits like a puzzle piece into the southeastern part of the Panhandle. This region, like the Panhandle, is sparsely populated with Wichita Falls (in Wichita County) and Abilene (in Jones and Taylor Counties) being the major population centers. Wichita County is ranked number 10 and Taylor County is ranked 17 in the state for risk.

This region, collectively, is more than a standard deviation above the mean for the state on the *Health & Disability* factor. As with the Panhandle, this factor points to a need for mental health services in the area. However, the need in this area for substance use treatment appears lower than it is in the Panhandle. This area has prenatal drug exposure rates in line with the state average (9.5 babies per 1,000 born). This region also has poor health behaviors during pregnancy, with most ZIP Codes having smoking during pregnancy rates around 10% of mothers, which is two times higher than what is seen in the rest of the state. Further, this area has low rates of breastfeeding initiation in the hospital. Therefore, it is likely that the needs reflected in the *Health & Disability* factor are more related to the health behaviors in the area, than to substance use needs.

This area is also has high scores on *Child Safety & Health* and *Assaults Needing Medical Attention*, suggesting that a focus on safety is also needed in this area. It is important to point out that this area also has strengths including a relatively low concentration of families in poverty and access to affordable housing.

4.2.3 Region 3. Dallas/Fort Worth Area



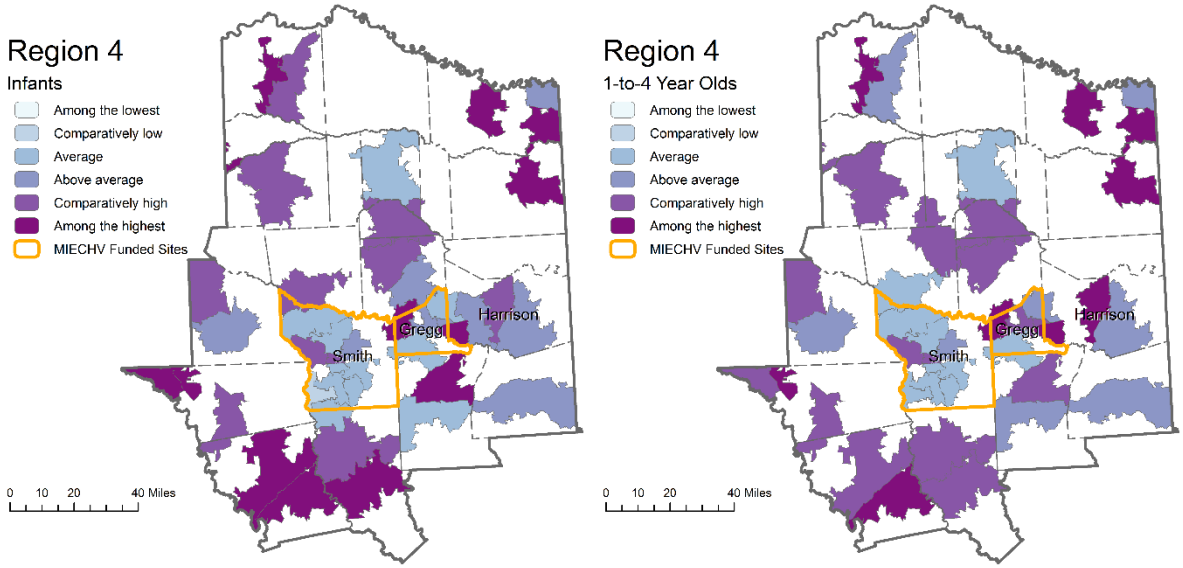
The Dallas/Fort Worth region is directly east of the North Texas region. This area is the largest metropolitan area in Texas with a population of 7.4 million. The metro area is often divided into the Fort Worth-Arlington (mainly within Tarrant County) area and the Dallas-Plano-Irving (Dallas and Collin Counties) area. Dallas County is ranked number 4 in risk in the state with an estimated 14,424 children (7.4% of the child population in the county) living in a high-risk ZIP Code. Despite its significantly smaller population, Tarrant County is ranked number 2 in risk for the state with 15,818 children (11.6% of the child population in the county) living in a high-risk ZIP Code. Dallas and Collin Counties have MIECHV funded home visiting. Tarrant County does not have these funds, but it does have a variety of state-funded prevention programs.

As would be expected, averaging over ZIP Codes in these highly populated counties results in both counties appearing low risk. However, looking at needs in the high-risk areas paints a different picture.

High-risk areas in Dallas are more than 2 standard deviations above the state mean for *Assaults Needing Medical Attention* and nearly 2 standard deviations above the mean for *Infant Mortality*. While not as dramatic as other parts of the state, these areas are also a half of a standard deviation above the mean on *Health & Disability*. These ZIP Codes have prenatal drug exposure rates 2 to 3 times the state rate.

High-risk areas in Tarrant County, like in Dallas, have above average rates of *Infant Mortality* and have assault levels two standard deviations higher than the state average. There is also a higher number of families who spend more than 30% of their income on rent in these areas. These high-risk areas in Tarrant County do show protective factors with low factor scores on *Child Safety & Health*, indicating that there are strong child safety programs in the area.

4.2.4 Region 4. Northeast Texas



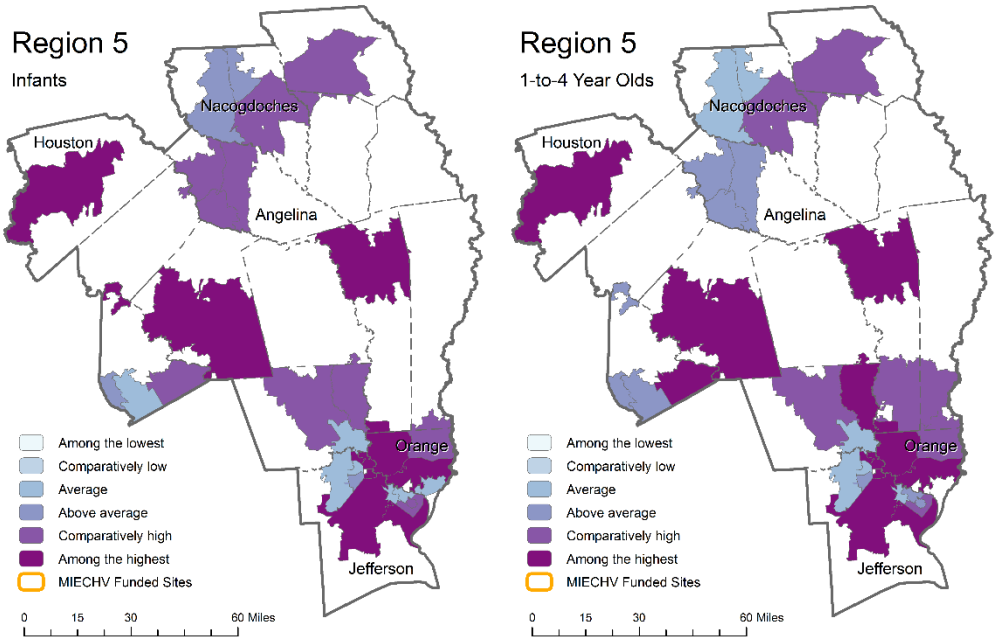
The Northeast Texas region is directly east of Dallas/Fort Worth. The north of this region is bordered by Oklahoma, and the east is bordered by Arkansas and Louisiana. This region is mainly classified as rural, with the exception of Smith and Gregg Counties, which are home to Tyler and Longview, respectively. Tyler is home to a university and health science center with an academic hospital. Smith County is the most populated and highest resourced county in the region.

As with most rural areas in the state, the concentration of poverty in this area is lower than the state average. However, there are substantial needs in the area as revealed by poor and risky health behaviors. This area is considered one of the least healthy in the state [7]. This poor health is also reflected in the *Health & Disability* and the *Child Health & Safety* factors, which are both more than half a standard deviation above the mean in this region. Smoking during pregnancy rates in this area are as high as 20% of births. Only one ZIP Code in this region has a smoking during pregnancy rate at or below the state rate.

Further, this area has rates of preschool enrollment nearly half a standard deviation below the state mean, showing a clear challenge with accessing this protective and important service in the region.

While Smith County has fewer high-risk ZIP Codes than other counties in the area, 10% of births in this county are to a teen mother, one of the highest percentages in the state. Smith County is ranked 20 in risk. Gregg County is ranked 18, and Harrison is ranked 23.

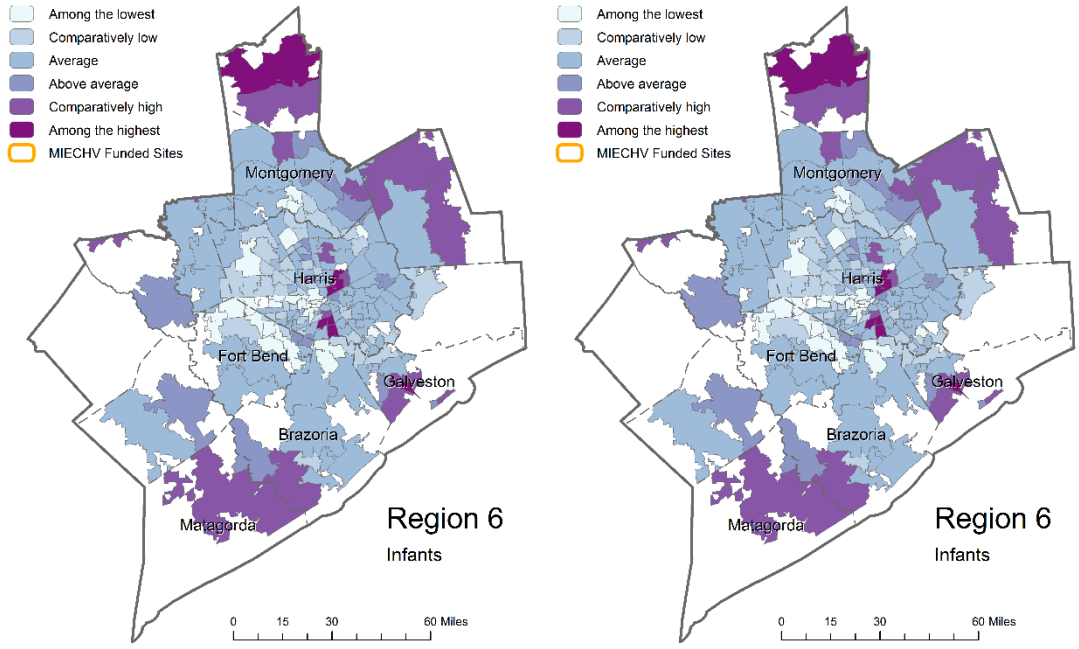
4.2.5 Region 5. Southeast Texas



The southeast region is directly south of the northeast region. The eastern border of this region is Louisiana. The most southern border of Jefferson County is the beginning of the Gulf of Mexico. There are no MIECHV funded sites in this region, but there are funded prevention programs in this area. Jefferson County is ranked number 7 in risk in the state, with 58% of children living in a high-risk ZIP Code. This county is home to Beaumont and has the largest population in the region.

This region has very high scores on the *Health & Disability* factor, nearly 1.5 standard deviation above the mean. As with northeast Texas, this area has very high rates of smoking during pregnancy. Further, this area, especially Orange and Jefferson Counties, has high rates of infant mortality. Jefferson County has the highest rate of *Assaults Needing Medical Attention* among large counties and the 6th highest rate of all counties included in the modeling.

4.2.6 Region 6. Houston Area

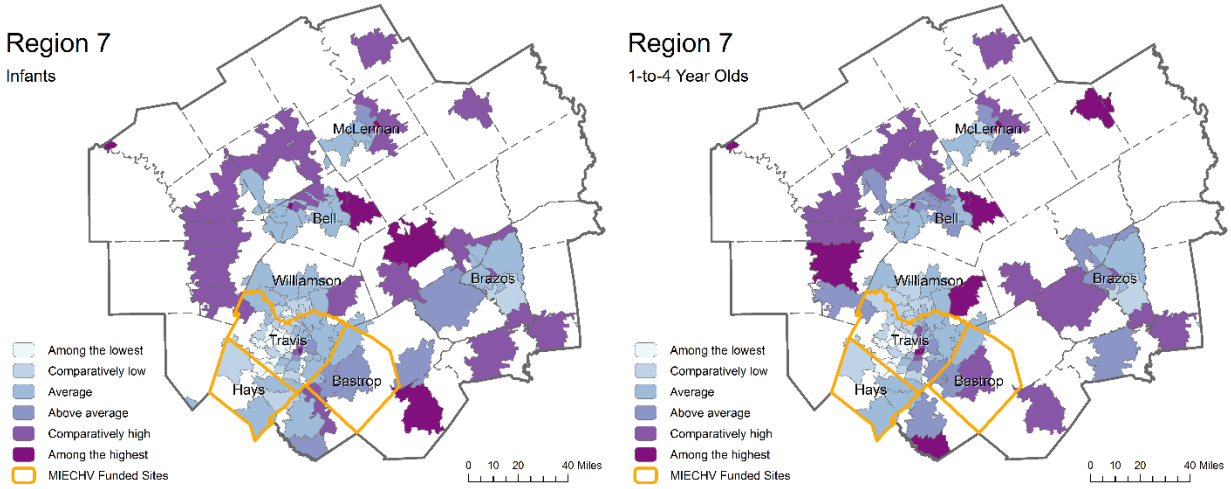


The Houston region is to the southwest of the southeast region. This region consists of mainly the Houston metropolitan area, although the Houston MSA extends outside of this region's boundaries. Harris County is where the majority of Houston is located and has the largest county and city-level population in the state. Galveston County also has a substantial and large population. These two counties are ranked 3 and 9 for risk in the state. This region does not have any MIECHV funded agencies, but there are several state-funded prevention and home visiting programs in these counties.

As with all metropolitan areas, averaging over this region shows very little risk. The high-risk areas in Harris County are clustered in two areas. Both clusters have high concentrations of families in poverty and with low incomes. These two clusters also have very high rates of *Assaults Needing Medical Attention*. One of the ZIP Codes in the northern cluster in Harris County has one of the highest rates of assault in the state. Both clusters also have high scores on the *Health & Disability* factor. Consistent with this score, these two clusters also have the highest rates of prenatal drug exposure in the county. In the Houston area, stimulant use (such as cocaine) is quite high, but there has been a rise in use and overdoses being attributed to mixing stimulants and opioids.

In Galveston County, there is a mix of risk and protective factors. This area has high rates of prenatal drug exposure, with many ZIP Codes having rates twice as high as the state rate. As expected, this area also has scores on *Health & Disability* that are 1.5 standard deviations above the state average. While substance use is clearly a problem in this area, there is also a need to assess how workplace injuries are contributing to risk. This area is important for the gas and oil industry and home base to those that work on and repair offshore oil rigs and pipelines. These jobs may be contributing to high rates of adult disability, but these jobs also translate to a low concentration of poverty in this county. Further, this county also has high rates of enrollment in formal preschool, another important protective factor.

4.2.7 Region 7. Austin and Central Texas



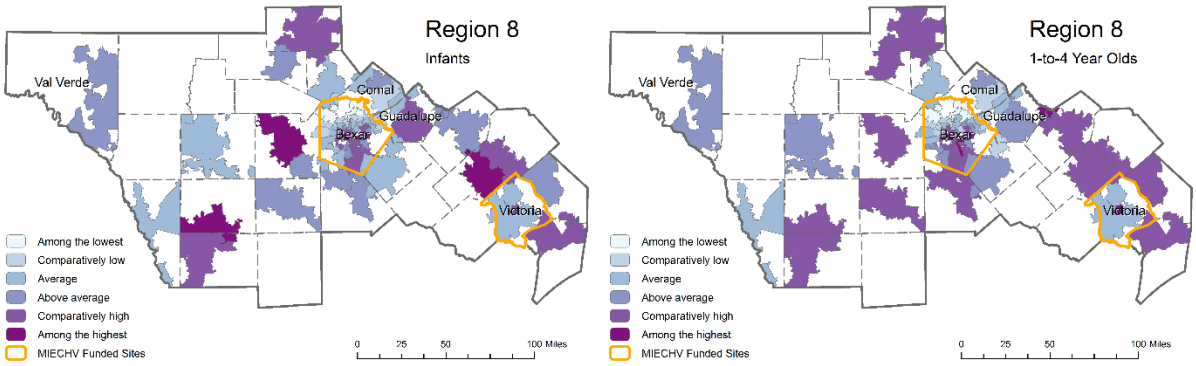
The Austin and Central Texas region is northwest of the Houston region. This region consists of three distinct metropolitan areas. The Austin-Round Rock metropolitan area consists of Travis, Williamson, Hays, Bastrop, and Caldwell Counties. This area was the fastest growing region in the United States from 2010 to 2018. The metropolitan area to the north of Austin is the Killeen-Temple area, which includes Bell, Coryell, and Lampasas Counties. This area is notable as it includes Fort Hood, which is one of the largest military bases in the world. The metropolitan area to the north of Killeen is Waco, which is in McLennan and Falls Counties. In Texas the four contiguous metropolitan areas from San Antonio to Waco is known as the I-35 Corridor.

Travis County has the highest per capita income among Texas counties with more than 1 million people and the fifth highest per capita income of counties with a population greater than half a million people. Despite its affluence, it is ranked 5th in the state for risk. The high-risk areas in Travis County are slightly different from other high-risk areas in the state in that scores for *Health & Disability* are not high in this county. High risk areas in this county are marked by high scores on *Child Health & Safety* (1.5 standard deviations above the mean), *Assaults Needing Medical Attention* (1 standard deviation) and needs for affordable housing (1 standard deviation). Bastrop County (ranked 46th in risk) sees the same pattern of risk, apart from affordable housing.

Hays County is not identified as a high-risk county in Texas but does receive MIECHV funding. However, it is thought that risk will change with data that reflects the current state of the county. The affordability issues in Travis County has pushed populations to the more affordable Hays County. The population of this county has nearly doubled in the past 10 years, with most of that growth being in the past 4 years. Our data are not current enough to capture the growing risks in this county.

Bell and McLennan Counties have a profile of risk similar to other areas, with high risk areas having very high assault scores and *Health & Disability* scores. Both counties also have very high rates of prenatal drug exposure. McLennan County has the ZIP Code with the highest prenatal drug exposure rate (67.6 per 1,000 infants) in the state. This rate has skyrocketed since 2011, when it was 8.9 per 1,000 infants. This rise does not appear to be driven by opioid use; rather it is suspected that marijuana and methamphetamine use is driving this increase.

4.2.8 Region 8. San Antonio Area

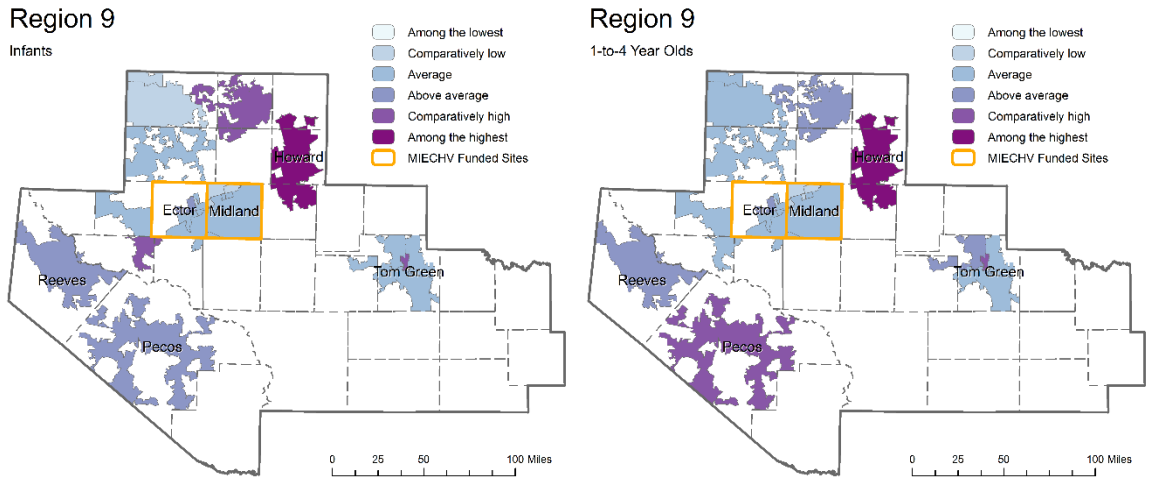


The San Antonio region is directly south of the Central Texas region. San Antonio is in Bexar County, which has the third largest 0 to 4-year old child population in the state. In 2018, Bexar County replaced Travis County as the fastest growing county in the United States. It is now the second most populous county in Texas.

Bexar County has the highest risk in the state. It is home to 2.6% of all children in the state that live in a high-risk ZIP Code. In contrast, Harris County, which has more than double the child population, is only home to 0.85% of all children in the state that live in a high-risk ZIP Code. A major factor that contributes to this area being high risk is substance use. Bexar County has a prenatal drug exposure rate nearly two times higher than the state rate. Several ZIP Codes in the county have consistently high rates of prenatal drug exposure. In these ZIP Codes, more than 4% of the infants born in the ZIP Code have prenatal drug exposure. Unlike other areas of the state that have experienced a substantial amount of simulant and methamphetamine use, Bexar County's substance use is dominated by opioids, mainly heroin[8].

Victoria County is ranked 24 for risk in the state. Victoria only has one high-risk ZIP Code, but that community has 50% of the 0-4 population for the county. Risk in this county is being driven by high scores on *Child Health & Safety* factor. There is also a disparity in the county in terms of access to childcare. ZIP Codes with relatively low risk show high utilization of formal childcare/preschool, whereas children living the in the high-risk ZIP Code have very low utilization.

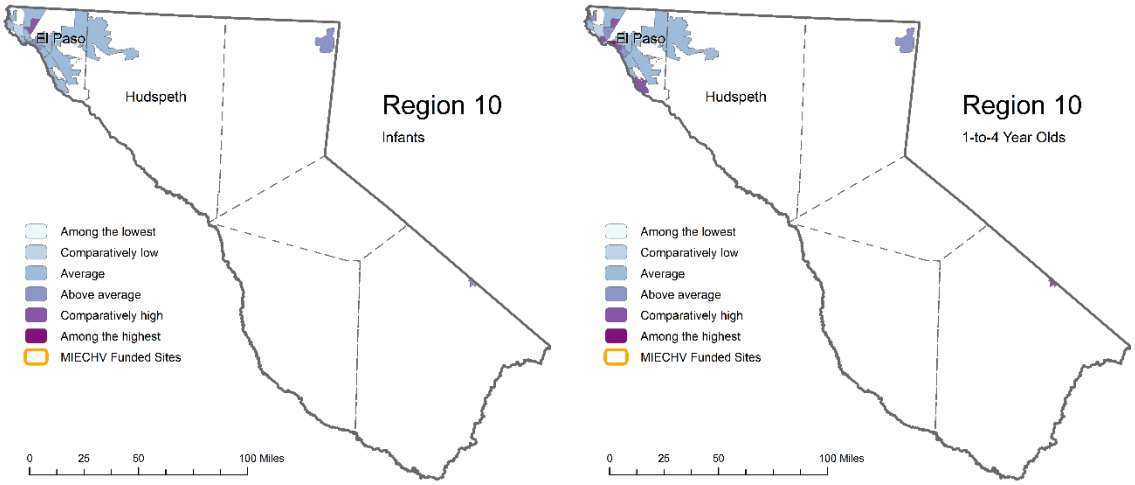
4.2.9 Region 9. Odessa Midland- West Texas



The Odessa Midland region is to the northwest of the San Antonio region and is the beginning of the west Texas region of the state. This region is known as the Permian Basin and is the heart of field-based oil extraction in the state. This area has a large transient workforce because of oil extraction, with a large percent of the workforce coming to the area for several days then returning to their permanent residence for several days. Odessa is in Ector County and Midland is in Midland County, but the two cities share resources and services. Tom Greene County is home to San Angelo and Goodfellow Air Force Base.

This region appears to be low risk, but as with other areas with a transient workforce, risks are hard to capture for this region because official residency is somewhere else for many who need and utilize resources. Teen pregnancy is high in this area. Ector County has 7.45% of all births being to a teen mother, giving this county a risk rank of 52.

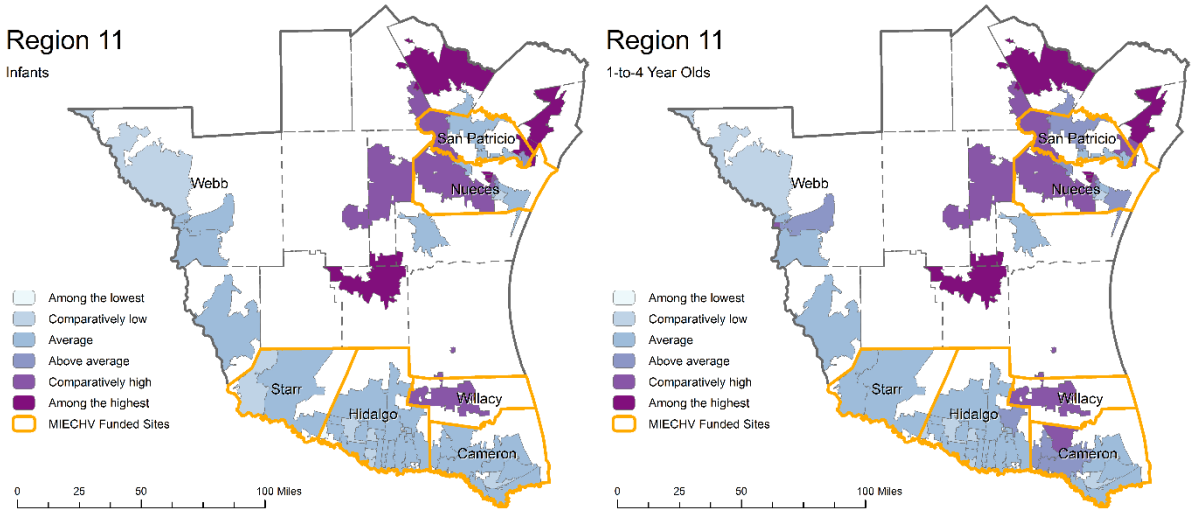
4.2.10 Region 10. El Paso – Far West Texas



The El Paso region is the furthest western tip of Texas. It is bordered by New Mexico to the north and Mexico to the south. The southern area of this region is Big Bend National Park, which accounts for the lack of population in those two large counties. El Paso is home to Fort Bliss, which is the second largest military reservation by size in the United States. The largest military reservation is White Sands, which begins just north of El Paso in New Mexico. This region does not have MIECHIV funding but does have other state-funded prevention programs. El Paso is ranked 6th in the state for risk.

El Paso has high scores on the *Family Poverty* and *Child Health & Safety* factors. El Paso has a particularly high rate of children hospitalized for falls, pointing to a need for coordinated injury prevention in the area. The El Paso region has a high concentration of families living in poverty. This concentration of poverty is seen through all border communities.

4.2.11 Region 11. South Texas & Coastal Bend



The South Texas & Coastal Bend region is the most southern tip of the state. It is bordered by Mexico to the west and south and the Gulf of Mexico to the east. This region of the state is predominantly Mexican-American and the majority of the population is bilingual. Corpus Christi is one of the largest cities in the area and is located in Nueces County. The Corpus Christi metropolitan area extends to San Patricio County. The Starr-Hidalgo-Cameron-Willacy area is a single service area that includes two metropolitan areas.

Nueces is ranked 8th in risk and San Patricio is ranked 45th. Nueces has high scores on the *Child Health & Safety* factor and the assault measure. Nueces has the third highest ratio of *Assaults Needing Medical Attention* to adult population among all large counties. This county's poor *Child Health & Safety* scores are being driven by high rates of falls resulting in hospitalization. Compounding the risks that are seen in Nueces County is a high prenatal drug exposure rate (16.1 babies per every 1000 births). While opioids are not the majority of these exposures, opioid exposure is significantly higher here than in the rest of the state and only trails the San Antonio region.

The far southern tip of Texas appears to be very low risk. These four counties are all ranked in the top ten of counties with high concentration of *Families in Poverty*. Despite this risk, Hidalgo and Starr have no at-risk ZIP Codes as assessed by our risk modeling. However, Starr County has 8.86% of births being to a teen mother, ranking this county 54th in risk. Cameron County is higher risk and ranks 16th in the state. This risk rating is driven by a lack of protective factors. Hidalgo and Cameron have very similar factors scores on *Families in Poverty* and rental affordability. What separates the two counties is that Hidalgo has more 18 & 19-year old youth enrolled in school.

Willacy is where risk is concentrated in this area. This county's factor score on *Health & Disability* is more than 1 standard deviation above the state average. This county has the fourth highest percent of the working adult population receiving disability benefits. Coupled with that indicator, the prenatal drug exposure rates in this county is over 16 per 1,000 babies. Willacy has a child population below 2,000, therefore, it is not included in our risk rankings.

5 IDENTIFYING QUALITY AND CAPACITY OF EXISTING PROGRAMS

5.1 METHOD OF ASSESSING QUALITY AND CAPACITY

All federally funded home visiting programs in Texas, except two, serve over 90% of their funded capacity and 10 sites serve more than their funded capacity. These sites are meeting and exceeding their capacity. For this Needs Assessment, capacity was assessed using administrative data, model fidelity guidance, and quarterly and monthly narrative reports for MIECHV funded and other home visiting programs. The quality of home visiting programs was assessed by the role each program plays in their community, including each program's ability to meet the needs of their families by connecting them to additional resources. This was assessed through: the ways that need was assessed, the strength of referrals that programs make, and how the program was connected to the broader community.

Quality was assessed through an online survey and follow-up structured interviews with home visiting program directors and direct home visiting service providers in Texas. The survey asked each program about their practices with referring families to 40 different programs or events that either connected the family to the broader community or helped meet a specific need of the family. Fourteen of the fifteen MIECHV-funded agencies responded to the survey and completed at least one interview.

Follow-up interviews were also conducted with each agency to further understand how referrals are made by the program and to ask about need gaps in the community. It is important to note that these interviews took place after Texas issued a "shelter-in-place" order due to the COVID-19 pandemic. Some of the gaps that were identified are unique to the COVID-19 order, but many of these gaps will be enduring and represent new challenges faced by communities.

5.2 TEXAS' HOME VISITING SYSTEM

Texas has a robust home visiting system. In Fiscal Year 2016, the state of Texas consolidated all home visiting programs under a single agency and division, DFPS-PEI. In fiscal year 2019, DFPS-PEI supports home visiting through several programs, some of which are geared towards more general upstream prevention and child wellbeing and some of which are geared towards specific high-risk or priority populations.

5.2.1 Home Visiting Service Capacity in Texas

Home visiting programs in Texas are funded using both federal and state funds. With state and federal resources combined, DFPS-PEI home visiting has capacity to serve nearly 11,500 of the 2.5 million children under 5 in Texas, over 320,000 of whom live in high-risk zip codes. PEI funds home visiting services through five programs utilizing state and federal funding, including MIECHV funds.

- ***Helping Through Intervention and Prevention (HIP)***

  A free, voluntary program, Helping through Intervention and Prevention (HIP) provides targeted families with an extensive family assessment, home visiting that includes parent education, and basic needs support.

  Counties Served with Home Visiting in Fiscal Year 2019: Angelina, Austin, Bell, Bowie, Cameron, Collin, Colorado, Coryell, Dallas, Falls, Galveston, Gregg, Harris, Hays, Hidalgo, Jefferson

Kaufman, Lampasas, Lubbock, McLennan, Montgomery, Nacogdoches, Orange, Polk, Rusk, San Jacinto, Tarrant, Travis, Walker

Population Served in Fiscal Year 2019: Families with a new child and a prior history of a confirmed child maltreatment fatality or termination of parental rights; and former and current foster youth who are expecting and/or are new parents.

Measured Outcomes: Children remain safe during services, within 1 year, and within 3 years; Increase in protective factors such as: family functioning and resiliency; social supports and nurturing/attachment

Program Overview: Home-based assessments, home visiting program that provides evidence-based parent education, and basic needs support up to $200

- ***Healthy Outcomes through Prevention and Early Support (HOPES)***

The HOPES Program offers parent education and support services in communities across the state to strengthen and promote protective factors for families of children ages 0 to 5; support safe, nurturing homes for children; and reduce the risk of child abuse and neglect across communities.

Counties Served with Home Visiting in Fiscal Year 2019: Bastrop, Bell, Bexar, Bosque, Brazoria, Brazos, Callahan, Cameron, Chambers, Clay, Coryell, Dallas, Denton, Ector, El Paso, Ellis, Fort Bend, Galveston, Gregg, Harris, Harrison, Hidalgo, Hood, Hudspeth, Jefferson, Johnson, Jones, Kleberg, Lampasas, Liberty, Limestone, Lubbock, McLennan, Medina, Midland, Montgomery, Nolan, Nueces, Potter, Randall, Rusk, San Patricio, Shackelford, Tarrant, Taylor, Travis, Upshur, Waller, Webb, Wichita, Williamson

Population Served in Fiscal Year 2019: Families with children ages 0-5 years old who are considered at risk for abuse and neglect.

Measured Outcomes: Children remain safe during services, within 1 year, and within 3 years, increase in protective factors such as: family functioning and resiliency; social supports and nurturing/attachment

Program Overview: The HOPES Program includes an array of parent education and support programs, including home visiting, services that promote family well-being such as case management, counseling, and referrals, and community and systems work. Providers use evidence-based programming and approaches as well as implement innovative community-level initiatives.

- ***Military Families and Veterans Pilot Prevention Program (MFP)***

The Military Families and Veterans Pilot Prevention program supports military families and veterans and their families in Bell, Bexar and El Paso counties. These counties are home to Fort Hood, Fort Sam Houston, Lackland Air Force Base, Randolph Air Force Base, and Fort Bliss.

Counties Served with Home Visiting in Fiscal Year 2019: Bexar, El Paso, Guadalupe, Hudspeth

Population Served in Fiscal Year 2019: Military families and veterans who have committed, have experienced or who are at a high risk of family violence and/or abuse and neglect

Measured Outcomes: Children remain safe during services, within 1 year, and within 3 years; Increase in protective factors such as: family functioning and resiliency; social supports and nurturing/attachment

Program Overview: Through parenting, education, counseling, home visiting, and support services, this program is designed to: Prevent child abuse and neglect in military communities; Help military and veteran parents have more positive parental involvement in their children's lives; Improve the ability of these parents to give their children emotional, physical, and financial support; and Build community coalitions focused on preventing child abuse and neglect.

- ***Texas Home Visiting (THV)***

Texas Home Visiting (THV) is a free, voluntary program through which early childhood and health professionals regularly visit the homes of at-risk pregnant women or families with children under age 6. Texas Home Visiting includes sites that are funded by MIECHV and state general revenue.

Counties Served with Home Visiting in Fiscal Year 2019: Bastrop, Bexar, Cameron, Collin, Dallas, Ector, Gregg, Harris, Hays, Hidalgo, Midland, Montgomery, Nueces, Potter, Randall, San Patricio, Smith, Starr, Tarrant, Tom Green, Travis, Victoria, Wichita, Willacy

Population Served in Fiscal Year 2019: Expecting parents, parents and caregivers of pre-kindergarten children who need help getting school-ready, raising multiple children, and/or getting back together after being apart

Measured Outcomes: Children remain safe during services, within 1 year, and within 3 years; Increase in parent/child interaction, ability to cope with parental stress; Support positive health outcomes by addressing premature birth outcomes, attending well child visits and support breastfeeding

Program Overview: Services offered through THV include evidence-based home visiting, parent education and local systems building

- ***Texas Nurse Family Partnership (TNFP)***

Texas Nurse Family Partnership (TNFP) is a free, voluntary program through which nurses regularly visit the homes of at-risk pregnant women or families with children under age 2. Families start services with TNFP by their 28th week of pregnancy and can receive services until the child reaches two years of age.

Counties Served in Fiscal Year 2019: Bexar, Chambers, Crosby, Dallas, El Paso, Floyd, Fort Bend, Garza, Hale, Hardin, Harris, Hidalgo, Hockley, Jefferson, Lamb, Lubbock, Lynn, McLennan, Orange, Tarrant, Terry, Willacy

Population Served in Fiscal Year 2019: First -time low income mothers and their families, from before their 28th week of pregnancy through their child's second birthday, ϖ

Measured Outcomes: Children remain safe during services, within 1 year, and within 3 years; Increase in parent/child interaction, ability to cope with parental stress; Support positive health outcomes by addressing premature birth outcomes, attending well child visits and support breastfeeding

Program Overview: Services offered through TNFP includes evidence-based home visiting by a licensed nurse to address issues related to health, self-sufficiency, parenting and stress management.

5.2.1.1 Home Visiting System Staffing

Home visiting in Texas is provided by both professionals and paraprofessionals based on model requirements. All home visiting programs funded by state or federal funds meet the staffing requirements

necessary for alignment with model fidelity, ranging from a high school degree or GED for HIPPY home visitors to registered nurses with a Bachelor's Degree in nursing for Nurse Family Partnership and Family Connects. In Fiscal Year 2019, DFPS-PEI used its MIECHV grant to fund 169 home visitors and 39 direct service supervisors across the state of Texas, including:

- 81 Parents as Teachers parent educators
- 33 Nurse Family Partnership nurse home visitors
- 53 HIPPY peer home visitors
- 2 Healthy Families America home visitors

During FY2019, turnover and attrition were noted and addressed with all MIECHV funded sites reporting at least one vacancy in direct service supervisor, home visitor, or both types of positions at some time over the fiscal year.

5.2.2 Gaps in Home Visiting in Texas

Texas is a large and diverse state, both geographically and based on population. The 2019 Texas child population ages 0 to 5 was nearly 2.5 million, representing 8.6 percent of Texas' overall population. Texas' largest county, Harris County had an estimated 0 to 5 population of over 450,000 while Texas' smallest county, Loving County, had an estimated 0 to 5 population of only six. Geographically, Texas is a large state, over 800 miles north to south, and nearly 800 miles east to west, taking over 12 hours to drive across.

In a state like Texas, there are sure to be gaps in any system, and despite the substantial state and federal investment in home visiting, the home visiting system is no exception. In Fiscal Year 2019, MIECHV funded home visiting served nearly 4,000 families, with approximately 7,600 families served by state-funded home visiting programs. This represents only 0.5 percent of all children ages 0 to 5 in Texas.

Of course, not all Texas children need home visiting services, and not all families would choose to enroll in home visiting. Based on its analysis of risk and protective factors data described above, DFPS-PEI estimates that just over 223,000 families in Texas are in need of home visiting services. This suggests that only 5 percent of Texas children in need are currently receiving home visiting services.

Gaps in home visiting in Texas can be addressed in two ways. There is need to both expand existing services to assist additional families in areas where home visiting already exists and the need to build readiness for home visiting programming in new areas of the state where services do not already exist. Both strategies are necessary to address need across the state.

There is no county in Texas with home visiting capacity to serve the majority of families in need. There are five counties in Texas with capacity to serve between 25 and 50 percent of families in need: Randall, Ector, Gregg, Wichita, and Potter. All of these communities are served by both MIECHV-funded and state-funded programs. In contrast, there are 15 counties in Texas with at least some home visiting available where less than 5 percent of the estimated number of families in need were served in fiscal year 2019: Bell, Galveston, Fort Bend, Chambers, Harris, Hardin, Garza, Clay, Floyd, Brazos, Tarrant, Lamb, San Patricio, Bastrop, and El Paso.

Of the 54 counties identified as high priority for home visiting services, DFPS-PEI provides at least some home visiting services in 29 of them, and no home visiting in 25 of them. DFPS-PEI identified the five largest counties as the highest priority counties for investment in home visiting. While some home visiting services are provided in each of these counties, there is a significant need in each. While DFPS-

PEI has the capacity to serve approximately 12 percent of families in need in Travis County, there is only capacity to serve approximately 2 percent of families in need in Harris County.

DFPS-PEI has also identified counties in need where no home visiting services are currently provided. In many cases, these counties are small and with fewer resources than the counties where some need has been met. Of the 54 counties ranked as priority for home visiting investment, Johnson, Grayson, Hunt, Bowie, and Henderson Counties are ranked as the most in need. Since fiscal year 2019, DFPS-PEI has already begun serving families in Henderson County, and is working to build capacity in Grayson County and East Texas where Johnson and Bowie County are located.

5.2.3 Community Readiness for Home Visiting

Implementing high quality early childhood home visiting programs requires the use of evidence-based and promising practice models. MIECHV-funded programs require implementation to model fidelity of evidence-based home visiting programs, which necessitates a partnership between the state, the local community, and evidence-based models. DFPS-PEI works closely with the developers of home visiting models on both implementation of current programs and building readiness for additional programs in the state.

DFPS-PEI determines where and how to fund home visiting programs based on competitive grant applications through a request for application process. Community readiness is one element of the application that communities must demonstrate to be considered for funding. Of course, many of the communities most in need of services are also some of the least ready for the intensity of implementing evidence-based home visiting.

As a proxy measure for community readiness for evidence-based home visiting services, DFPS-PEI used data from the 2018 County Business Patterns dataset, published by the United States Census Bureau, along with administrative data on investments in community readiness. Generally, home visiting in Texas is implemented by one of four types of organizations: healthcare organizations like hospitals or federally qualified health centers (NAICS Codes 621 and 622); educational service organizations (NAICS code 611); social assistance organizations (NAICS code 624); or religious, grantmaking, civic, professional, and similar organizations (NAICS code 813), these organizations are referred to as "potential implementing agencies" in the narrative sections below.

5.2.3.1 Community Readiness in Counties Currently Implementing Home Visiting

The counties identified as high priority for additional investment in home visiting demonstrate a high degree of readiness for expansion of services. It should be noted; however, that these counties tend to be larger than the priority counties not yet implementing home visiting, so rates of potential implementing organizations tend to be lower than in non-implementing counties. The five largest counties in Texas, ranked 1 through 5 in priority based on need, range from 3 establishments per 1,000 people in Bexar, Tarrant, and Harris County to 4 per 1,000 in Dallas and Tarrant Counties. It should be noted that this represents thousands of organizations, (from a low of 5,413 in Travis County to a high of 15,251 in Harris County). These organizations represent a sizable network of community-based organizations that could potentially implement additional home visiting services, partner with existing home visiting services to better serve families, or both.

These communities also display a high degree of readiness for investment at the systems level. DFPS-PEI requires participation in an early childhood coalition for home visiting programs funded by its HOPES, TNFP, and THV programs. Home visiting providers funded by other sources are encouraged, but not

required to participate in these coalitions. The goal of the coalitions is to build cross-sector support for investment in early childhood and build protective factors to improve child and family well-being.

PEI also has provided individualized Results-Based Accountability (RBA) training and on-going technical assistance to the following priority counties that are currently implementing home visiting: Bexar, Tarrant, Harris, Nueces, Potter, Wichita, Cameron, Gregg, Webb, Victoria, Montgomery, Tom Green, Bastrop, and Ector Counties. These trainings help build systems level coordination and readiness for early childhood work, that is data driven and multi-sectoral.

5.2.3.2 Community Readiness in Counties Not Yet Implementing Home Visiting

Amongst those 25 priority counties where DFPS-PEI is not currently implementing home visiting programs, the number of potential community based organizations that could implement some form of evidence-based home visiting ranges from 2 per 1,000 people in Liberty County to 5 per 1,000 people in Lamar County. It should be noted; however, that this measure is an imperfect proxy for the number of organizations, and not all of the organizations counted could or would be engaged in implementation of home visiting.

Another potential measure of community readiness is the county's proximity to a county that is implementing evidence-based home visiting services. In many instances, DFPS-PEI has been able to work with community-based organizations to partner across county lines and build capacity for services in neighboring counties. Of those 25 counties not currently receiving home visiting services, 18 are contiguous to a county with home visiting. Geographically, many of these counties are in Region 3, the Dallas/Fort Worth Area, and Region 4, Northeast Texas. DFPS-PEI has already begun working with providers in these areas on potential expansion plans to serve neighboring counties identified as priorities based upon this needs assessment.

To ensure that investments are made where need is high but readiness may be emerging, DFPS-PEI piloted a build initiative using MIECHV funds in two more rural, under-resourced counties: Bastrop and Victoria. These pilots provide a model for how DFPS-PEI can invest in communities to build the readiness required to implement evidence-based home visiting in under-resourced communities. This model includes investment in home visiting programs, as well as systems level work through RBA and universal intake and referral programs. DFPS-PEI is following a similar model through state funded home visiting in Navarro and Hood Counties.

5.2.4 Quality of Referral Systems

5.2.4.1 Assessing Need

Referrals can only be high quality if a need is assessed. There are three primary ways that home visitors identify the needs of parents and families in home visiting programs. These include through initial intake paperwork, formal screening methods that are done at specific times of enrollment or life stage, and informal assessments.

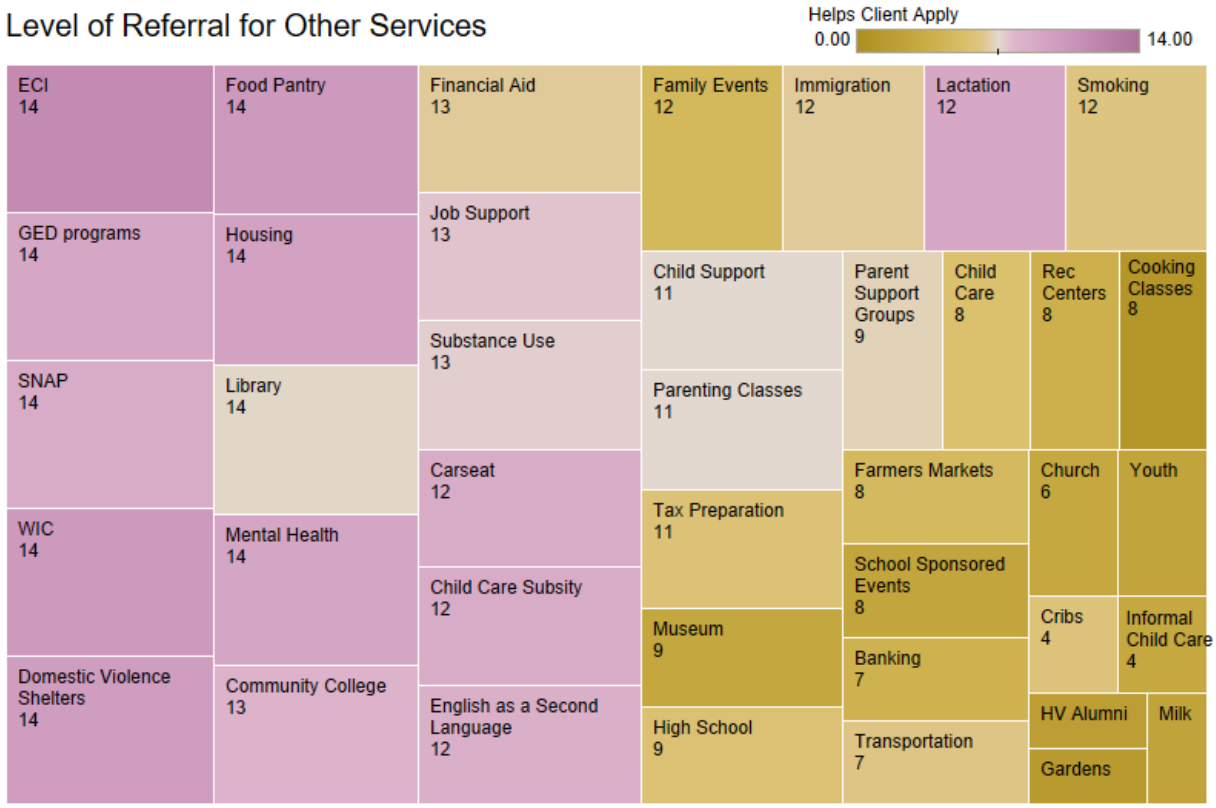
Intake Paperwork. For all home visiting programs, initial intake paperwork serves as an important source of information for referral needs such as housing, food assistance, and smoking cessation programs.

Formal Assessments. In addition to the intake paperwork, formal assessments and screening tools are used according to prescribed timelines to assess potential concerns such as child development (ASQ for ECI referral) and postpartum depression (Edinburgh for PPD). These are most commonly completed within the first few months of enrollment in the program, annually, or based on the life stage of the parent or child.

Informal Assessments. The most common way to identify a parent, child, or family need is through informal assessments that are based on the relationship between the home visitor and the family. This might take the form of personal conversations, thoughts, or comments that the family shares with the home visitor, changes the home visitor notices in the home environment of the family, or concerns voiced by the parent or family member. This informal assessment is common for needs related to mental health, food insecurity, housing, education, or employment support.

> *"Through our first 10 minutes of conversation, only when our home visitor walks in the door with the family, we just ask how they're doing that week, do they have everything that they need. And so that's kind of just a needs-based assessment we do each time we're in the home. We ask them if they're doing well on electricity, food, is there anything they need. And so they'll indicate what they need, and so then the home visitor knows how to refer them at that point." - Home Visitor*

5.2.4.2 Referral Strength and Quality



The figure above shows the number of agencies that referred to each service (size of box and number in box). Further, the strength of how that referral was made is indicated by the color of the box. Darker pink boxes indicated that the agency would help the family apply for the program (warm referrals). Dark beige boxes indicate that the agency would only tell the family about the program or service (cold referrals). With a few exceptions, warm referrals tended to be need-based services. These services were clearly prioritized by the programs as almost all had these types of referrals. The cold referrals tended to be for enduring programs that would build community connections for the family. Legal services, substance use programs, and parenting groups fell into a middle ground and reflect diversity across the state in access to these services.

Based on interviews with the programs, most referrals start with cold referral strategies such as providing information, flyers, pamphlets, or cards with minimal support to initiate a personal connection at the referred agency. If the cold referral does not result in the family accessing the services, the home visitor will take additional steps at the next home visit such as helping the family set up an appointment. Initial warm referrals tend to address high and emergency service needs (such as domestic violence, mental health, *etc*.). Warm referrals that are not these emergency situations seem to be more dependent on the home visitor's personal connections to the programs and services that the home visitor suggests to families.

5.2.5 Home Visiting's Connection to the Broader Community

5.2.5.1 Community Resource Tracking

Few home visiting programs in Texas have well-developed internal databases of referral providers and services. The primary reasons why home visiting programs did not maintain their own databases were related to inability to keep the reference list up-to-date. Of the programs that did have internal databases, the maintenance of it poses challenges, such as changing contact information of partner agencies or organization funding for special programs. A lack of central resource information creates a challenge for home visitors when they need to refer families to lesser-used programs or those that are not in their coalition. Instead of hosting their own internal database of referrals, home visiting programs often leverage other networks of referrals and service providers through services such as 2-1-1.

> *"We are connected at the United Way with 211 and so 211 is a great source for us as far as referrals." - Director*

Similar to having a central database of referrals for other social services, few (if any) home visiting programs in Texas have formal tracking systems for community events. Most home visiting programs in Texas use informal methods for sharing information about upcoming events. These methods include sharing information through word-of-mouth at home visits, text messages to families about upcoming events, social media (e.g., Facebook postings from the program), or occasionally listserv emails from the program's community coalition to home visitors and families. Some home visiting programs rely on other's event calendars and will refer their families to the local city events calendar or local library calendar, as their resources were more comprehensive or up-to-date than what could be maintained internally.

> *"Usually through the local newspaper, and we also check the different […] public library to see what they have, the children discovery museum, and sometimes too through [school district] email, it might be an email from someone letting us know about an event, a free event, a low cost even, and then we look for the flyer, and then we will hand it to [the parents]." - Home Visitor*

> *"All three programs have a Facebook presence. So if there's something going on in a community, a free event or that kind of thing, they'll push that out to their families as well in addition to the coalition. Success By 6 Coalition does the same thing. The families can take advantage of library activity or the art museum or that kind of thing that maybe they wouldn't necessarily have been aware of. Again, it's totally voluntary but it gets important to at least give them the information and then they'll do with it as they will." – Director*

5.2.5.2 Community Connections

The diversity of community connections and referrals was particularly strong when home visiting programs were well-connected within their community coalition, families within the program, and even between the other home visiting models in their agency. This cohesion can be seen when the agencies

host events or meetings across all models. A common example is when all models are invited to 'group connections' or health resource fairs. These events provide an increased opportunity for families and home visitors to share resources and learn about other programs.

> *"[O]ur local coalitions played a huge part in learning about the different referrals that we can make now." - Supervisor*

All home visiting programs interviewed commonly mentioned referring families to community resources such as parks and libraries. To further encourage families to engage with parks and libraries, home visiting programs often host their group meetings or events in these locations to facilitate use of the resources. Libraries and parks appear to be the most common because of their extensive availability within communities and that they are often free. Other community resources such as museums and or kid friendly attractions (e.g., zoo) are less commonly referred to because they are associated with entrance fees. A common saying among home visiting programs is that they are primarily referring to resources that are "low cost, no cost," as these are the resources that are more likely to result in family attendance.

While local coalitions are important for these referral networks, the extent to which the home visiting provider made these referrals was often dependent on his or her first-hand knowledge and experience with the resource. This first-hand knowledge was particularly important when it came to resources that are not provided by members of the community coalition, such as farmer's markets and faith-based programs.

> *"Well, now that you said farmers market, we have farmers market on Wednesday evenings and Saturday mornings. I want to say it's the first Wednesday of the month, they do veggie vouchers. If you go to the farmers market that night you get a voucher. I can't even think of what the value of it is, but using that you can get some free items from the farmers market. That we have shared with families. I wouldn't say that we refer them to it, but we've shared that information, we've shared that resource." -Program Coordinator*

> *"That's how I get a lot of my information, because my church is on the eastside, which is the low [socio-economic] area, so they have a lot of resources, too. So, they give me a lot of the information because they know I work with families, and we go out to a lot of their events that they throw. But I either from my church, HUB, or I'll Google it online or 211." - Home Visitor*

Many of the interviewees discussed how COVID-19 had changed the way they do referrals, but the largest changes appeared to be to how they helped connect families to community resources that were not need-based. There was the sense that everything that they had done to help families gain connectedness to the larger community evaporated overnight and was replaced by crisis-based referrals and help.

5.3 The Number and Types of Families Who Are Receiving Services Under Home Visiting

In FY 2019 MIECHV funded home visiting programs in Texas served 3,911 households including 3,914 adults and 3,904 children. Families accessing home visiting are predominately Hispanic with 71% of adults identifying with this ethnicity. Unsurprisingly, 37.9% of the families served speak Spanish at home. In the general population of the state, 29% speak Spanish at home. This high percentage of Spanish speakers does create an important, and difficult to fill, workforce need for bilingual home visitors. Approximately 10% of families served by home visiting programs are Black. This percentage is comparable to the general population distribution in the state. However, given disparities surrounding birth outcomes, welfare involvement, and other risks, special attention should be paid by home visiting programs to include these families in order to help address these inequities.

Among adults being served, there is a high proportion that have no health insurance. Texas has one of the lowest insurance rates in the nation, and the families served through home visiting reflects that, with 36% of adults not having insurance. Among pregnant women, 12% do not have any insurance. This rate is high for what is seen in the state, generally. Texas is one of the few states to cover pregnancy through Children Health Insurance Program for those that are not eligible for Medicaid for non-income reasons (i.e., due to immigration status). This high rate of no insurance may be reflective of the time when the data are collected or may reflect home visiting programs needing additional training to help families access health insurance during pregnancy.

Families being served also have a host of needs that are reflected in their family history and current situation. Approximately 8% of families have a history of child maltreatment or are involved in child welfare services. This is higher than the general population where it is estimated that only 4% of children under the age of 4 years old have had a history of maltreatment in the state. Substance use history is rare among families being served by home visiting programs (3%). This rarity is also reflected in our interviews with home visitors. When asked about referrals to substance use treatment, programs often said that was not a need among their families. Given the prevalence of prenatal drug exposure in high risk communities, the difference between what home visiting programs see and the risks in the communities should be explored.

Education is also another need that arises in home visiting families. Among adults, 40% have a high school diploma or less and nearly 19% have not completed high school. Home visiting programs are working hard to meet this need with all having strong connections to GED programs. Further, many see that this service connection could be stronger by integrating these programs into the home visiting agency or by coordinating services to overcome barriers to completing a GED.

5.4 UNMET NEEDS IN THE COMMUNITIES.

5.4.1 Barriers and Unmet Needs within Home Visiting Programs

5.4.1.1 Transportation

A key barrier mentioned across most interviews was the lack of consistent transportation to and from the referral location. While many programs do provide transportation vouchers and bus passes, without direct, easy-to-access transportation for the whole family, families are less likely to follow through with appointments at referral locations or participation in community events. Some home visiting agencies indicated that they can efficiently access transportation benefits for families through Medicaid. It should be noted that even when families are able to access this resource, limitations often exist for the number of family members that are able to use this service.

> *"[T]ransportation limits us as well. So I wish we could do more of that sort of thing. I wish there was a way that we could find a service that would help them with transportation. We've tried the bus, we've got an agreement with Uber and Lyft. We've used the taxi service. We've tried to help parents figure out carpooling arrangements and all of it is semi-effective but not totally."* - *Supervisor*

All supervisors, directors, and home visitors were asked what their wish would be for their program if there were no limit on their scope, charge, or model. By far the most common wish was to address the transportation barriers for families. This included providing resources for families to gain better access to transportation options, but also the ability of the home visitor to transport the family. Many models prohibit home visitors from transporting families to appointment and events.

"Well, it would probably be 24-hour transportation. We have two big meat packing plants here in our community and we have several parents that work nights, work different shifts, and it's always just such a huge barrier for them, is to-and-from, and then navigating to the resources that they need. We don't even have ... our transportation cuts off at 6:00 PM. Well, not everybody works a 9:00 to 5:00 job." - Director

"*I know that all of them wish they could give them a ride but that's prohibited in both. But I know that something was like, I wish I could take them to their prenatal appointment or things like that." - Director*

"I wish that we could ... Again, I guess it's tying back to the transportation. Like take them. Like, "Okay. This is your need. Let's go. On our next visit, this is where we're going." Just getting them there. A big barrier a lot of the times for them, accessing their needs is that transportation so we could transport them." - Home Visitor

5.4.1.2 Flexible time to meet needs

Home visitor also indicated that they felt time and lack of flexibility during the home visit was a barrier. Many indicated that if they could change something, they would increase the duration of a home visit or make it flexible to address the needs of the families. COVID-19 amplified this wish as many home visitors focused on helping families with basic needs such as food, diapers, and home essentials after the stay-at-home order. However, it is clear from the interviews that this barrier is enduring and impacts their ability to meet the needs that they see their families have.

"*We have the hour to also deliver the curriculum, but I wish that we had a little more funding so we had a little more time for the families so that instead of having to do a quick 10 minutes evaluation, we could spend even five more minutes, 15 minutes to visit with the family to see what they need and then jump into the curriculum, if that makes sense." - Supervisor*

"If there was no limit, then I wish that we could provide more of the things they need as far as educational activities and learning opportunities, field trips. Things like that, that would really enhance what they're able to do with their children ..." - Director

"Just to be able to help them just provide that GED. It'd be nice if we could partner up with the thing and be able to do our own classes for the family to get their GED, because with us if we're doing like the meetings or something, we can watch the kids while the parents are doing it. That would be awesome to do." - Home Visitor

5.4.1.3 Warm hand-off referrals and training

When asked about what would help home visiting programs the most, a common response from home visitors was for the program to have more "warm hand-off" referrals. Home visitors most often believed that the program had a sufficient scope of referrals but was lacking in their referral strength.

"I think there's plenty of referrals out there, they're going to be found, but I think that warm handoff is where it's at. We can refer parents left and right, but if we don't have anybody we can reach to, connect directly with, makes it really hard for our parents. Because they're trusting us that we are sending them somewhere that we trust, and sometimes it's hard to do that because we can't get ahold of anybody...So that stronger referral and that warm handoff, I think, would be, if anything, is going to be very important for us." – Supervisor

Warm hand-offs are very important to get families into services, especially services that are challenging to access. However, the success of any referral is built on shared decision making with the families. Providing additional training to home visitors on motivational interviewing and shared decision making may result in more successful utilization of resources. While no interviewee directly mentioned this need, there is a clear theme through the interviews that home visitors feel families do not use the resources provided.

> *"I believe we have a good amount of resources that we provide or that our community provides. It is really families utilizing those resources. That's where it comes, is in the follow-up, and we can only do so much making the referrals and then the follow-through with that for families. I'm not speaking for all, but I mean, usually what happens, we give out these referrals and then that's just not on their radar. It's just not something that they want."* - Home Visitor

Training in these techniques may mitigate some of the frustration home visitors feel when families do not leverage the recommended resources. A need for additional training was mentioned in some interviews for context-specific knowledge (meal planning and budgeting), suggesting that Home Visitors would be open to this additional training.

> *"Then I think more training so that our staff can provide other services like budgeting and meal planning, and things like that to offer to our families, because we've already built that rapport. So then to be able to offer that, I think it just becomes more meaningful. It's like that phrase, they don't care what you know until they know that you care. I think that would be ideal for us."* - Supervisor

5.4.2 Barriers and Unmet Needs within the Community

5.4.2.1 Mental Health Services

> *"My dream is that our program would be like a one stop shop for everything. I actually want to write it into our plan that we have counselors on board, because like I said, the South Texas Children's Home not even accepting people on our wait list and that's the only... maybe not only, but one of the only free counseling services that you can receive. If I had to choose between spending my money on counseling and spending my money on healthcare or groceries, well that counseling is not going to take priority. I would love to be able to offer that."* - Supervisor

Needs for mental health services is a common theme across interviews with home visitors and in our risk modeling data. Texas consistently ranks low in mental health service provision generally.

5.4.2.2 Childcare

Utilization of formal childcare for children between 3 and 4 years old is a protective factor in the risk modeling. In some neighboring communities this factor is the difference between being a high-risk and low-risk neighborhood. Access to affordable childcare not only impacts a family's ability to advance their education or training but their ability to work. Access to a childcare slot may be the make or break point for a single parent entering the workforce.

> *"Well, we definitely need more resources, especially when it comes to childcare because we want our families to succeed, getting their GEDs because that's something that we try to get our families to do, but it's hard when we don't have that childcare, the free childcare. Because you can get childcare anywhere, but you can't get free childcare."* - Home Visitor

Both cost and availability of childcare is a barrier that is seen throughout the state. In the 2019 legislative session, a route towards full-day prekindergarten was established for eligible children. As this program is offered, some of the childcare burdens will be alleviated for families. But this program will not necessarily increase availability or decrease cost for families with younger children.

The necessary response of closing schools and childcare centers in order to contain the spread of COVID-19 has made this need worse. Some estimates suggest that 50% of childcare slots will remain permanently closed after re-opening due the economic fragility of childcares centers[9]. High quality childcare is a central need for working families. Meeting this need was a challenge before the pandemic and will become a greater challenge as families try to return to work.

6 CAPACITY FOR PROVIDING SUBSTANCE USE DISORDER TREATMENT AND COUNSELING SERVICES

6.1 SUBSTANCE USE DISORDER TREATMENT FOR PREGNANT WOMEN AND FAMILIES

To address substance use disorders among pregnant women and families, research and evidence-based practice suggest that integrated treatment models, including those that combine on-site pregnancy, parenting, and child-related services with addiction services, are among the most successful.

Pregnant, Postpartum Intervention (PPI) programs are leading the way for substance use disorder treatment throughout the state of Texas. In 2016, service among PPI programs was expanded to provide Opioid Treatment Services (OTS) support by increasing outreach, enhancing education, and expanding services to women at risk of having a child born with neonatal abstinence syndrome (NAS) and women in substance use disorder treatment, as well as increasing access to healthcare information. In 2016, there were 18 PPI programs that served 4,880 high-risk or at-risk women[10].

Mommies Program. One of the most successful programs in Texas for substance use disorders among pregnant women and families is the Mommies Program. Established in 2014, the Mommies Program was created to address the increase prevalence of substance use among pregnant women in Bexar County, which represented 26% of all reported cases of neonatal abstinence syndrome in 2014. Mommies Program is a collaborative program between the University Health System and the Center for Health Care Services, A Department of State Health Services funded Medication Assisted Treatment program and substance disorder treatment provider. Key features of the Mommies Program are that pregnant women with any type of diagnosed substance use disorders are eligible for the program; all services are centralized to a single, centralized location; and services include free transportation and childcare, seamless benefits coordination, qualified and dedicated staff for each mother, and decreased stigma for receiving services while pregnant. Results of the Mommies Program suggest that if a woman participates, there is a 33% reduction in the length of infants' Neonatal Intensive Care Unit stay due to neonatal abstinence syndrome. Given the success of the Mommies program, by 2016, seven of the eighteen PPI sites in Texas were funded to implement the Mommies Program[10]. An additional 5 sites were funded in 2018 to implement this program.

In 2017, PPI and Opioid Treatment Services were integrated to create a service that was designed to allow low-income women to maintain the same care provider for opioid treatment services after all Medicaid resources were exhausted. In Fiscal Year 2017, this program served 200 pregnant women[10]. Another

initiative in 2017, The Statewide Pregnancy Stabilization Center, Pregnancy, Postpartum Women (NAS-PPW), which allows women to enter a single substance use disorder treatment and recovery program with their children, served an average of 14.5 women each month, for a total of 57 unique women[10].

Given the success of these early prevention programs for pregnant and postpartum women who experience substance use disorders, Texas has focused on funding a variety of initiatives focused on addressing neonatal abstinence syndrome including, Overdose Prevention Training, Kangaroo Mother Care, Media Campaign, MOM Study, Targeted Outreach and Engagement, Specialized Treatment, Mommies Program, and a Statewide Stabilization Center.

In 2018, there were approximately 502 substance use treatment facilities in Texas. Of those treatment facilities, an estimated 121 substance use treatment facilities serve pregnant women (24.1% of all treatment facilities)[11]. Yet a recent report from Texans Care for Children reports that Texas only supports 10 residential treatment facilities that allow the family to stay together during treatment and recovery[12]. There is also evidence that even if a pregnant or postpartum woman needs treatment, she is not always able to receive it. In 2017, it is estimated that substance use prevention block grants were able to provide funding to treat 32,405 individuals in Texas, while there were an additional 13,117 individuals that were on waitlists to receive treatment[13]. Of the more than 13,000 individuals on a waitlist to receive treatment, 114 were pregnant women[13].

Among treatment facilities, most screen for substance abuse (98.2%), while only 62.4% screen for mental health disorders. Among all substance use treatment facilities in 2018, most offer individual counseling (98.0%) or group counseling (93.0%), while fewer report supporting family counseling (82.5%) or couples counseling (53.4%)[11].

6.2 Barriers and Gaps in the Current Level of Treatment

While Texas has a stellar model for substance use treatment for pregnant women, it is not widely available and there are gaps in these services. There is still a lack of treatment facilities that allow for families to stay together with adequate support (e.g., parenting classes, counseling, family therapy) while receiving substance use treatment and through the recovery stage. Further, the waitlist data show that more beds are needed in high risk areas. Pregnant women are prioritized for substance use treatment in the state, but these women do not have the time to wait for a bed to become open, therefore waitlists among this population are a sign of a need and gap in service.

6.3 Opportunities for Collaboration to Address Gaps and Barriers to Care

Texas is one of eight states participating in the National Academy for State Health Policy, Maternal Child Health Policy Innovation Program. Participating state teams will identify, promote, and advance innovative state-level policy initiatives to improve access to care for Medicaid-eligible pregnant and parenting women with or at-risk of substance use disorder (SUD) and/or mental health conditions through health care delivery system transformation. The Policy Academy will emphasize policy strategies that promote integration of care and systems; align with state initiatives to transform how care is provided and paid for (e.g., Medicaid managed care, accountable care organizations, value-based payment, etc.); and ultimately, improve health outcomes for pregnant and parenting women. Health and Human Services Commission, Medicaid/CHIP Services Division is the lead in this initiative and Department of Family Protective Services-Prevention and Early Intervention (DFPS-PEI) is a team member. DFPS-PEI oversees home visiting programs in the state including MIECHV-funded home visiting.

Stigma and fear are barriers to SUD treatment for pregnant and parenting women. Child removal is a strong predictor of maternal overdose, which is a leading cause of maternal death in Texas. To address this, the Health and Human Services Commission and Department of State Health Services plan to partner with DFPS on educational activities to reduce stigma and promote evidence-based interventions.

In 2019 DFPS and HHSC formed a Substance Use Disorder Leadership Team to guide collaborative work to improve outcomes related to substance use in the Texas child welfare system. This group meets monthly. The creation of a DFPS Behavioral Health Division in 2019 has allowed for expanded opportunities to collaborate and provide support around Substance Use in child welfare. There are plans for implementing training across organizations that will address simplifying the referral process. DFPS is collaborating with Texas Institute for Excellence in Mental Health (and other state and behavioral health agencies) to provide a co-occurring disorder training. The CPS Behavioral Health Division is training CPS caseworkers about substance use disorders and treatment options, including medication-assisted treatment. CPS is also collaborating with drug court agencies to provide families with resources access to treatment services.

The Plans of Safe Care Federal Visit in August of 2019 brought DFPS and HHSC together to identify the ways in which our state agencies are implementing Plans of Safe Care for substance-exposed newborns across the state. There is a pilot program in Harris County that is utilizing a standardized Plan of Safe Care form completed by the hospital social worker. Plans of Safe Care are utilized to keep the baby safely with the mother rather than seeking removal due to substance exposure. DFPS-PEI will be funding the expansion of this pilot in the coming year. DFPS is working with HHSC to refer pregnant women with substance use disorder to the Mommies program.

7 COORDINATING WITH TITLE V MCH, HEAD START, AND CAPTA NEEDS ASSESSMENTS

7.1 COORDINATION AND COLLABORATION WITH OTHER NEEDS ASSESSMENTS

The Prevention and Early Intervention Division (DFPS-PEI) at the Department of Family and Protective Services (DFPS) is the grantee for MIECHV funds in Texas. This division also receives other funds that it uses to expand prevention services through the state. This needs assessment was done in coordination with the Title V MCH and CAPTA needs assessments. The applying agency for MIECHV funding is also the agency leading all CAPTA efforts in the state.

DFPS-PEI division's 5-year strategic plan serves as the prevention strategies outlined in Texas' CAPTA grant. The risk modelling that is the quantitative bases for this need assessment is being used across DFPS-PEI's service decisions. Given this wide application of the modelling, the risk modeling was developed in consultation with DFPS analysts, including those that work on the CAPTA needs assessment, to help harmonize data and to consult on interpretation. This consultation insured that community metrics and maltreatment had similar definitions and differences could be explained to leadership and stakeholders.

Title V MCH programs are administered through the Department of State Health Services. Title V and DFPS-PEI have been working closely together on these Needs Assessments. The strategy for gathering qualitative information was developed in consultation with Title V's Needs Assessment team to ensure that data gathered here was unique to home visiting programs since many of the same providers were

interviewed or surveyed for the Title V Needs Assessment. Further, many of the health metrics included in the risk modelling are also included in Title V's Needs Assessment. DFPS-PEI was included as a major stakeholder in Title V's statewide priority selection and was included in all Title V Needs Assessment updates.

DFPS-PEI worked closely with the Texas Education Agency (TEA) to assess needs related to early childhood education, including Head Start, through both the Early Childhood Systems Integration Group and the Preschool Development Block Grant planning grant workgroup. Both groups collaborated on a cross-agency needs assessment that was then incorporated into both the Head Start Needs Assessment and the MIECHV Needs Assessment, as well as an interagency score card used as a results-based accountability tool. Through these groups, early childhood serving agencies, including TEA and DFPS-PEI agreed to use the resulting needs assessments and score card for program planning.

7.2 Stakeholder Feedback on Results

The Maltreatment Risk Modeling is publicly available to all stakeholders[4] and was released in January of 2019. Since that time, the team at the University of Texas Health Science Center at Tyler, who developed the modelling, has been working with stakeholders on interpreting the maps. This feedback from stakeholders led to the work that solidified interpreting adult disability benefits as a proxy for mental health and substance use needs.

Further, the team has been providing technical assistance to these stakeholders on how they can use the maps for strategic planning, grant writing, and their internal Needs Assessments. The team has provided technical assistance to over 300 individuals in the state through webinars, conference workshops, and invited presentations to individual organizations.

7.3 Interagency Work to Address Needs

7.3.1 Service Coordination

A barrier that has been identified in both the Title V Needs Assessment and the MIECHV needs assessment is coordination of services for families. This coordination not only helps families get the help that they need, it also makes services more efficient and reduces duplication. There are several strategies that are being evaluated for this coordination, including the expansion of the Family Connects home visiting model and the provision of tools to local organizations to create central service coordination and referral points.

One of the strategies to support service coordination is being conducted in close collaboration with Title-V at the Department of State Health Services (DSHS-TV). DFPS-PEI is collaborating with DSHS-TV to lead the expansion of Help Me Grow (https://helpmegrownational.org/) in Texas. DSHS-TV will serve as the hub and central intake point for new affiliate communities. They will also coordinate the development of a strategic plan via a steering committee that will include state-level agencies and organizations that are champions of the components necessary in the early childhood system. DSHS-TV will be the intake point for communities interested in joining Help Me Grow network, the connection between regional communities and HMG National Center, and the lead agency in statewide coordination efforts. DSHS-TV will also be representative for Texas in the national affiliate network, providing an opportunity to collaborate and participate in learning experiences with other affiliated states. DFPS-PEI will coordinate state efforts to implement the Help Me Grow model by involving their Project HOPES and MIECHV funded communities.

In addition to helping communities coordinate resources, DFPS-PEI works to create and sustain early childhood system collaboration at the state level. The Early Childhood Systems Integration Group (ECSIG) is a collaboration of Texas state agencies working together to identify, coordinate and implement cross-sector initiatives for young children and their families. The work group ensures that organizations are coordinating and not duplicating services. It addresses issues and opportunities related to service delivery, systems design, and data coordination. This effort to optimize state services and systems includes representatives from the Health and Human Services Commission, Department of Family and Protective Services, Department of Assistive and Rehabilitative Services, Department of State Health Services, Texas Education Agency, and Texas Workforce Commission. DFPS-PEI provided leadership since the group's inception. In FY 2020, DFPS-PEI transitioned leadership to Texas Education Agency, but DFPS-PEI will continue to participate in and provide staff support for the group. ECSIG allows both the sharing of needs assessments and also leadership on developing funding opportunities and resources to address specific needs that cross the agencies.

DFPS-PEI recognizes that quality in its home visiting programs is a result of the connections that the program has to other organizations in its service area. This strength is demonstrated in this Needs Assessment. DFPS-PEI ensures that its contracting agencies coordinate with comprehensive statewide early childhood systems by contractually requiring them to address community-level issues that are negatively impacting children and families in their communities. The emphasis on coordinating comprehensive early childhood systems is incorporated into the language from the most recent Request for Applications (RFA) and the Statement of Work for the grantee.

> *"The purpose of the [DFPS-PEI Home Visiting] grant program is to support community partnerships that enhance outcomes around maternal child health, parent child attachment, child development, child safety, family stability, and school readiness. This is achieved through partnering with key leaders to change policies/practices, and community infrastructure that impede families as well as providing evidence-based direct home visiting services. Funded communities should propose a project that combines service and non-service, community-change strategies that address localized barriers to health and well-being of young children and families."*

> *"Grantee should develop or enhance a local early childhood coalition to:*
> 1. *Identify community-level needs as related to school-readiness and maternal/child health outcomes;*
> 2. *Integrate services to create streamlined access across different sectors;*
> 3. *Implement system-level strategies that address broad policy, practice, or community infrastructure issues that impact young children/families and benefit the community at large (enhance the public transportation system, improve family-friendly business policies, increase access to community parks/playgrounds, etc.); and/or build relationships with key stakeholders to create a foundation for long-term sustainability."*

7.3.2 Mental Health

Mental health services have also been identified as a need for both Title-V and in this Needs Assessment. As with service coordination and responding to substance use disorder, coordination and collaboration across agencies will be required to address this issue in Texas.

The Texas Collaborative for Health Mothers and Babies (TCHMB) is the state's perinatal quality improvement collaborative. It is a multidisciplinary network made up of health professionals throughout the state that works to advance health care quality and patient safety for all Texas mothers and babies, through the collaboration of health and community stakeholders in the development of joint quality

improvement initiatives, the advancement of data-driven best practices, and the promotion of education and training. DSHS-TV is the main funder of TCHMB and the DFPS-PEI Associate Commissioner is a member of the executive committee. The TCHMB is part of a collaboration of several organizations to gain a better understanding of the training needs, referral networks, use of integrated behavioral health, and the impact of COVID-19 on identification and treatment for perinatal mental health needs in primary care, obstetrics, pediatrics, and Neonatal Intensive Care Units. The TCHMB plans to use this information to launch a multi-sector quality improvement project focused on improving the state's response to perinatal mood disorders.

Texas' goal is to integrate behavioral health care into health care settings where individuals first initiate care (i.e., obstetric practice, primary care, and emergency department), with a focus on enhanced screening and referrals to treatment for substance use disorder in the prenatal and postpartum periods. The work of the TCHMB and other organizations will help facilitate this integration.

DFPS is also collaborating with HHSC, STAR Health, managed care contractors, residential providers and staff to support appropriate medical services to children in DFPS care. The Director of CPS Services sits on this collaboration for DFPS. DFPS-PEI's funded HOPES sites also work to provide mental health services to youth and families with mental health needs.

7.3.3 Father Involvement

Within the risk modelling, father involvement, as measured by paternity establishment at birth, is a risk that is present in the factors that represent the biggest contributors to community-level maltreatment risk. Father involvement is also a major indicator of individual risk. Because of the nature of who is in home visiting programs, it is important that interagency work is focused on the needs of fathers, increasing safe paternal involvement in the perinatal period, and providing support to the family when it is not safe or feasible for him to be involved.

Fatherhood Interagency Workgroup: DFPS-PEI collaborates with the Child and Family Research Partnership (CFRP) at the University of Texas at Austin to convene quarterly meetings of stakeholders across state agencies who are supporting fathers and child abuse/neglect prevention. The goals of the workgroup are: identify the ways in which programs and services across the state are successfully addressing the needs of fathers; apprise peers of any changes or progress on program objectives; share connections and resources; and increase efficiencies to reduce duplication. In addition, the group informs the direction of the annual Texas Fatherhood Summit, which is organized and hosted by DFPS-PEI and CFRP. The agencies represented include Women, Infant and Children (WIC), Office of Attorney General (OAG), Texas Education Association (TEA), Child Protective Services (CPS), DFPS-PEI, and other state human service agency staff.

7.4 CONCLUSION

Texas is a large and diverse state with diverse needs. It is clear that there are needs that are felt across the state, including those surrounding substance use disorder, mental health, and service coordination for families. However, there are specific needs in each region and each community that must be addressed.

Communities have had access to the data presented in this report for a year, and their feedback on the data and risk profiles shows their investment in using these data to take action in their communities. The regional assessment of risk has also been presented to stakeholders throughout the state at DFPS-PEI virtual listening sessions in the summer of 2020. Through incorporating these data into local needs assessments, using the data for program improvements, and continuing to present to local and state

organizations, the results of this Needs Assessment will be used to improve the health and well-being of young children and families in the state.

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