Tulare County

Home Visiting Coordination Needs Assessment

Tulare County
Home Visiting Coordination Advisory Committee

June 21, 2021

Barbara Aved Associates

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"We tried to check in regularly with parents but they felt overwhelmed and essentially zoomed out, leading to less participation."— Agency Survey Respondent

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INTRODUCTION

"We are not creating a program [home visiting] and then trying to create a demand for it. Families do understand the benefit of the services and want it." – Key Informant Interview

Home visiting has served an essential role in addressing the needs of young children by connecting families to programs, supports, and services. Home visitors build relationships that extend beyond parenting and child development. While every family with a young child may benefit from community and social support to help adjust to developmental stages and promote their child's healthy development, for those with fewest assets, home visiting is a critical service to help families access supports and resources to help their child thrive. Home visiting, an integral part of the early childhood system of care (see Attachment 5), has been called "a lifeline for families during the COVID-19 pandemic"[1]

While Tulare County, along with other California counties, responded rapidly and effectively to the COVID-19 pandemic to protect residents, the virus "took hold" of the community: as of June 14, 2021, Tulare County had experienced 49,537 confirmed cases of COVID-19, resulting in 848 deaths.[2] School and business closures, stay-at-home restrictions, changes in the workplace and requirements for social distancing due to COVID-19 challenged home visiting programs in meeting the needs of impacted families with young children, particularly where inequities based on income and race/ethnicity exist. Many experts are now optimistic, however, that with the increase in vaccinations and natural immunity from many people having had the disease the worst of the pandemic is past. There is confidence that we are largely now in "life after COVID" recovery, while continuing to ensure home visiting services can continue in a safe and effective manner.

In October 2019, the First 5 California State Commission approved up to $24 million in funding for fiscal years 2019–20 through 2024–2025 to help counties create a sustainable, unified local home visiting system that supports families with the services they need and to maximize available funding to serve more families. As of January 1, 2021, 50 counties, including Tulare County, are receiving F5CA Home Visiting Coordination (HVC) funding and technical assistance.[3]

A comprehensive First 5 Tulare County Home Visiting Coordination Action Plan we developed detailed the activities to be carried out in FY 2020-21 to identify the effects of COVID-19 on families and the local home visiting infrastructure. This needs assessment, supported by the F5CA HVC grant, fulfills an important part of the Action Plan. The collaborative effort represented by this assessment report reflects the commitment and full partnership of the HVC Advisory Group (described in the next section) to strengthen the home visiting system in Tulare County. The report was produced by Barbara Aved Associates.

OUR SHARED VISION

Tulare County families will have access to and be supported by a coordinated and integrated system of culturally responsive, home-based family-strengthening services that optimizes child development, reduces negative childhood experiences, enhances parenting skills and resilience and safeguards health.

OUR MISSION

To improve the health and well-being of children and families through a collaborative and integrative system of family-centered services delivered in the home setting.

GOALS

The following goals reflect the desired results the HVC Advisory Group envisions, and will guide its work in addressing the needs of families impacted by COVID-19 through home visiting.

1. Increase home visiting coordination and referral among agencies that provide home visiting and family support services within the early childhood system of care.
2. Create and maintain effective community systems of care to increase accessibility of services.
3. Decrease duplication of services and maintain strong, ongoing communication and collaboration among home visiting and family-serving organizations.
4. Identify and address health and social/emotional concerns that affect child development and families in complex ways to improve outcomes.
5. Reduce adverse childhood experiences by strengthening parental capacity and encouraging positive parenting practices.
6. Foster child development and school readiness.
7. Promote family health and self-sufficiency.
8. Prepare, retain and support a well-qualified home visiting workforce.
9. Cultivate "vision ambassadors" who can serve as champions for children and families and help foster community buy-in.

THE EVIDENCE BASE FOR HOME VISITING*

Healthy Babies

Safe Homes & Nurturing Relationships

Optimal Early Learning and Long-Term Academic Achievement

Self-Sufficient Parents

ANTICIPATED OUTCOMES

The HVC Advisory Group is committed to tracking the following outcomes. Measuring their progress will help us see if the work we are doing is achieving the goals we intend to accomplish.

Family Focused…….

- Improvement in child health and safety (physical, social-emotional and cognitive)
- Reduction of child injuries and maltreatment
- Increased parent-child attachment
- Increased parental capacity
- Improvement in school readiness and achievement

Community Systems Focused……

- Effective service linkages
- Uniform standards and core competencies of home visitors
- Training and professional development opportunities
- Continuous quality improvement

* Adapted from the National Home Visiting Resource Center.

THE PROCESS AND DATA SOURCES

"We've got to get back to home visiting; it should be a priority." – HVC Advisory Group Member

Needs assessments inform action plan development and involve gathering, analyzing and *applying* quantitative (statistical) and qualitative (community input) data and other information for strategic purposes. These methods provide the necessary input to inform advisory groups, service providers and decision makers about community well-being, available programs, service gaps and priority areas where support is most needed. This environmental scan, focusing on the impact of COVID-19, also revealed some of the challenges collaborating Tulare County organizations faced in addressing the needs of pregnant women, young children, and families through home visiting, in-person or virtually.

HVC ADVISORY GROUP

A 17-member Home Visiting Coordination (HVC) Advisory Committee (Attachment 1) was formed to provide insight and guidance toward a more coordinated home visiting system among the organizations that provide early childhood and family support services in Tulare County. In addition to County, non-profit and Family Resource Center (FRC) organizations, two parent representatives from Lindsay and Visalia FRCs served on the Committee. The Committee met monthly between February and June and helped to develop the vision, mission statements and goals; offered many practical suggestions (e.g., adding important questions to draft surveys); promoted data collection efforts by participating in key informant interviews and raising awareness of the parent survey; reviewed and provided feedback to this report; and helped to develop next steps.

DATA SOURCES AND METHODS

Existing Data and Information

Statistical and other data, used to create a community profile, along with other commonly gathered community indicator data, were collected from applicable existing public sources and included demographic, socio economic and health status indicators. To give context to this assessment, we also reviewed: other local and regional needs assessment for relevancy; evidence-based home visiting models; case studies of others' experience; and related articles and reports that could inform the assessment. For example, data collected for other sources, such as the Hospital Council of Northern and Central California *Central Valley Community Health Needs Assessment, 2019*[4] and the recent home visitor workforce study, *Findings from the First 5 California Home Visiting Workforce Study – Child Trends,*[5] where relevant are cited in this report.

Organizations and providers offering home visiting services to Tulare County families were identified, and information about the type and availability of their services were gathered from surveys, interviews, email communication and, in some cases, retrieved from websites.

Community Input

To gain a better understanding of families' and organizations' perspectives about needs and home visiting services, input from Tulare County parents and providers were gathered through interviews and surveys. Ongoing input from the HVC Advisory Group also facilitated an understanding of the early childhood system of care in Tulare County.

Community Surveys

An online *Parent Survey* (Attachment 4) was developed in English and Spanish and the link sent to the Family Resource Centers and other appropriate early childhood organizations in Tulare County who obtained input from parents/caregivers, representing a convenience sample of the families who were in some way connected to the HVC partner agencies. The purpose of the survey was to learn more about the families' circumstances and solicit their opinions about priority needs and concerns—particularly during the time of the COVID-19 pandemic—experiences with home visiting services, awareness of services, barriers to access, and suggestions for ways service providers could be more helpful. Certain questions that served as markers for access to services (e.g., delays in getting needed dental or medical care) were also included. The survey was open for response between March 26 and May 14, 2021. We are deeply grateful to the families who participated in the survey and the agencies that facilitated their access to it.

The online *Partner Agency Survey* (Attachment 3a) sought to understand the service delivery models and staffing utilized by Tulare County home visiting and other early childhood care agencies, the ways they were meeting the needs of families, and changes in their work due to the pandemic. Some of the survey questions were designed to mirror the ones asked of parents to look for common themes and compare perspectives. The survey occurred between March 23 and April 23, 2021. A *Partner Follow-up Survey* (Attachment 3b) was later sent via email in June 2021 and asked for additional information about home visiting client demographics and services levels. We appreciate and value the participation of the respondents in sharing their data, experiences and perspectives. Data from all surveys were exported into Microsoft Excel spreadsheets, cleaned, coded and analyzed using standard data security measures.

Key Informant Interviews

Key informants are considered experts with first-hand knowledge about the community. Telephone interviews, using a set of semi-structured questions along with certain tailored questions to obtain more in-depth information, were conducted with 14 individuals who responded to an email invitation to participate. The key informants were identified from a representative cross-section of Tulare County health and human service agencies, community- and faith-based organizations, school personnel, and others with an informed perspective about the Tulare County population and the needs of families (Attachment 2). The Key Informant input was recorded in writing by the consultant during the telephone call then transferred to conventional summary notes and reviewed, coded and summarized for analysis based on thematic topics.

PART 1. OVERVIEW OF TULARE COUNTY

"Going into the home gives you the real-world picture—that an office visit simply can't—that informs how to respond to a family's needs." — Key Informant Interview

Population Characteristics

Centrally located in the Central Valley of California, Tulare County—the 18th most populated county in the state of 58 counties—is composed of 8 incorporated cities and 71 unincorporated communities. In 2019, the county was home to an estimated population of 466,195. With a median age of 31.4 years, Tulare County residents are one of the youngest regional populations in California.

Much of Tulare County's population is rural, where it can be difficult to access services. While overall city population changes vary from year to year, Tulare County city/county population estimates with annual percent change between January 1, 2019 and January 1, 2020 show a slight growth for the county overall (Table 1).

Table 1. Population Estimates of Tulare County Cities

County/City	Total Population		Percent Change
	1/1/2019	1/1/2020	
Tulare County	461,589	466,339	1.0
Dinuba	25,689	25,994	1.2
Exeter	11,009	11,030	0.2
Farmersville	11,396	11,399	0.0
Lindsay	13,153	13,154	0.0
Porterville	59,490	59,655	0.3
Tulare	66,457	67,834	2.1
Visalia	137,696	138,649	0.7
Woodlake	7,691	7,773	1.1
Balance of County	144,007	144,489	0.3

Source: State of California, Department of Finance, *E-1 Population Estimates for Cities, Counties and the State with Annual Percent Change — January 1, 2019 and 2020.* Sacramento, California,

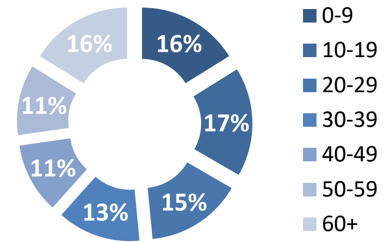
Age Groups

The pie chart on the next page on the right (Figure 1) displays population figures by age groups. A more detailed breakout of children ages 0-17 is shown in Table 2 to the left of the pie chart. As a group, Tulare County has a higher proportion of children under age 18 (30.5%) than statewide (22.5%).

Table 2. Child Population by Age Group

	Number	Percent
Ages 0-2	20,524	7.8%
Ages 3-5	21,761	
Ages 6-10	40,403	
Ages 11-13	25,310	30.5%
Ages 14-17	32,956	
Ages 0-17	140,954	

Figure 1. Percent of Population by Age Group

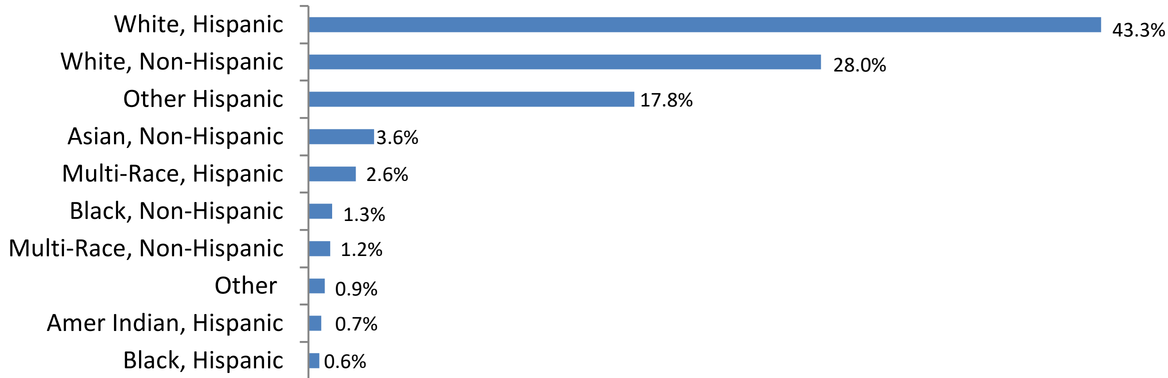


Source: U.S. Census, 2020

Race and Ethnicity

Hispanics (of any origin) make up about 65% of Tulare County's total population. The chart below (Figure 2) displays the details of the eight main race/ethnic groups represented in the county as a share of the total population. Note that though Black and Hispanic families have been disproportionately affected by the COVID-19 pandemic,[6] the data in this report are not presented by race and ethnic group due to mostly small-size populations.

Figure 2. Race/Ethnic Groups



Source: U.S. Census/American Community Survey, 2019

PART II. SELECT COMMUNITY INDICATORS

"The biggest driver of child well-being during COVID is how parents are functioning."
— National children's hospital study

Needs assessments reveal population trends, identify areas of increasing or decreasing risk, and point to gaps where additional resources are needed to support families. The selected measures of risk in this section help create a community profile for home visiting programs, and illustrate important characteristics and gauges. Some of these are characteristics used to select families for home visiting (e.g., poverty) and others relate to targeted outcomes of home visiting programs (e.g., child maltreatment). Though some of these indicators may have worsened since March 2020, most of the available data reflect the status of the community before the COVID-19 pandemic,

Family Demographics and Socio-Economic Well-Being

Families have been negatively impacted by the pandemic yet the effect is deeper among families who suffer from social and health inequities. The pandemic has also unveiled countless examples of the wide-ranging disparities such as unemployment, food scarcities, anxieties and family stressors.

Family Composition

Designing a home visiting framework requires understanding about families and family composition. (While "family" can mean many things, it is officially defined by the U.S. Census as a householder and one or more other people related to the householder by birth, marriage, or adoption.) About one-quarter (25.8%) of Tulare County children ages 0-5 lives in a home with their own parents who are married to each other, 35.2% with a female head of household with no spouse present, and 14.0% with a male head with no spouse present (Table 3).

Table 3. Family Composition, Tulare County*

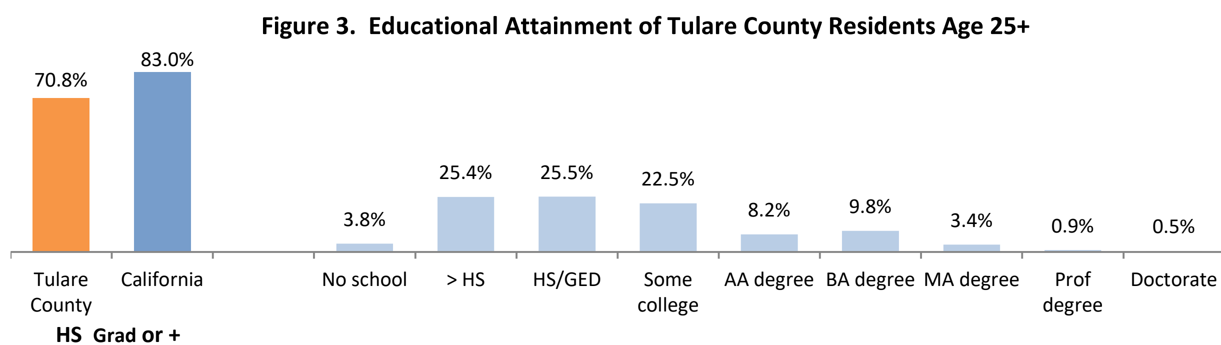
	Tulare County	California	Year
Households with children 0-17[7]	44.7%	34.0%	2017
Husband and wife families as a percent of all families[8]	68.1%	72.0%	2018
Percent of children ages 0-5 living with householder of own children who are[9] a) married b) female head c) male head	a) 25.8% b) 35.2% c) 14.0%	a) 21.4% b) 20.0% c) 15.8%	2019
Percent of children ages 0-5 living with grandparent householder with no parent present in the home[10]	17.1%	24.7%	2018

*See Endnotes for data sources.

Educational Attainment

In general, higher levels of education equate to the ability to earn higher wages, experience less unemployment and enjoy increased family stability. The community indicator typically used to measure educational attainment is "persons aged 25 and older with less than a high school education." In Tulare County, 71% of people aged 25 years or older, compared to 83% statewide, either graduated from high school or completed the Graduate Equivalency Degree (GED) or some equivalent certification/credential. Figure 5 also shows residents' various levels of educational attainment.

Figure 3. Educational Attainment of Tulare County Residents Age 25+



Source: U. S. Census Bureau, American Community Survey, 2020

Language/Linguistic Isolation

Linguistic isolation is defined by the U.S. Census Bureau as living in a household in which all members aged 14 years and older speak a non-English language and also speak English less than "very well" (i.e., have difficulty with English).[11] In Tulare County in 2015-2019, over half (51.3%) of persons age 5 years and older reported speaking a language other than English at home (vs. 44.2% statewide).[12] The percent of the population age 5+ who speak a language other than English at home who speaks English *less than* "very well" (considered a "linguistically isolated household" in needs assessment) is 23.2%.[13]

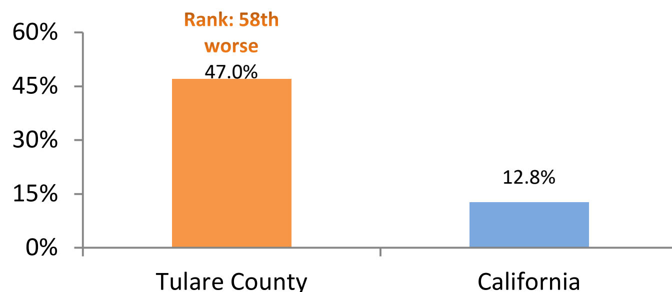
This information is important to understand how well people in the community speak and understand English to ensure that information about health, education, laws, polices and support services are communicated in languages that community members understand.
As an example of how this might impact individuals in the long run, of Tulare City School District's total 2019-20 K-12 enrollment, 7.1% of the English-Learners were considered at-risk of becoming a "long-term English learner in the next 4-5 years" compared to 5.7% statewide.[14]

Income and Poverty

In 2019, Tulare County had a median household income* of $49,687, about three-quarters of the amount in California. Approximately 18.8% of the population lives below the poverty line, about 1.5 times the rate in California.[15] Poverty is a major cause of poor health and family well-being. Some of the ways in which it contributes to ill health are immediately obvious: for instance, lack of healthy foods may lead to susceptibility to chronic disease. Poverty in children can reduce a readiness for school because it leads to poor physical health and motor skills, and diminishes a

child's ability to concentrate and remember information. Indigence is also a predictive factor in teen pregnancy rates (inordinately high in Tulare County), which, in turn, increases the risk of poverty and poor health outcomes of the adolescent parent(s) and their offspring.[16] Poverty is a pressing issue for the county: in 2015-17, nearly half (47%) of children ages 0-18 were living in areas of concentrated poverty, compared to the 12.8% state average[17] (Figure 4). In every age group above 18 years, women outnumber men by the proportion living in poverty.[18]

Figure 4. Children 0-18 Living in Areas of Concentrated Poverty, 2015-17



Source: U.S. Census Bureau, American Community Survey

Unemployment

Beyond the obvious relationship to family income, the ability to have employment can have a significant impact on an individual's self-esteem and well-being. While about 11% of Tulare County's labor force was unemployed in February 2021 (down from 18.6% immediately post-COVID shutdown last April),[19] the proportion of unemployed varies widely, ranging from 5.5% in communities like Goshen to 32.6% in Terra Bella (Table 4).

Table 4. Percent of the Tulare County Population Unemployed, February 2021 (in alphabetical order by area)

Area Name	Unemployment Rate	Area Name	Unemployment Rate
Tulare County	**11.4%**		
Alpaugh CDP*	27.1%	Pixley CDP	21.4%
Cutler CDP	18.1%	Poplar Cotton Center CDP	40.4%
Dinuba city	13.7%	Porterville city	13.5%
Ducor CDP	9.7%	Richgrove CDP	44.6%
Earlimart CDP	16.3%	Springville CDP	5.6%
East Orosi CDP	23.8%	Strathmore CDP	20.7%
East Porterville CDP	25.9%	Terra Bella CDP	32.6%
Exeter city	15.5%	Three Rivers CDP	5.9%
Farmersville city	14.8%	Tipton CDP	13.9%
Goshen CDP	5.5%	Traver CDP	4.9%
Ivanhoe CDP	13.4%	Tulare city	8.6%
Lemon Cove CDP	6.1%	Visalia city	6.9%
Lindsay city	18.8%	Woodlake city	8.4%
London CDP	17.3%	Woodville CDP	18.7%

Source: California Department of Labor.
*CDP is "Census Designated Place" - a recognized community.

Food Security

Food insecurity is a measure of lack of access, at times, to enough food for a healthy life for all household members, and limited or uncertain availability of *nutritionally adequate* foods. Food insecure children are those children living in households experiencing food insecurity. In Tulare County, one-third (33.2%) of the general population reached through the UCLA CHIS household survey reported being unable to afford enough food in 2019;[20] a separate survey the same year found one-quarter (25.7%) of children 0-17 living in food insecure households. During COVID-19, however, those proportions likely increased (Table 5).[21]

Table 5. Food Insecure Households, 2019

	Tulare County	CA
The percent of adults unable to afford enough food (food insecure)	33.2%	41.9%
The percent of children ages 0-17 living in households with limited or uncertain access to adequate food	25.7%	18.1%

In FY 2019-20, 76.5% (up from 62% in 2016) of eligible students—105,055 students—received free or reduced-price meals during the school year in Tulare County.[22]

Table 6 reports the estimated percentage of Tulare County households receiving the Supplemental Nutrition Assistance Program (SNAP) benefits. This indicator is relevant because it assesses vulnerable populations that are more likely to have multiple access, health status and social support needs.

Table 6. Percent of Households Receiving SNAP Benefits, 2018

Report Area	Total Population	Non-Hispanic White	Black	Asian	American Indian / Alaska Native	Other Race	Multiple Race	Hispanic or Latino
Tulare County	10.6%	19%	2%	1%	0%	0%	2%	75%
California	5.0%	28%	14%	6%	1%	6%	1%	45%

Source: California Department of Social Services, CalFresh Data Tables (Oct. 2018) as reported in kidsdata.org.

Homelessness

Homelessness at any point in a person's life, and especially a child's, can cause severe trauma, disrupt relationships, and put health and safety at risk. Like the rest of the state, the number of people experiencing homelessness in Tulare County has increased significantly—almost 30% since 2015. According to the Point-in-Time Count, on a given night in 2019, there were 814 men, women and children experiencing homelessness in Tulare County with 576 of those people living unsheltered on the streets, in vehicles, or in encampments. More than 90% of these individuals had their last stable residence in Tulare County.[23] It is worth noting, however, that the number of people who experience homelessness in Tulare County over the course of a year is much higher.

This is because the Point-in-Time Count only measures the number of people who are homeless on a given day and does not account for the many people who fall in and out of homelessness during the rest of the year. Of Tulare County public school students, 3.1%—or 2,160 school-age children—were estimated to be homeless at some point during the 2018 school year.[24]

ACES

Adverse Childhood Experiences (ACES) impact the health and well-being of children, families and communities across Tulare County. Based on a study of four years of data collected prior to the pandemic, the prevalence of people with ACES was estimated as shown in Table 7.[25] The findings mirrored the statewide average.

Table 7. Prevalence of People with ACES in Tulare County

Number of ACES	Percent of the Population	
0	38.9%	
1	21.1%	61% of
2 or 3	21.2%	residents
4 or >	18.8%	have 1 or >

Maternal and Child Health

Births

In 2020, there were 6,084 live births reported for women in Tulare County.[26] The average age of women giving birth in 2019 was 28.06, the lowest in the state except for Kings and Kern Counties (which were 27.82 and 27.98, respectively).[27] The county's birth rate (i.e., the general fertility rate) is about 20% higher than the average for the state (Table 8).[28]

Table 8. Birth Rate, 2017

Tulare County	California
72.8	58.7

Source: CDC. Natality public-use data.
Rate per 1,000.

While about half (46.6%) of the births in California were to women of Hispanic origin, in Tulare County close to three-quarters (72.7%) of births were to this group (Table 5).

Table 9. Births by Race/Ethnicity, 2017

	Tulare County	California
Hispanic	72.7%	46.6%
White	19.8%	26.9%
Black	1.1%	4.9%
American Indian	0.8%	0.3%
Asian/Pacific Islander	3.2%	15.6%
Multiracial	1.6%	2.5%

Source: California Department of Public Health.

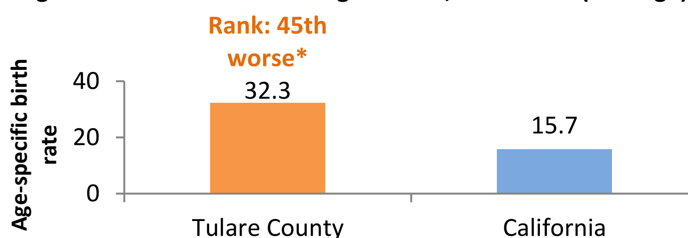
Births to Teen Mothers

Studies have detailed the negative consequences associated with unintended pregnancies for teen parents and their children. These concerns include preterm delivery and low birth weight, maternal depression and missed educational opportunities (increased risk of early dropout from school) locking the young mother into a poverty syndrome. Pregnant adolescents are also more likely to smoke and use alcohol than are older women, increasing the risks associates with those health behaviors.[29]

While across the state adolescent birth rates are declining—due in part to more comprehensive sex education, better access to birth control and better contraception methods—the rates in some California counties remain very high. Tulare County's three-year average adolescent birth rate was 32.3 in 2015-2017, twice the statewide rate of 15.7, ranking the County second from the bottom of

California counties (Figure 5). The extent of difference between the county and statewide adolescent birth rates has not significantly changed in the last decade.[30]

Figure 5. Births to Mothers Aged 15-19, 2015-2017 (Average)



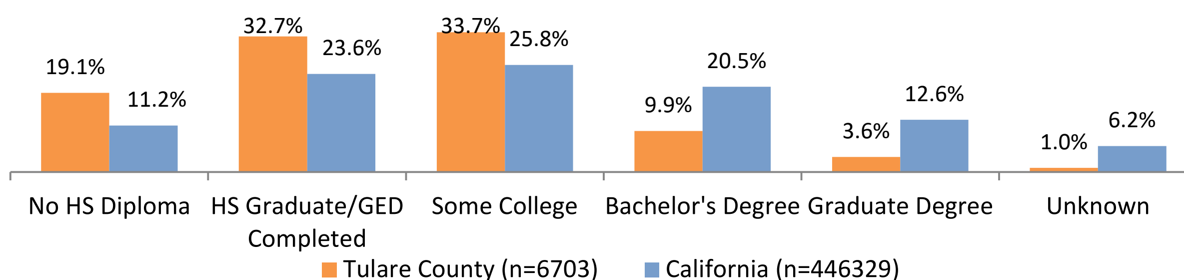
*Among the 46 California counties with >20 teen births reported per year.
Source: California Department of Public Health

Also significant, the county's *repeat* teen birth rate of 21.3—calculated as the percentage of all births to mothers aged 15-19 with one or more previous live births—exceeds the statewide average of 17.0.[31] The national figure is 18.3%.[32] Repeat teen births pose greater challenges because additional births can further constrain the mother's ability to attend school and obtain job experience.

Births by Education and Marital Status

Maternal socioeconomic disparities, such as maternal education at the time of birth, strongly affect child health. Among mothers aged 25 and over in Tulare County who gave birth in 2019, 19.1% did not have a high school/GED diploma, a proportion nearly twice the state as a whole (Figure 6).[33] Births to *unwed mothers* with less than high school graduation were even higher, 40%, ranking Tulare County among the highest in the state.[34]

Figure 6. Mother's Education at the Time of Birth, 2019



Source: California Department of Public Health Birth Files.

Prenatal Care

While the percentage of women receiving prenatal care in the first trimester is lower in the county than in the state, the percent of adequate/adequate plus prenatal care—and the proportion of infant deaths—generally matches the statewide average (Table 10).

Table 10. Prenatal Care and Birth Weight, 2015-2017 (average)

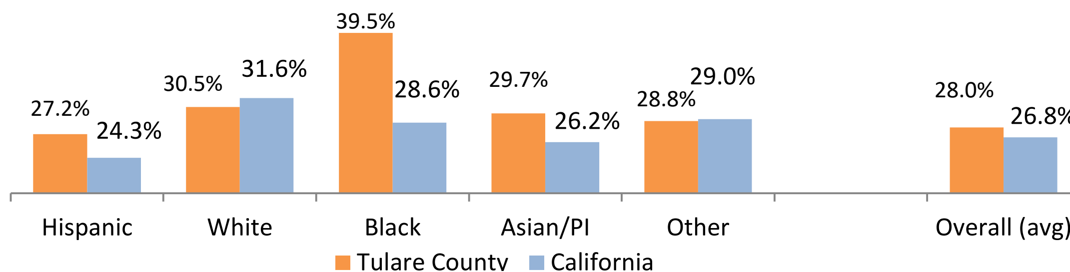
Measure	Tulare County		California
	Rank Order	Percent	Percent
First trimester prenatal care	37	73.4%	83.5%
Adequate/adequate plus prenatal care	23	78.2%	77.9%
Low birth weight infants	38	7.0%	6.9%

Source: California Department of Public Health, Health Status Profiles 2019.

Birth Interval

Access to contraception—a subject that home visitors may not address if not trained to do so—is associated with adequate birth spacing. Closely spaced births are an important issue because short birth intervals—although not necessarily causally—can have health consequences for both the mother and infant.[35] (An inter-pregnancy interval is considered short if it is less than 18 months.) Among all women giving birth in Tulare County in 2012—the last year for which these data were available—28% vs. 26.8% statewide experienced a short birth interval.[36] As Figure 7 shows, white and Black mothers had slightly shorter birth intervals than the county average.

Figure 7. Mothers with Inter-Pregnancy Intervals Less than 18 Months



Source: California. 1991-2012 Birth Cohort and Birth Statistical Master Files

Infant mortality (the number of deaths among children under age 1 per 1,000 live births) is a key measure of community health, reflecting socioeconomic conditions, maternal health, public health practices, and access to high-quality medical care, among other factors. Tulare County's rate exceeds the statewide average (Table 11). (Note, while African American babies in the U.S. and California die at more than twice the rate of other groups, the sample size in Tulare County is too small to calculate a rate.)

Table 11. Infant Mortality Rate, All Race/Ethnic Groups, 2014-2016

Tulare County	California
6.1	4.3

Source: California Dept. of Public Health, Birth and Death Statistical Master Files; National Center for Health Statistics
Rate per 1,000.

Maternal Depression

Maternal depression is considered a risk factor for the socioemotional and cognitive development of children.[37] Mothers already at risk for depression are particularly fragile during the first months postpartum when home visiting services can be so beneficial. According to the UCSF 2013-2015 Maternal and Infant Health Assessment (MIHA)—a valuable survey among California women for many MCH-related issues— 10.4% of Tulare County women reported having postpartum depression.[38] Because home visitors tend to encounter new mothers repeatedly, it is important that they have the knowledge and skills for the detection of symptoms of maternal depression.

Breastfeeding

Many women after giving birth benefit from support both to initiate and be able to sustain breastfeeding at home afterwards. Table 12 shows the percent of women who initiate any or exclusive breastfeeding after childbirth and the percent of women who continue it for at least 3 months.

Table12. Percent of Breastfeeding

	At Hospital Initiation[1]	
	Tulare County	**California**
Any	89.9	93.8%
Exclusive	53.0%	70.2%
	1 – 3 Months Later[2]	
Any, 1 mo. after	68.1%	83.8%
Exclusive, 1 mo. after	37.4%	44.2%
Any, 3 mos. after	49.4%	67.3%
Exclusive, 3 mos. after	22.2%	29.1%

Source: [1]CA Dept. Public Health, In-Hospital Breastfeeding as Indicated on the Newborn Screening Test Form Statewide and Maternal County of Residence by Race/Ethnicity: 2018.
[2]California Department of Public Health: MIHA Data Snapshot, Tulare County, 2013-2015 Maternal and Infant Health Assessment (MIHA) Survey.

Infants Born Drug-Exposed/Children's Exposure

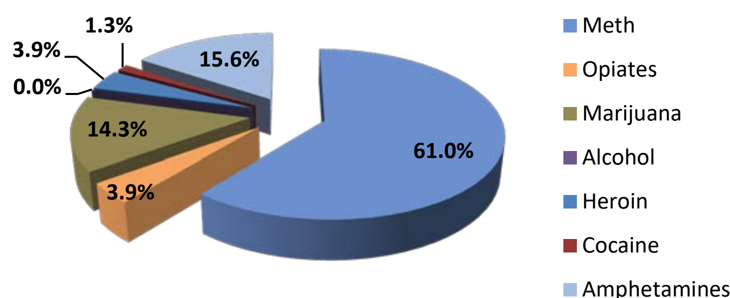
Infants exposed to alcohol and drugs during pregnancy run the risk of suffering from birth defects, low birth weight, premature birth, sudden infant death syndrome (SIDS), and subsequent developmental and behavioral delays and/or challenges. Applying the national estimate of 11.2% of live births affected by prenatal alcohol or illicit drug exposure, [39] —an acceptable deduction with known data but probably on the low side for Tulare County—798 babies (of 7,134 births) in Tulare County were estimated to be born substance exposed in 2018.

Statistics from the Tulare County CWS system related to perinatal substance abuse add to the local picture but are very difficult to pull. This is for several reasons: because allegations do not include substance abuse as a reporting code—the referral of an allegation would be due to something else such as general neglect, physical abuse, and so forth; it is not always clear whether the parent

(mother) involved was pregnant at the time of the allegation; and, not all cases, even when referred by a maternity hospital or other medical provider for a newborn positive tox screen, do not always (in fact, do not generally) result in the need to open a case, according to CWS.[40] CWS assesses these referrals, and factors such as the type, frequency and amount of the substance used dictate that decision. For instance, because marijuana is legal in California, it is uncommon for evidence of that in the newborn to be the reason for opening a case. Other factors for not opening a CWS case include the mother's support system (such as if the baby is being cared for by the grandparents), and breastfeeding status (the risk is lowered when the mother is *not* breastfeeding, which, paradoxically, works against the county's breastfeeding promotion efforts).

Parental substance use disorder is one of the leading underlying factors contributing to the finding of neglect as the basis for child removal. Using the best query possible to capture the total Drug Exposed Infant (DEI) referrals, CWS identified 64 open cases at the time of our request,[*] where the condition for the child being removed was prenatal drug/alcohol exposure.[41] (This is likely an undercount as these referrals do not capture the many more that were not open to a case.) Figure 8 displays the type of substances that were involved, with methamphetamine the most common, at 61%.

Figure 8. Substance Use in Tulare County Currently-Open Cases of Drug-Exposed Infants, 7/1/20 – 5/31/21 (n=64)



Source: Tulare County Child Welfare Services, June 3, 2021
Note: 10 of the 67 open cases represented by this graphic had more than one substance reported.

Given the widely-recognized magnitude of substance abuse in Tulare County,[42] there are relatively few reported parent referrals to CWS for substance abuse services (again, the referral allegation would be due to something else such as general neglect, severe neglect, physical abuse). Since January 1, 2019, there have been 62 cases where the mother—and 78 cases where the father—was referred for Substance Abuse Testing or Substance Abuse Services. The referrals involving mothers represent 52 children, 24 (39%) of whom were ages 0-5.[43]

Immunizations

Parents and providers are doing a good job of keeping up with immunizations; the percentage of Tulare County children entering kindergarten fully immunized in 2019, 98.1%, was more favorable

[*] 16 of the cases were opened in 2019; 13 in 2020. The other cases were opened before 2019 except one that opened in 2021 and is still open at the time of this writing.

than the statewide average (94.8%)—and in fact was bested by only one other county, Modoc County.[44]

Children with Special Health Care Needs

According to an analysis of children's health from the American Community Survey (2016-2019), the estimated percentage of children ages 0-17 with special health care needs in Tulare County was 14.9%.[45] In another analysis of families, this one with children under age 5, 15% of children 0-5 were estimated to have special health care needs.[46]

Children's Mental Health

There is no questions that Tulare County children and youth have experienced as unique a crisis, and all at once, as during the COVID-19 pandemic: social isolation during lockdowns, family stress and financial instability, a breakdown of routine, learning interruptions and, for some, loss of a parent or grandparent. While "hard" local mental and behavioral health status data during COVID and in this late-pandemic period would be important to have, the data are mostly anecdotal at this time. However, a national survey of parents with children 0-17 showed that since March 2020, 27% of parents reported worsening mental health for themselves, and 14% reported worsening behavioral health for their children.

What will be the long-term effects of this last year remains one of the most important questions to address in home visiting programs—monitoring indicators of children's mental health, promoting coping and resilience, and expanding access to services to support children's mental and behavioral health needs.

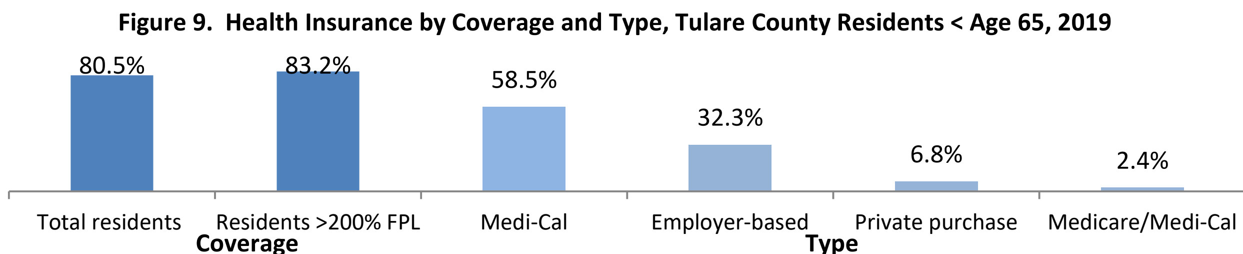
Access and Utilization

The First 5 CA Strong Start Index paints a portrait of the resources that promote resilience for children in a given neighborhood, county, or region. In 2017, the Index gave Tulare County an average score of 7.5 (vs. 9.3 in California).[47] It is worth noting that year-over-year differences mostly represent demographic shifts and not necessarily differences in resources available and child characteristics.

Health Insurance

CHIS data[48] regarding health insurance coverage in Tulare County show 80.5% of all residents under age 65 have health insurance; the proportion increases to 83.2% for those living at 200% or less of the federal poverty level (Figure 9). The same data source reports the main reasons for not having coverage by those currently uninsured as not offered by employer/insurance dropped or cancelled (35.5%); cost (35.4%); and change in working status or family situation (26.2%).

Figure 9. Health Insurance by Coverage and Type, Tulare County Residents < Age 65, 2019



Source: 2019 California Health Information Survey (CHIS)

Dental/Medical Services

Oral health status and use of dental services—an issue which may not be on the radar of all home visitors—is a good marker for children's (and other family members') access to preventive services. While many young children in Tulare County are free of visible dental disease when screened, a remarkably high percentage is not. Screening data of children 0-5 by Family Healthcare Network and Altura Centers for Health in FY 2019-20 showed an *average* 32.2% and 31.5% of children, respectively, with evidence of dental disease. Yet, dental visits for children with Medi-Cal—in which comprehensive dental services are a benefit—show just over half of the 0-5 population made a visit in 2018 (Table 13).[49]

Table 13. Dental Visit within the Last 12 Months, Children with Medi-Cal, 2018

Age Group	Percent
Ages 1-2	26.8%
Ages 3-5	56.5%
Ages 6-9	63.9%

In 2018, fewer than half (43%) of children with Medi-Cal, despite enrollment in a *managed* care system, had an annual preventive medical check-up.[50]

Child Development

Screening

Screening plays an important role in assessing a child's development and provides early detection so that children experiencing delays can be identified and referred. In FY 2019-20, of about 350 children assessed through First 5 with the Ages and Stages Questionnaire (ASQ), close to 9% demonstrated sufficient concern to warrant referrals for further evaluation (Table 14).[51]

Table 14. ASQ Results with the Need for Referral / Further Evaluation

Tulare County First 5 Sample	California/National
9% average, in 2019-20	6%-7% avg. sample of other First 5s 5%-9% est. national average

Early Childhood Education and Learning

Across all Tulare County households with children 0-5, 57.9% of parents report reading books or singing songs with their children every day.[52] Among parents who participate in First 5 programs, however, the proportion is more impressive, averaging about 63%.[53]

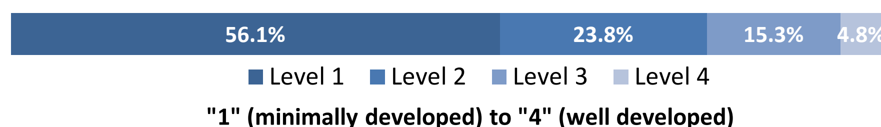
Based on state and local estimates, the percentage of young children in Tulare County without access to or not enrolled in early childhood education program is high. Table 15 displays findings from various sources and the year of publication.

Table 15. Early Childhood Education and Preschool Attendance

Early Childhood Education (ECE)	Attends preschool, nursery school, or Head Start at least 10 hours/week[54]	12.2% (2019)
	The percent of infants/toddlers *not* served[55]	86% (Low-income families), in 2016 77% (Working families)
	The percent of preschoolers *not* served[56]	58% (Low-income families), in 2016 61% (Working families)
Preschool Enrollment	The estimated percent of children ages 3-5 not enrolled in preschool or kindergarten[57]	47.3%, average, 2012-16

Figure 10 displays the percent of English Learner Kindergarten students' oral language performance, a rating of Tulare County children speaking other than English at home determined to lack the clearly defined English language skills to succeed in the school's regular instructional programs), an indicator home visitors may need to consider in providing books and other educational materials.[58]

Figure 10. English Learner Kindergarten Students' Oral Language Performance



Child and Family Safety

Child Maltreatment

Incidents involving children under the age of 4 make up a disproportionately high percentage of child abuse and neglect reports. *Pre*-COVID, the rates of alleged and substantiated child abuse and neglect in Tulare County (shown in Table 16 for 2019), though trending downward, were slightly higher than statewide averages, with children age < 1 at highest risk. Anecdotal reports from community providers suggest the rates have increased as a result of the pandemic (e.g., many children stuck with their abusers, without the safe space that school would normally offer). "Hard" data such as current emergency room visits for severe abusive injuries are unavailable or comprise a too-small sample size.

Table 16. Child Abuse and Neglect by Age Group, 2019

Rate of child abuse and neglect allegations per 1,000 children[59]	Age < 1	97.0
	Ages 1-2	64.1
	Ages 3-5	73.8
Rate of substantiated cases of child abuse and neglect per 1,000 children[60]	Age < 1	38.3
	Ages 1-2	9.2
	Ages 3-5	7.2

Foster Care

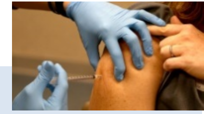
Providers report there are currently fewer children coming into foster care because there have been fewer eyes on the children, i.e., no teachers, parents, or friends to call CPS. (Though they've adapted, it has also been extremely challenging for case workers to conduct adoptions and foster care placements remotely.) *Pre*-COVID, the rate of entry into care in Tulare County (shown in Table 17 for 2019) was slightly higher than statewide with the youngest children at highest risk.

Table 17. Foster Care Experience by Age Group, 2019

Rate of child entry into foster care per 1,000 children[61]	Age < 1	19.0
	Ages 1-2	5.5
	Ages 3-5	4.4

Domestic Violence

Similar to child maltreatment, since the restrictions imposed by COVID-19, not everyone may be safer staying at home. Pre-pandemic (2015), 6.2% of the women in Tulare County responding to the UCSF Maternal Infant Health Assessment survey reported physical or psychological intimate partner violence during their most recent pregnancy.[62] Pre-pandemic (2019), the Tulare County Sheriff reported a total of 616 domestic violence incidents (i.e., *cases* of domestic violence, not calls for service which don't necessarily result in a case report). Based on monthly crime reports for 2020—the "COVID year"—there were 787 reported incidents—a 27.8% increase over the previous year.[63]



COVID-19

During the COVID-19 pandemic and recovery, the need for home visiting has been more critical as families have faced new or expanding challenges. Vaccines to prevent coronavirus disease, along with adherence to other safety precautions are considered the best hope for ending the pandemic. They are also the most promising strategy to increase families' (and workers') comfort level in restoring in-person home visiting. Although all COVID-19 vaccines currently available have been shown to be safe and effective,[64] vaccine hesitancy, misinformation, a lack of trust in medical institutions, and transportation access have contributed to low inoculation rates. An April 2021 study found residents in the Central Valley were more likely than those in the Los Angeles and San Francisco Bay Areas to express vaccine hesitancy.[65] In Tulare County, as of June 10, 2021, only 39.9% of the population age 12+ had been fully vaccinated (Figure 18).

Table 18. COVID-19 Vaccine Progress Dashboard Data by ZIP Code (June 10, 2021)

Zip Code	12+ Population	Persons Fully Vaccinated	Percent of Population Fully Vaccinated	Persons Partially Vaccinated	Percent of Population Partially Vaccinated	Percent of Population with 1+ Dose
93201	1168	330	28.3%	75	8.0%	34.7%
93218	726	277	38.2%	62	8.5%	46.7%
93219	8136	3311	40.7%	628	7.7%	48.4%
93221	11596	4326	37.3%	870	7.5%	44.8%
93223	8725	2655	30.4%	756	8.7%	39.1%
93235	3367	1327	39.4%	307	9.1%	48.5%
93244	284	166	58.5%	17	6.0%	64.5%
93247	14706	5070	34.5%	1050	7.1%	41.6%
93256	4079	1391	34.1%	252	6.2%	40.3%
93257	61520	23205	37.7%	5263	8.6%	46.3%
93258	1788	940	52.6%	229	12.8%	65.4%
93261	1970	849	43.1%	177	9.0%	52.1%
93265	3091	1433	46.4%	211	6.8%	53.2%
93267	5401	1646	30.5%	343	6.4%	36.8%
93270	4466	1847	41.4%	409	9.2%	50.5%
93271	2288	1026	44.8%	136	5.9%	50.8%
93272	3520	915	26.0%	161	4.6%	30.6%
93274	57353	20413	35.6%	4556	7.9%	43.5%
93277	42465	16980	40.0%	3632	8.6%	48.5%
93286	7718	3108	40.3%	631	8.2%	48.4%
93291	46880	18115	38.6%	4495	9.6%	48.2%
93292	32860	12770	38.9%	2964	9.0%	47.9%
93615	4874	1628	33.4%	348	7.1%	40.5%
93618	24482	9754	39.8%	2511	10.3%	50.1%
93647	8610	3345	38.8%	794	9.2%	48.1%
93666	566	186	32.9%	47	8.3%	41.2%
93673	616	273	44.3%	50	8.1%	52.5%
TOTALS/AVGs	**363252**	**137286**	**39.9%**	**30974**	**8.0%**	**46.8%**

Source: CA Department of Health Services. https://data.ca.gov/dataset/covid-19-vaccine-progress-dashboard-data-by-zip-code

PART III: LOCAL RESOURCES, CAPACITY AND PERCEPTIONS

"We see a gap—and there we are with resources! We [Tulare County organizations] are such a close-knit community of caring organizations; no big egos involved." — Key Informant Interview

Research indicates that early intervention tools like evidence-based home visiting can reduce or prevent the effects of adverse experiences for children.[66] Tulare County has a long history of investing in home visiting services beginning with Early Head Start home-based services and Migrant Education programs. However, at present the number of children in Tulare County who would most benefit from home visiting outweighs the current service levels.

HOME VISITING PROGRAMS IN TULARE COUNTY

The California Home Visiting Supply & Demand Tracker, funded by First 5 CA, provides county-level information about family characteristics associated with benefiting from home visiting, as well as available home visiting services.[67] A snapshot of Tulare County shows there are 21,783 families* with children under age 5 who are eligible for home visiting services based on the characteristics we described above, e.g., child age, pregnancy, adolescent mothers, single parents, low-income families, CalFresh recipients and so forth. This analysis reports a total of 19 programs described as "14 evidence-based models per HHS guidelines, four models that are home visiting-compatible, and one model that is implemented in multiple communities" with enough funded slots to serve 883 families. ** The available data therefore suggest considerable unmet need for home visiting among Tulare County families.

Table 19. Tulare County Home Visiting Supply and Demand Snapshot

Program Eligibility	Number of Families	Home visiting programs serving families with selected characteristics		Home visiting programs require selected characteristics for program eligibility	
		Number of Funded Slots	Number of Programs	Number of Funded Slots	Number of Programs
Families with children under age 5	21,783	883	19	883	19

Source: Child Trends, February 2021.

The home visiting programs in the county, their sponsoring organizations and contact individuals are shown in Table 20 on the next page. (See Section V. of this report for a description of these models.)

* Each household could include multiple families; if so, those families were counted as separate families. Same-sex parents were also counted. If there is no parent in a family, the head of the household and their spouse (e.g., grandparents) were counted as the parents.
**The number of families served may be not be precise due to the possibility of families receiving services from more than one program, differing time periods for determining those served, attrition, non-voluntary (e.g., CPS) vs. voluntary home visits, etc.

Table 20. Tulare County Home Visiting Programs

Organization	Contact Person	Description
Community Services & Employment Training (CSET) Tulare FRC	Angel Avitia angel.avitia@cset.org	▪ *SafeCare* ▪ *Differential Response* ▪ *Parenting Wisely*
Culter-Orosi Family Resource Center	Cyndee Garcia CAGarcia@cojusd.org	▪ *Parents as Teachers* ▪ *Parenting Wisely* ▪ *Differential Response* ▪ *SafeCare*
Dinuba Family Resource Center (Parenting Network)	Armando Villarreal armando@parentingnetwork.org	▪ *Parents as Teachers* ▪ *Differential Response* ▪ *SafeCare* ▪ *Parenting Wisely*
Family Services of Tulare County	Julia Castro Julia.Castro@fstc.net	▪ *SafeCare* ▪ *Parenting Wisely*
Lindsay Healthy Start Family Resource Center	Linda Ledesma lledesma@lindsay.k12.ca.us	▪ *Parents as Teachers* ▪ *Differential Response* ▪ *SafeCare* ▪ *Parenting Wisely*
Porterville Family Resource Center (Parenting Network)	Paul Prado paul@parentingnetwork.org	▪ *Parents as Teachers* ▪ *Differential Response* ▪ *SafeCare* ▪ *Parenting Wisely*
SAVE the Children – Early Steps to School Success	SaRonn Mitchell smitchell@savechildren.org	▪ *ESSS home visits*
TCOE Early Childhood Education Program	Claudia Carter claudiac@cc.tcoe.org	▪ *Early Head Start home-based services*
Tulare County Public Health MCAH Program	Tammy Wiggins Twiggins@tularehhsa.org	▪ *Nurse Family Partnership program*
Visalia Family Resource Center (Parenting Network)	Timberly Romero timberlyr@parentingnetwork.org	▪ *Parents as Teachers* ▪ *Differential Response* ▪ *SafeCare* ▪ *Parenting Wisely*
Woodlake Family Resource Center	Adela Hernandez ahernandez@w-usd.org	▪ *SafeCare* ▪ *Parenting Wisely* ▪ *Parents as Teachers* ▪ *Differential Response*

HVC PARTNERS' SURVEYS

The online and email follow-up *Agency Surveys* sent to the HVC Advisory Group gave us the opportunity to understand the service delivery models and staffing utilized by Tulare County home visiting and other early childhood care agencies. We also learned how these organizations are meeting the needs of families, and changes they made in their work due to the pandemic.

Survey Sample

We received 10 responses to the online agency survey, and 10 responses from the emailed follow-up survey, representing 10 organization *sites*;* it is likely these are the same respondents from each survey, though they may have identified their agency type somewhat differently in each reply (Figures 11 and 12, respectively). The purposeful mailing makes it possible to believe the findings are reflective of the number and types of home visiting services being provided in Tulare County. Because the sample size is relatively small the results were analyzed by home visiting model type, not by respondents.

Figure 11. Type of Agency Respondents, Online (n=10)

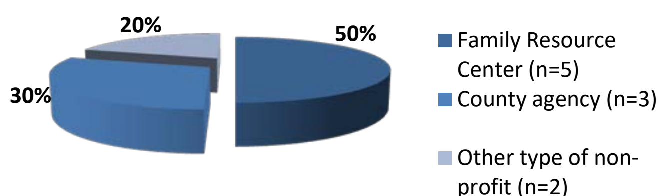
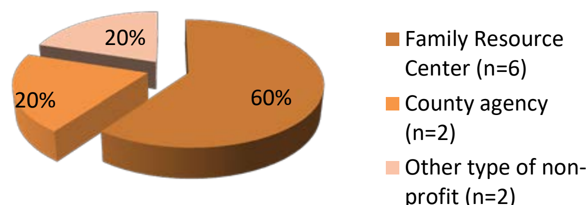


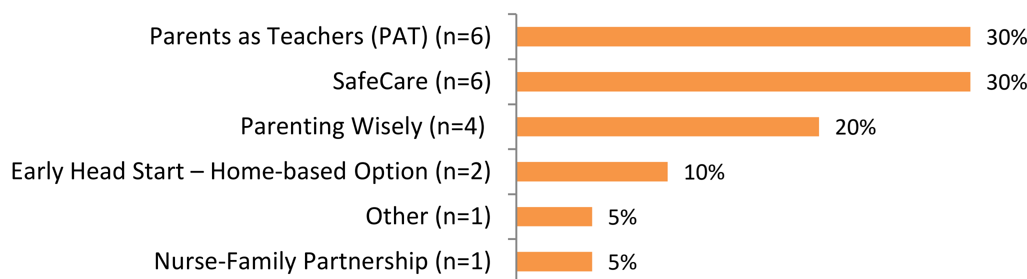
Figure 12. Type of Agency Respondents, Email (n=10)



Home Visiting Models and Roles

Half of the organizations reported using more than one home visiting model; the most common response was using both Safe Care and Parents as Teachers (Figure 13).

Figure 13. Types of Home Visiting Models Used by Respondents (n=10)

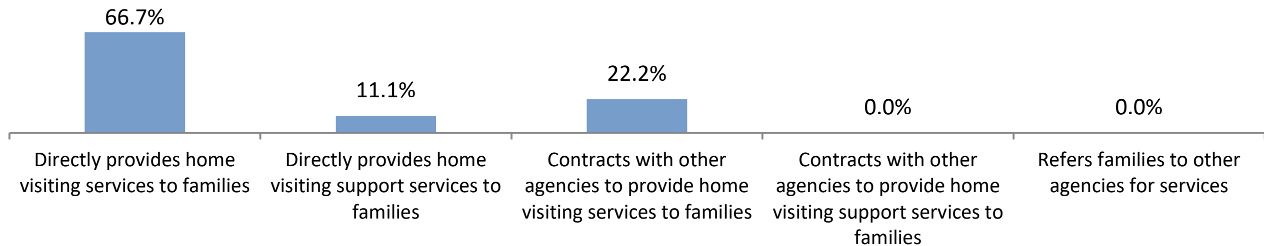


Source: Online Partner Survey

* The partners were asked that only one response be submitted from each agency; however that turned out not to be the case. Because the online survey was anonymous to promote confidential and candid responses to the open-ended questions, it is not possible to be certain exactly which entities participated in that survey. However, the respondent organizations/sites are nearly the same between the two rounds of surveyed partners.

The majority (66.7%) of the agencies with a role in home visiting prior to COVID (one responded it had none), described its role as *providing* home visiting services vs. less direct methods of providing support as described in Figure 14. The services provided align with documented needs of families enrolled.

Figure 14. Agencies' Role in HV Prior to COVID (n=7)

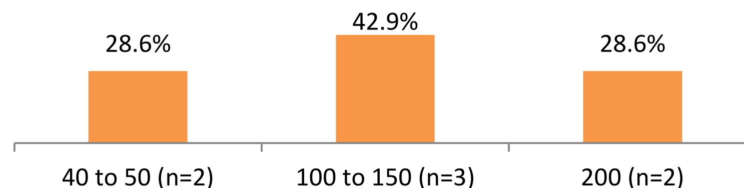


Source: Online Partner Survey

Agency Capacity

In the online survey, the seven partners who answered the question about number of home visiting client "slots," reported having between 40 and 200 slots; three said they "didn't know." In some cases, the numbers are likely the result of the home visiting model type (e.g., client-visitor ratio requirements) as much as the size of the agency. Taken together from all funding sources for home visiting, the seven agencies reported having a total of 840 client slots, or potential openings.

Figure 15. Number of Available Client Openings for Home Visiting Services (n=7)



Source: Online Partner Survey

However, the 10 partners later responding to the follow-up survey described having 1,828 available slots for home visiting, 1,333 (73%) that were currently filled, suggesting if all things were equal—which they are not—across all home visiting models there would be a 19% unfilled capacity (Table 21 on the next page). However, capacity is affected by several factors, including staffing availability such as hiring or training status; for example, the NFP program is currently in the process of implementation and hiring nurses. Additionally, the numbers vary throughout the year based on caseloads, number of staff working at the time (for instance, some staff work 10, 11, & 12 month schedules), and the frequency in which families are scheduled. If a FRC staff is delivering the service to families on their case management case load, for example, the availability is dependent on how many families they are serving, the curriculum, and other activities. Parenting Wisely sessions are shorter than Safe Care sessions, for instance.

Table 21. Availability of Client Openings for Home Visiting Services (n=9)

HV Model	# of Available (i.e., funded) Client Slots	# of Currently Filled Client Slots	% More Capacity	# on a Waitlist
Parents as Teachers (PAT) (n=6)	197	125	37%	0
SafeCare (n=6)	228	169	26%	12
Parenting Wisely (n=4)	130	98	25%	0
Differential Response (n=4)	334	195	42%	0
Early Steps to School Success (ESSS) (n=1)	120	121	-1.0%	0
Nurse Family Partnership (n=1)	75	17	77%	0
Early Start Home Base (n=1)	564	461	18%	0
Early Head Start Home Base (n=1)	180	145	19%	0
Total	1828	1333	27%	0

Source: Follow-up Partner Survey.

Client Demographics

Consistent with the overall demographic picture of Tulare County, the families who might most benefit from home visiting and other family support-related services appear to be those groups the HVC partners are serving: 65.4% of the parents/caregivers served during FY 2020-21 were White Hispanic families, followed by White families at 21.4%; Black families at 2.1% may be slightly underrepresented in receiving home visiting services..

Table 22. Parents/Caregivers Served in FY 2020-21 by Race/Ethnicity (n=9)

HV Model	Number of Primary Caregivers (an unduplicated count) by Race/Ethnicity							Number by Primary Language		
	White, Hispanic	White, non-Hispanic	African Amer	Amer Indian	Asian/ Pacific Isl	Multi-race	Other	English	Spanish	Other
PAT	92	16	0	0	1	0	0	62	25	0
SafeCare	336	101	7	1	3	33	0	437	106	0
PW	148	51	5	2	1	0	0	131	76	0
DF	282	147	20	1	12	52	55	0	0	0
ESSS	139	14	0	0	0	0	10	45	118	0
NFP	16	2	0	0	0	0	1	17	2	0
Total (n=1548)	**1013**	**331**	**32**	**4**	**17**	**85**	**66**	**692**	**327**	**0**
Percent	65.4%	21.4%	2.1%	0.2%	1.1%	5.5%	4.3%	67.9%	32.1%	0.0%

Source: Follow-up Partner Survey.
Note: Data missing for Early Start /Early Head Start Home Base.

Table 23 on the next page shows the number of pregnant women and children 0-5 living in the households the partners reported serving with home visiting in FY 2020-21. The age of the children may be a reflection of the program scope of the individual home visiting models.

Table 23. Number of Pregnant Women and Children Ages 0-5 Served in FY 2020-21 by Age Group (n=9)

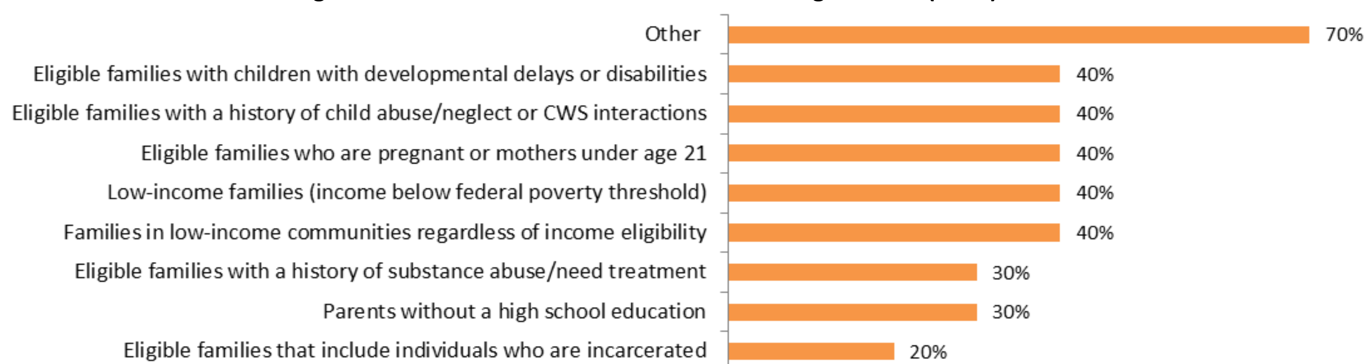
HV Model	Number of Unduplicated Pregnant Women and Children					
	Prenatal (Pregnant Women)	0-11 mos	12-23 mos	24-35 mos	36-47 mos	48-60 mos
PAT	13	33	44	24	17	13
SafeCare	32	72	68	61	57	51
PW	4	20	25	22	17	20
ESSS	16	31	35	39	52	141
NFP	19	0	0	0	0	0
Total (n=926)	**84**	**156**	**172**	**146**	**143**	**225**
Percentage	9.1%	16.8%	18.6%	15.8%	15.4%	24.3%

Source: Follow-up Partner Survey.
Note: Data missing for Family Services, that tracks by age group 0-11 years and 12-17 years, Early State/Early Head Start Home-Base, and DR mode that is only by total age group 0-5 years.

Client Enrollment and Retention

Agencies' criteria for enrolling clients in home visiting services included the various types of eligibility described in Figure 16.

Figure 17. Enrollment Criteria for Home Visiting Services (n=10)



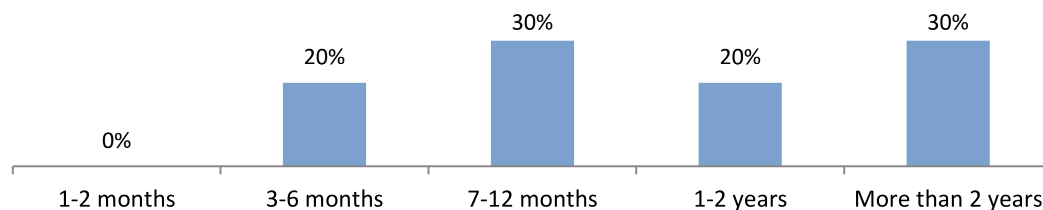
Source: Online Partner Survey
Note: Respondents could select more than one response choice.

The "other" criteria respondents mentioned included variations on age-of-child requirements (due to home visiting model requirements) and the following:

- Eligible families who receive TANF, foster children and those who are homeless
- CalWORKs eligible family with at least one child under 24 months of age
- Cal-Works recipients approved by Tulare County HHSA, families with children ages 0-7 years
- Families with a child 0-5 years in the household
- Dependents of the Juvenile Court
- Pregnant women and youngest child 0-3 year old; neediest families with various risk factors
- For PAT, parents referred/approved by CalWORKS; for Safe Care, the family with child 0-7 years old

About one year was the length of time clients generally remained enrolled in the agencies' home visiting programs, though close to a third (30%) continue for more than two years (Figure 18).

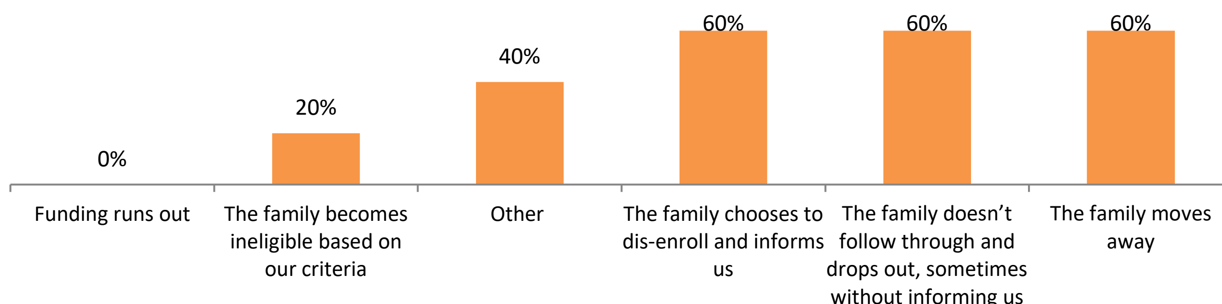
Figure 19. Typical Time a Client Stays Enrolled in Home Visiting Services (n=10)



Source: Online Partner Survey

The most commonly cited reasons for a family's disenrollment in home visiting was based on family actions, e.g., choosing to dis-enroll—with or without notifying the agency—or not following through and dropping out. In other cases, some families leave because they move away (Figure 20). This is consistent with other research that shows most disengaged families choose to discontinue services on their own volition, i.e., they verbally tell their home visitors that services are no longer desired, or passively decline further services by not answering phone calls and letters.[68]

Figure 20. Typical Reasons that Limit Clients' Continued Enrollment in HV Services (n=10)



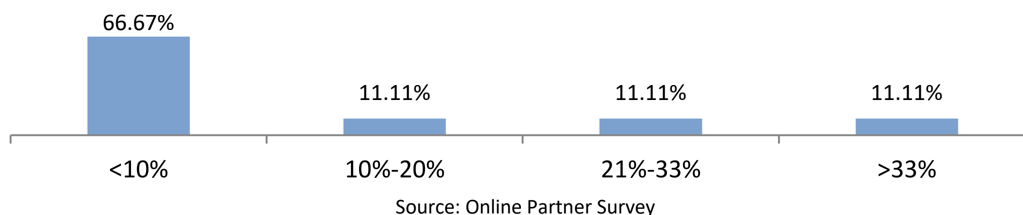
Source: Online Partner Survey
Note: Respondents could select more than one response choice.

Other comments regarding disenrollment from the respondents include the following:

- Family situation impacts ability to fully engage in services and meet model fidelity requirements (n=2)
- Family obtains a job and is unable to continue participating (n=2)
- The child ages out (n=1)

Just as some families drop out of home visiting for a multitude of reasons, a few ("about 10 percent of them") families re-enter services in Tulare County for various reasons (Figure 21 on the next page).

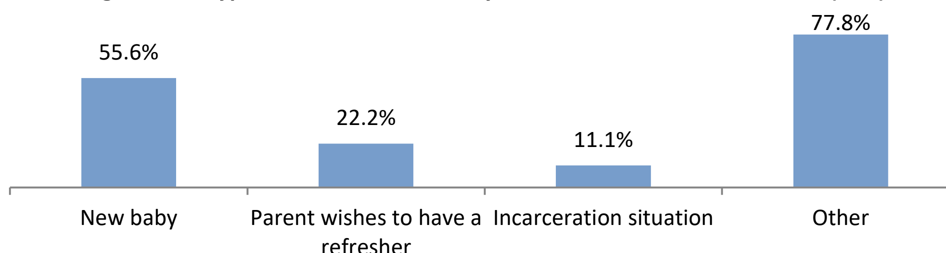
Figure 21. Percentage of Families Who Re-Enroll In Home Visiting Services (n=9)



Source: Online Partner Survey

Nine of the agencies reported the typical reasons families re-enter home visiting, and added "other reasons" listed in the box below Figure 22.

Figure 22. Typical Reasons for Family Re-Enrollment in HV Services (n=9)



Source: Online Partner Survey
Note: Respondents could select more than one response choice.

- Family moves back to Tulare County (n=2)
- Family situation now stabilized to allow for parent to fully commit and engage in services (n=2)
- Child becomes age-eligible into new program
- The family finds themselves in a situation where they need extra support (CWS involvement, loss of job or income, loss of housing, or child in need of special education services)
- CWS recommendation that the parent take classes

Client Referrals

We were also hoping to learn how many families were referred last year from the partners' home visiting programs to another *outside* home visiting program, and what the main reasons were for the referrals. However, because the survey question was not clear enough and some respondents instead reported internal referrals of clients between HV models, we aren't able to show the data.

The partners did report the number of families who were referred from their home visiting program to some outside type of family support service in FY 2020/21; they also indicated how many of these families/referrals resulted in linkage to service (Table 24 on the next page). In some cases, such as with Differential Response, it was possible for the agency to know that the client did actually achieve the linkage because verification of that was necessary as a contract term to receive funding.

Table 24. Family Referrals and Linkages to Tulare County Family Support Services in FY 2020-21 (n=9)

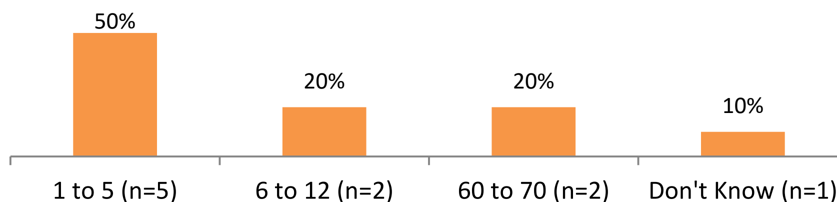
Name of Model	Number of HV Families Referred/Number of Linkages Made															
	Early Care/educ		Early intervention		Mental/ behavioral health		Basic needs/income support		Child welfare		Educ and training		Physical/ oral health		Social services support	
	#	# linked	#	# linked	#	# linked	#	# linked	#	# linked	#	# linked	#	# linked	#	# linked
PAT	24	9	4	4	14	13	132	132	1	0	27	27	27	27	35	35
SafeCare	26	19	20	16	27	27	198	198	44	44	13	13	120	90	21	21
PW	13	13	2	2	29	29	96	96	1	0	1	1	5	1	32	31
DF	11	5	28	12	157	137	551	551	54	49	209	170	5	1	35	31
ESSS	61	39	13	11	7	5	99	97	10	10	85	56	12	12	99	95
FNP	1	1	0	0	7	3	5	4	0	0	5	5	0	0	2	0
Early Start	9	6	23	18	7	6	456	326	0	0	0	0	0	0	0	0
Total	145	92	90	63	248	220	1537	1404	110	103	340	272	169	131	224	213

Source: Follow-up Partner Survey.

Home Visiting Workforce

Taking into account all of the funding sources that support their home visiting services, half of the partners reported having between "1 and 5" full- or part-time positions whose main role was home visiting; 70% have up to 12 positions to support these services (Figure 23). Workforce capacity was higher for two of the partners, however, as these agencies—understandably the larger-agency respondents—reported having an average of 60 positions devoted to home visiting.

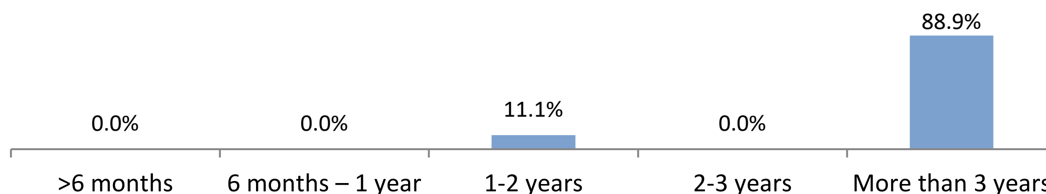
Figure 23. Total Number of Staff Positions Whose Main Role is Home Visiting Services (n=10)



Source: Online Partner Survey
Note: Includes both f full- and part-time positions.

Staff retention is relatively favorable as nearly all (88.9%) of the agencies reported retaining home visiting staff in that capacity for more than three years (Figure 24).

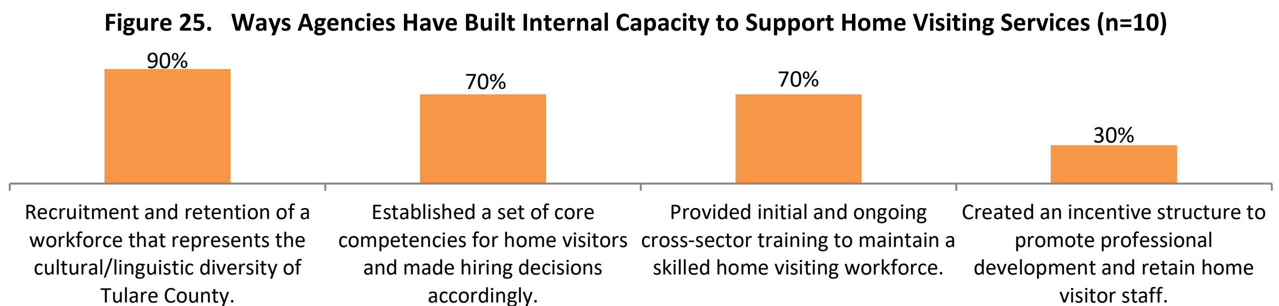
Figure 24. Typical Length of Employment of Staff in a Home Visiting Capacity (n=9)



Source: Online Partner Survey

The partner agencies reported employing various workplace strategies to build and maintain their internal capacity to support home visiting services. The most common means, according to 90% of them, was creating a workforce that reflects Tulare County's linguistic and cultural diversity—cited in literature as a critical success factor.[69] Most (70%) of the agencies had established core competencies for these positions, made hiring decisions accordingly, and provided ongoing training to support and maintain skillsets (Figure 25). As one respondent wrote, "*We've realized this time has been a heavier lift for home visitors, so we built in additional opportunities for reflection and encouraged home visitors to take time off to care for themselves and/or their own families.*" Three of the 10 agencies offered an incentive structure toward professional development and retention.

Figure 25. Ways Agencies Have Built Internal Capacity to Support Home Visiting Services (n=10)

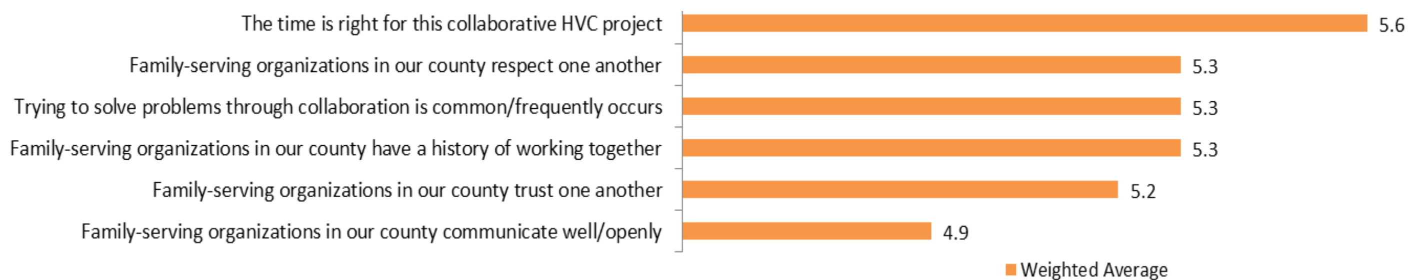


Source: Online Partner Survey
Note: Respondents could select more than one response choice.

Relationships and Coordination Among Partners

The partners were also asked for their perceptions about areas of the relationships among early childhood system of care organizations in Tulare County, such as communication, problem solving, trust, and so on. It is clear from their ratings (Figure 26) these organizations value and respect one another, appreciate a shared history of working together and, for the most part, feel they communicate openly and well with one another. Most importantly, there was strong affirmation (mean of 5.6 on a 1-6 scale) that "the time is right for this collaborative HVC project."

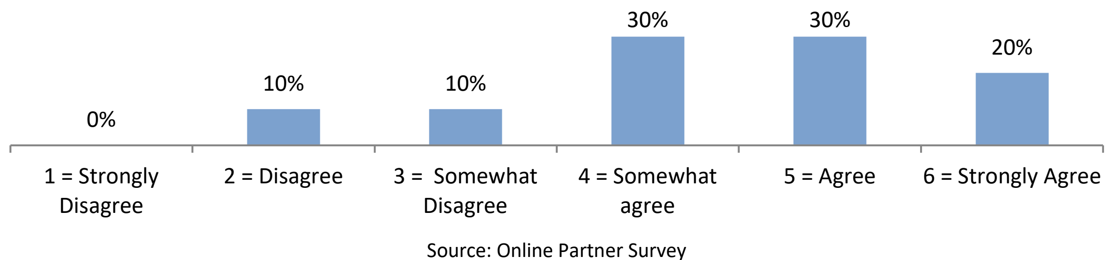
Figure 26. Agencies' Agreement about Relationships Among Family-Serving Organizations in Tulare County (n=10)



Scale: 1= Strongly Disagree to 6= Strongly Agree
Source: Online Partner Survey

In addition to constructive relationships, 80% of the respondents expressed some level of agreement—20% strongly so—that in Tulare County there currently *is* a coordinated early childhood system of care (this was left undefined in the survey but discussed by these respondents during the first HVC Advisory Group meeting). This perception would suggest the goal of this First 5 CA HVC Initiative—and thus the goal of the Tulare County HVC—is largely currently being met in the county. Two (20%) of the respondents, however, did not agree that a coordinated early childhood system of care was an accurate depiction of the local system. It is worth noting that both view (more positive and more negative) were not related to the type of agency submitting the survey.

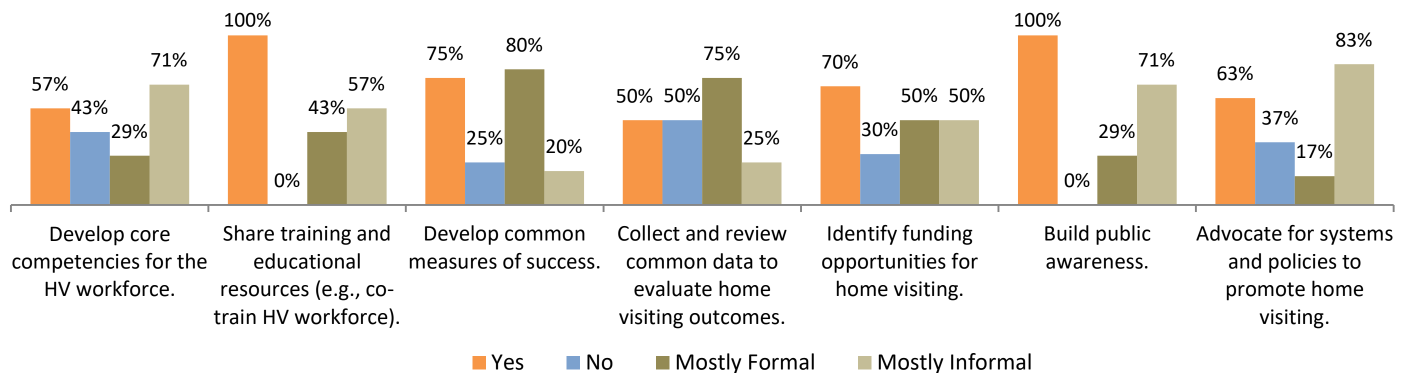
Figure 27. Agencies' Agreement with "Tulare County Has a Coordinated Early Childhood System of Care?" (n=10)



Source: Online Partner Survey

The partners reported various ways they collaborate. These activities included building public awareness, sharing training and educational resources and, to a somewhat lesser degree, identifying funding opportunities and common success measures. Their least-occurring shared activity was reviewing common data to look for home visiting outcomes; however, when that *did* occur, it was generally on a formal basis. Most of the other collaborative activities, when undertaken, tended to happen informally (Figure 28; note the footnote under the bar graph).

Figure 28. Ways Agencies Work Together with Local Partner Home Visiting Service Programs (n=varies by item*)



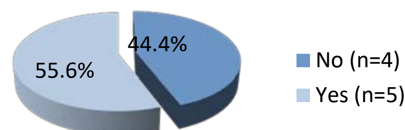
Source: Online Partner Survey

*Note: All 10 agencies answered some of the items; none of them answered all 7 items. The mostly commonly-answered Yes/No item (n=8) was "Build public awareness." The least answered items were whether the activity occurred on a mostly formal or mostly informal basis.

Just over half (55%) of the partners said they had formal relationships for collaboration/ coordination between their HV program and other family-serving/HV program model organizations in Tulare County (Figure 29). All of the relationships were by contract, none by Memoranda of

Understanding (MOU). The examples offered were Parenting Network contracted with TCOE to provide support groups and training, and SafeCare classes, and Woodlake and Cutler-Orosi FRCs contracted with Family Services to implement Parenting Wisely program, funded through MHSA.

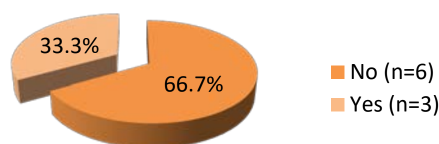
Figure 29. Formal Relationships for Collaboration with Other Family-Serving/HV Model Organizations (n=9)



Source: Follow-up Partner Survey.

Data sharing arrangements were reported to be in place between the HV program and other family-serving/HV program model organizations for 33% of the respondents (Figure 30). These examples included sharing information with TCOE, Bright Start, Child Welfare Services and Central Valley Regional Center.

Figure 30. Formal Relationships for Data-Sharing with Other Family-Serving/HV Model Organizations (n=9)



Source: Follow-up Partner Survey.

Highest Identified Needs During COVID

We asked respondents to query their home visiting staff to see what *they* would identify as the two highest needs of families at the present time (during COVID-19) that were not being adequately met that could benefit by home visiting. Unquestionably, mental/behavioral/emotional support services for parents/caregivers as well as children was cited as the most important need. The toll that isolation and lack of social interactions have taken on family members was also identified as an important role for home visiting to help address (Table 25).

Table 25. Highest Unmet Needs to Benefit from Home Visiting Identified by Agencies' Home Visiting Staff (n=8)

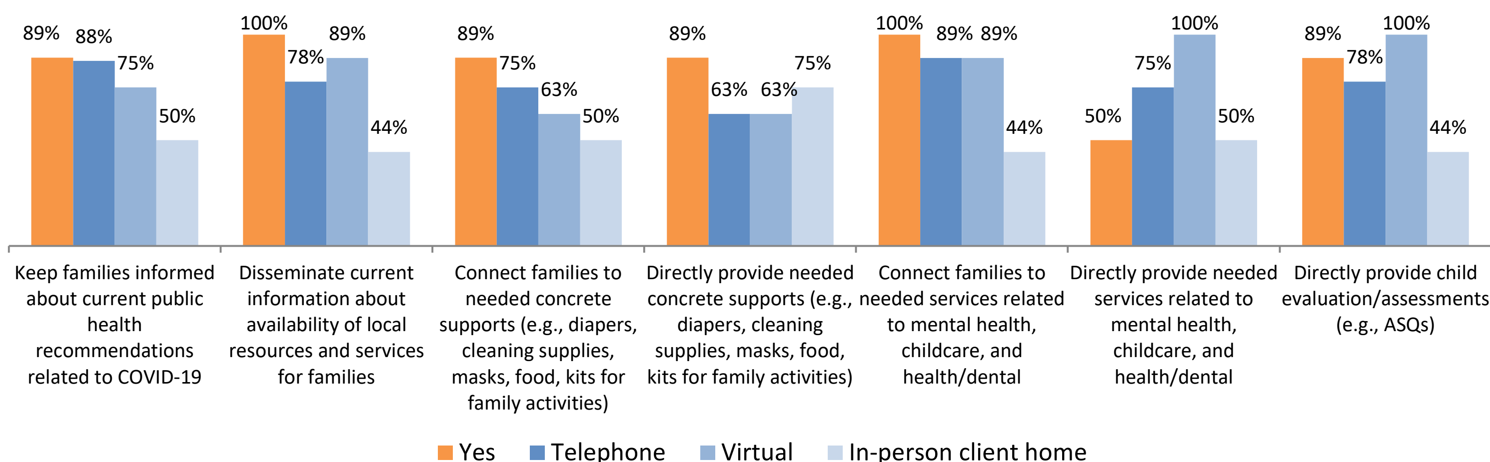
In order of frequency
▪ Mental health/emotional support services (child and adult) (n=5)
▪ Social connections - parents and children lacking their normal social interactions with others (n=3)
▪ Staff unable to observe the children -- could miss those with possible developmental delays
▪ Financial assistance for rental/mortgage/utilities support
▪ Food
▪ Linkages to training and employment resource
▪ Privacy needs for group/appointment sessions
▪ Struggles with technology (or lack of it)

Support During COVID

We learned through an earlier survey [70] that the First 5 Tulare County grantees responded immediately to the crisis of the pandemic, giving us a baseline picture of their responses. The present survey shows how these and other early childhood system of care organizations in the county have continued to serve families throughout this last year.

The various ways the partners are currently involved in providing services are shown in Figure 31, where there was 89% -100% affirmation of engagement in each of the activities we asked about. (One agency did not respond to this question.) Except for activities like the delivery of diapers and food, where in-person or drop off visits would be expected, virtual resources that help bridge connections with families—especially in rural areas, assuming internet connectivity—are the most common way agencies are currently connecting with families—a contact method used 83% of the time on average in delivering services. Telephone contacts are used for these activities in an average of 78% of the cases, and in-person and/or in-home visits an average of 47%.

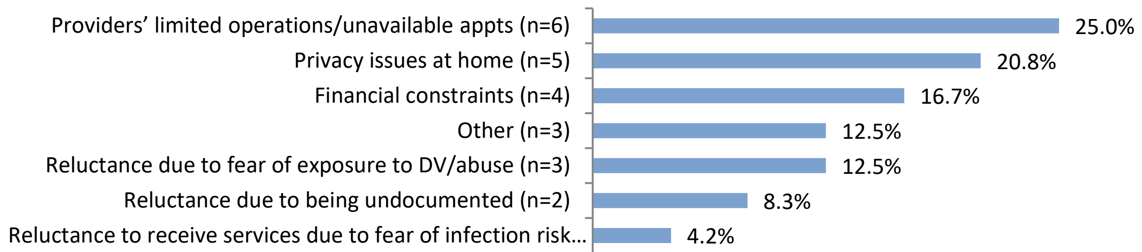
Figure 31. Current Engagement and Methods in Providing Home Visiting Services (n=9)



Source: Online Partner Survey

Family engagement in home visitation programs includes overcoming the challenges of not only getting families to enroll and keeping them in the program, but sustaining their interest and commitment during and between visits. The COVID-19 pandemic has added to these challenges. The barriers the respondents reported observing that are “unique or especially worse during this time,” include provider access (limited days/hours of operation/appointments), privacy issues (clients not feeling comfortable interacting via zoom when others are at home) and reluctance to receive services due to fear of exposure to domestic violence or child maltreatment (Figure 32 on the next page).

Figure 32. The Main Barriers to Delivering Services during COVID-19 (n=9)*



Source: Online Partner Survey
Note: Percentages represent frequency of response choices, not respondents.
Respondents could select more than one response choice.

When asked by the survey whether any of the barriers respondents had identified were unique to their own agency, only one agency answered "yes." The explanation offered was brief, and described as "with a loss of income (once funding streams ran out) we had nowhere to send [clients]." Table 26 shares additional partner feedback that highlights the challenges of providing home visiting services during COVID-19 recovery.

Table 26. Additional Feedback that Highlights the Challenges of Providing Home Visiting and Other Support Services*

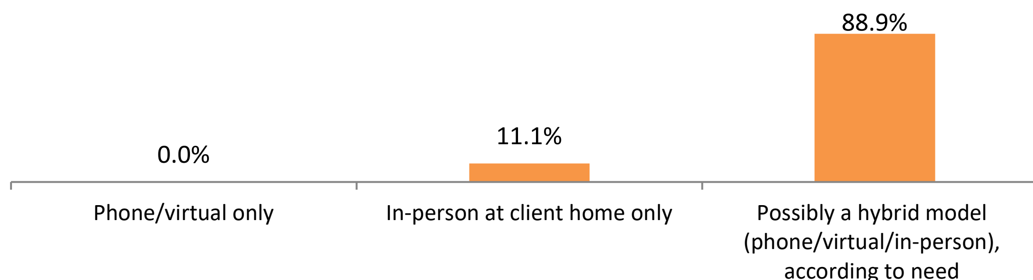
- *"There has been very long wait times on the phone for access to many public benefits programs."*
- *"Parents report being overwhelmed with all of the children being home during distance learning, which impacted the parents' ability to engage and fully participate."*
- *"Reliable technology (internet connectivity and lack of devices) is not available or consistent, so even virtual assistance can be spotty."*
- *"It has been difficult to connect directly with some potential families because we have not been working from the office."*
- *"There are much more distractions and the families were overwhelmed with their roles in supporting education in their homes."'*
- *"We saw many parents quit jobs to support their children with distance learning, and this created undue stress for many of our working families. We saw children and parents become disengaged with the virtual learning in later half of the year. It was an emotional and financial draining time for a lot of our parents and children, so we tried to be sure to check in regularly with them, but for our parenting programs they felt overwhelmed and essentially zoomed out, leading to less participation."*

*Comments are verbatim without editing.

Plans for Home Visiting and Other Support Services *Post*-COVID

Respondents described changes in the types and levels of services, as well as the methods they planned to use, in delivering home visiting services during COVID recovery/post-COVID.* It is clear that despite the sometimes unreliable technology and the privacy issues of having others in the home, the partners have recognized the benefit of virtual resources, so much so that nearly all of them say they will consider continuing to use it as a hybrid method along with in-person visits, according to family need (Figure 33).

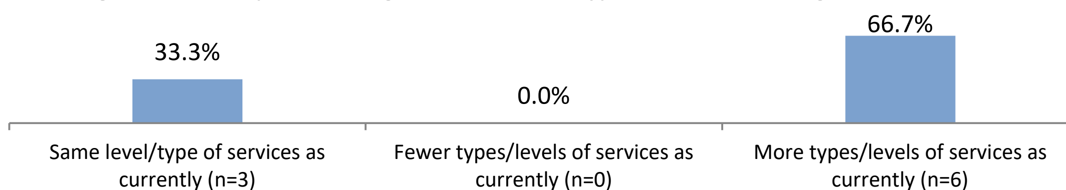
Figure 33. Methods Agencies Plan to Use to Provide Home Visiting Services Post-COVID (n=9)



Source: Online Partner Survey

None of the respondents said they would be offering *fewer* services post-COVID. Three of them expect to continue offering the same type and level of services, while six of them said their specific plans are to offer *more* types and levels of services than they currently do (Figure 34).

Figure 34. Agencies' Anticipated Changes in Levels and Types of Home Visiting Services Post-COVID (n=9)



Source: Online Partner Survey

Responses to the question of what additional types and/or additional levels of services will be considered include those in the box below. The verbatim comments are displayed in their full length below to reflect the agencies' flexibility, resourcefulness and continued commitment to serving families through home visiting services.

- *"We will go back to having in-person support groups, Mommy and Me, Extraordinary Parents, Special Lives without Limits, and other activities."*
- *"Our agency will be providing a hybrid home visiting model to accommodate the varying comfort levels of families to engage in services. The agency intends to highly encourage in*

* Post-COVID was defined in the survey as "after the pandemic is considered reasonably under control through a sustained vaccination program and there is a return to a general sense of "normalcy."

person services, but also needs to be responsive to the families' needs. The agency is currently open to receiving families on site and will continue to have that as an option, plus virtual sessions, and in home options post COVID."

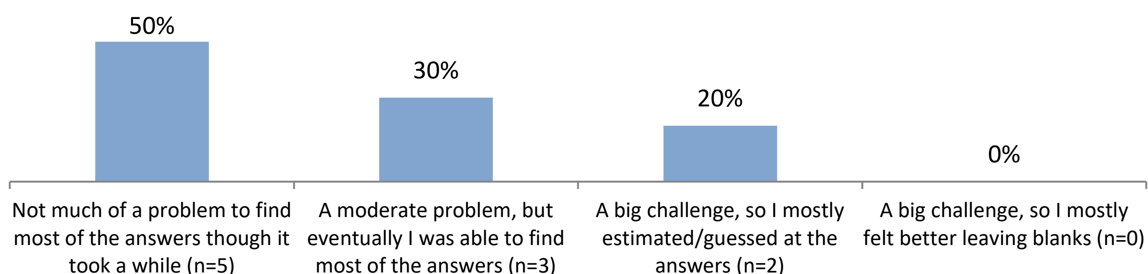
- *"We will be attempting to provide PAT model and also conduct more in-home visiting."*
- *"This is not set in stone, but I believe the pandemic has shown us that we could be more innovative in our approach to home visiting. By doing so, we could further our reach for those families who may traditionally have had challenges with conventional models. While there are some limitations with remote visiting, the benefits of virtual/remote visits far outweigh a child having 'no visits.'"*
- *"Prolonged home visits have been restricted due to COVID. Post COVID, the agency will resume in person home visiting services. Based on differing comfort levels of families in the community, the agency will plan on having multiple options for families including the hybrid model (in person and virtual visits)."*
- *"Additional case management support, linkage to Transitional Coach once the grant starts (additional mental health support) and linkages to more short-term therapy supports."*
- *"We are continuing to think about how to best support enrolled families and home visitation staff during this time. We realize we can't approach this work with a one-size-fits-all approach, so we continue to adapt to improve our practice. When we began to hear families speak of feeling isolated and exhibit signs of stress, we developed tools to share with families on self-care and strategies to combat stress."*

*Comments are verbatim without editing.

Data Reporting Challenges for this Needs Assessment

We wanted to know how difficult it was for the partners to report the type of demographic and capacity questions F5CA hopes to collect across the state. Although they said it took a while to provide, half of the 10 partners thought it "wasn't much of a problem to find most of the answers to the follow-up survey;" 20%, found it "a big challenge and had to estimate or guess at the answers" (Figure 35).

Figure 35. HVC Partners' Ease of Providing Requested Follow-up HV Data (n=10)



Source: Online Partner Survey

KEY INFORMANT PERSPECTIVES

Fourteen Tulare County community leaders and professionals who participated in key informant interviews offered the following valuable insights about community needs, provided updates on home visiting services—to the extent they were aware—and suggested ways home visiting could be even more effective in benefitting pregnant women and families with young children.

Highest Needs and Concerns

The *types* of some needs have not necessarily changed for families since COVID-19, according to most key informants; they have just been intensified by the pandemic. A key example is the need of low-income families and those who lost jobs to be able to afford basics like food and rent that escalated due to COVID. At the same time, it was recognized that the pandemic introduced new stressors that have challenged families, notably in trying to balance work-at-home with children's distant learning circumstances, frequently mentioned as a significant issue.

Consistent with the community indicator data and other input gathered in this needs assessment, the main concerns the key informants believe should be addressed center around the continuing great need for mental/emotional health support, affordability of childcare, housing/safe shelter options and help for families experiencing addiction and domestic violence (Table 27).

Table 27. Highest Needs Identified by Key Informants (n=14)

- Intensive **mental health support** for parents, especially young and first-time parents, pregnant and postpartum women, heightened by issues such as fear and anxiety about the virus; parent lack of connectivity with other parents; families struggling to manage at-home job/distance learning challenges.
- **Safe shelter** including therapeutic intervention for young children who may be experiencing adverse conditions at home.
- **Childcare** (especially 0-3) for parents who don't quality for subsidized care, for children to gain access to early childhood development opportunities, and to address the challenge of different schedules.
- **Food insecurity** issues.
- Affordable/better mix of **housing** options.
- Better **internet capacity** in rural areas.
- **Educational opportunities**—with incentives—for parents to enroll in training and certification programs, and basic "life skills" classes that could lead to self-sufficiency.

Although identified by the majority, it should be noted that a couple of interviewees felt food and housing were actually *not* currently high-priority issues. They said this was because of the "huge outpouring of support" by food banks and access to meals with school openings, and "availability of funds such as the $14.5 million the Tulare County Homeless Coalition has for sheltering people."

Although clearly a minority viewpoint, another interviewee suggested the need for mental health services has lessened due to "much more current mental health funding in the county."

Additional concerns that interviewees expressed, primarily related to mental/behavioral health (some that may not be just the result of COVID-19), include the following:

- *"There is currently a 'fatherless generation' that needs to be addressed from situations such as language barriers between parent and child (English-language capability; 'old county' vs 'new country' thinking), incarceration, or abandonment by fathers returning to Mexico and leaving the family."*
- *"Some new mothers are self-medicating as a means of coping; the postpartum period can be a critical time to address women's mental health that can affect all family members."*
- *"Many parents don't have the skills to identify anxiety and depression, some of which has been the result of social isolation."*
- *"We still can't provide mental health services to many people because of the restriction on diagnosis: for the non-Medi-Cal population to be eligible, you have to meet strict guidelines about severity of illness."*
- *"The biggest gap is in the early mental health [youngest] age group because some of these kids aren't identified until they enter school."*

Family Responses During COVID and Recovery

There does not seem to be a lack of interest in receiving home visiting services among families, just a little reticence, according to about half of the key informants directly knowledgeable about families' attitudes. All of the key informants' clients had willingly and gratefully received home delivery of services where drop-offs were involved (diapers, wipes, food, books). In a few cases, some parents were said to be "no shows" when *they* were responsible for having to pick up items themselves (which could have been due to work hours or lack of transportation). Although infrequent, a small amount of "home visiting" has more recently occurred on people's front porches or, weather permitting, in front yards.

A few of the key informants reported seeing "a recent shift" in family attitudes toward receiving home-based services and having their children be seen in-person by providers; schools' re-opening was said to have helped. The interviewees felt that "between about 50% and 70%" of the families who were already enrolled in home visiting prior to COVID were now ready to resume services; fewer of their newer clients were. Families who were well connected to and had been receiving multiple other services from an agency (e.g., a Family Resource Center) were believed to be more ready to having visitors come in to their home. It was also reported that families with limited transportation seemed more receptive to home visiting services.

The following key informant observations (Table 28) further highlight COVID's impact and suggest where families are in their recovery, including receptivity to home visiting services.

Table 28. Additional Observations and Concerns of Key Informants Regarding COVID Recovery

- The virus has created different dynamics than people have ever known; some parents just don't have the coping skills to deal with the new/additional stress.
- Referrals of children to mental health agencies are primarily from schools; distance learning has resulted in ↓ referrals; this may be improving, however.
- Families don't reach out themselves when they have other priorities or aren't comfortable with telephone/virtual mental health services (reasons = limited space at home, interruptions, privacy issues).
- "Unconnected" families are slower in accepting home visiting; they have never had to ask for help before, and pride makes them reticent to do so.
- Children returning to school are anxiety-ridden; some seem "completely disengaged" now from learning and may fall further behind (short term? long term?).
- Parents have ambivalence about sending children to school; though they want to, some are not ready to do so. Rural families seem most ready because school = childcare for those who have jobs.
- The biggest distance learning frustration of parents (beyond balancing parents' at-home work) has been dealing with the youngest children's needs vs. the older kids (who get more attention?)
- One big benefit of virtual home visiting = parent learning; parents listening in to the preschool teacher working with the child indirectly teaches parents what to do; parents also receive parenting strategies from "visits" by mental health therapists.
- Child Welfare is reporting ↓ cases because some children have become "invisible" to mandated reporters ("*some families are able to remain hidden*").
- Addiction/substance abuse is a significant problem in Tulare County; not everyone is willing to reveal this or be open to getting help or willing to take on the responsibility to stop using.
- Despite good access now to the vaccine, a certain segment of the population (including agency staff) is still indecisive or unwilling to receive a vaccination = ↓ family acceptance of home visitors and ↓ number of available home visiting staff.

System Challenges

The key informants mentioned a few systems issues that could be important to take into account in looking to expand home visiting services in the county. These included:

Staff/agency readiness. Home visiting programs, according to the interviewees, are not all in agreement about readiness to return. In general, though, they said there is "about a 70%/30% split" between the home visiting staff comfortable enough to go back into homes and those not. One agency representative remarked, "*We're ready for customers—more referrals please*!" One organization ready to return to home visiting was facing opposition from a labor union over a job description issue. A couple of agency representatives indicated they weren't ready to *allow* staff to return because of the work involved in contact tracing in the event of a positive exposure.

Funding issues. Lack of consistent funding was the most frequently mentioned challenge. For instance, though First 5 is a major funder of home visiting, the requirement of re-applying for a grant every three years does not guarantee continued support. Concern was also expressed about the short-term nature of the government and private responses to COVID that have included various relief funds; not all of these funding sources offer a long-term solution, raising the importance of helping families achieve self-sufficiency.

Marketing. It was pointed out that the marketing piece of home visiting will be important in the future. For example, it may be challenging getting people to enroll if agencies don't go into the community as much to outreach to families (one individual asked, rhetorically, "*Is it better to do other outreach strategies with less exposure to germs?*"). Enrollment in some programs seems now to be more parent-driven/parent choice. As one of the interviewees remarked, "*You can't flip a switch and suddenly announce to families you're coming into their home; it has to be progressive, family-by-family decision making.*" Retention could also be a challenge as families return to the workforce.

Key Informants' Recommendations

The key informants—some of whom themselves are members of the HVC Advisory Group—offered the following recommendations toward improving home visiting services and meeting the goals of the HVC:

1. Support multiple models. Given the different fidelity and other requirements of home visiting programs, the key informants question whether the HVC goal of "coordinating…..the [home visiting] system…." means identifying fewer models that "….may best meet highest local needs." As one of the interviewees asked, "*Does it really matter is there's more than one home visiting program [model] in Tulare County if the funding requirements and foci are different?*"
2. Share information. Although some agencies share certain databases (e.g., HHSA and CSET for the homeless program), it would be optimal if the same data were collected across the board, such as a uniform intake form. For example, data that local programs could report to HHSA that could report to the state so that only one agency is responsible for collecting/reporting. Doing so could also reduce the potential for "over serving" people.
3. Improve internet capacity. A number of the interviewees believe that in the future some level of home visiting services will continue to be delivered through virtual resources.[*] Some families have even tried to make it a family experience. Thus, it is imperative that consistent internet capacity be secured throughout the county ("*the hotspots are just temporary fixes*").
4. Raise community awareness of resources. The key informants had mixed opinions about public awareness of resources to help in COVID recovery, e.g., mental health, employment services, domestic violence, etc. Some non-FRC interviewees acknowledged their staff was "*maybe not having these conversations with clients but should*;" the reasons ranged from staff unfamiliarity

[*] This was confirmed in the results of Agency Survey.

with local resources; supervisory staff not monitoring intake processes to ensure information was being provided; county staff being pulled into emergency services due to the high needs brought on by COVID (e.g., workers too busy with processing welfare benefit applications). While it was acknowledged that "*a lot of staff time (as well as staff) was lost to COVID,*" and agencies are trying to get back on track, the more newly-eligible families—families that did not need services before—need more information about resources, and home visiting can help serve that purpose.

5. Capitalize on preschools' connections with families. The uniqueness of preschool is that parents have to drop off and pick up their children vs. school-age children who may just be dropped off at the curb. Finding ways to build relationships with and offer a multitude of services to these parents—beyond what the preschools themselves may be required to provide—was advocated as another marketing opportunity for home visiting services.

6. Use pregnancy as an ideal opportunity. Similar to the above, because home visiting is "*relational, winning someone over,*" using pregnancy—a "teachable moment''—was suggested as an optimal time to promote home visiting services—regardless of the model—because "*everyone wants a healthy baby.*"

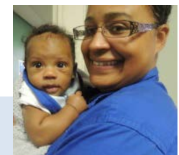
7. Strengthen coordination of the services system. There was nearly universal agreement that home visiting organizations in the county work collaboratively. Some were less sure whether the work would be considered *coordinated*—as per the HVC goal—though one individual remarked, "*we don't duplicate; we look at who's doing what*." Three of the interviewees expressed slightly different views than that: one said, in general, their agency "*doesn't relate to the other home visiting programs*;" one thought Tulare County "could do a better job collaborating among county agencies." Another suggested "*we cross over each other so much*" (but expressed hope that the HVC could improve this). As the goal of the HVC is "a coordinated system of early childhood care system," the next step should be defining what that means and what outcomes could be expected.

PART IV: COMMUNITY NEEDS AND EXPERIENCES

"Families need us and miss us." – Key Informant Interview

"The more presence we have—whether porch pickup or Zoom—to build relationships with the family to get into the home is what's necessary for successful home visiting." – Key Informant Interview

The parent survey conducted for this needs assessment updates findings from the spring 2020 (pre-COVID) parent survey,[71] and provides important information about the social and economic effects of the coronavirus on Tulare County families served by the HVC partner agencies as they are beginning to recover. Gathering such data about families' needs and experiences is essential to inform policy decisions, resource allocations, and service delivery.

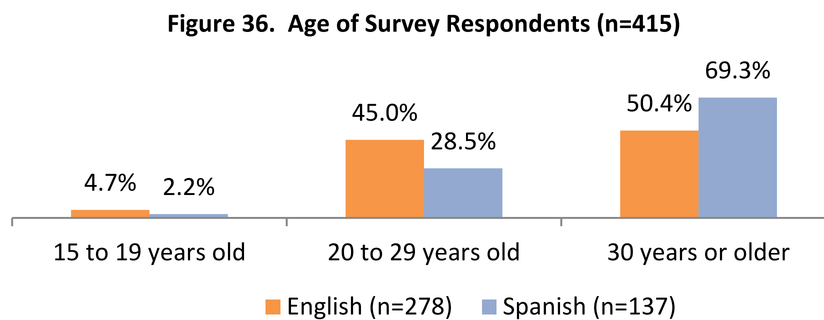


PARENT PERSPECTIVES

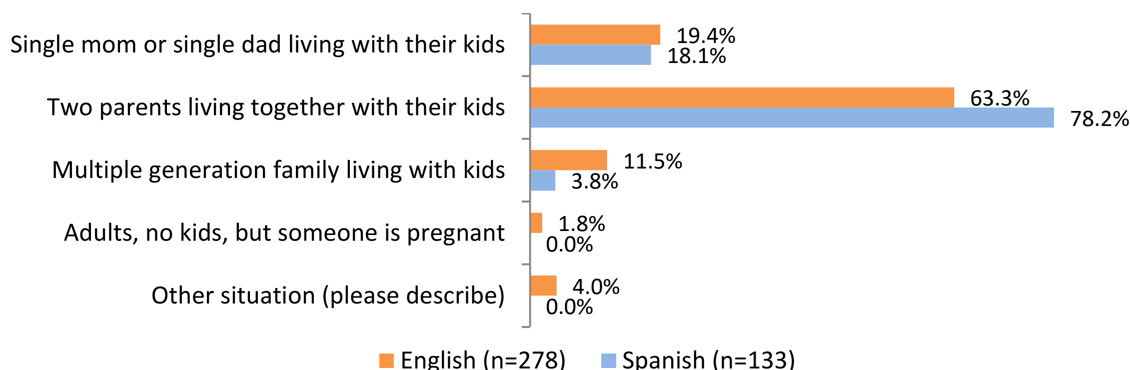
Respondent Characteristics

A total of 415 parents/caregivers participated in the online Parent Survey; two-thirds completed the English version and one-third the Spanish version. As a group, the Spanish-language respondents were older than those who took the survey in English (Figure 36).

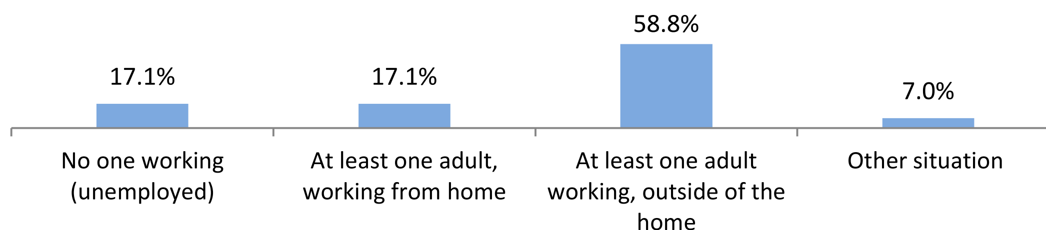
Figure 36. Age of Survey Respondents (n=415)



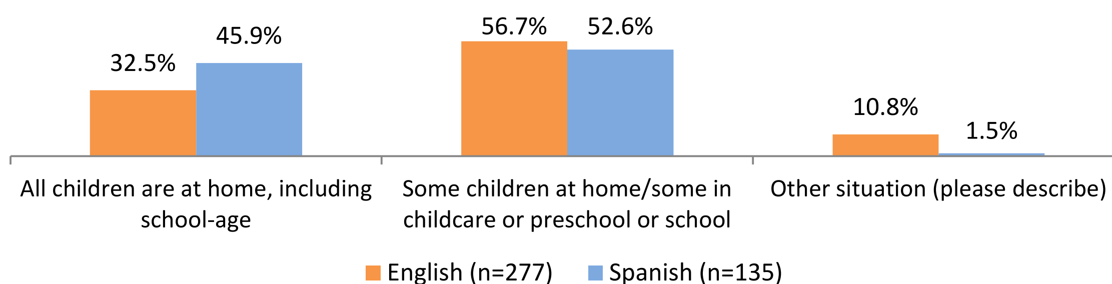
The majority (63% English/78% Spanish) of the respondents lived in a two-parent household with children, though close to 20% were composed of single mothers or fathers living with their children (Figure 37 on the next pate). Despite marking "other situation" (only the English respondents did), most of the descriptions written in actually fit with one of the response choices already provided.



In 83% of the households, at least one adult* was employed at the time of the survey—one year from the COVID "shut down"—and most of them reported working outside of the home (Figure 38). The only notable difference by survey language type, and then only slightly, 18.4% of English respondents and 14.5% of Spanish, was in being unemployed.



We also asked about childcare/schooling arrangements to get a sense of the impact of COVID-19 on working parents. As Figure 39 indicates, a greater proportion of the Spanish-language respondents had all children, including school-age, at home, though both groups to about the same extent had a mix of in-home and out-of-home situations. "Other" situations, in order of frequency, included being pregnant with no other children; all children were now able to be in-person at school or childcare; and children were being babysat by grandparents or other relatives. A few misread the response choices and described one of the response categories already provided.

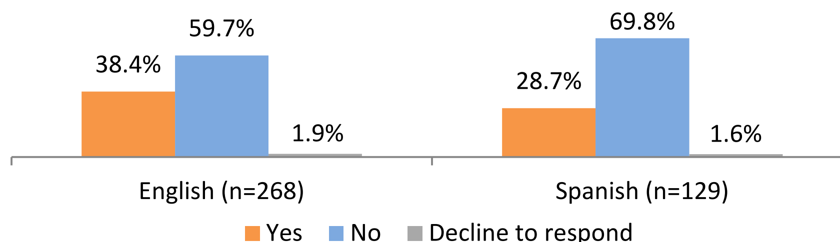


* The wording of the question "at least one adult working…." was apparently unclear to 24 of the 29 respondents who marked "other" situation, as those respondents wrote in some form of "*both of us are working.*"

Experience with COVID-19

Tulare County, along with the other CA Central Valley counties, became a hotspot for the virus at the height of the crisis. Extrapolating from the total confirmed cases of COVID in Tulare County among the population ages 18-64[72]—to some extent a comparable age group to those who took this survey—conceivably represents about 21.3% of residents who had tested positive for COVID at the time of the survey. Based on that estimate, it would appear the surveyed parents/caregivers—if their self- reports are accurate—are overrepresented among the proportion of county residents with COVID experience as Figure 40 shows, the English-language respondents to a greater extent.

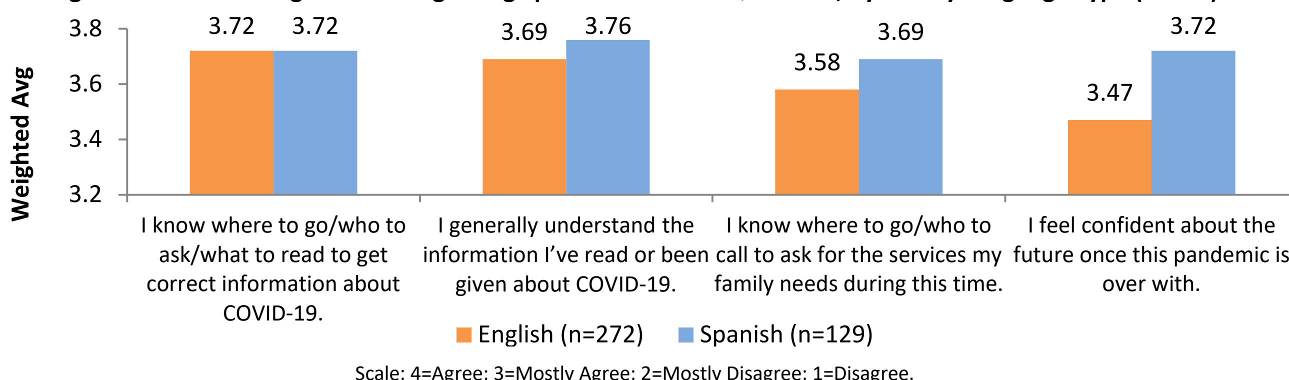
Figure 40. Percentage of Respondents with Self or a Household Member who had COVID-19 (n=397)



Awareness of Resources and Information

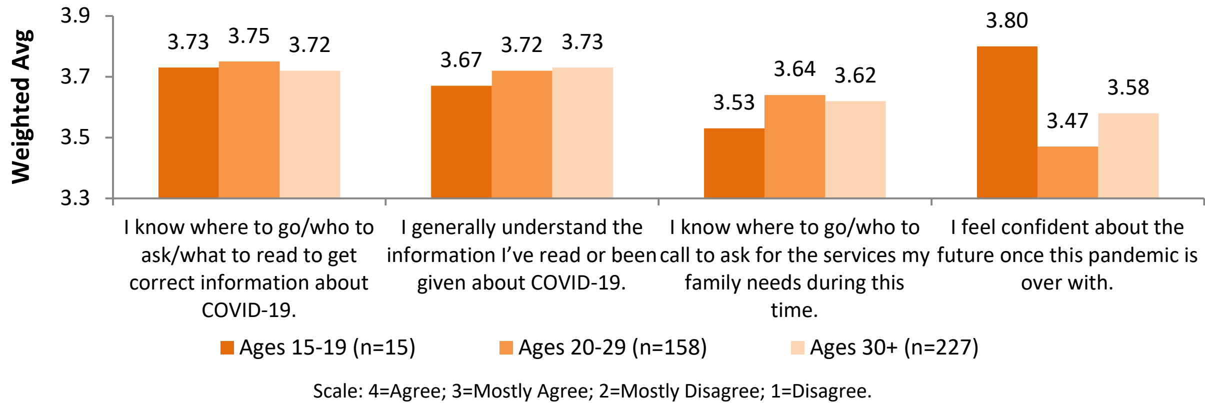
Respondents were asked to rate their agreement with various statements concerning information, confidence, etc. about COVID. Those who took the survey in Spanish were more likely to know where to go/who to ask for needed services, and quite a bit more confident about the post-COVID future (Figure 41). Looking at these same statements by age group of respondents (Figure 42 on the next page), the adolescents were the least likely to understand information about COVID or know where to go/who to ask for services they needed, but clearly the most confident about the future when the pandemic was behind them. Except for the confidence statement, the differences were relatively small between the older age groups.

Figure 41. Levels of Agreement Regarding Specific COVID-19 Questions, by Survey Language Type (n=401)



Scale: 4=Agree; 3=Mostly Agree; 2=Mostly Disagree; 1=Disagree.

Figure 42. Levels of Agreement Regarding Specific COVID-19 Questions, by Age Group (n=400)

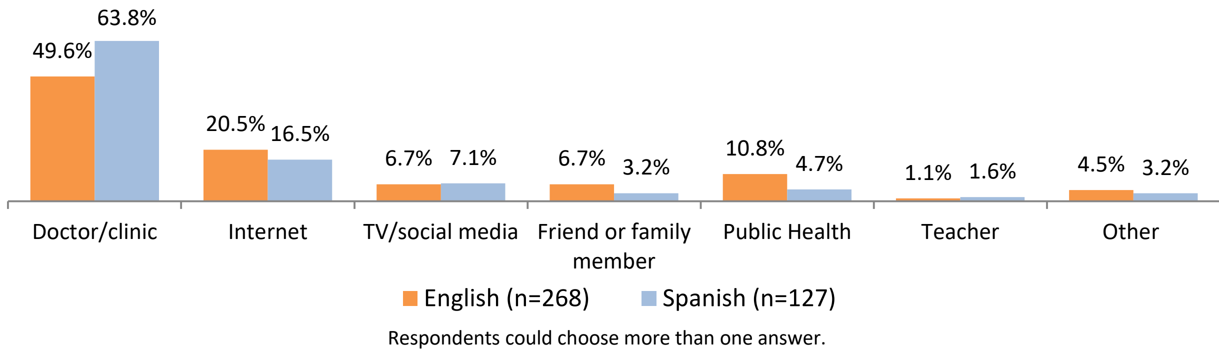


Scale: 4=Agree; 3=Mostly Agree; 2=Mostly Disagree; 1=Disagree.

Information Sources

When parents/caregivers want to get information about COVID-19, e.g., how to reduce risk, where to get tested, the greatest majority of the English- and Spanish-language respondents, 49.6% and 63.8%, respectively, say they depend on their physician or clinic (Figure 43). The internet also serves as an important source for 19.2% of all respondents. There were no significant differences in the responses by age group.

Figure 43. Sources of Information about COVID-19 (n=395)

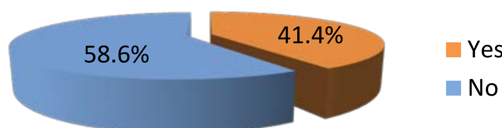


Respondents could choose more than one answer.

Accessing Medical/Dental Care

About 40% of parents (in both survey language versions) reported being unable to get or were delayed in getting necessary medical or dental care for themselves or their children in the last year *due to COVID-19* (Figure 44).

Figure 44. Delayed or Did Not Obtain Necessary Medical or Dental Care Due to COVID-19 (n=408)



The main problems in getting or experiencing a delay in getting care, as described by the 68 individuals who answered the question giving a *reason* (as opposed to writing in a “yes”) were generally those shown below in Table 29.

Table 29. Reasons for Unattained Necessary Medical or Dental Care Due to COVID-19 (n=68)

Reason	Approx. %
Office closed/limited appointments	64.1%
Fear of exposure to the virus	12.3%
Childcare because of limitations on number of people allowed in	7.1%
Family was in quarantine when need for care arose	7.1%
Delay for referral to a specialist (mostly pregnancy–related)	5.2%
Provider only open to emergency visits	5.2%
No health insurance	5.2%
Transportation	5.2%
Treatment not amenable to being provided via zoom	4.6%

*In a few cases, people wrote in more than one reason.

By a very large margin, dental services were reported as the main unfulfilled need—due to office closures, primarily—followed by deferrals for immunizations. Some representative comments that illustrate the reasons included:

- *“It was difficult to get follow up services from doctor due to office on restricted hours and times; they didn’t call me back.”*
- *“They gave our kid medical [services] through Medi-Cal but they didn't give her dental. It has been hard finding dental services that are a low costs.”*
- *“Didn’t feel it was worth the risk to follow up on the regular physical and dental exams this year.”*
- *“I was having [multiple birth] pregnancy and couldn’t get in to the specialist they wanted me to see.”*
- *“We were staying home and trying not to further burden our healthcare providers.”*
- *“The kind of dental and medical services we needed were limited to virtual platforms and those were ineffectual and did not meet my family's health care needs.”*
- *“Because of dentist shut down for cleaning in favor of more serious dental surgery, now my child has a more serious issue when we just got back in.”*

Experience with Home Visiting Services

The respondents were asked if both before and during COVID-19 they were receiving various services from a home visitor. (A home visitor was described in the survey as "someone who comes to your home to offer information and support services related to the needs of someone in your family.") Looking at the responses by language type (Figure 45), Spanish-language respondents reported receiving more home visiting services before the pandemic, and quite a bit more during it, particularly receipt of books, educational videos and school/art supplies. Parents who took the survey in English reported being provided with more child screening and referral services, both before and during COVID. Both respondent types reported about the same extent of case management and other family support services.

Figure 45. Use and Type of Home Visiting Services Received Before and After COVID-19

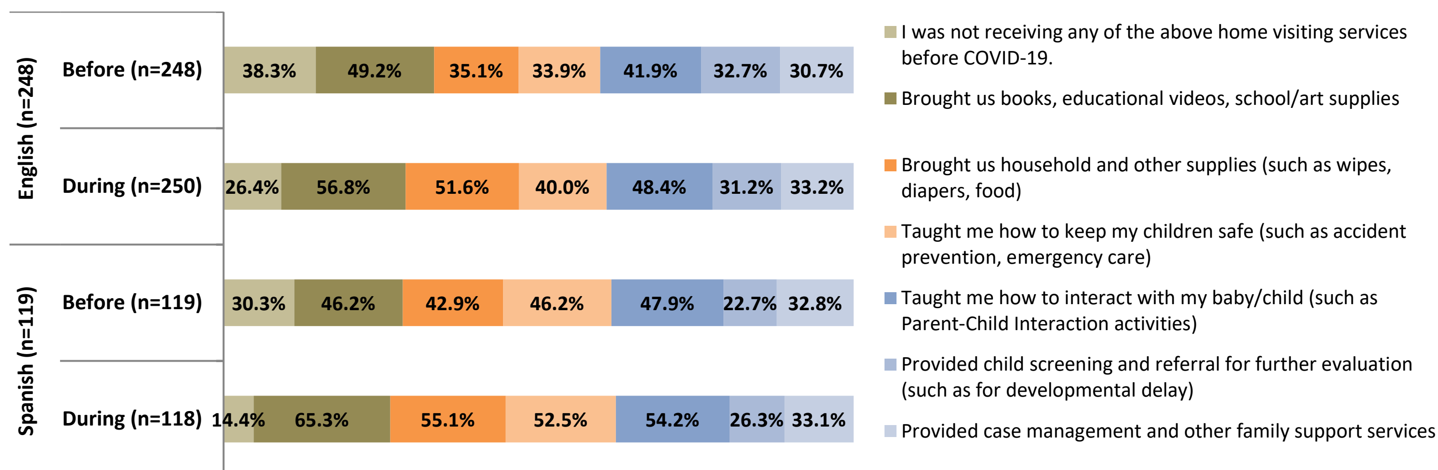
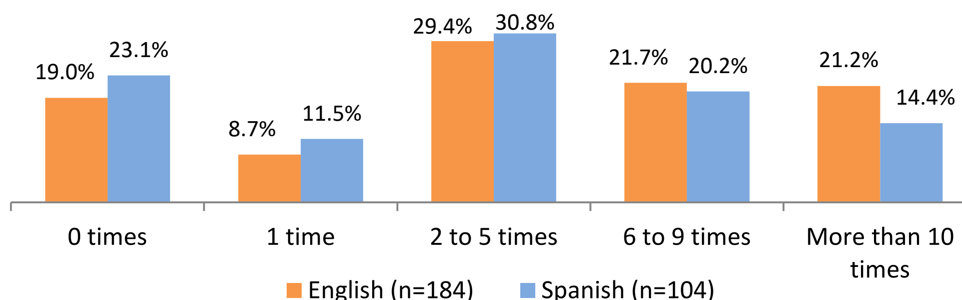


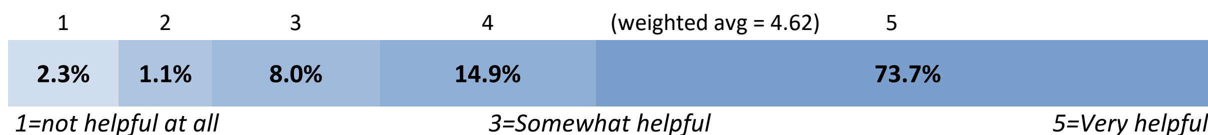
Figure 46indicates the number of times respondents estimated a home visitor came to their home (inside or standing outside) last year. (They were told if more than one home visitor came to count them as one person.) The responses from those saying they received no visits (19.0% English/ 23.1% Spanish) conflicts a little with their answers to the previous question—or indicates misremembering or confusion about what constituted a "home visit." Looking at both this and the previous question by age group did not yield any meaningful results.

Figure 46. Number of Times Respondents Received a Home Visit During COVID-19



Three-quarters (73.7%) of the respondents, regardless of which language they took the survey in, thought the home visiting services they'd received were very helpful (weighted mean = 4.62 on the 1 to 5 helpfulness scale shown in Figure 47).

Figure 47. Perceived Helpfulness of Home Visiting Services (n=272)



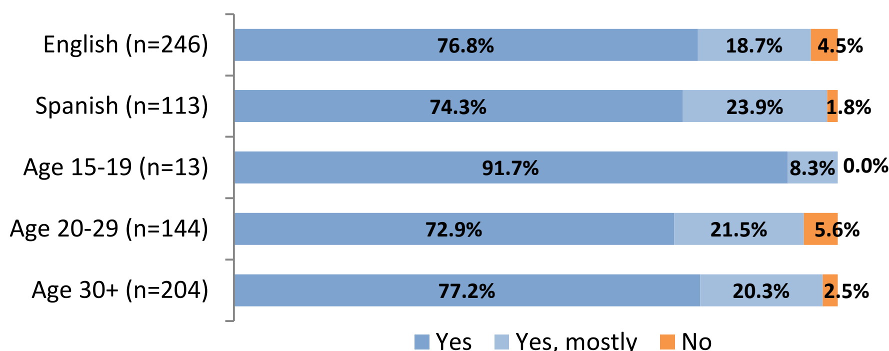
Nearly 80% of all respondents (both language groups) reported being "comfortable talking to or getting information from the home visitor (weighted mean = 4.71 on the 1 to 5 comfort scale, Figure 48).

Figure 48. Perceived Comfort Level Talking to or Getting Information from Home Visitor (n=270)

Needs and Community Resources

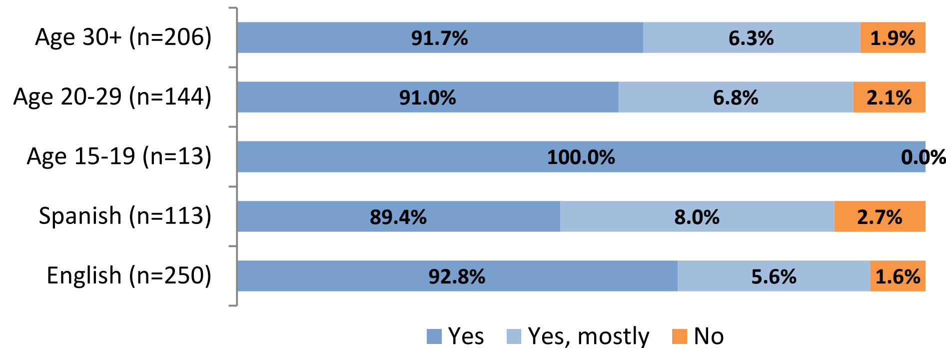
Having someone to talk to when worried about their child or family—which most people said was the case—was reported slightly more often by individuals who took the survey in English (76.8% v. 74.3%); when taken together with the response choice "yes, mostly have someone," it was the Spanish-language group with the higher proportion of reported sources they could go to (Figure 49). Looking at the responses by age, relatively more of the adolescents than the older age groups reported having someone to talk to when worried.

Figure 49. Has Someone to Talk to When Worried about Child/Family Member



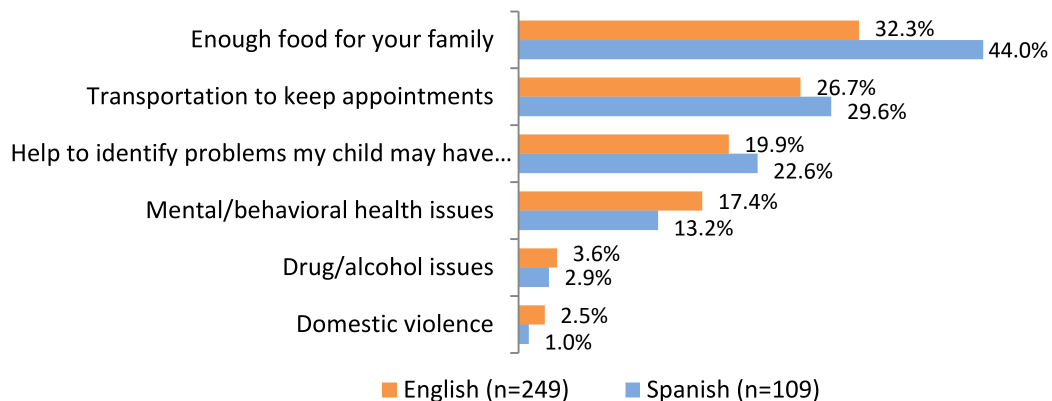
While nearly everyone said they "felt safe living with members of our household," as a group, adolescents represented the highest proportion of respondents who reported this (Figure 50). A slightly higher proportion of individuals who took the survey in Spanish than English (2.7% v. 1.6%) said they did *not* feel safe.

Figure 50. Feeling Safe Living with Household Members



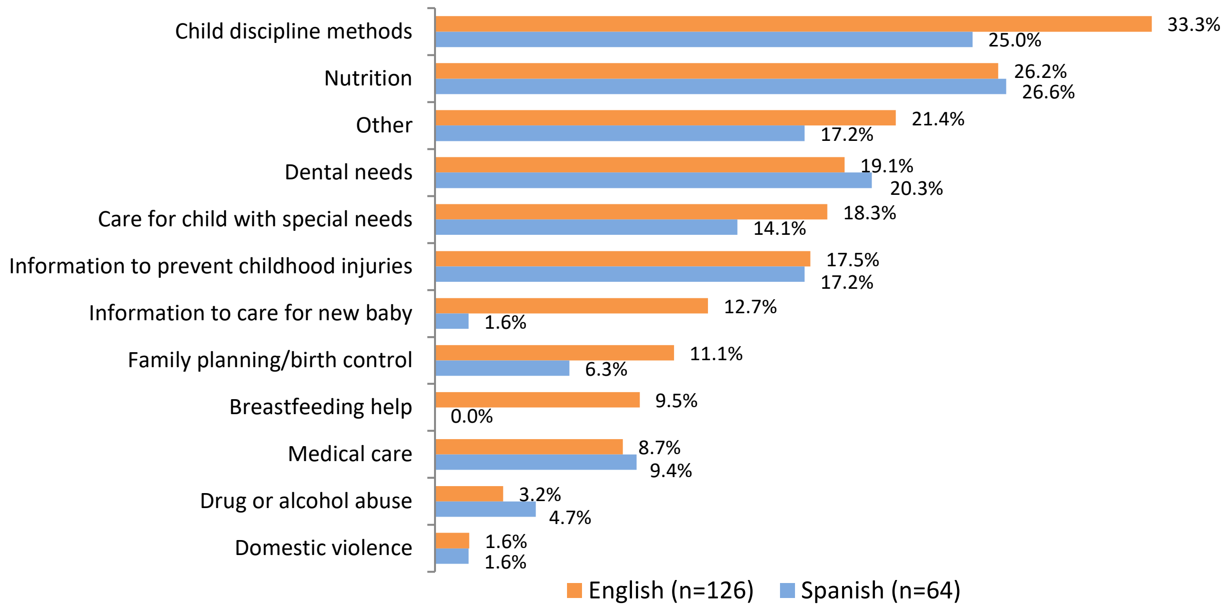
The survey asked parents/caregivers to think about the needs of their family currently and inform us whether they had any concerns about a given list of questions. Having enough food, followed by transportation to keep appointments and help identifying problems their child might have, topped the list of concerns—more so for Spanish-language respondents

Figure 50. Percent of Respondents Answering "Yes" to Various Concerns



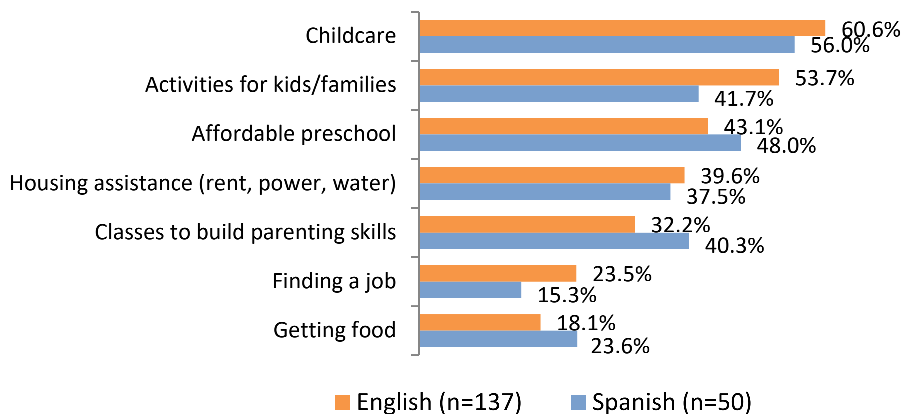
When asked what services related to health and development parents/caregivers needed now and couldn't find, "child discipline methods" received the highest priority—consistent with findings from previous First 5 Tulare parent surveys—reported in 33.3% English and 25% Spanish-language surveys. Although Figure __ suggests that a relatively large proportion of "other" needs was identified, respondents misunderstood the question as half of them wrote "need nothing" in the "other" box provided. All appropriate "other" responses are described in Table 30 on page 54.

Figure 51. Percent of Respondents Who Needed/Couldn't Find Services Related to Health and Development



Services identified as needed but difficult to find regarding early care and education included childcare, family activities and affordable preschool as the top three in importance. With the exception of affordable preschool, parenting classes and getting food, the needs for the other items shown in Figure 52 were a slightly higher priority for parents completing the survey in English.

Figure 52. Percent of Respondents Who Needed/Couldn't Find Services and Resources Related to Early Care and Education



Respondents wrote in a few "other" services and resources they needed that were not included in the survey. The most frequently requested service was counseling for couples, followed by transportation (Table 30).

Table 30. "Other" Services and Resources Respondents Needed

Services and Resources	Frequency
Couples counseling	5
Transportation	4
Housing	3
Vision	1
Orthopedics	1
Speech therapy	1
Assessment for Autism	1
Learn sign language	1
Find fun activities	1
Diapers	1
None/nothing needed	14*

*Mistakenly written in to the "other" option by some respondents

Close to 30% of the parents responded in some manner to the question about additional ways First 5 could help families. However, with the exception of the seven verbatim comments below, all of those responses written in stated that "nothing is needed," though a few of these added "thank you First 5."

- *"Great work by First 5 and all of the Resource Centers in providing information, resources and support"*
- *"Bilingual programs in our community"*
- *"Low-cost dental services"*
- *"School district being connected to our local family resource center"*
- *"Gasoline for transporting children to school"*
- *"Help families with young children to better organize their homes/keep them clean"*
- *"Support our local library with incentives/programming to better serve our community's early literacy programs"*

PART V: BEST PRACTICES

“You can’t just flip a switch and suddenly start showing up in people’s homes [post-COVID]; it has to be progressive and family-driven.” – Key Informant Interview

Home visiting as a service delivery strategy that connects home visitors with expectant parents and families with young children to provide information, resources, and support has shown evidence of improving outcomes in maternal and child health, child maltreatment, parenting, child development, and family economic self-sufficiency. In addition to sufficient funding, the success of evidence-based home visiting models, and the other models described below, is highly dependent on an adequate supply of knowledgeable, culturally sensitive home visitors, as made clear in the recent *First 5 California Home Visiting Workforce Study.*[73]

The unique working conditions of home visiting, the involvement of both professionals and paraprofessionals, and the increasing demand for home visiting programs as part of an overall system of community integrated services underscores the importance of workforce issues including readiness to return to in-person services. As restrictions on businesses, schools and other public spaces are being lifted around California, home visitors, who shifted to virtual visits as a “’best practice” during the pandemic, and their supervisors, are thinking through how this transition and return to “normal” will impact connections with families going forward.

EVIDENCE-BASED MODELS

The Department of Health and Human Services launched the Home Visiting Evidence of Effectiveness (HomVEE) review to conduct a thorough review of early childhood home visiting models. HomVEE provides an assessment of the evidence of effectiveness for early childhood home visiting models that serve families with pregnant women and children from birth to kindergarten entry (i.e., through age 5). The models described beginning on the next page have met HHS criteria[*] as “evidence-based early childhood home visiting service delivery models.”[74] The first three of these models are also part of the California Home Visiting Program (CHVP), of which Tulare County is a part, designed for overburdened families who are at risk for Adverse Childhood Experiences (ACEs).[75]

[*] Note that while these models meet the criteria for the general public some may not meet the criteria for tribal populations.

Nurse-Family Partnership (NFP)

Intended Recipients:

- Women with low-incomes and pregnant with their first child.
- The women must enroll and receive first home visit no later than the 28th week of pregnancy.
- Home visits continue until the child is 2 years old.

Goals for Home Visiting:

- Improve pregnancy outcomes
- Improve child health and development
- Improve families' economic self-sufficiency

Specific Services Provided:

Public health nurses provide education on parenting, share resources, make referrals and help with follow-through, and perform health checks on the children. The nurse home visitors follow a visitor schedule keyed to the developmental stages of pregnancy and childhood. They use input from parents, nursing experience, nursing practice, and model-specific resources – coupled with the principles of motivational interviewing – to promote low-income, first-time mothers' health during pregnancy, care of their child, and own personal growth and development.

Parents as Teachers (PAT)

Intended Recipients:

- All pregnant women and children birth through age 5 experiencing one or more stressors in their lives
- Families may enter at any time but must agree to stay for 2 years

Goals for Home Visiting:

- Increase parent knowledge of early childhood development and improve parenting skills
- Provide early detection of developmental delays and health issues
- Prevent child abuse and neglect
- Increase children's school readiness and school success

Specific Services Provided:

The model consists of four components: one-on-one home visits; group meetings; developmental screenings for children; and a resource network for families. Home visiting services can range in intensity, from weekly to monthly, as well as in duration, based on the number of stressors, and include: parent-child activity and book sharing, child observation and discussion, problem-solving and goal setting, parenting information sharing and handouts, resource referral and follow-up, developmental screening using a standardized tool, informal health information, hearing and vision screening.

Healthy Families America (HFA)

Intended Recipients:

- Low-income families who must be enrolled within the first 3 months after an infant's birth (HFA recommends families initiate services prenatally, if possible, but allows for families to enroll after the child is born. Programs are required to enroll at least 80 percent of families by the time the child is 3 months old)

- Service provision continues until the child enters kindergarten

Goals for Home Visiting:

- Enhancing family functioning by reducing risk and building protective factors
- Build and sustain community partnerships
- Reducing child maltreatment
- Increasing prenatal care
- Improving parent-child interactions and school readiness
- Promoting healthy child development
- Improving positive parenting skills of caregivers
- Promoting family self-sufficiency/decreasing dependency on social services
- Improving primary health care access
- Improving child immunization rates.

Specific Services Provided:

A trained paraprofessional provides one-on-one home visits focusing on family strengths to help families manage life challenges. Home visits take place based on a family's level of need. All families are offered weekly home visits for at least 6 months after the birth of the child. Family progress criteria are then used to determine a family's readiness to move to less frequent visits, starting with every other week, then monthly, and finally, quarterly. Services are provided for a duration of 3 to 5 years. Local programs define target populations based on community needs data. All families receive an initial risk assessment to tailor services to meet their specific needs.

Early Head Start (EHS) Home-Based Option

Intended Recipients:

- Low-income pregnant women and children birth to age 3, most of whom are at or below the federal poverty level or eligible for Part C services under the Individuals with Disabilities Education Act

Goals for Home Visiting:

- Early, continuous, intensive and comprehensive child development and family support services on a year-round basis
- Enhance children's physical, social, emotional and intellectual development
- Support parents' efforts to fulfill their parental roles, emphasizing the role of the parent as the child's first and most important relationship
- Help parents move toward self-sufficiency
- Collaboration with community partnerships that allows the program to expand its services

Specific Services Provided:

The EHS Home-Based Option services include a minimum of 1 weekly 90-minute home visit and 2 group socialization activities per month for parents and their children. Important aspects of the program include focus on cultural competence that acknowledges the profound role culture plays in early development, and activities that offer parents a meaningful and strategic role in the program's vision, services, and governance. Home visitors are required to have a minimum of a HV Child Development Associate a(CDA) or comparable credential, or equivalent coursework as part of an AA or BA degree.

Play and Learning Strategies (PALS) Infant Mission

Intended Recipients:

- Teenage mothers or teenage parents
- Unmarried mothers or single parents
- Parents/caregivers with limited education
- Children with developmental delays or disabilities
- Families with a history of child abuse or neglect/involvement with child welfare system
- PALS requires families to initiate services following the birth of the child. Families may enroll when the child is between 5 and 59 months old, although the model recommends that families enroll before the child is 4 years old.

Goals for Home Visiting:

- Educate parents about typical behaviors to expect from children at different ages so that parents can support the healthy development of their young children
- Help parents master specific skills for interacting with their infants, toddlers and preschoolers to lead to better child outcomes

Specific Services Provided:

There are two versions of the model: PALS Infant curriculum for families with children 5 to 18 months, which consists of 10 weekly sessions; and PALS Toddler/Preschooler curriculum for children 18 months through 4 years, which consists of 12 weekly sessions. Both versions are offered through 90-minute home visits conducted by a parent educator. The model requires an associate's degree in early childhood or work experience commensurate with education and a high school diploma for home visitors; a BA degree is recommended.

Home Instruction for Parents of Preschool Youngsters (HIPPY)

Intended Recipients:

- Parents with children ages 2 through 5 years
- Parents may have only limited formal education, limited English proficiency, limited financial resources, or other risk factors that can hinder their ability to provide quality preschool education to their child

Goals for Home Visiting:

- Support parents and caregivers as their children's first teacher
- Help parents to gain confidence in their ability to teach their children and fully prepare them for success

Specific Services Provided:

The Coordinator makes the initial visit, and then considers which of the program's home visitors would be the best fit for the family. The model includes five required components: 1) a developmentally appropriate school readiness curriculum; 2) one-on-one weekly home visits;
3) group meetings; 4) role play as the method of instruction; 5) peer home visitors and professional coordinators. HIPPY offers weekly, hour-long home visits for 30 weeks per year and two-hour group meetings at least six times per year. Sites are encouraged to offer the four-year program option serving 2- through 5-year-olds but must offer at least a two-year program option. The home visitors are typically drawn from the same population that a HIPPY site serves, and each site is staffed by a professional program coordinator who oversees implementation and supervises the home visitors.

OTHER MODELS OF HOME VISITING

The National Home Visiting Resource Center collects data from emerging models that do not meet HomVEE criteria, and was a helpful source for the information below. While not all of the following programs are *home visiting* models, per se, their curricula are intended to support the work of HV.

Early Steps to School Success (ESSS)

Intended Recipients:

- Pregnant women and children birth through age 3
- This model targets resource poor, rural communities

Goals for Home Visiting:

- Parents will have the knowledge and skills to support their children's education
- Home/school connections will be strong
- Early childhood knowledge and skills in communities will be significantly increased
- Increase children's school readiness and school success

Specific Services Provided:

Parent education and support, home visiting and pre-literacy and language development, connecting parents and schools, community collaboration. Home visit coordinators advise parents on topics such as establishing healthy sleeping routines, interpreting and responding to babies' efforts to communicate, and helping toddlers develop self-control and problem-solving skills. They foster a love of learning supplying families with children's books that encourage reading frequency, comprehensive and parent-child interactions.

SafeCare*

Intended Recipients:

- Families with children, ages birth through 5 who are at-risk or have been reported for child maltreatment. The child's safety is the center of focus for the delivery of this curriculum

Goals for Home Visiting:

- Assist the CWS social worker to assess the safety of the child and their home environment
- Engage the families to reduce the threats of hazards in the home
- Work with parents to increase their safe parenting skills
- Communicate with CWS any concerns regarding any safety issues regarding the child
- Address health and safety issues

Specific Services Provided:

SafeCare providers work with families in their homes to improve parents' skills in three areas: (1) parent-infant/child interaction skills, (2) health care skills, and (3) home safety. SafeCare is typically conducted in weekly home visits lasting from 60-90 minutes each. Each module is taught over the course of approximately 6 sessions. Each module begins with an observational assessment to determine parents' current skills and areas in need of improvement. A series of training sessions follows (typically four sessions), and Home Visitors work with parents until they show mastery of module skills. A final observational assessment is used to assess parents' uptake of skills.

*Note: SafeCare *Augmented* is an evidence-based home visiting model. The SafeCare program funded by First 5 Tulare—an evidence-based intervention for child neglect—is not.

Differential Response

Intended Recipients:

- Differential response (also called alternative response) encourages community agencies to participate in supporting families who are considered low risk, allowing CPS to focus on the more serious cases in which abuse and neglect have been confirmed.
- Families are served in a non-investigative pathway without a formal determination of child maltreatment.
- Families can receive services for up to 6 months with the option to extend an additional 3 months, if deemed necessary to complete the family case plan goals.

Goals for Home Visiting:

- Address the needs of families who are at risk of entering or re-entering the Child Welfare System by connecting them to supportive services prior to them being called to the attention of CWS
- Support families to ensure that children remain in their home
- Increase positive family engagement, involvement, and experience of care
- Increase safety and protection of the most vulnerable children referred to CPS
- Maintain children safely in their home with community support and services in the effort to avoid court intervention
- Increase family and community understanding and commitment to the protection of children
- Address the needs of adopted children who are at risk of re-entry to assist in stabilizing the family and maintain permanency
- Increase natural networks of supportive relationships
- Reduce/prevent incarceration/Juvenile Justice involvement

Specific Services Provided:

Services are provided through contracts with community-based organizations through four "pathways"—such as when a referral is made to child welfare but determined to not require a visit from the social worker. Services include case management, parent education/coaching, therapeutic services, and parent partner support.

Great Kids

Intended Recipients:

- Professionals who work in programs and serve parents and their pre-birth to age 5 children
- Newly hired Home Visitors not yet Growing Great Kids® certified to provide the foundational knowledge and skills that result in relationship-based, child-focused, family-driven, and strength-enhancing visits; materials support for up to 4-months of family visits.

Goals for Home Visiting:

- Enhance participants' competencies for building trusting, empathetic relationships with families that cultivate the growth of secure attachment relationships between caregivers and children
- Build protective buffers and life skills
- Increase parents' confidence and competence in the ability to protect children and their childhoods
- Help strengthen families and assure optimal child development

Specific Services Provided:

Provide programs and products with professional development, consultation, and evidence-based

parenting curricula to help home visitors create inspired and meaningful practices with families. In-person classroom certification seminar consists of 4 full days of engaging instruction. The virtual certification seminar is a blended learning model consists of 5 days of training with 3 hours of instructor-led virtual instruction each day followed by 2 hours of independent learning time. The tailored training constructs are embedded in the Protective Factors Framework, align with and build upon the HFA model approach, and exceed Head Start curriculum requirements.

Parenting Wisely (PW)

Intended Recipients:

- Parents with children ages 3-11 (Young Child edition)
- Parents with children ages 11 and above (Teen edition)

Goals for Home Visiting:

- Give parents the skills they need to improve their family relationships
- Reduce teen alcohol and drug use
- Reduce aggressive behavior
- Improve family communication.
- Promote positive child rearing

Specific Services Provided:

Highly interactive online parenting curriculum that can be used either in-home or in the office to help parents with tips and tools to parent their children in difficult situations. Conducted on a one-to-one basis. The curriculum includes video scenarios, interactive quizzes, skills practice and an online parent forum.

SUMMARY & CONCLUSIONS

“I believe the pandemic has shown us that we could be more innovative in our approach to home visiting.” – Agency Survey Respondent

The following key needs assessment findings—in no particular order of importance—should guide expansion or implementation of new evidence-based home visiting models in Tulare County to ensure that families—especially those most impacted by COVID-19—are able to obtain the services and supports they need.

- The Home Visiting Coordination partners value and respect one another and appreciate a shared history of working together; there was strong affirmation that “the time is right for this collaborative HVC project.”
- Even though there are home visiting services provided in many communities in Tulare County, it is serving only a small portion of the eligible families and children. There continue to be many children and families experiencing risk factors that do not have access to home visiting programs.
- Inconsistent or inadequate funding and, in some cases, complex fidelity requirements of some models, limits partners’ abilities to expand home visiting services.
- While the services provided by the partner agencies align with the documented needs of enrolled families, eligibility and capacity to provide mental/behavioral health—the issue with the highest identified need according to community input—is a limiting factor to more fully meet the demand.
- In-person screening, virtually non-existent during COVID, is critical to assess a child's development and, especially in the case of ACES, provides early detection so that children experiencing problems can be identified and referred.
- Not everyone was safer staying at home during the pandemic. Monthly domestic violence crime reports for 2020—the “COVID year”—increased 27.8% over the previous year.
- The surveyed parents/caregivers—if their self- reports are accurate—appear to be overrepresented among the proportion of all county residents with COVID-19 experience; as a group Black and Hispanic families have been disproportionately affected.
- Vaccine hesitancy—due to fear, misinformation and mistrust—is contributing to a disappointingly low COVID-19 vaccination rate, similar to other California counties. In Tulare County, as of June 1, 2021, only 38.8% of the population age 12+ has been fully vaccinated.

- “At least half” of families previously served through home visiting are said to be ready to have a home visitor again; new clients are a little less willing, but it is expected many will become receptive.
- Nearly all of the parents/caregivers thought the home visits they had received were helpful to very helpful, and said they were comfortable talking to or getting information from a home visitor.
- Besides getting families to enroll, family engagement requires sustaining their interest and commitment during and between visits. The most disengaged families are the ones who most often choose to discontinue home visiting services—with or without notifying the agency. These families may require a more tailored program or intensive visit schedule.
- “Linguistically isolated households,” in which close to a quarter of the county’s population lives, is a consideration that could influence outreach efforts and service delivery.
- Nearly all (90%) of the partners say they will consider continuing to use virtual home visiting as a hybrid method along with in-person visits, according to family need.
- Certain community health indicators continue to signal a problem; births to teen mothers, substance abuse and food insecurity are the most striking examples.

NEXT STEPS

Over the course of FY 2021-22, the HVC Advisory Group will:

- Convene around the findings in this report and continue to engage in discussions to identify common points of entry for families where linkages should be made or strengthened.
- Expand and/or implement new evidence-based home visiting programs to ensure families impacted by COVID-19 are able to obtain needed services and support.
- Identify and prioritize families who could benefit from home visiting but are not already being served, and develop effective strategies to overcome barriers and increase access.
- Identify “vision ambassadors” to build synergy, mobilize stakeholders, and help cultivate buy-in to support home visiting and family support services within the early childhood system of care.
- Build capacity and skills of HVC partners and other family-serving organizations that provide critical services to support families with children ages 0-5.
- Recommend any program or fiscal policies that could inform and support the State’s efforts to build a coordinated home visiting infrastructure/workforce.
- Meet regularly to track progress and outcomes, and alter approaches based on learning.
- Re-assess local needs to determine outcomes and achievement of goals, and share results.

ATTACHMENTS

"Some kids got lost in the dust and are still struggling emotionally."
– HVC Advisory Group Member

ATTACHMENT 1

HOME VISITING COORDINATION ADVISORY COMMITTEE MEMBERS

(In alphabetical order by first name)

Individual	Affiliation/Organization
Members	
Adela Hernandez	Woodlake Family Resource Center
Angel Avitia	Community Services & Employment Training – CSET Tulare FRC
Armando Villarreal	Dinuba Family Resource Center (Parenting Network)
Bianey Lagunas	Lindsay FRC Parent Representative
Claudia Carter	TCOE Early Childhood Education Program
Cyndee Garcia	Culter-Orosi Family Resource Center
Cynthia Molina	HHSA PLAY Liaison
Julia Castro	Family Services of Tulare County
Linda Ledesma	Lindsay Healthy Start Family Resource Center
Maricruz Hernandez-Baltazar	Visalia FRC Parent Representative
Mike Gibson	Parenting Network
Paul Prado	Porterville Family Resource Center (Parenting Network)
Raquel Gomez and Cyndee Garcia	FRC Network – Comprised of the local FRCs
Roxanna Cruz	Tulare County HHSA
SaRonn Mitchell	SAVE the Children – Early Steps to School Success
Sharon Lopez	Tulare County HHSA
Tammy Wiggins	Tulare County Public Health MCAH Program
Timberly Romero	Visalia Family Resource Center (Parenting Network)
Staff and Consultants	
Christina Sauceda	First 5 Tulare County
Michele Eaton	First 5 Tulare County
Barbara Aved	Barbara Aved Associates

KEY INFORMANT INTERVIEWEES

(In alphabetical order by first name)

Individual	Affiliation/Organization
Alexandria Elliott	Tulare County Office of Education
Amy Sullivan	Visalia Unified School District
Anita Ortiz	Tulare County Health and Human Services
Caity Meader	Family Services of Tulare County
Dorrine Henken	Love in the Name of Christ
Eddie Valero	Board of Supervisors
Irma Rangel	Turning Point of Center California
Mary Alice Escarsega-Fechner	Community Services Employment Training (CSET)
Michele Eaton	First 5 Tulare County
Mike Gibson	Parenting Network
Rosemary Caso	United Way
Roxanna Cruz	Tulare County HHSA
Tammy Wiggins	Tulare County Public Health MCAH Program
Tim Zavala	Tulare Youth Services Bureau

AGENCY SURVEY

Dear Home Visiting Coordination Partner:

Thank you for taking the time to complete this survey as part of the Home Visiting Coordination Needs Assessment process. The information will be used to help improve services for families in Tulare County who are served through home visiting and/or can benefit from receiving home visiting services. Feel free to confer with your home visiting team to help answer the following questions, but please complete and submit only one survey on behalf of your agency. Please note that this survey will close on April 30.

Before you start…..here are a few definitions relevant to this survey:

- *Home visiting = a service delivery strategy that links trained home visitors with expectant parents and families with young children to provide information, resources, and support.*
- *During COVID-19 = approximately March of last year to current.*
- *Post-COVID-19 = after the pandemic is considered reasonably under control through a sustained vaccination program and there is a return to a general sense of "normalcy."*
- *Virtual visit = can include zoom, GoToMeeting, social media app, etc.*

The first few questions ask you to describe your agency's role in delivering home visiting services.

1. What type of agency do you represent?
    a. Family Resource Center
    b. Other type of non-profit (name of agency? ____)
    c. County agency (e.g., Public Health, Welfare Department, TCOE)

2. Which of the following statements best describes your organization's role in home visiting prior to COVID-19? *(Check only one)*
    a. Directly provides home visiting services to families
    b. Directly provides home visiting *support* services to families
    c. Contracts with other agencies to provide home visiting services to families
    d. Contracts with other agencies to provide home visiting *support* services to families
    e. Refers families to other agencies for services
    f. None of the above

3. Which of the following models best describes your agency's home visiting model?
    a. Early Head Start – Home-based Option
    b. Nurse-Family Partnership
    c. Safe Care
    d. Parents as Teachers (PAT)
    e. Other (please specify ____)

***NOTE: THIS SURVEY WAS RE-FORMATTED IN SURVEY MONKEY FOR ONLINE USE.**

4. Across all of your funding sources for home visiting, about how many client "slots" does your organization have for home visiting? (Note: all members of one family/household represent a single caseload slot)
   a. Specify number of clients (______)
   b. Don't know

5. What are your criteria for enrolling clients in home visiting services? *(Check all that apply)*
   a. Families who reside in low-income communities regardless of income eligibility
   b. Low-income families (income below federal poverty threshold)
   c. Eligible families who are pregnant or mothers under age 21
   d. Parents without a high school education
   e. Eligible families that have a history of child abuse/neglect or had interactions with child welfare services
   f. Eligible families with children with developmental delays or disabilities
   g. Eligible families that have a history of substance abuse or need substance abuse treatment
   h. Eligible families that include individuals who are incarcerated
   i. Other (please specify ____)

6. What is the typical amount of time a family stays enrolled in your agency's home visiting program? *(Check only one)*
   a. 1-2 months
   b. 3-6 months
   c. 7-12 months
   d. 1-2 years
   e. More than 2 years

7. Which of the following reasons typically limits the time a family stays enrolled in your home visiting program? *(Check only the main reasons)*
   a. The family chooses to dis-enroll and informs us
   b. The family doesn't follow through and drops out, sometimes without informing us
   c. The family becomes ineligible based on our criteria
   d. The family moves away
   e. Funding runs out
   f. Other (please specify ____)

8. Approximately what percentage of families re-enrolls in your agency's home visiting program?
   a. <10%
   b. 10%-20%
   c. 21%-33%
   d. >33%

9. What are the typical reasons in your program for a family to re-enroll? (*check all that apply that are typical*)
   a. New baby
   b. Parent wishes to have a refresher
   c. Incarceration situation
   d. Other (please specify ____)

10. Across all of your funding sources <u>for home visiting</u>, about how many home visitor staff does your organization have for home visiting? (Note: count both full- and part-time positions whose *main role* is HV)
    a. Specify number of staff (______)
    b. Don't know

11. *In general*, about how long does a home visiting staff person stay with your agency <u>in a home visitor capacity</u>? *(We are asking about staff retention)*
    a. >6 months
    b. 6 months – 1 year
    c. 1-2 years
    d. 2-3 years
    e. More than 3 years

12. In which of the following ways has your agency built workforce capacity for home visiting? *(Check all that apply)*
    a. Recruitment and retention of a workforce that represents the cultural/linguistic diversity of Tulare County.
    b. Established a set of core competencies for home visitors and made hiring decisions accordingly.
    c. Provided initial and ongoing cross-sector training to maintain a skilled home visiting workforce.
    d. Created an incentive structure to promote professional development and retain home visitor staff.
    e. None of the above.

13. In which of the following ways do you work together with other Tulare County home visiting programs? *(Check yes or no, and indicate whether the activities occur on mostly a formal or informal basis.)*

	YES	NO		Mostly Formal	Mostly Informal
a. Develop core competencies for the HV workforce.					
b. Share training and educational resources (e.g., co-train HV workforce).					
c. Develop common measures of success.					
d. Collect and review common data to evaluate home visiting outcomes.					
e. Identify funding opportunities for home visiting.					
f. Build public awareness.					
g. Advocate for systems and policies to promote home visiting.					

The next set of questions asks you for your perceptions about home visiting coordination and relationships in Tulare County.

Please indicate on a scale of 1 to 6 the extent to which you agree with the statement "*Tulare County has a coordinated early childhood system of care*."

1 Strongly disagree	2 Disagree	3 Somewhat disagree	4 Somewhat agree	5 Agree	6 Strongly agree
O	O	O	O	O	O

14. As you think about the relationships among family-serving organizations in Tulare County, please indicate your level of agreement with the following statements.

	1 Strongly disagree	2 Disagree	3 Somewhat disagree	4 Somewhat agree	5 Agree	6 Strongly agree
a. Family-serving organizations in our county have a history of working together.	O	O	O	O	O	O
b. Trying to solve problems through collaboration has been common among family-serving organizations in our county; it happens often.	O	O	O	O	O	O
c. Family-serving organizations in our county trust one another.	O	O	O	O	O	O
d. Family-serving organizations in our county respect one another.	O	O	O	O	O	O
e. Family-serving organizations in our county communicate well/openly with one another.	O	O	O	O	O	O
f. The time is right for this collaborative HVC project.	O	O	O	O	O	O

15. Please feel free to provide any additional information or comments that would inform our understanding of your home visiting services. ____

Organizations are contributing in different ways to respond to COVID-19. The final set of questions asks you to describe the ways in which you have continued to provide home visiting along with your other services to children and families during the pandemic.

16. In which of the following activities is your agency currently engaged in providing services during COVID-19? *(Check if yes; indicate all methods that apply)*

	✓		Telephone	Virtual	In-person client home
a. Keep families informed about current public health recommendations related to COVID-19					
b. Disseminate current information about availability of local resources and services for families					
c. **Connect** families to needed concrete supports (e.g., diapers, cleaning supplies, masks, food, kits for family activities)					
d. **Directly provide** needed concrete supports (e.g., diapers, cleaning supplies, masks, food, kits for family activities)					
e. **Connect** families to needed services related to mental health, childcare, and health/dental					
f. **Directly provide** needed services related to mental health, childcare, and health/dental					
g. **Directly provide** child evaluation/assessments (e.g., ASQs)					
h. Other (please specify) ____					

17. What are your agency's specific plans for *how* you plan to provide home visiting services post-COVID? *(Check only one)*
    a. Phone/virtual only
    b. In-person at client home only
    c. Possibly a hybrid model (phone/virtual/in-person), according to need

18. What are your agency's specific plans for providing the *type* and *level* of home visiting services post-COVID? *(Check only one)*
    a. Same level/type of services as currently
    b. Fewer types/levels of services as currently (which ones? ____)
    c. More types/levels of services as currently (which ones? ____)

19. Across Tulare County, what have been the main barriers to delivering services during COVID-19 you've observed that are *unique* to this time or especially worse during this time? (Check all that apply)
    a. Families' reluctance to receive services due to fear of infection risk
    b. Families' reluctance to receive services due to being undocumented
    c. Families' reluctance to accept help due to fear of exposure/reporting domestic violence/maltreatment
    d. Privacy issues (e.g., clients not feeling comfortable interacting via zoom when others are at home)
    e. Financial constraints (e.g., family can't pay copayments, loss of employer benefits but ineligible for relief funds)
    f. Providers' limited days/hours of operation/unavailable appointment slots
    g. Other (please specify ____)

20. For any of the main barriers you identified above, have any of them been unique to your agency?
    a. Yes (Which ones? ____)
    b. No

21. What would you/your home visiting staff say are the 2 highest needs of families during this time of COVID-19 that are not being adequately met that could benefit by home visiting?

#1
#2

22. Please feel free to provide additional information or comments that would inform our understanding of any special situations your agency has experienced delivering services to families during COVID-19.

____

____

Thank you for completing this survey!

AGENCY FOLLOW-UP SURVEY

HVC PARTNER AGENCY FOLLOW-UP SURVEY

Thank you for taking the time to help us complete the 2021 HVC Needs Assessment with these follow-up questions; the responses supplement the recent survey you completed. Some of the information requested, such as family enrollment and referral, is specifically for F5CA, who hopes to summarize data across all funders to create a complete picture of home visiting in California.

Instructions: Please complete only one of these forms per agency. Email the completed form to Barbara Aved (barbara@barbaraavedassociates.com) with cc to Christina Sauceda by JUNE 9.

Note: We are only interested in evidence-based HV models. We do not need to know the name of your organization; all data from this survey will be reported in the aggregate in the HVC Needs Assessment report.

1. Please use the following chart to tell us the number of available slots and number of families currently enrolled *in home visiting services* by each of your program models.

Name of Your HV Model	# of Available (i.e., funded) Client Slots	# of Currently Filled Client Slots	# on a Waitlist (if any)

Add more space to this and the following charts if you have more than 2 evidence-based HV models.

2. For each of your HV models, please provide the following demographic information about the *primary caregivers* you served during the 2020-2021 fiscal year.

Name of Your HV Model	Number of Primary Caregivers (an unduplicated count) by Race/Ethnicity							Number by Primary Language Spoken at Home		
	White, Hispanic	White, non-Hispanic	African Amer	Amer Indian	Asian/ Pacific Isl	Multi-race	Other	English	Spanish	Other

3. For each of your HV models, how many children ages 0-5 lived in the households you served in FY 20-21?

Name of Your HV Model	Number of Children (an unduplicated count) by Age Group					
	Prenatal	0-11 mos	12-23 mos	24-35 mos	36-47 mos	48-60 mos

4. Approximately how many of your families were referred from your home visiting program *to another home visiting program* in FY 20/21? What were the main reasons for these referrals?

Name of Your HV Model	# of Families Referred	Name of HV Program (Model) you Referred to	Main Reason(s)

5. Approximately how many of your families were referred from your home visiting program *to some type of family support service* in FY 20/21? How many of these families/referrals resulted in linkage to service?

Name of Your HV Model	Number of HV Families Referred / Number of Linkages Made															
	Early care/educ		Early intervention		Mental/ behavioral health		Basic needs/income support		Child welfare		Educ and training		Physical/ oral health		Social services support	
	#	# linked	#	# linked	#	# linked	#	# linked	#	# linked	#	# linked	#	# linked	#	# linked

Note: families can be referred to more than one type of support service.

6. Do you have a *formal* relationship for collaboration/coordination between your HV program and any other family-serving/HV program model organizations?

   a) _____ No
   b) _____ Yes (If Yes, with whom? what type of relationship? for what?)

Name of Other Family-Serving Organization/HV Model with whom you have a Formal Relationship	Type of Relationship				
	Check all that apply				Brief description of relationship purpose
	Contract (due to funding)	Contract (with no funding relationship)	MOU*	Other	

*Please attach a copy.

7. Do you have any data sharing arrangements between your HV program and other family-serving/HV program model organizations?

   a) _____ No
   b) _____ Yes (Please briefly describe below)

8. For Questions 2-5 above, which statement best describes the level of ease or difficulty you had in providing the requested data/information?

   a) _____ Not much of a problem to find most of the answers though it took a while
   b) _____ A moderate problem, but eventually I was able to find most of the answers
   c) _____ A big challenge, so I mostly estimated/guessed at the answers
   d) _____ A big challenge, so I mostly felt better leaving blanks
   e) _____ Other (What?

ATTACHMENT 4

PARENT SURVEY*

Dear Parents/Caregivers:

Please give us your input! We want to learn more about what families in Tulare County need during this time of COVID-19. The information will be used to help improve services for families. Thank you for taking the time to complete this survey.

Your Family:

1. What is your age? *[Circle only one]* a) 15-19 years old b) 20-29 years old c) 30 years or older

2. Which of the following best describes your household at the current time? a) Single mom or single dad living with their kids b) Two parents living together with their kids c) Multiple generation family living with kids d) Adults, no kids, but someone is pregnant e) Other situation (please describe ________________________)

3. Which of the following best describes your family's employment situation at the current time? A) No one working (unemployed) b) At least one adult, working from home c) At least one adult working, outside of the home d) Other situation (please describe________________________)

4. Please describe your current childcare arrangements. a) All children are at home, including school-age b) Some children at home/some in childcare or preschool c) Other situation (please describe (___________________)

Information:

[Circle the best answer]:

5. I know where to go/who to ask/what to read to get correct information about COVID-19. a) Agree b) Mostly agree c) Mostly disagree d) Disagree

6. I generally understand the information I've read or been given about COVID-19. a) Agree b) Mostly agree c) Mostly disagree d) Disagree

7. I know where to go/who to call to ask for the services my family needs during this time. a) Agree b) Mostly agree c) Mostly disagree d) Disagree

8. I feel confident about the future once this pandemic is over. a) Agree b) Mostly agree c) Mostly disagree d) Disagree

***NOTE: THIS SURVEY, IN ENGLISH AND SPANISH, WAS RE-FORMATTED IN SURVEY MONKEY FOR ONLINE USE.**

Experience:

9. Have you or anyone else in your immediate household ever had COVID-19? a) Yes b) No
10. When you want to get information about COVID-19 (how to reduce risk, where to get tested, etc.) where do you mainly get it? a) Doctor/clinic b) Internet c) TV/social media d) Friend or family member
    e) Public Health f) Teacher g) Other (where?______________________________________)
11. In the last year because of COVID-19 were you unable to get or did you delay getting any necessary medical or dental care for yourself or your child? *[Circle one]* a) No b) Yes (If yes, what was the main problem?
    ____)

Services:

12. Before COVID-19, were you receiving any of the following services from a home visitor (a professional who comes to your home to offer information and support services related to the needs of someone in your family)? (Check yes or no)

Someone who…..	Yes	No
a. Brought us books, educational videos, school/art supplies		
b. Brought us household and other supplies (such as wipes, diapers, food)		
c. Taught me how to keep my children safe (such as accident prevention, emergency care)		
d. Taught me how to interact with my baby/child (such as Parent-Child Interaction activities)		
e. Provided child screening and referral for further evaluation (such as for developmental delay)		
f. Provided case management and other family support services		

13. During COVID-19, have you received or are you currently receiving any of the following home visiting services (either in-person or through Zoom)? (Check yes or no)

Someone who…..	Yes	No
a. Provided us with books, educational videos, school/art supplies		
b. Provided us with household and other supplies (such as wipes, diapers, food)		
c. Taught me how to keep my children safe (such as accident prevention, emergency care)		
d. Taught me how to interact with my baby/child (such as Parent-Child Interaction activities)		
e. Provided child screening and referral for further evaluation (such as for developmental delay)		
f. Provided case management and other family support services		

If you answered "yes" to any of the home visiting services in the previous question, please answer the next 3 questions; otherwise, skip to Question 17 and continue.

14. About how many times did a home visitor come to your home (inside or standing outside) last year? (If more than one home visitor came, please count them as one person)
    a) 0 times b) 1 time c) 2-5 times d) 6-9 times e) more than 10 times

Please use the scale from 1 to 5 to answer the next 2 questions:

15. How helpful were the home visiting services?
    ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
    1 = not helpful at all 3 = somewhat helpful 5 = very helpful

16. How comfortable were you talking to or getting information from your home visitor?
    ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
    1 = not comfortable at all 3 = somewhat comfortable 5 = very comfortable

Needs and Community Resources

17. I have someone to talk to when I'm worried about my child or family. a) Yes b) Yes, mostly c) No

18. I/my children feel safe living with members of our household. a) Yes b) Yes, mostly c) No

19. Thinking about the needs of your family, do you <u>currently</u> have concerns about any of the following? *[✓ yes or no]*

    a) Enough food for your family __ No __ Yes
    b) Transportation to keep appointments __ No __ Yes
    c) Mental/behavioral health issues __ No __ Yes
    d) Drug/alcohol issues __ No __ Yes
    e) Domestic violence __ No __ Yes
    f) Help to identify problems my child may have (behavior, vision, speech, autism) __ No __ Yes
    g) Other (What? ______________________________)

20. What services do you want or need now for you or your family *that you can't find*? [✓ *all that apply]*

Help for…..						
Health and Development	**Yes**	**No**		**Early Care & Education**	**Yes**	**No**
Dental needs				Affordable preschool		
Nutrition				Child care		
Medical care				Other (what?		
Child discipline methods						
Care for child with special needs				**Resources for Families**		
Drug or alcohol abuse				Classes to build parenting skills		
Domestic violence				Activities for kids/families		

Information to care for new baby				Getting food		
Breastfeeding help				Finding a job		
Information to prevent childhood injuries				Housing assistance (rent, power, water)		
Family planning/birth control				Other (what?		

Additional Comments

28. Do you have any needs not mentioned above, or suggestions for other ways we can help your family?

___

___

Thank You!

Early Childhood System of Care

Source: First 5 California et al. California Home Visiting Coordination (HVC) Project TA Phase Kick-off, May 19, 2021.

END NOTES

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