# SANTA CLARA COUNTY HOME VISITING ENVIRONMENTAL SCAN

2021 REPORT

ASR

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# EXECUTIVE SUMMARY

## DATA COLLECTED

- Between June and August, we collected data from two sources: Parents/caregivers living in Santa Clara county and receiving home visiting services from the county's multitude of providers; and managers or supervisors of home visiting programs.

- Family Survey: We collected data from parents/caregivers using an online survey that was sent via the Home Visiting Collaborative partners. Families received a $20 e-gift card and a children's book for completing the survey.
  - A total of 93 parents/caregivers responded to the survey.
  - The majority of parents/caregivers who responded were Hispanic/Latinx (66%), some were Asian/Pacific Islander (14%), multi-racial (8), or other ethnicities (4%), with only a minority of respondents identified as white (5%).
  - The plurality of parents/caregivers was in the age range of 30 to 39, and about a half have three or more children.
  - A quarter were from single family households.
  - A third of the parents/caregivers did not finish high school.
  - Almost half lived in poverty.

- Family Interviews: As a follow-up to the survey, we interviewed 10 parents/caregivers who expressed interest in being contacted to give a fuller account of their experiences, challenges, and inform FIRST 5 Santa Clara County about other services and resources that families may need. Six of the interviews were conducted in Spanish and four were conducted in English. Interview participants received a $50 e-gift card for their participation.

- Provider Survey: A total of 27 home visiting program supervisors responded to an online survey.
  - Survey topics included home visiting model; characteristics of home visitors and families served; intake, assessment, and referral procedures; and data collection procedures and systems.
  - Respondents' job roles included facility owner, executive/program directors, supervisors, and managers, speech therapists or speech language pathologists (SLPs), nurse managers, home visitors, clinical coordinators, and case managers.

- Provider Interviews: Eight survey respondents also participated in follow-up interviews. Interviewees provided more in-depth views on the topics discussed in the survey related to their home visiting model, outcomes, processes, family recruitment, staffing or capacity issues, funding, and their vision for a collaborative network in Santa Clara County.

## HOME VISITING PROGRAM AND MODALITIES

- As a function of the way the survey was distributed (via partners), ParentChild+ was the most typically cited programs in which parents/caregivers participated (39%). Related to that, families most often heard about the programs from their engagement in Family Resource Centers (38%).

- Parent/Caregiver Interviewees were also asked to describe how they view the role of their home visiting program. Common responses included:
  - Preparing for preschool or kindergarten
  - Support learning to read
  - Ensuring that children are meeting their milestones
  - Working on parent-child interactions

- Parents/Caregivers mentioned receiving support, tips, or strategies to facilitate better interactions and support children's learning. Many also mentioned tangible skills they and their child were working on with their home visitor, such as learning colors, numbers/counting, sounds, and vocabulary. Parents/Caregivers also mentioned working on socialization and speech as well as other individual and family goals to address basic needs, mental, and physical health.

- Similar to what parents/caregivers described, most providers mentioned targeting parent-child interactions (92%) and child development and well-being (92%). Many (71%) also focused on the family functioning domain.

- Providers typically tailored program expectations to the needs of the family, with a focus on strengthening the parent-child relationship and getting children ready for school.

- Parents/caregivers reported that their sessions were typically conducted via video calls (71%), and only a minority had in person visits during the pandemic (17%). Yet almost half of the parents/caregivers (44%) indicated they preferred in person visits, whereas video calls were preferred by about a quester of respondents (29%). Phone calls were least frequently preferred (10%). Others did not have any preference (17%).

## PROGRAM PERCEIVED OUTCOMES

- The vast majority of those who receive home visiting services were very satisfied with the home visiting program overall.
  - Survey respondents indicated that their home visitor speaks to them clearly in a language they understand, respects their culture, spends enough time with the family, and taught them useful parenting skills (72-80% strongly agree).
  - Many also noted that they like working with the home visitor (78%) and that they felt more confident in managing stress and life challenges as a result of their participation in the program (68%).

- Interviewees further mentioned that their home visitor listened to them, connected with them as well as their child, and generally cared about their lives on a deeper level. The home visitor gave them space to ask questions, was flexible with the time spent and strategies used, and allow the parents/caregivers to feel as active partners.

- Most parents/caregivers surveyed (73%) felt that they as well as their children benefitted a lot from the home visiting program.
  - Parents/Caregivers who benefitted a lot often mentioned that they received helpful resources and tools to help their child and have learned much about their child's behavior and needs.

- Parents/Caregivers who felt their child benefitted a lot often expressed that their child has become more social, has learned a lot and/or is more ready for kindergarten, and can manage behaviors more effectively.

- Interviewed parents/caregivers often mentioned that as a result of home visiting, their child has become more social, learned numbers, colors, puzzles, and developed a love for learning. Parents/Caregivers have also seen improvements among all members of the family.

- The home visiting programs supported children' social development during COVID-19. The fact that the program was cultural and linguistically appropriate helped parents/caregivers connect with the home visitor.

- Interviewed providers also discussed insights gleaned from their data evaluation about their program's long-term impact for clients.
  - Families that are less engaged will not have as successful outcomes as those that remain engaged and committed to the process for the duration of the service period.
  - During the pandemic providers see success in parent-child connection measures but some drop in social cooperation measures, as the pandemic reduced many social opportunities for families and children.

## NEEDS OF FAMILIES

- Half of survey respondents reported that they experienced challenges or issues within the past 30 days. The number of needs families experienced positively correlated with the number of children in the family: Parents/Caregivers who take care of more children also experienced more challenges in their daily lives.

- Of those with needs, many parents/caregivers reported worrying about their child's development (45%) or managing their child's behavior (38%). Parents/Caregivers also worried a family member might get COVID-19 at their job (24%), or that their income will be reduced (24%).

- When matching expressed needs with referrals received, only about 50% of the needs were met with appropriate referrals.

- When talking to parents/caregivers directly, more needs surfaced:
  - Issues related to schooling came up several times as capacity of day cares was limited, information about available schooling was not readily available, and families needed support with back-to-school supplies.
  - Parents/Caregivers also experienced varying degrees of economic/financial impacts related to the pandemic. Several interviewees mentioned going to food banks and other places for fruits and vegetables and signing up to the diaper program. Some were struggling to pay bills or cover their rent.
  - Another common theme was the need for mental health support for themselves and for the entire family.
  - Parents/Caregivers noted difficulties accessing services and navigating the system, even after receiving a referral. Appointments take a long time (e.g., six months) or they cannot find the services needed.

- Similar to families, the majority of providers surveyed (80%) viewed worries about their child's development to be parents'/caregivers' most pressing need, followed by worries about managing their child's behavior (60%). To address these concerns, typically services are offered in-house.

- More than half of the providers also reported reduced wages/income (56%) and/or social isolation/loneliness (52%) as a pressing need. Interviewees added that a large portion of their families had pressing concerns related to basic needs, such as loss of housing, or lack of enough healthy food. In these cases, providers often referred families to community resources such as food banks, social services, CalWORKs, and other donation resources.

## INTAKE AND REFERRALS

- Overall, the majority of providers who use assessment tools follow up with education materials. Service referrals were slightly less common yet provided by about 40% or more of providers.

- Interviewed providers described a range of methods for incoming referrals, with large variation due to their distinct program structure or model requirements.
  - Most mentioned they engage in some form of outreach, such as attending community events, talking to other service providers, or using canvassing and marketing materials.

- Two common themes emerged regarding program procedures when a family cannot be served, whether due to capacity or eligibility criteria.
  - First, provider interviewed state that they rarely turned families away due to capacity issues; "They would find some way to make it work."
  - Second, they stated that they refer families to other services. This typically occurs when families do not meet eligibility criteria. In these cases they would provide the family with resources that would be good for them or go through a referral process to connect them with another agency.

- Home visitors frequently helped families get connected to additional services and the vast majority of providers surveyed (91%) track completions of referrals, or "close the loop."

- Interview participants provided additional insights into this process, which includes a variety of direct support (marking calls for families), engaging in internal referrals and/or warm handoffs with other agencies, or following up directly with the family. They noted, however that warm-handoffs and direct engagement with the family may be effective strategies but can also be time consuming.

## AREAS FOR IMPROVEMENT

- Parents/Caregivers raised several aspects that can strengthen the programs, in their view:
  - Focusing more on working with toys and materials children will be using in preschool to gain familiarity.
  - Including group visits, so children learn to socialize and share toys.
  - Extending the program to last until preschool and/or to expanding the age requirement for participation.
  - Receiving more guidance and feedback to aid in their confidence and increase their ability to carry on their role outside of home visiting.

- Other issues raised were related to the process of receiving services: parents/caregivers mentioned calling several times to get information as it was unclear when they can join the home visiting program, waiting several months for services because of eligibility requirements, and not getting a diagnosis or referrals in a timely manner.

- Despite the many benefits and support that the home visitors provide to their engaged families, there may be remaining gaps between their referrals/information and the ability for families to receive tangible support from outside resources in the community. While some of the participants noted having few needs outside of the educational and parenting support that home visiting provides, others were experiencing several compounding needs which may be more challenging for home visitors to support more directly.

## PARTICIPATION BARRIERS AND SERVICE GAPS

- Providers surveyed cited cancelations (55%) and schedule conflicts (32%) most frequently as barriers for engagement in the program. About a quarter (27%) of providers also stated that some families are not interested in the services, or that travel time to the home is a barrier to providing services. Another quarter of providers (23%) reported that eligibility for services is a participation barrier as well as capacity issues (not enough available slots to serve families).
  - Provider survey respondents also reported other barriers such as families with shared or challenging/unstable housing situations, limited outreach to underserved communities, and organizational regulations that are not flexible to meet family needs.

- On top of these multitude of barriers, the emergence of the pandemic added another layer of challenges. Indeed, the COVID-19 pandemic was primarily cited by interviewees as the source of barriers impacting program delivery and participation.
  - In particular, the situation for families who often had complex needs was exacerbated by the pandemic.
  - Some providers reported that referrals drastically decreased with fewer families engaging with their primary referral sources during the shelter in place orders.
  - Providers also noted challenges engaging families due to the transition to virtual services, such as fewer opportunities for outreach/interactions with potential clients or clients' access to technology.
  - Other barriers reported included Zoom burnout as well as the "fear of potential exposure to COVID-19" during face-to-face sessions. This dichotomy further highlights the double-barreled impact of COVID-19, with families facing barriers to both virtual and in-person services as our communities continue to navigate the uncertainties and challenges of the pandemic.

  - For providers in medical-based facilities, the pandemic has had a particularly unique impact on program delivery as many nurses were rerouted to prioritize COVID-19 emergency response and may have had less availability for home visiting.
  - Some program staff left their jobs throughout the pandemic to navigate things like the added responsibility of having children without childcare. As a result, programs may experience staffing challenges as they return to full capacity.

- Forty percent of providers reported having a wait list for receiving home visiting services.

- Providers interviewed mentioned gaps in the community related to insufficient availability of mental health services (and in particular substance abuse support), limited housing resources, limited offerings of specialized medical providers, and not enough support for undocumented persons.

- Providers also commonly noted that even when services are available, accessing them remains challenging and that a more robust system is needed. Specifically, they mentioned that:
  - Families have challenges navigating medical services and systems. For certain types of insurance, families may need multiple referrals, then they may encounter out-of-network providers and/or long wait lists to engage in therapy services.
  - There is high need for developmental resources for children, but few resources available.

## PERSPECTIVES ON THE HOME VISITING COLLABORATIVE

- The majority of home visiting providers surveyed (88%) coordinate with other home visiting programs to some extent or as much as possible. Yet, none of the participants mentioned utilizing a shared software system or database to coordinate on referrals.

- Other than referrals for out-of-scope or support services, providers interviewed did not typically mention an extensive relationship with other home visiting programs.
  - Indeed, they mentioned that engagement typically involves incoming, rather than outgoing, referrals.
  - They want to be more engaged with other programs, but they have limited time and restricted funding; They primarily focus on their funder's strict requirements so that they would not risk losing funding due to the timelines of outside services.

- Providers envisioned a coordinated system of care as the importance of fostering and growing partnerships for collaboration. This includes:
  - Families being referred to the right resources
  - Tightening the referral process by having a one-stop-shop
  - Having a continuum where providers could maintain their own programs while focusing on where they can come together, such as establishing a curriculum that is best for all programs and shared strategies within reason.
  - Team building, mentorship, and social connections between programs.

- Seven of the ten parents/caregivers interviewed expressed interest in participating in the Santa Clara Home Visiting Collaborative meetings to contribute a family's perspective to the overall group.
  - Interest in participation included both English and Spanish interviewees, so it may also be important to identify the accessibility of engagement in participants' preferred language.
  - A clear description of responsibilities, expectations, and benefits may be necessary to secure parent/caregiver interest.
  - Parents/Caregivers typically prefer morning meetings over Zoom or within a short distance and noted needing support with childcare.
  - Some expressed that compensation would be helpful if it is available.

## HOME VISITING STAFF QUALIFICATIONS AND RETAINMENT

- In terms of background and education, most providers surveyed want their home visitor to have at least an associate degree (88%) and have knowledge or experience in early childhood education or development (83%); about a quarter do not require experience working with families.

- All interviewed providers reported that their home visitors met or exceeded their program's minimum requirements. Some also mentioned they provide training to home visitors during the onboarding process and make them get certified in assessment tools.

- About half of the providers surveyed (44%) reported one or more vacancies for home visitors. Yet, some interviewees reported no problems hiring or retaining home visitors.

- Challenges varied among those that did report difficulties hiring and/or retaining home visitors, including:
  - Their pay rate does not meet the cost of living in Santa Clara County,
  - Low application rate, and those who do apply might not meet all qualifications
  - Not enough applicants are bilingual
  - Hold ups in the administrative hiring process
  - Needing to adapt and accept work/lived experience in lieu of schooling
  - Needing to pull potential staff from the communities in which they are serving because of shortage

## MATCHING HOME VISITORS TO FAMILIES

- Almost all providers completing the survey (96%) reported matching home visitor's ethnicity with that of the families served to some extent or as much as possible. Most (72%) considered several aspects when matching families to home visitors (e.g., language spoken at home, staff availability). Others (20%) accommodated as many factors as possible while also assigning staff to specific census tracts. A minority (8%) matched home visitors to families based on staff availability.

- Interviewed participants typically reported that their facility employed bi- or multi-lingual staff. Otherwise, providers most commonly utilize the Language Line to support families with languages they were not able to serve directly, so they can serve families in their preferred language to the extent possible.

## STAFF PROFESSIONAL DEVELOPMENT

- Most providers offer professional development opportunities (84%). Most frequently they cover early childhood mental health (86%) and serving children or parents/caregivers with disabilities (81%). About two-thirds (67%) offer professional development on trauma informed practices, and about half (52%) cover maternal mental health.
  - Interviewed providers added that their program included coaching requirements on top of professional development opportunities. Coaching requirements varied by program but typically involved some form of review or one-on-one meetings with managers, performance reviews, weekly supervision hours, and in-depth trainings.

- Interviewees also mentioned some challenges in utilizing the professional development opportunities offered. These include:
  - Needing support or follow-up to trainings to ensure information learned is integrated into practice.
  - Staff not accessing the funds available for professional development due to their workload and/or prioritizing mandatory tasks. Programs appear to be more successful when considering professional development as a part of home visitors' workload and adjusting schedules accordingly, rather than as an additional, voluntary option.
  - Programs may also be successful with professional development when leadership identifies, offers, and supports trainings that are closest to the program scope and/or the specific interests of the staff being trained.

* * *

# FAMILIES' PERSPECTIVE

Ninety-three parents/caregivers responded to an online survey about their home visiting experiences in Santa Clara County.[1] All respondents received a $20 e-gift card and a children's book for participating. Consenting parents/caregivers were also invited to participate in a one-on-one follow-up interview. ASR completed a total of ten follow-up parent/caregiver interviews, six of which were in Spanish and four were conducted in English. The purpose of the follow-up interviews was to gain a deeper understanding of families' experiences with home visiting services and inform FIRST 5 Santa Clara County about other services and resources that families may need. Interview participants received a $50 e-gift card for their participation.

## CHARACTERISTICS OF SURVEY RESPONDENTS

More than half (53%) of the participants were between 30 and 39 years old and about 24% were between 40 and 49. One participant reported they were under the age of 18, and one was 50 or older, and about 15% were between 18 and 29 years of age.

About 88% of participants identified as female. Males represented 3% and the remaining 6% did not provide a response. Slightly less than a quarter of participants (24%) considered themselves to be a single parent/caregiver. Participants were most commonly located in 95116 (15%) and 95127 (11%) zip codes.

Most participants had either one (20%), two (25%) or three (29%) children.[2] Another one-quarter of those providing a response had four or more children. Parents/Caregivers most commonly reported having children between 3-5 years (65%), followed by 0–2-year-olds (44%), 10–14-year-olds (31%), and/or 6–9-year-olds (30%). About 18% had children that were between 15 and 17.

Almost two-thirds of the participants were Hispanic or Latinx (66%), and a14% were Asian or Pacific Islander.[3] About 8% were bi-or multi-racial, and 5% were white. Only 1% identified as Black/African American and 3% reported some other race/ethnicity. Spanish was the most common language spoken at home with primarily Spanish-speaking parents/caregivers representing 45% of participants, followed by 39% who most often spoke English, and 9% who most often spoke Vietnamese, Cantonese, Mandarin, other Chinese language, Hindi, Punjabi, or other South Asian language. Two-thirds (66%) of the parents/caregivers completed the survey in English, while one third (34%) completed the survey in Spanish. Although the survey was offered also in Vietnamese and Traditional Chinese, none had chosen to take the survey in these languages.

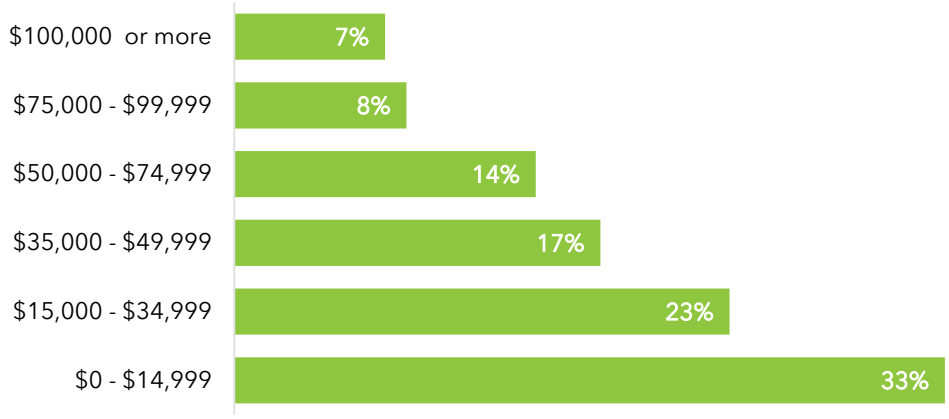
As shown in Figure 1, about a third (31%) of participants that provided education information had less than a high school degree, including those with some or no high school experience. About a quarter had obtained a high school diploma/GED (24%). Over a quarter had some college experience (18%) or obtained an associate-level degree (11%). A minority had a bachelor's degree (14%) or advanced degree (2%).

Figure 1: Parent/Caregiver Education Attainment (n=84)


[1] Includes 85 completed and 8 partially completed (50% or more completed)
[2] Percentages are based on valid responses only. Excludes 17 participants that did not provide a response to avoid overrepresenting those with more than three children.
[3] Asian/Pacific Islander includes Native Hawaiian/Pacific Islander (2%), East Asian (3%), Filipino (3%), Other South East Asian (3%), and South Asian (2%) participants. Excludes those reporting two or more race/ethnicities.

As seen in Figure 2, among the participants that provided income information,[4] almost three-quarters (73%) had an annual family income less than $50,000, including 33% reporting less than $15,000. About 14% had a family income between $50,000 and $74,999, and 15% earned $75,000 or more. Together with the information about the household size we estimate that about 44% of the respondents (who provided income information) live in poverty according to federal criteria.[5]

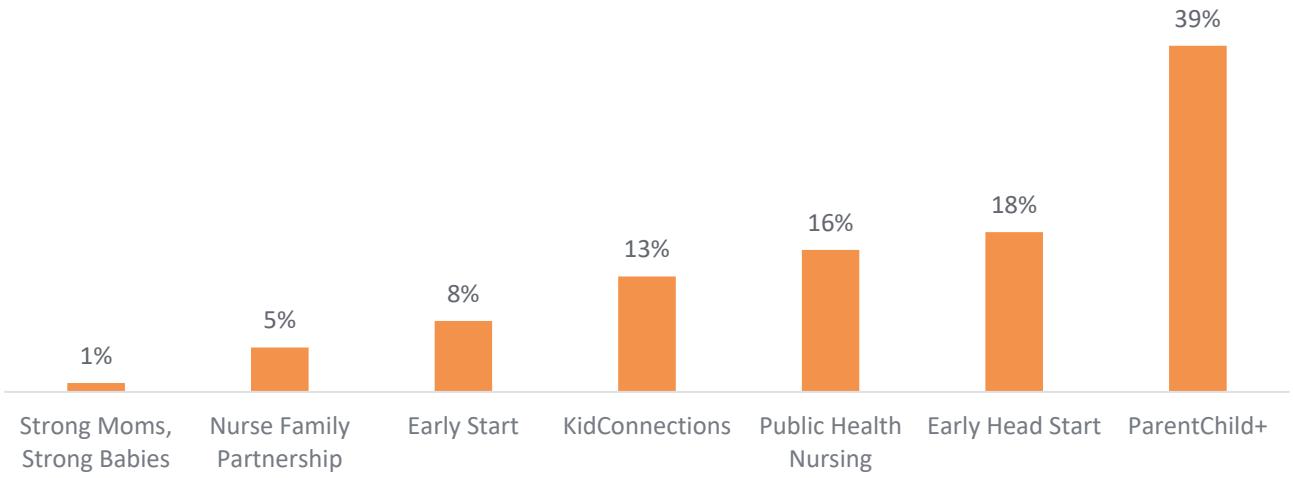
Figure 2: Household Income (n=66)




## HOME VISITING PROGRAM

Family survey participants most frequently participated in ParentChild+ (39%), followed by Early Head Start or Early Start (including programs offered through County Office of Education or San Andreas Regional Center) (26%). Some were engaged with Public Health Nursing program (16%) or KidConnections (13%). A minority also mentioned participating in Nurse Family Partnerships (5%) and Strong Moms, Strong Babies (1%).[6] (See Figure 3).

Figure 3: Programs in which Families Participated (n=84)




[4] N=65, excludes 30% of participants due to non-response (10%), did not know (11%) or preferred not to say (10%).
[5] https://aspe.hhs.gov/poverty-guidelines
[6] Because parents/caregivers were recruited to this study through home visiting providers, the distribution of the programs and the way families heard about the program are influenced by the providers who pushed the survey the most. Therefore, these percentages might not reflect the totality of home visiting participants

More than one-quarter (28%) of participants heard about their home visiting program through a Family Resource Center (FRC). Fourteen percent also learned about home visiting through word of mouth, including family and friends that have participated in the program. Families also learned about home visiting programs through flyers (12%), public health nurses (11%), and pediatricians, hospitals, or other medical specialists (11%). Some families (8%) also learned about home visiting through other programs, such as Bridge to Kinder, CalWORKs, or Parisi House on the Hill. The least common ways that families learned about home visiting services were through preschools (3%), newsletters (2%), or walk-in/self-referral (2%).

**Top 5 Ways Families Learned About Home Visiting Programs**

- ⇨ Family Resource Centers
- ⇨ Word of Mouth
- ⇨ Flyers
- ⇨ Public Health Nurses
- ⇨ Pediatricians/Hospitals

Interview participants often heard about their home visiting program through engagement with another program or event in Santa Clara County, including Somos Mayfair, Cesar Chavez school, Christmas program, FIRST 5 Santa Clara County, or community events, such as an event at the Mexican Heritage Plaza or a City Team Outreach event.

Interviewees were also asked to describe how they view the role of their home visiting program. Common responses related to preparing for preschool or kindergarten, support learning to read, ensure children are meeting their milestones, and work on parent-child interactions. Parents/Caregivers mentioned receiving support, tips, or strategies to facilitate better interactions and support children's learning. Many also mentioned tangible skills they and their child were working on with their home visitor, such as learning colors, numbers/counting, sounds, and vocabulary. Interviewees also mentioned working on socialization and speech as well as other individual and family goals to address basic needs, mental, and physical health.

Parents'/Caregivers' expectations for their home visiting programs ranged from wanting their children to *"enjoy the program and learn new things,"* develop routines and navigate developmental challenges, interact with other children. One parent felt that their expectations were not met, noting that their home visiting program did not provide referrals for their child's speech issues. Instead, they obtained these referrals from their pediatrician and faced challenges due to the timing of the referral and delayed intervention. This parent felt *"left in the limbo."*

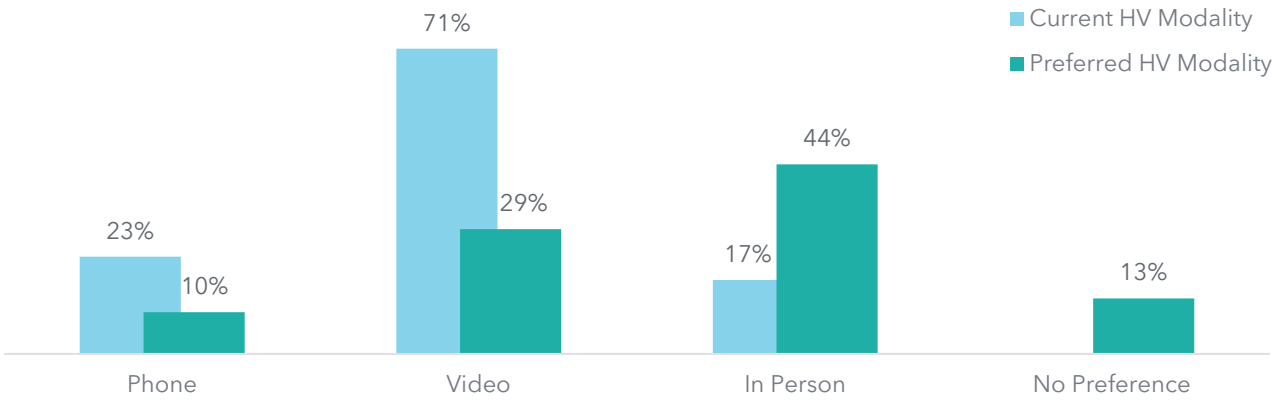
## HOME VISITING MODALITIES

More than a quarter (26%) of participants had been receiving home visiting services for six months or less. Twenty percent have been participating for 7-11 months, and 43% have participated between one and two years. About 6% have participated for three or more years. Seventy-one percent of the families reported their home visiting sessions were more than once per week (40%) or once per week (31%).

Six of the 93 online survey participants did not have access to reliable home internet/devices for home visiting video calls. However, it is important to note that this response may be an underrepresentation as participants completed an online survey and are thus more likely to have reliable internet to participate in this voluntary survey.

Families participating in the survey also described how they are currently receiving services and their preferred method of home visiting services. As see in Figure 4, participants were typically doing home visiting sessions through video calls (e.g., Skype, Zoom) (71%), while 17% were doing in person home visiting. In contrast, almost half of the participants (44%) preferred in-person visits, and 29% preferred video call sessions. Phone calls were least frequently preferred (10%).

Figure 4: Families' Current and Preferred Home Visiting Modality (n=93)




*Note:* Respondents could select multiple "current" modalities, but only one "preferred" modality.

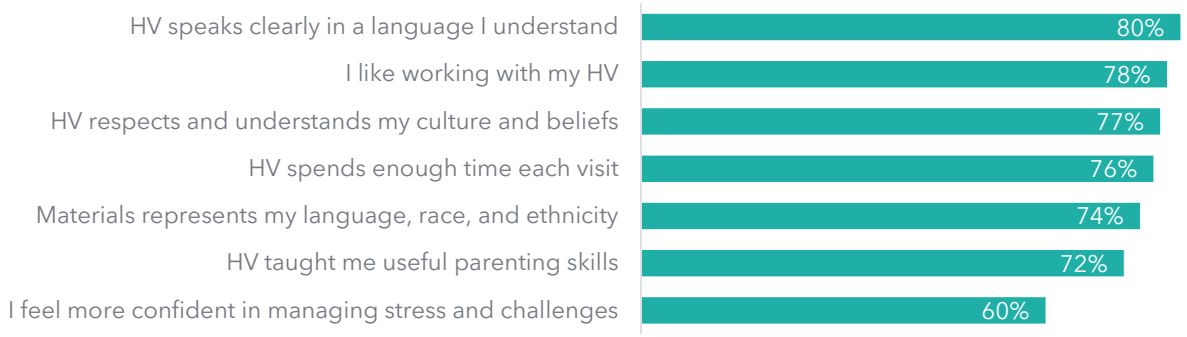
All interviewed participants mentioned that they were currently receiving home visiting through phone or video call (i.e., Zoom). Some started receiving home visiting in-person prior to the COVID-19 pandemic. Each of the interviewed participants reported that they preferred to have home visiting in-person (pending safety precautions).

## PROGRAM IMPRESSIONS AND BENEFITS

The majority of survey respondents highly valued the home visiting program. Specifically, about 90% of participants strongly agreed (78%) or somewhat agreed (12%) that, overall, they were very satisfied with their home visiting program.[7]

Participants also typically agreed with more specific measures (see Figure 5). Eighty percent of participants strongly agreed that their home visitor speaks to them clearly in a language they understand, and 78% strongly agreed that they like working with their home visitor. About 60% strongly agreed that they felt more confident in managing stress and life challenges as a result of home visiting, while another 26% somewhat agreed with this statement.

Figure 5: Families' Assessment of the Program and its Delivery (n=93)




*Note:* Numbers represent percent of respondents who selected "Strongly agree" on a 5 point agreement scale.

All interviewed participants felt their home visitor was a good match. For the Spanish interviewees, the fact that their home visitors were Latinas and spoke Spanish helped with the communication. Participants highlighted

[7] A small number of participants strongly disagreed (4%) with overall and specific measures, yet among them, at least half reported benefitting a lot from the program, suggesting that some of these responses may have been entered in error. Additionally, none of the participants that strongly disagreed responded to survey questions asking for feedback on how the program could be improved.

that their home visitor listened to them and that they felt they were active partners, or a team. The home visitor connected with the parents/caregivers as well as the child. Participants also reported that their home visitor provided resources, cared about their lives on a deeper level, gave the parents/caregivers space to ask questions, and were flexible with the time spent and strategies used.

*"It has helped us (my partner and myself) understand our child's needs when communication is a huge barrier."*

Most survey participants felt that they, **as parents/guardians, benefitted** from the home visiting program a lot (73%) or a moderate amount (14%). Parents/caregivers that benefitted a lot often mentioned that they received helpful resources and tools to help their child, have learned a lot (such as understanding their child's behavior and needs), and have benefitted from the ways that home visiting has helped their child.

One participant that felt they did not benefit at all noted that *"it was over the phone,"* suggesting that this participant may prefer in-person services to feel as though they are benefitting. Another that felt they benefitted a little bit suggested that *"some resources are also provided by my doctors."* Others that benefitted a moderate degree mentioned that they need more time to see the full benefit of the home visiting program, as one parent explained, *"[w]e've only been involved for a short time, but I am eager* to see what the future visits provide for my foster children."

Similarly, most parents/caregivers reported that their **children benefitted** from home visiting a lot (72%) or a moderate amount (13%). The parents/caregivers that felt their child benefitted a lot often expressed that their child has become more social, has learned a lot and/or is more ready for kindergarten, and can manage behaviors more effectively. Several mentioned that their children look forward to sessions with their home visitor and/or gets excited about reading and learning. Parents/Caregivers that reported benefitting a little bit (4%) or a moderate degree indicated that they were "just getting started" or needed "more sessions to see more improvement."

Similar to comments provided in the survey, interviewees often mentioned that as a result of home visiting, their child has become more social, learned numbers, colors, puzzles, and developed a love for learning. Parents/Caregivers have also seen improvements among all members of the family, such as more actively including parents/caregivers and siblings in reading routines/activities and *"helped us to be united."*

*"Le gusta mucho leer y la entusiasma todo"*
*Translation: She likes to read a lot and is excited about everything*

*"She paid a lot of attention to the puzzles, then she started saying words and now she can talk in complete sentences."*

Parents/Caregivers also reported positive outcomes from their home visiting experiences in relation to their own role as parents/caregivers and understanding their child. As one participant described, *"sometimes I am in difficult situations and my son cries a lot and I don't know why. They have a lot of experience with same age kids so our teacher will explain that I don't have to worry, that it's okay."*
Interviewed participants mentioned several ways that the home visiting program met their needs. Some mentioned receiving support with tangible resources, such as diapers, books, and toys. These resources

supported parents/caregivers with financial limitations and provided options to entertain and teach children during the COVID-19 pandemic, with one parent noting *"instead of watching TV, we practiced and played…."* Several parents/caregivers mentioned that they liked their home visiting program's flexibility with time and days of meetings, *"no worries about driving or taking him some place, they will come to me,"* as well as the flexibility in transitioning to Zoom during COVID for added safety. One participant also mentioned the benefit of being able to participate in a program that would otherwise be so expensive, and others received emotional and mental health support.

The home visiting programs supported families' social development during COVID-19. The fact that the program was cultural and linguistically appropriate helped parents/caregivers connect with the home visitors.

## OPPORTUNITIES FOR IMPROVEMENT

Interviewed parents'/caregivers' suggestions for improvements often included shortcomings related to the COVID-19 pandemic. One participant mentioned challenges with home visiting via Zoom but acknowledged that they understand they cannot currently do in-person visits. Another mentioned that they do not have the same connection with their home visitor through Zoom as they did with the home visitor they saw in person.

Some parents/caregivers mentioned opportunities for improvements related to the overall structure of home visiting. One mentioned they would like the program to focus on familiarity with the toys and materials children will be using in preschool. Another participant stated that they would prefer *"group visits instead of one-on-one, so they can socialize and share the toys."* One parent suggested that the program should last until the child is ready to go to preschool and another would like to see the age requirement expanded.

Lastly, one participant noted that *"the program is focused on the child not on the parents. The program needs to plant a seed on the parents to continue the process."* This parent suggested that parents/caregivers need more guidance and feedback through the process to aid in their confidence and ability to carry on their role outside of home visiting. One parent also noted that their FIRST 5 home visiting program evaluated their child but did not provide referrals and that they had issues with receiving a timely diagnosis.

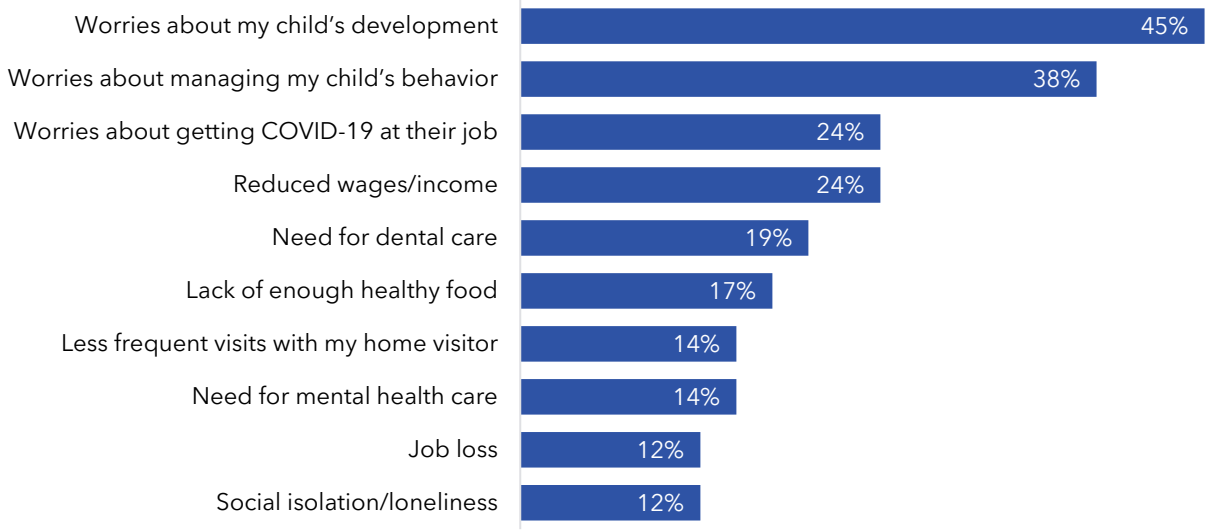
About half of the interviewed participants did not experience any difficulties or obstacles accessing the program, although one had to wait around three to four months because their child did not meet the age requirement for participation. Another parent mentioned calling several times and had to keep trying as it was unclear if their child could be accepted due to their age.

Four interviewed parents/caregivers experienced difficulties with the transition to Zoom due to the COVID-19 pandemic, although one noted that their FIRST 5 home visitor had the empathy to understand their child's unique needs and did not require the child to look at the camera. This parent's challenges appear to be challenges related to their child's development and diagnoses, but it may be possible that their experiences would be differently managed if home visiting sessions were in-person instead of virtual.

# FAMILY NEEDS AND SERVICE GAPS

About half of survey respondents reported that they experienced challenges or issues within the past 30 days. As shown in Figure 6, of those parents/caregivers who expressed worries and challenges, many reported worrying about their child's development (45%), followed by worries about managing their child's behavior (38%). A quarter of those who expressed concerns worried about a family member getting COVID-19 at their job and/or reduced wages/income. Participants were least likely to have experienced personal/family violence, loss of life or illness due to COVID-19, loss of health insurance, or loss of childcare in the past 30 days. The number of challenges and needs indicated positively correlated with the number of children in the family: Parents/Caregivers who take care of more children also experienced more challenges.

Figure 6: Top Ten Family Needs in the Past 30 Days (n=42)




*Note:* Numbers represent percent of respondents who selected each need. Multiple selections were possible.

Interview participants provided more insight into their most pressing needs. For instance, one parent noted that they got sick, separated from their spouse, and lost their job due to the pandemic and considers *"having a place to live and food to eat" to* be their most pressing needs. Another parent was actively seeking mental health support for all members of their family, but having a hard time connecting with providers, and one parent considered their most pressing need to be their child's speech, as their therapy is coming to an end but the child is not yet talking.

Three parents/caregivers mentioned schooling related needs, including difficulty enrolling their child in schools due to capacity, needing information about schooling, or support with back-to-school supplies and school uniforms.

Two interview participants noted that they did not have any urgent or pressing needs, although one mentioned that they have fewer social opportunities due to the pandemic but did not need assistance. The other lost work and had had difficulty paying rent due to the pandemic but no longer has these concerns.

Similarly, parents/caregivers experienced varying degrees of economic/financial impacts related to the pandemic. For instance, one parent reported they were able to adapt their expenses through the process of their husband losing two jobs, while another reported *"drastic economic changes."* In particular, their entire family got COVID-19, and they now have a lot of bills and many accounts in collection. Several interviewees mentioned going to food banks and other places for fruits and vegetables and signing up to the diaper program. Another parent mentioned that they receive food stamps but still need help paying rent.

It is important to note that some Spanish interviewees expressed misconceptions related to social security numbers and rent relief programs that might prevent them from applying. Most Spanish interviewees that expressed financial impacts did not receive rent relief or county support, even when they were infected with

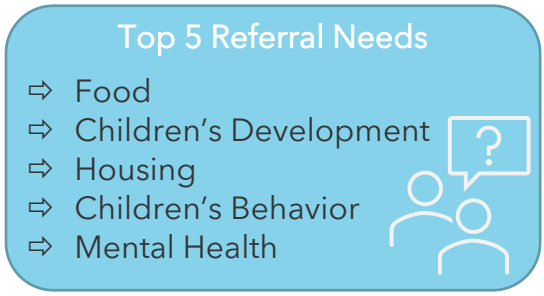
COVID-19. On the other hand, most did have access to diapers, food, gift cards for Christmas, and the Backpack Program.

Several interviewees talked a lot about their struggle trying to find services for their children with learning disabilities, speech challenges, or those diagnosed with autism. Participants noted difficulties accessing services and navigating the system, even after receiving a referral. For instance, appointments take a long time (e.g., six months for speech therapy), they can't find the services needed, and/or the schools are not doing enough.

Another common theme was the need for mental health support for themselves and for the entire family. Depression and anxiety continue to impact adults and children. One parent reported needing money for basic needs and mental health support for their children, noting that their three-year-old suffers from anxiety. Another wanted the County to offer classes for parents/caregivers to learn how to talk to their pre-teen children, while others generally mentioned needs related to finding therapists/psychologists for themselves and their children.

## REFERRALS

Slightly more than half (53%) of the survey participants were referred by their home visitor to services at other agencies. Among them, the most common needs for which families received referrals included food (61%), concerns about children's development (41%), housing (35%), and managing children's behavior (31%).




A small portion of participants receiving referrals were referred to mental health services (16%), medical (14%), dental (12%), family violence (10%), or employment needs (6%). About 10% were referred to other services including school/pre-kindergarten/daycare, social-emotional support systems, or where and when to get a COVID vaccine.

Almost three-quarters of the participants receiving referrals to outside services (75%) reported additional help from their home visitor (e.g., their home visitor called on their behalf, went with them).

About one in five (18%) survey respondents reported difficulties connecting to outside services. These participants were most likely on a waiting list (i.e., Head Start, housing support) or were not eligible for the services for which they were referred. For instance, one Spanish respondent mentioned that they could not qualify for mental health services as a parent without a family plan and that their four-year-old child was not age qualified for services as plans only covered 0-3 or 5-17 age groups. Another respondent also mentioned that *"it is super hard and a long process to start ABA"* or Applied Behavior Analysis.

Similar survey respondents, interviewees reported that their home visitor provided referrals and helped them connect with outside services. Most received information regarding general resources such as food and diapers but were less likely to receive support about County Rent Relief Program, when needed.

The majority mentioned that the home visitor provided resources by sending group mails and informing them about community outreach events. Some mentioned receiving Christmas cards and toys. One person indicated that the home visitor was available to help with writing letters if needed. Home visitors also helped parents/caregivers identify a good quality preschool for their child and/or volunteer opportunities for their teenage children.

Despite the many benefits and support that the home visitors provide to their engaged families, there may be remaining gaps between their referrals/information and the ability for families to receive tangible support from outside resources in the community. While some of the participants noted having few needs outside of the educational and parenting support that home visiting provides, others were experiencing several compounding needs which may be more challenging for home visitors to support more directly.

## PARTICIPATION IN THE HOME VISITING COLLABORATIVE

Seven of the ten interviewed participants expressed interest in participating in the Santa Clara County Home Visiting Collaborative meetings to contribute a family's perspective to the overall group. Some participants were not able to clearly identify what support they would need to be able to attend. However, parents/caregivers typically noted that mornings would be best for their schedule, as well as support with childcare. One participant noted that Zoom meetings would be best, and another mentioned requiring a travel distance of no more than five miles. Monetary compensation was not a key factor mentioned but some expressed that compensation would be helpful if it is available. One parent mentioned that a $20-25 gift card for each session would be reasonable compensation.

A clear description of responsibilities, expectations, and benefits may be necessary to secure parent/caregiver interest in the collaborative meetings, but most parents/caregivers were interested in learning more. One participant that was not interested noted that it was because they were expecting to move out of the area. Interest in participation included both English and Spanish interviewees, so it may also be important to identify the accessibility of engagement in participants' preferred language.


* * *

# PROVIDERS' PERSPECTIVE

A total of 27[8] home visiting program supervisors completed an online survey about their home visiting model, characteristics of home visitors and families served, intake, assessment, and referral procedures, and data collection. Participants' roles included facility owner, executive/program directors, supervisors, and managers, speech therapists or speech language pathologists (SLPs), nurse managers, home visitors, clinical coordinators, and case managers.

Additionally, survey participants were invited to participate in a one-on-one follow-up interview. ASR completed a total of eight follow-up interviews. Participants provided more in-depth view on the topics discussed in the survey related to their home visiting model, outcomes, processes, family recruitment, staffing or capacity issues, funding, and their vision for a collaborative network in Santa Clara County.

## HOME VISITING MODEL

Survey respondents utilized a range of home visiting models within their agency. Several programs reported using Early Head Start (EHS)- Home Based Option (28%) as well as other Early Start, Early Intervention, and EI/SLP Services (16%). Parents as Teachers (PAT) (12%) and Strong Moms, Strong Babies (SMSB) (8%) were also mentioned by multiple providers. Five providers noted that their programs used two or more home visiting models, and three mentioned they do not use a specific home visiting model.

Interviewed providers described the desired outcomes of their home visiting program. Providers typically tailored program expectations to the needs of the family, with a focus on strengthening the parent-child relationship and getting children ready for school. Some providers mentioned focusing on children's developmental or emotional progress.

Nearly all (96%) providers targeted families with children aged 0 to 24 months, families with children between two and three years, and families with children who have a developmental delays or disabilities. Slightly more than half (58%) of the providers targeted low socioeconomic status families and 42% targeted families with children between the ages of 4 and 5, families with a history of domestic violence, and families with a history of substance abuse.

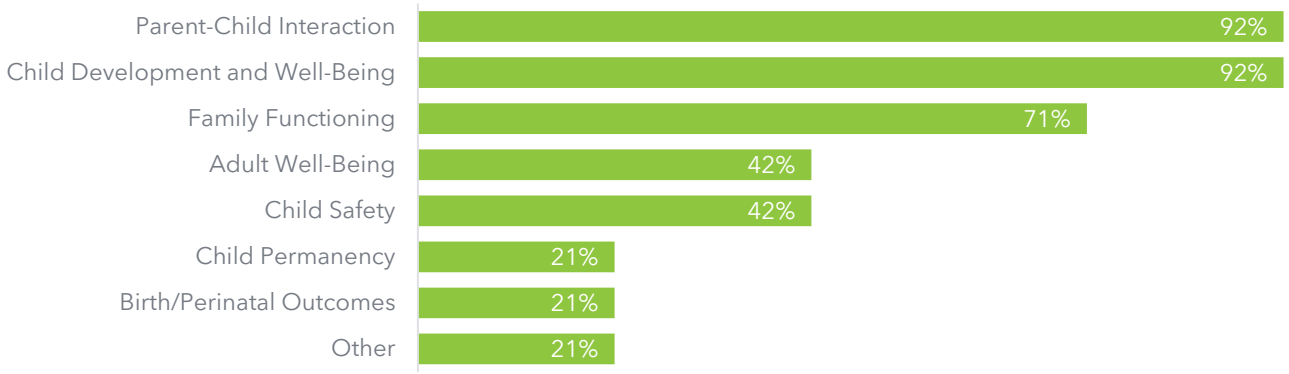
As see in Figure 7, the vast majority of provider survey respondents targeted parent-child interactions (92%) and child development and well-being (92%). Over two-thirds (71%) of the providers also targeted the family functioning domain. About one in five participating providers targeted Child permanency and birth/perinatal outcomes (22%). Other domains reported (22%) ranged from speech and language development and social development/behaviors to parent-to-parent support, mentoring, and coaching.

**Top 3 Family Types Targeted by Home Visiting Programs**

- ⇨ Children 0 to 24 months
- ⇨ Children 2 to 3 years
- ⇨ Children with disability or developmental delays

[8] Twenty four providers completed the survey, and 3 responded to about two thirds of the survey.

Figure 7: Targeted Domains of Home Visiting Programs (N=23)




*Note:* Numbers represent percent of respondents who selected each domain. Multiple selections were possible.

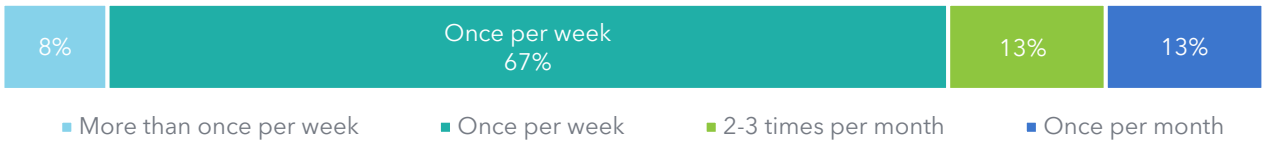
In terms of populations targeted, fewer than ten of the participating providers focus on families with a history of child maltreatment (38%), teen moms (29%), incarcerated parents (25%), school-aged children (25%), or pregnant women (17%). About one in five programs targeted families from a certain ethnic group, including Latinx, Asian, Native American, and other populations. One provider mentioned that their home visiting program targets a specific population with developmental needs related to children that are visually impaired, blind, and risk factors for neurological visual impairment.

## HOME VISITING SESSIONS

In the past 12 months, participants typically conducted home visiting sessions via video calls (92%) and/or by phone (88%). Slightly more than half of participating providers held in-person home visits in the past 12 months. The proportion of providers utilizing in-person home visits may include those that recently resumed in-person home visiting, as well as providers that met families in person at an office, park, or other location. Providers reported the length of time families stay in the program with averages ranging between three and 36 months. Among all responding providers, the average length of stay for families is about 16.5 months. Slightly more than two-thirds (68%) of programs' families typically stay in their home visiting program between 12 and 24 months. Another 23% of programs serve families for less than 12 months, on average, and 9% of programs serve families for more than two years.

As seen in Figure 8, home visiting sessions were typically once per week (67%). About 8% of participants met with families more than once per week, while more than a quarter (26%) met less than once a week.

Figure 8: Frequency of Home Visiting Service (n=24)




A majority of participants (76%) reported that their home visits typically last about 60 minutes. About 12% of providers typically held 90-minute visits. Four out of the 25 participants (16%) offered incentives or stipends to families to complete the program. Reported incentives included age appropriate developmental/education resources or activities targeting developmental milestones, a weekly gift of a book or educational toy, or gift cards.

## HOME VISITING STAFF, TRAINING, AND ASSIGNMENT

As see in Figure 9, the majority of provider respondents typically require home visitors to have a bachelor's or graduate degree. Another 4% required an associate degree. Among those that required an associate, bachelor's, or graduate degree, 83% prefer home visitors with an Early Childhood Education area of study. Fifty-seven percent prefer home visitors with an area of study in Special Education. About one-quarter (26%) prefer some other area of study, including Speech Language Pathology, credentials in teaching children with visual impairments, occupational therapy, and/or physical therapy. The two participants (8%) that require a high school diploma or no educational requirements expect their home visitors to have previous knowledge of child development.

About a quarter of all participants did not require home visitors to have any previous experience working with families, while about 40% require one to two years of experience. Another 20% require five or more years of experience, which may highlight some of the providers that target specialized care by licensed therapists or other advanced professionals.

Figure 9: Home Visitor Requirements

| | N (%) |
|---|---|
| **Education Requirements(n=25)** | |
| High school diploma | 1 (4%) |
| Associate Degree | 1 (4%) |
| Bachelor's Degree | 14 (56%) |
| Graduate level Degree | 8 (32%) |
| No Education Requirements | 1 (4%) |
| **Preferred Areas of Study(n=23)[a]** | |
| Early Childhood Education | 19 (83%) |
| Special Education | 13 (57%) |
| Psychology | 8 (35%) |
| Social Work | 7 (30%) |
| Nursing | 3 (13%) |
| Other | 6 (26%) |
| **Years of Experience Required(n=25)** | |
| 1-2 years | 10 (40%) |
| 3-4 years | 2 (8%) |
| 5 or more years | 5 (20%) |
| No experience required | 6 (24%) |

[a] Among those requiring at least an associate degree

Two of the interviewees that require a bachelor's degree noted that their organization also considers lived experience, professional goals related to the population served, and/or personality fit. At least three other interviewees (excluding those with licensed professional requirements) held other experience requirements, such as experience working with a 0-5 population and/or children with developmental delays.

*"When you have flexibility and a diverse [staff], you have a richer home visiting program"*

All interviewed providers reported that their home visitors met or exceeded their program's minimum requirements, and some also mentioned the training home visitors receive during the onboarding process and getting certified in assessment tools. Several interviewees also mentioned their home visitors were bilingual and/or bicultural. As one participant described, *"my staff are brilliant, bilingual, bicultural, and they are wanting to go into our world."*

Home visitors typically earned less than $60,000 a year (68%). In particular, 32% of providers reported a salary range of home visitors between $30,000 and $44,999 and 36% had a salary range of $45,000 to $59,999 for home visitors. About a quarter (23%) reported that their home visitors earn $75,000 or more annually. This may highlight some of the providers whose visitors are also licensed therapists and/or have advanced credentials/training.

Slightly less than half (45%) of the providers reported their home visitors typically stay in their role for five or more years. About one-third (32%) of providers' home visitors stay in their role for three to four years and only a minority stay for one to two year (5%). Other providers reported that their program has only been in operation for two years, or that their home visiting staff varies in tenure, or that they are self-employed contractor(s). About half of the providers completing a survey had one or more vacancies for home visitors.


Half (50%) of the interview participants reported no problems hiring or retaining home visitors. Among them, two providers noted that their programs did not have issues with hiring home visitors due to the reputation of their based model and/or specific "in-house" characteristics that attracted staff coming from in-home roles as they did not want to be on the road so frequently.

Challenges varied among those that did report difficulties hiring and/or retaining home visitors. One participant noted that their pay rate does not meet the cost of living in Santa Clara County, suggesting that this challenge requires a systems change that affects more than their program.

*"…our rate does not meet cost of living in our area, so we are always on the verge of losing people because we cannot pay them enough to … retain them."*

Another mentioned challenges "to get people to even apply," and adapted to these challenges by accepting work/lived experience in lieu of schooling and pulling potential staff from the communities in which they are serving. Program specific challenges include things like finding staff that meet all qualifications and are bilingual or hold ups in the administrative hiring process. Other reasons staff have left their home visiting role ranged from moving out of the area, burn out, and/or expanding their education.

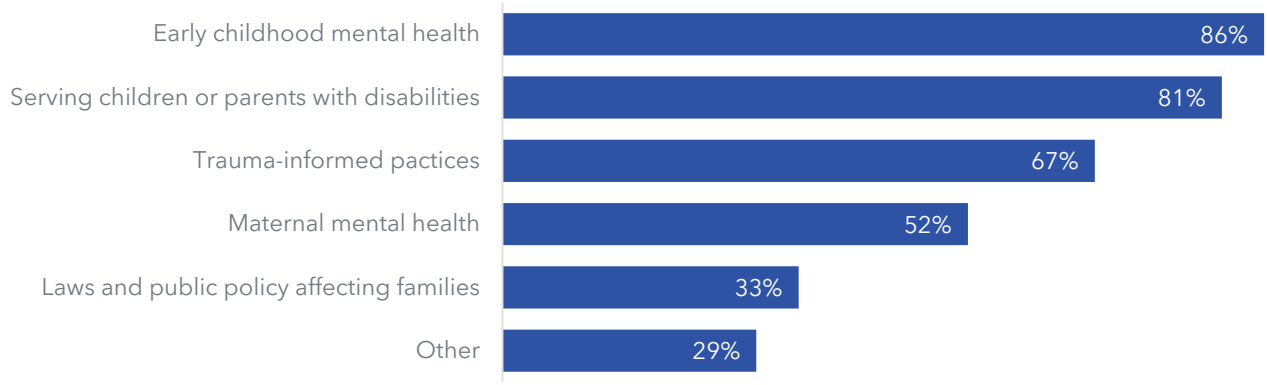
## PROFESSIONAL DEVELOPMENT

Many provider survey respondents (84%) reported that they offered professional development opportunities for home visitors. One respondent did not offer professional development but was interested, one did not offer professional development, and two providers did not respond.

Among those offering professional development opportunities, providers most frequently covered early childhood mental health (86%) and serving children or parents/caregivers with disabilities (81%). About two-thirds (67%) offer professional development on trauma informed practices, and about half (52%) cover maternal mental health (see Figure 10). One-third (33%) offer professional development opportunities addressing laws and public policies that affect the families they serve. Other opportunities include assessment, diagnoses, accommodations, and interventions specific to the populations served, parent/caregiver coaching,

cultural competence, applied behavior analysis, and credits that individual staff members can use to select courses related to their work.

Figure 10: Professional Development Topics (n=21)




*Note:* Numbers represent percent of respondents who selected each topic. Multiple selections were possible.

Interviewed providers agreed that their program included **coaching requirements** and professional development opportunities. Coaching requirements varied by program but typically involved some form of review or one-on-one meetings with managers, performance reviews, weekly supervision hours, and in-depth trainings. Professional development within home visiting programs ranged from required certifications to voluntary virtual training opportunities offered through the County.

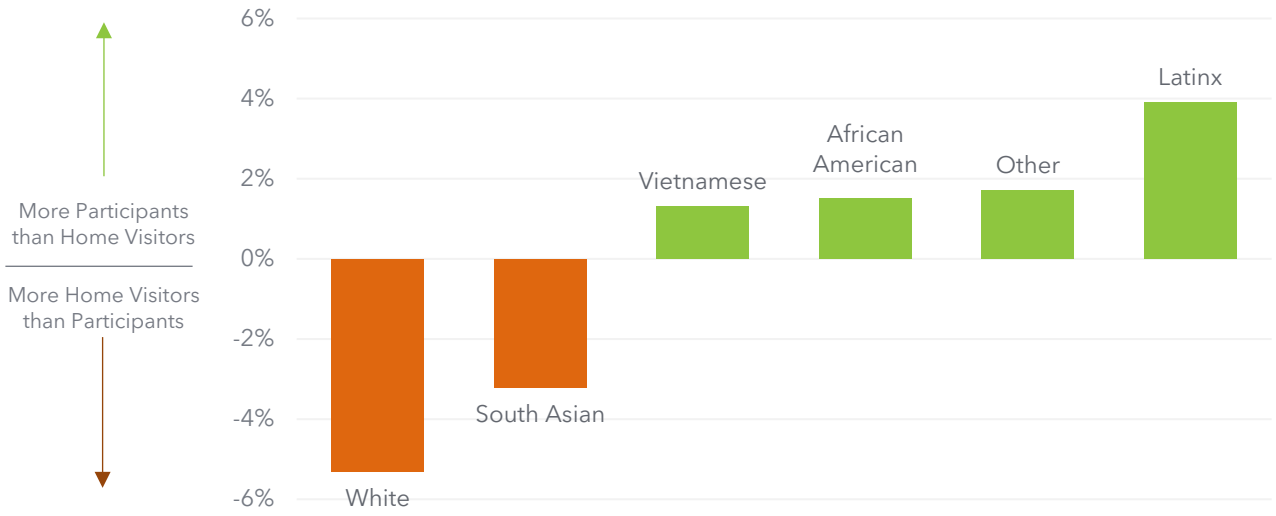
Providers described **barriers or needs related to their home visitors' professional development**. For instance, one provider mentioned that integration is a challenge – particularly needing support or follow-up to trainings to ensure information learned is integrated into practice. Another facility's professional development practices included allocated funds for training opportunities, but this provider mentioned a trend of staff not utilizing these funds. Several staff felt overwhelmed, burnt out, or anxious and struggled with accessing training due to workload and/or prioritizing mandatory tasks. Programs appear to be more successful when considering professional development as a part of home visitors' workload and adjusting schedules accordingly, rather than as an additional, voluntary option. Programs may also be successful with professional development when leadership identifies, offers, and supports trainings that are closest to the program scope and/or the specific interests of the staff being trained.

## MATCHING FAMILIES TO HOME VISITORS

Almost all providers completing the survey (96%) reported matching home visitor's ethnicity with that of the families served to some extent or as much as possible. Most (72%) considered several aspects when matching families to home visitors (e.g., language spoken at home, staff availability). Others (20%) accommodated as many factors as possible while also assigning staff to specific census tracts. A minority (8%) matched home visitors to families based on staff availability (including one of which that reported they were the only home visitor).

As seen in Figure 11, on average, White and South Asian home visitors outnumbered home visiting participants, while participants were more likely to be Vietnamese, African American, Latinx, or some other ethnicity, compared to home visitors. In particular, the proportion of white home visiting clients is about five percentage points lower, on average, than the white home visitors. Similarly, the proportion of South Asian home visiting clients is about three percentage points lower than the proportion of home visitors. On the other hand, clients were more likely to be Latinx than home visitors, with an average difference of about 4% percentage points more Latinx home visiting participants than Latinx home visitors. The proportion of Vietnamese, African American, and other home visiting participants were also slightly higher, on average, than home visitors of the same race/ethnicity.

Figure 11: Percentage Point Difference between Family's Ethnicity and Home Visitor's Ethnicity

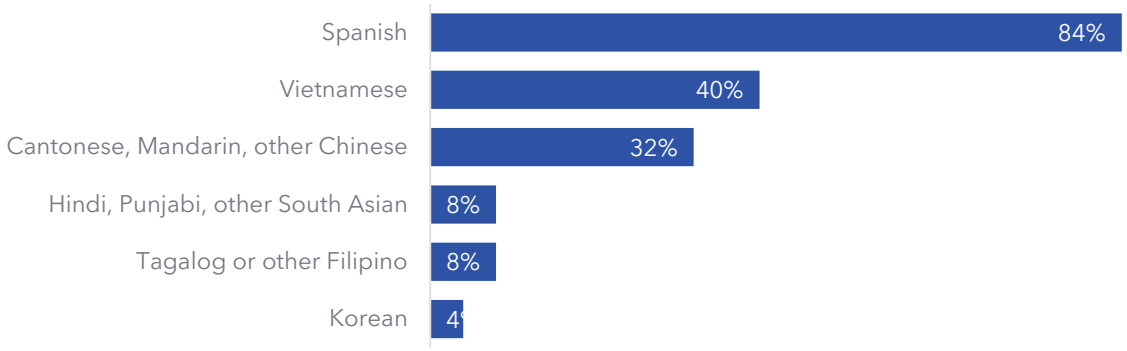



*Note:* Negative numbers represent more home visitors than participants, while positive numbers represent more participants/clients of a given race/ethnicity.

The majority of providers that responded to the survey reported offering services in Spanish (84%). Forty percent also provided home visiting services in Vietnamese, and about one-third (32%) offered services in Cantonese, Mandarin, or another Chinese language (see Figure 12). South Asian and Filipino languages were least commonly supported by home visiting programs. American Sign Language was also mentioned by one provider.

Figure 12: Additional Languages in which Services are Offered (n=25)

Similarly, providers completing the survey were asked how they serve families when staff does not speak the




*Note:* Numbers represent percent of respondents who selected each language offerd. Multiple selections were possible.

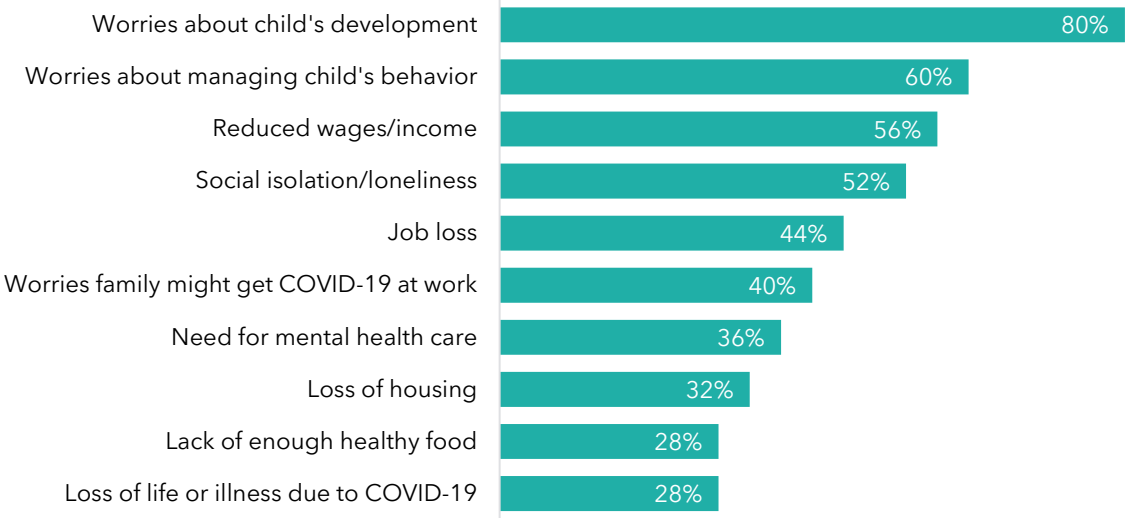
family's language. In addition to offering bi- or multi-lingual services, about 65% of responding providers mentioned using interpreters, translators or the Language Lines offered by insurance providers or the county. Two providers mentioned that they would not serve these families, either placing them on a wait list, serve them in English (if possible), or refer the family back out to other services that can support them. Another mentioned focusing on cross-cultural universals using pictures, signs, or other alternative means. Lastly, one provider mentioned that they have not encountered an inability to serve families due to language as *"they have always been fluent enough in English, or at least one of the parents has…."*

Interviewed participants typically reported that their facility employed bi- or multi-lingual staff. Otherwise, providers most commonly mentioned utilizing the Language Line to support families with languages they were not able to serve directly. One provider noted that potential home visitors go through a rigorous bilingual assessment during the interview process to ensure those hired are the most capable serving families with limited English proficiency. Another provider noted that they *"did their best"* to support the most common languages in Santa Clara County, but recognized that language is difficult to comprehensively address, noting that they have heard estimates of over 40 languages spoken in Santa Clara.

## NEEDS OF FAMILIES

Providers participating in the survey reported what they saw as the most pressing needs of families in the past 30 days. Eighty percent of providers viewed worries about their child's development to be the most pressing need, followed by worries about managing their child's behavior (60%). More than half of the providers also reported reduced wages/income (56%) and/or social isolation/loneliness (52%) as a pressing need. Loss of childcare (24%), a need for medical care (20%), domestic violence (20%), loss of health insurance (12%), community violence (8%), and a need for dental care (4%) were the least commonly reported pressing needs of families, according to provider participants. (See Figure 13.)

Figure 13: Pressing Needs of Families, According to Providers (n=25)



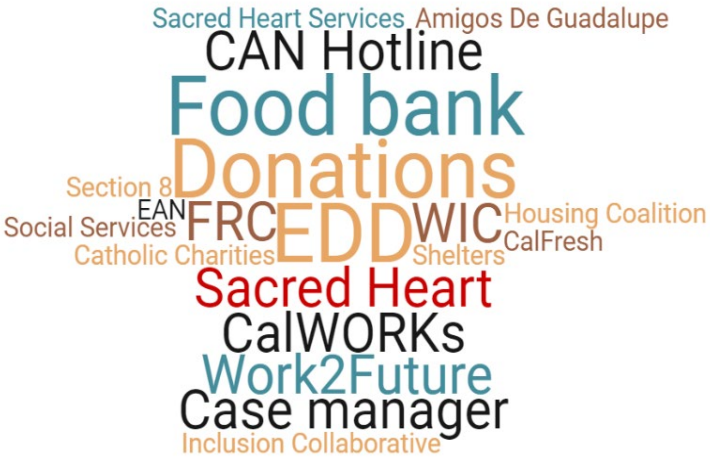

*Note:* Numbers represent percent of providers who selected each family need. Multiple selections were possible.

Providers referred families to various resources depending on the needs identified. Providers often handled families that worried about their child's development and/or managing their child's behavior internally. Families with concerns about their child's development/behavior would often receive support within the agency, as one respondent described, *"I evaluate the child's progress and offer services as appropriate."* Developmental and behavioral concerns were also referred to therapists (either within or outside the responding organization), case managers, or Early Start or school districts *"depending on the age."* (See figure 14.)

Figure 14: Where Providers Refer Families for Developmental/Behavioral Needs

Providers also expressed a large portion of their families had pressing concerns related to basic needs, such as reduced wages/income, job loss, loss of housing, or lack of enough healthy food. In these cases, providers often referred families to community resources such as food banks, social services, CalWORKs, and other donation resources such as funds provided by Uplift, agency donated gift cards, and donation closets for clothing and hygiene products. (See Figure 15.)

Figure 15: Where Providers Refer Families for Basic Needs

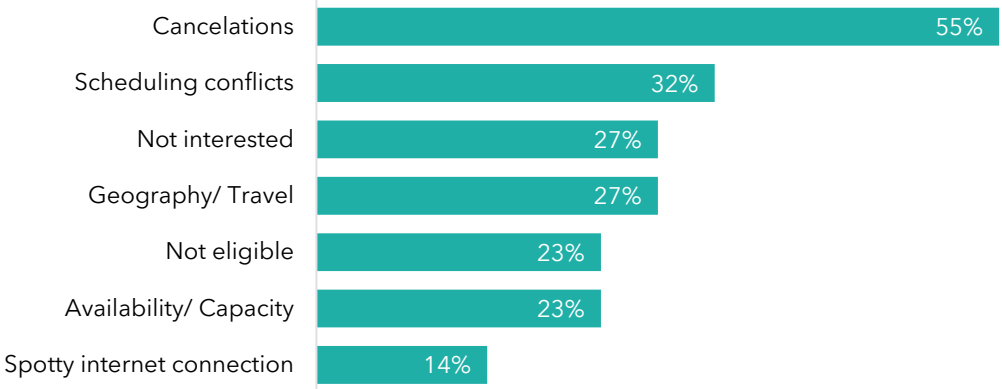



Providers typically referred families with concerns related to COVID-19 (i.e., loss of life or illness or worries a family might get COVID at their job) to the CDC website, the Santa Clara County Public Health Department, or 2-1-1 for general information. Families were also referred to COVID testing sites or medical providers to address concerns related to COVID-19 status or treatment. Those experiencing loss related to COVID were referred to grief support groups, such as the Centre for Living with Dying or NAMI Santa Clara, and grant programs that help cover funeral expenses related to COVID.

## BARRIERS TO PARTICIPATION

Among the providers describing families' barriers to home visiting services, cancelations (55%) and schedule conflicts (32%) were most commonly reported (see Figure 16). About a quarter (27%) of providers also described families not interested in home visiting and geographical reasons (such as time needed to travel to homes) as barriers to providing services. Another quarter of providers (23%) reported that eligibility for services is a participation barrier as well as capacity issues (not enough available slots to serve families.) A small portion of providers (14%) reported that the families they serve face barriers related to internet connection for virtual home visiting.

Figure 16: Barriers to Home Visiting Services (n=22)




*Note:* Numbers represent percent of providers who selected each barrier. Multiple selections were possible.

Provider survey respondents also reported other barriers such as families with shared or challenging/unstable housing situations, limited outreach to underserved communities, and organizational regulations that are not flexible to meet family needs. Additionally, some providers mentioned that families face barriers to home visiting when they do not understand the purpose, or when the referring agency does not appropriately explain the reason for referral, *"so when home visitors call, family is confused."*

Interviewees reiterated the challenge families faced in maintaining appointments, particularly for those that work multiple jobs and cannot find time for home visiting. One program's model required twice-weekly visits for two years, a commitment that is often a challenge for families to fit within their routines, especially when they have multiple children. Household type was another reported barrier. For some families, sharing a living space with other families make in-home visits more challenging. Similarly, one provider noted that some families may frequently move between homes and/or face embarrassment about their circumstances.

*"We got families that live in a house and another family live in the garage or another family live upstairs—those types of situations are hard."*

Additionally, barriers for some families relate to needs that are more pressing for them than the curriculum of home visiting services. For families facing issues related to meeting their basic needs (e.g., housing/homelessness, food insecurity, loss of work), staying engaged in a home visiting program may be a challenge.

On top of these multitude of barriers, the emergence of the pandemic added another layer of challenges. Indeed, the COVID-19 pandemic was primarily cited by interviewees as the source of barriers impacting program delivery and participation. In particular, the situation for families who often had complex needs was exacerbated by the pandemic. Yet some providers reported that referrals drastically decreased with fewer families engaging with their primary referral sources during the shelter in place orders. Providers also noted challenges engaging families due to the transition to virtual services, such as fewer opportunities for outreach/interactions with potential clients or clients' access to technology. One participant noted that at the start of the pandemic, they had to work to ensure each family had more than just a phone for getting services, such as internet connection/hot spots and/or a tablet or computer.

*"We were down to like 15 referrals during COVID and it was really difficult reconnecting with our partners…"*

Other barriers reported included Zoom burnout as well as the *"fear of potential exposure to COVID-19"* during face-to-face sessions. This dichotomy further highlights the double-barreled impact of COVID-19, with families facing barriers to both virtual and in-person services as our communities continue to navigate the uncertainties and challenges of the pandemic.

For providers in medical-based facilities, the pandemic has had a particularly unique impact on program delivery as many nurses were rerouted to prioritize COVID-19 emergency response and may have had less availability for home visiting. Even as vaccines become more available and facilities begin adapting new ways to return to in-person services, the pandemic continues to have a lasting impact on providers and families.

*"People are fearful, but the need was still there."*

When asked if they expect lingering impacts of the pandemic as we continue to collectively "recover," interviewed providers commonly mentioned being generally uncertain about the return to normalcy in the next few months. As one provider described, *"there are just tricky things … on how to handle coming back."* For instance, providers mentioned growing concerns about emerging variants and additional surges, challenges with misinformation and fear, low vaccination rates, and overall lingering impacts at the community, state, and national level. Parents and caregivers remain concerned about in-person visits or schooling, as one provider mentioned *"even now that we are vaccinated, families sometimes don't want us in their homes."* This participant also mentioned that they are noticing caregivers have concern about having their children in pre-school face-to-face.

*"The unknowns have huge impacts on our families, especially when it comes to their jobs and livelihood."*

Another interview participant also described that they see huge lingering impacts for program delivery and overall impacts on families. For instance, participating families were already not stable before the pandemic and experienced exacerbated impacts on things like basic necessities. While the general population may feel that it is moving back to "normalcy," all families are not having the same experience. Additionally, program staff were not immune to the impacts of COVID, some of which left their jobs throughout the pandemic to navigate things like the added responsibility of having children without childcare or schools to go to during the day. As a result, programs may experience staffing challenges as they return to full capacity.

## PROGRAMS CAPACITY AND SERVICE GAPS

In total, two programs reported that they were not currently able to serve all eligible families referred to them in a timely manner.
Half[9] of the providers reported on the number of children they are funded to serve and the number of children they are currently serving. Those who provided responses to these questions noted that they were funded to serve up to 1,800 children in Santa Clara County. Among them, programs were typically serving at or below their funded capacity. Programs serving less than funded to support may be experiencing the continued impacts from the pandemic. Conversely, many providers (40%) reported having a wait list for home visiting services.

**40%**
**of providers reported having a wait list for home visiting**

Consideration of challenges related to home visiting service delivery, enrollment, and engagement also raises the question of other service barriers that families and providers face. These barriers refer to the services that are needed in the community but are not offered or difficult to access.
Providers mentioned gaps in the community related to insufficient availability of mental health services (and in particular substance abuse support), limited housing resources, limited offerings of specialized medical providers, and not enough support for undocumented persons. Providers also commonly noted that even when services are available, accessing them remains challenging.
Families faced barriers navigating medical services and systems. For certain types of insurance, families may need multiple referrals for things like applied behavior analysis (ABA) therapy, then they may encounter out-of-network providers and/or long wait lists to engage in therapy services. Children in need of developmental resources also face long wait lists, have challenges getting deemed eligible for services, and/or have issues related to the cost of or access to available resources. As one provider described, there is a high need for developmental resources for children, but few resources available. Similarly, one participant mentioned that specialized services, such as resources for children with specific hearing or visual deficits, is a particular challenge. The community resources that could support these families with specialized needs are often full and limited.

Another provider mentioned that helping undocumented families access mental health services is a particular challenge as they do not have insurance, cannot pay out of pocket, and programs designed to provide free support *"ran out of funds, and they have been unable to support us."* Additionally, one participant described a specialized need for supporting pregnant women with substance abuse/addiction issues. This provider expressed that a more robust system is needed, stating *"we have several agencies like transitional housing, but it's always challenging."*
One provider noted that in Santa Clara County, and in the Bay Area more generally, affordable housing is an increasing challenge for families. Participants struggle with basic needs such as food, rent support, utility bills, and more. As mentioned above, another

[9] N = 13 (52%). 12 participants did not provide a response

provider described ways that even accessing services that are available can be a particular challenge for families. This provider noted that being undocumented is always concerning as families do not know what impact saying yes to services may have in the future. Additionally, while things like food pantries provide essential resources to families, it may not always be as easy to access them.

*"If you have a family of six, let's say, you are in line every day of the week to get enough food for your family."*

## INTAKE AND REFERRALS

All providers survey reported that they have a consent form to share information with other providers. Most of them, except one had an intake form in place. As seen in Figure 17, the majority (72%) provided child development assessments during intake, specifically using the Ages and Stages Questionnaire (ASQ). Among them, more than 80% provided education materials following the assessment, and about two-thirds provided service referrals following an assessment.

About one-third of the providers also employ child behavior and/or family functioning assessments. A minority (20%) also assess for Adverse Childhood Experiences (ACEs) assessments. Few participants provided substance abuse, depression, domestic violence, or tobacco use screenings/assessments.

Overall, a majority of participants providing assessments followed up with education materials. Service referrals were slightly less common yet provided by about 40% or more of providers.

Figure 17: Assessments and Follow Up Services provided

| | Providing Assessment N (%) | Providing Materials[a] % | Providing Referrals[a] % |
|---|---|---|---|
| Child development (e.g., ASQ, ASQ-SE) | 18 (72%) | 83% | 67% |
| Child behavior (e.g., CBCL) | 8 (32%) | 75% | 38% |
| Family functioning (e.g., CANS) | 8 (32%) | 63% | 50% |
| Adverse Childhood Experiences (ACEs) | 5 (20%) | 80% | 40% |
| Substance abuse | 3 (12%) | 100% | 100% |
| Depression screen | 3 (12%) | 100% | 100% |
| Domestic violence | 3 (12%) | 100% | 100% |
| Tobacco use or vaping | 1 (4%) | 100% | 0% |
| Other | 10 (%) | 90% | 70% |

[a]Numbers represent percent out of those who provide the particular assessment.

Interviewed providers described a range of methods for **incoming referrals**, with large variation due to their distinct program structure or model requirements. For one provider, about 90% of referrals come from pediatricians, and all referrals get funneled through a call center to determine eligibility and intake. Another mentioned they primarily receive referrals from family resource centers (FRCs) and partnerships with CalWORKs. One provider noted that they were mandated to do a "child find" and that a lot of their referrals come from the hospital systems. Additionally, most interviewed providers mentioned that they engage in some form of outreach, such as attending community events, talking to other service providers, or using canvassing and marketing materials (e.g., billboards, advertisements on buses, church bulletins, social media,

multi-lingual public service announcements). Two participants also mentioned word of mouth as a source of incoming referrals.

Intake staff screen incoming referrals based on their program/model's **eligibility requirements**. Some programs may require specific forms such as a copy of an IFSP for children with disabilities, income documentation, or proof of Medi-Cal to ensure families meet their program's specific criteria. For some providers, the screening process also includes an overview of what services look like, so that by the time staff is engaging families for intake, *"they already have an idea of our services."*

Two common themes emerged regarding program procedures when a family cannot be served, whether due to **capacity or eligibility criteria**. First, participants rarely turned families away due to capacity issues. Either capacity was not seen as an issue, or providers would find some way to make it work. One provider mentioned that they may place families on a waitlist if they cannot be served in their preferred language right away. If the family's "fit" was unclear, programs would err on the side of acceptance and consider the potential benefits more closely.

*"Our philosophy is, if we are not sure, we are going to take them in. We will have discussions as a team and … decide if they can benefit from our services."*

The second way that providers handled families that they could not serve would be to refer them to other services. This typically occurs when families do not meet eligibility criteria, such as the child's age or need for medical treatment, or if the family is not within the service area. Providers consistently mentioned that they would provide the family with resources that would be good for them or go through a referral process to connect them with another agency. Sometimes this involves additional research by program staff to find an appropriate link, such as when the participant moves out of state. As one provider described, "we don't just say 'we can't serve you,' we research their county/area."

*"if this happens, we would not leave the family hanging. … we will still try to provide linkage so the family feels supported."*

In one unique case, the provider mentioned that families typically use their home visiting program as an easier way to transition to center-based care for their children. When a family is just waiting to get a center-based spot and the home visiting program does not have capacity to serve them, program staff will do their best to work with other providers to get them into another center-based or family child-care spot. As the provider explained, *"rarely are they dying to do a home visiting program, but if that was the case, we would connect them with other [home visiting programs]."*

On the other hand, once a willing family meets eligibility requirements and enrolls with the home visiting program, both intake staff and home visitors often contribute to identifying families' needs. For instance, programs will use assessment and/or incoming referral forms to recognize family needs. However, for most of the home visiting programs participating in interviews, the home visitors play a larger role in recognizing family needs through relationship building and conversations with the family about their concerns, basic needs, experiences, and their desired outcomes.

Most of the survey respondents (91%) track completions of referrals, or "close the loop." Interview participants provided additional insights into the process of following-up/closing the loop. This process included a variety of direct support (marking calls for families), engaging in internal referrals and/or warm handoffs with other agencies, or following up directly with the family. For instance, following a referral, a home visitor may ask the family if they have pursued the referral at their next meeting and, if needed, offer to do the referral together. Warm-handoffs and direct engagement with the family may be effective strategies but can also be time consuming.

## COLLABORATION WITH OTHER HOME VISITING SERVICES

Despite discussions above regarding referrals to other home visiting programs and closing the loop on outgoing referrals, slightly less than half (45%) of the survey participants reported that they make referrals to other home visiting programs. On average, about 20% of families were referred to other home visiting programs, with responses ranging from 1% to 75%. Participants referred families to Early Head Start/Head Start, San Andreas Regional Center (SARC), Parents Helping Parents, Local Educational Agency (LEA) programs, Stars, A is for Apple, Young Interventions, HOPE Services, Parent Child+, or other various programs based on the family's needs, or "*if caregiver request to have a Provider that speaks a specific language. [sic]*" About 88% of hoe visiting providers participating in the survey coordinate with other home visiting programs to some extent or as much as possible. Yet, none of the participants mentioned utilizing a shared software system or database to coordinate on referrals.

Interviewees mentioned that they primarily coordinate with other programs through incoming or outgoing referrals. For instance, home visiting programs may refer to or receive referrals from other home visiting programs based on the parameters of their program. One participant mentioned "warm handoffs" from case managers in another program for children six and older if they encounter a child under five. Others reported having "sister programs" within their larger organization, for instance a separate home visiting program for children with CPS involvement.

Other than referrals for out-of-scope or support services, **participants did not typically mention an extensive relationship with other home visiting programs.** In fact, one program provider mentioned that their program was bound to specific timelines to screen, assess, and provide services to children. This interviewee reported coordinating with other providers (e.g., dentists, doctors) that could provide services within their strict timelines, otherwise they would handle the service themselves or hire consultants if they do not have content expertise. This interviewee wanted to be more engaged with other programs but were primarily focused on their funder's strict requirements so that they would not risk losing funding due to the timelines of outside services.

The range of responses within the survey and between surveys and interviews regarding engagement with/referrals to other home visiting services or referrals to outside services offers an opportunity for additional explorations about nuances in these experiences and interpretations about the extent referrals are utilized. Programs may provide a substantial number of services in-house and may not need to refer out as often, yet they may interpret their engagement with others "as much as possible" to include those circumstances that are less possible or necessary. Others may refer families to other services if/when not able to serve them, but this might be a rare occurrence based on distinct eligibility and/or incoming referral processes. One interview participant also mentioned that engagement with other home visiting programs typically involves incoming, rather than outgoing, referrals. As a result, the home visiting collaborative should explore more about the processes, needs, and challenges related to incoming or outgoing referrals.

When asked about community engagement, program providers mentioned incorporating community voice into their home visiting model primarily through things like feedback from families in satisfaction surveys, community groups, collecting and incorporating information on what parents/caregivers need. One provider mentioned that they would like to be able to gather families together to share resources and develop social support, and another mentioned that they were actively gathering feedback from parents/caregivers but could not guarantee that all families were asked.

Providers envisioned a coordinated system of care as the importance of fostering and growing partnerships for collaboration. For one participant, a coordinated vision means *"every family being referred to the right resource."* Another mentioned that currently, *"a lot gets lost in the process of referral,"* suggesting that Santa Clara County needs more of a one-stop-shop. On the other hand, the program provider concerned with timelines and funding mentioned that they would envision the Santa Clara County Home Visiting Collaborative to be a type of continuum where providers could maintain their own programs while focusing on where they can come together, such as establishing a curriculum that is best for all programs and shared strategies within

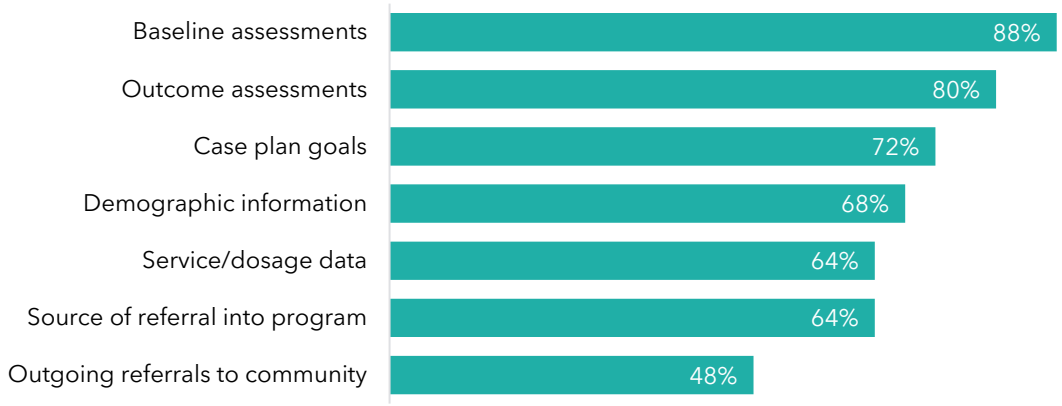
reason. This provider was not willing to relinquish their program (including their funder's expectations/requirements) but was willing to do things that are reasonable. Some of the participants indicated that a coordinated system of care should include team building, mentorship, and social connections between programs. For instance, supervisors currently meet monthly about capacity, barriers, and challenges. One provider mentioned the importance of adding activities to get to know each other more and learn from each other.

As providers learn more about other program challenges and successes, they may find ways to improve their own or contribute ideas to help others. Additionally, establishing more camaraderie between providers may assist with warm handoffs and a deeper understanding of the scope and availability of other services in the community. What may still be needed in this relationship building is a clear understanding of how those with supportive scopes and those with overlapping scopes could benefit each other in a collaborative, rather than competitive way.

## DATA COLLECTION

As shown in Figure 18, a majority of home visiting providers collect baseline assessment data (88%), outcomes assessments (80%), and case plan goals (72%). Similarly, about two-thirds of the providers collected demographic information on clients (68%), followed by service/dosage data (64%) and the source of the family's referral into their programs (64%). Slightly less than half of the participants collected data on their outgoing referrals to other community services (48%). This proportion may be slightly lower than others as some providers previously reported that they handle all services internally and may not refer families to outside services.

Figure 18: Data Collected by Home Visiting Programs (n=25)




*Note:* Numbers represent percent of providers who selected each data point collected. Multiple selections were possible.

Each provider that collected case plan goals reported that they track case goal completion.

Participants used a variety of systems to store client-level data. Six participants used some form of Excel spreadsheets, including Google Sheets and Google Suite. Two participants used each SIRAS Systems, Public Health Information Health System (PHIHS), EHR System, or KidNet. Other participants reported using Early Start Report (ESR), EMR-Fusion Web Clinic, Welligent, Central Reach, AVATAR, Child Plus, Salesforce, or their own internal database software.

The large variety in data systems usage for client-level data storage may highlight challenges in collaborative communication, data sharing, and/or closed loop tracking between community services.

Among those that collected baseline (n=22) and/or outcomes (n=20) assessments, the most commonly used tools were Beck Depression Inventory (BDI), Ages and Stages Questionnaire (ASQ), and the Receptive-Expressive Emergent Language Test (REEL). Providers typically reported using the same tool(s) for baseline and outcomes assessments (see Figure 19).

Figure 19: Baseline and Outcomes Assessments


Interviewees reported that they track implementation/model fidelity through standardized assessments (e.g., KIPS, CBCL, CANS, ASQs) at different points in time. Some providers mentioned that they tracked specific data requested by the state, federal government, or other funding sources (such as grants). Others also mentioned using anecdotal assessments based on families' goals.

Interviewees also discussed insights gleaned from their data evaluation about their program's long-term impact for clients. One provider mentioned that their data show *"really great outcomes for the family"* but that they still face challenges related to engagement. Their data show that a family's level of engagement is reflected in the outcomes. Families that are less engaged will not have as successful outcomes as those that remain engaged and committed to the process for the duration of the program's service period. This provider mentioned that home visitors will use these findings to discuss with families the importance of engagement and insights into why they work to meet on a weekly basis, while also nothing that *"we can't force them to show up and be engaged."*

One provider noted that they do not have long-term data to evaluate as their program is relatively new. Providers also often mentioned that their long-term data are currently impacted by the COVID-19 pandemic. This includes lower client numbers and less impact on things like social cooperation, as the pandemic reduced many social opportunities for families and children with an extended period of time with social distancing and shelter in place orders. However, this participant noted that these evaluation data highlight successes in other assessment areas which has helped them also evaluate the transition to a hybrid model.

*"Almost all the kids … showed improvement on their Piccolo and CBT scores through the pandemic. … that has been really beneficial for us to understand how a hybrid model might work."*

* * *