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Family Home Visiting Program

Minnesota Department of Health

Report to the Minnesota Legislature 2012

January 2012

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Background

Introduction

For over 100 years, nurse home visiting has been used as a service delivery strategy to improve the health and well-being of families. Public health family home visiting is a voluntary maternal and child health intervention, ideally delivered prenatally and often beginning with a comprehensive public health nursing assessment.

Home visiting services are delivered in the home environment in an effort to

- link pregnant women with prenatal care,
- support parents early in their role as a child's first teacher, and
- ensure that very young children develop in safe and healthy environments.

Meeting families in their home environments allows home visitors to individualize services to families' unique interests and situations, maximizing both time and resources. [i]

Trained home visitors provide health education and caregiving support to families and connect them to community resources as needed. Families receive information on prenatal and infant care, child growth and development, effective parenting approaches, home safety, disease prevention, and preventing exposure to environmental hazards such as lead and second-hand smoke.

Children who experience economic hardships, maltreatment and other trauma face distinct risks to their overall health and development. Screening, assessment and science-based interventions provided by highly-trained, well-supervised home visitors promote the resilience families need to buffer the negative effects of toxic stress.[ii]

> *"It is easier to build strong children than to repair broken men."*
> - Frederick Douglass (1817–1895)

Evidence-based home visiting programs have evolved over the years to include highly-specialized, intensive interventions designed to ameliorate risks that can result in costly negative lifelong outcomes. Evidence-based family home visiting models targeted to families at risk have been shown to be an effective service strategy for improving outcomes in

- maternal and child health,
- family safety,
- school readiness, and
- economic stability and self-sufficiency.

Family home visiting practice grounded in empirically-based research is linked with cost savings at the community, state and federal levels through improved outcomes in the following areas:

- child maltreatment,
- juvenile arrests,
- maternal convictions,
- emergency department use, and
- cognitive and behavioral problems among children.[iii]

Research-based family home visiting models have proven that for every public health dollar invested, a return of up to $5.70 can be expected in savings to programs including Medicaid and food support[iv]. In Minnesota, by a child's fifth birthday, state and local government cost savings total $4,550 per family served by the Nurse-Family Partnership program.[v]

Depending upon the source(s) of funding and program capacity, public health family home visiting services may range from a total of one or two visits up to bi-weekly visits delivered throughout a child's toddlerhood and beyond as needed. A public health nursing assessment determines the range of interventions and referrals to other community resources that may be offered. Families with multiple risk factors may consider ongoing evidence-based interventions with higher intensity and more frequency of home visits.

Statutory Requirements

Minnesota Statute Section §145A.17 governs the Family Home Visiting (FHV) Program. The Minnesota Legislature directs federal Temporary Assistance for Needy Families (TANF) grant funding to Community Health Boards (CHBs) and Tribal Governments for services provided under the statute. Grants are distributed to CHBs and Tribal Governments on a formula basis. (Appendix A includes the 2011 FHV Program Statute; Appendix B includes the 2012 CHB award allocations.)

The statute requires grantees to submit a plan to the Commissioner of Health describing a multidisciplinary approach to providing targeted home visiting services to families. Program requirements include training and supervision standards and the establishment of measures to determine the impact of FHV programs funded under the statute.

In even-numbered years, a report is required to be submitted to the legislature on the FHV Program established by this statute. The purpose of this report is to fulfill the requirement for 2012 by describing the activities as mandated.

Goal of the Program

The goal of the FHV Program is to provide targeted home visiting services, delivered prenatally whenever possible and designed to:

- foster healthy beginnings,
- improve pregnancy outcomes,
- promote school readiness,
- prevent child abuse and neglect,
- reduce juvenile delinquency,
- promote positive parenting and resiliency in children, and
- promote family health and economic self-sufficiency for children and families.

Services are to be coordinated and delivered in partnership with multidisciplinary teams of public health nursing, social work and early childhood education professionals.

The statute requires services to be delivered to families at or below 200 percent of the federal poverty guidelines, and other families at risk for, but not limited to, child maltreatment or juvenile delinquency. Funded programs must target families with the following risk factors:

- Adolescent parents
- History of alcohol and drug abuse
- History of child abuse, domestic abuse, or other types of violence
- A history of domestic abuse, rape, or other forms of victimization
- Reduced cognitive functioning
- Lack of knowledge of child growth and development stages
- Low resiliency to adversities and environmental stresses
- Insufficient financial resources to meet family needs
- History of homelessness
- Risk of welfare dependence or family instability due to employment barriers

- Other risk factors, as determined by the commissioner

Program Administration

The Minnesota Department of Health (MDH) provides administrative oversight, training and technical assistance, and the collection of statewide outcomes and measures of FHV services delivered at the community level. In 2007, the MDH convened a steering committee to provide the department with guidance for statewide implementation of the FHV Program statute.

The FHV Steering Committee represented state and community-based stakeholders including local health department directors, community health administrators and supervisors from metro and non-metro areas; the Local Public Health Association of Minnesota; the Minnesota Departments of Education, Health and Human Services; Tribal Governments; Head Start and Ready4K. The committee was co-chaired by a local health department director from greater Minnesota and the MDH Maternal and Child Health Section Manager (See Appendix C: Family Home Visiting Steering Committee Members). The committee was successful in guiding the development of the FHV Program and completed its work in 2011.

From 2010 through 2011, the MDH further enhanced the FHV Program in the following areas:

- Provided regional training, consultation and technical assistance on evidence-based interventions and models to family home visitors and supervisors, including public health nursing, social work and early childhood education professionals, as well as other family service providers.
- Provided training and mentoring in high quality supervision focused on reflective practice.
- Collected and monitored statewide outcome and performance measures.

In recent years, the body of science regarding the effectiveness of long-term, intensive family home visiting services has grown to demonstrate that targeted FHV services can support children at risk in achieving lifelong health and productivity. Public and private investments and policy initiatives are advancing evidence-based home visiting programs that include the following key elements:

- Clear goals and objectives
- Voluntary services
- Targeted to most at risk
- Long-term, intensive
- Family-focused, strengths-based
- Respect for diversity
- Carefully recruited, well-trained staff
- Limited caseloads
- Ongoing, high quality supervision
- Promotion of preventative health care
- Promotion of delaying subsequent pregnancies
- Linking with community services
- Continuous Quality Improvement
- Theory-driven
- Evaluation

The MDH provides statewide training, consultation and reflective practice mentoring, described below in more detail, to promote the above components of effective home visiting programs. There is a strong body of science and broad-based support for family home visiting among public and private stakeholders in health, human services, and education sectors. This has prioritized the need for enhanced collaborative policy and planning activities. Federal, state and community initiatives, such as the Maternal, Infant and Early Childhood Home Visiting Program, described below, and the education sector's Race to the Top, provide for timely

opportunities to maximize and enhance coordination of Minnesota's early childhood-related activities and investments.

To ensure effective early childhood systems alignment and appropriate coordination of programs and services, the MDH's Maternal and Child Health Advisory Task Force will convene a new Family Home Visiting Committee in January 2012. The committee will be comprised of professional representatives and consumers of health, public health and early childhood services and systems. The committee is charged with developing a vision and guiding principles for use by the Commissioner of Health to enhance capacity for a statewide public health home visiting system. A committee report, including recommendations to the commissioner, will be completed by December 2012.

The Affordable Care Act of 2010 created the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) to respond to the diverse needs of children and families in communities at risk and through collaboration and partnership at the Federal, State, and community levels to improve the health and development outcomes for at-risk children through evidence-based home visiting programs. The MDH submitted an application for funding and a statewide needs assessment in 2010 and an Updated State Plan in 2011. This federal program provides further impetus for MDH and stakeholders to advance a system that is integral to the continuum of health care and imbedded in community-based early childhood development, care and education systems.

Professional Development
MDH provides statewide program and data collection technical assistance, training, reflective practice mentoring and other professional development support to family home visiting program staff. Studies have shown that high levels of training to home visiting staff positively impact the effectiveness of home visiting interventions on the physical and social/emotional development of children and the prevention of child maltreatment.[vi]

> *"Research has demonstrated the extent to which higher levels of staff training and expertise predict the effectiveness of these kinds of services in such areas as developmental progress and reduction of child maltreatment."*
>
> -Jack P. Shonkoff, MD

Training
A statewide multidisciplinary MDH Training Work Group convened in 2008 to develop a training plan addressing the requirements in the FHV statute. The plan may be viewed at: http://www.health.state.mn.us/divs/fh/mch/fhv/documents/FHVTrainingPlan.pdf

In 2010 and 2011, the MDH provided training to over 1,000 multidisciplinary training participants at community-based sites in all regions of the state and some tribal communities. Training topics included:

- Chemical Dependency
- Growing Great Kids Prenatal to 36 months Parenting Curriculum
- Integrated Strategies Core Home Visitor Seminar
- Motivational Interviewing (including follow-up coaching sessions)
- NCAST: Parent-Child Interaction Feeding and Teaching Scales, Sleep Activity Record, and Re-reliability
- Partners In Parenting Education (PIPE) Curriculum
- Promoting Maternal Mental Health During Pregnancy
- Promoting Relationships With Relationships
- Reflective Practice

- Social/Emotional Development During the Earliest Years
- Working With Adolescent Parents & Their Children

The MDH Training Plan will be evaluated in 2012 for currency and reach, and continues to guide the development of a year-round MDH FHV training schedule and the identification and development of new curricula. The plan is also a well-used tool for statewide collaborative planning activities, informing the development of learning objectives for professional conferences and the Practice Matters Work Group of Minnesota's Targeted Home Visiting Coalition.

MDH home visiting consultants provide support and consultation, as needed, to a range of public health family home visiting programs on capacity building, program planning and a range of maternal and child health topics. These activities continuously inform the MDH training agenda via the identification of learning objectives and the ongoing training needs of home visiting practitioners across the state.

The MDH has established working relationships with the model developers of two evidence-based home visiting models, Healthy Families America (HFA) and Nurse-Family Partnership (NFP). These partnerships advance a strong base of home visiting practice support in the implementation of HFA and NFP. Supported by federal funds secured in a competitive process, MDH has invested in the specialized training of two staff nurses to serve as statewide NFP consultants. In addition to statewide consultation on the NFP model, MDH also co-convenes with the NFP National Service Office Community of Practice meetings for staff from NFP implementing agencies.

Federal funding provides support for NFP training of MDH staff and staff in NFP implementing agencies, as well as training and technical assistance to HFA implementing agencies. In addition, MDH provides technical assistance, quality assurance functions and training support toward accreditation of HFA implementing agencies.

Reflective Practice Mentoring for High Quality Supervision

Reflective supervision is a requirement of evidence-based home visiting models and is distinct from administrative supervision. Reflective practice principles support high quality supervision that includes consistent and frequent meetings focused on supporting, teaching, guiding, and exploring perspectives and the impact of the parallel process on working relationships and caregiver-infant relationships.

Also supported with federal funding, the MDH provides personalized, intensive mentoring to FHV supervisors interested in advancing the application of reflective practice within their programs. The process provides learning opportunities through training in concepts and theory, and through participation in reflective practice activities, such as reflective supervision and reflective practice groups.

Grantee Plans

Per the Family Home Visiting statute, local public health grantees submitted plans in 2008 to the Commissioner of Health describing their multidisciplinary approach to providing targeted home visiting services to families. Also as required by the statute, the MDH provided forms for the completion and submission of plans. In 2012, an updated plan format will be disseminated to local public health home visiting programs. The new format will reflect current best practice in family home visiting and will provide an opportunity for local programs to

reassess their community needs and to identify their collaborative plans to reach high risk families with evidence-based interventions.

Tribal home visiting programs submitted work plans in 2011. Significant strides in tribal home visiting programs in 2010 and 2011 include the successful applications by the Fond du Lac Band of Lake Superior Chippewa and the White Earth Reservation to become implementation sites for the Nurse-Family Partnership (NFP) Program. MDH supported a year of planning by the Fond du Lac Band of Lake Superior Chippewa, the Leech Lake Band of Chippewa, and the White Earth Reservation with the NFP National Service Office and Dr. David Olds. Their planning activities resulted in the identification of cultural supplements to the NFP Program materials. In addition, the White Earth Reservation was successful in securing a competitive federal Maternal, Infant and Early Childhood Home Visiting grant.

2010 Public Health Family Home Visiting
The year of 2010 was the first full year of family home visiting data collected and submitted to MDH by local public health home visiting programs. Measures used were identified in partnership with an Evaluation Work Group comprised of staff from local public health and MDH.

MDH works with local public health on enhancing data collection and reporting activities, and assesses the ongoing effectiveness of the data collection system. The Health Resources and Services Administration, US Department of Health and Human Services, and the Design Options for Maternal, Infant, and Early Childhood Home Visiting Evaluation Technical Assistance Center provide data collection technical assistance to MDH. (See Appendix D for the 2010 local public health family home visiting demographic characteristics).

Screening for Developmental Delay
The American Academy of Pediatrics identifies screening as the first step to providing targeted assessment, intervention, referral and community collaboration to support families living with high levels of stress and adversity.[vii] Family home visitors conduct a comprehensive family assessment and a developmental screening schedule for children using age-appropriate, standardized tools. This early identification of risk factors plays a key role in delivering timely and effective preventive care to families.

Of 16,134 children ages 0-6 years served by public health home visiting in Minnesota, 10,356 were eligible for a developmental screening based on:

- the child's age,
- the screening interval indicated by the screening instrument utilized by the home visitor, and
- the scheduling of the home visit.

Of those children screened, 84 percent met developmental milestones as indicated by the screening instrument utilized.

Children who did not meet developmental milestones were referred for further assessment to programs including Child and Teen Checkups (Minnesota's Early Periodic Screening, Diagnosis, and Treatment program), Early Childhood Family Education, Early Childhood Special Education, Early Head Start, and the Follow Along Program.

The Minnesota Interagency Developmental Screening Task Force, comprised of representatives of the Minnesota Departments of Education, Health, and Human Services, and the University of Minnesota, Irving B. Harris Center for Infant and Toddler Development, recommends and/or approves developmental and social-emotional screening tools as reviewed at this site: http://www.health.state.mn.us/divs/fh/mch/devscrn/

Child Maltreatment

The US Centers for Disease Control and Prevention promote the prevention of child maltreatment as a public health concern. Extensive research has demonstrated that a key strategy in the prevention of child maltreatment is to support the relationship between a parent/primary caregiver and the child.[viii] Maternal depression or other mental disorders, parental substance abuse, a history of child and/or parent trauma, or pre-existing disorders, disabilities, illnesses or challenging temperaments of a child may all compromise the necessary reciprocity in a parent and child relationship.

Of 16,134 children ages 0-6 years served by public health home visiting in Minnesota, 555 infants and children (3.4 percent) were identified as having been reported for child maltreatment (substantiated and self-report). Local public health home visitors utilize interventions with families that are designed to support healthy and safe parent-child relationships. Evidence-based home visiting models such as HFA and NFP, begun prenatally whenever possible, demonstrate strong outcomes in parent-child interactions and parental capacity, with significant reductions in child maltreatment and parental stress. [ix] [x]

Conclusion

Appendix E is a map indicating statewide implementation of HFA, NFP and Reflective Practice Mentoring (as of December 2011). In addition, Minnesota's local public health FHV programs offer a range of interventions including programs that are:

- in various stages of applying to become an HFA and/or NFP implementing agency;
- exploring evidence-based models and reflective practice mentoring;
- learning and/or implementing evidence-based interventions and reflective practice; and/or
- implementing locally-developed promising practice FHV models, some seeking more formal identification as an evidence-based model by national FHV evaluation experts.

The MDH secured competitive federal dollars and is maximizing other federal funding to advance the use of evidence-based home visiting models and interventions to further impact the intended outcomes identified in Minnesota's FHV statute. In 2012, the framework for grantee plans, as required for use of TANF FHV funds, and other capacity-building activities by MDH will continue to promote the use of local, state and federal funds to support the statewide scaling up of evidence-based FHV models, practices, and other key elements of effective FHV programs. Ongoing training, consultation, reflective practice mentoring and data collection by MDH will continue to advance the use of TANF funding for evidence-based home visiting programs designed to impact the outcomes as defined in the statute.

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[i] Korfmacher, J, Green, B, et al. *Parent Involvement in Early Childhood Home Visiting*. Child & Youth Care Forum, v37 n4 p171-196 Aug 2008. Springer Science+Business Media, LLC.

[ii] Kitzman HJ, Olds DL, Cole RE, et al. Enduring effects of prenatal and infancy home visiting by nurses on children: follow-up of a randomized trial among children at age 12 years. Arch Pediatr Adolesc Med. 2010; 164(5):412–418

[iii] Nurse-Family Partnership (June 2010). *Benefits and Costs: A Program with Proven and Measurable Results.* Denver, CO: Nurse-Family Partnership.
[iv] Karoly, L., Kilburn, M., Cannon, J.; *Early Childhood Interventions: Proven Results, Future Promise*; RAND Corporation; 2005.
[v] Miller, T. (February 2011). *Cost Offsets of Nurse-Family Partnership in Minnesota*. Calverton, MD: Pacific Institute for Research and Evaluation.
[vi] National Scientific Council on the Developing Child (July 2010). *The Foundations of Lifelong Health are Built in Early Childhood.* Cambridge, MA: Harvard University, Center on the Developing Child.
[vii] Committee on Psychosocial Aspects of Child and Family Health, Committee on Early Childhood, Adoption, and Dependent Care, and Section on Developmental and Behavioral Pediatrics. American Academy of Pediatrics. Early childhood adversity, toxic stress, and the role of the pediatrician: Translating developmental science into lifelong health. *Pediatrics*. 2012;129:e224–e231.
[viii] Shonkoff, JP, Garner, AS, et al. The lifelong effects of early childhood adversity and toxic stress. *Pediatrics*. 2012;129:e232–e246.
[ix] PCA America (2001). *Healthy Families America Reduces Child Maltreatment.* www.healthyfamiliesamerica.org
[x] Nurse-Family Partnership, *Nurse-Family Partnership Snapshot*. http://www.nursefamilypartnership.org/assets/PDF/Fact-sheets/NFP_Snapshot, September 2010.

Appendix: A

145A.17 FAMILY HOME VISITING PROGRAMS.

Subdivision 1. **Establishment; goals.** The commissioner shall establish a program to fund family home visiting programs designed to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. The commissioner shall promote partnerships, collaboration, and multidisciplinary visiting done by teams of professionals and paraprofessionals from the fields of public health nursing, social work, and early childhood education. A program funded under this section must serve families at or below 200 percent of the federal poverty guidelines, and other families determined to be at risk, including but not limited to being at risk for child abuse, child neglect, or juvenile delinquency. Programs must begin prenatally whenever possible and must be targeted to families with:

(1) adolescent parents;

(2) a history of alcohol or other drug abuse;

(3) a history of child abuse, domestic abuse, or other types of violence;

(4) a history of domestic abuse, rape, or other forms of victimization;

(5) reduced cognitive functioning;

(6) a lack of knowledge of child growth and development stages;

(7) low resiliency to adversities and environmental stresses;

(8) insufficient financial resources to meet family needs;

(9) a history of homelessness;

(10) a risk of long-term welfare dependence or family instability due to employment barriers; or

(11) other risk factors as determined by the commissioner.

Subd. 2. [Repealed, 1Sp2003 c 14 art 8 s 32]

Subd. 3. **Requirements for programs; process.** (a) Community health boards and tribal governments that receive funding under this section must submit a plan to the commissioner describing a multidisciplinary approach to targeted home visiting for families. The plan must be submitted on forms provided by the commissioner. At a minimum, the plan must include the following:

(1) a description of outreach strategies to families prenatally or at birth;

(2) provisions for the seamless delivery of health, safety, and early learning services;

(3) methods to promote continuity of services when families move within the state;

(4) a description of the community demographics;

(5) a plan for meeting outcome measures; and

(6) a proposed work plan that includes:

(i) coordination to ensure nonduplication of services for children and families;

(ii) a description of the strategies to ensure that children and families at greatest risk receive appropriate services; and

(iii) collaboration with multidisciplinary partners including public health, ECFE, Head Start, community health workers, social workers, community home visiting programs, school districts, and other relevant partners. Letters of intent from multidisciplinary partners must be submitted with the plan.

(b) Each program that receives funds must accomplish the following program requirements:

(1) use a community-based strategy to provide preventive and early intervention home visiting services;

(2) offer a home visit by a trained home visitor. If a home visit is accepted, the first home visit must occur prenatally or as soon after birth as possible and must include a public health nursing assessment by a public health nurse;

(3) offer, at a minimum, information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services available in the community;

(4) provide information on and referrals to health care services, if needed, including information on and assistance in applying for health care coverage for which the child or family may be eligible; and provide information on preventive services, developmental assessments, and the availability of public assistance programs as appropriate;

(5) provide youth development programs when appropriate;

(6) recruit home visitors who will represent, to the extent possible, the races, cultures, and languages spoken by families that may be served;

(7) train and supervise home visitors in accordance with the requirements established under subdivision 4;

(8) maximize resources and minimize duplication by coordinating or contracting with local social and human services organizations, education organizations, and other appropriate governmental entities and community-based organizations and agencies;

(9) utilize appropriate racial and ethnic approaches to providing home visiting services; and

(10) connect eligible families, as needed, to additional resources available in the community, including, but not limited to, early care and education programs, health or mental health services, family literacy programs, employment agencies, social services, and child care resources and referral agencies.

(c) When available, programs that receive funds under this section must offer or provide the family with a referral to center-based or group meetings that meet at least once per month for those families identified with additional needs. The meetings must focus on further enhancing the information, activities, and skill-building addressed during home visitation; offering opportunities for parents to meet with and support each other; and offering infants and toddlers a safe, nurturing, and stimulating environment for socialization and supervised play with qualified teachers.

(d) Funds available under this section shall not be used for medical services. The commissioner shall establish an administrative cost limit for recipients of funds. The outcome

measures established under subdivision 6 must be specified to recipients of funds at the time the funds are distributed.

(e) Data collected on individuals served by the home visiting programs must remain confidential and must not be disclosed by providers of home visiting services without a specific informed written consent that identifies disclosures to be made. Upon request, agencies providing home visiting services must provide recipients with information on disclosures, including the names of entities and individuals receiving the information and the general purpose of the disclosure. Prospective and current recipients of home visiting services must be told and informed in writing that written consent for disclosure of data is not required for access to home visiting services.

(f) Upon initial contact with a family, programs that receive funding under this section must receive permission from the family to share with other family service providers information about services the family is receiving and unmet needs of the family in order to select a lead agency for the family and coordinate available resources. For purposes of this paragraph, the term "family service providers" includes local public health, social services, school districts, Head Start programs, health care providers, and other public agencies.

Subd. 4. **Training.** The commissioner shall establish training requirements for home visitors and minimum requirements for supervision. The requirements for nurses must be consistent with chapter 148. The commissioner must provide training for home visitors. Training must include the following:

(1) effective relationships for engaging and retaining families and ensuring family health, safety, and early learning;

(2) effective methods of implementing parent education, conducting home visiting, and promoting quality early childhood development;

(3) early childhood development from birth to age five;

(4) diverse cultural practices in child rearing and family systems;

(5) recruiting, supervising, and retaining qualified staff;

(6) increasing services for underserved populations; and

(7) relevant issues related to child welfare and protective services, with information provided being consistent with state child welfare agency training.

Subd. 4a. **Home visitors as MFIP employment and training service providers.** The county social service agency and the local public health department may mutually agree to utilize home visitors under this section as MFIP employment and training service providers under section 256J.49, subdivision 4, for MFIP participants who are: (1) ill or incapacitated under section 256J.425, subdivision 2; or (2) minor caregivers under section 256J.54. The county social service agency and the local public health department may also mutually agree to utilize home visitors to provide outreach to MFIP families who are being sanctioned or who have been terminated from MFIP due to the 60-month time limit.

Subd. 5. **Technical assistance.** The commissioner shall provide administrative and technical assistance to each program, including assistance in data collection and other activities related to conducting short- and long-term evaluations of the programs as required under subdivision 7. The commissioner may request research and evaluation support from the University of Minnesota.

Subd. 6. **Outcome and performance measures.** The commissioner shall establish measures to determine the impact of family home visiting programs funded under this section on the following areas:

(1) appropriate utilization of preventive health care;

(2) rates of substantiated child abuse and neglect;

(3) rates of unintentional child injuries;

(4) rates of children who are screened and who pass early childhood screening;

(5) rates of children accessing early care and educational services;

(6) program retention rates;

(7) number of home visits provided compared to the number of home visits planned;

(8) participant satisfaction;

(9) rates of at-risk populations reached; and

(10) any additional qualitative goals and quantitative measures established by the commissioner.

Subd. 7. **Evaluation.** Using the qualitative goals and quantitative outcome and performance measures established under subdivisions 1 and 6, the commissioner shall conduct ongoing evaluations of the programs funded under this section. Community health boards and tribal governments shall cooperate with the commissioner in the evaluations and shall provide the commissioner with the information necessary to conduct the evaluations. As part of the ongoing evaluations, the commissioner shall rate the impact of the programs on the outcome measures listed in subdivision 6, and shall periodically determine whether home visiting programs are the best way to achieve the qualitative goals established under subdivisions 1 and 6. If the commissioner determines that home visiting programs are not the best way to achieve these goals, the commissioner shall provide the legislature with alternative methods for achieving them.

Subd. 8. **Report.** By January 15, 2002, and January 15 of each even-numbered year thereafter, the commissioner shall submit a report to the legislature on the family home visiting programs funded under this section and on the results of the evaluations conducted under subdivision 7.

Subd. 9. **No supplanting of existing funds.** Funding available under this section may be used only to supplement, not to replace, nonstate funds being used for home visiting services as of July 1, 2001.

History: *1Sp2001 c 9 art 1 s 53; 2002 c 379 art 1 s 113; 2007 c 147 art 17 s 1; 2009 c 79 art 2 s 8; 1Sp2011 c 9 art 2 s 22*

Appendix: B

Community Health Board Funding Allocations
Calendar Year 2012 Awards

Community Health Board	TOTAL Award	TANF Federal Funds	Title V Federal Funds	LPHA State Funds
AITKIN-ITASCA-KOOCHICHING	588,528	121,926	103,724	362,878
ANOKA	1,522,996	315,520	268,417	939,059
BECKER	235,175	48,721	41,448	145,006
BENTON	211,523	43,821	37,280	130,422
BLUE EARTH	333,539	69,100	58,784	205,655
BROWN-NICOLLET	350,858	72,688	61,835	216,335
CARLTON- COOK -LAKE-ST. LOUIS	1,880,146	389,511	331,363	1,159,272
CARVER	274,876	56,946	48,445	169,485
CASS	199,117	41,251	35,093	122,773
CHISAGO	219,109	45,394	38,616	135,099
CLAY- WILKIN	462,240	95,762	81,467	285,011
COTTONWOOD-JACKSON	191,192	39,610	33,696	117,886
COUNTRYSIDE (BIG STONE-CHIPPEWA-LAC QUI PARLE-SWIFT -YELLOW MEDICINE)	419,638	86,937	73,958	258,743
CROW WING	363,732	75,355	64,104	224,273
DAKOTA	1,570,466	325,356	276,783	968,327
DODGE-STEELE	315,246	65,310	55,559	194,377
FARIBAULT- MARTIN	257,324	53,310	45,352	158,662
FILLMORE-HOUSTON	267,387	55,394	47,126	164,867
FREEBORN	213,674	44,266	37,659	131,749
GOODHUE	229,099	47,462	40,377	141,260
HENN-BLOOMINGTON	428,346	88,741	75,492	264,113
HENN-EDINA	193,055	39,995	34,025	119,035
HENN-RICHFIELD	217,940	45,150	38,411	134,379
HENN-MINNEAPOLIS	4,729,343	979,782	833,512	2,916,049
HENN-SUBURBAN	3,308,026	685,328	583,015	2,039,683
HORIZON (DOUGLAS-GRANT -POPE-STEVENS-TRAVERSE)	484,464	99,331	84,502	300,631
ISANTI-MILLE LACS	373,579	77,395	65,839	230,345
KANABEC-PINE	329,662	68,296	58,101	203,265
KANDIYOHI	295,985	61,320	52,165	182,500
LE SUEUR-WASECA	282,172	58,458	49,731	173,983
MEEKER- McLEOD-SIBLEY	458,615	95,011	80,828	282,776
MORRISON-TODD-WADENA	547,503	113,428	96,493	337,582

Community Health Board	TOTAL Award	TANF Federal Funds	Title V Federal Funds	LPHA State Funds
MOWER	245,273	50,814	43,227	151,232
NOBLES	142,961	30,999	26,370	85,592
NORMAN-MAHNOMEN	114,614	23,745	20,200	70,669
NORTH COUNTRY (BELTRAMI-CLEARWATER-HUBBARD-LAKE OF THE WOODS)	590,858	122,410	104,133	364,315
OLMSTED	730,994	151,441	128,832	450,721
OTTER TAIL	366,032	75,831	64,510	225,691
POLK	250,302	51,856	44,114	154,332
QUIN (KITTSON-MARSHALL-PENNINGTON-RED LAKE-ROSEAU)	407,453	84,413	71,810	251,230
RAMSEY	4,801,498	994,733	846,227	2,960,538
REDWOOD-RENVILLE	244,997	50,756	43,179	151,062
RICE	307,229	63,650	54,147	189,432
SCOTT	369,583	76,567	65,137	227,879
SHERBURNE	295,460	61,212	52,073	182,175
STEARNS	751,174	155,623	132,389	463,162
SOUTHWEST HEALTH AND HUMAN SERVICES (LINCOLN-LYON-MURRAY-PIPESTONE-ROCK)	474,836	98,026	83,392	293,418
WABASHA	134,535	27,873	23,710	82,952
WASHINGTON	881,011	182,520	155,272	543,219
WATONWAN	102,218	21,177	18,015	63,026
WINONA	284,794	59,002	50,193	175,599
WRIGHT	436,722	90,477	76,969	269,276
TOTAL	**33,687,099**	**6,979,000**	**5,937,099**	**20,771,000**

Appendix: C

Family Home Visiting Steering Committee

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Appendix: D

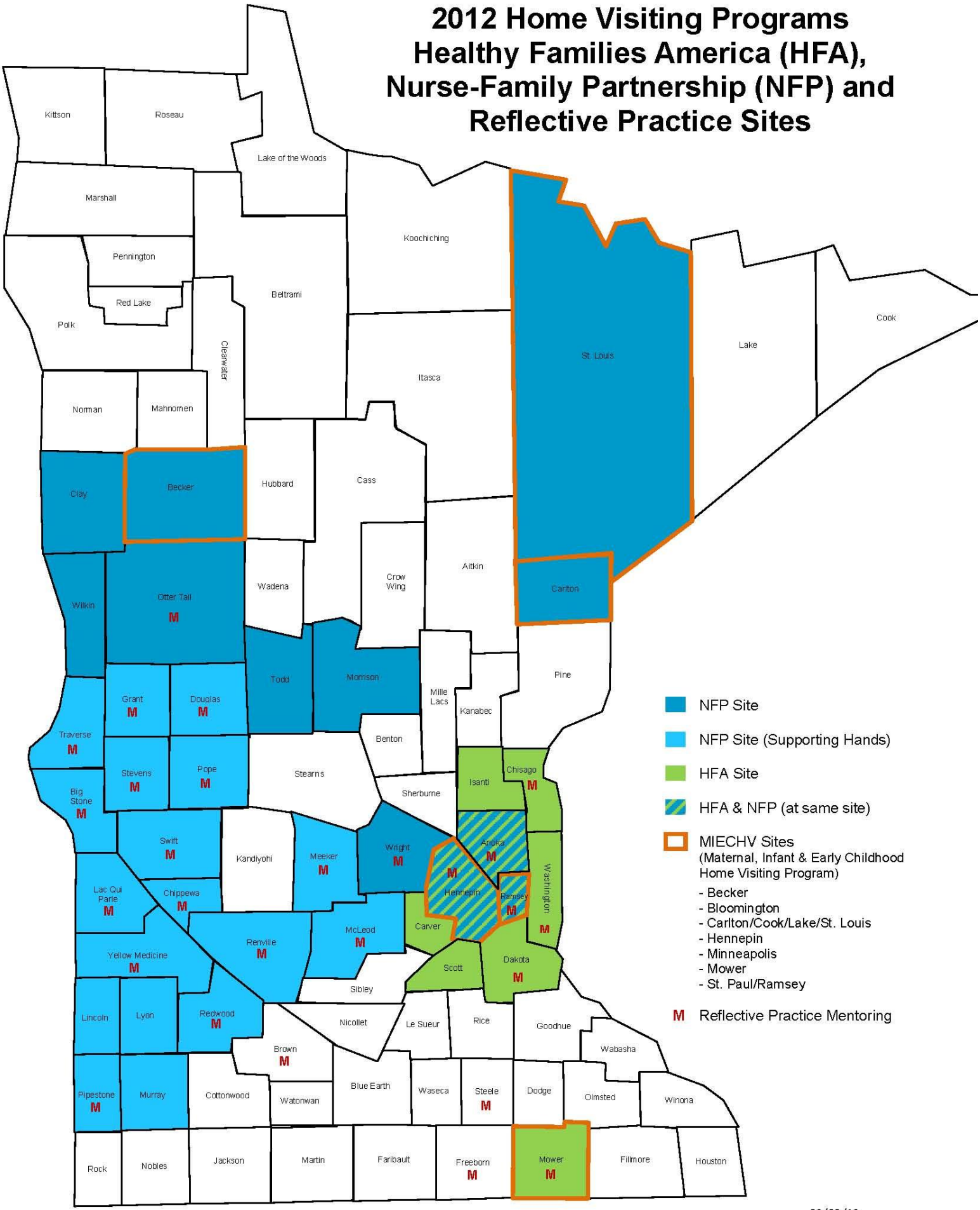
Local Public Health Family Home Visiting: 2010 Demographic Characteristics[1]

Indicator/Category	N	Percent[2]
Total Enrollment	**32,936**	**100**
Primary Caregivers	11,647	35
Prenatal Clients	5155	16
Infants and Children	16134	49
Age Group - Primary Caregiver & Prenatal Clients	**16,802**	**100**
<15	123	<1
15-17	1365	8
18-19	1981	12
20-21	1839	11
22-24	2505	15
25-34	6068	36
35+	1465	9
Race - Primary Caregiver & Prenatal Clients	**16802**	**100**
White	10748	64
Black/ African American	2556	15
American Indian/ Alaskan Native	477	3
Asian	836	5
Native Hawaiian/ Other PI	36	<1
1+ Race Reported	370	2
Race of Infants & Children	**14,232**	**100**
White	8148	57
Black/ African American	2114	15
American Indian/ Alaskan Native	389	3
Asian	827	6
Native Hawaiian/ Other PI	31	<1
1+ Race Reported	701	5
Hispanic Ethnicity - Primary Caregivers & Prenatal Clients	**3713**	**22**
Maternal/Primary Caregiver/Prenatal Client Education	**16804**	**100**
No high school diploma/GED	5228	31
High school diploma/GED	4719	28
Some post-secondary education or degree	4002	24

[1]Includes data from reporting period January 1 – December 31, 2010.
[2]Column totals not equaling 100 percent are due to unknown, other, or missing values.
These data do not reflect tribal home visiting programs. MDH continues to work with tribal programs on identifying data collection activities that meet the needs of tribal communities.

Appendix: E

2012 Home Visiting Programs Healthy Families America (HFA), Nurse-Family Partnership (NFP) and Reflective Practice Sites



02/03/12