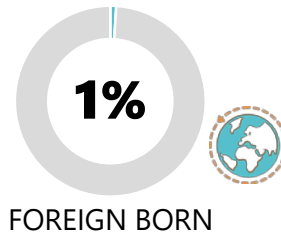
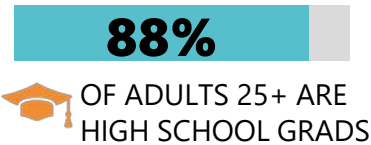
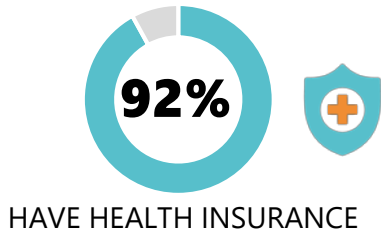


# 2020 HOME VISITING NEEDS ASSESSMENT

## OSCEOLA COUNTY

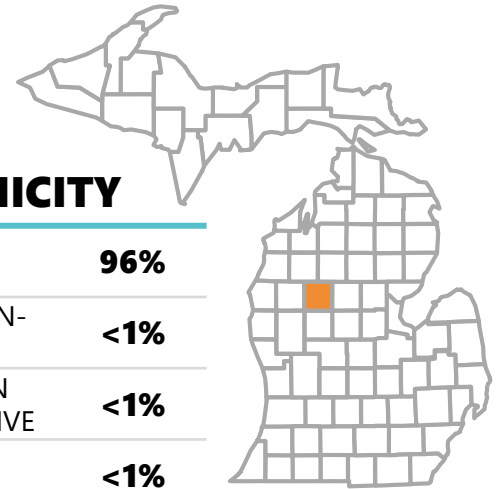


### KEY DEMOGRAPHICS & CULTURAL CHARACTERISTICS

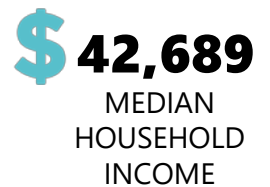


#### RACE/ETHNICITY

WHITE	<b>96%</b>
BLACK OR AFRICAN-AMERICAN	<b>&lt;1%</b>
AMERICAN INDIAN AND ALASKA NATIVE	<b>&lt;1%</b>
ASIAN	<b>&lt;1%</b>
NATIVE HAWAIIAN	<b>&lt;1%</b>
MULTIRACIAL	<b>2%</b>
HISPANIC OR LATINO	<b>2%</b>
WHITE, NOT HISPANIC OR LATINO	<b>94%</b>



OSCEOLA COUNTY



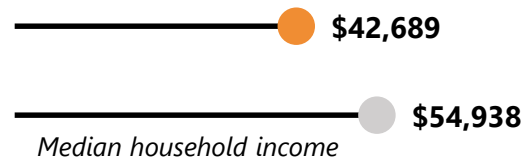
### OUTCOMES IMPACTED BY HOME VISITING

#### COUNTY PRIORITIES

- MATERNAL HEALTH
- CHILD HEALTH
- CHILD DEVELOPMENT & SCHOOL READINESS
- POSITIVE PARENTING PRACTICES
- CHILD MALTREATMENT
- FAMILY ECONOMIC SELF-SUFFICIENCY**
- LINKAGES AND REFERRALS
- JUVENILE DELINQUENCY, FAMILY VIOLENCE, AND CRIME



Families in Osceola County have a **lower median household income** than Michigan's median household income.

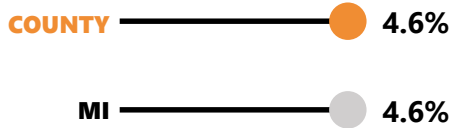


# COMMUNITY CONDITIONS IMPACTING FAMILIES

## HOMELESSNESS AMONG CHILDREN



% of children ages 0-4 who experienced homelessness during the school year



The county rate for homelessness is **equal to** Michigan's rate.

## HOUSEHOLDS RECEIVING PUBLIC ASSISTANCE



% of households receiving supplemental security income or other public assistance

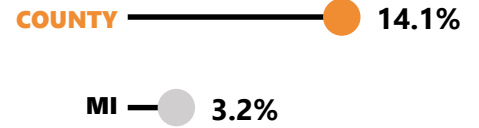


The county rate for receiving public assistance is **higher** than the rate in Michigan.

## NO HIGH SCHOOL DIPLOMA



% of persons 16-19 years of age not enrolled in school with no high school diploma



The county rate of persons without a high school diploma is **higher** than Michigan.

## NO HEALTH INSURANCE



% of persons without health insurance, under age 65 years



The county rate for no health insurance is **higher** than the rate in Michigan.

## UNEMPLOYMENT



% of unemployed persons 16 years of age or older within the civilian labor force

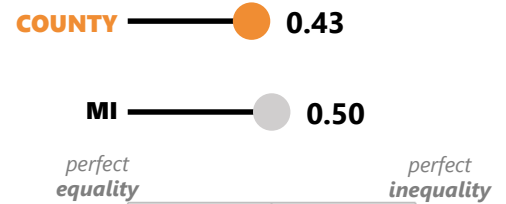


The county rate for unemployment is **higher** than the rate in Michigan.

## INCOME INEQUALITY



A measurement of how far the wealth or income distribution differs from being equal (Gini Coefficient).

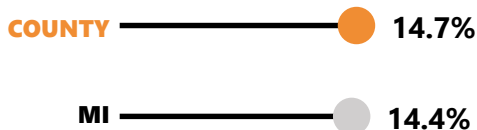


The county measure of income inequality is **lower** than in Michigan.

## FAMILIES LIVING IN POVERTY



% population living below 100% of the federal poverty level



The county rate for poverty is **higher** than the poverty rate in Michigan.

## CHILDREN EXPERIENCING POVERTY



% of children ages 0-17 who live below the poverty threshold

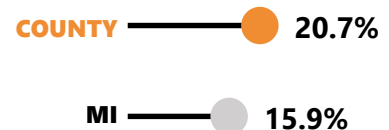


The county rate for children experiencing poverty is **higher** than Michigan's rate.

## CHILDHOOD FOOD INSECURITY



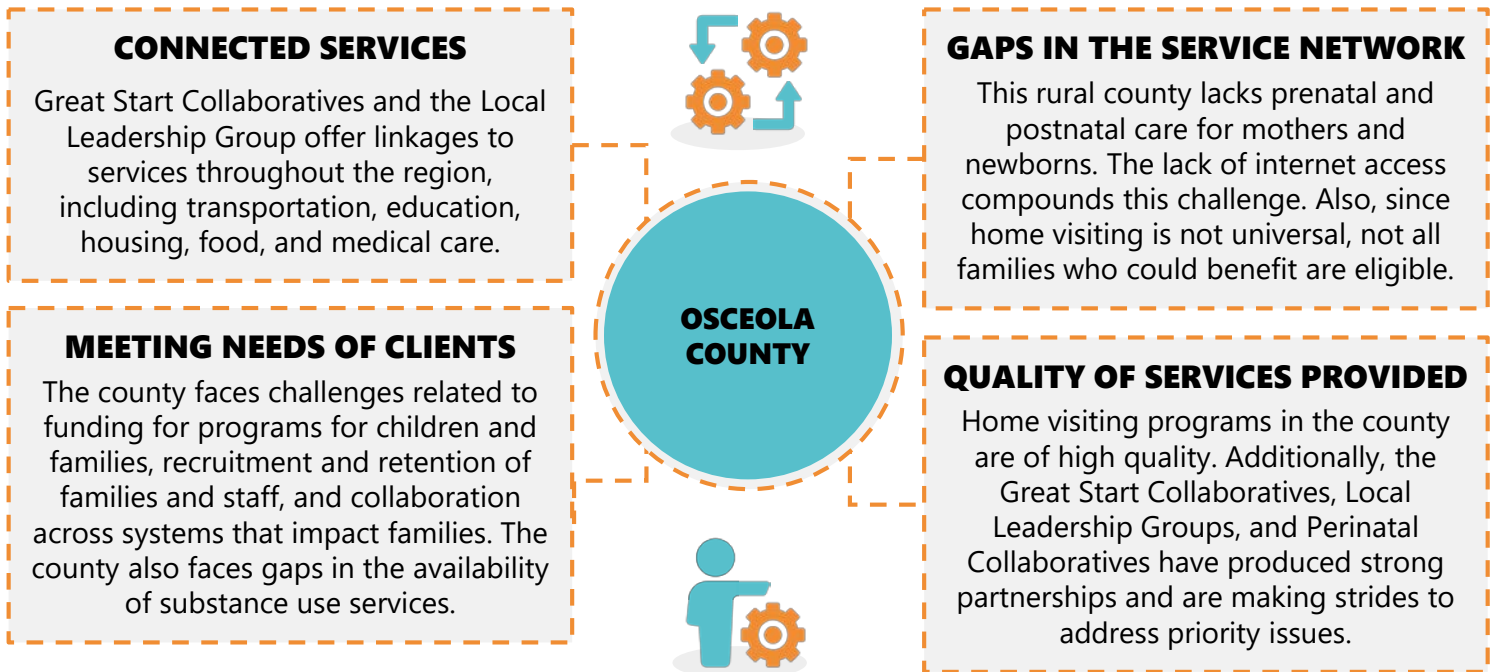
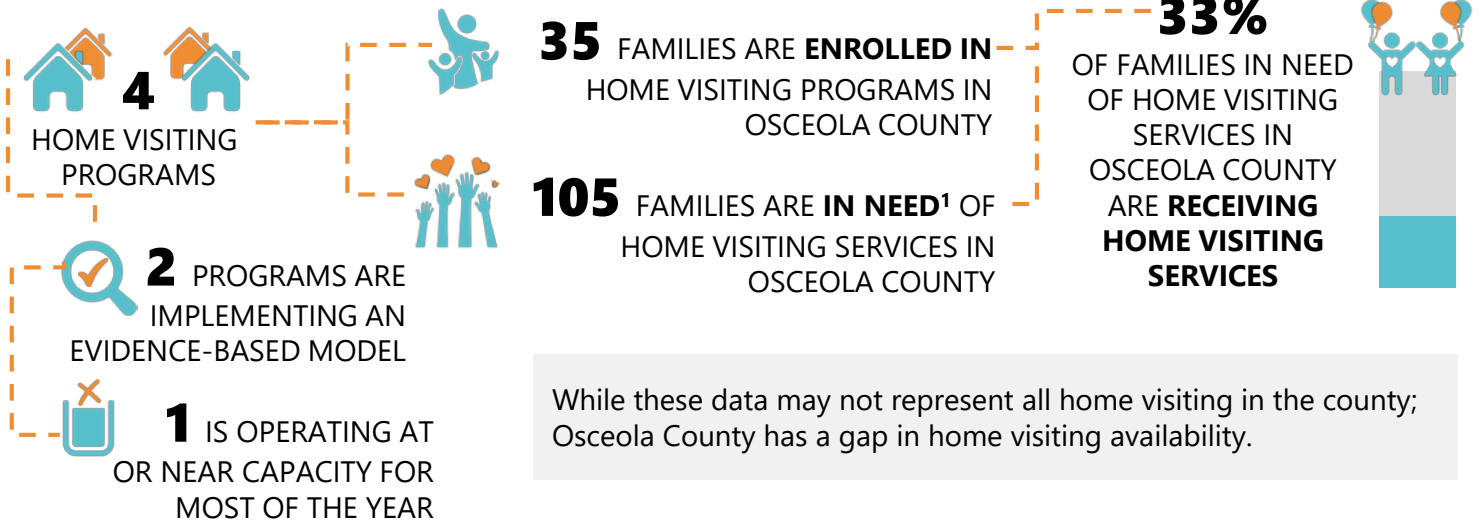
% of children experiencing food insecurity (lack of access, at times, to enough food)



The county rate for childhood food insecurity is **higher** than Michigan's rate.

# EXISTING HOME VISITING PROGRAMS

Home visiting programs sit at the intersection of families and communities. They provide critical linkages between families and community service systems. Osceola County identified the reach and quality of services for families that partner with home visiting and identified strengths and gaps in the service network. Some patterns of reach and quality for home visiting clients and the service delivery network were noted during the assessment, and ideas for strengthening the service delivery network are described below.



## STRENGTHENING THE SERVICE DELIVERY NETWORK

The service delivery network in this county could be strengthened by expanding services to address mental health needs. Additionally, it would support system building and decision making to have greater participation by top leadership in key meetings. Finally, programs would benefit from higher reimbursement related to the rural nature of the counties and the time it takes to reach families who are spread out geographically.

<sup>1</sup>Number of families likely to be eligible for MIECHV services based on the criteria: Number of families with children under the age of 6 living below 100% of the poverty line + number of families in poverty with a child under the age of 1 and no other children under the age of 6; AND belongs to one or more of the following at-risk sub-populations: Mothers with low education (high school diploma or less), young mothers under the age of 21, and/or families with an infant (child under the age of 1). Data Source: ACS 2017 1-Yr PUMS Data

# COMMUNITY READINESS TO EXPAND HOME VISITING

New or expanded programs and services are most successful in communities that are clear about their readiness to provide a supportive context. Home Visiting partners were convened to discuss the five dimensions of readiness to expand home visiting and identified both community strengths and weaknesses. For each of these domains, the community partners scored each dimension as a 0 (no readiness), 1 (limited readiness), 2 (moderate readiness), 3 (significant readiness), or 4 (full readiness).

## COMMUNITY KNOWLEDGE OF FAMILY NEEDS      COMMUNITY PURSUIT OF EQUITY

**MODERATE READINESS**

4  
3  
2  
1

Knowledge of family needs comes primarily from one-on-one check-ins with families receiving services, as well as through the work of the Great Start Collaboratives. However, family needs include economic development, and the community lacks economic development committees. The community also lacks ideas for special needs children.

**MODERATE READINESS**

4  
3  
2  
1

The community is moving toward universal social determinants of health screenings in programs, hiring bilingual staff, working with tribal programs, and hiring people who are peers and live in the community. Wages make recruitment and retention challenging, and the community could better engage the LGBTQIA population.

## COMMUNITY KNOWLEDGE OF HOME VISITING      COMMUNITY LEADERSHIP

**MODERATE READINESS**

4  
3  
2  
1

Home visiting is a key connection point for families to other services. However, businesses and the general public often do not know about early childhood programs. The community could do a better job getting the word out, but not being able to offer programs to everyone makes awareness efforts complicated.

**SIGNIFICANT READINESS**

4  
3  
2  
1

The Perinatal Collaborative involves several traditional and non-traditional partners, and local leaders have supported priority issues in early childhood. However, hospital systems tend to operate from their own agenda, and some dental clinics are not as connected to home visiting.

## COMMUNITY CLIMATE      COMMUNITY RESOURCES

**MODERATE READINESS**

4  
3  
2  
1

The community has taken steps to make services more accessible such as offering late clinic hours for working families and letting other caregivers take children to appointments. Also, some programs can pay better wages, and the health department has buy-in from its Board of Health. However, stigma is attached with home visiting and WIC programs, and the community sometimes discriminates against families on public assistance.

**MODERATE READINESS**

4  
3  
2  
1

Several groups have invested in home visiting in the community by providing training and making donations. However, home visiting is limited by restrictions on eligibility and is not universal. Additionally, the community has a gap in Infant Mental Health services. As a rural county, the area struggles with poor options for internet and telehealth.

# NEED & CAPACITY TO EXPAND HOME VISITING

Home visiting partners in Osceola County are unsure if they have the need and capacity to expand evidence-based home visiting.

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This process engaged families to participate as partners and leaders by seeking participation from current LLG parents during the process. The LLG recruited additional parents through collaborating with the local GSCs and gathered their input via focus groups.

**Thank you to the parents and community partners who engaged in the assessment process.**

*Data collected by Health Department of Northwest Michigan/RR2 LLG with assistance from MPH-CHC. For more information about this assessment, contact Health Department of Northwest Michigan/RR2 LLG. This program is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$7,799,696 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.*