Alabama Department of
Early Childhood Education

2020

First Teacher Home Visiting Program

Needs Assessment

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program

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1. Introduction

The Alabama Department of Early Childhood Education (ADECE) is a part of the Executive Department of state government, principally established to enable the Governor to effectively and efficiently coordinate efforts and programs to serve children throughout the state. ADECE is the designated lead state agency for home visiting in Alabama. Through the First Teacher Home Visiting Program, ADECE is able to provide home visiting in all 67 counties with the following funding sources: Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV); Medicaid; Department of Human Resources (DHR); Governor Kay Ivey's Infant Mortality Reduction Initiative; Pregnancy Assistance Fund (PAF); and the state's Education Trust Fund (ETF). While ADECE is the lead agency for home visiting in Alabama and supports the majority of home visiting capacity, it is important to recognize that other agencies and organizations across the state also provide grant and private funding to support local implementing agencies (LIAs) to serve children and families, including the Alabama Department for Child Abuse and Neglect Prevention-Children's Trust Fund of Alabama (CTF).

Currently, ADECE uses Home Instruction for Parents of Preschool Youngsters (HIPPY), Nurse-Family Partnership (NFP), and Parents as Teachers (PAT) as evidence-based models to support at-risk pregnant women and families with children through Kindergarten age who participate in the voluntary home visiting program, First Teacher. The First Teacher Home Visiting Program focuses on 6 priority areas:

- Improving maternal physical and mental health
- Reducing physical abuse
- Improving treatment of children (including health and nutrition)
- Promoting economic self-sufficiency for families
- Educating families on how to use the resources that are available to them in their area
- Promoting school readiness

First Teacher is led by a team of early childhood specialists at ADECE who award funds to community-based organizations throughout the state to provide the three identified evidence-based models. Each organization works with ADECE's First Teacher team to ensure delivery of high-quality home visiting services and creation of a systematic and coordinated approach to assess the multiple impacts on families. First Teacher has also implemented a parent educator-focused technical assistance team to provide targeted support and ensure that high-quality reflective supervision is provided at the service-delivery level. Technical assistance uses a continuous quality improvement process and statewide data system to ensure the use of current best practices and maintenance of model fidelity. Furthermore, the technical assistance team addresses the need for comprehensive early childhood professional development by collaborating statewide across the early childhood system and implementing statewide core competencies.

In order to meet the HRSA statutory mandate that requires the completion of a statewide home visiting system needs assessment in 2020, ADECE partnered with the Home Visiting Evaluation Team and the Applied Evaluation and Assessment Center (AEAC) at the University of Alabama at Birmingham School of Public Health to facilitate a comprehensive assessment to identify communities (counties) with concentrations of defined risk factors, assess the quality and capacity of early childhood home visiting services in Alabama, and assess the state's capacity for

providing substance abuse treatment and counseling services. The UAB Evaluation Team has consistently supported First Teacher for needs assessment, program evaluation, data management and performance reporting, and continuous quality improvement efforts since the original MIECHV needs assessment in 2009-2010.

In addition to meeting statutory requirements, ADECE and the First Teacher Home Visiting Program will use the updated needs assessment to:

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

2. Identifying Communities with Concentrations of Risk

The Health Resources and Services Administration (HRSA) provided each state with summary data to support the identification of at-risk communities (counties) and reduce burden for completing the needs assessment update. Further, HRSA developed a methodology that uses publicly available, county-level data drawn from national sources, aggregating 13 indicators of risk into five domains: low socioeconomic status, adverse perinatal outcomes, child maltreatment, crime, and substance abuse. This method is referred to as the "simplified method." Alabama has chosen to use this "simplified method" and data provided in the Needs Assessment Summary Data file that was shared by the MIECHV Program to identify communities with concentrations of risk (operationalized as a county). Table 1 presents domains, indicators of risk, and data sources included in calculations for the "simplified method."

In addition to the "simplified method," Alabama reviewed and re-analyzed relevant existing needs assessment reports and data, gather additional data from state partners and home visiting system representatives, and considered counties within the context of current MIECHV funding and/or designation as a focus for ongoing systems initiatives and policies related to prevention in the state. This combined approach led to the identification of 54 "at-risk" counties (19 based on "simplified method" and 35 based on additional considerations – see narrative on pages 6-7 and 27-28 and Table 10 on pages 29-32).

Table 1. Domains and Indicators of Risk

Domain	Indicator	Indicator Definition	Data Source	Year
Socioeconomic Status (SES)	**Poverty**	% population living below %100 FPL	Census Small Area Income and Poverty Estimates	2017
	Unemployment	Unemployed percent of the civilian labor force	Bureau of Labor Statistic	2017
	HS Dropout	% of 16-19 year olds not enrolled in school with no high school diploma	American Community Survey[1]	2017 or 2013-2017
	Income Inequality	Gini Coefficient - 1 Yr or 5 Yr Estimate		
Adverse Perinatal Outcomes	**Preterm Birth**	% live births <37 weeks	NVSS - Raw Natality File[2]	2013-2017
	Low Birth Weight	% live births <2500 g		
Substance Use Disorder	**Alcohol**	Prevalence rate: Binge alcohol use in past month	SAMHSA - National Survey of Drug Use and Health[3]	2012-2014
	Marijuana	Prevalence rate: Marijuana use in past month		2014-2016
	Illicit Drugs	Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month		2012-2014
	Pain Relievers	Prevalence rate: Nonmedical use of pain medication in past year		2012-2014
Crime	**Crime Reports**	# reported crimes/1000 residents	Institute for Social Research - National Archive of Criminal Justice Data	2016
	Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17		
Child Maltreatment	**Child Maltreatment**	Rate of maltreatment victims aged <1-17 per 1,000 child (aged <1-17) residents	Agency for Children and Families (ACF)	2016

1. 1-year estimates used for counties with populations >65,000; 5-year estimate used for counties with populations <65,000
2. Births <10 were suppressed; the mean of counties was inputted for counties with missing data
3. County estimates are inputted based on Substance Abuse Treatment Planning Regional estimate; nonmedical use of pain relievers refer to any form of prescription pain relievers that were not prescribed for the person or that the person took only for the experience or feeling they caused.

The "simplified method" calculates the proportion of indicators within each domain for which a given county is in the 'worst' 16% of all counties in the state (z-score greater than or equal to one standard deviation higher than the mean of all counties in the state). A county is considered "at-risk" if at least half of the indicators within at least two domains had z-scores greater than or equal to one standard deviation higher than the mean of all counties in the state; i.e., are the "worst" 16% in the state. Using this method, 19 of Alabama's 67 counties meet the threshold definition for "at-risk communities." Two of these counties have three at-risk domains, with the remaining 17 having two at-risk domains. An additional 28 counties have one at-risk domain. Table 2 presents Alabama counties by number and type of at-risk domains.

Table 2. Number of At-Risk Domains by County, Alabama

2a. Counties meeting at-risk definition per HRSA guidelines

County	SES	Adverse Perinatal Outcomes	Substance Use Disorder	Crime	Child Maltreatment	Number of At Risk Domains
Clarke	✓	✓		✓		3
Dallas	✓	✓		✓		
Bibb			✓		✓	2
Blount			✓		✓	
Calhoun			✓	✓		
Cleburne			✓		✓	
Coosa		✓	✓			
Etowah				✓	✓	
Greene	✓	✓				
Jefferson			✓	✓		
Lowndes	✓	✓				
Macon	✓	✓				
Perry	✓	✓				
Pickens		✓	✓			
Pike	✓			✓		
Talladega			✓	✓		
Tallapoosa		✓		✓		
Tuscaloosa			✓	✓		
Wilcox	✓	✓				

2b. Risk domains for the remaining counties in the state

County	SES	Adverse Perinatal Outcomes	Substance Use Disorder	Crime	Child Maltreatment	Number of At Risk Domains
Autauga				✓		1
Baldwin				✓		
Barbour				✓		
Bullock		✓				
Butler				✓		
Chambers				✓		
Chilton			✓			
Choctaw		✓				
Clay			✓			
Conecuh		✓				
Cullman					✓	
Fayette					✓	
Hale		✓				
Houston				✓		
Jackson				✓		
Lamar					✓	
Lauderdale					✓	
Madison				✓		
Marengo				✓		
Marion				✓		
Mobile				✓		
Monroe	✓					
Montgomery				✓		
Randolph			✓			
Shelby			✓			
St. Clair			✓			
Sumter	✓					
Winston					✓	
Cherokee, Coffee, Colbert, Covington, Crenshaw, Dale, DeKalb, Elmore, Escambia, Franklin, Geneva, Henry, Lawrence, Lee, Limestone, Marshall, Morgan, Russell, Walker, Washington						0

Alabama is a relatively rural and impoverished state that often ranks near the bottom of national lists for health, wellness, and educational outcomes. Across many circles, stakeholders describe the entire state as at-risk for poor outcomes. Though identifying communities of concentrated risk is inherently political and stimulates debate among stakeholders, ADECE is satisfied that in general, the counties identified through the "simplified method" represent the highest concentration of at-risk communities. In fact, 12 of 19 at-risk counties identified through the "simplified method" for this needs assessment update were also identified in the top 3 (worst) quintiles during the initial 2010 MIECHV needs assessment. This finding, taken together with a review of indicator data during the interim years

through the most recent updates, suggests there has been minimal variation in population-level indicators of risk.

In addition to the 19 counties identified as "at-risk" through the "simplified method", an additional 28 counties have one of the five domains meeting the definition of "at-risk" (at least half of the indicators in the domain have z-scores greater than or equal to one standard deviation higher than the mean of all counties in the state). Even counties that do not meet this threshold have pockets of risk within the borders. Many of these counties are currently served with MIECHV funds following the plan for initial implementation and expansion established through the original 2010 MIECHV needs assessment and based upon the county rankings developed from those analyses. Further, Governor Kay Ivey, the state legislature, and community stakeholders recognize the crucial role home visiting plays in sustaining high-quality, comprehensive statewide early childhood systems that support pregnant women, families, and children from birth to kindergarten entry. As such, there has been strong support for policy initiatives that promote and expand the current home visiting system, while highlighting the importance of using evidence-based home visiting approaches which are proven to help parents become better "first teachers" for their children. This commitment for support and a combination of federal, state, and local funds has increased access to evidence-based home visiting in all 67 Alabama counties. Although every county is served to some extent through evidence-based models, access may be limited, and some counties may also be served by home visiting programs that use other models that have not met the Department of Health and Human Services (HHS) criteria for evidence of effectiveness. Table 10 in section 3 (pages 29-32) displays information about home visiting program access, model, and capacity by county.

Though no additional quantitative data indicators were added to calculations to identify "at-risk" counties, ADECE and the UAB Evaluation/Needs Assessment team recognized the opportunity to capitalize on other recent and ongoing needs assessments in the state, as well as the need for additional qualitative data-gathering specifically from the home visiting system/provider perspective to support a deeper, richer understanding of the needs of at-risk communities and to guide program planning efforts to provide effective services tailored to families' needs throughout the state. The UAB team reviewed existing needs assessment reports as secondary data, re-analyzed data from these processes, and gathered new primary data to supplement and enhance the MIECHV needs assessment.

Additional counties were added to the list of 19 counties meeting the definition of "at-risk" according to the "simplified method." These additions were based on consideration of the data provided through the "simplified method," review and re-analyses of relevant existing needs assessments, and reflection on each county in the context of current MIECHV funding and/or designation as a focus for ongoing systems initiatives and policies related to prevention in the state. See Section 3 narrative on pages 27-28 and Table 10 on pages 29-32 for more information and discussion. Counties were added to the "at-risk" list if they met one or more of the following four criteria:

1. Currently receives MIECHV funding (out of a desire to continue/strengthen ongoing early childhood systems development and partnership)
2. Focus of Governor Kay Ivey's Infant Mortality Reduction Initiative
3. Identified as a Safe Sleep Awareness Focus Area by the Alabama Department of Public Health (sleep-related death "hot spot" ZIP code within the county)
4. a. Identified as a county with a percentage of 4th graders who are not proficient in reading higher than the state average percentage of 4th graders who are not proficient in reading (53%)

based on 2018-2019 Scantron results. These counties are part of Governor Kay Ivey's Alabama Campaign for Grade Level Reading.

AND

b. Contains at least one "failing school" as defined by the Alabama Accountability Act (passed in 2013, identifies the bottom 6% of schools as measured by the percentage of students who are proficient on the standardized test taken the previous spring)

Reviewing and Re-Coding Recent and Ongoing Needs Assessments

In May 2016, Alabama received a grant from the Alliance for Early Success to explore Home Visiting advocacy in our state. To support this effort, the UAB team partnered with the Alabama Partnership for Children (APC), ADECE, and the Alabama Department of Child Abuse and Neglect Prevention (ADCANP) to conduct a multi-phase environmental scan to support understanding of the then current home visiting system in the state. The findings from the environmental scan were reviewed to support the MIECHV needs assessment update.

Also, the timing of MIECHV-required needs assessment overlapped with several other needs assessment/strategic planning efforts occurring in the state, including the Title V Maternal and Child Health Service Block Grant 5-Year Needs Assessment (Title V) and the Preschool Development Birth to Five Systems Grant Needs Assessment (B5). These two comprehensive, mixed methods needs assessment processes included both primary data collection (surveys, focus groups, semi-structured key informant interviews) and secondary data analyses (federally-available data, national survey data, state indicator data from the KidsCount Data Book for Alabama, review of recent related needs assessments). The Title V Needs Assessment gathered information to identify and prioritize needs for women/pregnant women, infants, children, adolescents, and children and youth with special health care needs. The B5 Needs Assessment gathered information to identify needs to inform a strategic plan for the early childhood care and education system in the state. The B5 process specifically involved review of 59 state needs assessments and program reports, including Title V, Head Start, and CAPTA (Child Abuse Prevention and Treatment Act). Both needs assessments included data-gathering from families, youth/adolescents, early childhood care and education providers, health care providers, and statewide leadership. Figure 1 below presents an overview of the methods and stakeholder reach of the Title V and B5 needs assessments.

Figure 1. Title V Maternal and Child Health (Title V) and Preschool Development Birth to Five Systems Grant (B5) Needs Assessments – Overview of Methods and Stakeholder Reach

B5

Stakeholder Engagement				
Interviewees	**Provider Focus Groups**		**Family Focus Groups**	
35 Participants	**16** Provider Groups	**275** Participants	**12** Family Groups	**158** Participants
468 Total Participants				

Title V (Women, Perinatal/Infant, Children, and Adolescents)

Federally Available Data	Surveys			Focus Groups		Key Informant Interviews
Key MCH indicators provided to states	Families (online and print; English and Spanish)	Health care providers (online)	Adolescents (online)	• Women • Parents/caregivers of infants, children, and adolescents • Adolescents/young adults • Spanish-speaking families • LGBTQ adults • Women with disabilities		Representatives of local, state, public, and private groups that work with MCH population
	874 respondents	119 respondents	86 respondents	17 groups	147 participants	22 interviewees
	Total stakeholders engaged: 1,247					

Title V (Children and Youth with Special Health Care Need – CYSHCN)

Federally Available Data	Surveys		Focus Groups		Key Informant Interviews
Key MCH indicators provided to states	Families (online and print; English and Spanish)	Youth (online and print)	• Parents/caregivers of CYSHCN • Fathers of CYSHCN • Spanish-speaking/ Hispanic parents/ caregivers of CYSHCN • Youth/young adults with SHCN		Health providers, allied health therapists, equipment and interpreter service vendors, special education professionals, and administrators
	416 respondents	147 respondents	5 groups	26 participants	17 interviewees
	Total stakeholders engaged: 606				

The UAB team facilitated the Title V needs assessment and was involved in the B5 needs assessment (conducted by Clarus Consulting Group). As such, the team had access to both the summary information on needs identified through these related needs assessments, as well as the raw data from surveys, focus group transcripts and notes, and notes from semi-structured key informant interviews. The summary information, including themes that emerged from the data and identified

needs, was reviewed to identify needs for which home visiting could be a strategy or potential solution. Following the summary review, raw data were re-analyzed and re-coded using NVivo qualitative software to specifically identify home visiting themes. These data and results are further described in section 3. Based on summary review and re-coding, the UAB team developed additional data-gathering methods to finalize the MIECHV needs assessment.

Additional Data-Gathering and Analyses to Enhance MIECHV Needs Assessment

In addition to the above methods, the UAB team facilitated semi-structured interviews with state-level home visiting leadership, early childhood system agency representatives, and local home visiting program leadership/directors. Also, a survey was sent to all home visitors providing services in First Teacher and CTF-funded sites across the state. Semi-structured interviews and surveys were used to capture the differing perspectives and experiences with the home visiting program, including successes, gaps and barriers, and challenges. Interviews were conducted with 14 state-level and agency partners representing the following systems: ADECE, ADCANP, The Sylacauga Alliance for Family Enhancement, APC, Alabama Department of Public Health, Department of Mental Health Office of Infant and Early Childhood Special Programs, Alabama Early Intervention System, Children's Policy Cooperative, The Hispanic Interest Coalition of Alabama, and YWCA Domestic Violence Services and Programs. Additionally, key informant interviews were conducted with leadership/directors from 16 home visiting LIAs, and 160 home visitors from across the state submitted survey responses.

Data from state level and agency partners, home visiting leadership, and home visitor surveys were independently imported and coded in NVivo. Themes and sub-themes were identified for each group of interviewees and survey respondents, and common themes were identified.

3. Identifying Quality and Capacity of Existing Programs

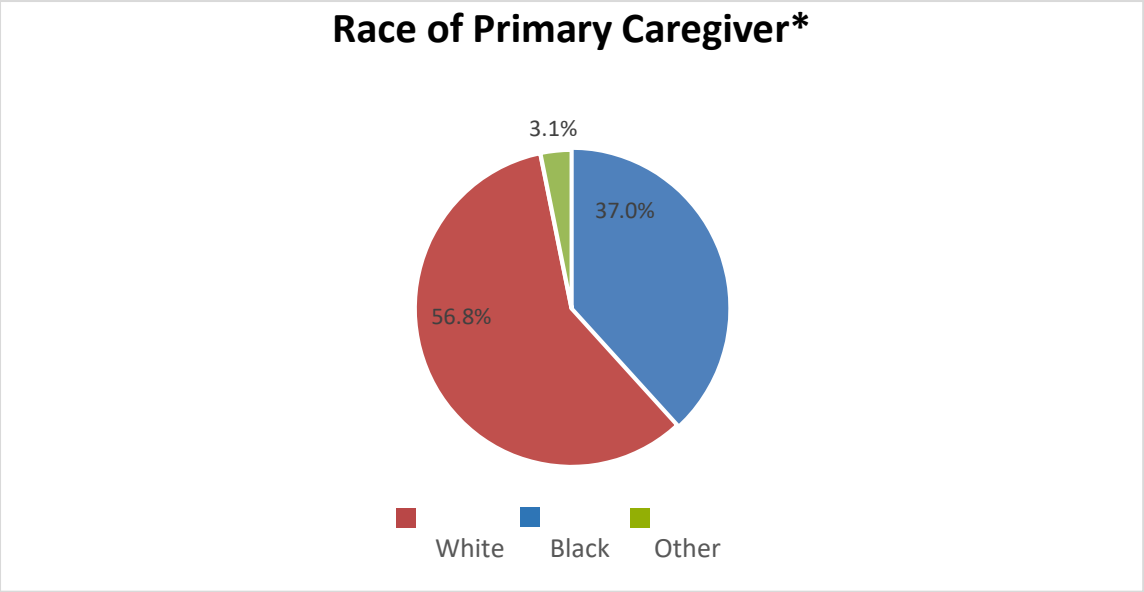
Demographics and Characteristics of Families Served in Alabama

The following demographics describe the portion of Alabama families and children served during FY2019 by the First Teacher program using MIECHV funds. Alabama is not able to provide these same data for families served through other funding sources within the First Teacher program or for families who receive home visiting services provided by agencies other than ADECE. As of FY2020, ADECE has implemented standardized data collection requirements for all First Teacher sites, regardless of funding source. Although the demographics presented below do not include all families and children that are currently receiving home visiting in Alabama, we are confident that these are representative of all families currently enrolled. In FY2019, Alabama's First Teacher MIECHV-funded awardees served 1,917 families and 2,181 children, while conducting 24,085 home visits.

Race of Primary Caregiver

Most enrollees were white or black, with a slightly higher percentage of enrollees who identified themselves as black. The percent black (37.0%) is significantly higher than the overall percentage of Alabamians who identify as black (26.8%, U.S. Census Bureau, 2019). The percent white

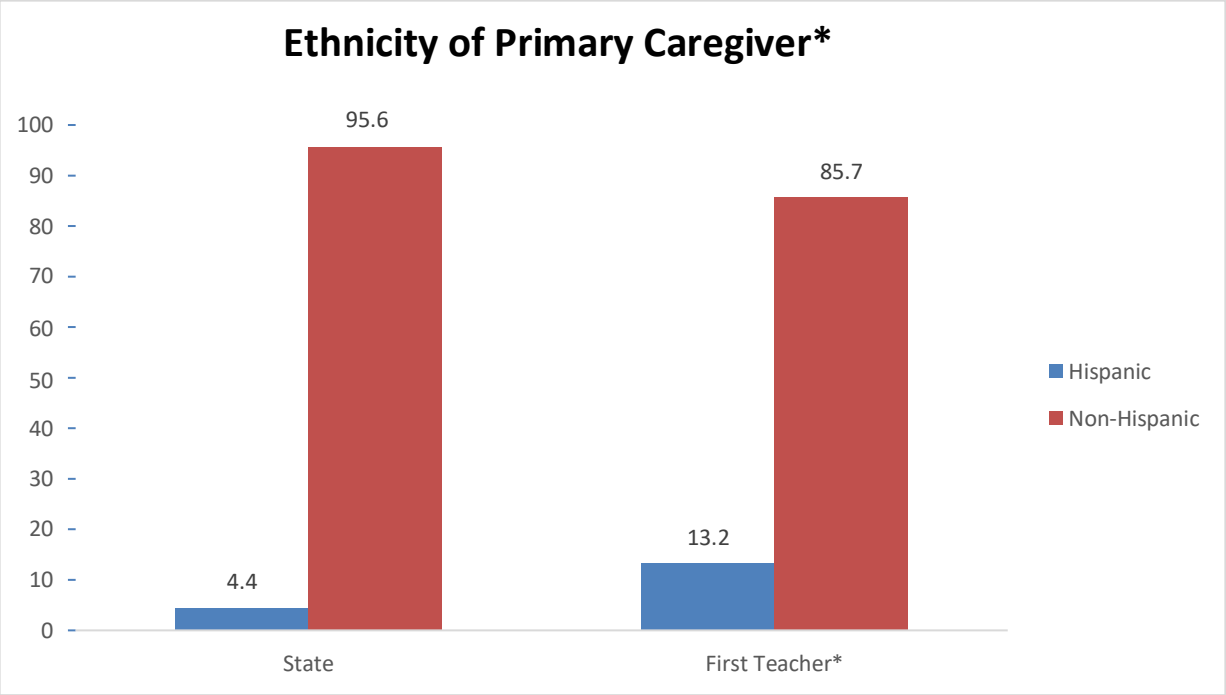
(56.8%) is significantly lower than the overall percentage of Alabamians who identify as white (65.4%, U.S. Census Bureau, 2019).



*3.2% Not Reported

Ethnicity of Primary Caregiver

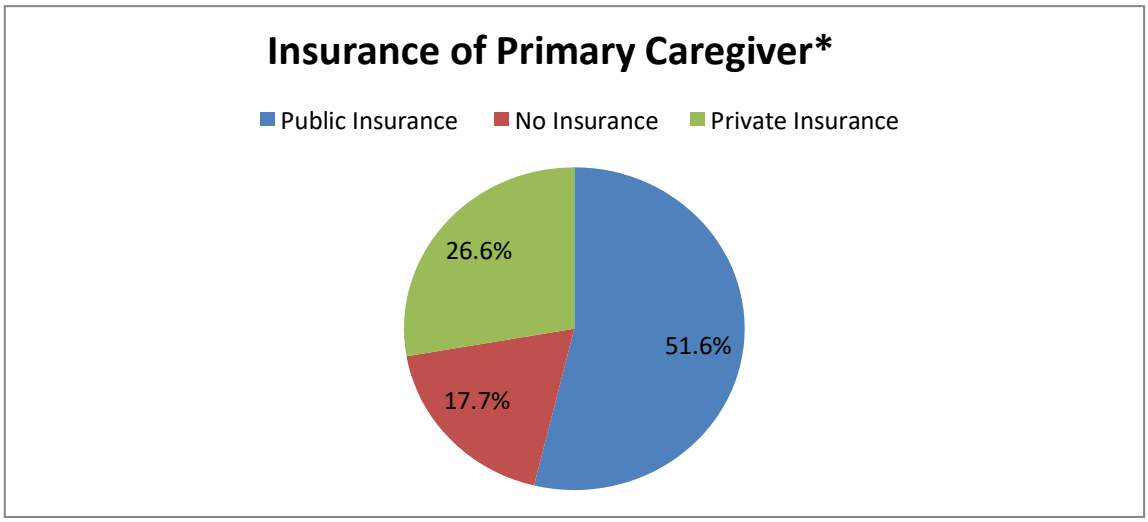
Most enrollees were non-Hispanic, but the percent Hispanic (13.2%) is significantly higher than the overall percentage of Alabamians who identify as Hispanic (4.4%, U.S. Census Bureau, 2019).



*1.1% Not Reported

Insurance Status of Primary Caregiver

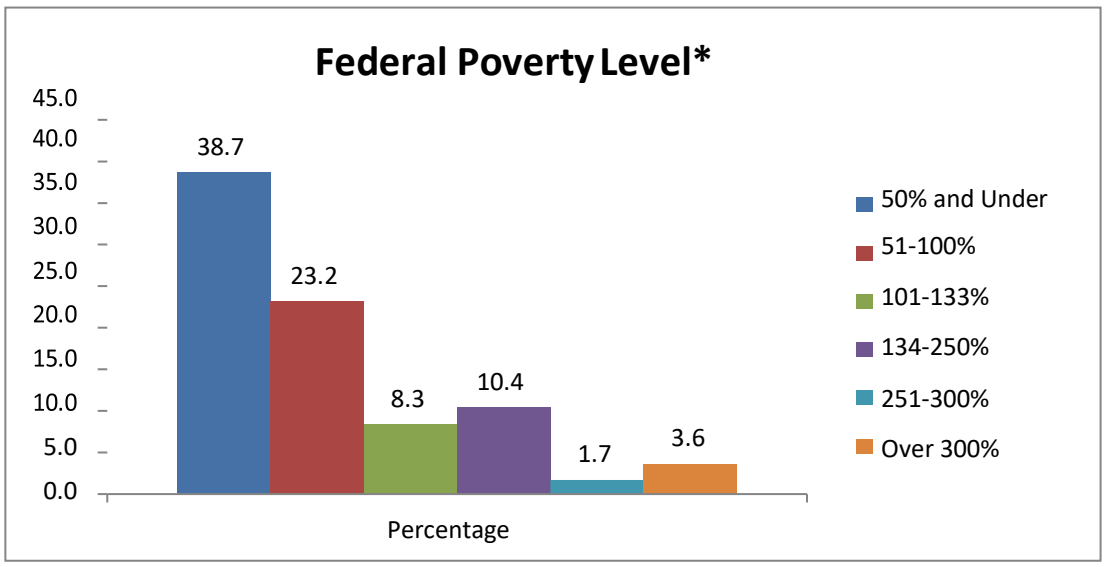
Nearly 1 out of 5 caregivers (17.7%) did not have insurance. Most of these were non-pregnant women. Close to 30% have private insurance and more than half of caregivers (51.6%) report some form of public insurance – ACA, Medicaid, and Tricare.



*4.1% Not Reported

Income of Families Served

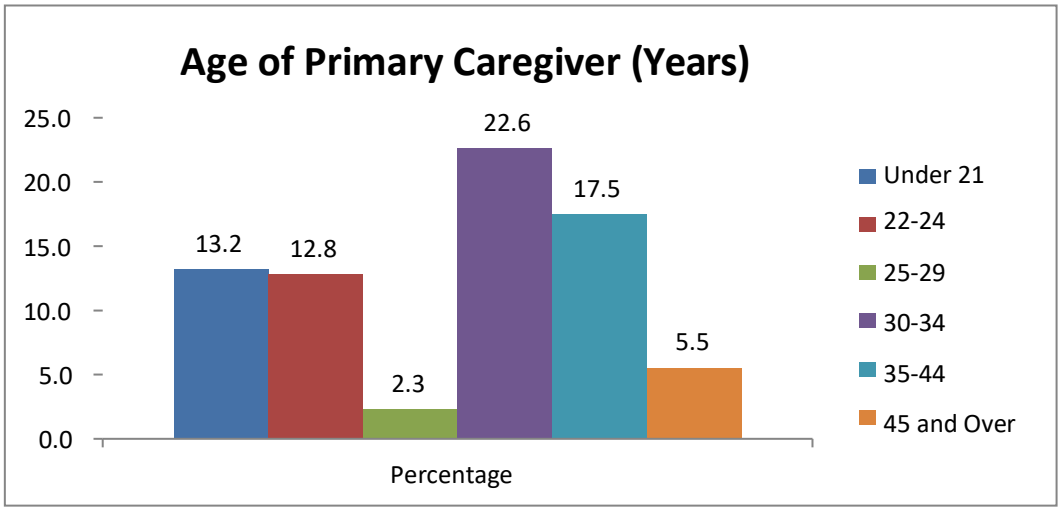
First Teacher serves some of Alabama's most-vulnerable families. Nearly two-thirds meet the federal definition for poverty, and the majority of those are in extreme poverty, 50% or less of the poverty threshold.



*14.1 Not Reported

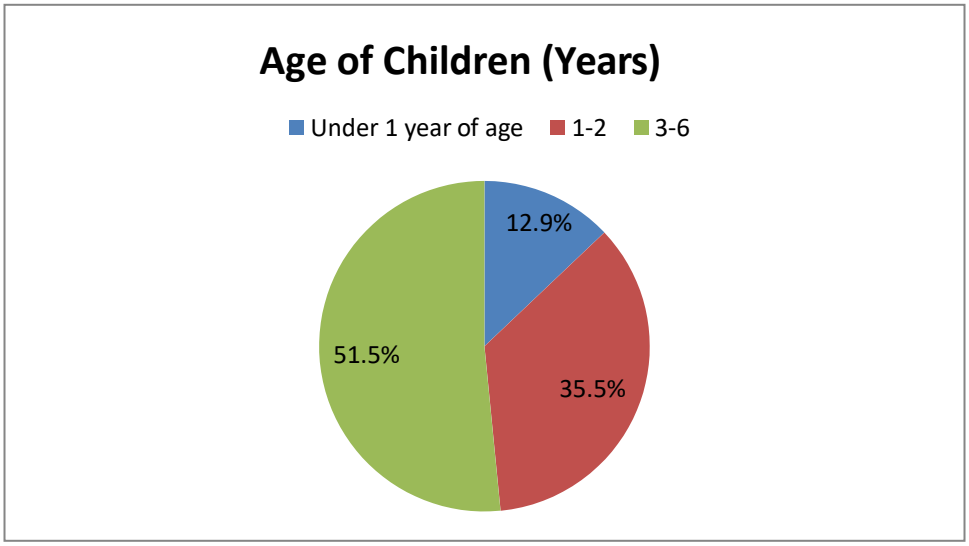
Age of Primary Caregiver

First Teacher serves primarily young families, with one-quarter of enrollees under 25 years old.



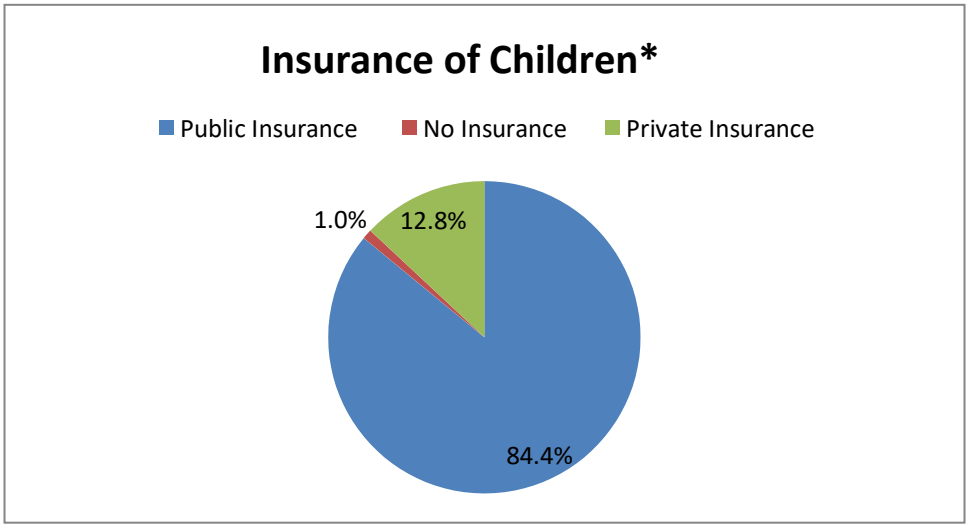
Age of Children

First Teacher serves children, prenatal through kindergarten entry. Nearly half of all children enrolled in First Teacher (MIECHV-funded sites) are age 2 or younger.



Insurance Status of Children

Almost all children in First Teacher have insurance. Children are mostly covered by public insurance – Medicaid or ALL Kids.



*1.9% Not Reported

Gaps, Barriers, Needs, Challenges, and Opportunities for Improvement – Successes and Positive Outcomes

Information discussed in this sub-section represents a system-wide perspective and includes a synthesis of data from other recent, relevant needs assessments and new information collected from state-level home visiting leadership, early childhood system agency representatives, local home visiting program leadership/directors, and front-line home visitors throughout the state.

Review of May 2016 Home Visiting System Environmental Scan

Most agencies that provide voluntary home visiting services report being full to capacity. The need for home visiting services frequently far outstrips their ability to provide these services, leaving children and families on waiting lists in many communities.

Review of Preschool Development Birth to Five Systems Grant (B5) Needs Assessment

Table 3 presents selected themes and needs that were identified in the B5 needs assessment. These represent gaps or challenges that could be addressed through home visiting and/or are issues that are within the focus of MIECHV benchmark requirements and evidence-based home visiting models.

Table 3. Selected Home-Visiting Relevant Themes and Needs Identified in the B5 Needs Assessment

Theme	Description
Birth to Three-Year-Old Focus	Stakeholders would like to strengthen the early childhood care and education system for birth to three-year-olds. This includes increased funding, expanded services, improved data collection, and increased awareness of the importance of providing a solid foundation for this age group.
Availability of High-Quality Early Childhood Care and Education Programs	In addition to the importance of high-quality childcare settings, stakeholders discussed home visiting program access. While more families are using home visiting and family strengthening programs such as HIPPY, Nurse-Family Partnership, and Parents as Teachers, there is limited availability in these programs, especially in rural areas.
Parent and Caregiver Inclusion and Involvement	Stakeholders felt that having a greater understanding of child development and developmentally appropriate activities would help parents better understand the value of play-based learning and educational approaches that promote positive growth and development. Parents are more likely to be engaged in the care of their children if basic needs are met, highlighting a need to connect vulnerable families with resources to help reduce the factors that put them at risk. Parents and caregivers often lack awareness and information about the resources available to them, and therefore cannot make informed decisions or access programs that could benefit their families.
Early Screening and Detection	Stakeholders noted that parents and early care and education providers need to be aware of the early warning signs of developmental delays so children can be referred to screenings and care as early as possible.
Mental and Behavioral Health System	Stakeholders reported there were too few providers who can work with children and their families, especially in rural communities. Participants noted the importance of having trauma-informed training for mental health professionals who are working with children and their families.

Review and Re-analyses of Title V Maternal and Child Health Needs Assessment

Table 4 presents selected themes and needs that were identified in the Title V needs assessment and/or through re-analyses of raw data from surveys, focus group transcripts, and interview notes. Table 5 lists selected needs statements that emerged from the process. These represent gaps or challenges that could be addressed through home visiting and/or are issues that are within the focus of MIECHV benchmark requirements and evidence-based home visiting models.

Table 4. Selected Home-Visiting Relevant Themes and Needs Identified in the Title V Needs Assessment

Theme	Description
Infant Mortality	Concerns about quality and quantity of prenatal care; Lack of access to safe car seats and cribs; Concerns about lack of safe sleep practices; Need for education and resources for young and new parents, teen parents (parenting classes); Concerns that distracted caregivers and untreated caregiver mental health issues could lead to neglect, which could contribute to infant mortality
Safe Sleep	Lack of awareness of safe sleep guidelines and access to safe cribs/sleeping surfaces can contribute to infant mortality

Breastfeeding	Limited information, education, and resources to support breastfeeding in communities; Need for community and peer/family support for breastfeeding, especially after hospital discharge; Differences of opinions on breastfeeding across cultures and generations can be a challenge
Child Health and Wellness	Much discussion of the childcare and early childhood education system; Need stronger focus on birth to 3 programs; Importance of early identification of developmental delays and need for more screening, especially in rural communities; Concerns about lack of Kindergarten/school readiness and social/emotional support for children to prepare them for the classroom
Family Supports	Lack of access to parenting education, guidance, and mentorship related to pregnancy, delivery, and raising their children; Feelings of stress, isolation, and unpreparedness; Challenges for pregnant and parenting teens and young families/new parents Need for community support/resource, peer support groups, and in-home resources, particularly for caregivers that are foster parents, grandparents, teen/young/new parents, and single parents
Maternal Health	Lack of access to family planning services and information; Lack of quality maternal health care (comprehensive, pre-natal and beyond); Lack of attention to maternal health can contribute to infant mortality and poor maternal health or mortality
Mental Health Care/Behavioral and Developmental Services	*Adults*: Lack of access to mental health services, specifically for prevention, ongoing, and non-crisis/urgent care; Issues with access to services for postpartum mental health, depression, and anxiety; Linked to lack of confidence in parenting abilities and feelings of loneliness/isolation; Unhealthy coping mechanisms for unmet needs (overeating leading to obesity; substance use); Screening is inadequate; Lack of knowledge of available resources *Children/Adolescents*: Lack of age-appropriate mental health services for adolescents and children, especially in rural areas; Need for mental, behavioral and developmental health care access; Need for education on appropriate disciplining; Need parent education on developmental milestones and how to promote mental/behavioral/developmental health in the home
Smoking, Substance, and Alcohol Use	Concerns about substance use/abuse and addiction in communities; Use of substances as a coping mechanisms to address stress, anxiety, and unmet mental health needs; Need and desire for rehabilitation, but inability to access or concern will lose children (fear of DHR) or cause justice system involvement
Access to Health Care	Hard for families to care for themselves and their children due to difficulty navigating the system and inconsistencies across type of insurance; Issues such as transportation barriers, socioeconomic status, low education, neighborhood crime and safety, intimate partner violence, low literacy, and unstable housing were all mentioned as barriers to accessing health services and health maintenance
Social Determinants of Health and Wellness	Recognition of the role non-biological issues play in the health and outcomes of families and children (education, employment, environment, safe neighborhoods, equity/inequity, housing, income, personal safety, family dynamics, stigma); Need for supports in home (home visiting) and supports for rural communities, low-income parents trying to get GED, and those who have low literacy levels; Limited education prevents employment; Limited jobs available in rural and poor communities; Embarrassment of home situation may make family unwilling to accept home visiting

Table 5. Selected Home-Visiting Relevant Needs Statements Identified in the Title V Needs Assessment

High levels of infant mortality (and associated factors of preterm birth and low birth weight)
High levels and worsening trends of sleep-related/SUID deaths
Lack of or inadequate access to breastfeeding supports
Lack of or inadequate smoking, alcohol, and substance use prevention education
Lack of or inadequate access to comprehensive mental health services (prevention, crisis care, postpartum)
Lack of supports for pregnant and parenting teens and young/new parents
Limited access to adult role models and mentors
Lack of timely, appropriate, and consistent health and developmental screenings
Lack of access to quality early childhood programs that are safe and affordable, especially for children with disabilities

Analyses of New, Home-Visiting-Specific Data: State-Level Home Visiting Leadership, Early Childhood System Agency Representatives, Local Home Visiting Program Leadership/Directors, and Home Visitors

State-level home visiting leadership, early childhood system agency representatives, local home visiting program leadership/directors, and home visitors were asked to comment on major challenges, difficult to access resources, biggest needs they would like to address, success stories/biggest "wins", COVID-19 experiences, and ideas about home visiting they would share with policymakers. Key quotes are presented in the Appendix to this document.

Table 6 presents themes related to barriers, challenges, gaps, and opportunities for improvement as identified by the four groups listed above. Table 7 includes successes and positive outcomes. There was a great deal of consistency in the themes, with notable overlap during the interviews and in open-ended survey comments. The "source" column on these tables identifies which group or groups discussed the theme and any differences in the definition are presented separately. Table 8 presents broader systems and workforce development themes from state leadership/partners.

Table 9 displays themes that emerged from discussions about adaptations to home visiting service delivery in response to the COVID-19 pandemic. Home visiting services were modified to support the safety and well-being of home visitors and caregivers. First Teacher programs began virtual home visits in March 2020 and have been encouraged to continue until at least October 2, 2020. Virtual home visits may continue past this date if Governor Kay Ivey's Safer at Home order is extended.

The following key identifies the source of themes and definitions presented in Table 7 and 8:

HV = Home Visitors
LHVPL/D = Local Home Visiting Program Leadership/Directors
SLHVL/SP = State-Level Home Visiting Leadership and System Partners

Table 6. Barriers, Challenges, Gaps, and Opportunities for Improvement

Theme	Source	Definition
Basic Needs	HV, LHVPL/D	Most respondents noted safe, stable housing is an issue for families. They also discussed the families' needs of employment, food assistance, childcare, utilities, etc. Some programs have figured out creative ways to help families, partnering with community resources, but many families still struggle with basic needs and that makes it difficult for families to focus and prioritize home visiting sessions.
Communication	SLHVL/SP	Informants noted families enrolled in home visiting programs are often enrolled in other programs that provide wraparound services for the family. Respondents stated that communication between those systems can be a challenge and needs to be improved. At times, families can communicate different things to different service providers, which causes systems and services to overlap. Lastly, one informant noted some families experience prevention service overload and stated systems need to work together to provide more streamlined services and resources that prevent families from having to tell their story and relive traumatic experiences.
Cultural Competency and Sensitivity	SLHVL/SP	Respondents noted differences across families' experiences and cultures that influence child rearing practices. They stated understanding those cultures, being well-rounded, and engaging with families in a non-judgmental and sensitive manner needs to be prioritized. Informants stated home visitors need to be aware of the culture of our country, the racial and socioeconomic split of our nation, and be truthful about implicit biases that may inform their approach to serving families. Lastly, informants stated competency and sensitivity to substance involved caregivers or caregivers involved in domestic violence needs to be improved. An informant representing the Spanish-speaking community noted the need for competent and sensitive engagement of non-English speakers. Investing in culturally sensitive home visitors and understanding and respecting the different norms of Spanish speaking and other cultures is important. Additionally, respondent noted having services and materials available to them in their language is critical.
Equity and Economic Stability	HV, LHVPL/D	Respondents noted the challenges their families face with economic stability and equal access to services, specifically undocumented families. Respondents stated access to good paying jobs would improve the economic situation of families and help provide safe and stable housing.
Family Dynamics	SLHVL/SP	Respondents stated the difficulty in working with families that have many additional stressors and expectations placed on them. Informants stated that families in the most need are focused on meeting their family's basic needs and adding an extra commitment, such as home visiting, is overwhelming. Respondents felt work needs to be done on successful collaboration with families and helping them understand the value of the service. Additionally, informants noted the different cultures and family types (i.e. non-custodian caregiver) across Alabama and the need for home visiting to engage each unique situation appropriately and not have a "one size fits all" mentality.

Funding and Resources	SLHVL/SP	Informants noted limited funding is a barrier to growth for the home visiting program across Alabama. Respondents stated additional funding will allow for more families to be served and more complex needs to be met (i.e. transportation). Additionally, respondents discussed additional funding will allow for an increase in workforce and better compensation and resources available to home visitors to help reduce turnover.
	HV, LHVPL/D	Respondents noted the challenges in serving more families and meeting the demands of families currently enrolled in the programs due to lack of resources and funding. Respondents noted with more funding and resources they could start more home visiting programs and provide their staff with unlimited training to increase the quality of services provided.
Health Care Access	HV	Respondents noted the challenges families face in obtaining health insurance due to a variety of reasons and stated that poses a challenge to the overall family health and wellness because often illnesses are detected late. Respondents stated access to quality and affordable health insurance for parents, specifically single mothers, is critical, in addition to quality and affordable health insurance for their children.
Home Visiting Awareness and Education	SLHVL/SP	Informants discussed lack of understanding, awareness and clarity of the work of home visiting to those who would participant in the program and other organizations and professionals. Respondents stated there are differences in models, but most do not know or understand the different models and their differences. There is a need for common language and knowledge about home visiting to help the state understand its role and value. Additionally, informants noted perceptions of home visiting from caregivers is not always positive due to the nature of someone from "the system" coming into their home. Reframing and educating the public on the benefits of home visiting and reducing the stigma will be helpful to caregivers and professionals.
	LHVPL/D	Respondents noted limited providers understand what and how valuable home visiting is for the community and how it can aid the state in reducing issues such as infant mortality. Additionally, respondents noted that home visiting should be visible to all physicians, nurse practitioners, and allied health professionals.
Location of Services and Service Delivery	SLHVL/SP	Respondents noted the need to be more flexible with where to provide home visiting services. They stated there are barriers with certain families to meeting in the home and that requires creative locations and service delivery models to meet those needs. Informants mentioned utilizing community spaces, such as libraries, or technology if the family has access.
Mental Health Access and Education	SLHVL/SP	Informants noted mental health as an emerging issue for families and children, especially since the introduction of COVID-19. Respondents noted improvements needed to address infant and early childhood mental health issues and caregiver mental health issues (i.e., stress, anxiety/depression, fear). Moreover, respondents discussed accessibility issues regarding mental health, including availability of services in rural communities and cost/coverage of intervention. Lastly, respondents noted the challenge regarding the stigma of mental health with certain populations and in some communities. An informant representing the Spanish speaking community noted the challenge of reducing the stigma of mental health among this population. They perceive mental health needs as negative and do not what to share their history with someone who is a stranger.
	HV, LHVPL/D	Respondents noted mental health resources and services are an issue. They have noticed mental health challenges emerging for clients, but not being able to meet their mental health needs due to scarcity of resources and access barriers.

Parent Engagement and Relationship	SLHVL/SP	Respondents noted the challenge and importance of creating a rapport and trust with the caregivers and family to produce better engagement and involvement with the home visiting program. They stated families need to be understood and not shamed for their family's condition. Additionally, informants stated there needs to be more of a focus on parent health and health education. Respondent representing the Spanish speaking community noted this population does not have a stake in how important their health is and keeping up with their health, so delivering more services to parents and educating them on their health and nutrition is critical. Additionally, access to community resources for those that are undocumented is a challenge and area of need.
Parent Involvement	HV, LHVPL/D	Respondents noted they would like to see increased motivation from the parent and implementation of the tips, tools and education the home visitors provide. Additionally, respondents stated they would like to see more involvement with their child in the schools after they leave the home visiting programs.
Rural Access and Engagement	SLHVL/SP, HV, LHVPL/D	Respondents discussed the difficulty in meeting needs in rural and under-resourced communities. Many pockets of the state do not have access to a high-quality and well-trained home visiting workforce or other services. Informants stated transportation in rural and under-resourced communities is problematic and bandwidth issues prevent using technology to connect with families.
Scheduling and Availability	SLHVL/SP	Respondents noted scheduling and availability of home visitors around the work hours of families is a barrier. Informants stated the schedules of families are transient and inconsistent, due to jobs, family dynamics, etc., and having consistency from the home visiting program is difficult. An informant representing the Spanish-speaking community noted that this group usually works in jobs that do not have a set schedule and their hours change or are long. It was stated they often do not have time to schedule people to come into their home because if they do not work, they do not get paid.
System Navigation	HV	Respondents stated families often struggle to get help for their children. They stated it is difficult for families to provide basic needs, but also to find services that meet their child's mental, developmental, social/emotional, and physical needs as well. Many home visitors noted the families they see want help and want to provide these things for their children, but do not know the resources available in their community or from the state, and do not know how to navigate the system of care to access those resources that they are aware of.
Technology	SLHVL/SP	Respondents noted that COVID-19 has required programs to adapt their service delivery and utilize technology as a means of connecting with families. Informants stated this has proven to be an effective means to reach out to families more regularly, but many families do not have access to technology or internet to receive home visiting services virtually. Respondents discussed barriers to access families in poverty who are technology poor or families in rural areas with limited to not broadband connection.
Transportation	HV, LHVPL/D	All respondents noted transportation challenges for families in both rural and urban areas. They stated public transportation is unreliable or unavailable, and reliance on family and friends has caused safety challenges for children because they are less likely to use safety seats when changing vehicles.
Trust in System	SLHVL/SP	Informants stated some families are not receptive to a workforce representative of the system coming into their home because they've previously had poor experiences with workers that come into their home. Respondents noted the relationship the home visitor has with the family is critical to distinguish between the home visiting program and other government services they may have encountered. An informant representing the Spanish-speaking community noted

		this population often has a difficult time trusting people that are not the same culture or do not speak their language. These communities are very close knit and wary of people outside of their family and community coming into their home.

Table 7. Successes and Positive Outcomes

Theme	Source	Definition
Community Engagement	HV, LHVPL/D	Respondents noted there are many partners in the community willing to help families and provide resources to those in need. Additionally, home visiting programs investing in these community partnerships have helped bridge families to needed resources and services.
Early Identification and Prevention	HV, LHVPL/D	Respondents reported they are able to connect with families and identify areas of concern at an early stage. This preventative approach that takes place in the home can aid with large scale issues, such as infant mortality and maternal morbidity, and identify micro-level issues such as ACES (adverse childhood experiences), domestic violence, mental health concerns, developmental delays or other issues that may be occurring in the home.
	SLHVL/SP	Informants discussed the preventative work of Home Visiting, stating home visitors can get involved with the family prenatally and identify areas of concern and addressing them before they become a larger issue. Respondents reported this prevention approach that takes place in the home can aid with large scale issues, such as infant mortality and maternal morbidity, and identify micro-level issues such as ACES, mental health concerns, developmental delays or other issues that may be occurring in the home.
Expansion	SLHVL/SP	Respondents discussed the success in the expansion of home visiting over the years and the accomplishment of the program being available in all 67 counties. Informants stated in some areas of rural Alabama, home visiting is the only assistance and help in promoting the optimal development of children and families. One informant stated this program is a building block or foundation to assist the state in many measures, such as maternal morbidity, infant mortality, child education, developmental milestones, etc.
Holistic	SLHVL/SP	Informants noted meeting in the participants' natural environment, their home, allows for more context and a holistic understanding of the family dynamics and personalities. Respondents stated home visitors are able to go into the most intimate setting with a family and can help meet all types of social/emotional, educational, basic, and/or medical needs for the caregiver and child, and monitor issues as the family continues in the program.
Improved Parent-Child Interaction	HV	Many respondents stated the increased confidence the parent has interacting with their child is a positive outcome of the program. They noted parents blossoming, engaging and connecting with their child on a deeper level, bonding, and working to help their child succeed.
Long-Term Parent Involvement	HV, LHVPL/D	Respondents noted that many parents love being part of the home visiting program and stay in it over the long-term as they have younger children that can benefit from the program as older children graduate, which helps strengthen the relationship between the home visitor and the family. Respondents stated many families become successful after the program, attending college and growing into careers. Additionally, some respondents noted clients from the program attend college and return to work as a home visitor within the system.

Meeting Basic Needs	HV	Due to being present in the home, respondents noted their unique ability to understand the basic needs of the family and utilize community resources to help families meet those needs. Many respondents noted their passion and commitment to their families has resulted in them doing all they can to meet those needs, in addition to providing emotional support when needed.
Parent/Caregiver Education	HV, LHVPL/D	Respondents noted the home visitors are the confidante for families and the first person to help educate them on working with their children. Home visitors are skilled at meeting families where they are and providing resources and materials that they would not have received otherwise. Interviewees stated education is the key to prevention and helps build an academic future in the communities they serve. An informant who primarily works with Spanish speaking families stated that these families are very shy and not talkative towards the beginning, but by the 6th session their self-confidence and self-esteem has greatly improved.
	SLHVL/SP	Respondents discussed the positive outcomes that result from parent (caregiver) education within the home visiting program. Caregivers can receive education as early as the prenatal period to learn about parent (caregiver)/child interactions and help families navigate parenthood and discover other resources that are available to them. Additionally, informants stated a good model and support system in the home in the early days/months/years can positively impact the future trajectory of a family and child.
Parent Confidence and Self-Efficacy	HV	Many respondents noted the growth in confidence of the parents they serve as one of the biggest success stories of their program. With the education and resources provided to them, parents build confidence in their ability to care for their family, their child, and continue to navigate the system of care long-term.
School Readiness	HV LHVPL/D	Respondents noted that home visiting services actively help parents prepare their children for kindergarten. Informants reported that many school systems have told home visiting programs they can tell when a child has been through their program because they are better prepared, and teachers see the difference. Respondents noted they educate parents to be self-sufficient and empower them to help prepare their child for school.
	SLHVL/SP	Informants noted the improvement outcomes home visiting has made in school readiness for children across Alabama. Home visitors can work with the child, but also teach the family how to become actively involved in the child's education and learning in the home to aid in the process of school readiness.
Social Determinants of Health and Wellness	SLHVL/SP	Informants noted the unique nature of home visiting services and their ability to address social determinants of health and wellness. Home visitors can see a family in their natural environment, which results in their ability to identify and address social determinants that would otherwise be difficult to identify. Respondents noted the home visiting program can teach caregivers to become more self-sufficient and economically stable that will continuously improve their outcomes.
Strengthens Families	HV, LHVPL/D	Respondents noted home visiting helps strengthen families and helps them become more stable and self-sufficient, empowering families and helping them to become a strong family unit. Respondents stated stronger families reduces health disparities and reliance on government programs.
System Navigation	SLHVL/SP	Respondents stated many families do not know the resources available to them or how to access those resources. The home visitors help to identify concerns and connect families with the resources that allow them to have better outcomes. Additionally, informants sated home visitors empower families and help them learn how to interdependently navigate the system.

Table 8. State-Level Home Visiting Leadership and Early Childhood System Agency Partners – Systems Perspective

Theme	Sub-theme	Definition
Systems Development	***Advocacy***	Respondents noted the importance of advocacy to access an increase in funding for home visiting services. Informants stated presentation of data is important but presenting data without family representation or stories does not adequately tell the story of home visiting and how impactful it is to the state of Alabama.
	Collaboration and Engagement	Informants noted the opportunity for partnership and stated the need for cross sector collaboration amongst agencies and organizations who provide home visiting and service this population. Respondents stated the home visiting system can work with partners to align deliverables and understand services to avoid duplication and provide better engagement of the target population. It was stated that every entity that touches the family should be collaborating and engaging each other to provide quality services. Lastly, one respondent noted confusion that can occur from multiple funding agencies overseeing programs and making it difficult to maintain quality and communication/collaboration across all home visiting programs.
	Eligibility Requirements	Respondents stated the eligibility requirements are a barrier and the home visiting program should consider expanding qualifications for services to allow everyone with a newborn baby, regardless of socioeconomic status, to access the services. Informants stated that all families, regardless of income level, can benefit from these services and focusing on the lower income families results in middle class families falling through the cracks.
	Family Voices and Involvement	Informants stated the importance of teaching families to advocate and allowing families enrolled in the program to provide their input and perspective to the legislature and people across the system. Respondents stated stories from families are a powerful advocacy tool and should always be used alongside other data. Additionally, informants noted the importance of having caregivers on advisory councils or in planning meetings to allow for their voice and perspective to be heard. Lastly, one informant noted stories of parents who were previously participants in home visiting and actively engaged are now providing home visiting services.
	Local and State Partnerships	Respondents noted the need to improve who is at the table and better engagement of stakeholders like families, state and community partners. Informants noted their needs to be a systematic approach to partnership for the home visiting system and involving all local and state entities that may engage with the families (e.g., ALSDE, faith-based organizations, local school systems, employment, housing, AAP)
Workforce Development	***Community Engagement***	Informants noted the need to find workers that are embedded in the communities that home visiting serves and can understand the collaboration and resources available within that community. Respondents stated the home visiting program needs to be aware of high-risk communities and send larger workforce to meet the needs in those areas. Additionally, respondents noted the need for community engagement and pipeline to recruit potential home visitors from universities and institutions of higher education that understand the big picture and the life course perspective.
	Qualifications and Compensation	Informants stated it can be difficult to find qualified staff for home visiting because the models are involved. Respondents noted many programs are unable to pay well enough to attract qualified staff with a bachelors

		or master's degree or retain those that are hired. Additionally, respondents noted investing in resources and equipment for home visitors is critical to retention.
	Staff Training and Supervision	Respondents stated continuous access to professional and local trainings and professional development is critical to quality workforce. Informants noted home visitors have high expectations and need to be provided with reflective supervision and trauma informed training to process difficult things they are exposed to in the homes. Respondents discussed the need for home visitors to be culturally sensitive, well-rounded and trained in the life-course perspective to be able to identify red flags and assist families in a meaningful way.

Table 9. COVID-19 as an Emerging Issue

Theme	Sub-Theme	Source	Definition
Impact of COVID	***Home Visitor and Caregiver Relationship***	HV, LHVPL/D	Respondents noted the home visitor and caregiver relationship has been difficult to maintain during COVID because home visitors are unable to spend time in their families' homes. Home visitors discussed the challenges to remain connected to families and expressed concern because they are unable to spend time with families and understand their concerns in the intimate setting of the home. Additionally, home visitors noted changes in parent participation with some parents stating their families miss spending time with their home visitor.
	Increased Workload	LHVPL/D	Leadership noted increased workloads due to limited staff in the offices. Respondents also noted strains on all staff because the demands of families rose and staff were tasked with meeting those demands, often receiving phone calls after hours.
	Technology	HV, LHVPL/D	Respondents discussed the pivot to virtual home visits as a result of the pandemic and inability to go into the homes. This shift has been a positive change for some families, increasing their involvement with the program, but has been negative for others who feel overwhelmed by virtual visits and a loss from the lack of personal contact or do not have access to technology (internet, limited data, etc.). The shift has also been challenging for staff who do not have access to the internet at their homes or have a difficult time working in an isolated setting disconnected from their team members.
Challenges of COVID	***Increased Basic Needs***	HV, LHVPL/D	Respondents noted an increase in families' basic needs as a result of job loss or inability to work. Families were having a difficult time receiving unemployment checks, acquiring money for utilities, diapers, wipes, food, etc. One respondent noted the extreme poverty in their county and the reliance many had on their children getting fed at school. Additionally, another respondent noted some clients contracted COVID and were asked to leave their housing, which left their families homeless while trying to recover.
	New Employee Training,	HV, LHVPL/D	Respondents noted the onboarding process for employees hired immediately before or during the pandemic has been difficult due to limited spots and offers for the virtual trainings. Certain components of training, such as role play, were difficult to do because the trainings were virtual.

	Onboarding, and Retention		Interviewees noted the lack of face-to-face teaching from supervisors has been a hardship on readying new home visitors with the skills needed to enter the homes and educate using the curriculum. Additionally, respondents noted supervising and supporting staff regarding the mental health has been difficult, but many have tried to employ virtual reflective supervision.
	Parent Involvement	LHVPL/D	Respondents have noticed that some families have not been as present or involved during this time due to the lack of personal contact. Some families have limited education and low reading levels and have been overwhelmed with trying to understand the curriculum in the virtual format. Home visitors noted they are unable to see issues in the home and are not able to intervene with families as they would have in person. Lastly, home visitors noted difficulty with parents losing attention during virtual visits or do not keep their scheduled visits.
	Recruitment and Rapport	HV, LHVPL/D	Respondents noted it has been difficult to recruit new families without doing their Spring recruitment activities. Home visitors have reported difficulty building rapport with those that are newly enrolled in the program due to the inability to connect in the home.
	Safety and Mental Health	HV, LHVPL/D	Respondents discussed the challenge of keeping their teams safe with limited PPE during the early days of the pandemic. Mental health challenges for staff and clients emerged during the pandemic, with concern over their safety and fear of contracting the virus. Additionally, respondents noted the mental health of the children during this time as they struggle to process the changes to society and their daily schedules.
	Technology	HV, LHVPL/D	The majority of respondents noted challenges with technology barriers due to serving clients in areas with no internet connection. Respondents stated many families, in addition to limited or no internet connection, did not have access to a computer or phone, or had limited data on their phones. Lastly, respondents noted technology felt like a barrier to personal connection and visits via phone or video chat seemed to result in some parents lacking follow through with their visits.
	Visit Structure	HV, LHVPL/D	Home visiting programs have had to change their visit structure to adapt to the online format of their sessions. Some respondents noted dropping materials off or mailing materials to families, but not being able to monitor the activity for the parent or observe the parent/child interactions. Other respondents stated, for those that were able to connect via zoom, they had to break the session up into two or three visits rather than the standard one-hour visit. Additionally, respondents discussed tweaking assessments to make the deliverable over the phone or video chat.
Successes During COVID	***Basic Needs and Emotional Support***	HV	Home visitors reported successes and many examples of being able to assist families to meet the basic and emotional support needs that have increased due to COVID-19.
	Evaluate Process and Procedures	LHVPL/D	Respondents noted the pandemic forced programs to step back and evaluate their process and routines, streamline their approach, and become more efficient in their work. It helped programs understand better ways to advocate for families and find resources.

	Improved Parent-Child Interaction	HV	Home visitors reported improved parent-child interaction in some families because members were home with the children more and could focus on these relationships.
	Intentional and Increased Communication; Home Visitor and Caregiver Relationship	HV, LHVPL/D	Respondents stated the pandemic taught home visitors how to be intentional with their time. Due to lack of visits in the home, home visitors had more frequent contact with families, which allowed them to nurture relationships, help families problem solve, and check in on their mental well-being during this difficult time. Some respondents noted this shift in communication, more frequent and not in the home, has made families more comfortable. Additionally, most respondents stated their programs have created an online presence, which has allowed more frequent contact with families.
	Technology	HV, LHVPL/D	Though technology has been difficult with some clients, respondents noted the use of technology has allowed connection with families that were uncomfortable with someone coming into their home. The use of technology for home visits is helpful for some families that need the flexibility and the use of social media has allowed for an increased connection to families. Additionally, one respondent noted the use of technology with visits has helped their program save money allowing their program to spend money on other supplies.
Continued Changes from COVID	***Intentional and Increased Communication***	HV, LHVPL/D	Respondents noted they would like to continue the frequent contact between visits, well-being check-ins, and social media presence after things return to “normal”. Additionally, respondents noted they would like to continue collaborating and knowledge sharing at the state level, and partner with other community resources to provide essential items to families.
	Technology	HV, LHVPL/D	Respondents noted they would like to continue offering virtual visits and virtual group connections for families who need the flexibility of the virtual format, have medical conditions, or feel more comfortable and prefer the virtual format. Additionally, respondents noted they would like to continue their strong social media presence.

Attrition rates among families served by home visiting programs

Attrition rates among families served in the First Teacher Program have been constant over the last two years, according to MIECHV Annual Performance Reporting. Since the COVID-19 pandemic, there has been a decrease in families served in Alabama. Respondents have shared that families without access to telephones or electronics are difficult to reach and are lost in service delivery. Families are also difficult to recruit while Alabama is continuing virtual home visits. Families are unaware of programs and LIAs are not able to promote their home visiting services at this time.

Home visiting personnel staff qualifications and attrition rates, professional development opportunities

Attrition rates among staff in the First Teacher Program have been constant over the last two years, according to MIECHV Annual Performance Reporting. With the recent COVID-19 pandemic, programs have noted that this consistency in staff retention has changed recently. Staff members are uncomfortable going on home visits and possibly exposing their families to COVID-19.

Home visiting personnel qualifications are specific to the model that is being implemented at the local site. Minimum education and experience requirements differ according to the model, and local sites may set higher standards. Within the evidence-based models used approved for use in the First Teacher program, HIPPY and PAT do not require a college degree to be model-certified, but NFP requires a Bachelor of Nursing degree at minimum. State-level partners also shared that more funding is needed to support professional development training opportunities for current staff.

Strengths and weaknesses in service utilization and outcome data of existing home visiting programs

First Teacher has consistently demonstrated improvement in the MIECHV legislatively-mandated benchmark areas (as evidenced by improvement in at least half of the constructs associated with each benchmark from baseline to a comparison period). Based on experience to date, one of the greatest challenges in designing and implementing the home visiting program is developing and maintaining the data management system and data collection itself. A longer than anticipated software development process and underestimated training needs for local staff to transition to the new system impeded early data collection, resulting in excessive amounts of missing data over the first years of the project, along with data entry errors and lack of compliance with data collection schedules. To address these challenges, ADECE and the UAB Evaluation Team implemented an intensive technical assistance protocol; provided remedial training (screening tools, data collection schedule, data system); and developed standardized blank forms, online resources, a data system user guide, and tools to support timely data collection. These strategies resulted in significant decreases in the amount of missing data and improvements in data collection accuracy and timeliness, leading to outcome improvement across benchmarks and constructs. A more structured approach to training, monitoring, and technical assistance for each home visiting site resulted in an ability to use data to set priorities for quality assurance and continuous quality improvement projects and assure compliance by grantees to meet home visiting model standards.

There is a strong data management plan in place in which UAB prepares monthly site/LIA reports to verify the validity, accuracy, timeliness, completeness, consistency, and uniformity of the data. LIAs are notified of any missing or incorrect data and then have a specified amount of time to correct and/or input data. UAB follows up to ensure corrections and entries are made. Local site administrators can also access these reports for ongoing use throughout the month. This process has resulted in minimal missing data for the most recent DGIS reporting period. UAB also prepares statewide and site/LIA-level DGIS Form 2 reports at the mid-point of each year to identify any issues for targeted improvement and support to assure progress toward MIECHV benchmarks and constructs. These monthly, quarterly, bi-annual, and annual performance reports are prepared by UAB and ADECE for site monitoring and to support overall programmatic and policy decision-making. These are also used in discussion with federal project officers, including issues related to site capacity, families served, and attrition.

Continuous Quality Improvement in Alabama

Alabama has enhanced the quality of home visiting services to mothers and families through Continuous Quality Improvement (CQI). CQI is defined as a systematic approach to improving processes and outcomes through regular data collection, examination of performance relative to pre-determined targets, review of practices that promote or impede improvements, and application of changes in practice that may lead to improvements in performance. Since 2014, the Alabama First Teacher Program has strived to improve measures related to priority topics in home visiting, such as tobacco cessation, well child visits, and maternal depression.

In 2019, Alabama participated in Home Visiting CoIIN 2.0 (HV CoIIN) with a focus on maternal depression. One of the transformative resources provided to local implementing agencies (LIAs) through HV CoIIN was the Mothers and Babies (MB) curriculum, a cognitive-based intervention for reducing and preventing depressive symptoms and preventing depressive symptoms among perinatal women. Currently, Alabama is designated as a Health Professional Shortage Area (HPSA) for mental health providers due to a high unmet need.[2] This need for mental health services was continuously raised in key informant interviews and surveys associated with the needs assessment. Since the MB curriculum is administered by home visitors in the home with clients who screen positive for mild to moderate depressive symptoms on the PHQ-9, it is considered a referral. Moreover, it effectively addresses the difficult and frequently stigmatized topic of maternal depression in a state that is under-resourced and among individuals who frequently lack access to community resources. Moving forward, Alabama will train an additional eight LIAs in the MB curriculum so that all 16 MIECHV awardee LIAs will be able to implement the MB curriculum in homes of at-risk mothers and families.

Extent to which home visiting programs are meeting the needs of eligible families

Table 10 provides a description of the home visiting system by county in Alabama. It is ordered by the number of at-risk domains and sorted from high to low and then alphabetically within those groupings. This chart is intended to provide an overview of the capacity, quality, and extent to which home visiting programs are meeting the needs of eligible families in local communities. Rural counties are indicated, and table notes designate certain counties that are part of ongoing policy and prevention initiatives in the state (Governor Kay Ivey's Infant Mortality Reduction Initiative and Alabama Campaign for Grade Level Reading; Safe Sleep Awareness Focus Areas) and/or counties that

contain at least one “failing school” as defined by the Alabama Accountability Act (passed in 2013, identifies the bottom 6% of schools as measured by the percentage of students who are proficient on the standardized test taken the previous spring). Using a combination of federal, state, and local funds, home visiting services are provided in all 67 counties and are delivered through various LIAs. HRSA-approved evidence-based models are used throughout the state in the First Teacher program (MIECHV and state funds), though some programs use other models that have not yet been approved as eligible for implementation by MIECHV. In most every county, the number of potentially eligible families exceed the capacity to serve them.

Table 10. Home Visiting System Description by County, in order of Number of HRSA-Defined At-Risk Domains, Alabama

3 Domains At-Risk												
County	HV Present	EB HV Present	MIECHV Funded	Other Funding[1]	HRSA-Approved Evidence-Model Present in County	Capacity[2]	Families Needing HV[3]	Rural County[4]	Sleep-Related Death Hot-Spot[5]	Infant Mortality Reduction Initiative[6]	"Failing Schools" List[7]	Non-Proficient 4th Grade Reading Above State Average[8]
1. Clarke	✓	✓		✓	HIPPY, PAT	65	129	✓				✓
2. Dallas	✓	✓	✓	✓	HIPPY, PAT	88	283	✓	✓		✓	✓

2 Domains At-Risk												
County	HV Present	EB HV Present	MIECHV Funded	Other Funding[1]	HRSA-Approved Evidence-Model Present in County	Capacity[2]	Families Needing HV[3]	Rural County[4]	Sleep-Related Death Hot-Spot[5]	Infant Mortality Reduction Initiative[6]	"Failing Schools" List[7]	Non-Proficient 4th Grade Reading Above State Average[8]
3. Bibb	✓	✓	✓	✓	PAT	85	159	✓				✓
4. Blount	✓	✓	✓		PAT	27	301	✓				
5. Calhoun	✓	✓	✓		PAT	20	2088					
6. Cleburne	✓	✓	✓		PAT	20	200	✓				
7. Coosa	✓	✓	✓	✓	HIPPY, PAT	51	34	✓				✓
8. Etowah	✓	✓		✓	HIPPY, PAT	315	1521					
9. Greene	✓	✓	✓		PAT	22	60	✓			✓	✓
10. Jefferson	✓	✓	✓	✓	NFP, PAT	265	4723		✓		✓	✓
11. Lowndes	✓	✓	✓	✓	HIPPY, PAT	88	127	✓			✓	✓
12. Macon	✓	✓	✓	✓	HIPPY, NFP, PAT	131	303	✓		✓		✓
13. Perry	✓	✓	✓	✓	PAT, HIPPY	112	68	✓				✓
14. Pickens	✓	✓	✓	✓	PAT	22	46	✓			✓	✓
15. Pike	✓	✓		✓	PAT	18	534	✓				✓
16. Talladega	✓	✓	✓	✓	HIPPY, PAT	196	1075	✓			✓	✓
17. Tallapoosa	✓	✓	✓	✓	HIPPY, PAT	84	131	✓				✓

18. Tuscaloosa	✓	✓	✓	✓	HIPPY, NFP, PAT	165	609		✓		✓	✓
19. Wilcox	✓	✓	✓	✓	HIPPY, PAT	76	58	✓			✓	✓

1 Domain At-Risk

County	HV Present	EB HV Present	MIECHV Funded	Other Funding[1]	HRSA-Approved Evidence-Model Present in County	Capacity[2]	Families Needing HV[3]	Rural County[4]	Sleep-Related Death Hot-Spot[5]	Infant Mortality Reduction Initiative[6]	"Failing Schools" List[7]	Non-Proficient 4th Grade Reading Above State Average[8]
20. Autauga	✓	✓		✓	NFP, PAT	18	676	✓				
21. Baldwin	✓	✓		✓	HIPPY, PAT	300	370	✓	✓			
22. Barbour	✓	✓	✓	✓	HIPPY, PAT	104	416	✓			✓	✓
23. Bullock	✓	✓	✓		PAT	43	167	✓			✓	✓
24. Butler	✓	✓	✓	✓	PAT	43	281	✓				✓
25. Chambers	✓	✓	✓	✓	PAT	44	109	✓			✓	✓
26. Chilton	✓	✓	✓		PAT	22	141	✓				✓
27. Choctaw	✓	✓		✓	PAT	5	69	✓			✓	✓
28. Clay	✓	✓	✓		PAT	21	181	✓				✓
29. Conecuh	✓	✓	✓	✓	HIPPY, PAT	88	66	✓			✓	✓
30. Cullman	✓	✓	✓		PAT	27	244	✓				
31. Fayette	✓	✓		✓	NFP	25	135	✓				
32. Hale	✓	✓	✓		PAT	22	106	✓				✓
33. Houston	✓	✓		✓	HIPPY	21	1137		✓		✓	
34. Jackson	✓	✓		✓	PAT	15	460	✓				
35. Lamar	✓	✓	✓	✓	NFP, PAT	76	114	✓				
36. Lauderdale	✓	✓		✓	PAT	15	281		✓			
37. Madison	✓	✓		✓	HFA, HIPPY	70	2518		✓		✓	
38. Marengo	✓	✓	✓		PAT	43	139	✓			✓	✓
39. Marion	✓	✓	✓	✓	NFP, PAT	20	207	✓				
40. Mobile	✓	✓	✓	✓	HIPPY, PAT	132	4929		✓		✓	✓
41. Monroe	✓	✓	✓	✓	HIPPY, PAT	133	114	✓			✓	✓
42. Montgomery	✓	✓	✓	✓	HIPPY, NFP, PAT	203	2556		✓	✓	✓	✓
43. Randolph	✓	✓	✓	✓	PAT	24	303	✓				✓

44. St. Clair	✓	✓		✓	PAT	25	458	✓				
45. Shelby	✓	✓	✓	✓	HIPPY, PAT	143	399					
46. Sumter	✓	✓	✓		PAT	22	92	✓				✓
47. Winston	✓	✓	✓	✓	PAT	20	70	✓				✓

0 Domains At-Risk

County	HV Present	EB HV Present	MIECHV Funded	Other Funding[1]	HRSA-Approved Evidence-Model Present in County	Capacity[2]	Families Needing HV[3]	Rural County[4]	Sleep-Related Death Hot-Spot[5]	Infant Mortality Reduction Initiative[6]	"Failing Schools" List[7]	Non-Proficient 4th Grade Reading Above State Average[8]
48. Cherokee	✓	✓	✓		PAT	20	345	✓				✓
49. Coffee	✓	✓		✓	HIPPY, PAT	85	720	✓				
50. Colbert	✓	✓	✓	✓	PAT	20	165	✓				
51. Covington	✓	✓		✓	PAT	15	527	✓				
52. Crenshaw	✓	✓		✓	PAT	18	195	✓				✓
53. Dale	✓	✓		✓	HIPPY	21	539	✓				✓
54. DeKalb	✓	✓	✓	✓	HIPPY, PAT	65	625	✓				✓
55. Elmore	✓	✓		✓	HIPPY	45	998	✓				
56. Escambia	✓	✓		✓	HIPPY, PAT	40	200	✓			✓	
57. Franklin	✓	✓	✓		PAT	20	96	✓				✓
58. Geneva	✓	✓	✓	✓	HIPPY	21	291	✓				
59. Henry	✓	✓	✓	✓	HIPPY	21	187	✓				✓
60. Lawrence	✓	✓		✓	PAT	15	235	✓			✓	✓
61. Lee	✓	✓		✓	PAT	79	579		✓			
62. Limestone	✓	✓		✓	PAT	15	433	✓				
63. Marshall	✓	✓	✓		PAT	110	1401	✓	✓			✓
64. Morgan	✓	✓		✓	PAT	72	841		✓			
65. Russell	✓	✓	✓	✓	NFP, PAT	89	931	✓	✓	✓		
66. Walker	✓	✓	✓	✓	HIPPY, NFP, PAT	107	534	✓				
67. Washington	✓	✓		✓	PAT	5	89	✓				

Shading **= county meets HRSA definition for "At-Risk County" based on 2 or more domains calculated as at-risk.**

1. “Other Funding” includes Governor Ivey’s Infant Mortality initiative, Department of Human Resources (DHR), Medicaid Match, Education Trust Fund (ETF), Pregnancy Assistance Fund (PAF), Children’s Trust Fund (CTF), and other private or philanthropic funding available to local implementing agencies (LIAs).
2. The capacity above is a best estimate of current number of families that can be served in each county. Capacity is determined by each LIA, with a number of LIAs serving multiple counties under one total program capacity number which can be divided based on need. For reporting purposes total capacity for programs serving multiple counties is evenly divided across counties.
3. The number of families in need of/potentially eligible for home visiting services is an estimate provided by HRSA based on the number of families with children under the age of 6 living below 100% of the federal poverty line and that meet one additional risk factor: mothers with low education (high school diploma or less); young mothers under the age of 21; families with an infant (child under the age of 1).
4. The Alabama Rural Health Association uses four widely accepted variables to determine what constitutes “rural.” Those variables are 1) percentage of total employment in the county which is comprised by those employed by the public elementary and secondary school systems (the local school system is most often the largest employer in rural counties), 2) the dollar value of agricultural production per square mile of land, 3) the population per square mile of land, and 4) an index used to assign a score to counties which considers the population of the largest city in the county, the populations of other cities in the county, and the population of cities which are in more than one county. Based on this definition, 55 of Alabama’s 67 counties are considered rural Alabama Rural Health Association. Analysis of Rural vs. Urban, June 2003: p. 1)[1].
5. County contains ZIP code designated a sleep-related death hot-spot by the Alabama Department of Public Health.
6. County is focus of Governor Kay Ivey’s Infant Mortality Reduction Initiative; funding is provided to support evidence-based home visiting as a strategy to reduce infant mortality in these counties by 20% within 5 years.
7. County contains at least one school on the 2019 “failing schools list” as defined by the Alabama Accountability Act.
8. County percentage of 4th graders who are not proficient in reading is higher than the state average percentage of 4th graders who are not proficient in reading (53%) based on 2018-2019 Scantron results. These counties are part of Governor Kay Ivey’s Alabama Campaign for Grade Level Reading.

4. Coordination with Title V, Head Start, and CAPTA

As previously discussed, the MIECHV-required needs assessment overlapped with several other needs assessment/strategic planning efforts occurring in the state, including the Title V Maternal and Child Health Service Block Grant 5-Year Needs Assessment (Title V) and the Preschool Development Birth to Five Systems Grant Needs Assessment & Strategic Plan (B5). Both of these needs assessment processes were guided by needs assessment-focused advisory committees. The First Teacher Home Visiting Program convenes an ongoing and established advisory committee that broadly supports home visiting systems development in the state (MIECHV and other home visiting), and this group provided guidance for the MIECHV needs assessment. All three of these advisory committees include stakeholders from state and community agencies and organizations, policymakers, and families. As the individual needs assessments were planned and implemented, each advisory committee was clear in its guidance that conveners leverage the opportunity of each process to avoid duplication of efforts, burden on participants in needs assessment activities, and support wider efforts (while meeting specific programmatic requirements). Given the timing and varied submission due dates, the MIECHV needs assessment was planned such that secondary data could be shared from the Title V and B5 processes and then additional data would be gathered to supplement as needed for more in-depth or home visiting specific analyses. In addition to the HRSA-provided quantitative data that supported at-risk county designations, results from the Title V and B5 needs assessments were presented to the First Teacher advisory committee. This review and discussion with the advisory committee guided the further implementation of the MIECHV needs assessment.

As discussed in section 2, the UAB Needs Assessment team reviewed summary information from the Title V and B5 (which included review and incorporation of Head Start and CAPTA needs assessments), including themes that emerged from the data and identified needs, to identify needs for which home visiting could be a strategy or potential solution. Following the summary review, raw data were re-analyzed and re-coded specifically to identify home visiting themes. Based on summary review and re-coding, the UAB team identified the need for additional data-gathering to finalize the MIECHV needs assessment. As such, coordination with other required needs assessments (Title V, B5, Head Start, and CAPTA) not only guided the planning and implementation of the MIECHV needs assessment approach, but also informed the findings in the update to support a comprehensive description of the home visiting and early childhood system in Alabama.

5. Conclusion

Evidence-based home visiting services are provided in all 67 Alabama counties through a combination of federal MIECHV, state, and local/community funding. However, the number of potentially eligible families far outstrips the capacity to serve them. The strong evaluation component of the First Teacher program supports data-driven approaches that guide continuous quality improvement efforts and statewide planning to better meet the needs of Alabama's most vulnerable children and families. Gaps, challenges, and barriers are balanced against successes and positive outcomes. Opportunities for improvement and expansion exist, yet the home visiting program in Alabama is well-established and a critical component of the early childhood system.

Citations

1. Alabama Rural Health Association. Analysis of Rural vs. Urban, June 2003: p. 1.
2. Kaiser Family Foundation. Health Professional Shortage Areas (HPSA). Available at: https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D Accessed September 4, 2020.

Appendix

Quotes from State-Level Home Visiting Leadership and Systems Agency Partners
“It is making a difference in the fabric of family and their children then the children and their families.”
“Home visiting like us is not a stand-alone system and we need to work together to reach the families in need.”
“The beliefs of child rearing related to culture make it difficult to teach safe and healthy parenting.”
“Those past experiences help inform their receptivity to the services.”
“Reframing the conversation and showing that “we’re all in this together” and not the approach of “you have a deficit and we’re here to help you”.
“How do we learn from some of the innovations that we’ve had to adapt to during COVID and use them in the future?”
“Encouraging families to engage and advocate in their communities and speak up for what’s going on in their communities rather than accepting it as their norm”
“So many times the professionals are talking to each other and never listening to the people.”
“People need help but we aren’t aware because your health system is crumbling in this state.”
“She wants to remove the negative stigma because so much comes with it that’s positive.”
“Some people feel like certain services aren’t for them. They feel shut out or less than, and we can be the voice that tells them they’re just as good as everyone else and have access to those services.”
“Opportunities for intimacy – that is unique because they are in the home and can strengthen the whole family. It’s a sacred space to be in someone’s home and have those relationships.”
“Just because you have good insurance doesn’t mean you know how to be a parent.”
“When we improve the health of those in our community the overall health of the state is community.”
“You must have workers that understand and empathize with the population they work with and put aside their biases to provide the families with what they need.”
“Until you enter into the family’s world and understand their story, you can’t begin to provide what they need.”
“They have someone to come beside them, walk with them, help them to navigate the system and provide them with the tools that they need to be better mothers and make sure they have the tools to care for their child.”
“I want home visiting to be isolated from other ECE programs—she wants all programs to be connected to build on the child’s and family’s outcomes and successes.”
“The parents are more aware of themselves and what they can do to improve themselves. As you improve parents you improve children.”
“To have the integrated systems of support where they aren’t isolated is important. We need to have those systems and the family resource centers are the model for that.”
“They are a direct line to see what is going with the family and move them to self-sufficiency and a healthy environment.”
“Home visiting enables you to continue the work and continue teaching once they’re gone”

Quotes from Local Home Visiting Leadership and Directors

"A mom told us, "You are the first person who has taken the time to teach me this." We plant seeds and they sprout. Families are reading with their kids more. They are connecting with more resources rather than isolating themselves. HV helps families create a plan to aid their child in meeting milestones."
"Communities and the workforce are healthier when families are healthier."
"Families are in a situation they have never been in, and they are very resilient. COVID 19 has allowed us to nurture relationships that we may not have had before."
"One of our former teen parents is now our coordinator, and she has a master's degree. So one of the biggest accomplishments is long-term success for the family."
"She reported that kindergarten teachers tell the program that they can tell when a HIPPY child is in their class, the children know the books in school."
"Nobody else goes to these homes like we do. We need home visiting."
"Education is the key to prevention."
"As with anything worth doing, there's always challenges but there's success too, even if it's not your entire caseload. If you make a difference in one family's life, you can change the path of that child. It's exciting. I think it's great work and people need it."
"Home visiting makes our families stronger, which makes our state stronger."

Quotes from Home Visitors

"A family entered the Parents as Teachers program while involved with the Department of Human Resources. The mother was enrolled in a drug treatment program and also received services from a service provider called XXX. While working with this mother, she completed drug treatment, obtained her an apartment, and enrolled into college. Currently, she remains in college and is currently employed at the treatment facility that assisted her through difficult times. She remains very active in the Parents as Teachers Program and she [has] great interest in her child's development."
"One of my young mothers (age 16 when pregnant) was able to complete high school, get a driver's license, and a job through Job Corp. Grandmother took care of the baby while she was away and we did visits through FaceTime because she wanted to be a part of her child's development as prepared for a better life. She is currently taking classes at the local college and working full time. That's the positive outcomes when we're able to work together."
"Home visiting reaches and meets families where they are. It is very important to families who lack transportation to go anywhere, families that are rural and parents who are alone. It provides a system of support for all families in need. These are some of our most vulnerable families and they are assisted in becoming stronger and better for their futures."
"It is some important for families to feel connected to their community and we share lots of opportunities for this to happen. When families feel connected, they take pride and want things to be better for their family."
"Our program has helped with getting furniture donated to a family in our community that was sitting on the floor. One of our educators reached out to our community and got 3 beds donated to a family that just moved to our area that was running from a domestic violence situation. This prevented children from sleeping on the floor. We have families that reach out after hours and our educators are always eager to help. We had a mom with a 5-month-old that an educator helped get placed at a local domestic violence shelter."
"Home visiting is not about seeing how others live. It's about learning why and how they got there in the first place. Empowering them to the best of our ability. Letting them see that they can go beyond their own expectations in any area of his/her life. They realize how much more they can do for their family."
"Seeing and hearing parents engaging with their children with more confidence over time. It is heartwarming to watch their confidence in themselves as a parent blossom with their continued participation in the program." [Speaking on biggest successes]
"I love being a part of something so wonderful and that it is a program that my daughter and participated in whenever she was younger."

“One of the children that I worked with made tremendous gains in all areas of development - Cognitive, Language, Social-Emotional, and Motor skills. In one year, she went from having deficits in 2 areas to excelling in those areas, according to the ASQ's. She even tripled her score in one domain! She began the year having regular emotional outbursts that included hitting and biting other children. By the Spring those outbursts had completely stopped. She began Kindergarten this month and she is doing wonderfully academically and socially.”
“The development of a child is greatly dependent upon the well-being of the family.”
“While we are a school readiness program, we also meet the family where they are providing resources for a more stable life at home. These are all changes that affect the entire family. Our children are entering kindergarten with more skills and our families are more ready for the transition.”
“The biggest "wins" for our program are the connections and differences our home visitors make in the lives of the families we serve. Even if it's a small goal met like making a phone call on your own. It can make a huge difference in the life of that person and for the future of their family. It can also lead to bigger goals met.”
“Children are more prepared for preschool, they are graduating high school with honors and furthering their education by attending college.”
“Seeing them go from unemployed, no transportation, struggling to pay bills and provide adequate food and clothing for their family to getting a job, getting a car, paying bills on time and providing for their families is what our work is all about. When families thrive, children thrive. We truly live by that.”
“Home Visiting in Alabama is vital to our community. We develop relationships with families that impact a lifetime and changes generations. When I think of home visiting, I think of questions. Questions like...How is this activity helping your child develop? What's happening developmentally while your child is doing this activity? Tell me a little about how things were when you were growing up. Is that how you want to raise your child? What would you do differently? Do you lay your baby on his back when he goes down for a nap? What are your dreams? In the last two weeks tell me how your mood has been? Have you thought about taking your life? These are some of the questions I ask the families that I work with on a daily basis. When I think of Home Visiting in Alabama, I think of referrals. I think of XXX Church and the diapers they give to needy families. I think of The XXX Center and the work they do with families in need. I think of XXX Site and the depressed mom that I've meet there to get her the help she needed for herself and her child. I think of the many Early Intervention referrals that I have made for families that have children who need help developmentally and socially. The work I do is invaluable to our communities! I just wish everyone knew that it was available to them. I wish that people could see WE ARE HERE!! I wish that I had a home visitor when my babies were growing up. I am thankful that I have the opportunity to work with families in Alabama!”
“An early start on learning will pay bigger dividends later.”
“Home visiting is not about just visiting homes, but it is about building families and restoring relationships one home at a time.”
“I was once a young parent a part of this program. Now, I am the program coordinator.”
“I would share with them that it takes guts to go into a person's house and subject yourself to what may be there, It also takes guts for that person to allow others into their homes after perhaps having lifelong experiences with authority figures that may not have been very good. All folks deserve to be treated respectfully, and the best we can do is to provide the answers and guidance to give them help.”
“Much like any relationship that is struggling, we must improve communication. Then we must follow through with a plan of action that includes the ideas of all of us working in this field. It must be implemented in a way that directly affects the families.”
“Speaking from someone that has had a home visitor for my child. It had a great impact on my life and my daughter’s life. With the help of my Home Visitor we were able to have a successful career in school.”
“I have been a home visitor for 6 years and from the first visit to the very last at dismissal there is an overall change in the parents knowing more and having confidence in being able to engage with their child. Parents learn so much in this program about their child's development and how they grow and learn.”
“There should be a statewide push for home visiting program and the stigma of "you need help raising your child" should be removed and parents should be praised for seeking the best for their children.”

Alabama's First Teacher Home Visiting Needs Assessment was led by staff from the Alabama Department of Early Childhood Education.

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