Family Home Visiting

Report to the Minnesota Legislature 2008

Minnesota Department of Health

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2008 Family Home Visiting Program Legislative Report

Executive Summary

Home visiting has been a successful service delivery strategy improving the health and well-being of families for at least 100 years.

Minnesota Statute, section 145A.17 governs the Minnesota's Family Home Visiting program. The 2007 Legislature amended the statute. Those changes are as follows:

1. Community Health Boards (CHBs) and Tribal Governments are required to submit a plan to the commissioner of health describing a multidisciplinary approach to targeted home visiting for families with identified risk factors;

2. New program requirements are added and must be implemented; and

3. The commissioner of health is required to establish training requirements for home visitors and establish measures to determine the impact of family home visiting programs funded under the statute.

The following 2008 Family Home Visiting Program Legislative Report:

1. Shares success stories of Minnesota's Family Home Visiting Program;

2. Provides an overview of current Family Home Visiting programs within the state provided by CHB; and

3. Serves as a status report of current activities addressing the 2007 Legislative revisions to the Family Home Visiting Statute.

Minnesota Department of Health
2008 Family Home Visiting Program
Legislative Report

Introduction

For at least 100 years, nurse home visiting has been used as a service delivery strategy to improve the health and well-being of families. Home visiting is an intervention where services are delivered in the home in an effort to influence parental skills and behaviors, and improve the environment in which children spend most of their time. Trained home visitors provide education to families and link them to resources that support expectant parents or parents with young children. The relationship between the family and home visitor is integral to the success in achieving the goals set together by the family and the home visitor.

The Centers for Disease Prevention and Control's (CDC) Task Force on Community Preventive Services estimates that 43 percent of all families with newborns could benefit from receiving home visiting services.[1] Home visiting has been shown to make a difference by increasing tax revenues while decreasing costs within the education, social service and criminal justice systems.[1, 2, 3, 4, 5, 6] Home visiting has also demonstrated a decrease in child abuse and neglect, decreased tobacco and alcohol use during pregnancy, increased breastfeeding rates, reductions in subsequent pregnancies, increased labor force participation by parents, and increased family income.[1, 2, 7, 8] The CDC Task Force on Community Preventive Services reviewed 25 studies on home visiting and concluded, "there is strong evidence to recommend home visitation to reduce child maltreatment".[1]

David Olds, Ph.D., Professor of Pediatrics, Psychiatry and Preventive Medicine at the University of Colorado, founded the nurse home visiting model over 30 years ago for low-income, first-time mothers. The model, called Nurse-Family Partnership (NFP), currently serves over 20,000 mothers in 20 states.

Olds and his associates measured NFP program effects in three different locations: Elmira, NY, Memphis, TN, and Denver, CO. As demonstrated by longitudinal studies over 30 years, the children studied by Olds and associates had fewer arrests and fewer convictions and probation violations as they became adults. [2,7,8] Furthermore, the Olds' studies found that program costs for two and a half years of nurse home visits for a family were recovered by the time the child was 4 years old.[2, 9] Cost-benefit studies have quantified the cost savings of home visiting models, including both the Olds model and non-Olds models, to be between $6,200 and $17,000 per youth. These studies concluded that:

1. *The Nurse Family Partnership for Low Income Women* saved $2.88 for every dollar of program costs;[3]

2. *The Home Visiting Programs for At-Risk Mothers and Children* saved $2.24 for every dollar spent; [3] and

3. *The Dakota Healthy Families Program* identified a total cost savings of $1.13 million when looking at the number of confirmed child-maltreatment cases avoided by providing home visiting services.[10]

In addition to the cost benefit of home visiting programs, there is immeasurable positive personal impact on those individuals and families participating in a home visiting program. The Minnesota Department of Health (MDH) Family Home Visiting (FHV) Program has collected stories over the years of the impact that home visiting has had on families. Two stories that demonstrate the impact home visiting has on families follow.

> A pregnant teen had a history of sexual abuse, low self-esteem and a poor support system. She lived with the father of her baby in a poorly maintained rented home. The Public Health Nurse (PHN) made frequent visits over 18 months providing prenatal and parenting education, promoting the importance of parent-infant attachment and the provision of a safe and nurturing environment for the baby, and providing support and linkages to various community resources. The teen entered counseling, delivered a healthy baby, graduated from high school and after high school, enrolled in a Certified Nursing Assistance program. In addition, the PHN advocated for the family with the landlord, which resulted in him making needed repairs to the home.
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> A PHN received a referral from a physician to teach a 30 year-old woman how to be a mother. The mother had a slight developmental delay and this was her first child. When the PHN and mom first met, the mother lived with her parents. The mom was a high school graduate who had previously served in the military. She was currently working at a local factory. The mom was screened and demonstrated an 8th grade literacy level. On the initial PHN visit, the baby was observed to be thriving. The mom was very shy and had difficulty making eye contact with the PHN. Overtime, the PHN developed a relationship with the mother. The PHN and mom discussed parenting issues and challenges. The PHN suggested local Early Childhood Family Education (ECFE) classes and the mom participated in those and frequently checked out books from the library to read to her baby. The mother gained confidence and eventually moved into her own home and ended her emotionally abusive relationship with the baby's father. She was promoted in her job, which allowed her to move off the Minnesota Family Investment Program (MFIP).

Home visiting is a successful strategy because it:

1. Engages "at-risk" families, including prenatal and postpartum women and infants, especially adolescent and first time parents;[1]

2. Effectively utilizes public health nurses, other professionals, and community health workers for mothers and children of color, American Indian and immigrant populations; and

3. Includes essential elements supported by evidence for success such as:
   services that have a family focus and include interventions that support parents, teach child development, and promote parent-child interaction;
   services that reflect the culture, racial and ethnic diversity of populations served;
   services that promote linkages such as early prenatal care for pregnant women; and
   services provided by trained, experienced home visitors who receive ongoing, effective supervision. [7]

Family Home Visiting In Minnesota

The 2007 Legislature amended the Family Home Visiting (FHV) statute (Minnesota Statutes, section 145A.17) and increased Temporary Assistance for Needy Families (TANF) funding to Community Health Boards (CHBs) and Tribal Governments in order to support the services provided under the statute. The amendment to the statute:

1. Requires that CHBs and Tribal Governments submit a plan to the commissioner of health describing a multidisciplinary approach to targeted home visiting for families with identified risk factors;

2. Adds new program requirements which must be implemented; and

3. Requests the commissioner to establish training requirements for home visitors, and establish measures to determine the impact of family home visiting programs funded under the statute.

The MDH's Family Home Visiting Conceptual Model, attached as Appendix A, illustrates the organizational structure and the role of partners within the MDH's Family Home Visiting Program.

Key stakeholders such as MDH, local public health departments and Ready4K contribute to the overall development and support of the FHV legislation, committees, and evaluation.

MDH coordinates a FHV program in Minnesota and collaborates with a number of organizations and individuals to do so.
MDH has convened a FHV Steering Committee, a Training Work Group, and an Outcome/Evaluation Work Group that advises the department on the implementation of the legislation.
Local public health departments and CHBs develop and implement family home visiting programs at the local level.
Evaluation is conducted at two levels: an overall evaluation is conducted for the MDH FHV program as a whole, and evaluation is conducted within family home visiting programs at the local public health department level.

Abbreviated Plan

In June 2007, all of the CHBs in Minnesota were required to submit an abbreviated plan that would assure FHV programs would continue after June 30, 2007 and address the revised FHV program statute. Multi-county CHBs were able to choose whether they would complete one plan or submit their plan as individual counties. Ninety-one plans were submitted.

The FHV statute identifies populations that should be targeted for family home visits. All of the plans submitted by CHBs indicated they would target adolescent parents. Over 90 percent of CHBs were targeting populations with a history of child abuse/neglect, reduced cognitive functioning, and lack of knowledge about child growth and development stages. Eighty-one percent of the plans indicated the CHB targeted families with a history of alcohol/drug abuse and/or welfare dependency. Just over half of the plans targeted populations with a history of family homelessness.

Table 1: Risk Factors Addressed by FHV Programs

Risk Factor	Percent
Adolescent parents	100.0
Lack of knowledge of child development	97.8
Reduced cognitive functioning	96.1
Child abuse/neglect, other violence	93.4
Alcohol/drug abuse	81.3
Long-term welfare/family instability	81.3
Low resiliency to adversities/stresses	78.0
Domestic abuse/rape, other victimization	69.2
Homelessness	56.0

All plans currently do or will be developing a plan to accomplish the following statutory requirements for funded programs:

Utilize community-based strategies
Offer home visits by trained professionals
Offer information outlined in statute
Provide referral information and assistance
Provide youth development programs when appropriate
Develop home visitor recruitment (representative of population served)
Maximize resources and minimize duplication
Utilize appropriate racial/ethnic approaches
Connect families to community resources
Initiate referral to center-based or group meetings

The majority of local home visiting programs partner or plan to partner with Early Childhood Family Education, social workers, school districts, Head Start, mental health professionals, and other relevant partners. Other home visiting partners include other home visiting programs, tribal health agencies, and community health workers.

Table 2: Community Partners

Partners	Percent
Early Childhood Family Education	95.6
School Districts	95.6
Social Workers	95.6
Head Start/Early Head Start	89.0
Mental Health Professionals	87.9
Other County Public Health Agencies	83.5
Other Home Visiting Programs	63.7
Community Health Workers	25.3
Tribal Health Agencies	24.2

Outreach strategies (sources) commonly used to identify clients include WIC clinics, community providers, social services/financial intake, and birth records. Less commonly used strategies include labor and delivery hospital units, parenting classes, fairs and events, prenatal classes, and media promotion.

Table 3: Sources for Outreach

Outreach	Percent
Community/providers	97.8
WIC Clinics	97.8
Social services/financial intake	94.5
Birth Records	81.3
Labor and delivery hospital units	70.3
Parenting classes	60.4
Fair/events	54.9
Prenatal classes	51.6
Media promotion	31.9

The Family Home Visiting Steering Committee

The Family Home Visiting Steering Committee provides the department of health with guidance to assure statewide implementation of the revised home visiting statute. The steering committee was integral to the development of the detailed plan that will be submitted by Community Health Boards (CHBs) in March 2008. The steering committee acts in an ongoing advisory capacity for the training and outcome/evaluation work groups.

The members of the steering committee represent a broad range of state and local partners with an interest in home visiting and its outcomes. Participants include local public health directors, Community Health Services administrators and supervisors from both metro and non-metro areas, the Local Public Health Association of Minnesota, the Minnesota Departments of Education and Human Services, tribal governments, Head Start and Ready4K. A local public health representative and the Maternal and Child Health section manager of MDH co-facilitate the steering committee meetings.

The steering committee began meeting in October 2007 with the goal of developing a plan for CHBs to fill out and submit to MDH by March of 2008. The detailed plan will contain information that includes the outreach strategies used by CHBs to engage at-risk targeted families in their family home visiting program. CHBs must also indicate how they will provide a seamless delivery of services and methods in order to promote continuity of services for families. An important change in the 2007 home visiting legislation, which CHBs will discuss in their detailed plan, is the collaboration they have

with multi-disciplinary partners in their communities. Information regarding current training and evaluation activities as well as any gaps in training and evaluation will inform and guide the work of the training and evaluation work groups.

Family Home Visiting Evaluation/Outcome Work Group

Both the MDH's Community and Family Health Division and the MDH's Center for Health Statistics are working in collaboration with several community partners and stakeholders to develop a comprehensive evaluation plan for the MDH FHV program. The evaluation plan will use qualitative and quantitative approaches for measuring the impact of programs on statewide outcomes defined in the legislation and assessing whether or not home visiting is the best approach to use in meeting Minnesota's FHV goals.

In developing an evaluation plan for the FHV program, MDH collaborates with a number of organizations and individuals, including community research experts and local public health representatives who have a wide range of expertise in evaluation and home visiting programs. MDH convened an Outcomes/Evaluation Work Group that is advising the department and the FHV Steering Committee on the development of the evaluation plan.

The Outcomes/Evaluation Work Group will:

1. Identify key stakeholders and stakeholder needs;

2. Develop a conceptual framework for the evaluation; and

3. Develop a process for identification of measurable outcomes (long term and intermediate).

The evaluation plan will include overall indicators for home visiting in Minnesota, methods for collection of data, and a plan for analysis of data at the state level.

Family Home Visiting Training Work Group

The charge to the Training Work Group is to advise MDH on developing an implementation plan for training that will assure quality home visiting services in Minnesota.

The Training Work Group includes representatives from local public health, the Local Public Health Association of Minnesota, the Minnesota Departments of Education and

Human Services, tribal governments, Head Start and local clinic and non-profit agencies that provide home visiting services to low income pregnant and parenting families.

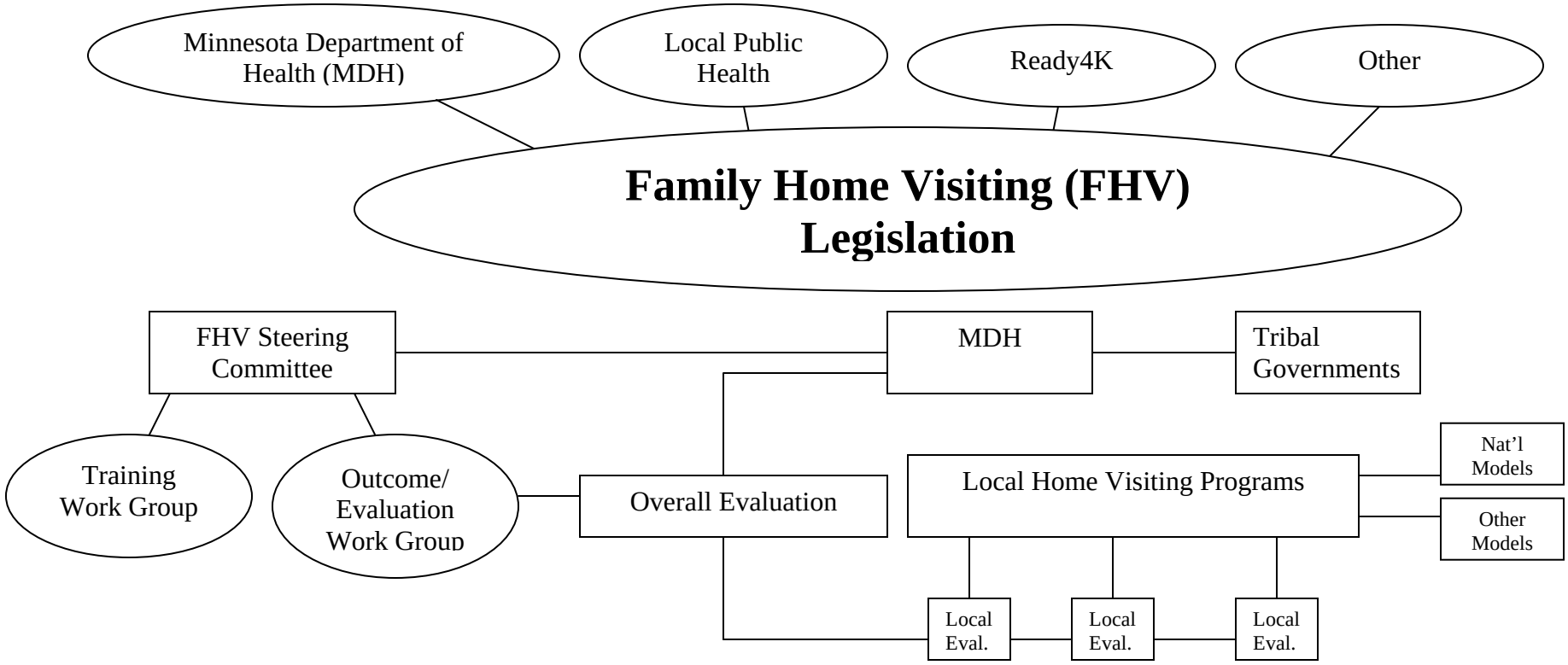
Work group members believe it is essential that collaboration occurs between state agencies and local partners to implement the training recommendations identified in the 2007 statute. The work group members have reviewed descriptions of home visitor trainings tentatively planned by MDH for 2008. The work group will develop a training plan by June 2008 and then meet periodically to update and revise the plan as the needs of home visitors change to assure that FHV outcomes are achieved.

Next Steps

This January, the Community Health Boards were sent the template for the detailed plan they will be completing and returning to MDH by March 7, 2008. The department will compile the information from the detailed plan submitted by the CHBs and provide a report for review by the FHV Steering Committee. The report will assist the steering committee in determining next steps and recommendations to guide and assure the effective implementation of FHV in Minnesota.

The next Family Home Visiting Report sent to the Minnesota State Legislature will be January, 2010.

APPENDIX A
Minnesota Department of Health's Family Home Visiting Conceptual Model



December 5, 2007

ENDNOTES

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