South Carolina Home Visiting Needs Assessment Update

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Introduction

Children's Trust of South Carolina serves as the state's designated 501(c)(3) organization for the prevention of child abuse, neglect, and unintentional injuries. As the state's leader for convening, equipping, training, and advocating with and for children and their well-being, the organization uses a neutral, flexible approach in its efforts to consolidate and streamline services and promote cost effective approaches to fulfill its mission and strategic goals.

The mission of Children's Trust is to ***strengthen families and lead communities to prevent child abuse, neglect, and injuries in South Carolina***. With an overall target to reduce confirmed cases of child abuse, neglect, and unintentional injuries in South Carolina by 50 percent in the next three years, its organizational strategic goals are as follows:

1. Define and measure our impact on our mission.
2. Develop and strengthen the state's prevention system to deliver on our mission.
3. Communicate our impact to create and foster sustainability of the work.
4. Build a successful business model to ensure long-term sustainability.
5. Provide a vibrant governance structure for organizational longevity.[1]

Children's Trust is the gubernatorial designated lead entity for the state's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. Since the program's inception in 2010, Children's Trust has worked to develop, grow, and maintain ***a statewide network of MIECHV Local Implementing Agencies (LIAs) that have served over 10,000 clients in its 10-year history.*** The South Carolina MIECHV program addresses critical areas of child well-being including the coordination and delivery of critical health, child development, early learning, child abuse and neglect prevention, and family support services through evidence-based home visiting. Children's Trust also supports coordination of the broader system of home visitation in the state through the South Carolina Home Visiting Consortium. These efforts ensure availability of a wide range of services, support, and resources for South Carolina's families.

With passage of the Bipartisan Budget Act of 2018, extended appropriated federal funding for the MIECHV program was approved, with a requirement for program awardees to conduct a statewide needs assessment no later than October 1, 2020.[2] Children's Trust partnered with two entities to complete this needs assessment: the Rural & Minority Health Research Center and the Core for Applied Research and Evaluation, both in the Arnold School of Public Health at the University of South Carolina. ***This document is presented as consideration for meeting the needs assessment update requirement.***

South Carolina's Children

In 2019, there were an estimated 292,464 children under 5 years of age in South Carolina;[3] approximately 26% of all children under 18 years of age and 5.7% of the total population of the state.[4,5] The reported race/ethnicity of children under 5 was 56.4% white, 30.7% Black, 10.7% Hispanic, and 2.3% some other race.[3] Almost a quarter of the under 5 population (23.6%) was estimated to live in a household with a total income that is below the Federal Poverty Line.[6] Over half (53%) of South Carolina children ages 3-4 were not enrolled in school (e.g., preschool, kindergarten, Head Start, etc.).[7] ***These factors, among others, contribute to South Carolina's consistently poor rankings in economic well-being, education, health, and family and community factors in the annual KIDS COUNT composite index of child well-being.***[7]

For these reasons, programs like MIECHV, and home visiting in general, are critical for ensuring positive outcomes for all of South Carolina's children. Through home visiting, South Carolina families receive the supports they need throughout a child's prenatal period up until the time for them to attend school.

These resources ensure optimal health outcomes for mothers and their child(ren), proper child development, use of positive parenting techniques, and economic stability for families.

Ten Years of Home Visiting in South Carolina

The first assessment of home visiting needs in South Carolina was completed by the South Carolina Department of Health and Environmental Control (DHEC), Maternal and Child Health (MCH) Bureau, Title V Program on September 20, 2010. The goal of the needs assessment was "to provide decision makers with accurate information necessary for engaging in meaningful planning activities surrounding the expansion and implementation of evidence-based home visiting programs in the state."[8] The needs assessment determined that all 46 of South Carolina's counties had some level of need with regards to addressing prenatal, maternal, newborn, or child health, and depending on the criteria used, all could be considered as at-risk for poor outcomes in these areas. Despite this conclusion, the 2010 needs assessment focused its definition of at-risk at the county level on both volume (absolute numbers of families with potential need) and burden (disproportionate need based on established rates/proportions). In all, ***30 counties were identified in the 2010 needs assessment as at-risk for poor prenatal, maternal, newborn, or child health outcomes*** (Figure 1).

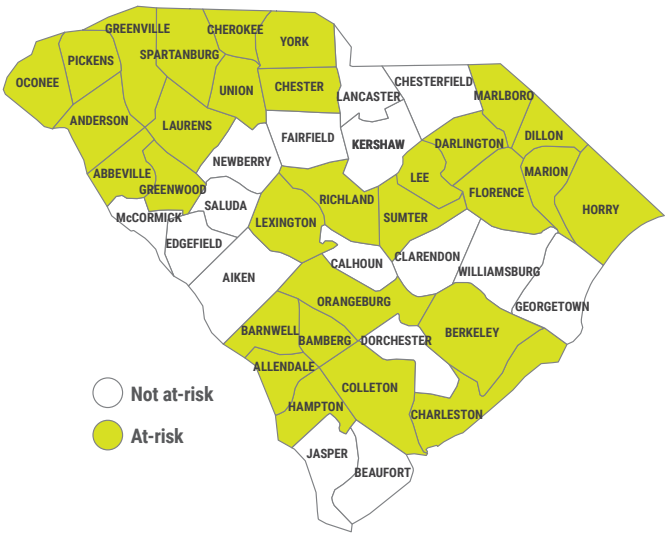

Figure 1. South Carolina At-Risk Counties, 2010 Home Visiting Needs Assessment

As a result of the 2010 needs assessment, Children's Trust organized the South Carolina MIECHV program using a "hub and spoke" approach, connecting more richly-resourced areas to contiguous, high-risk communities that lacked strong resources to establish a continuum of home visiting services throughout the state. The counties of Charleston, Greenville, Horry, Lexington, Richland, Spartanburg, and York represented the highest volume areas in the 2010 assessment and therefore were anchors of this approach. Collaboration and strategy work were critical at several levels to ensure success of this model. All contracted LIAs in targeted catchment areas were strongly encouraged to include the development of and/or connection to existing, local early childhood collaboratives in their program plans. Partnerships were also built by Children's Trust with several state agencies, local and private funders, early childhood initiatives, other home visiting models, resource developers, teen pregnancy prevention programs, schools, retailers and health care facilities and providers. Since 2010, the overall number of home visiting sites has grown 26% in South Carolina. The number of sites implementing three of the main evidence-based home visiting models in the state (i.e., Healthy Families America, Nurse-Family Partnership, and Parents as Teachers) has increased 65%.

Over the past decade, the South Carolina MIECHV program has continued to engage key partners and connect them with local sites, including BabyNet (Individuals with Disabilities Education Act (IDEA) Part C affiliate), the Consortium for Latino Immigration Studies, Fact Forward (teen pregnancy prevention), Family Connection of South Carolina, Help Me Grow South Carolina, PASOs, the South Carolina Department of Disabilities and Special Needs, the South Carolina Inclusion Collaborative, the South Carolina Program for Infant/Toddler Care, and Safe Kids/Safe Sleep. These connections have led to various opportunities, including access to technical assistance, trainings, workshops, and webinars; new local partnerships; and peer-learning opportunities, all of which complement the resources provided to sites through the HRSA MIECHV Technical Assistance Coordinating Center. In addition, Children's Trust has made available additional professional development opportunities to LIAs and their staff, including continuous quality improvement (CQI) learning collaboratives, home visiting retreats, and multiple training webinars and site visits to support data collection and improve performance measurement. Children's Trust has also sponsored multiple training opportunities, including the statewide Prevention Conference, Home Visiting Summit, and the SC Adverse Childhood Experiences (ACEs) Initiative.

Through coordinating these efforts across agencies while simultaneously considering the sustainability of programs, Children's Trust has worked to blend sources of financial support, including state and federal funding, to build a continuum of voluntary home visiting programs that meet the needs of families across the entire state of South Carolina. Public and private funding partners include the Blue Cross Blue Shield of South Carolina Foundation, The Duke Endowment, South Carolina First Steps for School Success, and South Carolina DHEC. In addition, in 2016, South Carolina began implementation of an innovative approach known as Pay for Success, which included a large investment by the South Carolina Department of Health and Human Services, the state's Medicaid agency.[9]

Efforts over the past decade have not only benefitted the South Carolina MIECHV program and its clients, but they also have strengthened home visiting programs and services throughout the state. Children's Trust further ensures the strength of this continuum through ongoing leadership and maintenance of the South Carolina Home Visiting Consortium. The Consortium engages other home visiting and child services organizations across the state in a collaborative model that seeks to "coordinate, promote, and advocate for home visiting efforts that support children and families in South Carolina" through three main activities: home visiting systems development, advocacy, and evaluation.[10]

Finally, in 2020, the South Carolina MIECHV program is currently in its sixth iteration of grantee-led evaluations to explore outcomes of interest to the program and its stakeholders. These evaluations have provided insight to home visiting leaders across the state on topics such as workforce development, systems development, available infrastructure, and client satisfaction and engagement.

Purpose of the Needs Assessment

In addition to fulfilling statutory requirements for the MIECHV program, ***South Carolina MIECHV program leaders desire to use this 2020 needs assessment to coordinate with other ongoing home visiting and early childhood efforts in the state to create and encourage statewide strategies for the work of home visiting for the next 10 years***. Within this context, Children's Trust has and will continue to use the socio-ecological model as its framework to establish early childhood development within a system of strong families, communities, and larger society. By strengthening the home visiting infrastructure associated with this framework, South Carolina's programs will assist in decreasing risk factors and increasing protective factors for children at risk for child abuse and neglect. In the pages that follow, current data are provided that identify the communities at risk, the quality and capacity of existing programs, and overall coordination on addressing the needs of families in South Carolina to date (including the need for substance use disorder treatment). These data provide the starting point for joint efforts that will lead to an even stronger early childhood continuum of services in South Carolina.

Identifying Communities with Concentrations of Risk

South Carolina is a small state with a population of approximately 5 million people living in 46 counties;[11] over a quarter of these residents (27%) live in rural areas.[12] For the purpose of this needs assessment, counties were chosen as the primary geographic unit used to define at-risk communities. This aligns with guidance provided by HRSA that instructed the use of counties as the geographic level of inquiry to enable access to standardized national data, utilize a "simplified method" of analysis, and create geographic continuity nationally on the perspective of the need for home visiting.[13] As further described below, this needs assessment was conducted using HRSA's Simplified Method with modifications to complete Phase One of the analysis of at-risk counties. Notably, for a small number of urban counties in the state, assessment of at-risk communities may be enhanced using sub-county data. However, for the purposes of continuity statewide, this assessment only used county-level statistics.

Phase One: Simplified Method with Updated Data

Measures used in the Simplified Method were chosen by HRSA to closely match the statutorily defined criteria for targeting communities for home visiting programs. Measures of infant mortality and domestic violence were excluded due to lack of data availability at the national level. Included measures were grouped into five domains for purposes of analysis: Socio-Economic Status, Adverse Perinatal Outcomes, Substance Use Disorder, Crime, and Child Maltreatment. Upon reviewing the provided Data Summary from HRSA, counties identified as at-risk using these data were not reflective of all current areas at-risk in the state. Thus, using the HRSA-defined measures and domains as a framework—keeping with the statutorily defined program criteria—South Carolina modified the Simplified Method by including measures updated to the most recent data available and/or to data available in the state at the county-level. A brief description of each of the domains and included measures is provided below; additional detail that includes sources of data is provided in Table 1.

- **SOCIOECONOMIC STATUS:** This domain included four measures: percent of population living below the Federal Poverty Line; percent of the civilian labor force that is unemployed; percent of the population 16-19 years old that is not enrolled in school and does not have a high school diploma; and a measure of income inequality, the Gini Coefficient. Data for these measures were available at the county-level for all 46 South Carolina counties using the original HRSA data sources (refer to Table 1). The most recent year of data available was 2018; thus, each measure was updated to reflect the most recent year or the 5-year average that included the most recent year.[a]

- **ADVERSE PERINATAL OUTCOMES:** This domain included two measures: percent of live births before 37 weeks and percent of live births with a birthweight of less than 2500 grams. Data for these measures were calculated using county-level birth certificate data from all 46 South Carolina counties available through the South Carolina DHEC Community Assessment Network (SCAN). The most recent year of data available from SCAN was 2018; both measures were updated to include the five-year average from 2014-2018.

- **SUBSTANCE USE DISORDER:** This domain had the most changes from the original HRSA indicators. Four measures were included: percent of adult population reporting binge alcohol use in the past month; prevalence rate of marijuana use in the past month; age-adjusted mortality rate of deaths involving heroin; and age-adjusted mortality rate of deaths involving cocaine. Measures for alcohol use, heroin, and cocaine were updated to include available county-level data. Data for these three measures were available for all 46 South Carolina counties using information available through South Carolina DHEC (refer to Table 1). The most recent year of data available was 2018; thus, each of these three measures were updated to reflect the most recent year or the five-year average that included the most recent year. The measure for marijuana use from the original data provided by HRSA was used, as no other sources were available that were either more recent or available at the county-level in South Carolina. Marijuana use was estimated at the sub-state level and values for each county were assigned based on their region. Data were from 2014-2016.

- **CRIME:** This domain included two measures: number of reported crimes per 1,000 residents and the number of juvenile arrests per 100,000 juveniles (ages 0-17). Both measures were included from the original data provided by HRSA, as no other sources were available that were more recent for South Carolina (refer to Table 1). Data were from 2016.

- **CHILD MALTREATMENT:** This domain only included one measure: rate of child maltreatment victims per 1,000 children (ages 0-17). Data for this measure were available at the county-level for all 46 South Carolina counties using updated child welfare information from the South Carolina Department of Social Services for 2018-2019. Using the rate methodology published in the 2019 Joint Citizens and Legislative Committee on Children's Data Book,[14] found child maltreatment reports were divided by 2018 child population estimates from SC DHEC's SCAN Population Tables to calculate county-level statistics per 1,000 children.

[a] *Five-year averages were used throughout the analysis to compensate for numbers from small counties when needed. When applied, every county used the five-year average, regardless of the county size.*

Table 1. Description of Phase One Measures

Domain	Indicator	Definition	Source, Year (Link)
SOCIOECONOMIC STATUS (SES)	Poverty	% population living below 100% Federal Poverty Line - all ages	Census Small Area Income and Poverty Estimates, 2018 (https://www.census.gov/content/census/en/data/datasets/2018/demo/saipe/2018-state-and-county.html)
	Unemployment	Unemployed percent of the civilian labor force	Bureau of Labor Statistics, 2018 (https://www.bls.gov/lau/#cntyaa; https://www.bls.gov/lau/lastrk18.htm)
	High School (HS) Dropout 5 Yr	% of 16-19-year-olds not enrolled in school with no high school diploma – 5 Year Estimate	American Community Survey, 2014-2018 (data.census.gov [Table B14005])
	Income Inequality 5 Yr	Gini Coefficient – 5 Year Estimate	American Community Survey, 2014-2018 (data.census.gov [Table B19083])
ADVERSE PERINATAL OUTCOMES	Preterm Birth	% live births <37 weeks	SC DHEC SCAN - Birth Tables, 2014-2018 (https://apps.dhec.sc.gov/Health/SCAN_BDP/tables/birthtable.aspx)
	Low Birth Weight	% live births <2500 g	SC DHEC SCAN - Birth Tables, 2014-2018 (https://apps.dhec.sc.gov/Health/SCAN_BDP/tables/birthtable.aspx)
SUBSTANCE USE DISORDER	Alcohol	Prevalence: Percent of adult population reporting binge alcohol use in past month	SC Behavioral Risk Factor Surveillance System - provided by SC Department of Alcohol and Other Drug Abuse Services, 2014-2018
	Marijuana	Prevalence rate: Marijuana use in past month	SAMHSA - National Survey of Drug Use and Health, 2014-2016 (https://www.samhsa.gov/data/population-data-nsduh/reports?tab=38)
	Heroin	Mortality rate: Age-adjusted rate of deaths per 100,000 involving heroin	SC DHEC Vital Statistics Drug Overdose Deaths - provided by SC Department of Alcohol and Other Drug Abuse Services, 2018 (http://justplainkillers.com/wp-content/uploads/2019/09/Mortality_Data_2014_2018.xlsx)
	Cocaine	Mortality rate: Age-adjusted rate of deaths per 100,000 involving cocaine	SC DHEC Vital Statistics Drug Overdose Deaths - provided by SC Department of Alcohol and Other Drug Abuse Services, 2018 (http://justplainkillers.com/wp-content/uploads/2019/09/Mortality_Data_2014_2018.xlsx)
CRIME	Crime Reports	# reported crimes/1000 residents	Institute for Social Research - National Archive of Criminal Justice Data, 2016 (https://www.icpsr.umich.edu/icpsrweb/NACJD/studies/37059)
	Juvenile Arrests	# crime arrests ages 0-17/100,000 juveniles aged 0-17	Institute for Social Research - National Archive of Criminal Justice Data, 2016 (https://www.icpsr.umich.edu/icpsrweb/NACJD/studies/37056)
CHILD MALTREATMENT	Child Maltreatment	Rate of maltreatment victims aged <1-17 per 1,000 children (aged <1-17) residents	SC Department of Social Services (founded maltreatments); SC DHEC SCAN (child population), 2018-2019 (https://dss.sc.gov/media/2150/ages-of-children-in-founded-investigations-for-sfy-2019.pdf; http://scangis.dhec.sc.gov/scan/bdp/tables/populationtable.aspx)

Table 2. Phase One Data for Determining At-Risk Counties

Provides county-level data for all 13 measures used in Phase One

County	Poverty (%)	Unemployment (%)	High School Dropout (%)	Income Inequality (Coefficient)	Preterm Birth (%)	Low Birth Weight (%)	Alcohol (%)	Marijuana (%)	Heroin (Mortality rate)	Cocaine (Mortality rate)	Crime Reports (Rate)	Juvenile Arrests (Rate)	Child Maltreatment (Rate)
ABBEVILLE	19.1	4	5.6	0.48	10.8	8.7	11.9	6.2	0	2.43	28.4	567.9	10.4
AIKEN	15	3.3	3	0.45	10.5	9.2	14.2	7.6	3.23	1.47	41.9	1417.9	19.3
ALLENDALE	37.3	5.8	13.1	0.5	16.5	13.7	13.1	7.6	0	0	41.2	115.3	25.9
ANDERSON	14.6	3.3	4.2	0.45	11.1	9.2	12	6.2	1.7	2.21	53.9	1563.1	19.7
BAMBERG	26.7	6.5	1.8	0.46	12.5	11.6	12.7	7.6	0	0	35.1	2264.2	15.9
BARNWELL	22.4	4.8	5.5	0.47	12.5	10.8	14.5	7.6	0	0	40.4	1923.8	12.8
BEAUFORT	10.9	3.2	1.6	0.48	9.7	7.9	18.2	7.6	4.14	3.29	23.8	2577.7	5.8
BERKELEY	12.8	3	2.6	0.42	10.7	8.6	16	7.6	2.27	4.5	28.6	2307.4	12.5
CALHOUN	18.4	4.2	1.1	0.49	12.4	10.6	14.6	7.6	0	0	23.1	784.7	15.8
CHARLESTON	14.2	2.8	4.4	0.51	10.7	9.3	22.6	7.6	9.66	6.19	34.3	3078.6	22.2
CHEROKEE	16.8	3.6	8.3	0.5	12.5	11.5	7.6	6.2	0	2.45	39	982.3	28.5
CHESTER	18.2	4.8	3.9	0.47	11.2	10.7	12.4	8.1	0	3.06	38.2	1406.5	34.3
CHESTERFIELD	20.9	3.3	4.5	0.45	10.6	10.8	11.2	8.1	0	0	36.9	658.1	13.9
CLARENDON	26.4	4.7	8.6	0.48	10.7	10.2	13.4	6.4	3.29	0	34.7	2394.9	7.9
COLLETON	20	4	1.4	0.45	13.4	11.5	15.8	7.6	10.05	2.82	43.2	2254.8	31.8
DARLINGTON	23.5	4.1	9.3	0.48	13	12.1	11.3	6.4	0	1.55	53.7	2700.1	39.1
DILLON	32.1	4.8	1.7	0.51	11.7	12.3	4.9	6.4	0	3.56	62.4	788.7	23.9
DORCHESTER	11	3	5	0.43	9.7	8.1	15.4	7.6	6.07	7.83	36.9	1386	15.8
EDGEFIELD	18.5	3.5	4.2	0.48	11.2	9.4	10.8	6.2	0	0	10.5	444.5	9.3
FAIRFIELD	23.7	6.2	0.8	0.51	13.1	11.1	13.2	8.1	0	0	41	1145.3	18.6
FLORENCE	18	3.7	2.3	0.48	12.8	13	12.5	6.4	3.76	11.53	47.2	2310.5	17.6
GEORGETOWN	19.6	4.5	2.7	0.49	11.6	10.5	15.3	6.4	2.35	15.25	35	2213.1	20.8
GREENVILLE	11.1	2.9	4.7	0.47	10.5	8.3	13	6.2	5.48	7.85	34	1611.9	16.1
GREENWOOD	18.3	3.6	7.3	0.48	12.5	10.5	16	6.2	0	5.46	44.9	2805	18

Note: Data sources are identified in Table 1.

Table 2 Continued. Phase One Data for Determining At-Risk Counties

Provides county-level data for all 13 measures used in Phase One

County	Poverty (%)	Unemployment (%)	High School Dropout (%)	Income Inequality (Coefficient)	Preterm Birth (%)	Low Birth Weight (%)	Alcohol (%)	Marijuana (%)	Heroin (Mortality rate)	Cocaine (Mortality rate)	Crime Reports (Rate)	Juvenile Arrests (Rate)	Child Maltreatment (Rate)
HAMPTON	25.8	3.5	3.7	0.4	13.1	12.8	16.1	7.6	0	0	37.2	2097.7	18.2
HORRY	14.3	4.2	3.6	0.45	11.8	9.4	15	6.4	2.13	13.89	51.5	2919.8	15.5
JASPER	19	3	4.3	0.46	9.9	10.4	12.7	7.6	9.6	3.81	33.7	1244.7	11.6
KERSHAW	14.5	3.5	6.5	0.44	10.7	9.5	9.2	8.1	5.06	7.97	26.1	492.8	12.1
LANCASTER	13.3	3.8	6.2	0.47	10.9	9.6	11.5	8.1	6.23	2.27	25	1280.4	28.2
LAURENS	19.7	3.6	5.7	0.45	12	11	10.4	6.2	0	3.48	32.5	2371.7	24.8
LEE	28.1	4.6	3.6	0.49	14.5	14.1	12.2	8.1	0	0	33	743	29.1
LEXINGTON	12.5	2.9	3.7	0.43	10.3	8.4	20.3	8.1	1.64	3.34	29.2	750.9	10.3
MCCORMICK	18.6	3.6	13.4	0.48	15	12.1	11.5	6.2	0	5.54	21.1	1975.3	12.9
MARION	25.5	5.5	4.9	0.53	13.3	12.7	12.5	6.4	0	0	59.2	2988.1	21.9
MARLBORO	30	5.1	5.9	0.47	11.6	11.2	8	6.4	0	0	47.1	934.1	23.7
NEWBERRY	17.1	3.1	3.7	0.45	12.2	11.5	14.8	6.2	0	0	23.9	4014.3	19.6
OCONEE	14.4	3.3	3.5	0.49	10.5	8.4	11.6	6.2	3.52	0	29.2	1185.2	35
ORANGEBURG	25.9	5.8	4.7	0.49	12.9	12.6	13.3	7.6	2.45	2.72	36.9	527.9	13.2
PICKENS	16.6	3.4	3.5	0.46	9.3	7.8	13.5	6.2	1.79	3.36	36.8	1292.2	21.4
RICHLAND	16.7	3.4	2.3	0.47	12.1	10.6	17.4	8.1	1.84	5.39	52.8	638.5	16.1
SALUDA	14.9	3.1	12.2	0.44	12.5	11.2	10.9	6.2	0	0	16.8	558	14.9
SPARTANBURG	13.6	3.1	5.3	0.46	11.1	9	11.1	6.2	2.46	2.37	34.3	520.2	19.1
SUMTER	18.7	4	1	0.44	11.2	10.8	12.9	6.4	7.76	11.89	39.1	2076.1	16.1
UNION	20.4	4.1	10.9	0.47	14	13.1	10.5	6.2	0	0	48.9	4032.9	26.6
WILLIAMSBURG	26	5.4	4.4	0.49	14.3	13.3	10.1	6.4	0	0	36.1	555	15.8
YORK	9.8	3.3	2.3	0.45	9.7	8.3	16.8	8.1	2.34	3.15	26.3	1640.8	8.9

Note: Data sources are identified in Table 1.

To determine which counties should be classified as at-risk using the Simplified Method, the algorithm provided by HRSA was applied to these data. The mean and standard deviation (and other descriptive statistics) for each measure were calculated using the raw data for all 46 counties. All data were then standardized by creating a Z-score for each measure for every county. Z-scores greater than or equal to 1 indicated that a county was in the worst 16% of all counties for the state for that measure. Within each domain, the number of measures with a Z-score greater than or equal to 1 were counted for each county. If at least half of the measures within the domain had qualifying Z-scores, the county was considered at-risk for that domain. To determine which counties should be considered at-risk overall, the number of domains the county was at-risk for were summed. Based on state-by-state comparisons derived from America's Health Rankings, the Socioeconomic Status, Adverse Perinatal Outcomes, and Crime domains were weighted (counted) twice to account for disproportionately poor outcomes in measures for these domains for South Carolina residents.[15] If the weighted count of domains was greater than 2, the county met the criteria of at-risk using the Phase One Simplified Method.

This initial analysis identified 24 counties as at-risk for poor prenatal, maternal, newborn, or child health outcomes in South Carolina (Table 3). These counties were reflective of areas in the state generally known to have consistently poor outcomes. However, this list of counties was found to not be inclusive of all counties at risk in South Carolina, as many counties currently providing MIECHV programs—especially many that benefit from the hub and spoke approach to providing MIECHV services—were excluded. Thus, Phase Two was considered and subsequently employed to incorporate additional data that would further demonstrate current risk for populations living in South Carolina counties.

Table 3. List of South Carolina Counties Identified as At-Risk in Phase One

South Carolina At-Risk Counties, Phase One					
ALLENDALE	CHEROKEE	DILLON	HAMPTON	MCCORMICK	ORANGEBURG
ANDERSON	CLARENDON	FAIRFIELD	HORRY	MARION	RICHLAND
BAMBERG	COLLETON	FLORENCE	LANCASTER	MARLBORO	UNION
CHARLESTON	DARLINGTON	GREENWOOD	LEE	NEWBERRY	WILLIAMSBURG

Phase Two: Additional Methods

Criteria for identification of measures for Phase Two were developed using a framework for target populations with risk for child abuse and/or threats to safe, nurturing environments as defined by Segal, Opie, and Dalziel.[16] This framework and associated measures were chosen because of their representative nature of current population needs in South Carolina. As a state, South Carolina is comparatively worse on child maltreatment occurrences and outcomes associated with these events. In 2018, the rate of confirmed victims of child maltreatment in South Carolina was 17 per 1,000 children; the state's ranking for this measure was 43 out of 50 (worst).[17] Measures associated with each of the framework's target populations were further identified based on their alignment with the MIECHV program's statutory criteria, as indicated below.[18] Defined measures were calculated for each county following the priority ranking of the identified target populations. Counties meeting the criteria for any measure at any point were automatically added to the list of at-risk counties for South Carolina. A brief description of each target population and associated measures is provided in priority order below; additional detail including sources of data is provided in Table 4.

1. **RISK OF CURRENT CHILD ABUSE**: Populations with one previous incident of child abuse and/or domestic violence are considered areas of "current risk" for child endangerment.[16] Two county-level measures were identified as aligned with this target population and the MIECHV criteria of child maltreatment: positive identification as a target county in South Carolina's Child Abuse and Prevention Treatment Act (CAPTA) Title II/Community-Based Child Abuse Prevention (CBCAP) plan of action (see Section 5) or positive identification as a county with an at-risk child maltreatment domain in Phase One. Data used for these measures were from 2018-2019 and were available for all 46 counties. Applying these measures resulted in the inclusion of 2 additional at-risk counties in South Carolina: Chester and Oconee.

2. **VERY HIGH AND HIGH RISK FOR CHILD ABUSE:** Populations with high volumes of behavioral health conditions (i.e., drug misuse and mental illness) among caregivers are at "very high" or "high" risk for child abuse.[16] Two county-level measures were identified as aligned with this target population and the MIECHV criteria of substance abuse and other indicators of maternal health. Both use Medicaid claims data from 2018 as a proxy for identifying

high need maternal/caregiver populations in the state based on South Carolina's Medicaid eligibility criteria.[19] These data were available for all 46 counties. Frequencies of diagnosis for (1) Opioid Use Disorder, or (2) inpatient and emergency department mental health diagnoses, were sorted into quartiles; counties in the upper quartile (>75th percentile) for either measure were included as at-risk. Applying these measures resulted in the inclusion of six additional at-risk counties in South Carolina: Berkeley, Dorchester, Greenville, Lexington, Spartanburg, and York.

3. **SOME ELEVATED RISK FOR CHILD ABUSE (A):** Populations with large proportions of racial/ethnic minority populations may have "some elevated risk" for child abuse.[16] This does not mean that the race of either the child or their caregiver is a direct risk factor for child maltreatment; rather, members of racial/ethnic minority groups are exposed to racism and other social conditions that result in these populations being disproportionately represented in these cases due to inequitable systems as well as a lack of needed supports.[20] Two measures at the county-level were identified in alignment with this population and the MIECHV criteria of other indicators of maternal and child health. Both use 2018 data and include all 46 South Carolina counties. Subpopulation data were sorted into quartiles; counties in the upper quartile (>75th percentile) for (1) percent of children under age 5 who are members of racial/ethnic minority populations, or (2) percent of women of childbearing age (15-44) who are members of racial/ethnic minority populations, were included as at-risk. Applying these measures resulted in the inclusion of one additional at-risk county in South Carolina: Jasper.

4. **SOME ELEVATED RISK FOR CHILD ABUSE (B):** Populations with lack of access to necessary health care services may also be at "some elevated risk" for child endangerment.[16] Pediatric medical homes provide critical opportunities for prevention and management of exposure to childhood traumas and in fact may be a unique source of continued relationships with parents after reports of child maltreatment.[21] Without pediatricians in the local community, a true medical home relationship is difficult to achieve. Likewise, a lack of local obstetrics providers has been associated with worse maternal outcomes, including preterm births.[22] Two county-level measures were identified as aligned with this target population and the MIECHV criteria of other indicators of maternal and child health: positive identification as a county in which there are no pediatric physicians practicing or positive identification as a county in which there are no obstetrics/gynecology physicians practicing. Data used for these measures were from 2017 and were available for all 46 counties. Applying these measures resulted in the inclusion of five additional at-risk counties in South Carolina: Abbeville, Barnwell, Calhoun, Edgefield, and Saluda.

5. **LOW RISK FOR CHILD ABUSE:** For the general population, mostly at "low risk" for child abuse, target populations include areas with large numbers of potentially vulnerable children.[16] Inclusion of these populations is also key for continuity in the South Carolina MIECHV program's hub and spoke model for provision of services widely across the state. Two county-level measures were identified in alignment with this target population and the MIECHV criteria of other indicators of maternal and child health. Both measures include all 46 South Carolina counties. Subpopulation data were sorted into quartiles; counties in the upper quartile (>75th percentile) for (1) number of births in 2018 with Medicaid as the anticipated payor, or (2) number of families in need in 2017 based on data provided by HRSA in its Data Summary supplement, were included as at-risk. Applying these measures resulted in the inclusion of two additional at-risk counties in South Carolina: Aiken and Georgetown.

Table 4. Description of Phase Two Measures

Target Population	Indicator	Definition	Source, Year (Link)
RISK OF CURRENT CHILD ABUSE	Child Abuse and Prevention Treatment Act (CAPTA) Title II /Community-Based Child Abuse Prevention (CBCAP)	County targeted in 2019 CBCAP plan	Children's Trust of South Carolina, 2019
	Child Maltreatment Domain	County identified as at-risk for child maltreatment domain in Phase One	HRSA Data Summary, 2018-2019
VERY HIGH OR HIGH RISK OF CHILD ABUSE	Opioid Use Disorder	County identified in upper quartile (>75th percentile) of Opioid Use Disorder diagnoses among the Medicaid population	SC Department of Health and Human Services - provided by SC Department of Alcohol and Other Drug Abuse Services, 2018 (http://justplainkillers.com/wp-content/uploads/2019/09/Medicaid_Data_2015_2018.xlsx)
	Mental Health	County identified in upper quartile (>75th percentile) of total inpatient and emergency department Medicaid diagnoses	SC Revenue and Fiscal Affairs Office, 2018 (http://rfa.sc.gov/healthcare/utilization)
SOME ELEVATED RISK OF CHILD ABUSE (A)	Child Population at Potential Risk	County in which greater than or equal to 63% of children under age 5 (identified in upper quartile (>75th percentile)) are members of a racial and/or ethnic minority group	CDC WONDER, 2018 (https://wonder.cdc.gov/bridged-race-population.html)
	Maternal Population at Potential Risk	County in which greater than or equal to 60% of women ages 15-44 (identified in upper quartile (>75th percentile)) are members of a racial and/or ethnic minority group	
SOME ELEVATED RISK OF CHILD ABUSE (B)	Lack of Pediatric Physicians	County has no pediatric physicians actively practicing	SC Area Health Education Consortium (AHEC), 2017 (https://www.scohw.org/docs/2019/SCOHW-Data-Book-2019.pdf)
	Lack of Obstetrics Physicians	County has no obstetrics physicians actively practicing	
LOW RISK FOR CHILD ABUSE	Medicaid Births	County identified in upper quartile (>75th percentile) of number of births with Medicaid as the anticipated payor	SC DHEC SCAN - Birth Tables, 2018 (https://apps.dhec.sc.gov/Health/SCAN_BDP/tables/birthtable.aspx)
	Families in Need	County identified in upper quartile (>75th percentile) of "families in need" data provided by HRSA	American Community Survey 1-Yr Public Use Microdata Sample (via HRSA), 2017

Table 5. Phase Two Data for Determining At-Risk Counties

Table 5 provides county-level data for all 10 measures used in Phase Two.

County	CAPTA Title II /CBCAP (indicator)	Child Maltreatment Domain (Indicator)	Opioid Use Disorder (# of diagnoses)	Mental Health (# of diagnoses)	Child Population At-Risk (%)	Maternal Population At-Risk (%)	Lack of Pediatric Physicians (Indicator)	Lack of Obstetrics Physicians (Indicator)	Medicaid Births (#)	Families in Need (#)
ABBEVILLE	No	No	25	114	34.4	31.7	Yes	Yes	111	266
AIKEN	No	No	163	535	42	39.1	No	No	952	600
ALLENDALE	No	No	6	37	86.5	84.7	Yes	Yes	68	57
ANDERSON	No	No	223	974	28.6	24.8	No	No	1,038	1,370
BAMBERG	No	No	13	75	69.3	70.2	Yes	Yes	84	93
BARNWELL	No	No	40	119	57.7	52	No	Yes	165	138
BEAUFORT	No	No	93	509	47.8	41.9	No	No	833	524
BERKELEY	No	No	231	1,231	40.8	38.2	No	No	1,174	1,452
CALHOUN	No	No	7	23	50	50.5	Yes	Yes	84	176
CHARLESTON	No	No	325	2,246	41.5	34.7	No	No	1,792	1,738
CHEROKEE	No	Yes	110	319	33.5	30.9	No	No	406	689
CHESTER	No	Yes	73	208	49.5	45.9	No	Yes	267	392
CHESTERFIELD	No	No	115	180	47.5	42	No	No	324	466
CLARENDON	No	No	45	169	61	57.8	No	No	232	190
COLLETON	No	Yes	84	403	50.6	45.3	No	No	336	243
DARLINGTON	No	Yes	215	446	52.6	50.2	No	No	570	928
DILLON	No	No	166	239	65.9	58.8	No	No	310	641
DORCHESTER	No	No	203	1,047	40.1	39.2	No	No	825	1,151
EDGEFIELD	No	No	17	57	49.8	43.7	Yes	Yes	104	95
FAIRFIELD	No	No	30	108	69.3	69.1	No	Yes	138	76
FLORENCE	No	No	440	1,045	56.6	54	No	No	1,107	1,920
GEORGETOWN	No	No	175	393	48.7	44.6	No	No	306	1,275
GREENVILLE	No	No	518	1,788	39	34.4	No	No	2,110	3,424
GREENWOOD	No	No	72	462	52.7	46.6	No	No	420	748

Note: Data sources are identified in Table 4.

Table 5 Continued. Phase Two Data for Determining At-Risk Counties

Table 5 provides county-level data for all 10 measures used in Phase Two.

County	CAPTA Title II /CBCAP (indicator)	Child Maltreatment Domain (Indicator)	Opioid Use Disorder (# of diagnoses)	Mental Health (# of diagnoses)	Child Population At-Risk (%)	Maternal Population At-Risk (%)	Lack of Pediatric Physicians (Indicator)	Lack of Obstetrics Physicians (Indicator)	Medicaid Births (#)	Families in Need (#)
HAMPTON	No	No	29	156	63.6	61.4	No	Yes	148	127
HORRY	No	No	1,014	2,185	33.9	28.0	No	No	1,874	3,782
JASPER	No	No	33	119	71.1	62.5	No	No	248	82
KERSHAW	No	No	112	318	36.5	33.2	No	No	386	763
LANCASTER	No	Yes	151	410	36.0	34.3	No	No	429	907
LAURENS	No	No	116	408	39.2	34.7	No	No	458	823
LEE	No	Yes	16	101	75.6	72.7	No	Yes	130	98
LEXINGTON	No	No	216	1,354	33.7	29.2	No	No	1,435	2,542
MCCORMICK	No	No	9	37	63.7	62.7	Yes	Yes	29	103
MARION	No	No	91	177	72.5	67.4	No	No	286	659
MARLBORO	Yes	No	83	140	63.9	62.6	No	No	219	273
NEWBERRY	No	No	43	159	52.9	43.9	No	No	252	463
OCONEE	Yes	Yes	84	326	24.5	18.4	No	No	359	183
ORANGEBURG	No	No	95	392	74.0	73.4	No	No	704	563
PICKENS	No	No	180	584	17.3	3.9	No	No	520	294
RICHLAND	Yes	No	174	2,031	65.0	59.9	No	No	2,226	2,660
SALUDA	No	No	15	78	57.4	46.9	Yes	Yes	116	227
SPARTANBURG	No	No	470	1,471	38.3	35.6	No	No	1,811	1,514
SUMTER	No	No	97	761	60.6	58.1	No	No	716	600
UNION	No	Yes	90	196	43.7	38.2	No	No	190	337
WILLIAMSBURG	No	No	45	237	72.7	72.2	Yes	No	210	178
YORK	No	No	329	873	35.9	33.7	No	No	1,175	1,857

Note: Data sources are identified in Table 4.

Addition of the Phase Two criteria resulted in 16 more South Carolina counties identified as at-risk for poor prenatal, maternal, newborn, and child health outcomes. Newly identified counties in Phase Two were reflective of areas in the state that were currently providing MIECHV services. Leaders from Children's Trust and the University of South Carolina met in April 2020 to review the list of identified at-risk counties to validate and finalize their inclusion. All group members agreed through consensus that the 40 identified at-risk counties were appropriate to include as a finding of this needs assessment. The group further discussed the six counties that had not met criteria for inclusion as at-risk. After reviewing available data on these counties, including previous assessments of risk and historical MIECHV enrollment data (see Figure 5), four additional counties were deemed at-risk and thus necessary to include in this assessment. ***This became the sixth and final criteria for Phase Two inclusion.*** Three of the counties (Beaufort, Laurens, and Pickens) had existing high enrollment of MIECHV clients, suggesting that needs of families were currently being identified and addressed by home visiting programs. The fourth county (Sumter) was previously identified as at-risk in the 2010 needs assessment yet had relatively low historical MIECHV enrollment—suggesting existing unmet need. The addition of these four counties to the 16 previously identified in Phase Two resulted in a total 20 additional counties included as at-risk. These were added to the 24 counties identified as at-risk in Phase One.

How Identified At-Risk Counties by Methodology Reflects Need in State

In all, using both Phase One and Phase Two criteria for at-risk counties, ***44 of South Carolina's 46 counties were identified in this needs assessment as at-risk due to poor prenatal, maternal, newborn, or child health outcomes*** (Figure 2). Inclusion of the majority of counties is unquestionably reflective of the needs of children and their caregivers in the state, as South Carolina's health outcomes are consistently among the worst in the nation.[15] Women and children, especially members of racial/ethnic minority groups, disproportionately suffer the devastating consequences of these poor outcomes. Although great strides have been made in building capacity and infrastructure for home visiting across the state, as detailed in Section 3 of this assessment, more work is necessary to address current need. These counties represent where this work has and will continue to occur in South Carolina.

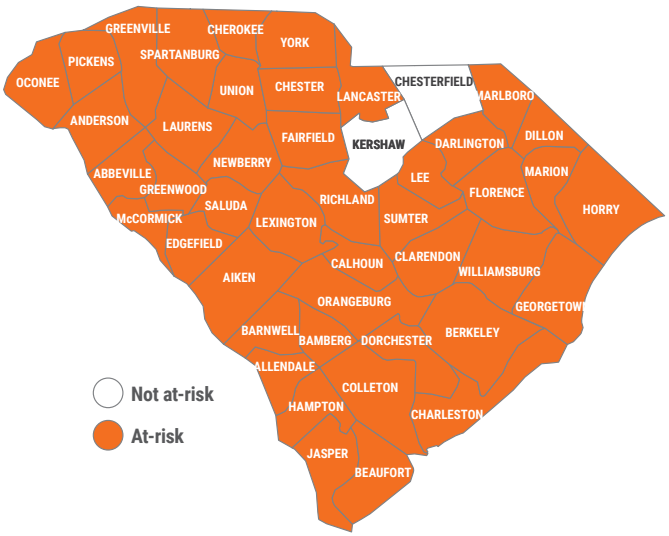

Figure 2. South Carolina At-Risk Counties, 2020 Home Visiting Needs Assessment

Methodology Adjustments Due to COVID-19 Pandemic

Although the identification of at-risk counties was conducted successfully, several activities to provide context to these results did not occur due to the abrupt shift in activities beginning March 2020 due to the COVID-19 pandemic. Specifically, qualitative data collection was originally designed to include focus groups to understand family perspectives on home visiting services. However, as a result of the pandemic, conducting these focus groups was not feasible. Given the robust data leveraged from prior South Carolina MIECHV program evaluation work, the 2019-2020 South Carolina Title V MCH needs assessment, and a 2019 South Carolina First Steps evaluation project, it was determined that these findings adequately described family perspectives on home visiting services and their continued needs. Thus, an alternative approach to conducting additional focus groups, developed in partnership with Children's Trust, used a survey to understand the perspectives of home visiting stakeholders across the state. These stakeholders—state leaders, county level partners, home visiting program administrators, and home visitors—were invited to provide their feedback on the quality and capacity of existing home visiting services in South Carolina and the level of readiness among at-risk counties to implement home visiting. These survey results, as well as data leveraged from the referenced prior evaluations that illustrate family perspectives on the adequacy of home visiting, are included in the next section.

Finally, in addition to internal iterative reviews of the needs assessment findings—which were completed as planned—external reviews of findings by key stakeholder groups had been planned to coincide with regularly scheduled meetings, workshops, and conferences during the summer of 2020. Since these events were canceled, and other more urgent demands were prioritized, there was neither an appropriate forum nor opportunity to conduct these reviews. The result of this change in activities was that additional individual stakeholders were engaged (virtually) and additional needs assessments were reviewed for concordance with this assessment (see Section 5). This change will also require an intentional dissemination process of this assessment in late 2020 and early 2021. These adjustments—while not completely able to reconcile the planned activities of this assessment—are a best faith effort at ensuring home visiting stakeholders across the state of South Carolina were included in this process.

Identifying Quality and Capacity of Existing Home Visiting Programs

For over a decade, access to home visiting services has been available to families across South Carolina. A variety of home visiting programs and models currently operate in the state, each with varying foci and levels of evidence of program effectiveness. A snapshot of the county coverage of South Carolina's seven main models is provided in Table 6, with further details about each provided below.

Table 6. Current Home Visiting Model Coverage by County

County	Healthy Families America	Nurse-Family Partnership	Parents as Teachers	Early Head Start - Home-Based Option	Early Steps to School Success	Healthy Start	Parent-Child Home+	Totals
ABBEVILLE	yes	yes	yes	no	no	no	no	3
AIKEN	yes	no	yes	no	no	no	no	2
ALLENDALE	yes	no	yes	no	no	yes	no	3
ANDERSON	yes	yes	no	no	no	no	no	2
BAMBERG	no	no	yes	yes	no	yes	no	3
BARNWELL	yes	no	no	no	yes	yes	no	3
BEAUFORT	no	no	yes	no	no	no	no	1
BERKELEY	yes	yes	yes	no	no	no	no	3
CALHOUN	no	no	yes	no	no	no	no	1
CHARLESTON	yes	yes	yes	yes	no	no	no	4
CHEROKEE	no	yes	no	no	no	no	no	1
CHESTER	no	yes	yes	no	no	no	no	2
CHESTERFIELD	no	yes	yes	no	no	yes	no	3
CLARENDON	no	yes	yes	no	yes	no	no	3
COLLETON	no	yes	yes	no	no	no	no	2
DARLINGTON	no	yes	yes	no	no	yes	no	3
DILLON	no	yes	yes	no	no	yes	no	3
DORCHESTER	yes	yes	yes	no	no	no	yes	4
EDGEFIELD	yes	yes	yes	no	no	no	no	3
FAIRFIELD	no	no	yes	no	no	no	no	1
FLORENCE	yes	yes	yes	no	no	yes	yes	5

Table 6 Continued. Current Home Visiting Model Coverage by County

County	Healthy Families America	Nurse-Family Partnership	Parents as Teachers	Early Head Start - Home-Based Option	Early Steps to School Success	Healthy Start	Parent-Child Home+	Totals
GEORGETOWN	yes	yes	yes	no	no	no	yes	4
GREENVILLE	yes	yes	no	no	no	no	no	2
GREENWOOD	yes	yes	yes	no	no	no	no	3
HAMPTON	no	no	yes	no	no	yes	no	2
HORRY	yes	yes	yes	no	no	no	yes	4
JASPER	no	no	yes	no	no	no	no	1
KERSHAW	no	no	yes	no	no	no	no	1
LANCASTER	no	yes	yes	yes	no	no	yes	4
LAURENS	yes	yes	yes	no	no	no	no	3
LEE	no	no	yes	no	yes	no	no	2
LEXINGTON	no	yes	yes	no	no	no	no	2
MCCORMICK	yes	yes	yes	no	no	no	no	3
MARION	no	yes	no	no	no	yes	no	2
MARLBORO	no	yes	no	no	no	yes	no	2
NEWBERRY	no	no	yes	no	no	no	no	1
OCONEE	yes	yes	no	no	no	no	no	2
ORANGEBURG	no	yes	no	no	yes	yes	no	3
PICKENS	yes	yes	no	no	no	no	no	2
RICHLAND	no	yes	yes	yes	no	yes	yes	5
SALUDA	yes	yes	yes	no	no	no	no	3
SPARTANBURG	no	yes	no	yes	no	no	no	2
SUMTER	no	yes	yes	no	no	yes	no	3
UNION	no	yes	yes	yes	no	no	no	3
WILLIAMSBURG	yes	yes	no	no	no	yes	yes	4
YORK	no	yes	yes	no	no	no	no	2
TOTALS	**20**	**34**	**35**	**6**	**4**	**14**	**7**	

The South Carolina MIECHV program currently supports three models that have met the U.S. Department of Health and Human Services (HHS) criteria for evidence-based home visiting: Healthy Families America, Nurse-Family Partnership, and Parents as Teachers.[13] In prior years, South Carolina MIECHV also provided support for two additional programs: Family Check-Up and Healthy Steps. Only two MIECHV LIAs ever implemented Family Check-Up. Both discontinued use of the model after a few years after struggles with implementation and model requirements. Healthy Steps, initially approved by HHS as a home visiting model that met evidence-based criteria (and thus eligible for MIECHV funding), was later removed from the list of approved models effective October 1, 2017. All South Carolina MIECHV LIAs delivering the Healthy Steps model transitioned to either Healthy Families America or Parents as Teachers, except for one LIA that opted to discontinue home visiting services at that time.

Current locations of MIECHV funded sites in the state, assessed by contracts established for the FY2019 program year, are shown in Figure 3. Eight counties are not currently supported by the South Carolina MIECHV program: Bamberg, Calhoun, Cherokee, Clarendon, Colleton, Kershaw, Lee, and Marion. (Kershaw County was not identified as at-risk in this assessment.) Eighteen counties have one MIECHV supported LIA. Six counties are served by two distinct MIECHV LIAs; it is common for counties to be served by multiple LIAs when they provide different program models (e.g., one LIA provides the Healthy Families America model, and another provides Nurse-Family Partnership). Fourteen counties use "blended" funding, where MIECHV support is combined with other local and/or private resources. Among the 14 counties that use blended funding, nine also have an additional MIECHV supported LIA in their county.

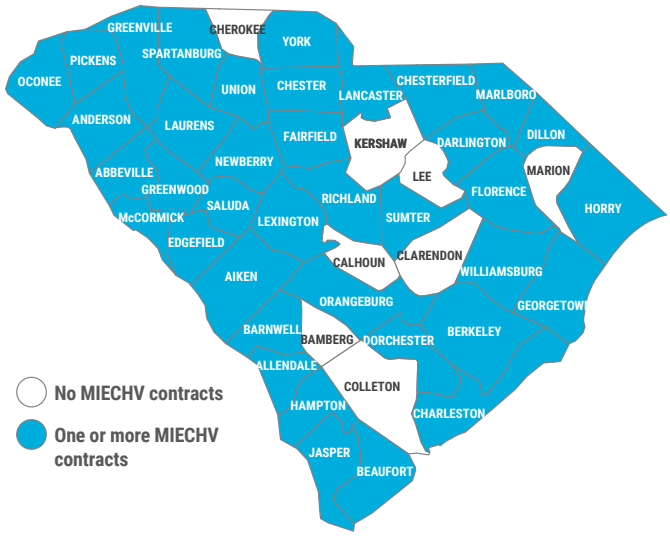

Figure 3. South Carolina MIECHV Program County Coverage, FY2019

Another way to assess current MIECHV access is to examine where home visiting clients receive services. Data collected and stored in the South Carolina MIECHV Client Database at the University of South Carolina was used for these analyses. Caregivers were used to represent the client population for a conservative, unduplicated number of families served. Figure 4 shows the estimated number of clients served by MIECHV LIAs by county displayed in quartiles for the most recent program year (October 1, 2018 – September 30, 2019 [n=613]). Counties with zero clients reported for FY2018 included Aiken, Calhoun, Chesterfield, Dillon, Hampton, Lee, Marion, Marlboro, and Newberry. (Chesterfield County was not identified as at-risk.) County of enrollment was not missing for any clients in FY2018 data.

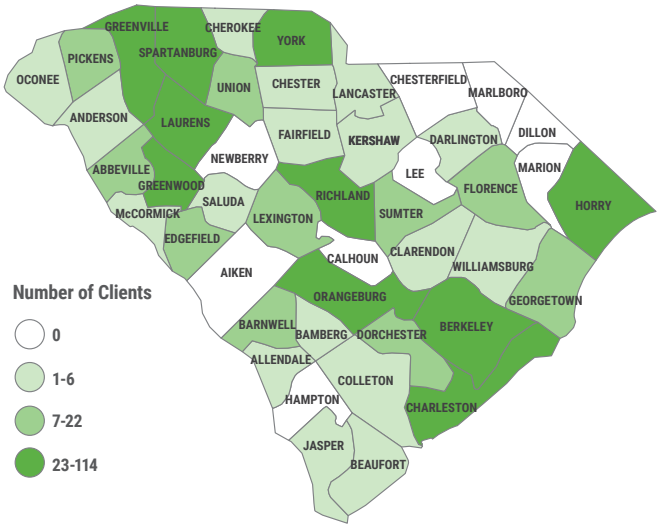

Figure 4. South Carolina MIECHV Program Enrollment Estimates by County, FY2018

In addition to current use of MIECHV services, a historical view of clients served by MIECHV supported LIAs provides further insight into service accessibility in the state over time. Data from five calendar years (2014-2018) were used to examine past MIECHV program participation in the state. Data include all home visiting models utilized during the time period (including Healthy Steps and Family Check-Up which, as described above, have been discontinued as part of the South Carolina MIECHV program). From 2014-2018, 4,066 clients were served by a MIECHV LIA in South Carolina. Figure 5 categorizes total enrollment counts by county over this period by tertiles. Four counties reported zero clients: Calhoun, Clarendon, Lee, and Marlboro. Enrollment county data were missing for ~30% of the client population during this period. Although most of these missing data were from earlier time points (i.e., 2014-2015), this is a limitation, as it is possible some counties are misrepresented by this analysis.

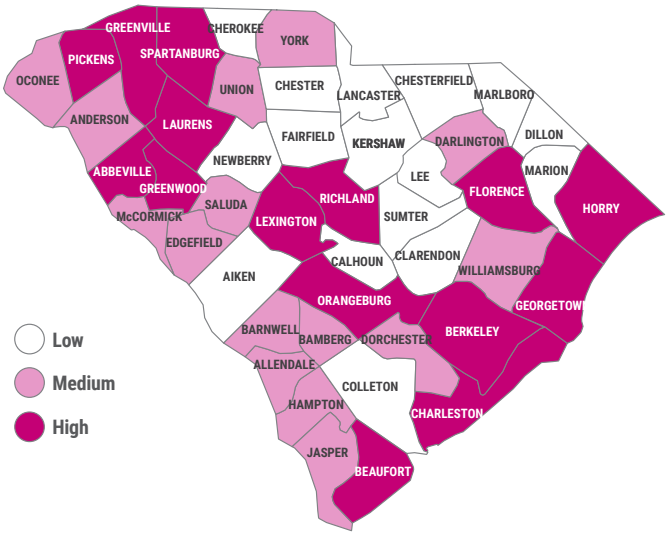

Figure 5. South Carolina MIECHV Program Enrollment Estimates by County, 2014-2018

To address this potential limitation and provide additional context to these data, a bivariate choropleth map was created that included these enrollment data and a proxy measure of client eligibility (Figure 6).[23,24] The total number of Medicaid births between 2014-2018 was used as a proxy measure of client eligibility—representing both potential volumes and high levels of need.[25] Overall, Figure 6 shows that the South Carolina MIECHV program has been successful in meeting one of its stated program targets in its 2010 needs assessment: providing home visiting services to clients that live in counties that have high target populations (depicted here as volume of Medicaid births).

Ten counties with "high client eligibility" also have relatively high numbers of clients served by MIECHV LIAs. Only five counties have high eligibility and either low or medium enrollment of clients supported by MIECHV LIAs.

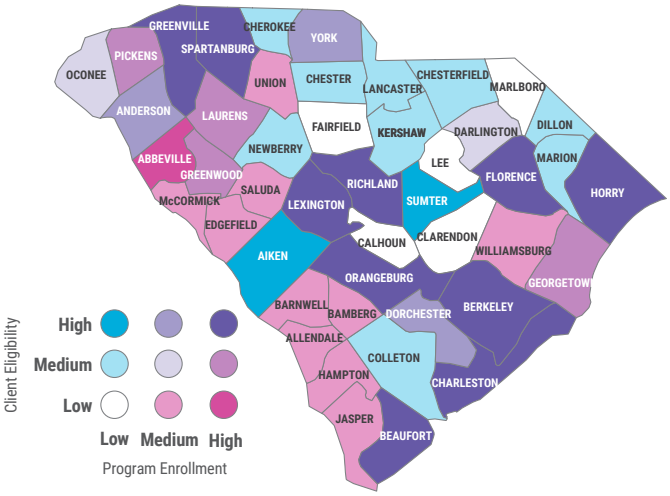

Figure 6. South Carolina MIECHV Program Enrollment and Client Eligibility Estimates by County, 2014-2018

In addition to the three models currently supported by the South Carolina MIECHV program, there are a variety of other options across the state for caregivers seeking home visiting services. South Carolina First Steps also provides Parents as Teachers through its network of local partnerships.[26] In 2020, First Steps announced that it would also begin providing funding for adoption of Home Instruction for Parents of Preschool Youngsters (HIPPY); a new model to the state that also meets HHS evidence-based criteria.[27] Four additional models currently have widespread adoption and buy-in in South Carolina: Early Head Start – Home-Based Option (meets HHS evidence-based criteria), Early Steps to School Success (a Save The Children program), Healthy Start, and ParentChild+ (formerly the Parent Child Home Program). These four models, together with the three South Carolina MIECHV program supported models, comprise South Carolina's seven main home visiting models and are thus the focus of determining existing quality and capacity for home visiting in South Carolina in this assessment.

There are other programs in South Carolina that include home visits as a part of their service delivery but are not defined as home visiting programs for the purpose of this assessment (i.e., home visits are few or infrequent and/or are supplemental to other services).[13]

Most programs listed here were identified through the home visiting stakeholder survey detailed further below. Two national programs, LENA Home and Healthy Steps (previously supported by South Carolina MIECHV), serve the following counties, respectively: Cherokee and Berkeley, Greenwood, and Laurens.[28,29] Two other national programs, Nurturing Parenting and Triple P, include home visiting in their services across multiple areas of South Carolina.[30,31,32] Statewide services that include home visits are also provided by (1) BabyNet, South Carolina's Individuals with Disabilities Education Act (IDEA) Part C program that targets infants and toddlers with developmental delays;[33] (2) South Carolina DHEC through Postpartum Newborn Home Visits and Neonatal Intensive Care Unit Pre-discharge Home Visits;[34] (3) South Carolina First Steps' Countdown to Kindergarten program;[35] and (4) Project Breathe Easy,[36] provided by Family Connection South Carolina for children with asthma. Finally, the central Midlands region of South Carolina is home to Prisma Health's Pediatric Ambulatory Care Management program and Spartanburg County benefits from a local doula model: BirthMatters.[37,38]

Home Visiting Models in South Carolina

To further examine existing quality and capacity for home visiting in South Carolina, the seven main home visiting models were studied individually to determine their overall reach in the state. Table 7 provides an overview of client enrollment by home visiting model for the most recently completed program year(s) for each as available. Data provided are the most reliable estimates available as of May 2020, considering blended funding from private and public sources for implementation where possible.

HEALTHY FAMILIES AMERICA (HFA): Through the MIECHV program, South Carolina currently supports five HFA LIAs covering 20 counties, all identified as at-risk (Figure B1). In FY2018, MIECHV LIAs using the HFA model served 121 clients.[39] At-risk families eligible for HFA are required to enroll either prenatally or within three months of a child's birth to receive services that continue until at least 3 years of age (and sometimes until age 5). The HFA model supports families through a focus on building nurturing relationships while seeking to achieve eight program outcomes: "(1) reduce child maltreatment; (2) improve parent-child interactions and children's social-emotional well-being; (3) increase school readiness; (4) promote child physical health and development; (5) promote positive parenting; (6) promote family self-sufficiency; (7) increase access to primary care medical services and community services; and (8) decrease child injuries and emergency department use."[40]

NURSE-FAMILY PARTNERSHIP (NFP): The NFP model is currently available in 34 South Carolina counties (Figure B2) and is supported by a variety of funding sources, including seven MIECHV supported sites in 21 counties.[41] One county served by NFP through other funding source(s) (Chesterfield) is not an at-risk county. In FY2018, MIECHV supported LIAs using the NFP model served 317 clients.[39] The total number of clients served through NFP in South Carolina is higher than this number; however, it is difficult to estimate a total unduplicated number served through NFP at the state or county levels due to the extensive blend of private and public funding sources used in implementation of this model. At-risk first-time mothers are eligible for NFP home visiting from their child's prenatal period through age 2. NFP's goals are to "(1) improve pregnancy outcomes by helping women engage in good preventive health practices; (2) improve child health and development by helping parents provide responsible and competent care; and (3) improve the economic self-sufficiency of the family by helping parents develop a vision for their own future."[41] Notably, NFP was chosen for the state's Pay for Success demonstration.[9]

PARENTS AS TEACHERS (PAT): PAT has the largest home visiting presence in South Carolina, serving clients in 35 counties total through the MIECHV program and South Carolina First Steps local partnerships (Figure B3).[42] Through the MIECHV program, South Carolina currently supports six PAT LIAs covering 24 counties, one of which (Chesterfield) was not identified as at-risk. In FY2018, MIECHV LIAs using the PAT model served 175 clients.[39] South Carolina First Steps local partnerships also currently provide the PAT model in 30 counties, one of which (Kershaw) was not identified as at-risk. In the most recently completed state fiscal year (South Carolina FY2019), First Steps local partnerships using the PAT model served approximately 1,280 caregiver clients.[43] Although some potential for duplicated counts between these funders exists, this potential is nearly eliminated due to different entities being funded to provide services at the local level. PAT provides home visiting for eligible at-risk families prenatally through kindergarten. The model's goals are to "(1) increase parent knowledge of early childhood development and improve parent practices; (2) provide early detection of developmental delays and health issues; (3) prevent child abuse and neglect; and (4) increase children's school readiness and success."[44]

EARLY HEAD START-HOME BASED OPTION (EHS-HBO): EHS-HBO services are provided through six designated Head Start Centers covering at least six South Carolina counties,[45] all identified as at-risk (Bamberg, Charleston, Lancaster, Richland, Spartanburg, and Union; refer to Figure B4). EHS-HBO served an estimated 229 children in

the state in 2017-2018.[45] EHS-HBO is administered by the Office of Head Start in the Administration for Children and Families. This model targets low-income families prenatally until the child reaches 3 years of age. Under the umbrella of Head Start programs, EHS-HBO strives to provide a comprehensive set of services that facilitate healthy child development and school readiness. The goals of EHS-HBO are to "(1) promote healthy prenatal outcomes for pregnant women, (2) enhance the development of very young children, and (3) promote healthy family functioning."[46] Also, at least 10% of the enrollment slots for Early Head Start must be made available to children who qualify for services under Part C of the Individuals with Disabilities Education Act (IDEA).[46]

EARLY STEPS TSCHOOL SUCCESS (ESSS): ESSS, a program of the national non-profit organization Save The Children, provides home visiting services in four South Carolina counties,[47] all identified as at-risk (Barnwell, Clarendon, Lee, and Orangeburg; refer to Figure B5). An estimated 340 children were served across the state in the most recent ESSS program year.[47] This program targets children 0-5 years of age for participation in home visiting, especially in rural and other under-resourced communities. The goal of ESSS is to foster early learning to ensure children are ready for school.[48]

HEALTHY START: Healthy Start is provided through three organizations in South Carolina, covering 14 counties total (Allendale, Bamberg, Barnwell, Chesterfield, Darlington, Dillon, Florence, Hampton, Marion, Marlboro, Orangeburg, Richland, Sumter, and Williamsburg)[49] (Figure B6). Chesterfield was not identified among the at-risk counties. In the most recent Healthy Start program year, 915 pregnant women were served/projected to be served by Healthy Start throughout the state.[49] Healthy Start is administered by the Maternal and Child Health Bureau at HRSA. Program participants are identified and provided home visiting services during pre-conception, inter-conception, and post-conception time periods. The program's goals are to "reduce differences in access to, and use of health services; improve the quality of the local health care system; empower women and their families; and increase consumer and community participation in health care decisions."[50]

PARENTCHILD+: The ParentChild+ home visiting model is provided in South Carolina through nine different organizations serving seven counties, all identified as at-risk (Dorchester, Florence, Georgetown, Horry, Lancaster, Richland, and Williamsburg)[51] (Figure B7). In 2019, 514 families were served by ParentChild+ in the state.[51] Local implementation of the model is supported by the non-profit ParentChild+ National Center; the program's focus is families who are low income, have limited education, are geographically isolated, are teen and/or single-parents, have immigrant or refugee status, and/or have literacy/language barriers. The model supports parent-child attachment between ages 2-3. The objectives of ParentChild+ are to "promote children's social-emotional development and cognitive competencies… [and] to connect families to other educational and social service resources in the community, as needed."[52]

Table 7. Current Home Visiting Model Enrollment by County

County	Healthy Families America - MIECHV 10/1/18 - 9/30/19	Nurse-Family Partnership - MIECHV 10/1/18- 9/30/19	Parents as Teachers - MIECHV 10/1/18- 9/30/19	Parents as Teachers - First Steps 7/1/18- 6/30/19	Early Head Start - Home- Based Option 2017-2018	Early Steps to School Success as of 5/27/20	Healthy Start 5/1/19- 4/30/20	Parent- Child Home+ 1/1/19- 12/31/19	Totals
ABBEVILLE	0	7	2	0	0	0	0	0	9
AIKEN	0	0	0	20	0	0	0	0	20
ALLENDALE	2	0	0	31	0	0	15	0	46
ANDERSON	4	1	1	0	0	0	0	0	2
BAMBERG	1	0	0	28	13	0	27	0	68
BARNWELL	22	0	0	0	0	80	20	0	100
BEAUFORT	0	0	5	29	0	0	0	0	34
BERKELEY	14	11	0	95	0	0	0	0	106
CALHOUN	0	0	0	45	0	0	0	0	45
CHARLESTON	25	14	0	71	24	0	0	0	109
CHEROKEE	0	1	0	0	0	0	0	0	1
CHESTER	0	1	1	39	0	0	0	0	41
CHESTERFIELD	0	0	0	0	0	0	35	0	35
CLARENDON	0	5	0	43	0	40	0	0	88
COLLETON	0	0	1	37	0	0	0	0	38
DARLINGTON	0	6	0	18	0	0	54	0	78
DILLON	0	0	0	63	0	0	26	0	89
DORCHESTER	1	7	0	21	0	0	0	20	48
EDGEFIELD	0	7	0	0	0	0	0	0	7
FAIRFIELD	0	0	2	33	0	0	0	0	35
FLORENCE	0	18	0	16	0	0	119	91	244
GEORGETOWN	15	0	0	12	0	0	0	78	90
GREENVILLE	8	85	21	0	0	0	0	0	106
GREENWOOD	16	25	14	0	0	0	0	0	39
HAMPTON	0	0	0	15	0	0	40	0	55
HORRY	0	0	27	60	0	0	0	182	269
JASPER	0	0	4	27	0	0	0	0	31

Table 7 Continued. Current Home Visiting Model Enrollment by County

County	Healthy Families America - MIECHV 10/1/18 - 9/30/19	Nurse-Family Partnership - MIECHV 10/1/18- 9/30/19	Parents as Teachers - MIECHV 10/1/18- 9/30/19	Parents as Teachers - First Steps 7/1/18- 6/30/19	Early Head Start - Home- Based Option 2017-2018	Early Steps to School Success as of 5/27/20	Healthy Start 5/1/19- 4/30/20	Parent- Child Home+ 1/1/19- 12/31/19	Totals
KERSHAW	0	0	2	29	0	0	0	0	31
LANCASTER	0	3	3	0	16	0	0	82	104
LAURENS	0	14	17	19	0	0	0	0	50
LEE	0	0	0	0	0	60	0	0	60
LEXINGTON	0	0	8	134	0	0	0	0	142
MCCORMICK	0	1	1	18	0	0	0	0	20
MARION	0	0	0	0	0	0	25	0	25
MARLBORO	0	0	0	27	0	0	18	0	45
NEWBERRY	0	0	0	23	0	0	0	0	23
OCONEE	5	1	0	0	0	0	0	0	1
ORANGEBURG	0	23	0	0	0	160	213	0	396
PICKENS	4	9	0	35	0	0	0	0	44
RICHLAND	0	0	42	109	56	0	247	19	473
SALUDA	0	3	1	0	0	0	0	0	4
SPARTANBURG	0	23	0	0	112	0	0	0	135
SUMTER	0	20	0	62	0	0	53	0	135
UNION	0	12	0	65	8	0	0	0	85
WILLIAMSBURG	4	0	0	0	0	0	23	42	65
YORK	0	20	23	56	0	0	0	0	99
TOTALS	**121**	**317**	**175**	**1280**	**229**	**340**	**915**	**514**	**3770**

Overall, based on examination of these seven models' reach, every county in South Carolina is served by at least one home visiting model. Furthermore, every county is served by at least one evidence-based home visiting model eligible for MIECHV program funding. Eight counties are not served by the South Carolina MIECHV program (seven of which are considered at-risk by this assessment). ***Despite this comprehensive geographic coverage, there is wide variation in the number of clients served by county in the most recent program year(s), ranging from 1 to 473*** (Table 7). Some of this variation may be due to inconsistencies in reporting, but it may also be the result of gaps in service delivery. ***To determine whether home visiting services are reaching the number of families in need in each county, data provided by HRSA was used to define need (Table 5).*** The number of clients served in identified at-risk counties in the most recent program year(s) was calculated as a proportion of the number of estimated families in need by county. ***These proportions also showed a wide range for the percent of families in need that were served by home visiting services*** (0.15-80.7%; data not shown).

To add context to these findings, a statewide home visiting stakeholder survey was administered in conjunction with an analysis of previously conducted family interviews. The purpose of these activities was to (1) assess the quality and capacity of home visiting services in the state, including gaps in home visiting and the extent to which programs are meeting family needs, and (2) understand community readiness among at-risk counties. A description of the methodology for these activities follows.

STAKEHOLDER SURVEY: An online survey was conducted among early childhood home visiting program representatives and partners from July 9-August 10, 2020 (see Appendix C). Purposive sampling was used to invite state leaders, county level partners, home visiting program administrators, and home visitors to complete the survey via email. Additionally, a snowball sampling technique was used; contacts receiving the survey were asked to disseminate it to other informants in their organization or professional network to increase the number and diversity of respondents. A total of 87 people were invited to complete the survey and after snowball sampling, 103 people responded. Basic descriptive statistics were calculated for survey responses by question. Open-ended questions were analyzed using an inductive approach to identify key themes. Survey limitations include response burden potentially leading to selection bias, as there were over 100 responses for the first two demographics questions, just over 90 for the fourth question, and about 70 for the remaining questions in the survey.

All 46 South Carolina counties were represented by individual survey responses, including the 44 at-risk counties. However, results here are not reported by county indicated to protect the privacy of survey respondents—the sample size of responses by county ranged from 1-12. Of 103 survey participants, a quarter (25%) identified that the organization they work in serves the whole state. Most participants were home visiting program administrators, managers, or supervisors (Table 8). Most (74%) said their organization directly implements home visiting, some (21%) said their organization supports home visiting, and a few (5%) said their organization does not directly implement or support home visiting.

Table 8. Stakeholder Survey Participants' Points of View

Point of View	Frequency	Percentage
Home visiting program administrator/manager/supervisor	40	38.83%
State agency or organization	27	26.21%
Home visitor	19	18.45%
Local nonprofit or advocacy organization	9	8.74%
Public health professional	2	1.94%
Social or other support service provider (social worker, community health worker, etc.)	2	1.94%
Other	2	1.94%
K-12 educator or other school staff	1	1%
Home visiting participant	1	1%

When asked which home visiting program model(s) their organization implements, respondents identified Parents as Teachers the most followed by Nurse-Family Partnership (Table 9). Participants identified with a race/ethnicity group as follows: 59% white, 29% Black/African American, 11% Hispanic or Latino, and 1% Asian. Respondents who identified themselves as home visitors were much more likely to also identify as Black/African American or Hispanic.

Table 9. Stakeholder Survey Participants' Home Visiting Model Representation

Model	Frequency
Parents as Teachers	28
Nurse-Family Partnership	18
Other*	9
Healthy Families America	7
Parent-Child+	3
Early Head State (Home-Based)	3
Healthy Start	2
Early Steps to School Success	1

**Other responses included Birth Matters, Childcare Scholarship, Early Intervention, IDEA Part C, LENA Home, Newborn Health Screenings, Nurturing Parenting, Project Breathe Easy, and Triple P.*

FAMILY INTERVIEWS: Secondary data analysis of prior interviews and focus groups with families was used to understand family perspectives toward home visiting. Data from multiple sources was used:

- A series of in-depth interviews (n=26) conducted with families served by home visiting programs for a South Carolina MIECHV program FY2017 grantee-led evaluation.
- Two focus groups (n=18) conducted in 2019 to understand family perspectives on financial health gathered for the South Carolina DHEC Collaborative Improvement and Innovation Network (CoIIN) project on reducing infant mortality.
- Four focus groups conducted from 2019-2020 that were a part of South Carolina DHEC's Title V MCH needs assessment. Participants included:
    1. Clients of a local diaper bank to understand their perspectives on health (n=4)
    2. Participants in a local fatherhood program (n=8)
    3. Parents of children and youth with special health care needs (n=9)
    4. Latino women to understand their perceptions and experiences utilizing health, social and/or other types of services, feelings of discrimination, and their programmatic needs (n=7)
- A series of in-depth interviews (n=8) that were conducted in 2019 with current and former clients of South Carolina First Steps as part of the organization's five-year evaluation.

An inductive approach was used to analyze all data, wherein emergent themes were identified.

Gaps in Delivery of Early Childhood Home Visiting Programs

Combining the results of the stakeholder survey and analysis of family interviews, three categories were identified that described potential gaps in delivery of home visiting programs in South Carolina.

1. Barriers Expectant or New Parents Experience When Accessing Home Visiting Services

Survey participants indicated that the most significant barriers parents experience when accessing home visiting services were ***(1) being unsure about having a home visitor come into their home, (2) lack of awareness of home visiting services, (3) competing family priorities, (4) lack of availability of services, and (5) lack of culturally competent care*** (Table 10). Additional barriers mentioned by participants included parents equating home visiting to Child Protective Services reporting or negative past experiences, a lack of providers, and recent changes due to the COVID-19 pandemic.

Table 10. Stakeholder Survey Participants' Rating of Most Significant Barriers Expectant or New Parents Experience When Accessing Home Visiting Services

Most Significant Barriers Expectant or New Parents Experience When Accessing Home Visiting Services	Mean Score*
Unsure about having a home visitor come into their home	3.1
Lack of awareness of home visiting services	4
Competing family priorities (e.g. work, school, etc.)	4.6
Lack of availability of services	5.7
Lack of culturally competent care (including services in a language other than English)	6.6
Geographic isolation/living in a rural area	6.7
Stigma of using home visiting services	7.2
Unstable housing/families move frequently	7.3
Resistance to accept help	7.5
Mental health or substance abuse issues in family	8.5
Families do not meet criteria to receive services	8.5
Inconvenient hours of service	8.6

**Lower number is worse (most significant).*

2. Barriers Home Visiting Programs Face in Addressing Service Gaps and Providing Services

Participants perceived that the most significant barriers home visiting programs face in providing services were ***(1) finding referral partners, (2) family engagement, (3) reaching families in rural areas, (4) lack of family awareness of home visiting services, and (5) identifying effective programs or services*** (Table 11). Additional barriers mentioned by survey participants included logistical issues such as limited flexibility with scheduling due to families returning to work or school and recent changes from the COVID-19 pandemic. Many survey participants also discussed how the number of qualifying families outnumber their funding capacities, noting that their home visiting programs do not have the resources, funds, or capacity to deliver services to all families in need.

Table 11. Stakeholder Survey Participants' Rating of Most Significant Barriers Home Visiting Programs Face in Addressing Service Gaps or in Providing Services

Most Significant Barriers Home Visiting Programs Face in Addressing Service Gaps or Providing Services	Mean Score*
Finding referral partners	3.8
Family engagement	4.5
Reaching families in rural areas	4.6
Lack of family awareness of home visiting services	4.9
Identifying effective programs or services	5.2
Securing sustainable funding	5.6
Reporting requirements of funding sources	6.2
Workforce development and retention	6.8
Providing services to meet a variety of cultural and language needs	7
Stigma of using home visiting services	7

**Lower number is worse (most significant).*

Half of survey respondents perceived that the need for home visiting services exceeds their home visiting program's capacity (50%). However, many said their program does not have a waiting list (47%). This indicates potential issues around knowledge and awareness of home visiting services, as well as finding and reaching all families in need. Survey respondents agreed that finding families and overall knowledge of home visiting services were barriers. Many noted that referral systems to home visiting services are inefficient, often have the wrong contact information, or only target a certain population rather than all families that could benefit from home visiting. A couple of participants mentioned that eligibility for home visiting services is also limited. For example, one participant wrote, ***"There is a perception that there are 'a lot' of home visiting programs in our geographic service areas; however, with home visiting programs requiring prenatal enrollment or enrollment shortly after birth, there are few to no home visiting resources available for many families who would benefit from home visiting after children are 1 month old. Home visiting models are increasingly restrictive in who qualifies for home visiting services."*** Another barrier that home visiting programs faced was lack of buy-in from families. Often families may refuse participation because of stigma around accepting services, their own family priorities, lack of trust, cultural barriers, or being reluctant to have someone come into their homes. Additionally, survey participants perceived rural families as being harder to reach for home visiting programs.

Although home visiting programs face many barriers, survey participants suggested ways to improve efforts to reach families that have great needs. Suggestions included:

- Allocating more funds for home visiting programs
- Promotion and education of home visiting services to families in the community
- Hiring qualified staff who represent minority populations and/or are bilingual
- Adapting services to include options for virtual visits
- Providing universal home visiting and care coordination
- Using community health workers as a liaison between programs and the community
- Creating a single statewide referral system

3. Equity in Home Visiting Services

Disparities in access to services based on individual experiences of race and/or poverty are a reality for some South Carolinians. In this survey, most participants indicated that the home visiting programs in their community were somewhat (58%) or very successful (25%) in reaching all families in need (including geographically isolated, racial/ethnic minority groups, and other marginalized populations). Respondents who answered that home visiting programs were not successful (16%) in reaching all families in need noted barriers previously mentioned. ***Importantly, most survey respondents felt that the home visiting program staff in their community were somewhat (44%) or very (39%) representative of the populations that live in their community that are in need.***

Extent to Which Home Visiting Services Meet Current Needs

Combining the results of the stakeholder survey and analysis of family interviews, five categories were identified that described the extent to which home visiting meets current needs of families in the state.

1. Home Visiting Programs Offer Families with Valuable Support

Over 75% of survey participants said home visiting programs were very effective in helping families. Participants also perceived that their home visiting programs have many strengths. One was the ability to reach families in isolated and rural areas. Home visiting removed the barrier of transportation by seeing families in their own homes. Additionally, participants noted that the home visiting workforce is committed to their jobs, have built relationships and trust among families they serve, and is well-trained and compassionate. One participant shared, ***"They [home visitors] become an extension of the family and their effectiveness expands beyond their regimented tasks."*** Additionally, survey respondents felt that home visiting work itself and the impact it has on families is a big strength. One participant said, ***"Some of the biggest strengths of the home visiting programs for families in our community is building resilience in families! Supporting families through service efforts that build and focuses on growing the family as a whole. Guiding families through uncertainties and give tools necessary to bounce back and strengthen families."*** Another participant noted, ***"We are helping our children and their parents get ready to attend school."***

2. **Families Emphasized the Support that Home Visiting Programs Offered New Parents**

When asking families why they chose to participate in home visiting programs, most talked about their need for support as new parents. One mother shared, ***"It was my first baby. I thought I needed the help – as much help as I possibly could get so that's what led me to enroll."*** Another parent said, ***"I really liked the idea of having someone to talk to who was professional and knowledgeable. I just thought it'd be a nice resource to take advantage of."*** Some families also discussed the value of having a home visitor as a ***"direct link to the doctor's office."*** One parent explained, ***"Being a first-time mom, there are so many things that can come up and you don't know, 'Should I bring them in for this, or is this normal,' so it's nice to have someone reassure you or help you find other resources that can help."***

3. **Value of Home Visiting Services for Families**

Several sub-themes describe the value of home visiting services to South Carolina families:

- **VALUABLE INFORMATION ABOUT GROWTH AND DEVELOPMENT:** Some families talked about the value of their home visitor explaining normal growth and development and providing ***"information that's relevant for [my child's] age and stage of development at that time."*** An interview participant shared, ***"There are certain things that I don't even know…like what milestones to look out for."*** Some families also discussed the activities (e.g., playing with objects of different textures, "tummy" time, describing objects to increase vocabulary, etc.) that their home visitor recommended to help their child with developmental milestones.

- **EMPOWERING PARENTS WITH SKILLS TO BE BETTER CAREGIVERS:** Most participants said that they are better parents because of the advice and skills that their home visitor has taught them. A parent said, ***"One of the biggest things that [home visitor] has taught me is parenting skills…like how to be a mother in a correct way…anybody can say they're a mother and don't have the correct parenting skills."*** Families felt that their home visitor provided valuable parenting advice on many topics, including feeding, sleeping, establishing a schedule, discipline, soothing techniques, and safety. Parents also expressed that their confidence as a parent increased because of their home visiting services.

- **CREATING A SAFE HOME ENVIRONMENT:** Many parents were grateful that their home visitor was focused on safety—particularly related to sleeping, choking hazards, and other potential dangers in the home. A mother shared, ***"My one-year old, he is all boy, and so I'm nervous about him hurting himself around the house… so [home visitior] is really concerned about his safety and I like that a lot."*** Several parents talked about how their home visitor helped them create ***"a safe play space"*** for their child with ***"age appropriate toys"*** by making minor changes to furniture arrangements. Some mothers explained that their home visitor had walked their house to identify potential safety concerns, and then followed-up by providing and installing protective products (e.g., safety latches, outlet plugs, safety gates, etc.) throughout the home. In addition to protective products, several parents said that their home visitor had provided a pack-n-play as a resource to discourage co-sleeping. Home visitors also provided guidance for household repair issues that can impact a family's health (e.g., mold, leaky roofs, etc.).

- **STRENGTHENING FAMILIES BY PROVIDING SUPPORT FOR MOTHERS:** Most of the mothers felt that one of the benefits of the program was that their home visitor provided personal support for their well-being, mental health, and other needs. One mother explained, ***"The most important part of the program is just the home visitor being there for the parent… somebody that's there for you."*** Some mothers shared that their home visitor helped with their mental health issues. As an example, one mother disclosed, ***"When I was going through postpartum depression, [home visitor] helped me get a therapist, and basically that helped me out with my depression."*** Another mother said, ***"I guess [home visitor] is like a second mom to me. She's just helped me get through a lot…some of it's kind of personal."*** Parents said that their home visitor ***"goes out of her way to help."*** For example, home visitors were often readily available via cell phone and assisted with appointment reminders.

- **PROVIDING NECESSARY RESOURCES AND LAYING THE GROUNDWORK FOR EARLY LITERACY:** Families appreciated the resources (e.g., diapers, wipes, formula, pacifiers, bottles, car seats, age-appropriate toys, books, safety products, etc.) that their home visitor provided.

In most cases, parents said that their home visitor brings a book each visit and emphasizes the importance of reading to their child. Parents also discussed that their home visitor taught them new educational games and age-specific activities. Parents reported that if they had not had a home visitor, their child would not be as prepared for school. Parents explained that the home visitors helped them register their child for school, get in the habit of doing homework with their child, and helped the child with activities that involve a lot of sensory. Parents said home visitors helped with learning letters and words, recognizing numbers and colors, counting to 10, reading, following directions, and communication skills.

- **CONVENIENCE:** Most families liked the fact that visits take place in the home. Parents appreciated the convenience for many reasons, including transportation issues, the hassle of traveling with children, work schedules, and the comfort and value of being in your own environment (e.g., direct observation of the child in their home).

- **POSITIVE IMPACT ON THE WHOLE FAMILY**: Most interview participants stated that their home visitor had a positive impact on their whole family. Many parents shared that their home visitor had developed a strong relationship with their older children and often included siblings in activities. Although mothers were often the participants in visits, home visitors also tried to engage other adult family members (e.g., dads, spouses, grandmothers, etc.) in the parenting information, activities, and skills. Some mothers said that their home visitor also provided information that was helpful to their relationship with their spouse/partner. As an example, a mother said, ***"[Home visitor] has good advice not only for the child, but as far as relationships for me and [spouse], too…how we should talk in front of the kids and what we should or should not talk about in front of the kids."*** Several interview participants also mentioned that their home visitor offered suggestions about family activities (e.g., a visit to the local library) and other resources in the community. Moreover, parents receiving home visiting services discussed how everyone in their family can participate in the activities and games they have learned with their home visitor. Parents reported that this has brought their families closer together and engaged not only both parents but also the family's older children.

4. Families Reported Positive Feedback About Home Visiting

Two sub-themes describe the positive feedback received about home visiting services in the state:

- **FAMILIES WERE VERY SATISFIED WITH THE HOME VISITING SERVICES:** Families were exceedingly positive about their experiences receiving home visiting services. One participant shared, ***"[The home visiting program] has exceeded my expectations."*** Another participant said, ***"I love the program…it's very, very helpful."*** When asked to explain why they were satisfied with the services, parents frequently talked about the relationship with their home visitor. Families often described their home visitor as ***"helpful," "a great resource,"*** and ***"friendly."*** Families also appreciated the home visit's structure, consistency, and ability to be tailored to meet needs. One parent shared, ***"It's like [the home visitor] goes above and beyond, they help you in any kind of way they can."*** Parents said that their children loved when the home visitor would come to the house and that the home visitor was always supportive of the whole family. Parents reported they would highly recommend and encourage anyone they knew to participate in home visiting services.

- **HOME VISITORS: LIKE A CLOSE FRIEND OR FAMILY MEMBER:** Most families described a strong, positive relationship with their home visitor like that of a close friend or family member. A participant shared her experience, "I don't have a lot of friends but [home visitor] is my best friend…she actually comes and talks to me…she listens…she helps me…she's encouraging…she's like a mentor to me." It was evident that families valued these strong and trusting relationships, and that home visitors were support systems for families.

5. Families Face Many Challenges and Have Continued Needs

Despite the ability of home visitors to satisfy many of their families' needs, there are still challenges families face that home visiting programs are not designed to address. The services and resources that were reported to be the hardest for families to access included ***(1) transportation, (2) basic needs (including material goods such as diapers, food, and safe housing), (3) child care, and (4) health care (including pre-natal and post-partum care*** (Table 12). These also align with some of the major unmet needs survey respondents indicated: ***(1) transportation, (2) childcare, (3) mental health services, (4) job needs, and (5) other basic needs.***

Of these, respondents indicated that there was low community capacity to address transportation, child care, mental health services, and job needs (Table 13). Identifying counties as rural or urban and then comparing responses by geography revealed potential disparities. More items overall were identified as "major problems" by respondents from rural counties compared to urban. For example, parenting support was identified as a major problem by respondents from rural counties but not by those in urban areas. Rural participants were also unique in identifying health care as a major problem. Respondents from rural counties also indicated that competing family priorities were a significant barrier to accessing home visiting. Other needs that survey participants mentioned were pro bono work, school support, housing, access to reproductive health services (i.e., sexually transmitted infection testing, contraception, etc.), dental care, services for families with deaf/hard of hearing children, and physical therapy.

Table 12. Stakeholder Survey Participants' Rating of the Kinds of Services and Resources That Are Hardest for Families to Access

Hardest Services for Families to Access	Mean Score*
Transportation	4.5
Basic needs (including material goods such as diapers, food, and safe housing)	5.2
Child care	5.7
Health care (including pre-natal and post-partum care)	6
Parenting support and information	6.4
Coordination and/or navigation to services	6.4
Job needs	6.4
Mental health services	6.4
Information about the resources and services	6.7
Services in languages other than English	8
Services for children and youth with special health care needs	9.3
Substance abuse services	9.9
Help with domestic violence	10.1

**Lower number is worse (most significant).*

Table 13. Stakeholder Survey Participants' Rating of Families' Unmet Needs and Their Communities' Abilities to Address Them

	Rating of Families' Unmet Need				*Communities' Level of Capacity to Address the Need*			
NEED	*Major Problem*	*Moderate Problem*	*Somewhat a Problem*	*Not a Problem*	Very Low	Low	Some	Adequate
Transportation	57	22	12	2	31	10	7	0
Child care	49	26	16	3	11	15	10	1
Mental health services	38	34	17	5	15	11	4	2
Job needs	38	30	23	1	6	19	6	1
Basic needs (including material goods such as diapers, food, and safe housing)	33	32	21	5	5	10	10	1
Services for children and youth with special health care needs	29	26	25	11	12	5	6	0
Coordination and/or navigation to services	25	34	29	5	3	7	5	3
Substance abuse services	22	28	29	13	8	8	2	2
Help with domestic violence	21	21	39	10	5	7	6	1
Services in languages other than English	20	42	17	11	7	6	2	1
Health care (including pre-natal and post-partum care)	19	23	29	21	1	7	6	0
Information about resources and services	18	38	26	12	3	3	5	3
Parenting support and information	13	35	24	21	3	2	4	0

The most significant barriers that expectant or new parents experienced when accessing community resources and services (such as the WIC program, mental health services, early intervention, etc.) were ***(1) lack of transportation, (2) lack of availability of services, (3) lack of awareness of available services, and (4) competing family priorities*** (Table 14). Additional barriers that survey participants mentioned were staff shortages, lack of providers to deliver the service, mistrust of service providers, and a low number of pediatric audiologists.

Table 14. Stakeholder Survey Participants' Rating of Barriers That Expectant or New Parents Experience When Accessing Community Resources and Services

Most Significant Barriers	Mean Score*
Lack of transportation	3.2
Lack of availability of services	3.7
Lack of awareness of available services	4.6
Competing family priorities & priorities (e.g. work, school, etc.)	4.9
Lack of childcare	5.8
Geographic isolation/living in a rural area	5.9
Lack of culturally competent care (including services in a language other than English)	6.2
Cost or perceived financial cost	7.3
Inconvenient hours of service	7.9
Stigma for using social services	8.2
Resistance to accept help	8.9

**Lower number is worse (most significant).*

When asked what else prevents families from accessing the services available in the community, participants described many of the barriers that families face:

- **ACCESS TO CARE, INCLUDING TRANSPORTATION AND ELIGIBILITY:** Families often must navigate complex and confusing systems when trying to access services. Families can be ineligible to receive services due to custody or citizenship issues. Families in rural areas have a hard time accessing transportation, and often providers will not work in rural areas.
- **LIMITED PROGRAM CAPACITY:** The need for home visiting services exceeds program funding and capacity. Limited services, long wait lists, and lack of care coordination in a timely manner prevent families from accessing the services and resources they need.
- **LACK OF AWARENESS:** There remains a lack of awareness and promotion of home visiting services among families in the community and policy makers.
- **LACK OF KNOWLEDGE ABOUT SERVICES:** Low education and literacy levels may prevent some families from understanding the information that is available to them. Additionally, many families do not know what they need or are unwilling to accept assistance.
- **HOUSING INSTABILITY:** Families in need often face housing instability and are transient.
- **LACK OF JOBS:** Availability of well-paying jobs is limited.
- **RACISM, IMMIGRATION, AND TRUST:** There remains a fear of accessing services due to immigration status and fear of being deported. Additionally, there is a lack of compassion and respect shown when families are accessing or using services. Participants also described a lack of trust of federal or state and local agencies because of the recent political climate.

Findings from interview data about the needs and challenges families face mirrored findings from the stakeholder survey.

Gaps in Staffing, Community Resources, and Other Requirements for Delivering Evidence-Based Home Visiting

Combining the results of the stakeholder survey and analysis of family interviews, the readiness of communities to deliver home visiting programs in South Carolina was established. Overall, survey participants perceived that their communities have low levels of infrastructure and leadership prioritization, but high levels of buy-in for implementation of home visiting programs (Figure 7). The gap between level of community buy-in for providing home visiting services and level of community infrastructure to provide such services was much larger for participants from rural counties. Participants who were home visitors also rated the level of infrastructure to support home visiting services below 5 (on a scale of 1-10) as compared to all other respondents who were not home visitors.

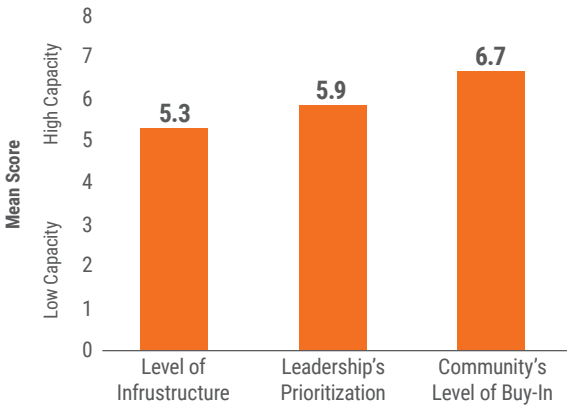

Figure 7. Stakeholder Survey Participant Perspectives on Community Readiness and Capacity to Implement Home Visiting

Most participants noted that their local home visiting program's existing partners and referral sources were somewhat (57%) or very (25%) sufficient for meeting the needs of families in the community. However, many participants suggested resources (including those beyond funding) that would be needed for expansion of home visiting programs in their community, including:

- **LOCAL CARE COORDINATION:** Having available access or referrals to home visiting services from any organization or having a ***"no wrong door"*** policy would help families get what they need. One participant suggested, ***"More collaborative partnerships and referring between similar agencies or agencies serving the same populations."***
- **EFFORTS TO INCREASE RECOGNITION AND AWARENESS OF HOME VISITING:** One participant suggested, ***"Buy-in from the community at large; universal services (so as to avoid negative stigma associated with using the programs); better partnerships for referrals; incentives for parents to participate in programs (some will not participate unless they get something tangible even when they really need the program)."***
- **WORKFORCE REDEVELOPMENT AND SUPPORT, INCLUDING SALARIES:** Programs benefit from a robust and qualified workforce, increasing salaries, and accessing affordable trainings.
- **A RANGE OF MODELS TO MEET THE DIVERSE NEEDS OF FAMILIES:** Having more options available to families, including different home visiting models, may help. One participant suggested, ***"More program variety. There aren't many programs available for 3-5 age group."***
- **MORE TRANSPORTATION OPTIONS:** Transportation remains a barrier. One participant suggested, ***"Having public transportation go past 6 p.m."***
- **VIRTUAL HOME VISITATION OPTIONS:** Participants suggested providing tablets or computers to families.
- **INCREASED FUNDING FOR HOME VISITING:** Having more funding will help increase program capacity.

Despite these challenges in community readiness to expand home visiting services, ***the state has at least one evidence-based home visiting model active in each of its 46 counties. Since 2010, the number of sites overall implementing an evidence-based home visiting model in South Carolina has increased by 65%. Demonstrated improvements in maternal and child outcomes have been achieved by South Carolina MIECHV participating sites since the program's inception.*** The challenges presented here reflect the need for additional resources, including funding and capacity building support, to expand upon the services in place to increase overall access to home visiting. The South Carolina Home Visiting Consortium (HVC), described in Section 5, is the primary statewide body that works to strategically inform such developments. In 2020, the HVC updated its strategic plan to include newly crafted mission, vision, and values statements. ***The strategic mission of the HVC is "to coordinate, strengthen, and advocate for home visiting initiatives that support all caregivers and children in South Carolina."***

Optional Considerations: Changes Due to Recent Events

Finally, survey participants shared ways that recent current events (including the COVID-19 pandemic and protests calling for racial justice) have impacted their local community's ability to engage families in home visiting services. Many survey participants shared that throughout the COVID-19 pandemic, home visiting services have continued virtually. Additionally, some participants indicated that their home visiting program was still providing supplies and materials by visiting the homes without going inside. One participant explained, ***"We leave the supplies in a designated place outside the home, and then call the parent to come outside. We are still able to talk with the parent during the visit by using social distancing guidelines."*** Participants shared that the pandemic has impacted recruitment, engagement, and retention of families. One participant said, ***"Many families in rural areas have spotty internet connections and telephone services. A few families do not like online or via phone; they prefer in person. However, most of our families have adapted well to the change and are now very comfortable with the new norm."*** Another participant said, ***"family engagement has improved and families have really missed their home visits or are more interested in virtual visits. However, it depends on the program population and the relationship with individual home visitors."***

Participants also noted the challenges that the pandemic has created, including family engagement and relationship building. Another participant described that some programs have had to cut back on staff: ***"Centers had to downsize so some staff were left without jobs. Owners of the centers don't have the funds to pay staff or to expand and update their buildings."*** Additionally, they perceived stress among families and lack of time to participate. One participant said, ***"With COVID-19 and school being closed, some parents are overwhelmed with multiple children, assisting older children with school work and taking care of household. Sometimes parents report that there's just not enough time."***

Most participants did not comment on how recent racial issues impacted home visiting in their local area. However, one participant noted that they have observed an increase in cultural sensitivity. Another participant explained some benefits in the context of the current social environment: ***"Current racial events have brought an awareness to our program, community and how we address and administer services to our families. These recent issues have helped in identifying opportunities to educate and build social connections with families."*** Another participant explained how they try to mitigate racial issues among families: ***"Local programs try to match home visitors culturally to their clients, and sometimes this means racially too, even if it's not an explicit policy. I think this might be another symptom of how our society segregates and has profound trust issues due to racism."***

Capacity for Providing Substance Use Disorder Treatment and Counseling Services

For the purpose of this needs assessment, HRSA adopted the U.S. Surgeon General's definition for substance use treatment services: "A service or set of services that may include medication, counseling, and other supportive services designed to enable an individual to reduce or eliminate alcohol and/or other drug use, address associated physical or mental health problems, and restore the patient to maximum functional ability."[53] In South Carolina, the range of treatment and counseling services available for pregnant women and families of young children differs based on whether an individual's treatment needs require inpatient or outpatient care.

Range of Treatment and Counseling Services – Inpatient Settings

In 2020, there were 14 South Carolina DHEC licensed inpatient treatment programs for Psychoactive Substance Abuse or Dependence with a total of 297 beds across the state.[54,55] Of these, seven programs—all of which were administered by county or state authorities— reported serving adult and/or pregnant/postpartum women.[56] These programs were in six counties: Charleston, Florence, Greenville, Horry, Sumter, and York. In addition, three private facilities, licensed by South Carolina DHEC as specialized hospitals for a total of 54 substance use disorder treatment beds, also reported serving adult and/or pregnant/postpartum women.[56,57] These facilities were in Charleston, Greenville, and Lexington counties. Table 15 provides a list of all inpatient substance use disorder treatment programs/facilities in the state and their respective licensed bed capacities.

Table 15. Inpatient Substance Use Disorder Treatment Providers in South Carolina, 2020

County	Facility Name	Funding	Residential Treatment Program Beds	Medical Detoxification Beds	Social Detoxification Beds	Specialty Hospital Substance Abuse Beds	Explicitly Serves Pregnant and/ or Adult Women
AIKEN	Aiken Regional Medical Centers	Private	0	0	0	18	No
BEAUFORT	Sunspire Health Hilton Head	Private	38	0	12	0	No
CHARLESTON	Charleston Center New Life Unit	Public	16	0	0	0	Yes
	Charleston Center Subacute Detoxification Program	Public	0	16	0	0	No
	Charleston Center Transitional Care Unit	Public	12	0	0	0	No
	Medical University of South Carolina (MUSC)	Public	0	0	0	23	No
	Palmetto Lowcountry Behavioral Health	Private	0	0	0	16	Yes
FLORENCE	Chrysalis Center	Public	16	0	0	0	Yes
	MUSC Health Florence Rehabilitation Center	Public	0	0	0	12	No
	Palmetto Center	Public	60	0	0	0	Yes
GREENVILLE	Carolina Center for Behavioral Health	Private	0	0	0	21	Yes
	Phoenix Center Detoxification Services	Public	0	10	0	0	No
	Serenity Place	Public	16	0	0	0	Yes
	Springbrook Behavioral Health System	Private	0	0	0	6	No
	White Horse Academy	Public	16	0	0	0	No

Table 15 Continued. Inpatient Substance Use Disorder Treatment Providers in South Carolina, 2020

County	Facility Name	Funding	Residential Treatment Program Beds	Medical Detoxification Beds	Social Detoxification Beds	Specialty Hospital Substance Abuse Beds	Explicitly Serves Pregnant and/ or Adult Women
HORRY	Lighthouse Behavioral Health Hospital	Private	0	0	0	29	No
	Shoreline Behavioral Health Services	Public	10	0	0	0	Yes
LANCASTER	Rebound Behavioral Health	Private	0	0	0	18	No
LEXINGTON	Three Rivers Behavioral Health	Private	0	0	0	17	Yes
ORANGEBURG	Waypoint Recovery Center	Private	35	0	0	0	No
RICHLAND	Lexington/ Richland Alcohol & Drug Abuse/Detox Unit	Public	0	16	0	0	No
	Morris Village	Public	0	0	0	163	No
	Prisma Health Baptist	Private	0	0	0	10	No
	Prisma Health Richland	Private	0	0	0	10	No
SUMTER	Sumter Behavioral Health Women's Residential Center	Public	4	0	6	0	Yes
YORK	Keystone Inpatient Services	Public	4	10	0	0	Yes

Three programs—New Life Center operated by the Charleston Center, Chrysalis Center operated by Circle Park Behavioral Health Services, and Serenity Place operated by The Phoenix Center—provided residential treatment services that allowed for up to two children age 5 and under (10 and under at Chrysalis) to reside with women while they received treatment.[58] Outpatient day treatment/partial hospitalizations were available at the Carolina Center for Behavioral Health, the Charleston Center, Keystone Substance Abuse Services, Palmetto Lowcountry Behavioral Health, and Three Rivers Behavioral Health Services[56]—all facilities that reported providing services to adult and/or pregnant/postpartum women. None of the inpatient programs/facilities were reported to operate transitional housing, halfway houses, or sober homes.

Range of Treatment and Counseling Services – Outpatient Settings

While the locations of inpatient treatment services were more likely to be in urban areas across South Carolina—especially services that reported providing treatment to adult and/or pregnant/postpartum women—outpatient treatment services were available in every county across the state in 2020. There are four main provider types: county alcohol and drug abuse authorities, other public behavioral health providers, private behavioral health providers, and Federally Qualified Health Centers (FQHCs). Table 16 lists the outpatient substance use disorder treatment locations that provide services for adult and/or pregnant/postpartum women in the state by county; Table 17 lists the FQHCs that provide substance use disorder treatment.

COUNTY ALCOHOL AND DRUG ABUSE AUTHORITIES: Established by South Carolina law in 1973, 32 agencies across 46 counties serve as local (county) alcohol and drug abuse authorities and provide most of the substance use disorder treatment services in the state.[58,59] These agencies receive funding from the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS)—the state's Single Agency for Substance Abuse Services—as part of the administration of the Substance Abuse Prevention and Treatment Block Grant (SABG) funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).[60] Services provided by local agencies include counseling (group, individual, and family outpatient); post-discharge services; the Alcohol and Drug Safety Action Program (ADSAP; South Carolina's DUI program); youth services; and primary prevention programs.[58] All 32 organizations are licensed by South Carolina DHEC to provide outpatient services for substance use disorder[61] and are additionally accredited by CARF International or the Joint Commission.[58] Each, through funding provided by the SABG, is obligated to provide services for pregnant women as a SAMHSA priority population.[60]

At the local level, substance use disorder programs and services designed for women, especially pregnant women and women with dependent children, provided and/or arranged support for primary health care, prenatal care, primary pediatric care, and child care (when it was a barrier to a woman receiving substance use disorder treatment).[60] Women's intensive outpatient (IOP) services provided at 11 local agencies all either directly provided on-site child care or had arrangements with local child care providers.[58] Counties served through IOP included Aiken, Anderson, Berkeley, Charleston, Dorchester, Horry, Lexington, Oconee, Pickens, Richland, Spartanburg, Sumter, and York. Outpatient day treatment services were available from local agencies in Anderson, Beaufort, and Oconee counties. No agencies reported operating transitional housing, halfway houses, or sober homes. Case management services to connect women and their families to needed resources were available widely as needed.[60] Women's treatment services were complemented by prevention services and augmented by ongoing announcements and advertisements of available treatment options.[58,60]

OTHER PUBLIC BEHAVIORAL HEALTH PROVIDERS: In addition to the county alcohol and drug abuse authorities, two additional publicly funded providers were notable in South Carolina. The U.S. Department of Veterans Affairs (VA) reported providing substance use disorder treatment services at three South Carolina locations in 2020: the Columbia VA Health Care System (Richland County), the Greenville, SC Vet Center (Greenville County), and the Ralph H. Johnson VA Medical Center (Charleston County).[62] The Johnson VA Medical Center was noted in the SAMHSA provider directory to serve adult women.[56]

Treatment services associated with the criminal legal system were also available in the state. According to South Carolina DHEC, the state reported four drug courts (in Anderson, Greenville, Horry, and Oconee counties) and one detention center affiliated treatment program (in Greenville County). Efforts such as these offer a multi-disciplinary approach to help persons who are incarcerated receive treatment for substance use disorder while also reducing further involvement with the legal system.[63]

PRIVATE BEHAVIORAL HEALTH PROVIDERS: In 2020, of the 51 private facilities licensed by South Carolina DHEC to provide outpatient treatment for Psychoactive Substance Abuse or Dependence, 20 reported serving adult and/or pregnant/postpartum women.[56,64] These facilities were in Anderson, Charleston, Darlington, Florence, Greenville, Greenwood, Horry, Jasper, Lexington, Pickens, Richland, and York counties.[b]

[b] *Some facilities may also provide services in additional locations in other counties, which is not captured by DHEC licensure data.*

Accreditation by CARF International or the Joint Commission was reported by 80% (n=16). Thirteen of the 20 had a SAMHSA-certified opioid use disorder treatment program; these facilities served Anderson, Charleston, Darlington, Florence, Greenwood, Horry, Jasper, Lexington, Pickens, Richland, and York counties. Seven of 20 facilities provided IOP services across three counties (Charleston, Greenville, and Richland). None of the 20 facilities reported providing child care. Outpatient day treatment services were available from one agency located in Greenville County (Solutions Recovery Center); the same agency was the only one to also report operation of transitional housing, halfway houses, or sober homes. Only two facilities reported not offering case management for their clients (Southwest Carolina Treatment Center and Hope for Families Recovery Center).[56]

Table 16. Selected Outpatient Substance Use Disorder Treatment Providers in South Carolina, 2020

County	Facility Name	Funding
ABBEVILLE	Cornerstone	Public
AIKEN	Aiken Center	Public
ALLENDALE	New Life Center Commission on Alcohol and Other Drug Abuse	Public
ANDERSON	Anderson-Oconee Behavioral Health Services	Public
	Southwest Carolina Treatment Center	Private
BAMBERG	Michael C. Watson Treatment Facility	Public
BARNWELL	Axis I Center of Barnwell	Public
BEAUFORT	Beaufort County Alcohol and Drug Abuse Department	Public
BERKELEY	Ernest E. Kennedy Center	Public
CALHOUN	Tri-County Commission on Alcohol and Drug Abuse	Public
CHARLESTON	Alternatives Life Improvement Center	Private
	Center for Behavioral Health	Private
	Charleston Center	Public
	Palmetto Lowcountry Behavioral Health	Private
	Ralph H. Johnson VA Medical Center	Public
CHEROKEE	Cherokee County Commission on Alcohol and Drug Abuse	Public
CHESTER	Hazel Pittman Center	Public
CHESTERFIELD	Alpha Center	Public
CLARENDON	Clarendon Behavioral Health Services	Public
COLLETON	Colleton County Commission on Alcohol and Drug Abuse	Public
DARLINGTON	Rubicon Addictions Center	Public
	Starting Point of Darlington	Private
DILLON	Trinity Behavioral Care	Public
DORCHESTER	Dorchester Alcohol and Drug Commission	Public
EDGEFIELD	Cornerstone	Public
FAIRFIELD	Fairfield Behavioral Health Services	Public
FLORENCE	Circle Park Family Counseling & Addiction Center	Public
	Starting Point of Florence	Private
GEORGETOWN	Georgetown County Alcohol and Drug Abuse Commission	Public
GREENVILLE	Don Foster & Associates Inc.	Private
	Hope for Families Recovery Center	Private
	Pavillon-Greenville Outpatient Services	Private
	Phoenix Center Outpatient Services	Public
	Solutions Recovery Center	Private
GREENWOOD	Cornerstone	Public
	Greenwood Treatment Specialists	Private
HAMPTON	New Life Center Commission on Alcohol and Other Drug Abuse	Public

Table 16 Continued. Selected Outpatient Substance Use Disorder Treatment Providers in South Carolina, 2020

County	Facility Name	Funding
HORRY	Center of Hope of Myrtle Beach	Private
	Shoreline Behavioral Health Services	Public
JASPER	New Life Center Commission on Alcohol and Other Drug Abuse	Public
	Recovery Concepts	Private
KERSHAW	Alpha Center	Public
LANCASTER	Counseling Services of Lancaster	Public
LAURENS	Gateway Counseling Center	Public
LEE	Lee Center	Public
LEXINGTON	Columbia Metro Treatment Center	Private
	Lexington Treatment Specialists	Private
	Lexington-Richland Alcohol and Drug Abuse Council	Public
MCCORMICK	Cornerstone	Public
MARION	Trinity Behavioral Care	Public
MARLBORO	Trinity Behavioral Care	Public
NEWBERRY	Westview Behavioral Health Services	Public
OCONEE	Anderson-Oconee Behavioral Health Services	Public
ORANGEBURG	Tri-County Commission on Alcohol and Drug Abuse	Public
PICKENS	Behavioral Health Services of Pickens County	Public
	Recovery Concepts of the Carolina Upstate	Private
RICHLAND	Crossroads Treatment Center of Columbia	Private
	Lexington Richland Center for Substance Abuse & Behavioral Program	Private
	Lexington-Richland Alcohol and Drug Abuse Council	Public
SALUDA	Westview Behavioral Health Services	Public
SPARTANBURG	The Forrester Center for Behavioral Health	Public
SUMTER	Sumter Behavioral Health Services Treatment Division	Public
UNION	Healthy U Behavioral Health	Public
WILLIAMSBURG	Williamsburg County Department on Alcohol and Drug Abuse	Public
YORK	Keystone Substance Abuse Services	Public
	Rock Hill Treatment Specialists	Private
	York County Treatment Center	Private

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS): HRSA's Health Center program has enabled accessible, quality health care delivery to people regardless of their ability to pay for nearly six decades.[65] In South Carolina, 23 FQHCs served nearly 500,000 people in 2019; 22% of whom were children under 18. Almost two-thirds (63%) of FQHC patients in the state in 2019 identified as a racial and/or ethnic minority; 71% of patients had incomes below the Federal Poverty Line.[66] While focused on providing primary care services, FQHCs are also an important part of the nation's safety net for addressing emergent health needs. In 2016, FQHCs around the nation were funded through the Substance Abuse Service Expansion grant program as a part of the federal government's effort to address the ongoing opioid crisis.[67] This expanded funding allowed Health Centers to explicitly focus on treatment for substance use disorders, specifically Medication-Assisted Treatment for opioid use disorder. As a result, the number of FQHCs that provided substance use disorder treatment for their patient populations increased dramatically. In South Carolina in 2019, 15 FQHCs covering 32 counties provided substance use disorder treatment to 4,070 patients (Table 17).[66] These 15 Health Centers also provided care to 3,898 prenatal patients in 2019, 77% of whom had their first prenatal visit within their first trimester of pregnancy.[66]

Table 17. Federally Qualified Health Center Substance Use Disorder Treatment Providers in South Carolina, 2019

Counties Served	Health Center Name
AIKEN	Rural Health Services
BAMBERG, CALHOUN, DORCHESTER, ORANGEBURG	Family Health Centers
BEAUFORT, HAMPTON, JASPER	Beaufort Jasper Comprehensive Health Services*
BERKELEY, CHARLESTON, COLLETON, DORCHESTER	Fetter Health Care Network
CHARLESTON, GEORGETOWN, WILLIAMSBURG	St. James-Santee Family Health Center*
CHEROKEE, SPARTANBURG, UNION	Regenesis Organization Community Health Center
CHESTERFIELD, DARLINGTON, DILLON, LEE, MARLBORO	CareSouth Carolina
CHESTERFIELD, KERSHAW, SUMTER	Sandhills Medical Foundation
CLARENDON, DARLINGTON, FLORENCE, WILLIAMSBURG	HopeHealth
DARLINGTON, FLORENCE	Genesis Healthcare
FAIRFIELD, LEXINGTON, NEWBERRY, RICHLAND	Eau Claire Cooperative Health Center*
GREENVILLE	New Horizon Family Health Services
HORRY	Little River Medical Center*
OCONEE	Rosa Clark Medical Clinic
SUMTER	Tandem Health

** Also a South Carolina MIECHV program LIA*

Gaps in Current Level of Treatment and Counseling Services

Several measures of need for substance use disorder treatment were used as criteria in the selection of counties at risk for poor prenatal, maternal, newborn, and child outcomes (refer to Section 2). To identify potential gaps in the current level of available treatment and counseling services, these measures were examined to detect the counties with the highest burden of substance use disorder. In Phase One, four measures were used:

- Percent of adult population reporting binge alcohol use in the past month – five-year average, 2014- 2018 (the top five counties with the highest percentages were Charleston, Lexington, Beaufort, Richland, and York; refer to Table 2);
- Prevalence rate of marijuana use in the past month – three-year average, 2014-2016 (the top counties were in SAMHSA substate region 2: Chester, Chesterfield, Fairfield, Kershaw, Lancaster, Lee, Lexington, Richland, and York; refer to Table 2);[68]
- Age-adjusted mortality rate of deaths involving heroin – 2018 (the top five counties with the highest rates were Colleton, Charleston, Jasper, Sumter, and Lancaster; refer to Table 2); and,
- Age-adjusted mortality rate of deaths involving cocaine – 2018 (the top five counties with the highest rates were Georgetown, Horry, Sumter, Florence, and Kershaw; refer to Table 2).

Phase Two also included a substance use disorder measure to represent a population that was potentially at "very high" or "high" risk for child abuse.[16] This measure used frequencies of diagnosis in South Carolina Medicaid claims data for opioid use disorder in 2018. The top five counties with the highest frequencies were Horry, Greenville, Spartanburg, Florence, and York (refer to Table 5). One additional substance use disorder measure is relevant for identifying service needs for pregnant women and families of young children: the prevalence of neonatal abstinence syndrome (NAS). In 2018, there were 262 occurrences of NAS across the state of South Carolina as identified by discharge codes in the county of occurrence. However, many counties' data were suppressed due to small numbers of cases.

For counties with available data, the top five in number of occurrences of NAS in 2018 were Horry, Greenville, Florence, Spartanburg and Charleston.[69]

Additional information on the need for substance use disorder treatment services and barriers to care among pregnant women and families of young children were also collected through the home visiting stakeholder survey (see Section 3). Survey respondents were first asked o to rate "mental health or substance abuse issues in family" among a list of "significant" barriers that expectant or new parents experience with regards to accessing home visiting services. While the overall mean rating for this need as a whole indicated that these services were not as significant of a barrier to home visiting as compared to others (Table 10), one respondent that reported working in four counties in the Midlands region of the state rated this need as most significant for families.

Survey participants were also asked to rate the overall ease of access of community resources. "Substance abuse services" overall were rated not as difficult to access compared to other resources (Table 12). No survey respondents rated access to substance abuse services as the hardest to access. Finally, the survey asked participants to categorize needs that families identify in their community that are not being met. Respondents were then asked to rate the ability of their community to meet the need on a scale from "very low" capacity to "adequate" capacity to address each need identified as a "major problem" in the community. "Substance abuse services" were identified by 16 respondents as a major problem that their community had very low (n=8) or low capacity (n=8) to address (Table 13). Most of these respondents represented counties in urban areas.

Need for substance use disorder treatment services in South Carolina is also monitored by South Carolina DHEC through the State Health Plan.[70] Authors of the Plan use data on current and projected need to determine the number of substance use disorder beds required in each of the state's inpatient hospitals with substance use disorder treatment programs (n=11). For 2020, the Plan stated that the current bed utilization for substance use disorder patients in these 11 facilities across the state was 140; the projected bed need was 148, therefore indicating a deficit in available services. Two service areas had double digit deficits in bed numbers: Berkeley, Charleston, Colleton, and Dorchester counties (17 bed deficit) and Fairfield, Kershaw, Lexington, Newberry, and Richland (15 bed deficit).

Together these data help identify areas of substance use disorder treatment need and gaps in care delivery for pregnant women and families of young children. The population health data used to identify at-risk South Carolina counties, plus the addition of the neonatal abstinence syndrome measure, resulted in a total of six measures of need. Four counties—Charleston, Florence, Horry, and York—were identified positively on half of the measures indicating significant need in these counties. Charleston County was also reported to have a deficit in substance use inpatient treatment beds.

Comparing these identified areas of need with the available services described above, treatment providers that reported serving adult and/or pregnant/postpartum women were available across the four counties identified to have significant need. All four had inpatient treatment services provided by county or state authorities; Charleston County additionally had one private provider that reported serving women. Charleston and Florence counties also operated residential treatment programs that allowed children to reside with women as they received treatment. Charleston and York counties offered day treatment programs. Charleston, Horry, and York counties also had access to intensive outpatient treatment at facilities that offered child care arrangements. All four counties had private providers with SAMHSA certified Opioid Treatment Programs. Charleston, Florence, and Horry counties also had FQHCs that provided substance use disorder treatment.

Use of this simplistic approach, while helpful in describing that the needs for women and families in these four counties have the potential to be met, yields limited results about gaps in care for South Carolina residents that live outside of these significant need areas. It is important to note that for the inpatient and residential treatment programs, these services may be used by clients from other counties. For example, most of the inpatient treatment availability in the state is concentrated in urban counties overall, which are utilized as needed by residents from both urban and rural areas. There is however at least one substance use disorder outpatient treatment provider in every county, with areas of high need/urban areas often having more than one. This is great news for women and families seeking treatment as it hopefully secures local physical access to service providers. However, it is also critical that more work is done to describe the quality and capacity of both inpatient and outpatient services around the state, as this may affect the true ability for women and families to access these services. Finally, access to transitional housing, halfway houses, or sober homes appears to be a large gap in available services in South Carolina. Of the agencies reporting that they served adult and/or pregnant/postpartum women, only one reported operating one of these services.

Barriers to Receipt of Treatment and Counseling Services

Service gaps clearly create barriers for pregnant women and families of young children who have a need for substance use disorder treatment and counseling services. However, even when physical accessibility to services can be secured, many other barriers to receipt of treatment for this population are evident in South Carolina. These barriers may be especially intensified for people who are members of racial/ethnic minority groups.[71] In the home visiting stakeholder survey, participants were asked to identify the most significant barriers that expectant or new parents experienced when accessing community resources and services. The top five rated barriers were ***(1) lack of transportation, (2) lack of availability of services, (3) lack of awareness of available services, (4) competing family priorities, and (5) lack of child care*** (Table 14). The identification of these barriers provides context to the identified gaps in care described above. For example, though access to outpatient services is available in each county, the ability for women or their families to physically get to those locations may be limited due to lack of public transportation.

In addition to these barriers, there are other known obstacles to accessing substance use disorder treatment services in the state. Uninsured and underinsured South Carolinians may especially have unmet treatment needs.[71] As a result of not expanding Medicaid access under the Affordable Care Act in 2014, an estimated 214,000 South Carolina residents currently do not have access to affordable health coverage.[72] This may be especially important for individuals that experience opioid use disorder as Medicaid provides coverage for approximately four out of every 10 nonelderly adults in the nation.[73] Fortunately, for those that do have Medicaid coverage, most of the inpatient and outpatient providers listed above do accept Medicaid as a form of payment for services.[56] Also, the state's Medicaid program recently expanded coverage to Opioid Treatment Programs in January 2019, providing access to beneficiaries for all forms of Medication-Assisted Treatment.[74] This is an important step to eliminating barriers for women and families due to potential costs of substance use disorder treatment.

Another barrier faced by pregnant women in South Carolina is that many are likely not getting necessary education on substance use during pregnancy. The Pregnancy Risk Assessment Monitoring System (PRAMS) is a data surveillance project of the Centers for Disease Control and Prevention (CDC) and South Carolina DHEC that collects state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy.[75] South Carolina PRAMS data from 2015 showed that 83.1% of postpartum women who have Medicaid coverage and 63.2% of postpartum women who do not have Medicaid coverage reported receiving prenatal education or information on illegal drugs.[76] Thousands of pregnant women in South Carolina would benefit from receiving important educational information about the use of substances during their pregnancy that would potentially help them identify the need to seek treatment services.

Increased stigma among pregnant women who use substances is also a major barrier to treatment.[77] In addition, there are societal and legal implications for substance use during pregnancy, especially in South Carolina. In *Ferguson v. City of Charleston* (October 2000), the U.S. Supreme Court heard oral arguments in a case brought by 10 women who were secretly tested for cocaine use while they were seeking routine prenatal care at a public hospital in South Carolina. The women who tested positive were arrested or threatened with the possibility of arrest for criminal child abuse for the use of an illicit substance during pregnancy. South Carolina is the only state in which the state Supreme Court has upheld the conviction of a woman charged with criminal child abuse for using cocaine during pregnancy, citing that a viable fetus is a person under the state's criminal child endangerment statute.[78]

Finally, pregnant women and families of young children may face additional barriers to seeking substance use disorder treatment due to staff shortages, lack of providers to deliver the service, and mistrust of service providers as indicated by responses to the home visiting stakeholder survey. Workforce shortages for addiction counselors and social workers in South Carolina were documented in 2016, with a deficit range of 540-810 and 1,010-1,750 respectively. By 2030, this deficit is expected to be resolved for social workers but remain for addiction counselors.[79] The South Carolina Department of Labor, Licensing, and Regulation regulates licensing and credentialing for addiction counselors and social workers in the state.[80,81] This includes certification requirements for substance use treatment counselors by the South Carolina Association of Alcoholism and Drug Abuse Counselors.[58] Additional attempts by the state to address mistrust of treatment providers include commitments by South Carolina DAODAS to address the cultural competency of providers. Cultural competency is an overarching component of DAODAS' Strategic Planning Framework and is also included as a part of the county alcohol and drug abuse authorities' organizational plans. South Carolina DAODAS also participates in the statewide Cultural Competency and Linguistic Collaborative, which seeks to provide information and training to communities and providers to address disparities and encourages the adoption of the National Cultural and Linguistically Appropriate Services (CLAS) Standards.[58]

Opportunities for Collaboration

Gaps in care and barriers to treatment provide opportunities for collaboration in South Carolina between substance use disorder provides and home visiting programs. The Touchpoints for Addressing Substance Use Issues in Home Visiting project, funded by the Administration for Children and Families' Office of Planning, Research, and Evaluation (OPRE) in collaboration with HRSA, was developed to examine how home visiting programs can best support families to address substance use issues. The *Touchpoints for Addressing Substance Use Issues in Home Visiting: Phase 1* Final Report, released March 2020, provides multiple iterations of a conceptual framework that is instructive for identifying opportunities for collaboration between home visiting programs and substance use disorder treatment providers. ***The essential "touchpoints" identified in this report for families receiving home visiting services and at-risk for substance use disorder included: (1) screening for and identification of substance use issues, (2) referral to treatment providers, (3) substance use education, (4) delivery of home visiting services using strategies to prevent and/or mitigate current substance use, and (5) case management services*** (refer to Appendix D).[82]

In program year 2018, 7.4% of South Carolina MIECHV program participants sought substance use disorder treatment.[39] Through use of the Touchpoints framework, connections between local home visiting programs and substance use disorder treatment providers may be strengthened. Increasing bi-directional awareness of the existence of these services at the county level is the first step in assuring screening, identification, and referral to treatment occurs.[83] Prevention staff at county alcohol and drug abuse authorities may be leveraged to provide additional education on substance use for pregnant women and families of young children. Treatment counselors may be able to provide training to home visiting staff to increase their knowledge of the risks of substance use and the benefits of treatment. Case management may also be a critical element to establish connections between home visiting programs and substance use disorder treatment providers. Almost all the treatment providers listed above provided some form of case management services. Case managers may be able to proactively support women in their care by connecting them directly with home visiting services and vice versa.[83]

At the state level, while there is not yet a current strategic approach or state plan for responding to substance use disorder treatment needs for pregnant women and families of young children, there are opportunities for connection and collaboration between home visiting and substance use disorder treatment stakeholders to address gaps in treatment services and barriers to care for this population. Children's Trust of South Carolina and South Carolina DAODAS are current partners on the Strengthening Families Program; the positive working relationship between these organizations easily lends itself to a more deliberate focus in the future on the integration of home visiting and substance use disorder treatment for families that would benefit from a dual approach to service provision.

Additionally, at least four robust coalitions exist at the state level that address the intersection of women's and families' needs and substance use disorder treatment in at least a minimal way: the South Carolina Behavioral Health Coalition,[84] the South Carolina Birth Outcomes Initiative,[85] the South Carolina Child Well-Being Coalition,[86] and the South Carolina Opioid Emergency Response Team.[87] These groups include representatives from entities such as South Carolina DAODAS, South Carolina Department of Mental Health, South Carolina DHEC, South Carolina Department of Health and Human Services (Medicaid), health care providers, public safety entities, and statewide advocacy groups (including Children's Trust). The value of these coalitions also resides in the fact that the representatives who participate in each are often the leaders and decision-makers within their organizations. Encouraging each of these groups to place an emphasis on activities that address the substance use disorder treatment needs of pregnant women and families with young children, including incorporating home visiting as a resource where appropriate, would increase awareness of—and ultimately resources to address—the gaps in treatment and barriers to care faced by this population.

Current Activities Aimed at Strengthening System of Care

In addition to supporting treatment services for pregnant women and families of young children in several facilities, South Carolina DAODAS currently supports several programs that support women and families seeking substance use disorder treatment with the expressed desire to ensure families stay together through treatment. Tools used by programs include treatment for co-occurring disorders and other ad hoc services as needed to serve clients holistically.[83] DAODAS also monitors areas in the state at risk for child maltreatment and other social conditions to proactively address issues related to substance use.[88] Three specific efforts of innovative activities happening in the state provide examples of how to strengthen the current system of care for pregnant women and families with young children.

The Partners in Achieving Independence through Recovery and Self-Sufficiency Strategies (PAIRS) program is conducted in partnership with the South Carolina Department of Social Services (DSS) using federal Temporary Assistance for Needy Families (TANF) funds.[60] This program provides substance use disorder treatment, case management, and transitional services to women and their families involved with DSS at a residential location – the Midlands Family Care Center.[58] In 2017-2018, 349 DSS clients were served.[60] Collaboration with the South Carolina

Department of Employment and Workforce has led to innovative partnerships through the Workforce Innovation and Opportunity Act (WIOA) that enables people impacted by substance use disorder the opportunity to receive training and match with an employer as they reenter the workforce. The Chrysalis Center (Florence County) and the Sumter Women's Recovery Center (Sumter County), both residential treatment facilities for women, have used this program to provide services to patients impacted by opioid and substance use disorders.[58] Finally, several county alcohol and drug abuse authorities provide parenting classes for their communities. One example is the Guiding Good Choices program at Cornerstone.[89]

Optional Considerations: Changes Due to Recent Events

While many strides have been made in South Carolina over the past decade to expand available substance use disorder treatment services, additional need for treatment and changes to service delivery as a result of the COVID-19 pandemic will be challenging for both providers and clients. A recent report showed data presented by South Carolina DAODAS that indicated a 52% increase in suspected opioid overdoses in the state in the first six months of 2020 compared to the same time period in 2019.[90] In June 2020, a new toll-free telephone line was established to support South Carolinians with substance use or mental health needs.[91] The South Carolina Medicaid program also responded to the pandemic by providing additional flexibility for providers to allow Medication-Assisted Treatment via telehealth as well as reimbursement for long-acting injectable opioid use disorder treatments.[74] As need increases and changes continue to occur, it is critical that treatment and counseling services for women and families in South Carolina are not forgotten and in fact continue to be expanded over the next decade.

Coordination with Title V MCH Block Grant, Head Start, CAPTA, and Other Needs Assessments

Examination of recent South Carolina Title V MCH Block Grant, Head Start, Child Abuse Prevention and Treatment Act (CAPTA) Title II, and other needs assessments and their processes was completed to identify additional data sources and areas of overlap. Overlap of specific needs, such as identification of areas with service gaps and duplication of services, was limited though given the different foci of each. ***Areas of coordination between each of these assessments, including incorporation of data and/or findings into this assessment, are described below.*** It is of note that ongoing, strong collaborations exist between the entities responsible for each of these plans. ***South Carolina is a small state and many of the people who serve in key roles within the organizations responsible for conducting these assessments and implementing the resulting plans often serve on the same committees with one another.*** This cross-pollination of work across early childhood systems in South Carolina helps to efficiently spread ideas and information, resulting in continuous, strong coordination among partners to assess and identify risk, unmet need, and gaps in care in the state. Children's Trust and many other home visiting stakeholders are established participants in these committees and conversations, which creates solid partnerships within systems at the state and county levels.

Coordination Efforts in Conducting Needs Assessments

Children's Trust has been a long-standing partner of the South Carolina Title V MCH program, which is administered by the South Carolina DHEC. Children's Trust regularly uses data and information provided by the program as a guide for decision-making. The Title V MCH program also supports a regional DHEC office in its role as a South Carolina MIECHV program LIA for Nurse-Family Partnership. In 2019, the Title V MCH program began work on its five-year needs assessment by forming an Advisory Committee consisting of 45 stakeholders and partners representing various organizations, including state agencies, community-based organizations, social services, the South Carolina Hospital Association, nurses, physicians, non-profit organizations, and academia. The roles of these individuals ranged from direct service providers to senior-level executives. The Title V MCH program also contracted with the Core for Applied Research and Evaluation (CARE) at the University of South Carolina to conduct a qualitative needs assessment to supplement their overall assessment. The CARE team members who conducted the qualitative needs assessment also served on the South Carolina home visiting needs assessment team. This cross-pollination facilitated regular communication with DHEC's MCH Director, Ms. Kimberly Seals, regarding both efforts. As a result, Ms. Seals approved the inclusion of data gathered from focus groups during the Title V MCH program needs assessment for use in the home visiting needs assessment. As described in detail in Section 3, four focus groups of parents and caregivers were included that helped to describe the quality and capacity of existing community efforts.

South Carolina Head Start programs, primarily through state-level facilitation provided by the South Carolina Head Start Collaboration Office administratively located within South Carolina DSS, are connected statewide through multiple partnerships with entities such as the South Carolina Association of Community Action Partnerships, South Carolina First Steps, and local school districts. The Office has shared a lengthy relationship with Children's Trust as well. The two organizations share many of the same goals, including strengthening early childhood systems in the state and enhancing the workforce that

comprises those systems.[92] Head Start needs assessments are conducted every five years with annual interim updates. Locally, Head Start programs also utilize 10-year county plans to adjust for changes in the local child population that can result in the relocation of program sites. Use of the Early Head Start-Home Based Option (EHS-HBO) also allows EHS sites the flexibility needed to serve large populations, especially those that are geographically dispersed. Ms. Mary Lynne Diggs, Director of the South Carolina Head Start Collaboration Office, emphasized the need to include local Head Start programs in a meaningful way in this home visiting needs assessment.[93] In addition to including data gathered from each entity's EHS Services Snapshot,[45] local programs were directly recruited for responses to the home visiting stakeholder survey (see Section 3).

In South Carolina, Title II of the CAPTA, the Community-Based Child Abuse Prevention (CBCAP) program, is administered and led by Children's Trust, which assured a direct linkage between needs identified by the CBCAP program and this home visiting needs assessment. Over the past decade, the CBCAP program has supported specific home visiting and parenting support programs across the state. In 2018, the strategy for CBCAP at the state level was redesigned to elevate collective impact activities in specific communities. This required a thorough assessment of both need and assets across South Carolina counties; ultimately three locations were targeted to address child abuse prevention (Marlboro, Oconee, and Richland counties).[94] This outcome was used to inform Phase Two criteria to define at-risk counties for this assessment (Section 2)—an ideal opportunity to align these efforts. Continuous leveraging of and comparisons between the implementation and findings of CBCAP and home visiting programs in the state provides an opportunity for ongoing alignment in the foreseeable future.

In addition to coordination with these three needs assessments, other recent needs assessments focused on early childhood outcomes in South Carolina were reviewed as a part of the home visiting needs assessment. For example, CARE contributed to an evaluation project in 2019 for South Carolina First Steps that included interviews with current and former First Steps families. The evaluation assessed progress towards the goals of the organization and the impact of their initiatives, many of which are home visiting programs. The collaboration between First Steps and CARE facilitated the inclusion of the findings from those interviews into this needs assessment (see Section 3). A multitude of reports recently completed in South Carolina were also reviewed for validation of this assessment:

- The 2020 KIDS COUNT Data Book[7]
- America's Health Rankings: South Carolina 2019 Health of Women and Children Report[95]
- Child Care and Development Fund (CCDF) Plan For South Carolina FFY 2019-2021[96]
- Committee on Children 2019 Data Reference Book[14]
- Preschool Development Grant Birth through Five (PDG B-5): South Carolina Needs Assessment Report 2019[97]
- South Carolina DHEC State Health Assessment and State Health Improvement Plan[98]
- South Carolina Early Childhood Data Report, February 2019[99]
- The State of South Carolina's Babies, 2020[100]

The Preschool Development Grant Birth through Five (PDG B-5) Needs Assessment in 2019 in particular was a robust assessment of early childhood needs across the state. The PDG B-5 methodology included 15 regional meetings, an online survey with 2,680 valid responses, and a series of focus groups that occurred in all 46 South Carolina counties with 1,495 participants. Findings of the PDG B-5 assessment were in congruence with findings from this home visiting needs assessment. Specifically, one of the overarching goals developed from the PDG B-5 findings, "families are supported," included a primary specific goal that noted a need for home visiting programs to connect families to resources in all areas.[97] Overall, all 12 assessments that were reviewed indicated similar challenges or barriers to services for families as well as consistent opportunities to strengthen and improve coordination of early childhood services.

Coordination Efforts in Review and Contextualization of Findings

As described in Section 2, external reviews of findings by key stakeholder groups, including further coordination with leaders of the Title V MCH Block Grant, Head Start, and CAPTA Title II needs assessments, had been planned for the summer of 2020. Due to the ongoing COVID-19 pandemic, there was neither an appropriate forum nor opportunity to conduct these reviews. The result of this change in activities was that additional individual stakeholders were engaged (virtually) and additional needs assessments, listed above, were reviewed for concordance with this needs assessment. This change will additionally require an intentional dissemination process of this needs assessment in late 2020 and early 2021 (see Section 6). Despite the inability to convene stakeholder groups for review of the needs assessment findings, ***existing coordination between the Title V MCH Block Grant, Head Start, and CAPTA Title II assessments, use of the home visiting stakeholder survey, and comparisons to the additionally referenced assessments resulted in good concordance of identified at-risk counties, overall unmet need, and gaps in services.***

Looking ahead, there will be other opportunities to review and contextualize the findings of this needs assessment through the activities of the South Carolina Home Visiting Consortium (HVC). As referenced in Section 1, the HVC engages home visiting stakeholders from across the state to strengthen the continuum of early childhood services through coordination, promotion, and advocacy. To this end, the Consortium's data workgroup has and will continue to update stakeholders as to the quality and capacity of home visiting services in South Carolina. A systematic data collection process that builds off of the findings of this needs assessment has been developed and will be deployed in 2021. Use of these data by the HVC are important for not only home visiting advocacy efforts but are a critical piece in avoiding duplication and unnecessary competition at the local level.[93] Representatives of the Title V MCH, Head Start, and CAPTA programs are all active in the HVC and will play an important role in continuous review and reconciliation of the findings of this assessment.

How Other Needs Assessments Informed the South Carolina Home Visiting Needs Assessment

Information gathered from the Title V MCH Block Grant, Head Start, CAPTA Title II, and other needs assessments as described above was integral to the completion of this South Carolina home visiting needs assessment. Engaging stakeholders from each of these efforts through cross-pollination of projects, an online survey, and individual meetings provided an opportunity to ensure this needs assessment was complementary to, if not aligned with, established statewide goals and metrics. Direct areas of overlap between assessments provided opportunities for collaborative work with the inclusion of focus group data from the Title V MCH assessment, program data from Head Start, and outcomes from the CAPTA Title II/CBCAP assessment. In addition, validation of data used in Phases One and Two of this needs assessment and survey data collected was achieved through review of these and other statewide reports. The process of data collection for this assessment provided an opportunity to further joint efforts that will lead to an even stronger early childhood services continuum in South Carolina.

Conclusion

Strengthening the home visiting infrastructure in South Carolina is an important preventive strategy that decreases risk factors and increases protective factors for children at risk for child abuse and neglect. The 2020 home visiting needs assessment presented in these pages provides a snapshot of the current communities (counties) at risk for poor prenatal, maternal, newborn, and child outcomes; the quality and capacity of existing home visiting programs; and overall coordination on addressing the needs of families in South Carolina to date (including the need for substance use disorder treatment and counseling). ***South Carolina MIECHV program leaders plan to use these findings to further coordinate with other ongoing home visiting and early childhood efforts in the state to create and encourage statewide strategies for the work of home visiting for the next 10 years.***

Summary of Major Findings

The number of at-risk South Carolina counties identified through this assessment is 44 out of a total of 46. Every county in the state is served by at least one home visiting model, and all are served by at least one evidence-based home visiting model that is eligible for MIECHV program funding. In general, home visiting programs provide a service that is much needed by South Carolina families. Home visiting gives valuable information to families about growth and development, parenting advice and skills, home safety, support for parents, and books and other supplies. Services are also convenient and helpful for the whole family. Programs are flexible, adapting to new situations rapidly when needed to provide services continuously to families, as evidenced by the utilization of virtual visits necessitated by the COVID-19 public health emergency in 2020. Home visitors in South Carolina are largely representative of the populations they serve, indicating a commitment to health equity across programs. Local communities have high levels of buy-in for implementation of home visiting services.

However, there are gaps in home visiting service delivery across the state. Home visiting programs supported by South Carolina MIECHV are widespread across the state but focused in high population areas, reflecting the hub and spoke nature of the program's approach. Other home visiting programs/models appear to be concentrated in smaller, more rural counties in the state. Specifically, most of these programs are in the eastern part of our state, many along the I-95 corridor—an area of persistent poverty—suggesting these home visiting models may be more feasible in under-resourced settings. Statewide, approximately 10% of families in need in at-risk counties were found to be receiving home visiting services, with wide disparities in the number of clients served by county. Several factors may contribute to these disparities. Local communities have low levels of infrastructure and leadership prioritization for home visiting programs. Families have many needs that require addressing deficiencies in the state's socioeconomic infrastructure such as transportation, child care, mental health services, job needs, and other basic life needs. Certainly, the COVID-19 pandemic has already and will continue to exacerbate these concerns, especially among families experiencing poverty. Work is needed to prevent the pandemic from deepening disparities in early childhood outcomes.

With regards to availability of substance use disorder treatment services for MIECHV eligible families, South Carolina has demonstrated capacity to provide care for a variety of needs in the outpatient setting statewide. Treatment in the inpatient setting appears to be closely aligned with population areas of need; most of these locations are in urban areas. Families continue to experience barriers to accessing services including (1) lack of transportation, (2) lack of availability of services, (3) lack of awareness of available services, (4) competing family priorities, (5) lack of child care, (6) lack of insurance, (7) lack of prenatal education related to substance use, and (8) stigma. There is great potential for increased collaboration between the substance use disorder treatment system and home visiting stakeholders building on current provision of treatment for pregnant women and families of young children.

Collaboration opportunities also exist at large between home visiting and early childhood system stakeholders. Relationships between these entities have strengthened over the past decade, yet more needs to be done to ensure everyone at the state and local levels are aware of home visiting as a resource. The South Carolina HVC is an appropriately primed vehicle for further uniting home visiting and early childhood stakeholders in the state around this common purpose. One specific way that the HVC will contribute to this is through its data and advocacy efforts. Through strengthening data capacity and sharing and continuously monitoring the capacity and quality of home visiting in the state, the HVC will provide valuable feedback in support of further coordination of the early childhood system in South Carolina. Data integration across early childhood agencies is a big part of the critical work needed in South Carolina moving forward.[97]

Overall, home visiting programs are widely available in South Carolina and are providing invaluable supports for families, including success in helping families connect to the services they need. Critical infrastructure and capacity for home visiting in South Carolina have expanded over the past 10 years as a result of MIECHV program funding. Currently, home visiting programs across the state appear to meet the needs of families that can access their services. However, programs could benefit from stronger referral and care coordination efforts as well as finding new ways to increase family engagement, including reaching families in rural areas. ***Additional resources are needed to assure equitable, adequate services are available to families in need in every county in the state.*** This may be accomplished through current programs increasing the number of clients they serve and/or the expansion of additional home visiting models.

New and expanded opportunities have been afforded to South Carolina recently through national efforts such as the Family First Prevention Services Act,[101] the PDG B-5 program,[102] and the Statewide Longitudinal Data Systems Grant Program,[103] as well as state and local initiatives focused on developing and strengthening pediatric medical homes,[104,105] networks of Family Resource Centers,[106] and the Perinatal Regionalized System of Care.[70] Use of these opportunities to promote further expansion and integration of existing home visiting efforts across the state would not only widely benefit South Carolina's families through direct service delivery, but it would also improve and strengthen coordination across the state's continuum of early childhood service providers. This needs assessment may be a useful guide for leaders seeking to identify priority areas and new opportunities to build stronger, more equitable, and coordinated home visiting and early childhood systems across South Carolina over the next decade.

Dissemination of Findings

Dissemination of the findings from this assessment will be coordinated by the South Carolina HVC. An initial presentation of findings to this group is planned for October 1, 2020. This group will ensure all HVC participants and individual contributors to the assessment receive a copy of the final report, to include the leaders of the South Carolina Title V MCH Block Grant, Head Start, and CAPTA Title II programs. The HVC will also connect with other collaborative efforts across the state to share the report findings, including but not limited to the South Carolina Child Well-Being Coalition, the South Carolina Early Childhood Advisory Council, the South Carolina Child Care Resource & Referral, the South Carolina Behavioral Health Coalition, and the South Carolina Birth Outcomes Initiative. The HVC website (https://www.schomevisiting.org/) is another tool for dissemination of findings from this assessment.

In addition, several opportunities to present these findings in person are available. Select data from this assessment will be a part of a presentation at the American Public Health Association in October 2020. Two events hosted by Children's Trust will provide in-state exposure to this report: the South Carolina Home Visiting Virtual All-Sites Assembly planned for October 28-29, 2020 and the Building Hope for Children Conference and Home Visiting Summit planned for March 23-24, 2021. Finally, at least one academic manuscript presenting select findings of this assessment is planned.

Nonprofit Documentation

This documentation is not required for the South Carolina MIECHV program.

Appendices

Appendix A: References

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Appendix B: Home Visiting Model Maps

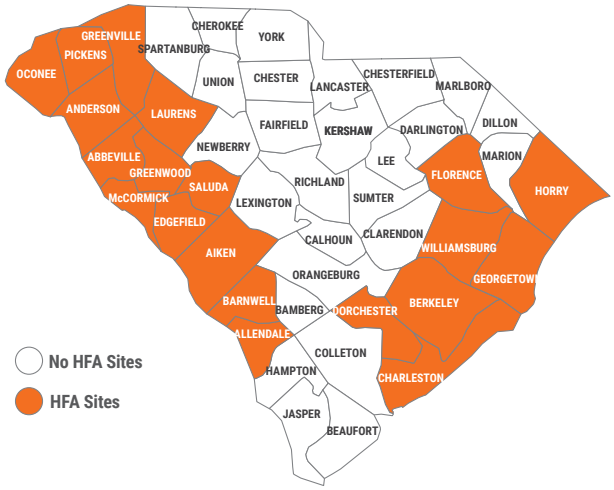

Figure B1. South Carolina Healthy Families America (HFA) County Coverage, 2019

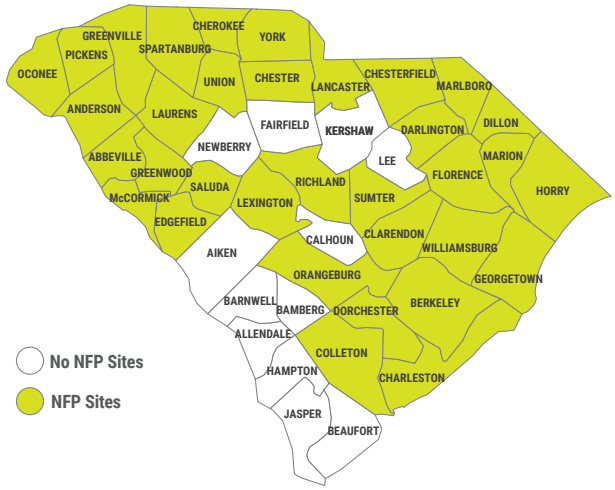

Figure B2. South Carolina Nurse-Family Partnership (NFP) County Coverage, 2019

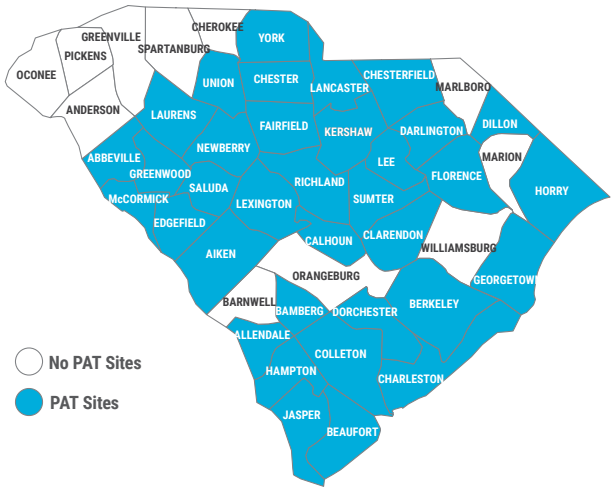

Figure B3. South Carolina Parents as Teachers (PAT) County Coverage, 2019

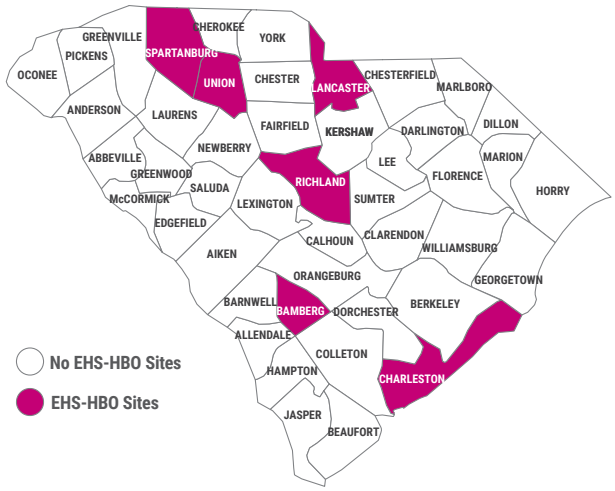

Figure B4. South Carolina Early Head Start-Home Based Option (EHS-HBO) County Coverage, 2017-2018

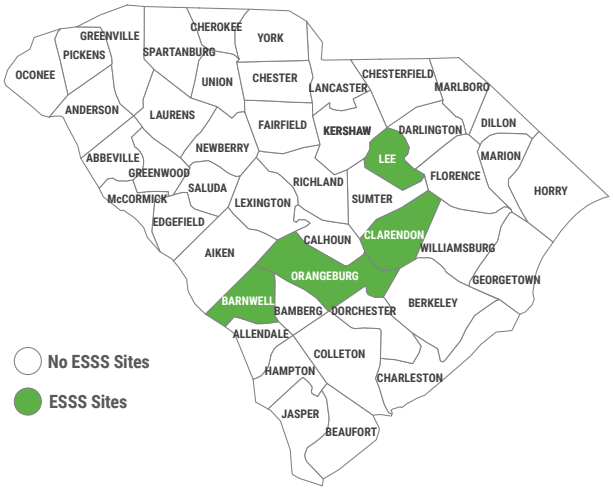

Figure B5. South Carolina Early Steps to School Success (ESSS) County Coverage, 2019

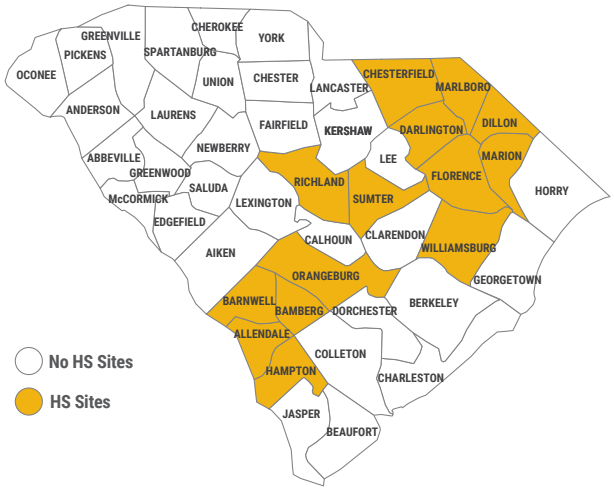

Figure B6. South Carolina Healthy Start (HS) County Coverage, 2019

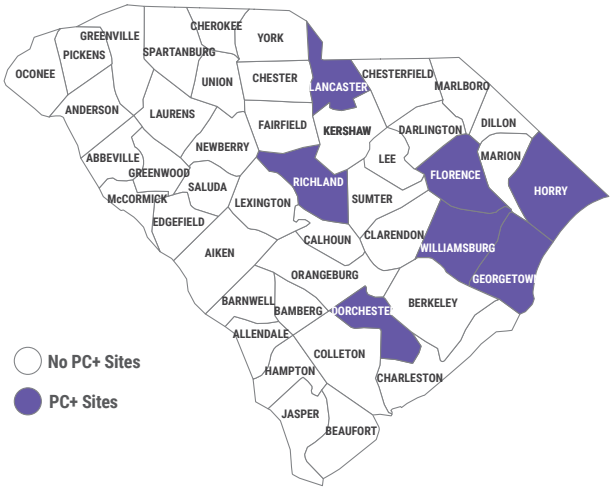

Figure B7. South Carolina Parent-Child+ (PC+) County Coverage, 2019

Appendix C: South Carolina Early Childhood Home Visiting Stakeholder Survey

As part of a federally mandated needs assessment, The Children's Trust of South Carolina is asking for your perspectives on the quality and capacity of home visiting services in our state. Conducted in partnership with the Arnold School of Public Health at the University of South Carolina, we invite you to participate in this brief needs assessment survey.

What is the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Needs Assessment?

The Maternal, Infant, and Early Childhood Home Visitation (MIECHV) program was established in 2010 to create a coordinated system of evidence-based only home visiting programs. The MIECHV Needs Assessment is a federally-mandated process to understand the needs of families and young children in SC. This process is important 1) to ensure that resources are appropriately allocated and 2) to understand key areas of need, barriers families face in accessing services, and inequities in access.

PURPOSE: While funded by MIECHV, the purpose of this needs assessment survey is to understand the needs related to all home visiting and early childhood systems across the state. This survey will ask questions about your perspectives on the quality and capacity of home visiting services in our state. The results of this survey will help to identify priorities to build a stronger and more equitable home visiting system across the state.

INSTRUCTIONS: Please answer each question as best as you can. We understand that all programs are unique and want to learn about the range of services across all communities. If you represent a state-level organization, please reflect on questions about "your community" regarding the local programs you serve or oversee.

The information that you share in this survey will be used to understand the landscape of home visiting in SC, not to evaluate any specific program. The information you provide, including information about yourself, is anonymous. Thank you for your participation in this important activity! If you have any questions about the survey, please contact Maria Zubizarreta at zubizarr@mailbox.sc.edu

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What Communities and Organizations Do You Represent?

If you represent a state level organization, please reflect on questions about "your community" regarding the local programs you serve or oversee.

1. What county(s) do you work in and/or represent? Please select all that apply.

- ○ Statewide
- ○ Abbeville County
- ○ Aiken County
- ○ Allendale County
- ○ Anderson County
- ○ Bamberg County
- ○ Barnwell County
- ○ Beaufort County
- ○ Berkeley County
- ○ Calhoun County
- ○ Charleston County
- ○ Cherokee County
- ○ Chester County
- ○ Chesterfield County
- ○ Clarendon County
- ○ Colleton County
- ○ Darlington County
- ○ Dillon County
- ○ Dorchester County
- ○ Edgefield County
- ○ Fairfield County
- ○ Florence County
- ○ Georgetown County
- ○ Greenville County
- ○ Greenwood County
- ○ Hampton County
- ○ Horry County
- ○ Jasper County
- ○ Kershaw County
- ○ Lancaster County
- ○ Laurens County
- ○ Lee County
- ○ Lexington County
- ○ Marion County
- ○ MarlborCounty
- ○ McCormick County
- ○ Newberry County
- ○ Oconee County
- ○ Orangeburg County
- ○ Pickens County
- ○ Richland County
- ○ Saluda County
- ○ Spartanburg County
- ○ Sumter County
- ○ Union County
- ○ Williamsburg County
- ○ York County

2. **From which point of view are you completing this survey (please select all that apply)?**

- ○ State agency or organization
- ○ Local child care provider
- ○ Home visiting program administrator/manager/ supervisor
- ○ Home visitor
- ○ Local nonprofit or advocacy organization
  - *Please list type of organization (e.g. child abuse prevention, substance abuse, social service, etc.):*

    _____
- ○ Local county government
  - *Please list type of organization (e.g. child abuse prevention, substance abuse, social service, etc.):*

    _____
- ○ Health care professional (e.g., physician, PA, nurse, etc.)
- ○ Public health professional
- ○ Social or other support service provider (social worker, community health worker, etc.)
- ○ K-12 educator or other school staff
- ○ University/college educator or other staff
- ○ Elected or other government official
- ○ Home visiting participant
- ○ Other:_____

3. **Based on your experiences, please rate each of the following areas of need from (not a problem) to (a major problem) based on what families say they need, but aren't getting.**

- ○ Health care (including pre-natal and post-partum care)
- ○ Parenting support and information
- ○ Information about resources and services
- ○ Coordination and/or navigation to services
- ○ Basic needs (including material goods such as diapers, food, and safe housing)
- ○ Job needs
- ○ Child care
- ○ Transportation
- ○ Services in languages other than English
- ○ Mental health services
- ○ Substance abuse services
- ○ Help with domestic violence
- ○ Services for children and youth with special health care needs
- ○ Other:_____

4. **Of the areas you identified as major needs, please rate each based on your community's ability to address them. [pre populated responses from q3]**

- ○ 1—very low capacity to address this need
- ○ 2—low capacity to address this need
- ○ 3—some capacity to address this need
- ○ 4—adequate capacity to address this need

5. **What barriers do expectant or new parents experience when accessing community resources and services (such as WIC, mental health services, early intervention, etc.)? Please rank from 1 (top need or most significant barrier) to 12 (least significant barrier).**

- ○ Lack of availability of services
- ○ Lack of transportation
- ○ Lack of culturally competent care (including services in a language other than English)
- ○ Competing family priorities & priorities (e.g. work, school, etc.)
- ○ Lack of awareness of available services
- ○ Geographic isolation/living in a rural area
- ○ Stigma for using social services
- ○ Lack of child care
- ○ Resistance to accept help
- ○ Inconvenient hours of service
- ○ Cost or perceived financial cost
- ○ Other:_____

6. **What kinds of services and resources are hardest for families to access? Please rank from 1 (hardest to access) to 14 (not as hard to access).**

- ○ Health care (including pre-natal and post-partum care)
- ○ Parenting support and information
- ○ Information about the resources and services
- ○ Coordination and/or navigation to services
- ○ Basic needs (including material goods such as diapers, food, and safe housing)
- ○ Job needs
- ○ Child care
- ○ Transportation
- ○ Services in languages other than English
- ○ Mental health services
- ○ Substance abuse services
- ○ Help with domestic violence
- ○ Services for children and youth with special health care needs
- ○ Other:_____

7. **From your perspective, what else is preventing families from accessing the services and resources available in your community? [open response]**

_____

_____

_____

_____

_____

8. **What are the most significant barriers expectant or new parents experience when accessing home visiting services? Please rank from 1 (hardest to access) to 13 (not as hard to access).**

- ○ Lack of availability of services
- ○ Lack of culturally competent care (including services in a language other than English)
- ○ Unsure about having a home visitor come into their home
- ○ Competing family priorities (e.g. work, school, etc.)
- ○ Lack of awareness of home visiting services
- ○ Geographic isolation/living in a rural area
- ○ Stigma of using home visiting services
- ○ Resistance to accept help
- ○ Inconvenient hours of service
- ○ Mental health or substance abuse issues in family
- ○ Families do not meet criteria to receive services
- ○ Unstable housing/families move frequently
- ○ Other: _____

9. **What are the most significant barriers home visiting programs face in addressing service gaps or in providing services? Please rank from 1 (most significant barrier) to 11 (not so much a barrier).**

- ○ Finding referral partners
- ○ Identifying effective programs or services
- ○ Reporting requirements of funding sources
- ○ Reaching families in rural areas
- ○ Family engagement
- ○ Workforce development and retention
- ○ Securing sustainable funding
- ○ Providing services to meet a variety of cultural and language needs
- ○ Stigma of using home visiting services
- ○ Lack of family awareness of home visiting services
- ○ Other:_____

10. **Does the need for home visiting services exceed your home visiting program's capacity?**

- ○ Yes
- ○ No
- ○ I don't know/unsure
- ○ n/a

11. **Does your program have a waitlist?**

- ○ Yes
- ○ No
- ○ I don't know/unsure
- ○ n/a

12. **From your perspective, how effective are home visiting programs in helping families in your local community get the services they need?**

- ○ Very effective
- ○ Somewhat effective
- ○ Not effective
- ○ I don't know/unsure

13. **From your perspective, how successful are home visiting programs in your local community in reaching all families in need (including geographically isolated, racial/ethnic minority groups, and other marginalized populations)?**

- ○ Very successful
- ○ Somewhat successful
- ○ Not successful
- ○ I don't know/unsure

14. **Why are home visiting programs in your local community not as successful in reaching all families in need? [open response]**

_____

_____

_____

_____

_____

_____

15. **To what extent do home visiting program staff in your community represent the minority and marginalized populations that live in your community?**

- ○ Home visiting staff are very representative of populations in need
- ○ Home visiting staff are somewhat representative of populations in need
- ○ Home visiting staff are not at all representative of populations in need
- ○ I don't know/unsure

16. **How could home visiting programs improve efforts to reach families in your community that are difficult to reach, but have great needs? [open response]**

_____

_____

_____

_____

_____

_____

17. **On a scale of 1 to 10, how would you rate your community's level of buy-in for providing services to meet the needs of expectant and new parents and their young children (1 is "no buy-in" and 10 is "the very high buy-in")?**

_____

18. **On a scale of 1 to 10, how would you rate your community leadership's prioritization of providing services to meet the needs of expectant and new parents and their young children (1 is "not a priority" and 10 is "the highest priority")?**

_____

19. **On a scale of 1 to 10, how would you assess the level of infrastructure in your local community to support home visiting services for expectant or new parents and their young children (1 is "no infrastructure" and 10 is "highest level of infrastructure")?**

_____

20. **How sufficient is your local home visiting program's group of existing partners and referral sources?**

- ○ Very sufficient
- ○ Somewhat sufficient
- ○ Not sufficient
- ○ I don't know/unsure

21. **What resources (including those beyond funding) would be needed for expansion of home visiting programs in your community? [open response]**

_____

_____

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22. **What are the biggest strengths of the home visiting programs for families in your community? [open response]**

_____

_____

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23. **What else would you like for us to know about unmet needs for young children and families in your local community? [open response]**

_____

_____

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_____

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24. **Is there anything else you would like to share about early childhood home visiting in South Carolina? [open response]**

_____

_____

_____

_____

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25. **How have recent current events (including COVID-19 and racial issues) impacted your local community's ability to engage families in home visiting services? [open response]**

_____

_____

_____

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_____

The last few questions will help us understand who responded to this survey.

26. **Does your organization directly implement or support home visiting programs in SC?**

- ○ Yes, we directly implement home visiting programs
- ○ Yes, we support home visiting programs in my community
- ○ No, we do not directly implement or support home visiting programs

27. **If yes, what home visiting program model(s) does your organization implement (select all that apply)?**

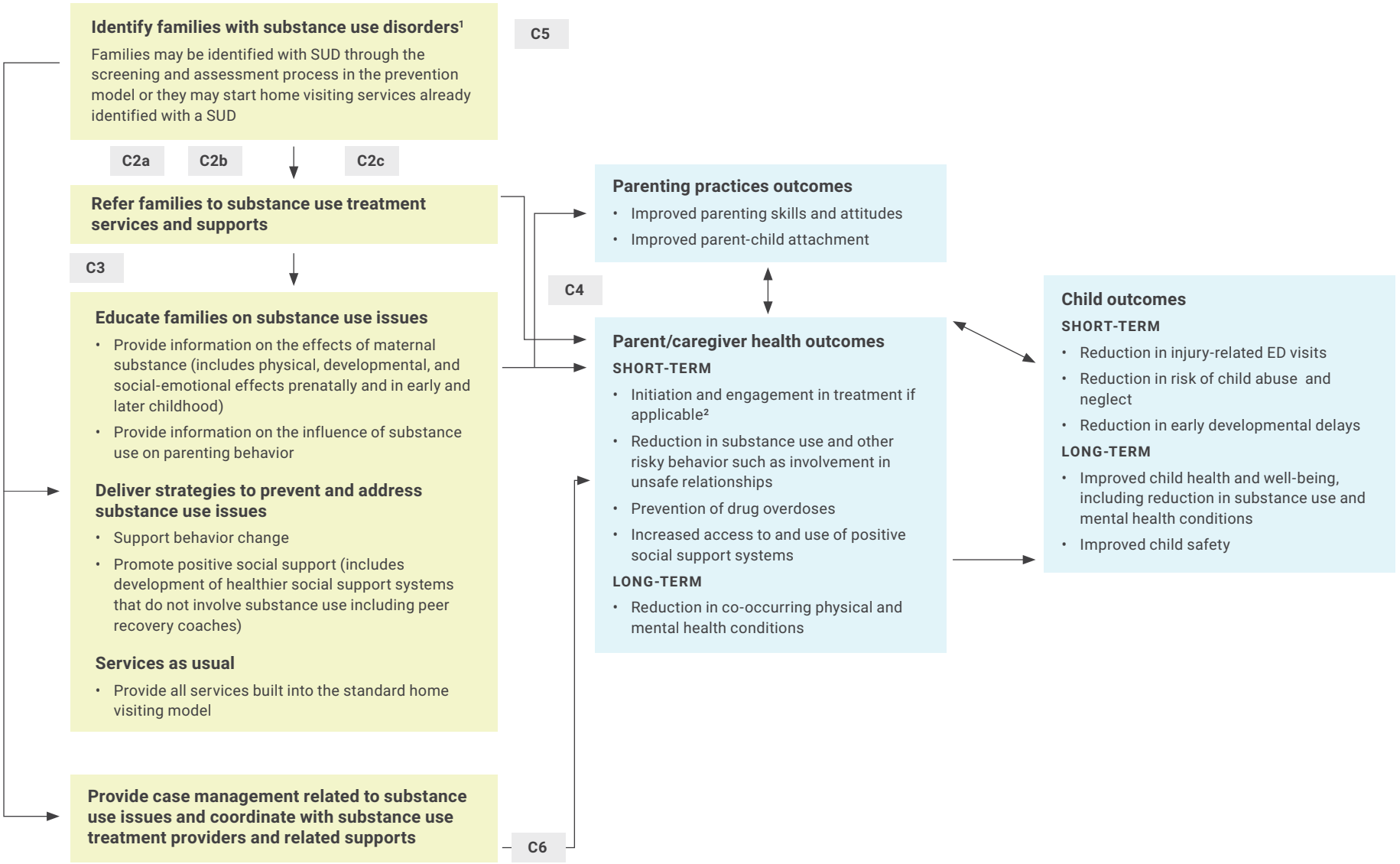
- ○ Early Head Start (Home-Based)
- ○ Early Steps to School Success
- ○ Healthy Families America
- ○ Healthy Start
- ○ Nurse-Family Partnership
- ○ Parents as Teachers
- ○ Parent-Child+
- ○ Other:_____

28. **What is your race/ethnicity? Please select all that apply.**

- ○ White
- ○ Black or African American
- ○ Native American or Alaska Native
- ○ Asian
- ○ Native Hawaiian or Other Pacific Islander
- ○ Hispanic or Latino
- ○ Other: _____
- ○ Prefer not to say

Thank you for taking the time to complete this survey. We value your feedback!

Appendix D: The Touchpoints Project Detailed Conceptual Model on Treatment and Recovery



Light yellow boxes denote touchpoints where home visiting services can address substance use issues among parents/caregivers.

1. Parents/caregivers may move from having a substance use disorder (treatment and recovery model) to being at risk for substance use issues (prevention model) and vice-versa at any time during their participation in home visiting serfvices.

2. Initiation and engagement in treatment is not a health outcome but is included in the box because it is critical to achieving the health outcomes listed.

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