Tulare County
Home Visiting Coordination
Updated Needs Assessment

Tulare County
Home Visiting Coordination Advisory Committee

June 2024

Barbara Aved Associates

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INTRODUCTION

"Clarifying what 'home visitation' means to the different agencies here has been one of the most useful things to come out of the Home Visiting Coordination project." — HVC Advisory Group Member

One of the central tenets of home visiting focuses on building on parents' strengths and supporting them in their vital roles as the primary influencers of their children's development.[1] That is because home visiting has the potential to have a strong positive impact on how parents and children interact. These models have served an essential role in addressing the needs of young children by connecting families to programs, supports, and services. Home visitors, through warm, caring, skillful interactions, 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.

Background

In October 2019, the First 5 California State Commission approved up to $24 million in funding through 2024–2025 to help counties create a sustainable, unified local home visiting system to supports families with the services they need and to maximize available funding to serve more families.[2] The initial First 5 Tulare County Home Visiting Coordination (HVC) Action Plan we developed under the grant called for conducting a comprehensive needs assessment and organizing the local home visiting infrastructure, and based on what was learned, activities to identify and ease what was at the time the many effects of COVID-19 on families. In partnership with the HVC Advisory Group, the initial and updated Action Plans were fulfilled over the course of FY 2020-24. To update planned activities going forward that align with current needs and goals, this subsequent Home Visiting Needs Assessment, produced in June 2024 by Barbara Aved Associates (BAA), was conducted.

HVC Advisory Group

The 17-member HVC Advisory Group (Attachment 1) formed among the organizations that provide early childhood and family support services in Tulare County have provided insight and direction to move towards a more coordinated home visiting system. The Committee's first effort was to develop the vision, mission statement and goals that appear on the next page which continued to provide guidance to this program. Meeting periodically, the HVC group has offered valuable and practical suggestions, helped raise awareness of the importance of home visiting, and facilitated workforce development and other activities that have enriched home visiting programs in Tulare County.

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

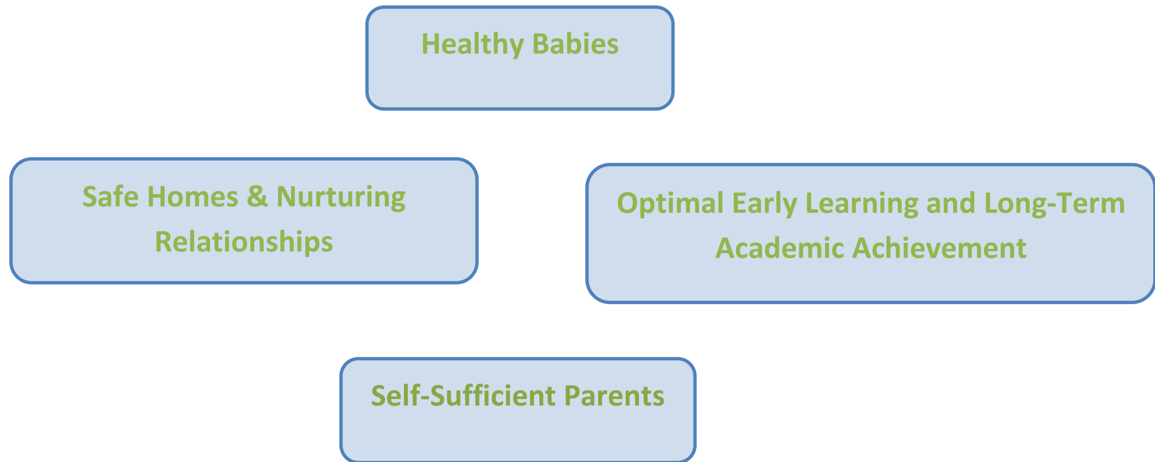
To improve the health and well-being of children and families through a collaborative and integrative system of family-centered services delivered in the home setting.

GOALS

The following goals continue to reflect the desired results the HVC Advisory Group envisions for home visiting services in Tulare County.

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*



ANTICIPATED OUTCOMES

The HVC Advisory Group is committed to continue tracking the following outcomes. Measuring their progress will help us continue to see if the work we are undertaking is achieving the goals we set out 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.

PROCESS AND DATA SOURCES

"How can we track if we're being efficient and effective for our First 5 families in Tulare County if we don't have a unified tracking system?"— HVC Advisory Group Member

Needs assessments inform action plan development and involve gathering, analyzing and *applying* statistical and community input data 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, which first focused on the immediate impact of the COVID-19 pandemic impact, has continued to reveal some of the challenges collaborating Tulare County organizations still face in addressing the needs of pregnant women, young children, and families through home visiting.

DATA SOURCES AND METHODS

Existing Data

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 assessments for relevancy; evidence-based home visiting models; case studies of others' experience; and related articles and reports that could inform the assessment. Relevant information from most recent needs assessment conducted by BAA for the *First 5 Tulare County 2023-2028 Strategic Plan* was also used in updating this report.

Data from 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 surveys. Ongoing input from the HVC Advisory Group also facilitated an understanding of the early childhood system of care in Tulare County.

Community and HVC Agency Surveys

A 2024 online and hard-copy *Parent Survey* (English/Spanish) 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, experiences with home visiting services, awareness of services, barriers to access, and suggestions for ways service providers could be more helpful. The survey findings continued to inform the current needs assessment.

Organizations and providers offering home visiting services to Tulare County families provided information directly to us through surveys, interviews, and specific assessments (see Appendices). The *HVC Partner Agency Survey* and the updated *Partners' Training Needs Assessments* (see Appendices for copies) that occurred between October 2021 and March 2024 sought to understand capacity issues, changes in the service delivery models and staffing utilized by Tulare County home visiting agencies, the ways they were meeting the needs of families, and priority training topics for home visitor staff. These findings are presented in Part IV of this report, and the questionnaires are included in the Appendix.

PART I. ESTIMATED NEED FOR HOME VISITING

"The birth of a baby is an exciting time, but it can also be overwhelming, especially for those without a positive parenting model or support network." — CA Home Visiting Program

Although California is investing in early interventions like home visiting in order to improve outcomes for children and their families, home visiting programs are out of reach for many children who could benefit from them. Ideally, every child would be healthy, growing and thriving in a strong family, and supported by a safe and nurturing community. The reality is, however, that human, social, and material assets vary widely across Tulare County's approximately 6,000 infants born each year.

While every Tulare County 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, we estimated the number of children age 0-5 who would most likely benefit from home visiting by those with the fewest assets (see page 10). The estimates are based on birth data, poverty rates, children participating in CalWORKS, families receiving CDSS behavioral health services, and eligibility for Medi-Cal, and are conservative estimates of the minimum need for home visiting services in the county.

Table 1. Tulare County Children and Population in Poverty, 2023

Tulare County Profile	
# of children 0-17	140,454
# of children living in poverty (24.7%)*	34,692
# of persons	474,507
# of persons living in poverty (18.2%)	86,360

*This percentage of child poverty is without any safety net services provided.
Sources: https://censusreporter.org/profiles/05000US06107-tulare-county-ca/
https://www.ppic.org/interactive/california-poverty-by-county-and-legislative-district/

CalWORKS

The number of children participating in CalWORKS is calculated by the number receiving at least $10 of CalWORKS cash aid in the month of January 2020 (the most recent data) per 1,000 children ages 0-17. In Tulare County, with 25,023 children participating in CalWORKS, the rate was striking: at 177.5 it was the highest among all 58 counties except for Del Norte, at 183.7; the statewide rate was 80). [3]

The following table (Table 2.a) shows the average number of individuals referred to and receiving CalWORKs services in each of 6 categories.[4] Knowing that behavioral/mental health needs are consistently ranked—by parents, providers, early childhood educators and others—as the highest need of families in Tulare County, these service delivery data should be suggestive of system capacity to provide services, not indicators of need. The same consideration should be given to the Supportive Services data provided to individuals in CalWORKS shown in Table 2.b.

Table 2.a. Behavioral Health Services Referrals and Participation, Tulare County CalWORKS Families: FY 2020-21

	MH Treatment *Total Referrals for MH Evaluation*	**MH Treatment** *Total MH Services Provided*	**Substance Abuse Treatment** *Total Referrals for Evaluation*	**Substance Abuse Treatment** *Total Services Provided*	**Domestic Abuse Treatment** *Total Referrals for Evaluation*	**Domestic Abuse Treatment** *Total Services Provided*
Two-Parent Families	15	136	0	17	8	35
All Other Families	37	1171	0	165	*	264
Total	52	1307	0	182	8	299

Source: California Department of Social Services, CalWORKs Annual Summary, November 2022.

Table 2.b. Monthly Average Number of Individuals in Tulare County CalWORKS Receiving Supportive Services: FY 2020-21

Child Care *All Families*	**Child Care** *Two-Parent Families*	**Transportation** *All Families*	**Transportation** *Two-Parent Families*	**Ancillary Services** *All Families*	**Ancillary Services** *Two-Parent Families*
1757	258	137	35	29	*

Source: California Department of Social Services, CalWORKs Annual Summary, November 2022.

Cost of Living Factors

A recent study by United Way of California found families living in Tulare County struggle more than most to meet the high cost of living. *How Much it Costs to Struggle: The Real Cost Measure in California 2023* highlighted education as the key factor in lifting households out of financial struggle, and showed Tulare County had the highest rate of struggling households (53%) led by a person with no more than a high school diploma.

Unlike the official poverty measure, the Real Cost Measure factors the costs of housing, food, health care, child care and other basic needs for a much more accurate measure of what it takes to make ends meet in California. In Tulare County, in 2023, 43% of households fell below the Real Cost Measure, and 35%-37% of households paid more than 30% of their income on housing, also known as rent burdened. While 48,989 of households countywide fell below the Real Cost Measure, in areas outside of Visalia, Tulare and Porterville it was 53% or 18,349 households.[5]

Self-Sufficiency Standard

The Self-Sufficiency Standard determines the amount of income required for working families to meet basic needs at a minimally adequate level, taking into account family composition, ages of children, and geographic differences in costs.[6] Because young children have a dramatic effect on a household's budget, we used a family scenario with 2 adults, an infant, a preschooler and 1 school-age child for illustration purposes, Table 3 on the next page is a display of the Self-Sufficiency Standard for each of these Tulare County families. With a median household income of $64,474 in the county in 2022, the wage gap for these families is quite evident.

Table 3. Self-Sufficiency Standard for Tulare County, 2023*

Household Budget		
	Monthly	**Annually**
Housing	$1,337	$16,044
Child care	$1,951	$23,412
Food	$1,158	$13,896
Health care	$1,069	$12,828
Transportation	$942	$11,304
Miscellaneous	$646	$7,752
Taxes	$1,156	$13,872
	$8,259	$99,108
It takes on average $99,108 for this household to make ends meet		

*2 adults, 1 infant, 1 preschooler, 1 school-age child.
http://www.selfsufficiencystandard.org/California

Medi-Cal Enrollment

California's Medi-Cal program—providing insurance coverage to uninsured populations with the goal of improving access to health care and, in doing so, to improve health—currently serves more than 13 million people in the state, half of whom are children. In Tulare County, in December 2023, there were 110,037 children age <18 enrolled in Medi-Cal; 32,877 (29.9%) of these children were ages 0-5.[7] Table 4 on the next page shows the number of children by age.

Table 4. Tulare County Children Age 0-17 Enrolled in Medi-Cal, December 2023

Age	Number
0	5383
1	5271
2	5292
3	5494
4	5692
5	5745
6	5990
7	5878
8	6141
9	6278
10	6264
11	6551
12	6492
13	6525
14	6776
15	6724
16	6919
17	6622
Total	110037

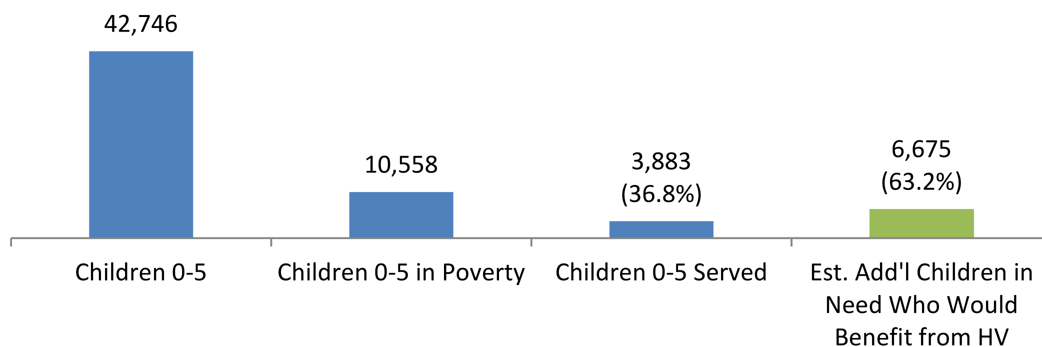
32,877 age 0-5

Source: CA Department of Health Care Services

Estimate of Need

In 2023, the HVC partner agencies reported serving 4,259 parents (families) and 3,883 children, or about 36.8% of the estimated need. (*In the prior HV needs assessment, the HV agencies reported serving only 20.2% of the need*.) As a conservative estimate, as Figure 1 shows, there are at least 6,675 additional Tulare County children age 0-5 – or 63.2% more – who could have benefitted from receiving home visiting services last year.

Figure 1. Estimated Need for Home Visiting Services, 2023



PART II. OVERVIEW OF TULARE COUNTY

"Increasing efficacy within [home visiting] services will improve the service delivery to families, providing support and promoting self-sufficiency." — HVC Advisory Group Member

Population Characteristics

Centrally located in the Central Valley of California, Tulare County—the 18th most populated county in the state of 58 counties and the 7th largest by total land area—is composed of 8 incorporated cities and 71 unincorporated communities. According to the most recent U.S. Census estimates, Tulare County's 2023 population—which has shown slight increases over the last decade, was estimated at 475,064, with a growth rate of 0.1% from the previous year.[8]

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, 2022 and January 1, 2023 showed a .01% growth for the county overall (Table 5).

Table 5. Population Estimates of Tulare County Cities

County/City	Total Population		Percent Change 2022-2023
	1/1/2022	1/1/2023	
Tulare County	474,507	475,064	0.1
Dinuba	25,222	25,469	1.0
Exeter	10,251	10,184	-0.7
Farmersville	10,221	10,151	-0.7
Lindsay	12,557	12,474	-0.7
Porterville	62,654	62,588	-0.1
Tulare	69,457	69,677	0.3
Visalia	142,066	143,031	0.7
Woodlake	7,647	7,711	0.8
Balance of county	134,432	133,779	-0.5

Source: State of California, Department of Finance, *E-1 Population Estimates for Cities, Counties and the State with Annual Percent Change — January 1, 2022 and 2023.* Sacramento, California.

Age Groups

With a median age of 31.4 years, Tulare County residents are one of the youngest regional populations in California. The pie chart on the next page on the right (Figure 2) displays population figures by age groups. A more detailed breakout of children ages 0-17 is shown in Table 6 to the

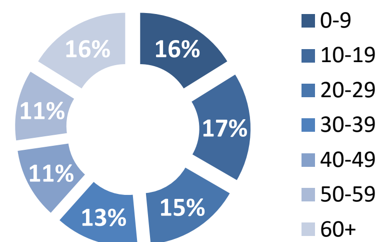
left of the pie chart. As a group, Tulare County has a higher proportion of children under age 18 (30.5%) than statewide (22.5%).

Table 6. Child Population by Age Group

	Number	
Ages 0-2	21,152	30.5%
Ages 3-5	21,594	
Ages 6-10	39,826	
Ages 11-13	24,749	
Ages 14-17	32,916	
Ages 0-17	140,237	

Source: U.S. Census, 2022

Figure 2. Percent of Population by Age Group

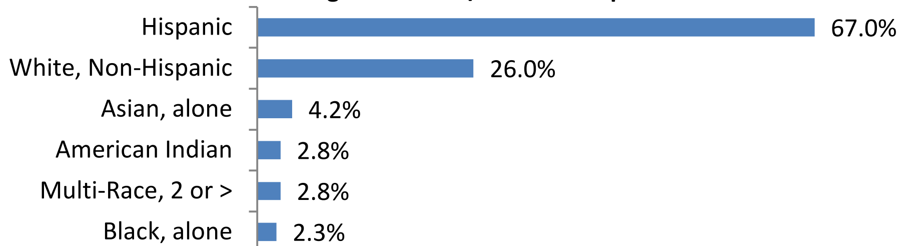


Source: U.S. Census, 2022

Race and Ethnicity

Hispanics (of any origin) make up about two-thirds (67.0%) of Tulare County's total population. The graph below (Figure 3) displays the details of the main race/ethnic groups represented in the county as a share of the total population.

Figure 3. Race/Ethnic Groups



Source: U.S. Census/American Community Survey, 2022

The Decennial Census[9] shows the ways in which the race/ethnicity groups have changed between 2010 and 2020. (Note: projected 2030 race/ethnic distributions are nearly the same as for 2020.)

Table 7. Population by Race/Ethnicity

		2010		2020		Change	
		#	%	#	%		
Race	**Total**	**442,178**		**473,117**		**7.0%**	↑
	White	265,618	60.1%	186,255	39.4%	-29.9%	↓
	Black	7,196	1.6%	6,668	1.4%	-7.3%	↓
	American Indian	6,993	1.6%	10,645	2.2%	52.2%	↑
	Asian	15,176	3.4%	17,194	3.6%	13.3%	↑
	Pacific Islander	509	0.1%	723	0.2%	42.0%	↑
	Other	128,261	29.0%	165,230	34.9%	28.8%	↑
	Two or more	18,424	4.2%	86,402	18.3%	369.0%	↑
Ethnicity	Hispanic	268,065	60.6%	309,895	65.5%	15.6%	↑

Source: 2020 Decennial Census

PART III. SELECTED COMMUNITY INDICATORS

"I didn't go to the dentist last year because I didn't make it a priority."
— Parent Survey respondent

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 to create a community profile for home visiting programs, and illustrate important characteristics and gauges. Some of these indicators 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). Various data may reflect the impact COVID-19 had on individuals and communities or, in the case where data in the "COVID year" (2020) were not available, there is a gap.

Family Demographics and Socio-Economic Well-Being

Though the onset of the pandemic is now four years past, families have been negatively impacted and the effect is deeper among those who suffer from social and health inequities. The pandemic has also unveiled examples of disparities such as financial insecurity, food scarcities, and family stress.

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 (24.4%) of Tulare County children ages 0-17 lives in a home with their own parents who are married to each other, 7.6% with a female householder with no spouse present, and 1.9% with a male head with no spouse present. Nearly one-quarter (23.8%) live with their grandparents who have sole responsibility for them (Table 8).

Table 8. Family Composition, Tulare County

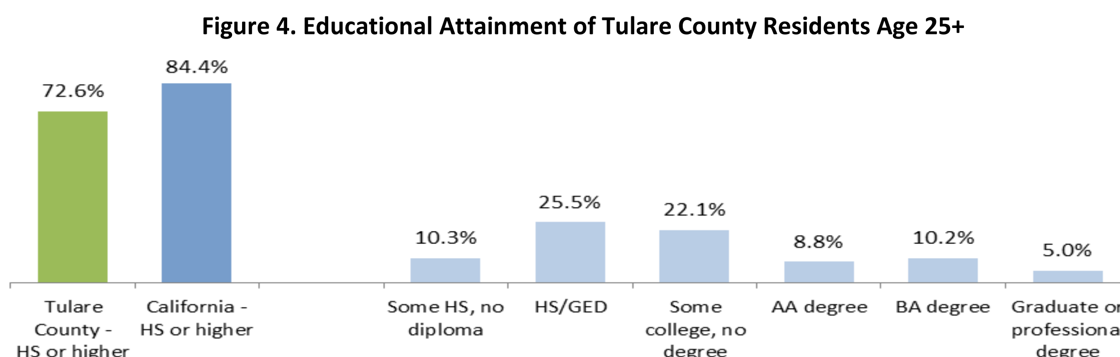
	Tulare County
Number of married couple households	72,615
Percent of married couple households	52.0%
Percent of households with own children of householder < age 18 who are:	
a) married couple	24.4%
b) co-habiting couple	5.2%
b) female head (no spouse present)	7.6%
c) male head (no spouse present)	1.9%
Number of grandparents living w/ own grandchildren <age 18	16,349
Number of grandparents living w/ and responsible for own grandchildren <age 18	3,895
Percent of grandparents responsible for own grandchildren <age 18	23.8%

Source: U.S. Census, American Community Survey, 5-year Estimates, 2022

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, 72.6% of people aged 25 years or older, compared to 84.4% statewide, either graduated from high school or completed the Graduate Equivalency Degree (GED) or higher (Figure 4).

Figure 4. Educational Attainment of Tulare County Residents Age 25+



Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates 2022.

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).[10] In Tulare County in 2018-2022, over half (50.3%) of persons age 5 years and older reported speaking a language other than English at home (vs. 43.9% statewide).[11] The percent of the population age 5+ who speaks a language other than English at home who speaks English *less than* "very well" (considered a "linguistically isolated household" in needs assessments) is 23.2%.[12]

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 County's total 2022-23 K-12 enrollment, 8.4% of the English-Learners were considered at-risk of becoming a "long-term English learner in the next 4-5 years" compared to 7.1% statewide.[13]

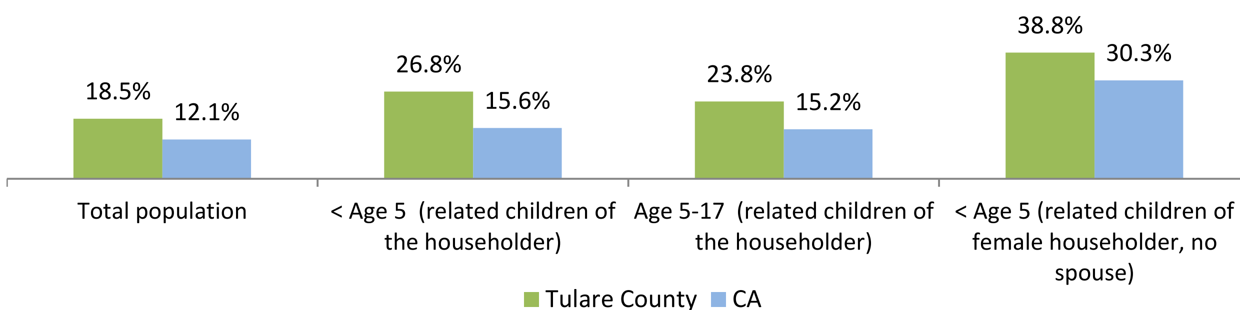
Income and Poverty

In 2022, Tulare County had a median household income of $64,474, about two-thirds of the statewide average.[14] Approximately 21.8% of the population lives below the poverty line, more than 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—which is 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 an especially pressing issue for young children. In 2022, nearly more than one-quarter (26.8%) of children ages 0-5 were living in areas of concentrated poverty, compared to the 15.6% state average[17] (Figure 5). In every age group above 18 years, women outnumber men by the proportion living in poverty.[18]

Figure 5. Poverty by Age Group, Tulare County, 2022



Source: U.S. Census, American Community Survey, 5-year Estimates, 2022

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 11.8% of Tulare County's labor force was unemployed in January 2024,[19] the proportion of unemployed varies widely, ranging from 6.3% and 6.5% in communities like Three Rivers and Visalia city, respectively, to 37.0% in Terra Bella (Table 9 on the next page).

Table 9. Percent of the Tulare County Population Unemployed, January 2024 (in alphabetical order by area)

Area Name	Unemployment Rate	Area Name	Unemployment Rate
Tulare County	**11.8%**		
Alpaugh CDP*	30.4%	Pixley CDP	18.6%
Cutler CDP	25.3%	Poplar Cotton Center CDP	34.7%
Dinuba city	16.7%	Porterville city	15.7%
Ducor CDP	8.5%	Richgrove CDP	38.6%
Earlimart CDP	19.4%	Springville CDP	11.5%
East Orosi CDP	27.7%	Strathmore CDP	28.4%
East Porterville CDP	30.2%	Terra Bella CDP	37.0%
Exeter city	20.5%	Three Rivers CDP	6.3%
Farmersville city	13.4%	Tipton CDP	11.5%
Goshen CDP	6.6%	Traver CDP	11.8%
Ivanhoe CDP	10.7%	Tulare city	7.7%
Lemon Cove CDP	6.7%	Visalia city	6.5%
Lindsay city	23.3%	Woodlake city	9.9%
London CDP	17.4%	Woodville CDP	21.9%

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

Food Security

Food insecurity is an important 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, 52.9% of the adult population whose income was less than 200% of the Federal Poverty Level reached through the 2022 UCLA CHIS household survey reported being unable to afford enough food;[20] a survey concerning children the prior year found 23.0% of the county's children 0-17 lived in food insecure households (Table 10).[21]

Table 10. Food Insecure Households in Tulare County

	Tulare County	CA
The percent of adults @ 200% FPL unable to afford enough food (food insecure)[1]	52.9%	44.0%
The percent of all children ages 0-17 living in households with limited or uncertain access to adequate food[2]	23.0 %	13.6%

[1]CHIS, 2022.
[2]Map the Meal, 2021

CalFresh provides nutrition assistance to low-income Californians, and plays an important role in alleviating poverty. In January 2024, 129,434 (27.2%) Tulare County children and adults were receiving CalFresh benefits compared to 13.8% statewide.[22] This indicator is relevant because it assesses vulnerable populations that are more likely to have multiple access, health status and social support needs. Table 11 on the next page reports the number of Tulare County individuals and households by age group receiving CalFresh benefits in July 2022.

Table 11. Number of Tulare County Individuals and Households Receiving CalFresh

	Point-in-Time July 2022
Children under age 18	56,888
Persons age 18-59	50,330
Persons age 60 and over	13,835
Persons with English as a Second Language	35,649

Source: CA Department of Social Services. CalFresh Data Dashboard.

Students

In FY 2022-23, 75.1% (up from 62% in 2016) of eligible K-12 students—77,551 students—received free or reduced-price meals during the school year in Tulare County, compared to 59.9% statewide.[23]

Undocumented Immigrants

Poverty is the main contributor to the disproportionate impact of food insecurity on non-citizens without legal permanent resident status. According to a recent analysis, [24] 45% of undocumented immigrants in California (an estimated 39,000 in Tulare County)[25] do not have access to healthy foods and are affected by food insecurity (county-level data were not provided). Food insecurity is especially dire among the children in these families as about 2 in 3 undocumented children go hungry.

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 60% since 2011.

According to the Point-in-Time Count, on a given night in January 2023, there were 1,053 (922 the prior year) men, women and children experiencing homelessness in Tulare County (10% which were families with children) with 779 of those people living unsheltered on the streets, in vehicles, or in encampments.[26] 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 3,301—school-age children were estimated to be homeless at some point during the 2022-23 school year.[27] The chart below (Table 12) shows where in 2023—the most recent data—these children were reported to be "housed." African American children had the highest proportion of homelessness (data not shown).

Table 12. "Housing" Status of Children with Homelessness in 2023 (n=3,301)

Temporarily Doubled-up	Temporary Shelter	Hotel/Motel	Temporarily Unsheltered
76.4%	5.7%	7.6%	10.4%

ACES

Adverse Childhood Experiences (ACES) impact the health and well-being of children, families and communities across Tulare County. Based on data collected from 436 parents/caregivers who were screened last year by First 5- funded programs—likely representative of a cross-section of Tulare County families eligible for home visiting services—the prevalence of adults with ACES was reported as shown in Table 13 below.

Table 13. Number of ACES Experienced by Adults (First 5 Parents)

Number of ACES	Percent
0	40.8%
1	16.7%
2	9.2%
3	6.9%
4	7.6%
5	4.6%
6	5.5%
7	3.2%
8	2.3%
9	2.8%
10	0.5%

Score of 0-3 without associated health condition = Low risk

Score of 1-3 with associated health condition = Intermediate risk

Score of 4+ with or without associated health condition = High risk (26.5%)

Source: First 5 Tulare 2023 Annual Evaluation Report, Barbara Aved Associates

Maternal and Child Health

Certain maternal and child as well as family demographic trends help project potential needs for education, child care, health care, and other services home visitors assess the need for and provide linkages to.

Births by Race/Ethnicity

In 2023, there were 6,547 live births (down from 6,796 in 2021) reported for women who live in Tulare County.[28] While about half of the births in California were to women of Hispanic origin, in Tulare County three-quarters (up from two-thirds) of births were to Hispanic mothers (Table 14).[29]

Table 14. Births by Mother's Race/Ethnicity, 2023

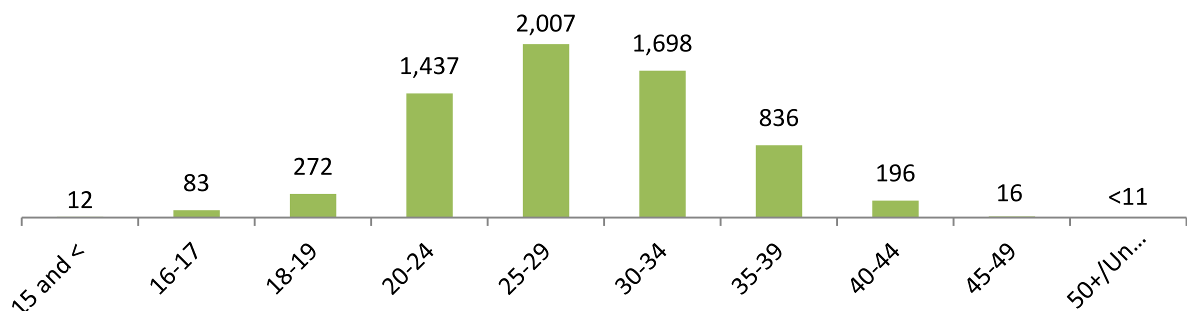
	Number	Percent
Non-Hispanic White	1208	18.5%
Non-Hispanic Black/African-American	86	1.3%
Non-Hispanic Native American/Alaskan Native	52	0.7%
Non-Hispanic Asian	172	2.6%
Non-Hispanic Multi-Race	65	0.9%
Hispanic	4936	75.4%
Unknown or Not Stated	28	0.4%

Source: California Department of Public Health.

Births by Age of Mother

Figure 6 shows the breakdown of the mother's age for births in 2023. Tulare County has one of the largest proportions of percent of births to mothers age 15-19—associated with a higher risk of dropping out of school—with only Kings and Kern Counties higher.

Figure 6. Number of Births by Mother's Age, 2023

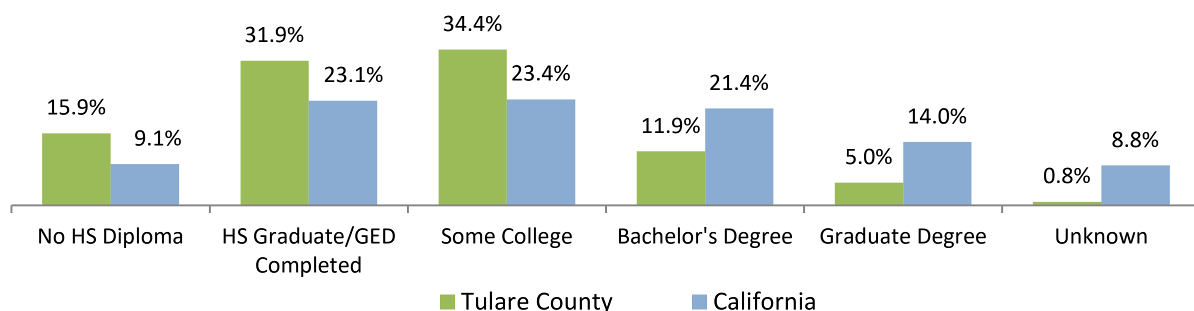


Source: California Department of Public Health.

Births by Education

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 2023, 15.9% did not have a high school/GED diploma compared to 9.1% statewide (Figure 7).[30] Births to *unwed mothers* with less than high school graduation were even higher, 40%, ranking Tulare County among the highest in the state.[31]

Figure 7. Mother's Education at the Time of Giving Birth, 2023

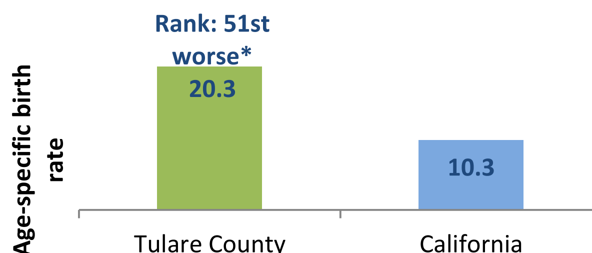


Source: California Department of Public Health Birth Files.

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.[32] Although 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 high. In 2021, Tulare County's adolescent birth rate, 20.3, was double the statewide average of 10.3 (Figure 8), and the 51st worst in the state.[33]

Figure 8. Births to Adolescents, 15 to 19 Years Old, 2021



Birth rate per 1,000, by county
*Among California counties with a sufficient number of teen birth data.
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.[34] The national figure is 18.3%.[35] Repeat teen births pose greater challenges because additional births can further constrain the mother's ability to attend school and obtain job experience.

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.[36] (An inter-pregnancy interval is considered short if it is less than 18 months.) Among all women giving birth in Tulare County in 2021, 26.8% (about the same as statewide) experienced a short birth interval.[37] As Table 15 shows, American Indian mothers had the shortest birth intervals; Hispanic and Asian mothers' intervals were just under the county average. By age, females less than 20 years had strikingly short birth intervals—showing how closely second babies followed an initial teen birth.

Table 15. Mothers with Inter-Pregnancy Intervals Less than 18 Months

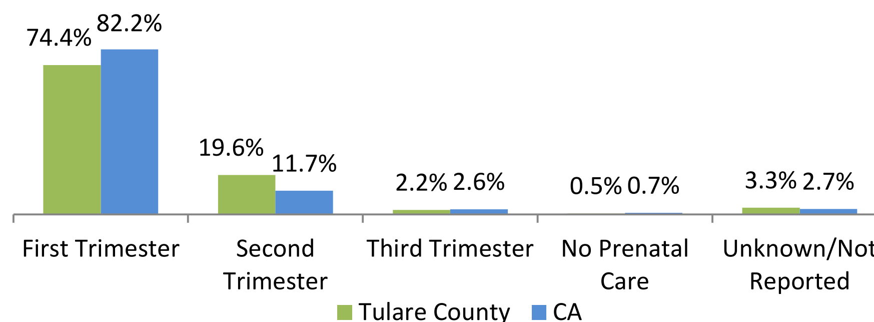
By Race/Ethnicity		By Age	
American Indian	42.5%	<20	67.7%
Black	32.4%	20-24	41.8%
White	29.4%	25-29	27.6%
Multi-Race	28.2%	30-34	22.3%
Hispanic	25.4%	35-39	17.7%
Asian	22.8%	40+	12.0%

Source: California Department of Public Health, 2019-2021 Birth Cohort and Birth Statistical Master Files

Prenatal Care

While the percentage of women receiving prenatal care in the first trimester is lower in the county than in the state, it rose to 74.4% in 2023 from 73.0% in the prior three-year period. The percent of adequate/adequate plus prenatal care and the proportion of infant deaths generally match the statewide averages for these indicators (Figure 9).

Figure 9. Entry into Prenatal Care, 2023



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. In the most recent data, Tulare County's rate, 6.86, or 46 infant deaths, exceeded the statewide average (Table 16). 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 16. Infant Mortality Rate, All Race/Ethnic Groups, 2020

Tulare County	California
6.86	5.42

Source: California Department of Public Health, Health Status Profiles.
Rate per 1,000 births.

Adult and Maternal Depression

When cost is a factor, commonly skipped health service is getting mental health care. The California Health Care Foundation conducted a statewide survey of adults in late 2021 to understand various views and experiences concerning health care. Although the findings are not Tulare County-specific, they can inform this assessment. Close to 22% of the adults—a higher proportion than in the previous year—said they skipped the mental health care they needed in the last 12 months due to cost. Those with lower incomes (<200 FPL) were about 1.5 times more likely to have skipped or postponed this service, with Black and Latinx adults the most likely to put it off.[38]

Maternal depression is considered a risk factor for the socioemotional and cognitive development of children.[39] 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 2019-2021 Maternal and Infant Health Assessment (MIHA), 17.7% of Tulare County women who gave birth during the reporting period reported having prenatal depression symptoms, and 16.7% postpartum depression symptoms. Of high importance, this figure was only 10.4% in the previous MIHA survey. Mothers with an income <100% of the federal poverty level experienced disproportionately higher rates of depression, close to 20%.[40] 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, and the ability to appropriately refer them.

Breastfeeding

Many women after giving birth benefit from support both to initiate and be able to sustain breastfeeding at home afterwards. Table 17 on the next page shows the breastfeeding experience of a representative sample of Tulare County and California women with a live birth in 2019-2021.[41] The percent of women with *intention* to breastfeed before delivery, and ever breastfeeding, were essentially the same county- and statewide (with the county slightly more favorable regarding the latter). Once the women delivered, however, the county experience fell somewhat behind the state experience, suggesting a greater need for lactation support post-delivery.

While overall California and Tulare County rates have not appreciably increased, the increases in breastfeeding 3 to 6 months post-delivery among the First 5-funded breastfeeding programs have been more impressive.

Table 17. Breastfeeding Experience, 2019-2021

	Tulare County	California
Intended to breastfeed, before birth	92.8%	92.6%
Intended to breastfeed exclusively, before birth	53.5%	63.0%
Ever breastfed	95.6%	94.6%
Any breastfeeding, 1 mo. after delivery	78.8%	85.9%
Exclusive breastfeeding, 1 mo. after delivery	40.5%	43.7%
Any breastfeeding, 3 mos. after delivery	59.3%	70.8%
Exclusive breastfeeding, 3 mos. after delivery	25.5%	32.0%

Source: CA Dept. Public Health, Maternal and Infant Health Assessment (MIHA).

Infants Born Drug-Exposed/Children's Exposure

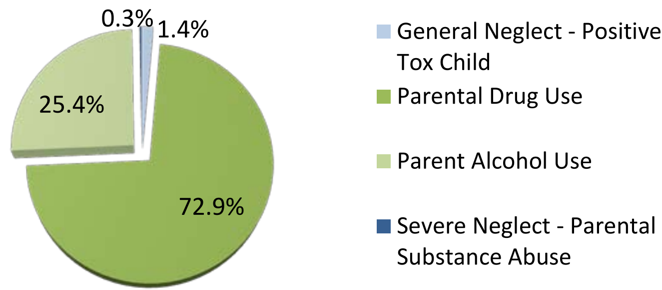
Infants exposed to alcohol and drugs during pregnancy run the risk of suffering from birth defects, low birth weight, premature birth, sudden infant death syndrome (SIDS), and subsequent developmental and behavioral delays and/or challenges.

Neonatal abstinence syndrome (NAS) is a drug withdrawal syndrome that most commonly occurs in newborns due to maternal use of opiates such as heroin, methadone, and prescription medications. Newborns with NAS have prolonged hospital stays with higher medical costs. Tulare County's NAS rate in 2020-2022, 1.7 (or 29 birth hospitalizations), was about 50% lower than the statewide rate, 2.6%. The rate, which has not changed significantly over the past decade, is about 4 times higher for white non-Hispanic newborns than for Hispanic newborns. (Note that hospital coding practices for a NAS diagnosis may vary by hospital and change over time, affecting rates.)

The magnitude of substance abuse of these and other substances in Tulare County is widely recognized.[42] Statistics from the Tulare County CWS system related to perinatal substance abuse add to the local picture but continue to be challenging to identify. This is because 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 what we learned from CWS in the original needs assessment.[43] The information is repeated here as it is the most currently available and may not have changed appreciably. CWS assesses these referrals, and factors such as the type, frequency and amount of the substance used dictate that decision. 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. In May 2022, there were 239 open cases with 291 types of exposures where the Case Intervention Reasons were coded according to the reasons shown in Figure 10. Between January 2019 and May 2022, there were 82 cases where the mother (and 101 cases where the father) was referred for Substance Abuse Testing or Substance Abuse Services.[44]

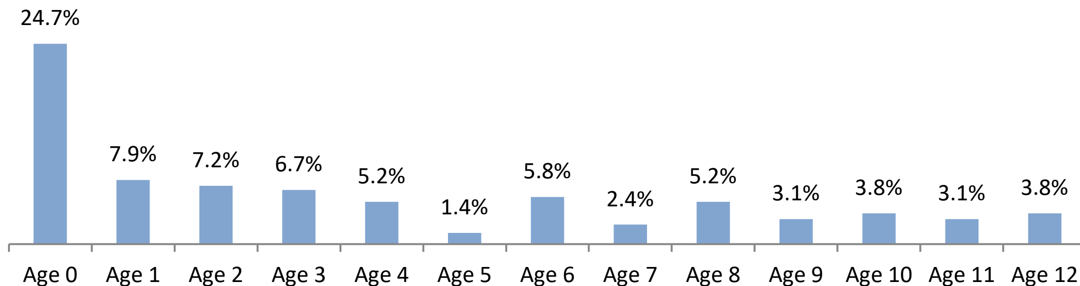
Figure 10. Currently-Open CWS Cases by Case Intervention Reason (n=239)



Source: Tulare County Child Welfare Services, May 21, 2022
Note: 52 of the 239 open cases represented by this graphic had more than one substance reported.

While infants comprised the majority (24.7%) of the children in referrals for substance abuse between January 1, 2019 and May 20, 2022, 53.1% (39.0% in the previous needs assessment) of those children were 5 years old or under (Figure 11).

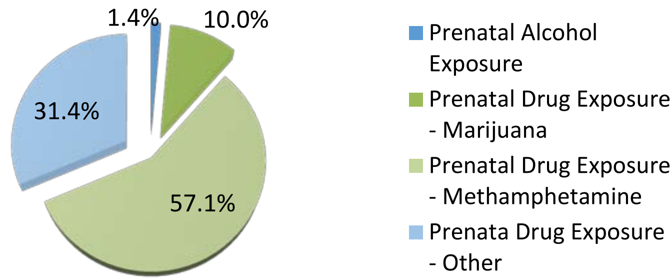
Figure 11. Age at Case Opening of Currently-Open CWS Case by Case Intervention Reason (239)



Source: Tulare County Child Welfare Services, May 21, 2022

Using the best query possible to capture the total Drug Exposed Infant referrals, CWS identified 64 open cases at the time of our original request, where the condition for the child being removed was prenatal drug/alcohol exposure.[45] (This is likely an undercount as these referrals do not capture the many more that were not open to a case.) Figure 12 on the next page displays the type of substances that were involved, with methamphetamine again the most common, at 57.1%.

Figure 12. Substance Use in Tulare County of Currently-Open CWS Cases of Drug-Exposed Infants (n=64)



Source: Tulare County Child Welfare Services, May 21, 2022
Note: 6 of the 64 open cases represented by this graphic had more than one substance reported.

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 2021-22, 97.8% (98.1% in 2019), was more favorable than the statewide average (96.0%)—and in fact was bested by only two other counties.[46]

Children with Special Health Care Needs

While definitions vary, children with special health care needs often are defined as those who have a chronic physical, developmental, behavioral, or emotional condition, and who also experience consequences due to their condition, such as above-routine use of health care and related services or limitations in activities compared with other children.

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%.[47] 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.[48] These needs include conditions such as anxiety, heart conditions, epilepsy, allergies and migraines.

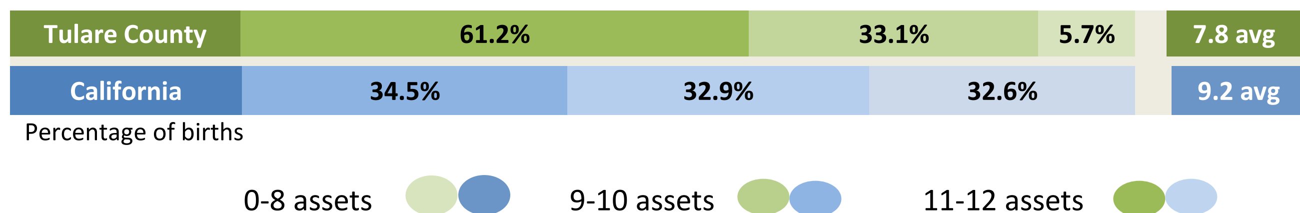
In estimates of disability status limited to hearing, vision, cognition, and ambulation, the 2022 American Community Survey shows 4.5% of Tulare County children 0-17, compared to 4.0% statewide, as having any disability.[49]

Access and Utilization

The First 5 California Strong Start Index[50] paints a portrait of the resources that promote resilience for children born within a given geography and year. The Index supports the whole-child concept of an integrated focus on health and social supports, child development, education and community resources. Using data that already exists for children and families, the Strong Start Index summarizes, in a standardized way, the conditions into which children are born, comprising 12 variables in four domains such as health, financial and parenting conditions. A birth asset score is calculated by simply counting the number of assets present (0-12) at the birth year. The tool can be useful to inform the expansion of family strengthening supports, to assess the need for and availability of resources, and to inform planning.

For 2021, the Index gave Tulare County an average score of 7.9 (down from 8.2 in 2019), vs. 9.2 in California (Figure 13). By comparison in the region, the average scores in Kings, Kern and Fresno Counties were 8.6, 8.6, and 8.5, respectively. It is worth noting that year-over-year differences mostly represent demographic shifts and not necessarily differences in resources available and child characteristics.

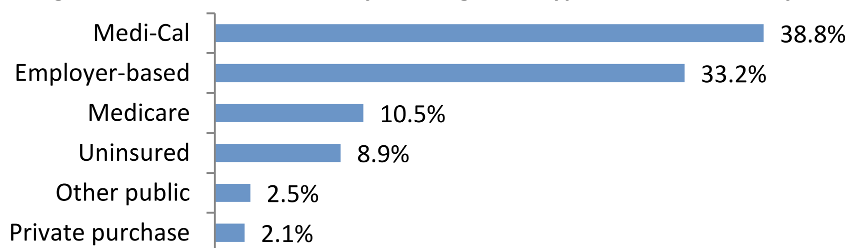
Figure 13. Tulare County Strong Start Index, 2021



Health Insurance

CHIS data[51] regarding health insurance coverage in Tulare County show about 90% of all residents in 2022 had some form of coverage, and 8.9% (5.3%, 2 years prior) were uninsured; 2.1% of residents paid out of pocket for their health care (Figure 14). The same data source reports the main reasons for not having coverage by those currently uninsured as cost-related: not offered or dropped by employer and change in working status or family situation such as unemployment.

Figure 14. Health Insurance by Coverage and Type, All Tulare County Residents



Source: 2022 California Health Information Survey (CHIS)

Simply having health insurance does not guarantee adequate access as Table 18 shows. Respondents to the CHIS who answered "yes" to having a usual source of care were asked if they had had difficulty "finding a general doctor who would see you" or "take you as a new patient." This was a problem for close to 5% of the adults; however, those living at less than 150% of the federal poverty level (typically with Medi-Cal) reported experiencing less of a problem.

Of equal interest concerning access, those who were born outside of the U.S. were asked if there was ever a time when they decided not to apply for one or more non-cash government benefits (e.g., Medi-Cal, food stamps, housing subsidies) because they were worried it would disqualify them or a family member from obtaining a green card or becoming a U.S. citizen. Regardless of income level, slightly more than 10% had avoided asking for such help.

Table 18. Tulare County Adults' Access and Barriers to Care

	All Adults	Adults <150% of FPL
Has a usual source of care	82.7%	73.6%
Difficulty finding primary care	4.6%	3.0%
Avoided apply for benefits	10.3%	10.5%

Source: UCLA, 2022 CHIS.

Dental Visits

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. Across all of Tulare County, 84.7% of children visited a dentist at least once in 2022.[52]

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 in 14 Tulare City School District schools by Altura Centers for Health in FY 2022-23 showed an *average* of 35.6% of children with evidence of dental disease—a figure with *little or no* change over the last decade and a half. Yet, dental visits for children with Medi-Cal—in which benefits are just as comprehensive as for commercially insured children—show just over half (56.3%) of 3-5-year-olds made a visit in 2022 (Table 19).[53] Dental sealants of children 6-9 and 10-14 with Medi-Cal (data not shown) are remarkably under-utilized, as is the case in most counties.

Table 19. Dental Visit Utilization

Children with Medi-Cal, by Age Group[1]	**2017**	**2019**	**2022**
Ages 1-2	27.4%	33.3%	36.6%
Ages 3-5	55.6%	61.6%	56.3%
Ages 6-9	62.2%	65.6%	60.5%
Women During Pregnancy[2]	**2012**	**2016-2018**	
Received dental care	53.0%	41.2%	No data yet

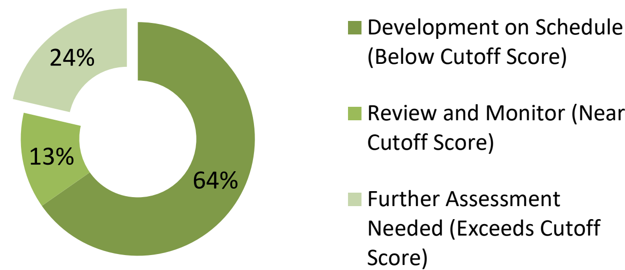
Sources: [1] Department of Health Care Services, Medi-Cal Dental Program. [2] CA Department of Public Health MIHA surveys.

Child Development

Screening and Referral

Screening through tools such as the *Ages & Stages Questionnaires* (ASQ) 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 a 3-year FY 2021-24 preliminary summary of 217 children assessed through First 5 with the Ages and Stages Questionnaire (ASQ), close to 24% on average (Figure 15) demonstrated sufficient concern to warrant referrals for further evaluation, with the 24-month age group proportionately highest.[54] While these ASQ findings cannot be applied to all children in Tulare County, they provide a reasonable picture for the children and families who can benefit from home visiting services.

Figure 15. Proportion of All Children Below, Near, and Above Cutoff Scores on the ASQ SE2 (n=217)



Source: First 5 Tulare Evaluation Data (internal), April 2024, Barbara Aved Associates

Parents of children older than age 1 responding to the 2020 CHIS survey were asked if their youngest child was ever referred to a specialist regarding his or her development. Although the numbers were too small for statistical stability, it may be instructive to see what Tulare County respondents reported (Table 20) as an indication of needs around child development.

Table 20. Doctor/Other Professional Referred Child to Specialist Regarding Development

Year	Percent*
2016	14.1%
2017	0.0%
2018	4.1%
2019	33.1%
2020	7.8%
2022	9.0%

Source: 2020 California Health Information Survey
*Statistically unstable.

Early Childhood Education and Learning

Across all Tulare County households with children 0-5, close to 40% of parents reported reading books or stories with their children every day; 46.5% of the respondents said they were reading

more to their young child "because of the *Talk, Read, Sing*" message." [55] Parents who participate in First 5 programs report a markedly different experience with early literacy activities.[56] These results provide evidence of the powerful effect of messaging and educational materials, which home visitors can help promote.

Table 21. Days per Week Reading Books or Stories with Child 0-5 Years

	Every Day	3-6 Days	1-2 Days
All Tulare children 0-5[1]	39.1%	33.9%	26.1%
First 5 participant children 0-5[2] (n=851)	57.1%	29.6%	8.0%

Sources: [1]2022 CHIS. [2]First 5 Tulare County FY 2021 Evaluation Report, Barbara Aved Associates

High-quality early childhood education programs deliver consistent, developmentally sound, and emotionally supportive care and education. This type of care before age 5 is associated with improved cognitive, social-emotional, behavioral, and physical health, as well as increased school readiness, academic achievement, and earnings in adulthood. However, finding affordable, high-quality ECE is a major challenge for many families.[57] In 2021 in Tulare County, 26% of requests for licensed child care in California were for infants (Table 22).

Table 22. Percentage of Tulare County Child Care Requests to Licensed Facilities, by Age Group

Age Group	Percent
Infant	26%
Preschooler	40%
School-Age	35%

Source: kidsdata.org.

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 23 displays findings from various sources and the latest year of publication.*

Table 23. Tulare County Early Childhood Education and Preschool Attendance

Early Childhood Education (ECE)	Age 3+ enrolled in preschool[58]	4.0% (2022)
	Attends preschool, nursery school, or Head Start at least 10 hours/week[59]	3.0% (2021)*
	Children enrolled in Transitional Kindergarten (TK)	1,644 (2021-22)
	Children for whom ECE spaces are available[60]	17.1% (2021)
	Children for whom ECE spaces are not available[61]	82.9% (2021)

*Note: In 2019 (pre-COVID), the figure was 13.6%; lingering fear from the pandemic about the risks of exposure may account for the large difference between the two time periods.

* Data from the most recent Tulare County Local Child Care Planning Council Needs Assessment report (2018) are not current enough to include.

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. *Substantiated* (vs. reported allegations) cases of child abuse and neglect in Tulare County are shown in Table 24 below. Children age < 1 are at highest risk. Other data that could be examined, such as current emergency department visits for severe abusive injuries, are unavailable or comprise a too-small sample size to report.

Table 24. Child Abuse and Neglect by Age Group, 2022

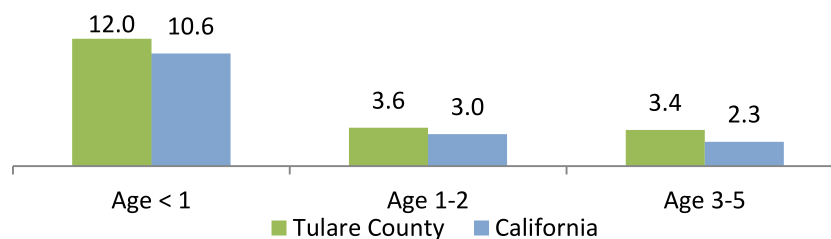
		Tulare County	CA
Rate of *substantiated* cases of child abuse and neglect per 1,000 children[62]	Age < 1	25.6	18.7
	Ages 1-2	7.1	7.4
	Ages 3-5	8.1	6.5

Source: UCBerkeley California Child Welfare Indicators
Rates are per 1,000 children.

Foster Care

A foster home can be "on hold" as a temporary placement for safety and nurturing. The role of some home visitors is to evaluate the prospective foster home's safety, cleanliness, and overall suitability for children in foster care. The proportion of Tulare County children who entered into foster care in 2022 was higher than in the state for every age group (Figure 16), the difference markedly so for the age group 0-1.[63]

Figure 16. Incidence Rates of Children Age 0-5 with Entries to Foster Care, 2022



Rates are per 1,000 children.
Source: UC Berkley, California Child Welfare Indicators Project Reports.

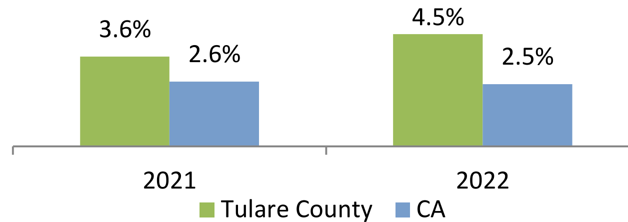
Domestic Violence

Home visitors' knowledge, system awareness, and confidence in supporting families with intimate partner violence is critical. Home visiting services geared toward pregnant women offer an opportunity to intervene and support mothers at risk for intimate partner violence. In 2019-21, 6.6% of the women in Tulare County vs. 5.4% statewide responding to the UCSF Maternal Infant Health Assessment (MIHA) survey reported physical or psychological intimate partner violence

during their most recent pregnancy.[64] (Note: in the 2016-2018 MIHA dataset the county figure was 9.0%.)

Data on intimate partner violence from the CA Health Interview Survey (only collected since 2021) show Tulare County adults reporting at a higher rate than statewide, and unlike statewide, slightly increasing between 2021 and 2022 (Figure 17). Data regarding calls[*] for domestic violence-related assistance in Tulare County during the 2-year period 2021-2022[65] are displayed in Table 25.

Figure 17. Experienced Physical or Sexual Violence by Intimate Partner in Past Year, Age >18



Source: 2021 and 2022 CA Health Interview Survey

Table 25. Calls for Domestic Violence-Related Assistance, 2021 – 2022.

Calls to:	# of Calls	% of Calls involving a Weapon
All Tulare County	6,177	28.9%
Tulare County Sheriff	1,753	30.1%
Porterville	513	5.8%[1]

[1]The most common cases reported involved strangulation and suffocation.
Source: CA Department of Justice

[*] Calls for service don't necessarily result in a case report.

PART IV: LOCAL RESOURCES, CAPACITY AND PERSPECTIVES

Research indicates that early intervention strategies 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 continues to outweigh 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 in 2021 (the most recent updated information) showed there were 21,783 families with children under age 5 and 3,710 families with a pregnant family member who were 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 15 programs described as "14 evidence-based models per HHS guidelines and one model that is implemented in multiple communities" with enough funded slots to serve 883 families and 48 pregnant women, specifically (Table 26).* The available data therefore suggest considerable unmet need for home visiting among Tulare County families.

Table 26. 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	15	883	15
Families expecting babies	3,710	883	15	48	2

Source: Child Trends, February 2021.

Home visiting in Tulare County represents a wide range of program models. The programs, their sponsoring organizations and contact individuals are shown in Table 27 on the next page. (See Section V. of this report for a description of these models.)

* 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 27. Tulare County Home Visiting Program Partners (May 2024)

Organization	Contact Person	Description
Culter-Orosi Family Resource Center	Maritza Gonzalez maritzagonzalez@cojusd.org	▪ *Parents as Teachers* ▪ *Parenting Wisely* ▪ *Differential Response* ▪ *SafeCare* ▪ *Differential Response* ▪ *Healthy Families America*
Dinuba Family Resource Center (Parenting Network)	Denise Pedregon d.pedregon@parentingnetwork.org	▪ *Parents as Teachers* ▪ *Differential Response* ▪ *SafeCare* ▪ *Parenting Wisely*
Family Services of Tulare County	Julia Castro Julia.Castro@fstc.net	▪ *SafeCare* ▪ *Parenting Wisely* ▪ *Parents as Teachers*
Lindsay Healthy Start Family Resource Center	Linda Ledesma lledesma@lindsay.k12.ca.us	▪ *Parents as Teachers* ▪ *Differential Response* ▪ *SafeCare* ▪ *Parenting Wisely* ▪ *Full Service Community Schools*
Porterville Family Resource Center (Parenting Network)	Flor Martinez fmartinez@parentingnetwork.org	▪ *Differential Response* ▪ *Parents as Teachers* ▪ *First 5 HVC*
SAVE the Children – Early Steps to School Success (ESSS)	Victoria Rodriguez vrodriguez@savechildren.org	▪ *Early Steps to School Success*
TCOE Early Childhood Education Program	Claudia Carter claudiac@cc.tcoe.org Lorena Castillo lorena.castillo@cc.tcoe.org	▪ *Parents as Teachers* ▪ *Head Start Home-Base* ▪ *Early Head Start home-base*
Tulare County Public Health MCAH Program	Tammy Wiggins Twiggins@tularehhsa.org	▪ *Nurse Family Partnership program*
Visalia Family Resource Center (Parenting Network)	Paul Prado paul@parentingnetwork.org	▪ *Parents as Teachers* ▪ *Differential Response* ▪ *SafeCare* ▪ *Parenting Wisely* ▪ *Healthy Families America* ▪ *Early Start* ▪ *Community Navigator Program*
Community Services Employment Training (CSET)	Angel Avitia angel.avitia@cset.org	▪ *Parents as Teachers* ▪ *Parenting Wisely* ▪ *SafeCare*
Woodlake Family Resource Center	Armando Villareal armando@parentingnetwork.org	▪ *SafeCare* ▪ *Parenting Wisely* ▪ *Parents as Teachers* ▪ *Differential Response* ▪ *Healthy Families America*

HVC PARTNER NEEDS ASSESSMENTS & TRAINING

During FY 2023-24, in addition to administering an updated HVC Agency Survey (see results in the next section), we conducted 3 needs assessments (1 by survey and 2 as part of post-training evaluations) to better understand the value of the trainings that had been offered and to learn about future training needs of the home visiting workforce.

Home Visitor Training Sessions

Based on cumulative input from the needs assessments, particularly the Tulare County HVC Advisory Group, the First 5 HVC project has planned and presented the following in-person training sessions. Attendance has ranged from about 65 to 110 home visitor and home visitor supervisor staff.

Date	Training	Presenter
January 2022	Safety During Home Visits: Recognizing and Reducing Risks	George Weaver, Training Officer/Firearms Training Unit Visalia Police Department
March 2022	Incorporating Trauma-Informed Care/ACES into Home Visiting	Brian Semsem, CEO Anagoconsulting
May 2022	Child Behavior: Helping Families to Understand and Address Problems	Genevieve Valentine, LMFT Merced County
October 2022	Supporting Families Experiencing Mental Health Issues	Genevieve Valentine, LMFT Merced County
March 2023	Domestic Violence and the Impact of Substance Abuse on Families	Sarah Sullivan Catalyst Domestic Violence Services
October 2023	Supporting Families Struggling with Substance Abuse Issues	Genevieve Valentine, LMFT San Joaquin County
March 2024	Mental Health Awareness	Darcy Massey, LCSW Tulare County Mental Health

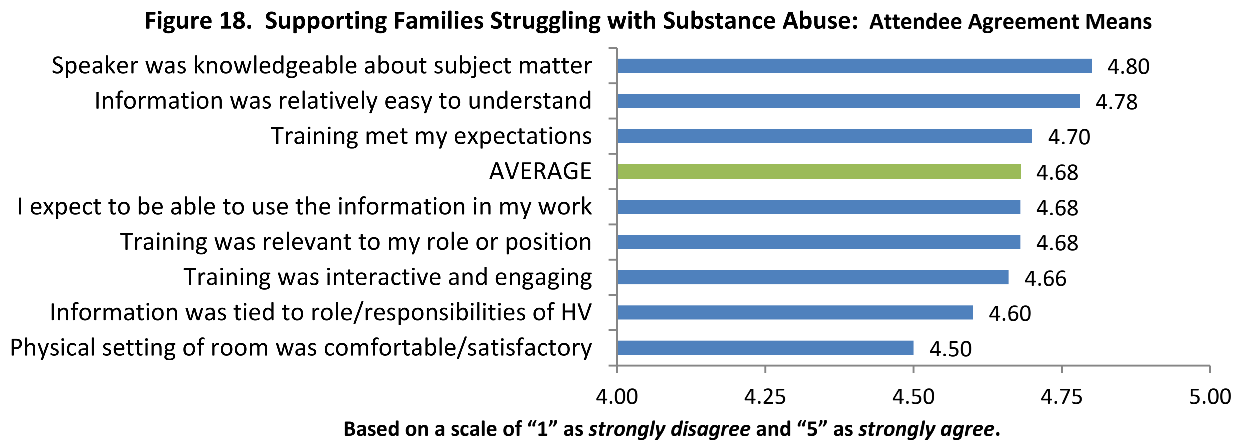
Additional trainings planned in FY 2024-25 include the following:

Date	Training	Presenter
July 2024	Support for Separating/Divorcing Parents and the Impact on Children	Audriana Freberg, LMFT, Andres Alvarez, MSW Family Services of Tulare County
October 2024	Addressing Child Development and Behavioral Issues from a Sensory Perspective	Lise Carter, OTR/L Private Practice, Truckee, CA
March 2025	TBA	TBA

Value of the Trainings

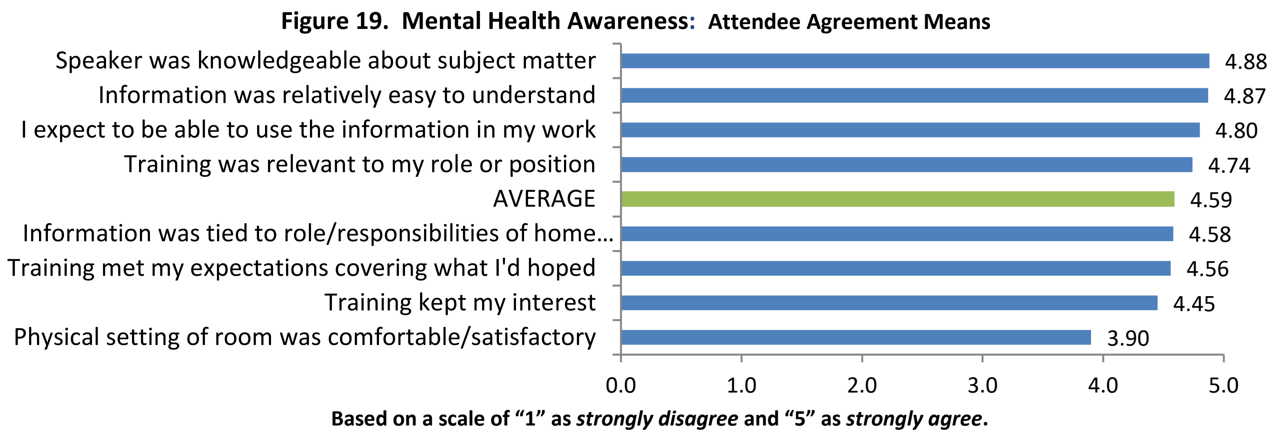
The attendees were asked to complete a post-training evaluation form to provide feedback about the experience to ensure the trainings were high quality and met the needs of home visitors. Examples from two of the sessions (Figures 18 and 19) indicate participants' overall positive responses about the content and speakers.

Figure 18. Supporting Families Struggling with Substance Abuse: Attendee Agreement Means



Based on a scale of "1" as *strongly disagree* and "5" as *strongly agree*.

Figure 19. Mental Health Awareness: Attendee Agreement Means



Based on a scale of "1" as *strongly disagree* and "5" as *strongly agree*.

Highest Value Outcomes

- Participants appreciated the opportunity to connect with home visitors from other models, which helped them to see their role as part of a larger workforce and early childhood system.
- Home visitors affirmed the value of the learning.
- Home visitors felt comfortable sharing with one another about the challenges of their work.
- Home visitors choose to work in the field out of genuine compassion for the families they serve.
- Reducing workplace stress and ensuring home visitor well-being continues to be a priority concern.
- Building staff capacity through training is viewed by grantees as an appropriate use of First 5 funds.
- The First 5 Tulare Commission's long-standing commitment to home visiting and significant presence throughout the county supporting home visiting is well-recognized.

Future Training Needs

Relative to future trainings, attendees—when they were specific, and many were not—suggested the topics shown in Table 28, generally in order of frequency mentioned. Some of these suggestions implied the home visitor may not have attended previous First 5 HVC trainings or perhaps some just wanted the topic reinforced with a “part 2” of a previously-offered training.

Table 28. Additional Training Topics Suggested by HVC Workforce

Topic
Many respondents:
▪ Personal safety during home visits, e.g., what to do when there are “red flags” (“identifying signs of an unsafe home environment”)
▪ Substance abuse, particularly regarding adolescents (“maybe tie this to human trafficking”)
▪ Effective ways to work with/engage with resistant, non-compliant, difficult clients who don’t show up, etc. (“Connecting with the hard to connect”)
▪ Families with special needs (autism, Down’s syndrome), resources for parents and children.
▪ Effective conversation skills (“help to make things flow and be more comfortable”); effectively developing rapport to establish a trusting relationship
▪ Challenging behaviors for children and teens
▪ Self-care for oneself, i.e., the home visitor
▪ How to help in single-parenting households
Several respondents:
▪ How to assist clients with HIV who have no support
▪ Relationship of mental health to domestic violence
▪ Working with the homeless, finding stable housing, preventing homelessness
▪ Setting boundaries in home visiting
▪ Student behavior
▪ Cultural competency
▪ ACES
▪ Eating disorders and how to help

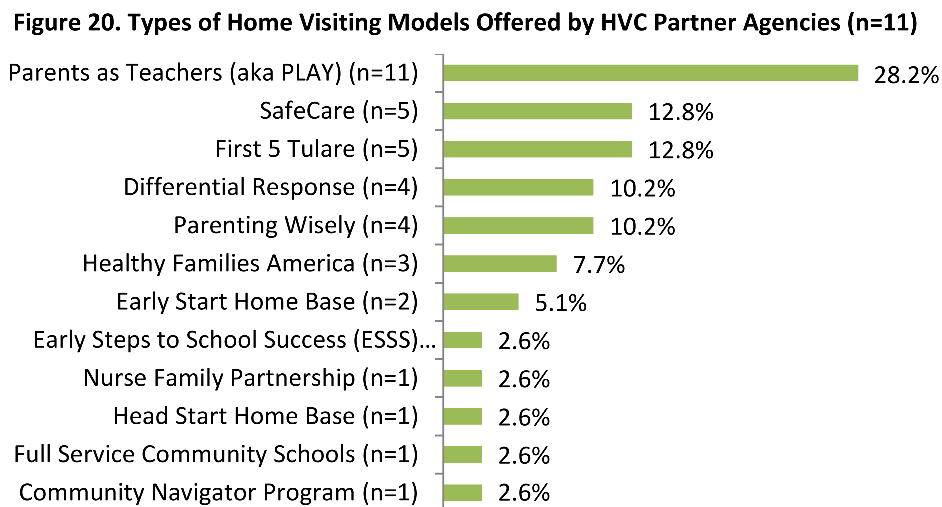
HVC PARTNERS EXPERIENCES AND PERSPECTIVES

The updated HVC Agency Survey (Attachment 2) sent to the HVC Partners gave us the opportunity to learn of any service delivery model and staffing changes the Tulare County home visiting and other early childhood care agencies made since the initial and follow-up surveys, along with having updated numbers of clients served. We also learned how these organizations currently viewed coordination relationships and their recommendations for the future of the local HVC program. So that we could have a full year of data, the reporting period for the survey was Calendar Year (CY) 2023. Eleven HVC partners returned a survey.

Home Visiting Models and Roles

Parents as Teachers (referred to by some as "PLAY") represents the largest proportion (31.4%) of the home visiting models used by organizations in Tulare County (Figure 20). Nine of the 11 organizations offer more than one model. Collectively, among the respondents, this represents 34 individual home visiting programs.*

Figure 20. Types of Home Visiting Models Offered by HVC Partner Agencies (n=11)



Client Services and Capacity

As Table 29 on the next page indicates, 4,259 parents and 3,883 children age 0-5 were reported by the 11 HVC organizations as receiving home visiting services in 2023. The "models" serving the most families are Differential Response and the funding specifically for home visiting provided by First 5 Tulare.

While it isn't possible to account for the duplication among families who may have received home visiting services from more than one program during the reporting period, the number of clients served nevertheless represents an impressive increase since the original HVC needs assessment.

* Note that not all of these programs are considered evidence-based models.

Table 29. Number of Clients Served by HVC Partners in 2023 (n=11)

HV Model	Total # of Families/Caregivers Served	Total # of Children 0-5 Served
Parents as Teachers (PAT) (n=11)	335	364
SafeCare (n=6)	66	67
Parenting Wisely (n=4)	149	91
Differential Response (n=4)	1,177	811
Healthy Families America (n=3)	5	6
First 5 HVC funded (n=5)	1,022	1,276
Early Steps to School Success (ESSS) (n=1)	138	179
Early Head Start Home Base (n=1)	738	636
Head Start Home Base (n=1)	488	315
Nurse Family Partnership (n=1)	85	68
Full Service Community Schools (n=1)	31	43
Community Navigator (n=1)	25	27
Total	4,259	3,883

Note: As reported by the organizations; not verified.

Table 30 shows the number of pregnant women and children 0-5 living in the households the partners reported serving with home visiting in CY 2023. The age of the children and number of prenatal clients may be a reflection of the program scope of the individual home visiting models. Importantly, because some organizations did not track age (e.g., Differential Response, PAT, by one FRC), these figures are an undercount, as is evident when one compares them to the figures that were reported above in Table 29—adding to the challenge of estimating unmet need for home visiting in Tulare County.

Table 30. Number of Pregnant Women and Children Ages 0-5 by Age Group Served in 2023 (n=11)

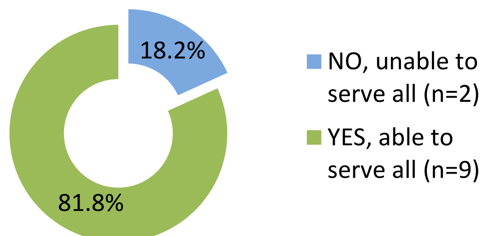
Unduplicated Pregnant Women and Children

HV Model	Prenatal	Age 1	Age 2	Age 3	Age 4	Age 5	Age 0-2	Age 3-5	Age 0-5	Total
Parents as Teachers (PAT)	19	118	55	16	8	1			18	235
SafeCare	11	23	8	5	5	7				59
Parenting Wisely	7	23	16	17	14	22				99
Differential Response	9	6	3	3	8	3			577	609
Healthy Families America	3	6								9
First 5 HVC funded	276			280			269	200	324	1,349
Early Steps to School Success	12	96	59	12						179
Early Head Start Home Base	426	122	94							642
Head Start Home Base			51	148	116					315
Nurse Family Partnership	39	68								107
Full Service Community Schools		10	10	4	6	13				43
Community Navigator	9			18						27
Total	811	472	296	503	157	46	269	200	919	3,673

Note: As reported by the organizations; not verified. In some HV programs, age was not tracked.
Some organizations do not track 0-5 by individual age.

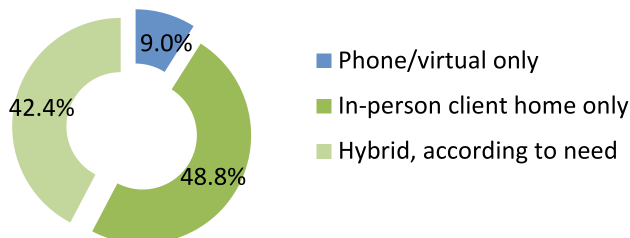
To assess capacity, the survey asked whether the organization had to turn away or not enroll any families *who they otherwise would have served* because of funding or capacity limitations. Of the 11 respondents, only 2 reported not being able to serve families through its home visiting services (Figure 21). TCOE reported it could have served 9 more Early Head Start Home-Base and 24 more Head Start Home-Base. Woodlake FRC said 70 clients were turned away because of ineligibility under program guidelines, staffing issues or funding limitations.[*]

Figure 21. Agency Capacity to Serve Families (n=11)



Largely from the experience of providing home visiting services during COVID, organizations now provide home visiting exclusively in the client's home about 42% of the time. About half of the visits use a combination of virtual/phone/in-person, according to need (Figure 22) due to reasons such as convenience for families and home visitors, HV staffing shortages, privacy and possibly continuing concern about COVID risk among some families.

Figure 22. Reported Ways Home Visiting Services are Provided (n=11)

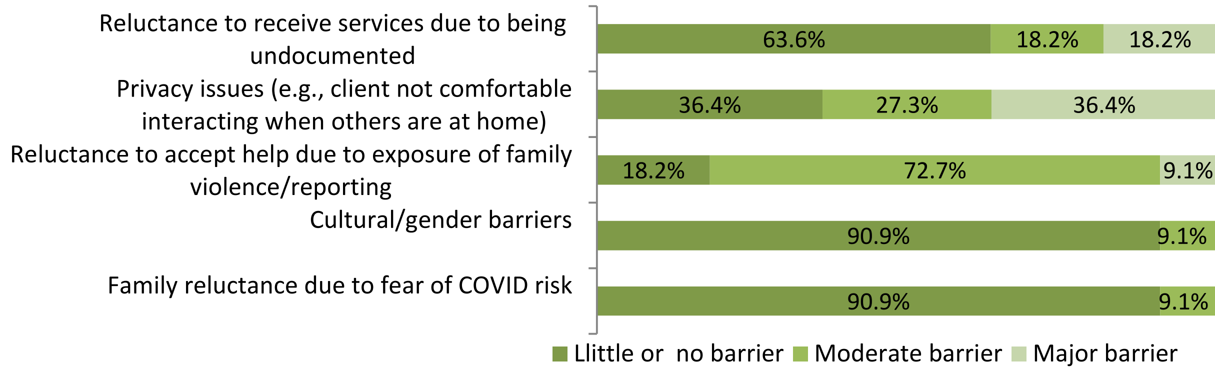


Client Enrollment and Retention

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 extent to which certain barriers affect families' response to home visiting are shown in Figure 23 below. According to the partners, cultural/gender barriers, such as when the home visitor is a different ethnicity from the client or the home visitor is a male, and fear of COVID risk, are rarely of concern. Privacy issues and reluctance to receive services because of undocumented status were the most important barriers reported.

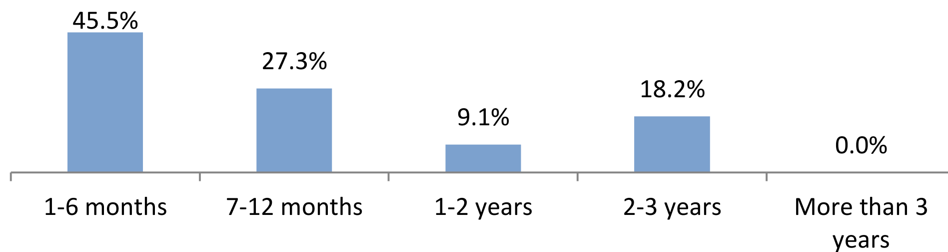
[*] The models and number of clients unable to be served were PAT (5), SafeCare (15), HFA (15), Family Check-up (15), First 5 HV (20).

Figure 23. Extent to Which Barriers Affect Successful Home Visiting (n=11)



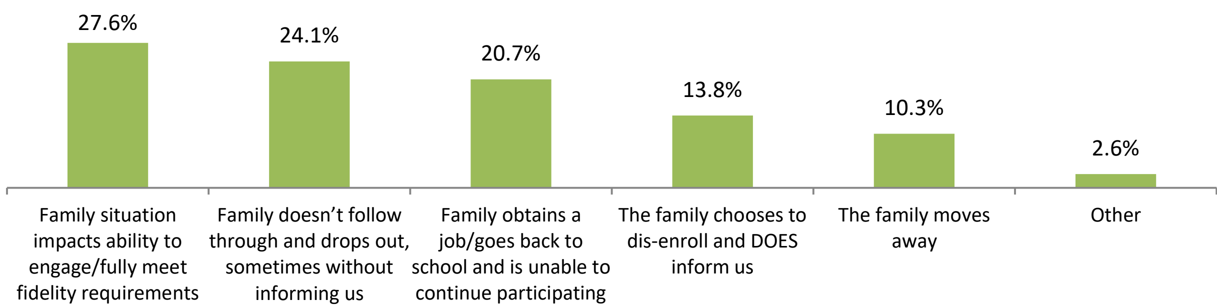
One year or less is the length of time clients *typically* remain enrolled in the home visiting programs (Figure 24), with close to half (45.5%) staying from 1 to 6 months. As with the age of the child, mentioned above, the duration may be a reflection of the program scope of the home visiting model.

Figure 24. Typical Time a Client Stays Enrolled in Home Visiting Services (n=11)



The most common reason for a family's disenrollment in home visiting, according to the partners, is their inability to engage in a way that fully meets the fidelity requirements of the HV model based. Other important reasons are the family not following through—sometimes failing to inform the program—and in other cases, leaving because the client becomes employed or goes back to school (Figure 25). Other factors not explored may also account for continuation of enrollment, e.g., family high-risk characteristics, maternal mental health and so forth.

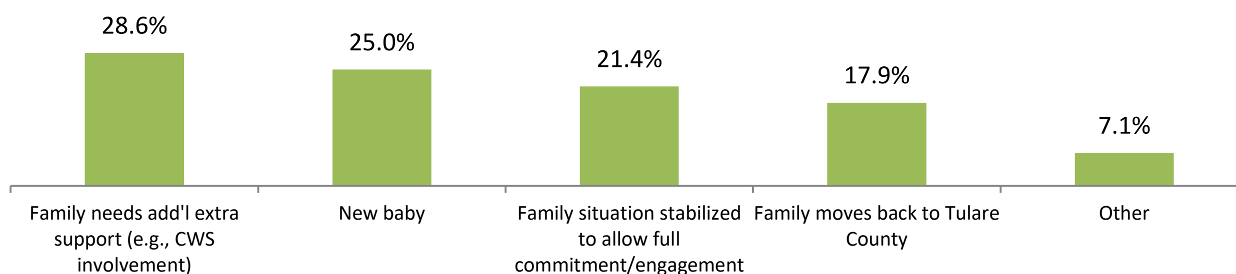
Figure 25. Typical Reasons that Limit Clients' Continued Enrollment in HV Services (n=11)



Note: Respondents could select more than one response choice.

Just as some families drop out of home visiting, some families re-enter services in Tulare County, due to various factors shown in Figure 26. Needing additional—and perhaps unanticipated—support as well as having a new baby are the most common reasons for re-enrollment. The "Other" responses given were changes in life goals and loss of employment/family instability. (Although the survey respondents were allowed to select "all that apply," they were asked for the *most typical* reasons families re-enroll in HV; most of them had a hard time limiting their responses to just a couple of reasons and had to be asked to choose the main ones.)

Figure 26. Typical Reasons Families Re-Enroll In Home Visiting Services (n=11)



Note: Respondents could select more than one response choice.

Highest Currently-Identified Needs

We asked respondents to query their home visiting staff to see what they would identify as the 2 highest needs of families at the present time that were not being adequately met *that could benefit by home visiting*. Nine specific needs were mentioned by the respondents, some with multiple endorsements (Table 31 on the next page), though some of the concerns are typically beyond the scope or ability of HV programs to address, such as utility assistance. (Note: utility assistance ranks #2 as the most common call for help to Tulare County 211.)

Similar to both prior HVC needs assessments, home visiting staff mostly identified the shortage of affordable housing/high rents and the scarcity of resources for mental health support as top needs. Unstable housing was stated by one individual as "contributing to disruption in HV services." Two people mentioned unaffordable child care, but otherwise transportation, immigration status, disabilities, language barriers and referral follow-up were each cited by only one individual. Thinking about what the community indicator data in the front section of this report tell us (and considering the HVC training topics over the last couple of years), it is interesting that no one mentioned food insecurity, the inordinately high teen pregnancy rate, the impact on families of substance abuse and domestic violence as high needs to address in home visiting..

Though it would be challenging to plan a HVC priority around financial security, a number of individuals cited "poverty" as an "unmet need" because of its relationship to family stability, access and well-being, e.g., "the cost of living continues to impact families' basic needs;" "low educational levels lead to an inability to earn higher wages to keep up;" "financial instability adds to housing problems."

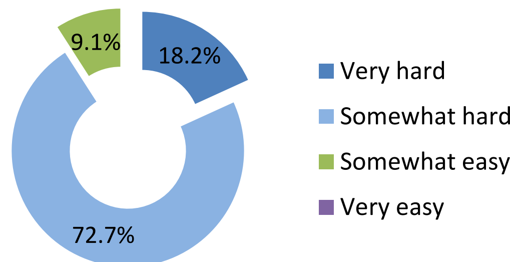
Table 31. Highest Unmet Needs to Benefit from Home Visiting Identified by Agencies' Home Visiting Staff (n=10)

In order of frequency
▪ Affordable housing (n=6) ▪ Access to mental health/emotional support (high demand + limited resources = ↑ wait times) (n=4) ▪ Affordable child care (n=2) ▪ Utility assistance (n=2) ▪ Transportation (n=1) ▪ Immigration issues (n=1) ▪ Language barriers (n=1) ▪ Services related to disabilities (n=1) ▪ Referral follow-up (n=1)

Home Visiting Workforce

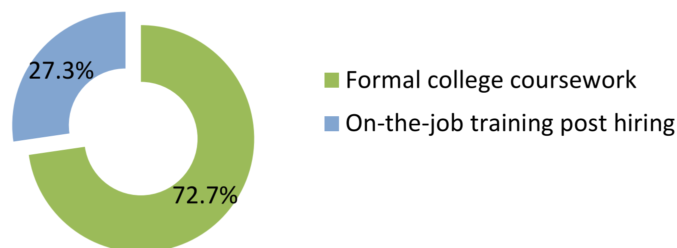
We asked about the difficulty the organizations had in recruiting qualified home visitor candidates. As Figure 27 indicates, close to three-quarters of the respondents reported it was "somewhat hard"—a slightly higher proportion than in the previous needs assessment. Two individuals reported recruitment as "very hard."

Figure 27. Ease of Difficulty Recruiting Home Visitor Staff (n=11)



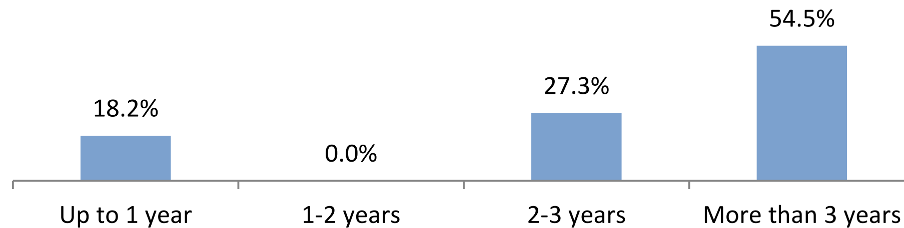
The survey also asked about the *typical* source of preparation the home visitor staff came with when hired. Where last time only half of the agencies had said the candidates had formal college coursework such as in child development, in the current assessment the proportion rose to about three-quarters (Figure 28), suggesting a candidate pool of more highly qualified home visitors. None of the respondents marked "on-the-job training at another agency" or "other work settings with family and children."

Figure 28. Typical Source of Preparation Home Visitor Staff have when Hired (n=11)



Staff retention is relatively favorable as the majority (54.5%; 66.7% previously) of the agencies reported retaining home visiting staff *in that capacity* for more than 3 years (Figure 29). In the initial HVC survey, 88.9% of the respondents reported that level of retention—an interesting difference.

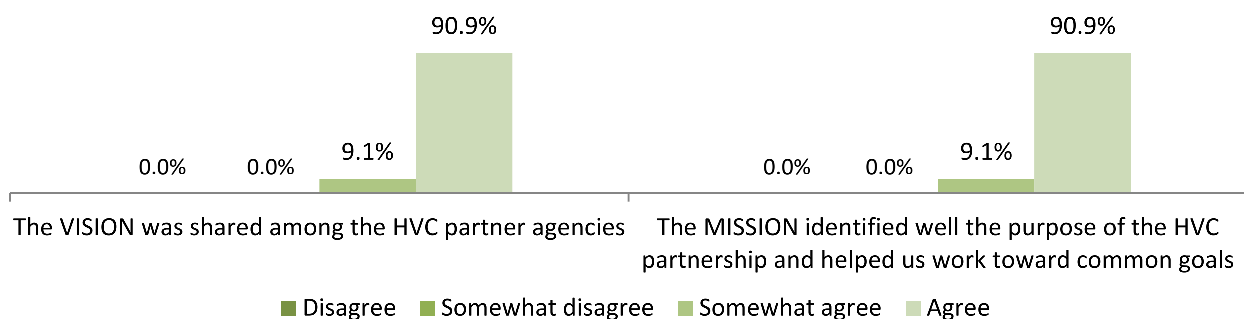
Figure 29. Typical Length of Employment of Staff in a Home Visiting Capacity (n=11)



HVC Coordination and Partner Relationships

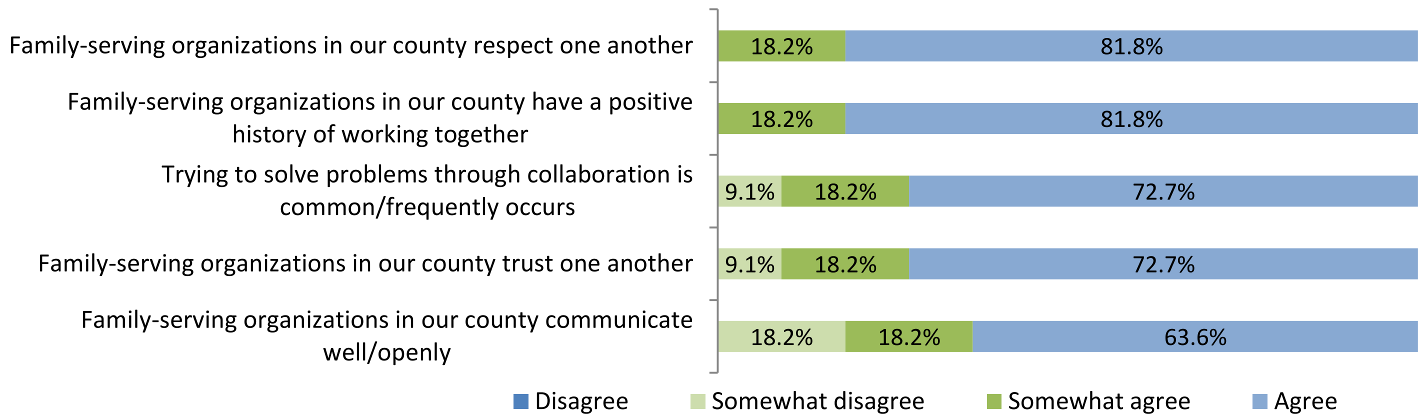
The partners were asked, thinking back, how much they agreed with statements about the vision and mission they created for the HVC. As Figure 30 shows, there was near universal concurrence of a shared vision and alignment with the mission purpose.

Figure 30. Agreement with Vision and Mission (n=11)



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 the ratings in Figure 31 on the next page that the HVC organizations value and respect one another and appreciate the positive history of working together. While there was general agreement about the other aspects of the relationships among home visiting organizations in Tulare County, some opinions differed a little about other aspects of it. For example, there was less concurrence about trust and that problem solving through collaboration happened often. The area of least agreement was in viewing their organizations as communicating openly and well with one another—a similar finding in the HVC previous needs assessments.

Figure 31. Agreement Regarding Aspects of HVC Partner Relationships (n=11)



The partners also offered their opinions about the extent to which the 9 goals they set at the beginning of the HVC had been achieved (Table 32). Fostering child development and school readiness (#6) and creating and maintaining effective community systems of care to increase accessibility of services (#2) were the goals they viewed as being the most closely achieved or "in progress." The goals they thought had the least extent of achievement—though some still thought they had been attained or were in progress—were decreasing duplication of services (#3), identifying and addressing health and social/emotional concerns (#4), and cultivating "vision ambassadors as champions (#9)—areas to continue to work on in the future.

Table 32. Agreement Regarding Achievement of HVC Goals (n=11)

GOALS	Achieved	In Progress	Begun but delayed or slow to progress	Not Yet Begun
1. Increase home visiting coordination and referral among agencies that provide home visiting and family support services within the early childhood system of care	9.1%	54.5%	36.4%	0.0%
2. Create and maintain effective community systems of care to increase accessibility of services	9.1%	72.7%	18.2%	0.0%
3. Decrease duplication of services and maintain strong, ongoing communication and collaboration among home visiting and family-serving organizations	9.1%	63.6%	18.2%	9.1%
4. Identify and address health and social/emotional concerns that affect child development and families in complex ways to improve outcomes	9.1%	54.5%	27.3%	9.1%
5. Reduce adverse childhood experiences by strengthening parental capacity and encouraging positive parenting practices (n=10)	10.0%	50.0%	40.0%	0.0%
6. Foster child development and school readiness	18.2%	45.5%	27.3%	9.1%
7. Promote family health and self-sufficiency	0.0%	72.7%	18.2%	0.0%
8. Prepare, retain and support a well-qualified home visiting workforce	0.0%	63.6%	36.4%	0.0%
9. Cultivate "vision ambassadors" who can serve as champions for children and families and help	0.0%	54.5%	36.4%	9.1%

Value of the HVC Partnership

In response to the question, "What was the most useful thing to you/to Tulare County to come out of this Home Visiting Coordination project?" they most commonly named the HVC training sessions and inter-agency collaboration (see Table 33).

Table 33. Outcomes of the HVC that Partners Viewed as Most Useful (n=11)

	n
Training sessions for the home visiting staff	6
Enhanced collaboration and organizational capacity building for HV	3
Clarifying what home visitation means to different agencies	1
Increasing support for and empowering families	1
More families are receiving HV services	1
Increased confidence of HV staff and ability to apply learning and resources they were given to build confidence in and provide advocacy for families	1

Recommended Next Steps

Seven of the 11 partners provided specific recommendations for how First 5 Tulare might continue to be supportive of home visiting services. In order to mention:

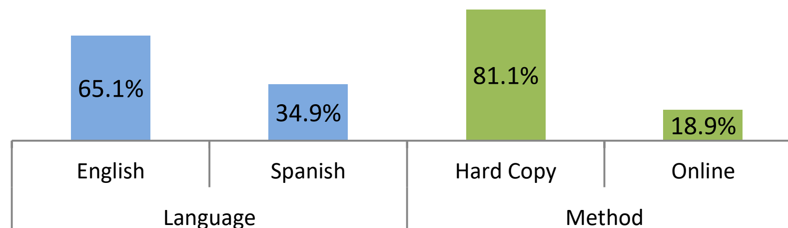
- Continue to sponsor—and increase—the HV training workshops. (Note: no particular topics were mentioned by anyone.)
- Provide sustainable operating support (funding) to maintain and expand HV programs to reach more families.
- Build into the training days some intentional collaboration, i.e., foster increased collaboration between HV programs by establishing "best fits" for each program and streamlined referral processes between agencies.
- Have a unified tracking system ("*How can we track if we are being efficient and effective for the First 5 families*?")
- Provide more tablets

PARENT EXPERIENCES AND PERSPECTIVES

"I didn't have any home visits – I'm homeless – but they [FRC] helped me."
-- Parent Survey respondent

A total of 441 parents/caregivers, primarily served through the Family Resource Centers, completed the English/Spanish Parent Survey in May 2024. Overall, 65.1% of the surveys were completed in English, 34.9% in Spanish. A greater majority than anticipated, 81.1%, were completed in hard copy vs. using the online version promoted through various social media outlets, as Figure 32 shows.

Figure 32. Survey Response Characteristics

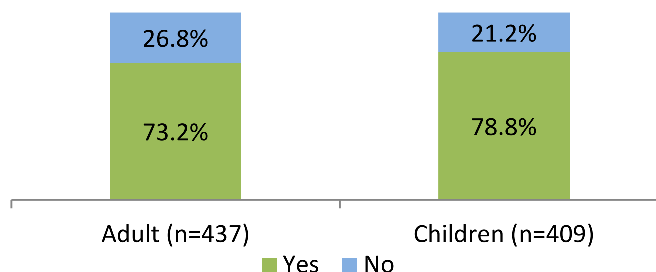


Health and Wellness

Very few (87.9%) of the respondents reported in the last year being unable to get – or delay getting – any health care they or any of their children needed. Of the 26 parents who did experience a problem, 82% described a medical-related issue and 18% a dental issue. The descriptions weren't clear enough to tell whether it was an adult or child in the family who had experienced an access problem; it was likely an adult, however, as most children would be covered by Medi-Cal, and "no insurance" and "high cost "were the most common reasons given for a delay or no treatment.

When it came to making a dental visit, the high proportion of children, and especially adults, who saw a dentist in the last year (Figure 33) was impressive and, notably, significantly higher than the Tulare County population with similar demographics in the recent CHIS survey (see page 26). *This clearly suggests that, overall, the efforts of First 5-funded organizations to help families understand and utilize oral health services have paid off.*

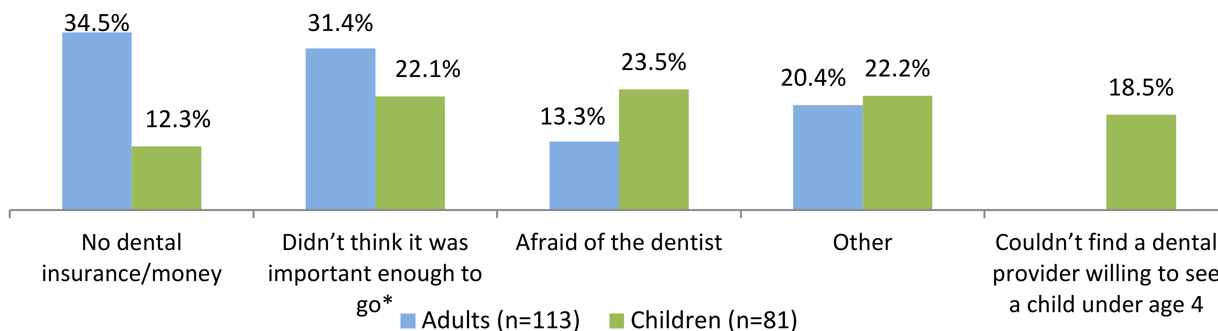
Figure 33. Dental Visit in the Last Year (Children Age 1-5)



Note: Infants <1 year of age were removed from the dataset.

For the group without a recent annual dental visit (26.8% adults; 21.2% children), the reasons displayed in Figure 34 are consistent with dental needs assessments and other studies, including those we've conducted. Fear, not uncommonly, was a big factor for children, as was parents' thinking that temporary or baby teeth were "not worth going" to the dentist. Close to 19% said they'd tried unsuccessfully to find a local dentist who would see young children. In checking the response choice "Didn't think it was important enough to go" for themselves, the respondents were remarkably candid: many wrote things like "I just haven't gotten around to it;" "I keep forgetting;" and "my teeth are OK"—implications for the need for more oral health education. "Other" responses relative to both children and adults' non-utilization generally included lack of transportation, lack of child care, inconsistent custody arrangements, recent arrival to the U.S., and special needs situations (e.g., autism) with no resources for accommodation.

Figure 34. Reasons for No Dental Visit in the Last Year (Children Age 1-5)



*For children, the question also included "because they have baby teeth and baby teeth are going to fall out anyway."
Note: Infants <1 year of age were removed from the dataset.

Close to 60% of parents knew correctly the recommended "First Tooth First Birthday" for a child's first dental visit (Figure 35). There was an obvious relationship between knowing this and utilizing dental services: parents who were more likely (30%, on average) to correctly know FTFB had gone to the dentist themselves in the last year and taken their age 1-5 year-old child to the dentist in the last year (Figure 36).

Figure 35. When Parents Thought a Child Should Make a First Dental Visit

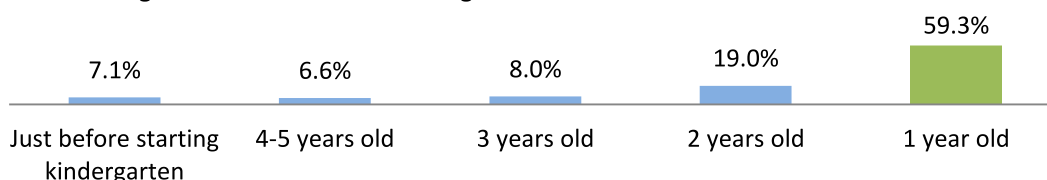
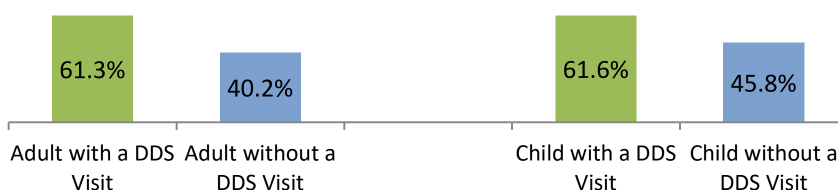
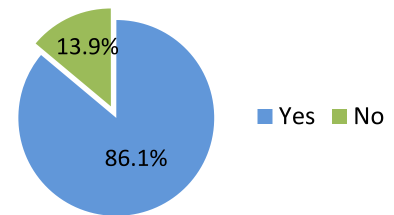


Figure 36. Percent of Parents Who Knew Correctly When a Child Should Visit the Dentist for the First Time



Although just over half of Tulare County adults <200% FPL reported in the 2022 CHIS they were food insecure,[68] most (86.1%) respondents in this survey said they or their family had had enough food to eat in the last 30 days (Figure 36).

Figure 37. Families Food Secure? (n=431)



Pregnancy and Breastfeeding Experience

About half (45.8%) of the survey respondents reported having a baby in the last two years. Of the 192 women who delivered, 186 told us how they had fed the baby. Although we hoped the proportion would be higher—given the efforts of the First 5 Commission to promote breastfeeding—only one quarter (24.2%) said they'd exclusively breastfed that baby. Similar to the data reported in our First 5 evaluations, twice the proportion of respondents who completed the survey in Spanish exclusively breastfed as those who responded in English (Figure 39).

Figure 38. Method of Feeding Baby (n=186)

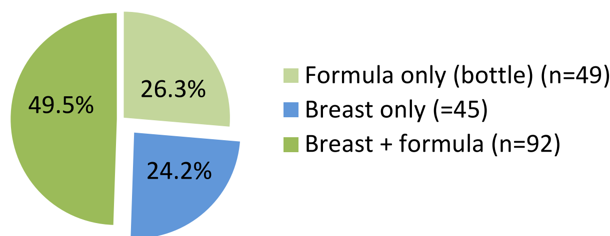
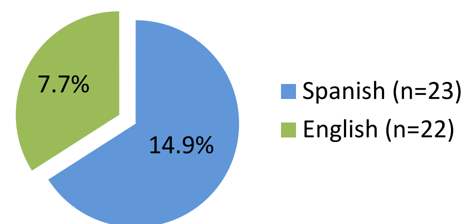


Figure 39. Exclusive Breastfeeding, by Survey Language (n=45)



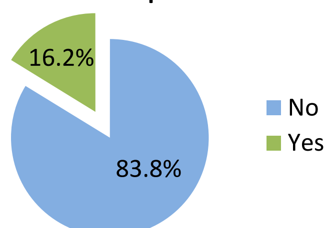
Looking at the duration of *any* breastfeeding—when also using formula—the average number of months among all women was 7 (the median was 6), with women using the English survey staying with it a little longer (Table 34). (Note: a disappointing 40% of the respondents who reported any breastfeeding did not answer the question of duration.)

Table 34. Duration of Breastfeeding (Any) Reported, by Survey Language (n=82)

	Average Number of Months	Minimum Number of Months	Maximum Number of Months
Total	7	1	24
English Survey	7.6	1	24
Spanish Survey	6.9	1	24

As Figure 40 shows, the majority of women said they did not need help with breastfeeding; 16.2%, however, said they did but did not get the help they needed.

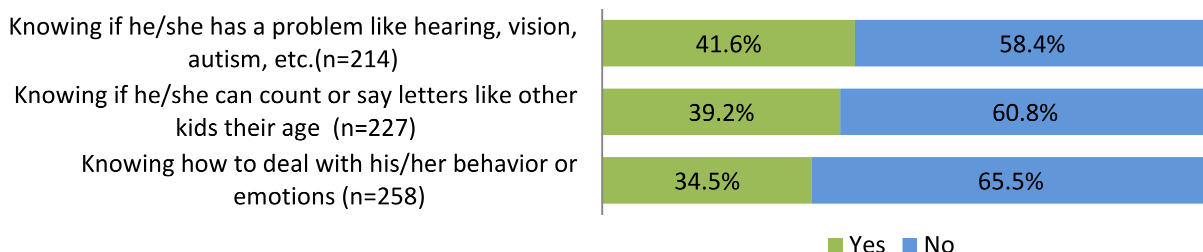
Figure 40. Did You Need Help with Breastfeeding You Didn't Get? (n=111)



Services and Resource Needs

Respondents with a child/ren between ages 2-6 were asked whether they could "use a little help" with 3 concerns common when raising young children. Although these parents/caregivers were already receiving various types of parenting services from the First 5-funded agencies administering the survey, over one-third indicated a need for some help—generally related to assessments and early learning concerns. Slightly more of those who completed the survey in paper than online answered "yes" (data not shown).

Figure 41. Percent of Parents Requesting Some Help with Childraising Concerns



Home Visiting

About two-thirds of the parents reported not having had a home visit within "the last couple of months" (Figure 42), defined in the survey as "a professional person who comes to your home [or, we allowed, "meets you at a school or park"] and offers information and support services related to the needs of someone in your family." When asked those who had responded "no," whether they *would* like a visit by a home visitor, interestingly, about three-quarters of them (74.1%) said they would not (Figure 43).

Figure 42. Home Visit Last 2 Months?

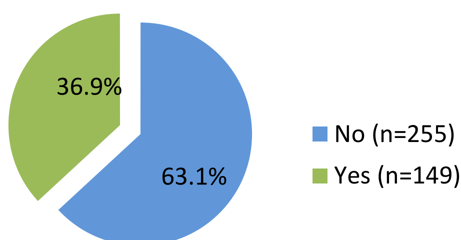
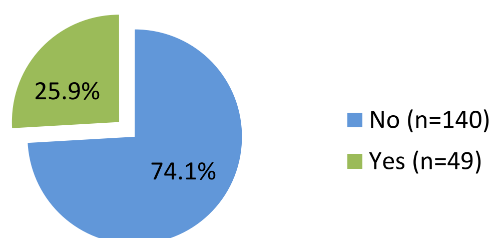
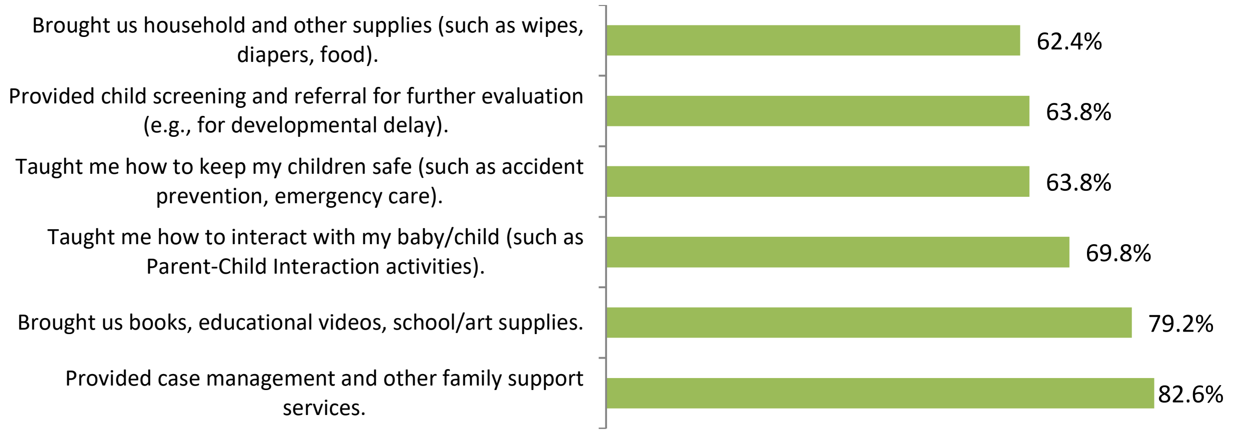


Figure 43. Preference for a Home Visit by Respondents With No Recent Home Visit



Parents who had indicated receiving a recent home visit were asked what those services consisted of. Figure 44 on the next page describes them. Not unexpectedly, case management and "other family support services" were most commonly indicated.

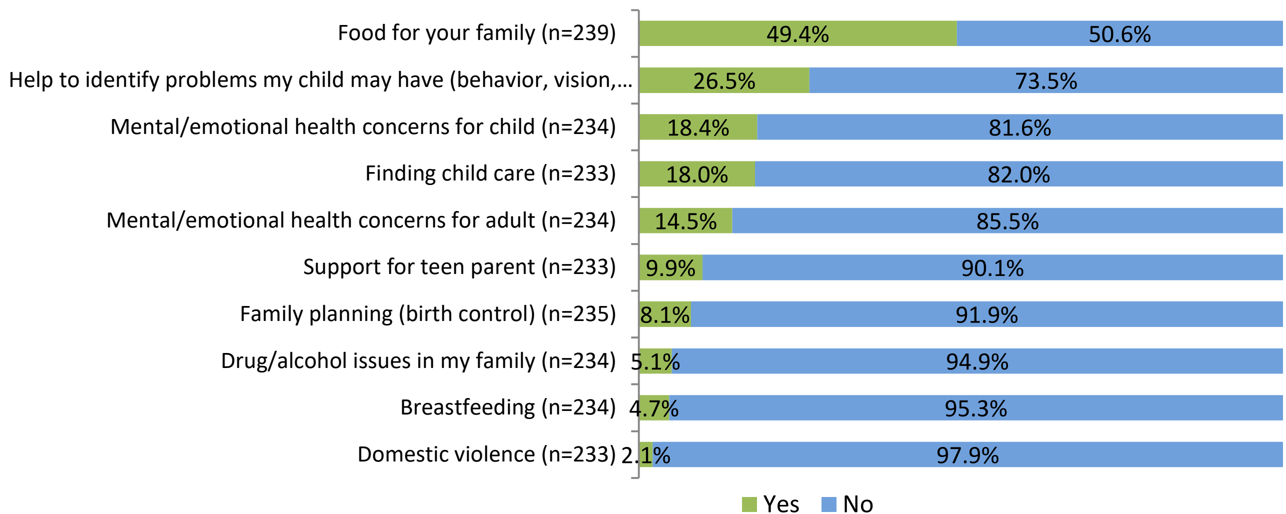
Figure 44. Type of Home Visiting Services Received (n=149)



Community Services and Parenting Classes

All parents—regardless of their involvement with home visiting—were asked about their *present* need for various types of community and/or home visiting services for their child or family. Just over half (57.4%) of the sample indicated that they "needed nothing," while 42.6% checked at least one of the services. As Figure 45 indicates, the need for help in obtaining food far exceeded the need for the other things, though help to identify problems their child may have (behavior, vision, speech, autism) requested by one-quarter (26.5%) of the parents.

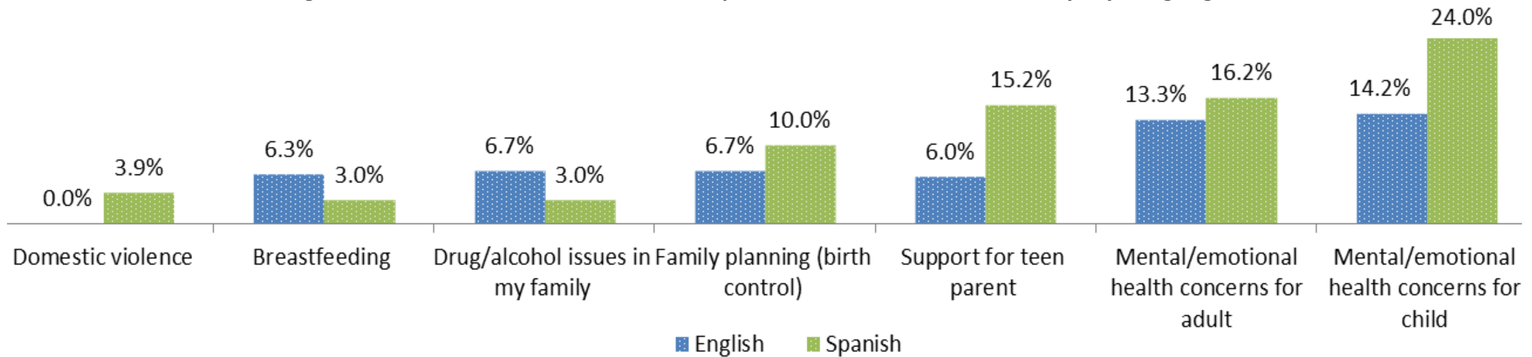
Figure 45. Services Families Needed Help with at the Time of the Survey



Thinking about the potential value of targeted outreach in home visiting to more closely link clients with needed resources, we looked at the services families said they needed help getting by survey language. We were particularly interested in some of the more self-disclosing, sensitive concerns. Figure 46 makes the differences clear. For example, one-and-a-half times the proportion of parents who completed the survey in Spanish wanted support for a teen parent in the family; 50% more

needed help finding a resource for birth control (quite possibly the teen parent/family planning concerns were linked); and 30% more wanted help for mental/emotional concerns related to a child. None of those completing the survey in English disclosed a need for domestic violence-related services, while 3.9% of the Spanish languages indicated a need for this.

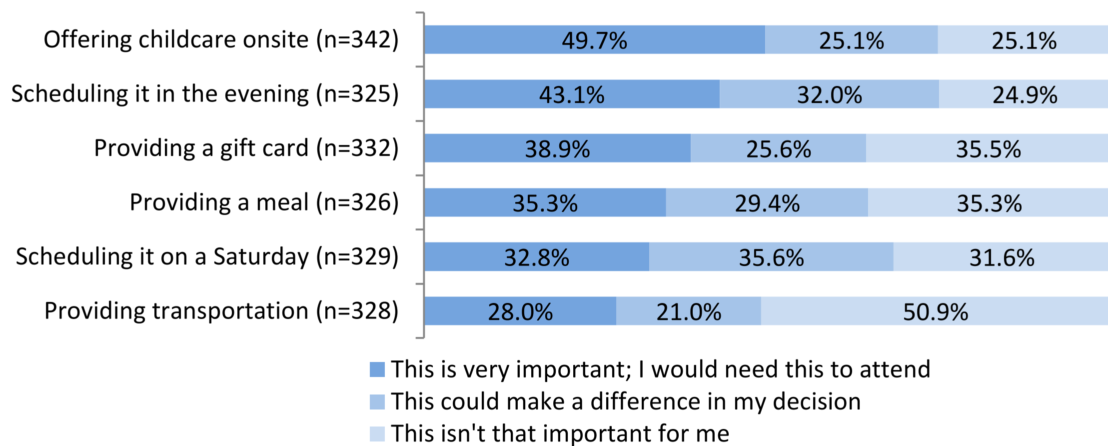
Figure 46. Services Families Needed Help with at the Time of the Survey, by Language*



*Note: Services without significant enough differences were not included in the graph.

Home visiting and other organizations invest a lot of time and money planning and offering classes for parents who want to build skills and learn more about raising children—e.g., cooking healthier meals, using appropriate discipline methods, doing arts and crafts projects together. Yet, in many cases, attendance can be disappointingly small. To better understand what it would take to increase participation—especially when parents have indicated an interest—the survey asked how important certain conveniences and inducements might be to their decision to attend. While all were important to some degree, as Figure 47 shows, offering onsite childcare and scheduling events during the evening are considered essential to attendance, according to these respondents. Help with transportation—necessary for some—was rated relatively less important to most.

Figure 47. The Relative Importance of Inducements to Participate in Parenting Classes

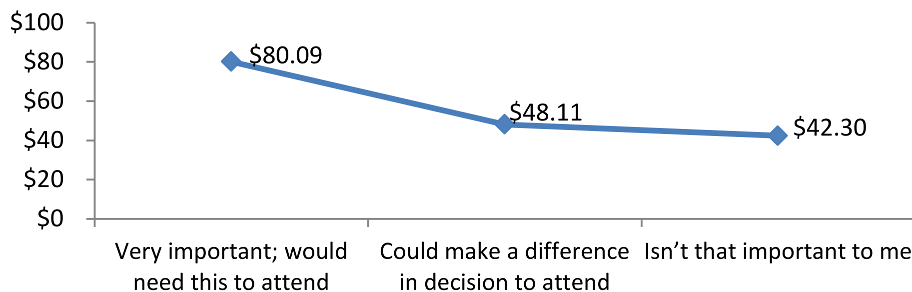


This survey also gave us a unique opportunity to ask about the amount (dollar value) clients thought a gift card should be as an incentive for participating in a parenting program. To avoid slanting or biasing the responses, we did not provide a range of fixed dollar amounts, but allowed clients to "fill in the blank."

We were surprised that of the 332 individuals who answered the question of relative importance (Figure 47 above), less than half (157, or 47%) wrote in a dollar amount. We found that the more important this incentive was to the person, the more inclined they were to provide a dollar amount: dollar amounts were provided by 62.8% who said the gift card was essential to their attendance; 30.4% by those who said it could make a difference; and by only 6.8% of those who said it wasn't that important.

Looking at the average dollar amount by its relative importance, we can see from Figure 48 that as the importance to the client decreased the "demand" or suggested value of the gift card decreased.

Figure 48. Relationship of Average Gift Card Value to Relative Importance to Respondents (n=148)



*The highest and lowest amounts (outliers) were removed to avoid skewing these calculations

Table 35. Dollar Value of the Gift Card Incentive Suggested by Survey Respondents (n=152)*

Answer Choice	Mean (Average) Average Dollar Value	Median Dollar Value[1]	Mode[2]	Range	
				Minimum Dollar Value	Maximum Dollar Value
Gift Card Incentive	$67.45	$50.00	$100.00	$2.00	$1,000.00

*A few respondents wrote in a dollar amount even when they did not answer the question about the importance of the gift card incentive.
[1]Median: the exact midpoint of the range of the numbers (dollar amount).
[2]Mode: the dollar amount that appeared the most times.

Table 36 on the next page shows the range of dollar values. For example, about half (51.6%) of the group for whom the gift card was most important wrote in $100 or higher as the suggested amount; about one quarter (23.7%) wrote in $50 exactly.

Table 36. Gift Card Amount Suggested by Relative Importance to Respondents (n=148)*

Dollar Value	Relative Importance by Group		
	Very important; would need this to attend (n=93)	Could make a difference in decision to attend (n=45)	Isn't that important to me (n=10)
$<25	4.3%	22.2%	30.0%
$25-$49	19.4%	33.3%	30.0%
$50-$74	24.7%	22.2%	20.0%
$75-$100	37.6%	22.2%	20.0%
$101-$149	6.5%	--	--
$150- $200	7.5%	--	--

*A few respondents wrote in a dollar amount even when they did not answer the question about the importance of the gift card incentive.

Although having this feedback from clients is important—and unique—for planning parenting support programs, the dollar values suggested by these clients may not be realistic for all home visiting programs or similar organizations to support. However, when coupled with onsite child care and an evening meal (for family members, too), a more modest-value gift card could still be an effective incentive.

PART V: BEST PRACTICES

"The ability to collaborate with other program providers is essential to launching home visiting programs." -- HVC Advisory Group Member

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. Meeting in a family's home provides home visitors with a unique opportunity to know families intimately. This sets the stage for close, trusting relationships—the critical element in any program designed to support children and their families.

In addition to having sufficient funding, the success of evidence-based home visiting models, and the other models described below, is dependent on a well-qualified and adequate workforce. 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 these models in helping families move forward with their goals for well-being, economic stability, and self-sufficiency.

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 that begin on the next page have met HHS criteria[*] as "evidence-based early childhood home visiting service delivery models."[69] 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).[70]

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.

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

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.

Growing Great Kids (GGK)

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

The following key needs assessment findings—some similar to what was reported in the initial and previously updated home visiting needs assessments—can continue to guide expansion or implementation of new evidence-based home visiting models in Tulare County to ensure that families 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 of the vision and mission statement they created at the beginning of this project. The partners value the time spent in sharing experiences and gaining new knowledge.

- The partners expressed a great deal of appreciation to First 5 Tulare for supporting their home visiting programs. They especially acknowledged in their written evaluations the value of the various trainings that have been offered; the original seating capacity at the sessions has been exceeded nearly every time.

- Families participating in a home visiting program are key stakeholders in home visiting success and can offer unique perspectives and feedback that aid program design. Despite best efforts, family member representation in the HVC advisory group turned out to be an unrealistic goal.

- Home visiting programs have done a good job since implementation of the HVC of increasing the proportion of families and children who can benefit from receiving these services. However, there is an estimated unmet need for another 63% of low-income children and families to have access to home visiting programs.

- As we reported last time, inconsistent or inadequate funding and, in some cases, complex fidelity requirements of some models limits partners' abilities to expand home visiting services. Beyond capacity issues, the hesitancy of some families to accept home visiting services—even with the risk of exposure to COVID-19 now a much less evident concern—is another factor that limits program growth.

- While the services provided by the partner agencies align with the documented needs of enrolled families, the capacity to provide mental/behavioral health for children *and* adults—the issue with the highest identified need according to community input—is a limiting factor to more fully meet the demand. Greater participation from mental health organizations/ therapists is a chronic need.

- We learned from looking at the parent surveys by language type (see Figure 42) that assumptions about the services that could be less important or needed based on a person's

language may not be accurate.   For example, stereotypes about "conservative" Hispanic families and interest in birth control education may have limited merit.

- Providing home visiting services, while rewarding, comes with unique challenges for home visitors, for example feelings of being unsafe, demands that exceed one's ability to cope, and responsibilities that do not align with current knowledge and skills. Not addressing this work-related stress can lead to burnout, reducing the quality of home visiting services, increasing staff turnover and inhibiting client engagement.

- Recognizing that families with young children need support, sites and in addition to resuming pre-COVID in-home visits staff are continuing supporting families remotely through phone and video calls. (In some cases, because of privacy or other concerns, they have met with families at remote/neutral locations.) While virtual visits *can be* an effective way to maintain contact with families, their therapeutic value may be questionable.

- Certain community health indicators continue to signal a problem: the most striking examples continue to include food insecurity, births to teen mothers, perinatal substance exposure, and emotional/mental health concerns. These indicators should not only be monitored but collectively better addressed.

NEXT STEPS

Over the course of FY 2024-25, the Tulare County Home Visiting Coordination project will:

- Continue to sponsor meetings of the HVC Advisory Group to share program information, challenges, successes and lessons learned.
- Participate in the regional HVC learning community efforts.
- Identify training topics based on workforce feedback, and support and encourage participation.
- Create opportunities/forums where home visitors can share their perspectives and experiences.
- Continue to make improving family mental health a priority by providing more supportive services.
- Look for more opportunities where the voices of families can be incorporated as part of the discussions.
- Continue to monitor progress of home visiting services in the county.
- Look for ways of increasing MIS capacity to obtain some of the information needed in the next or similar needs assessments.

ATTACHMENTS

ATTACHMENT 1

HOME VISITING COORDINATION ADVISORY COMMITTEE & COMMUNITY PARTNERS

(In alphabetical order by first name)

Individual	Affiliation/Organization
Members	
Adela Hernandez	Lindsay Healthy Start Family Resource Center
Aleyda Montenegro	CalWORKs Tulare County HHSA
Angel Avitia	Community Services & Employment Training – CSET Tulare FRC
Armando Villarreal	Woodlake Family Resource Center
Cynthia Molina	HHSA PLAY Liaison
Darcy Massey	Suicide Prevention Task Force, Tulare County Mental Health
Denise Pedregon	Parenting Network Dinuba FRC
Flor Martinez	Parenting Network Porterville FRC
Heather Collins	Nurse Family Partnership
Irma Rangel	Turning Point of Central California-Children's Mental Health
Jennifer Newell	Behavioral Health Services, Tulare County HHS
Julia Castro	Family Services of Tulare County
Linda Ledesma	Lindsay Healthy Start Family Resource Center
Lorena Castillo	TCOE Early Childhood Education Program
Maritza Gonzalez.	Cutler-Orosi Family Resource Center
Paul Prado	Parenting Network Inc.
Victoria Rodriguez	SAVE the Children, Senior Advisory
Tammy Wiggins	Tulare County Public Health MCAH Program
Victoria Rodriguez	SAVE the Children, Early Steps to School Success
Staff and Consultants	
Barbara Aved	Barbara Aved Associates
Christina Sauceda	First 5 Tulare County, Chief Program Officer
Michele Eaton	First 5 Tulare County, Executive Director
Timberly Romero	First 5 Tulare County, Play/Parents as Teachers Affiliate Supervisor

June 2024

HVC AGENCY SURVEY 2024

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 updated 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. Confer as needed with your home visiting team to help answer the questions; please complete and submit only 1 survey on behalf of your agency/HV program. (Note: multi-sited FRCs may submit 1 survey per FRC site.) Complete and return the survey to Dr. Barbara Aved at: barbara@barbaraavedassociates.com by April 22. Many thanks!

Name of Agency/Organization: ______________________________

Person completing this form: ______________________________

PROGRAMS AND CLIENTS

1. Please identify each of your HV program models, and how many you served during CY 2023.

Name of Your HV Model	Total # of parents/caregivers served	Total # of children age 0-5 served

Add more rows to this chart if you need it.

2. For each of your HV models, how many pregnant women and children did you serve? For children please provide a breakdown by age.

Name of Your HV Model	# of Pregnant women	Number (an unduplicated count) by Age Group				
		# of Age 0-1	# of Age 2	# of Age 3	# of Age 4	# of Age 5

Add more rows to this chart if you need it

3. Did you have to turn away or not enroll any families *who you otherwise would have served* because of funding limitations?

   a. ______ No, we were able to serve all who wanted to be enrolled

   b. ______ Yes, we had to turn away and couldn't serve some families who wanted to be enrolled (If "yes," please answer below)

   Approximately how many more families could you have served in each of your HVC programs if funding/capacity hadn't been a problem?

Name of Your HV Model	Total # of families could have served but NOT able to

4. Approximately, what percentage of your home visits is *currently* being provided through the following methods? *(Fill in the %.* Be sure your answers add up to 100%!*)*
   a. ____% Phone/virtual only
   b. ____% In-person at client home only
   c. ____% Hybrid model (phone/virtual/in-person), according to need

PROGRAM ENROLLMENT

5. How much of a barrier are the following to family enrollment in home visiting?

	Little or no barrier	*Moderate barrier*	*Major barrier*
Families' reluctance to receive services due to fear of COVID-19/infection risk	O	O	O
Families' reluctance to receive services due to being undocumented	O	O	O
Families' reluctance to accept help due to fear of exposure/reporting domestic violence or child abuse	O	O	O
Privacy issues (e.g., clients not feeling comfortable interacting via virtual visit when others are at home)	O	O	O
Cultural/gender barriers (e.g., home visitor is a different ethnicity from client; home visitor is a male)	O	O	O
Other: What?			

6. What is the typical amount of time a family stays enrolled in your agency's home visiting program? *(Check only one)*
   a. ____ 1-6 months
   b. ____ 7-12 months
   c. ____ 1-2 years
   d. ____ 2-3 years
   e. ____ More than 3 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. ____ Family chooses to dis-enroll and informs us
   b. ____ Family doesn't follow through and drops out, sometimes without informing us
   c. ____ Family situation impacts ability to fully engage in services and meet model fidelity requirements
   d. ____ Family moves away
   e. ____ Family obtains a job or goes back to school and is unable to continue participating
   f. ____ Other (please specify ____)
8. Some families who dis-enroll in home visiting, for whatever reason, re-enroll. 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. ____ Incarceration situation
   c. ____ Family moves back to Tulare County
   d. ____ Family situation now stabilized to allow parents to fully commit and engage in services
   e. ____ Family finds themselves in a situation where they need extra support (e.g., CWS involvement)
   f. ____ Other (please specify ____)

WORKFORCE

9. In general, what level of difficulty have you encountered in recruiting qualified home visitor candidates?
   a. ____ Very hard
   b. ____ Somewhat hard
   c. ____ Somewhat easy
   d. ____ Very easy

10. What is the *typical* source of preparation of the home visitor staff you hire? (*Check only one*)
Home Visitors who have received training through………
   a. ____ Formal college coursework such as in child development
   b. ____ On the job training at your agency
   c. ____ On the job training at another agency
   d. ____ Other settings working with families and children

11. About how long does a home visiting staff person stay with your agency in a home visitor capacity? *(We are asking about staff retention)*
   a. ____ up to 1 year
   b. ____ 1-2 years
   c. ____ 2-3 years
   d. ____ More than 3 years

12. What would you/your home visiting staff say are the 2 highest needs of families receiving home visiting services that are *not* being *adequately* met? Why not? *(Describe in a few words)*

HVC COORDINATION AND PARTNER RELATIONSHIPS

13. As you think about the relationships among home visiting organizations in Tulare County, please indicate your level of agreement with the following statements.

	Disagree	Somewhat disagree	Somewhat agree	Agree
a. Family-serving organizations in our county have a positive history of working together	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
c. Family-serving organizations in our county trust one another	O	O	O	O
d. Family-serving organizations in our county respect one another	O	O	O	O
e. Family-serving organizations in our county communicate well/ openly with one another	O	O	O	O

14. The **Shared Vision** that was created by the HVC partners was:

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.

And, the HVC **Mission Statement** was:

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.

Thinking back, please indicate how much you agree with each statement below regarding the Tulare County HVC Vision and Mission for home visiting coordination:

	1 Disagree	2 Somewhat disagree	3 Somewhat agree	4 Agree
a. The Vision was shared by all of the HVC partner agencies	O	O	O	O
b. The Mission identified well the purpose of the HVC partnership and helped us work toward common goals	O	O	O	O

15. How far do you think we got in addressing each of the 9 Goals we established for the HVC?

	GOALS	Achieved	In Progress	Begun but delayed or slow to progress	Not Yet Begun
1.	Increase home visiting coordination and referral among agencies that provide home visiting and family support services within the early childhood system of care.	O	O	O	O
2.	Create and maintain effective community systems of care to increase accessibility of services.	O	O	O	O
3.	Decrease duplication of services and maintain strong, ongoing communication and collaboration among home visiting and family-serving organizations.	O	O	O	O
4.	Identify and address health and social/emotional concerns that affect child development and families in complex ways to improve outcomes.	O	O	O	O
5.	Reduce adverse childhood experiences by strengthening parental capacity and encouraging positive parenting practices.	O	O	O	O
6.	Foster child development and school readiness.	O	O	O	O
7.	Promote family health and self-sufficiency.	O	O	O	O
8.	Prepare, retain and support a well-qualified home visiting workforce.	O	O	O	O
9.	Cultivate "vision ambassadors" who can serve as champions for children and families and help.	O	O	O	O

16. In your opinion, what has been the most useful thing to you/to Tulare County to come out of this Home Visiting Coordination project?

____

____

17. Going forward, what specific recommendations do you have for how First 5 Tulare might continue to be supportive of home visiting services?

____

____

Thank You for Completing this Survey!

Please return the survey to Dr. Barbara Aved <u>by April 22</u>.
Email: barbara@barbaraavedassociates.com

HVC PARENT SURVEY 2024 (ENGLISH)

Dear Parents/Caregivers:

We want to learn more about what families in Tulare County need and how we can help. The information will be used to improve services in our community. Thank you for taking the time to complete this survey.

HEALTH AND WELLNESS

1. In the last year were you unable to get – or did you delay getting – any health care you or any of your children needed? [Check only one]

___ NO
___ YES

If yes, what type of health care? ________________________________

What was the main problem?________________________________

2. In the last year, did you go to the dentist for a regular check-up? [Check only one]

___ YES
___ NO

If no, why not? [Check only the most important reasons]

___ No dental insurance/money
___ Didn't think it was important enough to go
___ Afraid of the dentist
___ Other (What?________________________________)

3. In the *last 6 months*, did your child between ages 1 and 5 go to the dentist for a regular check-up? [Check only one]

___ YES
___ NO

If no, why not? [Check only the most important reasons]

___ No dental insurance/money
___ Baby teeth fall out anyway, so I didn't think it was important enough to go
___ Afraid of the dentist
___ Couldn't find a dental provider to see a child under age 4
___ Other (What?________________________________)

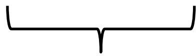
4. What is the age a child should visit the dentist for the first time?

___ Just before starting kindergarten
___ 4-5 years old
___ 3 years old
___ 2 years old
___ 1 year old

5. In the last 30 days, did you or your family have enough food to eat?
   ___ YES
   ___ NO

6. Did you have a baby in the last 2 years?
   ___ NO (please skip to Question 7)
   ___ YES

   How did you feed this baby? [Check only one]
   ___ Formula only (bottle)
   ___ Breast only
   ___ Breast + formula



How many months did you breastfeed this baby, even if you sometimes also used formula? (Write in the NUMBER of months you breastfed) ______

Did you need any help with breastfeeding <u>that you didn't get</u>?
___ NO
___ YES

RAISING YOUR CHILD

7. Please answer this question <u>only if you have a child ages 2-6</u>; if you do not, please skip to Question 8.

   I could use a little help with my child for:

	[Check one]	
	YES	NO
Knowing how to deal with his/her behavior or emotions		
Knowing if he/she can count or say letters like other kids their age		
Knowing if he/she has a problem like hearing, vision, autism, etc.		
Other: What?		

SERVICES FOR YOUR FAMILY

8. In the last couple of months, did a Home Visitor make a visit to your home? (This is a professional person who comes to your home to offer information and support services related to the needs of someone in your family)
   ___ NO

   Would you like a visit by a Home Visitor?
   ___ NO [Please skip to Question 9]
   ___ YES

   What would you like help with? ____

   ___ YES
   What did they help you with?

Someone …..	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 (e.g., for developmental delay)		
f. Provided case management and other family support services		

9. What do you need now for your child or your family?
   ___ Nothing
   ___ We could use some help with:

	[Check one]	
	YES	NO
Food for your family		
Mental/emotional health concerns for child		
Mental/emotional health concerns for adult		
Drug/alcohol issues in my family		
Domestic violence		
Help to identify problems my child may have (behavior, vision, speech, autism)		
Breastfeeding		
Family planning (birth control)		
Support for teen parent		
Finding child care		
Other: What?		

10. Some programs offer classes for parents who want more information about raising children – for example, cooking classes for healthy meal choices, learning to use appropriate discipline methods, doing art projects with kids, etc. In order for you to attend a class like these, how important are the following things? [Check just one box]

	This is very important; I would need this to attend	*This could make a difference in my decision*	*This isn't that important for me*
Scheduling it in the evening	☐	☐	☐
Scheduling it on a Saturday	☐	☐	☐
Providing a meal	☐	☐	☐
Providing transportation	☐	☐	☐
Offering childcare onsite	☐	☐	☐
Providing a gift card	☐	☐	☐
If getting a gift card was very important or might make a difference in deciding to attend, what would the value of the gift card need to be? $_______			

11. Do you have any special concerns or questions we didn't ask about that you'd like to bring to our attention?

Thank you for completing this survey!

[Please return it to the person who gave it to you]

Early Childhood System of Care

Source: First 5 California et al. California Home Visiting Coordination (HVC)

REFERENCES

[1] How Home Visiting Can Support Parent-Child Interactions. https://edc.org/sites/default/files/uploads/HVParentBrief.pdf
[2] https://www.ccfc.ca.gov/partners/investments.html
[3] https://www.kidsdata.org/topic/670/calworks/table
[4] California Department of Social Services. CalWORKs *California Families Working Together Annual Summary,* November 2022.
[5] https://unitedwaysca.org/realcost/
[6] http://www.selfsufficiencystandard.org/California
[7] https://data.chhs.ca.gov/dataset/eligible-individuals-under-age-21-enrolled-in-medi-cal-by-county
[8] https://worldpopulationreview.com/us-counties/ca/tulare-county-population
[9] https://data.visaliatimesdelta.com/census/total-population/total-population-change/tulare-county-california/050-06067/
[10] https://www.cdc.gov/pcd/issues/2006/jan/05_0055.htm#:~:text=Linguistic%20isolation%20is%20defined%20by,with%20English)%20(32).
[11] U. S. Census Bureau, American Community Survey, 5-Year Estimates. https://www.census.gov/quickfacts/CA
[12] U.S. Census. https://data.census.gov/cedsci/table?q=tulare%20county,%20california&tid=ACSST1Y2019.S0601&hidePreview=false
[13] California Department of Education. https://dq.cde.ca.gov/longtermel/EverElType.aspx?cds=54&agglevel=County&year=2019-20
Note: the percent values are calculated as a percent of the total-ever English Language learners.
[14] Household income includes income of the householder and all other people 15 years and older in the household, whether or not they are related to the householder.
[15] U.S. Census Bureau (2019). *Poverty Status in the Past 12 Months by Sex by Age American Community Survey 1 year estimates.* Retrieved from https://censusreporter.org
[16] Tepp KP, et al. Innovative Approaches to Address Social Determinants of Health Among Adolescents and Young Adults. Health Equity Volume 2.1, 2018
[17] U.S. Census Bureau, American Community Survey, 2002.
[18] https://datausa.io/profile/geo/tulare-county-ca
[19] California Department of Labor.https://www.labormarketinfo.edd.ca.gov/data/labor-force-and-unemployment-for-cities-and-census-areas.html
[20] UCLA California Health Information Survey, 2022.
[21] Gundersen, C., et al. *Map the Meal Gap*. Feeding America (July 2021) as cited on kidsdata.org.
[22] https://public.tableau.com/app/profile/california.department.of.social.services/viz/CFdashboard-PUBLIC/Home.
[23] https://dq.cde.ca.gov/dataquest/Cbeds2.asp?FreeLunch=on&cChoice=CoProf1&cYear=2019-20&TheCounty=54%2CTULARE&cLevel=County&cTopic=FRPM&myTimeFrame=S&submit1=Submit
[24] https://nourishca.org/wp-content/uploads/2022/04/Food4All-FoodInsecurityBrief-April2022.pdf
[25] https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/6107
https://static1.squarespace.com/static/579939fd197aea7457647213/t/64a857428433be7864d92c61/1688754006079/FINAL_2023+PIT+Report.pdf
[27] https://dq.cde.ca.gov/dataquest/DQCensus/HmlsEnrByDT.aspx?agglevel=County&cds=54&year=2022-23
[28] https://cal-vida.cdph.ca.gov/VSQWeb/ReportBuilder/BirthReport
[29] https://cal-vida.cdph.ca.gov/VSQWeb/ReportBuilder/BirthReport
[30] California Department of Public Health. https://cal-vida.cdph.ca.gov/VSQWeb/ReportBuilder/BirthReport
[31] 2020 American Community Survey as reported in https://www.towncharts.com/California/Top-25-Counties-in-California-ranked-by-Percent-Of-Unwed-Mothers-With-Less-Than-High-School-Education.html
[32] Amjad S, et al. Social determinants of health and adverse maternal and birth outcomes in adolescent pregnancies: A systematic review and meta-analysis. *Ped Perinatal Epidemiology.* December 2018.
[33] https://www.cdph.ca.gov/Programs/CHSI/Pages/County-Health-Status-Profiles.aspx
[34] Ibid.
[35] Vital Signs: Repeat Births Among Teens — United States, 2007–2010. *MMWR*. April 5, 2013;62(13):249-255
[36] Klerman LV. Another chance: preventing additional births to teen mothers. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy; 2004.
[37] https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Interpregnancy-Interval.aspx
[38] Catterson R et al. The 2022 CHCF California Health Policy Survey, January 2022. https://www.chcf.org/wp-content/uploads/2022/01/CHCF2022CAHealthPolicySurvey.pdf
[39] ***Maternal depression and child development.*** https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2724169/
[40] California Department of Public Health: MIHA Data Snapshot, Tulare County, https://www.cdph.ca.gov/Programs/CFH/DMCAH/surveillance/Pages/Maternal-Mental-Health.aspx
[41] https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/Pages/Data-Snapshots-Dashboard.aspx#msdynttrid=SbAHMcL6EePzXVNCOX34Ce3aVdgg8EPF-cPTvlFR_y8

[42] https://www.hospitalcouncil.org/sites/main/files/file-attachments/final_central_valley_chna_3.18.pdf?1553209460
[43] Personal communication with Joel Arevalo, Social Work Supervisor, Tulare County Child Welfare Services, 6/3/21.
[44] Tulare County Child Welfare Services, special data analysis, May 20, 2022.
[45] Tulare County Child Welfare Services, special data analysis 5/20/22. Personal communication with Darrell Watson.
[46] California Dept. of Public Health, Immunization Branch, https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/2021-22KindergartenSummaryReport.pdf
[47] Population Reference Bureau, analysis of data from the National Survey of Children's Health and the American Community Survey (Jan. 2021), as reported in kidsdata.org
[48] https://www.childtrends.org/publications/mapping-californias-home-visiting-landscape
[49] https://data.census.gov/table/ACSST5Y2022.S0901?q=children%20with%20disabilities&g=050XX00US06107
[50] https://strongstartindex.org/
[51] UCLA, 2022 California Health Information Survey (CHIS).
[52] UCLA, 2022 California Health Information Survey (CHIS).
[53]https://data.chhs.ca.gov/dataset/dhcs-test-dental-utilization-measures-and-sealant-data-by-ethnicity-calendar-year-2013-to-2022
[54] First 5 Tulare County, 3-year preliminary ASQ Screening Results, FY 2021-24 draft Evaluation Report, Barbara Aved Associates, June 2024.
[55] UCLA California Health Information Survey, 2022.
[56] First 5 Tulare County, 2-year analysis from the FY 2020-21 Evaluation Report, Barbara Aved Associates, September 2021.
[57] Child Care Aware of America. (2022). *Demanding change: Repairing our child care system*. Retrieved from: https://www.childcareaware.org/demanding-change-repairing-our-child-care-system as reported in kidsdata.org.
[58] https://data.census.gov/table/ACSST5Y2022.S1401?q=education&g=040XX00US06_050XX00US06107&d=ACS%205-Year%20Estimates%20Subject%20Table.
[59] UCLA California Health Information Survey, 2022.
[60] California Child Care Resource and Referral Network, California Child Care Portfolio (Nov. 2022); U.S. Census Bureau, American Community Survey public use microdata (Oct. 2022) as reported in kidsdata.org.
[61] Ibid.
[62] Webster, D, et al. California Child Welfare Indicators Project Reports. 2022. https://ccwip.berkeley.edu/childwelfare/reports/SubstantiationRates/MTSG/r/rts/s
[63] Ibid.
[64] https://www.cdph.ca.gov/Programs/CFH/DMCAH/MIHA/CDPH%20Document%20Library/2013-2015/SnapshotCo_Tulare_2013-2015_MaternalCharacteristics.pdf and https://files.constantcontact.com/68d497bd201/3c24025a-236a-421d-80d0-30694ef7c425.pdf?rdr=true
[65] https://openjustice.doj.ca.gov/exploration/crime-statistics/domestic-violence-related-calls-assistance
[66] Lynn A. Karoly, Rebecca Kilburn, and Jill S. Cannon, Proven Benefits of Early Childhood Interventions (RAND Corporation: 2005).
[67] https://www.childtrends.org/publications/mapping-californias-home-visiting-landscape
[68] [68] UCLA California Health Information Survey, 2022.
[69] https://homvee.acf.hhs.gov/effectiveness?model=&hhs=All&sort_by=title&sort_order=ASC&page=2
[70] https://www.cdph.ca.gov/Programs/CFH/DMCAH/CDPH%20Document%20Library/Communications/Profile-CHVP.pdf