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# **Family Home Visiting Program**

## **Minnesota Department of Health** *Report to the Minnesota Legislature 2014*

**March 2014**

# **Family Home Visiting Program**

**March 2014**

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# Background

"There is nothing more important to this nation's future than investing in our young people."

-First Lady Michelle Obama

## Introduction

All families experience joy and face challenges raising their children. For over 100 years, nurse home visiting has been used as a service strategy, to improve the health and well-being of families who want the best for their children.

The goal of Minnesota's Family Home Visiting Program is to provide targeted home visiting services that are 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
- Promote family health and economic self-sufficiency for children and families

Public health family home visiting services are ideally delivered beginning prenatally 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,
- ensure that very young children develop in safe and healthy environments, and
- provide parenting skills and support that decrease the risk of child abuse.

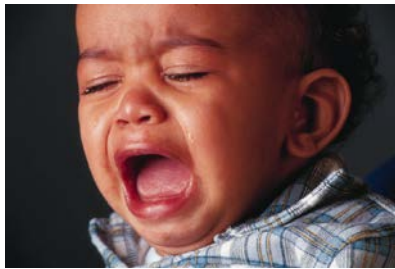
Depending on the goals identified by a family and based on a public health nursing assessment, a family may choose to work with a home visitor for up to two years or longer.

Research in early brain development indicates that experiences in the first few years of a child's life are the most critical and can have far reaching consequences. Family home visiting that is grounded in empirically-based research and targeted to those most at risk has been shown to be successful in mitigating adverse early experiences and change the child and families' development trajectory. Home visiting is linked with improving child and family outcomes resulting in significant cost savings at the community, state and federal levels through reductions in:

- child maltreatment,
- juvenile arrests,
- maternal convictions,
- emergency department use, and
- cognitive and behavioral problems.<sup>i</sup>

An extensive and growing body of research documents that adverse childhood experiences – those causing toxic levels of stress or trauma before age 18—are specifically linked to poor physical and mental health, chronic disease, lower educational achievement, lower economic success, and impaired social success in adulthood. Traumatic experiences such as mental illness, abuse, neglect, family violence and family substance abuse have a strong and cumulative impact on the health and functioning of adults and are major risk factors for leading causes of illness and death<sup>ii</sup> These negative lifelong outcomes create a significant toll on families as well as on communities and impact quality of life in both.

Poverty, maltreatment and other trauma that contribute to toxic stress are distinct risks to overall health and development. The trauma-informed care provided by highly trained home visitors, in partnership with other skilled community-based providers, supports and promotes the resilience families need to buffer the negative effects of toxic stress and support a positive healthy development trajectory for their child.<sup>iii</sup>



## **Statutory requirements**

Minnesota Statute Section §145A.17 (Appendix A) governs the Family Home Visiting Program. The Minnesota Legislature provides funding of \$7,827,300 annually to Community Health Boards and Tribal Governments for services provided under the statute. (Appendix B the 2014 calendar year Community Health Board Awards and, Appendix C the Tribal Government Awards state fiscal year). The Department of Health is responsible for training and supervision standards, establishment of measure to determine the impact of Family Home Visiting programs funded under the statute and to administer and monitor grantees. Minnesota Statute 145A.17 subd. 8 also requires the Commissioner of Health to submit a report to the legislature on the Family Home Visiting Program in even numbered years. The purpose of this report is to describe the activities as mandated.

The Family Home Visiting 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 directs services 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 begin prenatally whenever possible and target families with one or more of 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
- Serious mental health disorder, including maternal depression

# Program Administration

*“There has been a definite shift in understanding the importance of early referral and support for the Family Home Visiting population. The community has demonstrated a shift from blame and/or isolation to adopting the embracement of: When all children and families are successful, we all win. An example of this shift is evident in the implementation of a community diaper drive to support the financial impact young mothers and fathers face, with less income potential than older parents and/or parents with less risk factors.”*

-Hennepin County Family Home Visiting Program

The Minnesota Department of Health (MDH) provides administrative oversight, grants, training and technical assistance, and the collection of statewide outcomes and measures of family home visiting services delivered at the community level.

In 2011-12 MDH, under the purview of the Maternal and Child Health Advisory Task Force, convened a Family Home Visiting Advisory Committee. The charge of the group was to provide direction and guidance to the Commissioner of Health and MDH staff on issues related to the expansion and integration of evidence-based public health home visiting programs in Minnesota’s health and early childhood systems. Membership included representatives from local public health and a broad range of early childhood and other public health partners.

The committee work culminated in a set of recommendations and report to the Commissioner of Health. They can be found in Appendix D.

In January 2014, MDH convened an ongoing Family Home Visiting Advisory Group, comprised of representatives from local public health and other early childhood stakeholders, to develop an action plan to implement the report recommendations. The advisory group and its working committees (i.e., evaluation) will also serve to inform and guide program development of statewide activities focused on family home visiting and early childhood.

## **The Federal Maternal, Infant, and Early Childhood Home Visiting Program**

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 by funding evidence-based models that have proven effective. Administered by the U.S. Health Resources and Services Administration and implemented through collaboration at the federal, state, and community levels, the MIECHV Program aims to improve the health and development outcomes for at-risk children through state home visiting programs that use a federally approved list of evidence-based models which have demonstrated effectiveness in achieving positive maternal and child health outcomes.

This unprecedented infusion of federal funding to enhance systems of care for very young children and their families at risk for poor outcomes has significantly enhanced the state’s ability to provide effective public health home visiting programs to families who may benefit the most from them.

MDH receives approximately \$1.4 million a year in a formula-based MIECHV grant based. The MIECHV grant application was based on a statewide needs assessment. The needs assessment identified state program goals and Minnesota's highest risk communities based on maternal and child risk factors identified by the U.S. Health Resources and Services Administration. Of the highest risk communities identified in the statewide needs assessment, seven Community Health Boards representing five high risk counties agreed to partner with MDH to participate in the MIECHV program. The overall purpose of the program is to enhance the state's infrastructure to support evidence-based home visiting.

Two home visiting models from among those approved for selection by the U.S. Health Resources and Services Administration were chosen for implementation in Minnesota's MIECHV Program. The Healthy Families America and Nurse-Family Partnership models were selected based on the following criteria:

- Opportunity to maximize the state's existing federal grant focused on the Nurse-Family Partnership model
- Added the Healthy Families America model in addition to the Nurse-Family Partnership model to give the flexibility to serve more families (e.g., the Healthy Families America model has broader enrollment criteria, broader range of service providers)
- Building on the infrastructure and resources of two models already established in the state
- Strength of the Nurse-Family Partnership and Healthy Families America programs' evidence
- MDH capacity to support program expansion, including data collection

Often referred to as the MIECHV Formula grant, it includes:

- Grants which go through September 2014 to local and tribal public health totaling \$830,000 per year for start-up and training costs to implement evidence-based models approved by the U.S. Health Resources and Services Administration
- Training and technical assistance to local and tribal public health
- Data collection and continuous quality improvement



In June 2011, the U.S. Health Resources and Services Administration issued a competitive grant funding opportunity to expand the MIECHV Program. The program provides additional funding to states that have demonstrated capacity to expand and/or enhance their MIECHV programs. MDH submitted a proposal and in April 2012 was awarded a three-year grant for \$8 million per year (subsequently reduced by sequestration to \$7.6 million for federal fiscal year 2014).

Based on the same risk assessment used in the MIECHV formula grant, a total of 28 counties served by 19 Community Health Boards were allocated MIECHV expansion funding to implement the Healthy Families America and/or Nurse-Family Partnership home visiting models targeting their highest risk and unserved communities.

In 2013, nine Community Health Boards and one tribal government received Nurse-Family Partnership start-up and training mini-grants. Other statewide MIECHV expansion activities include home visiting program training and technical assistance, data collection and data systems development, continuous quality improvement, and a reflective practice evaluation conducted by the University of Minnesota Center for Early Education and Development (see MIECHV Expansion Executive Summary, Attachment E).

White Earth Nation was also successful in securing a competitive federal Maternal, Infant and Early Childhood Home Visiting grant to implement the Nurse-Family Partnership. Their participation is informing the development and evaluation of cultural adaptations to the Nurse-Family Partnership model.



## **Promoting quality practice standards**

A goal of the Family Home Visiting program is to continue to advance the practice of all home visitors. Training is an integral component to supporting the development of quality practices and appropriate delivery of evidence-based home visiting services. Training is embedded and integrated into practice in order to be effective in advancing the practice of home visitors. During the next two years, a focus of MDH staff will be in developing trainings and protocols, as well as identifying resources that will support advancing the practice of all home visitors.

The federal MIECHV grants have provided an opportunity to further the use of evidence-based practices standards in Family Home Visiting programs throughout the state. There is a range in length and intensity of home visiting services provided by local public health departments and tribal governments in the state. Some public health departments provide a single universal home visit shortly after birth, with additional visits if the family is found to be in need, while others provide intensive services to at-risk families.

*“At the end of the visit the mom said she felt as though an angel had come to visit.”*

- Becker County Family Home Visitor

The Minnesota Coalition for Targeted Home Visiting, a consortium of home visiting providers in the state, is also interested in advancing the practice of home visitors. The Coalition for Targeted Home Visiting and its partners are working to identify core competencies and standards that would be utilized by all home visiting programs. While some home visiting programs may have additional or higher level of standards based on models or curriculum used, this work will serve as a baseline for expectations for home visiting programs.

A key component in advancing practice is utilizing continuous quality improvement. MIECHV sites are currently undertaking quality improvement projects. Lessons learned will not only support practice improvement, they will serve as a model for others undertaking continuous quality improvement.

To advance practice through quality improvement, timely and quality data must be available. In an effort to improve the quality of data available, there will be a transition of the Family Home Visiting evaluation for all programs to the federally required benchmarks for the MIECHV grants wherever those measures are applicable. This transition will result in better quality data available at the state level and to local public health agencies which will further their quality improvement activities. Collecting the same data from MIECHV sites and other family home visiting programs also provides common points of comparison and the ability to determine if we are achieving better outcomes for Minnesota families.

## **Coordination and collaboration**

Collaboration and coordination with early childhood services at the local level is a mandatory component of the MIECHV program as well as a critical element of effective home visiting models. MIECHV sites provide regular reports as to the progress they are making in their collaborative efforts.



Even though evidence-based family home visiting curricula provide extensive information and support to families, it is a central function of theirs to link families to other needed resources and providers. Family home visits are not designed to provide whatever medical or social service a family member might need, usurping the role of medical, mental health or chemical dependency clinicians or other professionals. Rather, as needs are identified, either informally or through screenings administered, the family home visitor connects families to the appropriate resources in the community for further assessment, treatment or other needed expertise. For example, the MIECHV expansion program has provided an opportunity to support enhanced linkages between local public health family home visiting programs and community-based licensed infant mental health professionals. MIECHV-funded home visiting teams have regular access to qualified infant mental health consultation to partner in supporting families.

At the state level, a new collaboration between MDH and the Minnesota Department of Human Services links the delivery of home visiting services to pregnant and parenting teens more purposefully with Minnesota Family Investment Program families. This pilot project supports the development and evaluation of local program coordination strategies to promote high school graduation as well as optimal maternal and child health outcomes for teen parents.

## **Continuous professional development**

Studies have shown that high levels of training to home visiting staff positively impact the effectiveness of home visiting strategies on the physical and social/emotional development of children and the prevention of child maltreatment.<sup>iv</sup>

In 2012 MDH offered approximately 665 hours of training through 31 training events. In 2013 the MDH training program more than doubled that amount with 1,328 hours of training through 45 training events which included maternal and infant assessment, screening methods, implementation of evidenced based models, and particular topics such as child development and working with chemical dependency.

Training followed by coaching or facilitated follow up has proven to be most effective in imbedding good practice standards into home visiting practice.



MDH co-sponsored two community-wide professional development events:

1. Together with the Minnesota Coalition for Targeted Home Visiting in 2012: Home Visiting in the Context of Risk Integrated Learning Series. This event started with a one-day kick off broadcast through ITV and was followed by regional in-person facilitated

discussions about home visiting in the context of family risk factors. Follow up webinars were offered into 2013.

2. The Minnesota Birth to Three Institute: Strong Foundations (2012). This two-day event with national speakers invited all early childhood practitioners in Minnesota to the event with some tracks designed for home visitors.

MDH provided, under contract with Johns Hopkins University, two week-long sessions of Family Spirit training. Family Spirit is the only evidence-based home visiting program designed specifically for at-risk Native American families. The contract provided initial training and support and allows supervisors and the MDH tribal nurse consultant to train new staff during the coming year.

The MDH Home Safety Checklist was originally created in 1990, revised several times and updated in 2012. The Home Safety Checklist is intended to be a tool for family home visitors to use during visits with families and is available in English and Spanish.

MDH also provides statewide data collection and continuous quality improvement training and technical assistance to family home visiting program staff. Statewide webinars and “Open Mic” teleconferences, held monthly, serve to engage local public health home visiting staff in ongoing professional development and provide the opportunity to share learnings and innovation across programs.

# Public Health Family Home Visiting Data Collection and Program Evaluation

*“What the best and wisest parent wants for his own child, that must the community want for all its children.”*

-John Dewey, U.S. Philosopher and Educator

The identification of evaluation benchmarks was informed by the requirements of the federal MIECHV Program and the home visiting model developers (Healthy Families America and Nurse-Family Partnership). The federal MIECHV Program presents a valuable opportunity to maximize use of benchmark measures required by the federal program to develop more robust and uniform measures for all home visiting programs.

For the first time, local programs are reporting on standard measures of child development and parent-child interactions as determined by validated screening and assessment tools. A significant shift for local programs, the reporting of benchmark data now occurs on a quarterly basis. Data collection for home visiting in Minnesota has been challenged by the diversity of data collection systems that are used locally. Efforts to collect standard measures across programs and counties requires mapping the variables to existing fields in over six different data systems used by local public health agencies, ensuring that the definitions of fields and frequency of data collection is compatible. MDH has been working with local health departments that have transitioned from locally developed data gathering to reporting data based on the federal MIECHV benchmarks (see Appendix I). MDH is also working with the Nurse-Family Partnership to secure Minnesota-specific benchmark measures from their data system.

The table below shows the number of clients enrolled in all family home visiting programs for 2011 and 2012.

**Clients in All Family Home Visiting Programs 2011 and 2012**

	<b>2011</b>	<b>2012</b>
Primary caregivers enrolled	11,391	9,872
Prenatal clients enrolled	4,072	4,217
Infants & children enrolled	15,046	13,341
<b>Total clients enrolled</b>	<b>30,809</b>	<b>27,420</b>

The apparent decrease in clients served is likely due to a number of factors. Data quality has improved over time as local data collection has become more standard-based and state requirements were clarified. As the delivery of evidence-based models increases statewide, some local programs have shifted from providing short-term home visiting to providing the long-term intensive evidence based models needed to address the complex needs of higher risk families.

This data is reflected by County in the 2011-12 Local Public Health Family Home Visiting Demographic Characteristics Appendix G.

A subset of the enrollees received services through the MIECHV evidence-based models. MIECHV funding has already served 1,117 families for a total of 10,876 home visits as of December 31, 2013.

Additional data for 2013 will be available as enrollees reach the determined intervals for data collection (i.e., infant/child aged six months, 12 months, 18 months, 24 months).

An Evaluation Work Group and Data Repository Users Group comprised of local program staff work with MDH ensure stakeholders have access to meaningful program evaluation data.

### MIECHV funding and benefits

Research-based family home visiting models have proven that for every dollar invested, a return of between \$1.24 and \$5.70 can be expected in savings; savings per child to government programs alone ranges between \$2,005 and \$14,075 (2003 dollar values).<sup>v</sup> 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.<sup>vi</sup>



According to national data, the cost per family for delivering the two MIECHV approved evidence-based models chosen in Minnesota were:<sup>vii</sup>

<b>Healthy Families America (2004)</b>	
Range: \$1,590 - \$5,768 Average: \$3,348	Average trended to 2013 dollars: \$4,150
<b>Nurse Family Partnership (2008)</b>	
Range: \$2,914 - \$6,463 Average: \$4,500	Average trended to 2013 dollars: \$4,900

Costs in Minnesota for both the Healthy Families America and the Nurse-Family Partnership models combined range from \$2,344 to \$8,468 with an average cost of \$5,253<sup>viii</sup>. It is not

surprising that initial costs in Minnesota are somewhat higher as start-up for both these models require a significant investment training and administrative infrastructure.

The MIECHV funding expires September 2015 when federal authorization will be needed to continue this funding. Maintaining the current gains in infrastructure and expanding statewide high risk family access to effective programs would require the identification of new dedicated investments in the next couple of years.

*All throughout the visits, the Public Health Nurse (PHN) wrote letters to “Tracy” in the “voice of her baby.” These letters highlighted what the PHN and Tracy had talked about during their visits and they offered encouraging words and sentiments of thanks “from the baby” for all of the hard work she was doing.*

*At one visit, Tracy invited the PHN into her back bedroom. She showed her a graded test that she had taken for one of her Nursing Assistant courses. She had gotten an A, 100% correct!*

*She said, “I’ve never been 100% good at anything in my life. Thank you for making me think I can do this.”*

*The PHN asked Tracy what helped her keep going when times got tough. Tracy led her into a small, adjoining room and, with tears in her eyes, she said “These! These letters are everything!”*

*She pointed to all the letters she had received from the PHN that had been written in the voice of baby James. She had taped up each and every letter and they filled an entire wall. “When I feel like using, I stand here and look at them. They give me strength I didn’t know I had.”*

*Tracy is now employed at a nursing home as a Nursing Assistant. She celebrated a year of sobriety last month and her baby is thriving.*

*-Fond du Lac Family Home Visiting Program*

## **Expanding family access to evidence-based models**

A statewide map of the Health Families America and/or Nurse-Family Partnership implementation sites can be found in Appendix H. Family access to the evidence-based programs offered at these sites may be limited by the following factors, among others:

- Enrollment criteria of the programs themselves (i.e., must be a first-time mother for Nurse-Family Partnership)
- Service area reached by individual programs is limited to county or program boundaries
- Population outreach and engagement challenges
- Lack of local and state resources to adequately maintain and/or expand the implementation of an evidence-based model

In addition to sites offering Health Families America and/or Nurse-Family Partnership, Minnesota's local public health offers a range of Family Home Visiting programs including those that are:

- In various stages of applying to become an Health Families America and/or Nurse-Family Partnership implementing agency
- Exploring evidence-based models and implementing evidence-based practices
- Implementing locally-developed promising practice Family Home Visiting models, some seeking formal designation as an evidence-based model by national experts

Increasing family access to evidence-based programs offered by Community Health Boards and tribal governments is dependent upon adequate local and state capacity, stable funding, strong health care and early childhood collaborations and effective referral systems. In Minnesota, family access also depends upon opportunities for smaller programs in less populated communities to form multi-county or regional partnerships. For example, the Nurse-Family Partnership model typically requires that a community has an eligible population of 100 families (pregnant low-income women with no previous live births). Regional collaborations such as the Supporting Hands Nurse-Family Partnership Joint Powers Board (20 counties in west central MN) or smaller multi-county partnerships (i.e., Becker and Otter Tail Counties) can expand the reach of evidence-based models to families in communities that may be challenged to offer the models by themselves. Adequate staffing ratios, continuous professional development, high quality supervision, data collection, quality improvement and administrative functions can be maximized and shared across community programs in well-supported and managed collaborative partnerships.

## **Conclusion**

Family home visiting services have been proven successful in improving outcomes for at-risk families and children, as well as cost effective to communities and systems. Minnesota has laid a strong foundation to expand statewide capacity to link more families at-risk to programs that work, to measure their impact and to provide accountability to communities.

In partnership with local public health, tribal communities and other early childhood stakeholders, MDH will continue to promote the use of local, state and federal funds to scale up statewide implementation of evidence-based Family Home Visiting models, practices, and other key elements of effective programs. Ongoing leadership, consultation, continuous professional development and data collection by MDH will continue to advance the outcomes as defined in the statute and to improve the health and well-being of Minnesota's families.



## **Appendices**



**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;
- (11) a serious mental health disorder, including maternal depression as defined in section 145.907; or
- (12) other risk factors as determined by the commissioner.

Subd. 2. [Repealed, 1Sp2003 c 14 art 8s 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; 2013 c 108 art 12 s 49*

## Appendix B: Community Health Board Family Home Visiting Funding Allocations Calendar Year 2014 Awards

<b>Community Health Board</b>	<b>Funding</b>
AITKIN-ITASCA-KOOCHICHING	121,926
ANOKA	315,520
BECKER	48,721
BENTON	43,821
BLUE EARTH	69,100
BROWN-NICOLLET	72,688
CARLTON- COOK -LAKE-ST. LOUIS	389,511
CARVER	56,946
CASS	41,251
CHISAGO	45,394
CLAY- WILKIN	95,762
COUNTRYSIDE: (BIG STONE-CHIPPEWA-LAC QUI PARLE-SWIFT -YELLOW MEDICINE)	86,937
CROW WING	75,355
DAKOTA	325,356
DES MOINES VALLEY HEALTH AND HUMAN SERVICES	39,610
DODGE-STEELE	65,310
FARIBAUT- MARTIN	53,310
FILLMORE-HOUSTON	55,394
FREEBORN	44,266
GOODHUE	47,462
HENN-BLOOMINGTON	88,741
HENN-EDINA	39,995
HENN-RICHFIELD	45,150
HENN-MINNEAPOLIS	979,782
HENN-SUBURBAN	685,328
HORIZON: (DOUGLAS-GRANT-POPE-STEVENS-TRAVERSE)	99,331
ISANTI-MILLE LACS	77,395
KANABEC-PINE	68,296
KANDIYOHI-RENVILLE	82,226
LE SUEUR-WASECA	58,458
MEEKER- McLEOD-SIBLEY	95,011
MORRISON-TODD-WADENA	113,428
MOWER	50,814
NOBLES	30,999
NORTH COUNTRY: (BELTRAMI-CLEARWATER-HUBBARD-LAKE OF THE WOODS)	122,410
OLMSTED	151,441
OTTER TAIL	75,831
POLK-NORMAN-MAHNOMEN	75,601
QUIN: (KITTSOON-MARSHALL-PENNINGTON-RED LAKE-ROSEAU)	84,413
RAMSEY	994,733
RICE	63,650
SCOTT	76,567
SHERBURNE	61,212
STEARNS	155,623
SW HEALTH & HUMAN SERVICES: (LINCOLN-LYON-MURRAY-PIPESTONE-ROCK-REDWOOD)	127,876
WABASHA	27,873
WASHINGTON	182,520
WATONWAN	21,177
WINONA	59,002
WRIGHT	90,477
<b>TOTAL</b>	<b>6,979,000</b>

## Appendix C: Annual Tribal Government Awards (SFY 2014)

Tribal Government	Funding
Boise Forte Band of Ojibwe	58,398
Fond Du Lac Band of Lake Superior Chippewa	133,640
Grand Portage Band of Chippewa Indians	26,203
Leech Lake Band of Ojibwe	184,367
Lower Sioux Indian Community	30,006
Mille Lacs Band of Ojibwe	66,040
Red Lake Nation	160,736
Upper Sioux Indian Community	22,327
White Earth Nation	166,582



## **Appendix D: Family Home Visiting Committee Maternal and Child Health Advisory Task Force Summary Report**

(See full report at <http://www.health.state.mn.us/divs/fh/mchatf/FamilyHomeVisitingCommittee.html>)

### **I. INTRODUCTION**

In March of 2011 the Minnesota Department of Health (MDH), under the purview of the Maternal and Child Health Advisory Task Force, convened a Family Home Visiting (FHV) Committee. Membership included representatives from local public health and a broad range of early childhood and other public health partners.

#### **A. Committee Charge**

The charge of the Maternal Child Health Advisory Task Force FHV Committee was to provide direction and guidance to the Commissioner of Health and to MDH staff on issues related to the expansion and integration of evidence-based public health home visiting programs in Minnesota's health and early childhood systems. The responsibilities of the committee and its members included:

- Participating in the development of a vision and set of guiding principles for use by the MDH Family Home Visiting Program and stakeholders to inform the expansion and integration of public health evidence-based family home visiting programs in Minnesota's health and early childhood systems.
- Defining strategies to increase understanding and appreciation for the unique role of public health in family home visiting among Minnesota's policy leaders and other stakeholders in health and early childhood systems.
- Identifying strengths, opportunities, and challenges, as well as responses to the identified issues, in order to effectively advance the committee's vision, guiding principles, direction and strategies.
- Serving as a liaison to their own organization, community, and other stakeholders to champion the vision, guiding principles, direction and strategies developed by the committee.

The group met five times over the course of a year. In summary, the FHV Committee achieved the following objectives, which are summarized in this report:

- Outlined the history of public health family home visiting in Minnesota.
- Increased the understanding of the role that MDH has in family home visiting within Minnesota's early childhood and health systems.
- Increased the understanding of the role that local public health has in family home visiting.
- Reviewed a range of public health family home visiting activities in Minnesota.
- Developed a common understanding of evidence-based public health home visiting practices in Minnesota.
- Developed a vision for public health family home visiting in Minnesota
- Developed guiding principles for public health family home visiting in Minnesota.
- Identified recommendations to advance the vision and guiding principles.
- The committee discussions regarding guiding principles identified many strengths of the current system of public health family home visiting. Committee members also identified a number of challenges to effectively advance the vision and guiding principles. Key issues are highlighted under each guiding principle in the section of this report titled "A

Vision for Public Health Evidence-based Family Home Visiting.” Recommendations to the Commissioner of Health and to MDH staff are presented in at the end of this document.

## **II. FAMILY HOME VISITING IN MINNESOTA**

### **A. Public Health Family Home Visiting**

For over 100 years, public health nurse home visiting has been used as an intervention to improve the health and well-being of families. Public health family home visiting in Minnesota has been one strategy to improve maternal and child health outcomes. Home visits often begin with a comprehensive public health nursing assessment, ideally while a woman is pregnant, and continue through the child’s early years.

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

- Promote positive birth outcomes and link pregnant women with prenatal care;
- Foster healthy parent-child attachment;
- Support parents early in their role as a child’s first teacher;
- Enhance child growth and development to promote school readiness; and
- Ensure that very young children develop in safe and healthy environments.

Meeting families in their home environments gives the home visitor the family, neighborhood and community contexts in which the family lives, allowing the home visitor to individualize services to the family’s unique interests and situations and to maximize time and resources. Trained home visitors provide health education and parenting support to at-risk parents on positive parenting skills, child development and early literacy activities. The building of a trusting relationship between the home visitor and the family facilitates the sharing of information on prenatal and infant care, maternal depression and other mental health concerns, home safety and preventing exposure to environmental hazards such as lead and second-hand smoke. As needed, home visitors coordinate referrals to other community-based services and resources.

The MDH Family Home Visiting Program supports statewide evidence-based family home visiting programs. This is done through administration of funding and provision of technical assistance, training, reflective practice mentoring, data collection and evaluation to community health boards (CHBs) and Tribal governments.

Local public health departments are responsible for the delivery of public health family home visiting services. Depending upon the source(s) of funding and program capacity, public health family home visiting services may range from one or two visits up to biweekly visits delivered throughout toddlerhood and until a child is ready for preschool. 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 frequency of home visits.

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 CHBs and Tribal governments for services provided under the statute. Grants are distributed to CHBs and Tribal governments on a formula basis. A MDH legislative fact sheet about Minnesota’s Family Home Visiting Program can be viewed online on the <http://www.health.state.mn.us/divs/fh/mch/fhv/guidelines.html> and the full statute is available

online on the [Office of the Revisor of Statutes website](http://www.health.state.mn.us/divs/fh/mch/fhv/guidelines.html). The most current report to the Minnesota legislature on the Family Home Visiting Program can be viewed online on the <http://www.health.state.mn.us/divs/fh/mch/fhv/guidelines.html>.

## **B. A Brief History of Public Health Family Home Visiting**

While a full history of public health nursing goes back 150 years, including local and private initiatives, the MDH first received home visiting funding (Healthy Beginnings) in 1992. These first funds were distributed to local public health departments through a competitive grant to support the implementation of a number of home visiting programs.

In 2001 the family home visiting statute was first introduced that provided TANF funding to local health departments for family home visiting. In addition to TANF funding, local health departments have consistently used Maternal and Child Health (Title V) Block Grant funding and other sources of support for family home visiting. In 2007 the family home visiting statute was amended to allow for a significant increase in funding from TANF for home visiting.

The Affordable Care Act of 2010 created the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program to respond to the diverse needs of children and families in communities at risk. The program is designed to use collaborations 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 models. MIECHV formula funding to CHBs based on a comprehensive needs assessment and supports the implementation of two evidence-based family home visiting models targeting Minnesota's highest risk communities – Nurse Family Partnership (NFP) and Healthy Families America (HFA). Competitively secured MIECHV funding has similarly been allocated to CHBs to expand the reach of these models to additional at-risk communities. While this infusion of federal funding further enhances the capacity of the state to implement evidence-based family home visiting models, the majority of this funding expires in March of 2015.

A detailed timeline of public health family home visiting and additional relevant events over the past 25 years is presented in Appendix 3. The timeline shows the ebb and flow of local health department capacity to offer family home visiting services. The history and practice of public health family home visiting has been influenced by the following factors, among others:

- The initial focus on child abuse prevention has expanded to a focus on strengths-based approaches and relationship-based practice;
- The diversity of families and the complexity of challenges brought to home visiting practice have increased over time;
- Federal funding has influenced significant changes in the directions of state and local programming;
- The science of brain development as a key underpinning of early childhood development has enhanced practice and broadened appreciation for early intervention; and
- Trauma-informed care requires a highly-trained and well-supervised workforce.

## **C. The Unique Role of Public Health in Family Home Visiting**

### **Local Public Health's Role:**

A variety of organizations and providers in Minnesota offer home visiting services. Evidence-based public health family home visiting is unique among home visiting programs in that it provides the initial support and health interventions to pregnant women and families to promote

positive birth outcomes and to ensure healthy brain development, safe and secure parent-child relationships, and other critical maternal and child health outcomes.

It is unique in that it is an important component of both health and early childhood systems. The range of health services that may serve as points of referral to and from evidence-based home visiting include primary and pediatric care, WIC, health care homes, accountable care organizations, mental health and chemical health providers, hospitals and emergency rooms. Early childhood programs and other family services (such as child care, Head Start, Early Childhood Special Education, Early Childhood Family Education, child welfare, Minnesota Family Investment Program, and community-based organizations addressing domestic violence and other family risk factors) often work in strong local collaborations with public health home visiting programs.

The development and maintenance of multiple networks and referral systems is required to ensure public health home visiting programs are optimally utilized as part of the continuum of health care and early childhood services at the local level. Examples include:

- Facilitating referrals from a primary care doctor or pediatrician to an evidence-based public health FHV program,
- Consulting with mental health providers on how public health home visitors can effectively support management of maternal depression and promote healthy infant brain development, and
- Coordinating services with other early childhood providers.

Minnesota's local health departments have a strong history of, and expertise in, evidence-based health interventions delivered in the home to pregnant women and parenting families. These public health family home visiting programs are among a range of programs offered to families in communities across the state with varying levels of family access, adequate referral networks, and local service coordination.

Some families have complex needs and multi-generational histories of trauma and poverty. Service providers may be unclear as to how each other's interventions, delivered alone or as enhancements to each other, might best benefit individual families. Family access to needed services and supports is facilitated when health and early childhood systems align at the local level in a way that maximizes resources and assures families are offered the most appropriate interventions at the time they are most needed.

#### Minnesota Department of Health's Unique Role:

The MDH is currently engaged in a number of activities examining the roles played by state and local partners to improve school readiness for all children and to promote success for all families. These include the Race to the Top Early Learning Challenge Grant and the Prenatal to Three Framework. The effectiveness of all early childhood and health services that begin in the second and third year of life is predicated on a child receiving critical support prenatally to birth to promote early brain development. It is the unique contribution and role of MDH to ensure the foundation of early infant brain development for all babies born in the state through home visiting and family support. MDH provides administration of funding, technical assistance, training, evaluation and vital collaborative roles with local public health and other systems to assure high risk, prenatal populations have access to necessary services.

As the science supporting the effectiveness of evidence-based home visiting models demonstrates, the health and well-being of all Minnesota families is most effectively promoted

when the unique role of public health in family home visiting is understood and supported as an integral component of the state's continuum of health and early childhood systems.

#### **D. Public Health Evidence-based Family Home Visiting**

As reflected in the charge, the committee was to examine “issues related to the expansion and integration of *public health evidence-based family home visiting programs* in Minnesota’s health and early childhood systems.” To accomplish this objective, the committee worked to reach consensus on a shared definition of evidence-based practice to high risk populations. There is general agreement in the literature on the components of evidence-based practice but the committee focused on defining the parameters of evidence-based practice for Minnesota’s public health family home visiting program. The following list of **facts and assumptions** and **critical elements** were included in the discussion. The discussion acknowledged that a range of valuable, evidence-based maternal and child health services and activities are delivered by local public health and, for the purposes of the committee, the focus is on those practices that have demonstrated effectiveness with at-risk families.

##### Facts and Assumptions:

The committee reviewed the following facts and assumptions regarding the current state of evidence-based public health home visiting practice in Minnesota:

- State, Tribal and local systems of education, health and social services offer a variety of effective home visiting and other early childhood programs, services and interventions that promote a range of outcomes for families of very young children (learning readiness, health, prevention, etc.).
- Public health and others provide evidence-based maternal and child health programs, services, and interventions, including home visiting services that are not targeted (includes public health nursing practice more broadly as well as non-nurse delivered programs and services).
- Maternal and child health disparities persist in Minnesota.
- Federal, state and local health and early childhood stakeholders are increasingly interested in investing in what works to enhance outcomes for all families of very young children.
- Resources are scarce and judicious use of resources demands enhanced alignment and coordination of early childhood programs and health services, linking families to the programs/services that best address their unique circumstances.
- Local health department family home visiting programs specialize in maternal and child health.
- All targeted, evidence-based, home visiting programs in Minnesota remain under-resourced.
- Targeted, evidence-based home visiting programs delivered by local and tribal health departments are part of a continuum of maternal and child health programs and services for families of very young children.
- Family home visiting models demonstrating the most robust and widest range of maternal and child health outcomes deliver targeted, sophisticated, and intense interventions.
- Access to meaningful outcome data for evaluating effectiveness of family home visiting programs has been challenged at the state and community levels due to data privacy regulations, technology compatibility needed for data transfers/exchanges, adequate funding, and skill requirements, among others.

### Critical Elements:

The committee agreed upon the following critical elements of evidence-based public health home visiting practice:

- **Proven evidence of effectiveness** – intervention has been shown to improve defined outcomes.
- **High quality supervision** – assuring intensive reflective supervision and ongoing support for family home visitors that result in respectful family engagement.
- **Professional development** – assuring highly skilled, trained professional home visitors and training that includes both initial and ongoing training and support.
- **Continuous quality improvement** – adherence to standards of practice, appropriate intensity and dosage of services, and monitoring of quality
- **Rigorous data collection and monitoring** – ongoing monitoring of progress toward a core set of outcomes to evaluate the short and long term effectiveness of the program.

The committee also reviewed the benchmark plan for Minnesota’s MIECHV Program, which includes 35 maternal and child health constructs by which evidence-based models supported with federal MIECHV funding are measuring their impact. The committee agreed that the benchmark plan serves as a measure of public health evidence-based family home visiting. That is, programs aiming to demonstrate that their family home visiting interventions are effective with at-risk families will deliver interventions and measure progress toward advancing the 35 benchmarks in the plan. The benchmark plan may be viewed online at on the <http://www.health.state.mn.us/divs/fh/mch/fhv/index.html>.

### III. A VISION FOR PUBLIC HEALTH EVIDENCE-BASED FAMILY HOME VISITING

**Vision: Minnesota’s public health family home visiting program is further expanded and integrated with health and early childhood systems to support the health and development of infants, children and families.**

While a range of early childhood services available in the state support the success of families, the charge of the committee was to focus specifically on *public health family home visiting*. It was the goal of the committee to develop a vision and guiding principles that would assure that, at the local level, public health home visiting programs are well-integrated with other early childhood programs and health services in communities. Effective alignment of systems and services promotes:

- The reduction of program fragmentation and duplication of services for families;
- The enhancement of family access to the most appropriate services, a maximized and more stable mix of funding streams; and
- The coordination of public health family home visiting within a continuum of health care and early childhood services.

Additionally, at the state level, there is a need to assure that public health family home visiting programs are adequately reflected in the state’s early childhood and health systems policy and other planning activities.

## **A. Guiding Principles**

The purpose of the guiding principles is to provide a pathway for the delivery of effective public health family home visiting services in order to achieve the vision developed by the committee. These guiding principles lay the foundation for the further development of recommendations, strategies and action steps. Each of the guiding principles includes a summary discussion highlighting key issues and possible strategies and action steps.

### **1. Families statewide will have access to continuity and consistency of home visiting services. Access is facilitated by culturally competent service planning and delivery strategies.**

The awareness of the role of public health family home visiting programs as partners in promoting family health and well-being, beginning prenatally through the first years of a child's life, should be more widely promoted among families statewide. To reach families of different races and ethnicities, knowledge of differing cultures and cultural norms is essential in the planning of home visiting services and the way those services are delivered. The expertise of diverse community providers and other community partners is necessary to ensure that programs are developed to most effectively respond to the unique needs of communities and employ successful outreach and engagement strategies. Community-based, culture-specific early childhood and health providers, other community-based organizations, elders, faith communities and neighborhood groups play critical roles in facilitating meaningful and effective linkages of families to public health family home visiting programs.

The committee discussed the need for an increase in the consistency of public health family home visiting services statewide. Assuring statewide consistency may provide continuity of quality services to families regardless of where they live. Standardizing programs statewide, at least regarding a core set of evidence-based public health family home visiting interventions, may facilitate more cost-effective targeting of resources to families that need them. As all early childhood programs strive for consistency in quality standards statewide, community-based coordination of services and referrals may ensure family needs are matched with the most appropriate program or service mix at the most optimal time needed for a family to benefit from them.

The committee also identified the need for an adequate public health family home visiting infrastructure to ensure statewide family access at the community level for all populations. Increased demonstration and awareness of the effectiveness of public health family home visiting statewide among a range of policymakers and other stakeholders is needed to inform policy development and funding decisions in support of an adequately resourced statewide system of evidence-based public health family home visiting.

### **2. Services will be offered as part of a continuum of collaborative and interdisciplinary early childhood and health services at the community level.**

Families with unique and often complex needs benefit most from local systems of care and support when effective interventions are offered to *“the right people, with the right intensity, at the right time.”* Provider networks with a solid understanding of how the respective roles and interventions of each component of the local service mix can enhance outcomes for families may better ensure the most efficient allocation of resources to those who need them most. Not all families require interventions delivered at the same intensity or frequency and not all health and early childhood providers can meet all of the needs of at-risk families. Working

collaboratively, provider networks and community partners further promote a coordinated continuum of services that is more widely available to families.

The committee was interested in learning how systems might be better organized for the best outcomes for families. They identified a need for a better understanding of the continuum of health and early childhood services, including public health family home visiting programs. Planning activities would benefit from further clarification of provider roles and services, terminology used by various programs and disciplines, mandated responsibilities, funding streams, target populations and enhanced data linkages. A statewide assessment of resources may inform program budget development and the identification of community support and consultation needed, including culturally competent service planning and delivery of services.

**3. Programs will be informed by data and the most current research while also allowing for innovation.**

Meaningful data must be accurately collected, reported, and readily available to stakeholders. Similarly, providers need ready access to and support in the implementation of innovative, science-based programs.

The committee suggests that MDH facilitates local program access to technical support and funding for promising practices and evaluation of locally developed family home visiting programs. Regular reports on benchmarks and other data collected should be widely disseminated to inform programs, the public, policymakers and other stakeholders. Shared or linked statewide longitudinal data systems for public health and other health and early childhood systems may provide for an enhanced understanding of the impact of collective investments in the continuum of services provided.

**4. Services will be relationship-based, child and family focused and responsive to the many factors that impact families and communities.**

The quality of early caregiver-child relationships greatly impacts many aspects of a child's development. Practice has shifted from more didactic approaches to those that utilize caregiver-child and caregiver-provider relationships as the focus of intervention. With an emphasis on promoting positive parent-child interactions, effective services are those that are most relevant to family and community culture, history, environment, relationships, and health beliefs. Effective services utilize the caregiver-provider relationship as a tool for intervention and include the engagement of fathers and extended family members in home visits.

The committee identified a number of supports to local programs needed to enhance and maintain the delivery of the most effective programs. These include assistance in recruiting qualified staff representative of populations served and statewide training on evidence-based practice, relationship-based practices, cultural competence, motivational interviewing, reflective practice, supporting fidelity to the evidence-based models and measuring program impact.

**5. Services will be voluntary in nature, strengths-based and grounded in best practices for respectful engagement.**

The system of public health family home visiting is traditionally a voluntary service. That is, families are offered the service and have the choice to accept or reject the offer. Many evidence-based models and federal funders require that families be free to opt in or out of participation in a



program at any time. Best practice further indicates that opting out should not result in any punitive action placed on the family.

New models of family home visiting are emerging that more purposefully link them with other programs such as Minnesota Family Investment Program (MFIP). These approaches may be more effective in connecting programs with high-risk families, such as those headed by teen parents, who may otherwise not accept home visiting services.

Some concerns regarding these approaches include the possibility that, if traditional MFIP services for teens are replaced with family home visiting services, a family may lose their MFIP benefits if they discontinue home visiting services. Also, if a home visitor takes on some of the monitoring and compliance roles regarding MFIP requirements, this may introduce an untested variable in the principles of relationship-based practice. Alternatively, a family may lose MFIP eligibility but might continue with home visiting services.

The promise of success with blending these services may lie, in part, with the high skill-level of home visitors who may be able to sustain an effective working relationship with families. Data from some blended programs indicate similar outcomes on some measures comparable to programs that are not linked with mandatory programs. While the end goals of these programs are to support better outcomes for families, there is a lack of consensus on the best approach to this end. Long-term measurement of the impact of these approaches on a full range of maternal and child outcomes are necessary to inform these conversations.

Public health home visitors need ongoing, ready access to the knowledge and skill development necessary to provide evidence-based public health family home visiting services. Evidence-based home visiting models and public health family home visiting programs require varied levels of staff qualifications/competencies and training requirements. Practitioners often have not received the pre-service training and education needed to provide all of the evidence-based interventions needed to work effectively with at-risk populations. Local programs implement their agencies' professional development activities and provide skilled supervision to the extent they have the capacity to do so. Individual practitioners also seek out their own individualized professional development opportunities. MDH currently provides limited support, training consultation, and mentoring as needed, to a range of public health family home visiting programs on reflective practice, capacity building, program planning and maternal and child health topics. The impact and evaluation of these activities continuously informs the ongoing MDH training agenda.

The committee identified an ongoing need for MDH to continue to provide training and reflective practice mentoring to meet the professional development needs of family home visiting staff. If possible, this should be low cost and broadly available. They also encouraged the provision of program guidance for the professional development of staff at all skill levels, including the identification of core competencies and professional development strategies. Additional funding to support the public health family home visiting infrastructure would allow for more adequate reach to family home visiting staff statewide with training, reflective practice mentoring, and other ongoing professional development activities.

## **6. Programs will be accountable to families and communities, measuring and reporting on progress toward defined maternal and child health outcomes.**

Accountability to families and communities regarding investment in programs and subsequent outcomes is an essential element of all programs at both the state and community levels. The

committee indicated a critical need for Minnesota’s public health family home visiting program to work toward an enhanced system to measure the achievement of outcomes for families. This includes measuring client satisfaction and their views of the home visitor and the services provided.

The committee also discussed the need for a system that allows for the collection and analysis of both individual-level and aggregate outcomes. This should include the collection of information on populations served, outcome measures, fiscal information, funding sources and evidence-based models and interventions. The committee further promotes data systems that can be linked for cross-agency data analysis and that have enhanced health data interoperability.

Data systems are costly and complex, requiring continued investment of expertise, coordination and resources of data stakeholders. A recurring theme of the committee was to ensure adequate public health family home visiting infrastructure to accomplish these goals and others.

#### **IV. RECOMMENDATIONS**

The committee developed recommendations to the Commissioner of Health and to MDH staff based on issues identified during committee meetings. Further work is needed to fully expand these recommendations to advance the vision and guiding principles. This could include the identification of specific strategies and action steps to implement the recommendations and guiding principles and the identification of who is responsible for implementation. This report serves as a foundation to guide the development of a more detailed plan.

**Recommendation 1:** Increase awareness of, and further develop an action plan to, achieve the vision, guiding principles and recommendations of the Maternal Child Health Task Force Family Home Visiting Committee.

**Recommendation 2:** Provide enhanced leadership and advocacy to clarify and sustain the unique role of public health evidence-based family home visiting as a foundational cornerstone of early childhood service systems focused on prenatal to age three family home visiting services impacting positive pregnancy and infant health outcomes, brain development, school readiness, and safe and secure parent-child interactions.

**Recommendation 3:** Enhance the consistent delivery of high quality, evidence-based public health family home visiting services across the state through the exploration of:

- 1) The recruitment and retention of home visitors of diverse cultures;
- 2) The development and promotion of statewide minimum professional qualifications;
- 3) Statewide access to training and reflective practice mentoring;
- 4) The identification and promotion of practice standards;
- 5) An expanded role in statewide technical assistance to assure fidelity, continuous quality improvement; and

- 6) Statewide efficiencies in administrative functions (accreditation, data collection) as required of evidence-based family home visiting models.

**Recommendation 4:** Further promote as a best practice the ongoing outreach, coordination and communication across disciplines at the state and local levels to enhance understanding of each other's roles and expertise in assuring family access to a continuum of health and early childhood services maximizing the effective use of resources.

**Recommendation 5:** Ensure adequate and sustainable funding for evidence-based public health family home visiting.

**Recommendation 6:** Continue to partner with local public health departments to develop and/or improve a system of data collection, management and interoperability to demonstrate program outcomes at the state and local level, providing accountability to families, communities, policy makers and funders.



# **Appendix E: Maternal, Infant & Early Childhood Home Visiting (MIECHV)**

## **Updated State Plan for a State Home Visiting Program**

### **Minnesota Department of Health**

#### **Executive Summary**

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 (EBHV). The Minnesota Department of Health (MDH) submitted an application for funding in July 2010, a statewide needs assessment in September 2010, and an Updated State Plan on June 8, 2011. All submissions have been approved.

#### **UPDATED STATE PLAN COMPONENTS**

##### **Identification of the State's Targeted At-Risk Communities**

Minnesota's at-risk communities are identified by MDH based on the criteria below from among those highest risk communities identified in the MDH needs assessment completed in September 2010 in response to the MIECHV Supplemental Information Request (SIR). This "first cut" assessment resulted in the identification of 26 out of 52 Community Health Boards (CHB) with at least one county meeting the core risk factors identified in the SIR.

A CHB is a community health service area that may be a city, city-county, county, or multi-county area. In Minnesota, 52 locally-governed CHBs oversee local health departments that work in tandem with MDH to fulfill public health responsibilities. Their roles include assessing community health needs and assets, establishing public health priorities, and seeking public input on addressing local priorities and statewide outcomes.

In this first level of assessment, communities with a summative normative rank by rate greater than two and in the top ten by population for at least five of the core indicators were included. A summary of this needs assessment may be accessed at [www.health.state.mn.us/divs/fh/mch/fhv/documents/NeedsAssessmentSummary.pdf](http://www.health.state.mn.us/divs/fh/mch/fhv/documents/NeedsAssessmentSummary.pdf)

Minnesota's definition of community and prioritizing of MIECHV benchmarks, as described below, reflect the overall goals and objectives of the state home visiting program. The definition of community includes a CHB or a local public health department or group of local public health departments. This may include partnerships with tribal family home visiting (FHV) programs: 1) not currently funded by federal home visiting funds; 2) where tribal communities comprise any of the at-risk community; and 3) where families remain underserved by an existing home visiting program.

The criteria for further narrowing the selection of at-risk communities include constructs for the following three state-prioritized federal benchmarks:

- at-risk for maternal and newborn health
- at-risk for child injuries, child maltreatment and emergency room visits; and
- at-risk for economic self-sufficiency.

In addition, the following criteria also apply:

- community-identified characteristics and strengths;
- community need (unmet) for a home visiting program;
- service systems currently available for families, including home visiting programs currently operating and/or discontinued since March 23, 2010;
- access to other federal FHV funds; and
- ability/capacity to engage in community-planning, complete a detailed needs assessment, and engage in an evidence-based home visiting (EBHV) model.

Data for other benchmarks required by the SIR to be collected and monitored for improvement include school readiness and achievement, domestic violence, and coordination of referrals.

*A Summary Table of Benchmark Variables for At-risk Communities Identified by Core Measures* further narrows the list of at-risk communities to seven Minnesota counties: Becker, Beltrami, Hennepin, Mower, Nobles, Ramsey and St. Louis. These seven counties reflect both rural and urban communities in the northern, central and southern regions of the state as well as some tribal government areas. The table of benchmark data and explanation may be accessed at <http://www.health.state.mn.us/divs/fh/mch/fhv/documents/webupdate31411.pdf>

CHB staff in the seven at-risk communities identified above were invited to partner with the MDH to participate in the MIECHV program. Per the MIECHV SIR, requirements included the community's participation in a detailed needs assessment and identification of strategies to integrate their proposed home visiting services into an early childhood system, including existing efforts or resources to develop a coordinated early childhood system at the community level.

Of the seven counties identified above as being at highest risk in Minnesota, CHB staff representing two of those counties (Beltrami County and Nobles County) declined to participate in the MIECHV program at this time. Pending future MIECHV funding, these counties may be re-invited by MDH to reconsider their participation in the program.

A final total of seven CHBs, representing the five remaining counties identified at highest risk, agreed to partner with the MDH in the MIECHV program. They include:

1. Becker County Community Health Board
2. City of Bloomington Community Health Board (including Edina and Richfield)
3. Hennepin County Community Health Board
4. City of Minneapolis Community Health Board
5. Carlton-Cook-Lake-St. Louis Counties Community Health Board
6. Mower County Community Health Board
7. City of St. Paul - Ramsey County Community Health Board

The results of each community needs assessment, selection and justification of a home visiting model, and community collaboration plan are included in the Updated State Plan.

### **State Home Visiting Program Goals and Objectives**

The overall purpose of the state home visiting program is to enhance the infrastructure in the state to support evidence-based home visiting (EBHV). Program goals are to:

- strengthen and improve the programs and activities carried out under Title V;
- improve coordination of services for at-risk communities; and

- identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

### **Selection of Proposed Home Visiting Model(s) and Explanation of How the Model(s) Meet the Needs of Targeted Communities**

Of seven EBHV models approved for selection per the SIR, MDH selected Healthy Families America (HFA) and Nurse-Family Partnership (NFP). Criteria used by MDH to select models included:

- opportunity to maximize the State’s existing ACF grant focused on NFP;
- flexibility to serve more families with the addition of HFA (i.e., enrollment criteria, community-based agencies’ capacity/readiness for EBHV);
- strength of NFP and HFA program evidence to advance the MDH prioritized benchmarks; and
- MDH capacity to support program expansion, including data collection.

The identified at-risk communities selected one of the two EBHV models based on their needs assessment, as follows:

1. Becker County CHB – NFP
2. City of Bloomington CHB (including Edina and Richfield) - HFA
3. City of Minneapolis CHB - HFA
4. Hennepin County CHB – HFA
5. Mower County CHB - HFA
6. Carlton-Cook-Lake-St. Louis County CHB - NFP
7. City of St. Paul and Ramsey County CHB - HFA

### **The State may propose using up to 25 % of the grant to support a promising approach.**

MDH is declining to support research of a promising approach at this time. Rational includes the following:

- limited availability of funds,
- community at-risk needs and needs of community-based agencies,
- limited time frame due to late arrival of the SIR and pending due date for the Updated State Plan,
- current State program goals and objectives,
- limited and uncertain MDH and local FHV capacity and resources.

Future support for a research partnership addressing promising approaches will be re-evaluated annually.

### **Implementation Plan for Proposed State Home Visiting Program**

MDH staff are dedicated to:

- working closely with model developers;
- providing NFP, HFA and reflective practice training and consultation to the at-risk communities participating in the MIECHV program;
- working with the at-risk communities on benchmark and fidelity data collection, monitoring and reporting; and

- supporting at the community level and working at the state level to ensure planning coordination with other early childhood systems and organizations.

### **Plan for Meeting Mandated Benchmarks**

In consultation with HRSA and the model developers, MDH staff has identified benchmark and construct indicators and will work with the at-risk communities to collect data to measure improvement over the course of three years for families served in the program toward the following benchmarks, as identified in the SIR:

- Improved Maternal and Newborn Health
- Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits
- Improvements in School Readiness and Achievement
- Domestic Violence
- Family Economic Self-Sufficiency
- Coordination and Referrals for Other Community Resources and Supports.

### **Plan for Administration of State Home Visiting Program**

MDH will administer the State Home Visiting Program within the existing administrative structure. Pending continued state and federal funding, MDH will expand its capacity to provide reflective practice training and consultation, technical assistance on data collection and CQI, and EBHV training. MDH staff will work with local agencies to plan for enhanced and/or continued support of local administrative structures, as needed.

### **Plan for Continuous Quality Improvement**

MDH staff will provide technical assistance to NFP and HFA implementing agencies on collecting and monitoring fidelity and other data for continuous quality improvement at the local level. This includes site visits, teleconferences, reflective supervision, data fact sheets, and community of practice meetings. MDH staff currently, and will continue to, work with the NFP National Service Office, HFA and Mathematica to facilitate data collection and analysis.

### **Budget**

The budget includes a total of \$830,000 to support CHBs in their implementation of HFA or NFP. Minnesota's total home visiting award from HRSA, a combination of MIECHV and EBHV funds, also includes 1) grants to local and tribal public health for NFP start-up and training costs, 2) training and technical assistance to local and tribal public health on evidence-based practice (NCAST, PIPE, Integrated Strategies, etc.), 3) reflective practice training, consultation and mentoring, 4) data collection and CQI activities, and 5) web IT support.



## **Appendix F: Maternal, Infant and Early Childhood Home Visiting Expansion Program Minnesota Department of Health Executive Summary**

The Affordable Care Act of 2010 created the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) to improve health and development outcomes for at-risk children through evidence-based home visiting programs (EBHV). MIECHV Program formula funding was awarded to the Minnesota Department of Health (MDH) in September 2010. A summary of Minnesota's MIECHV Program and formula funded activities may be viewed at <http://www.health.state.mn.us/divs/fh/mch/fhv/documents/MIECHVExecSum112811.pdf>.

In June 2011 the Health Resources and Services Administration (HRSA), in collaboration with the Administration for Children and Families, issued a competitive Funding Opportunity Announcement to expand the MIECHV Program. The program provides additional funding to states that have demonstrated capacity to expand and/or enhance their programs. The MDH submitted a proposal in July 2011 and was awarded in April 2012 a three-year grant for \$8 million per year. Expenditure of these funds was approved in the fall of 2012 by the Minnesota Legislative Advisory Committee. As a result of the Budget Control Act of 2011, a revised Notice of Grant Award issued in April 2013 reflects a 5.1 percent reduction of the original annual award for the remainder of the Federal fiscal year.

### **Expansion Program Goals and Objectives**

Minnesota's MIECHV Expansion Program aims to provide enhanced support statewide to:

- 1) improve maternal, child and family health in Minnesota's communities at risk; and
- 2) expand the reach of Healthy Families America (HFA) and Nurse-Family Partnership (NFP) programs with fidelity to the models.

Activities include:

- Administering HFA and/or NFP funding to community health boards (CHBs);
- Providing EBHV training and consultation;
- Promoting reflective practice competencies via training and mentoring;
- Participating in an evaluation by the University of Minnesota's Center for Early Education & Development;
- Convening Communities of Practice for HFA- and NFP-implementing agencies and other agencies interested in more EBHV information and professional development;
- Supporting access to community-based infant mental health consultation;
- Collecting and reporting benchmark data as required by HRSA and approved by HFA and NFP model developers ([MN MIECHV Benchmark Plan, PDF: 372 KB/26 pages](#));
- Continuous quality improvement (CQI) focused on progress toward the benchmarks.

### **Allocations to the State's Targeted At-Risk Communities**

Minnesota's at-risk communities are identified in the MDH needs assessment completed in 2010 in response to the MIECHV Supplemental Information Request. In response to MDH's competitive MIECHV expansion grant award, an alphabetical list of all Minnesota counties and risk variables was compiled and may be viewed [at MIECHV Program: Risk Variables for All Minnesota Counties \(PDF: 472KB/2 pages\)](#). A table of composite risk scores was calculated to

aid in ranking counties by risk variables. The scores were determined by calculating the sum of the two blue columns in the document referenced above. Scores were then adjusted by adding 12 to each score so that no county would have a negative score. The resulting scores may be viewed at [2012 MIECHV County Risk Rankings by Composite Score \(PDF: 276KB/2 pages\)](#).

In May 2012, MDH requested Letters of Interest (LOI) from all CHBs interested in participating or expanding their participation in Minnesota's MIECHV Program. The MDH offered allocations to CHBs based on county risk rankings and submission of a Letter of Interest indicating CHB interest and readiness. The targeted high risk counties (in bold letters) and the CHBs serving them are as follows, including their selected EBHV model(s).

- **Anoka County** CHB - HFA and NFP
- **Becker County** CHB – NFP and HFA
- **Big Stone, Pope, Swift and Traverse Counties**, Meeker-McLeod-Sibley CHB via Supporting Hands - NFP
- **Cass County** Health, Human and Veteran Services CHB - NFP
- **Dakota County** CHB - HFA
- **Hennepin County**
  - By City of Bloomington CHB – HFA
  - By City of Minneapolis CHB – HFA and NFP
  - By Hennepin County CHB - HFA
- **Mille Lacs County**, Isanti-Mille Lacs CHB - HFA
- **Kanabec-Pine Counties** CHB – HFA and NFP
- **Todd and Wadena Counties**, Morrison-Todd-Wadena CHB - NFP
- **Mower County** CHB - HFA
- **Norman and Mahnomen Counties**, Polk-Norman-Mahnomen CHB - NFP
- **Beltrami, Clearwater, Hubbard and Lake of the Woods Counties**, North Country CHB - HFA
- **Marshall, Pennington, and Red Lake Counties**, Quin Community Health Services CHB - HFA
- **Ramsey County**, City of St. Paul-Ramsey County CHB - HFA and NFP
- **Stearns County** CHB – HFA and NFP
- **Washington County** CHB - HFA
- **St. Louis County**, Carlton-Cook-Lake-St. Louis CHB – NFP

The CHBs accepting allocations agree to the following program requirements:

- Identification of the most at-risk population(s) not being served by other home visiting programs based on needs assessment completed with community stakeholders.
- Completion of a work plan, including a community collaboration plan.
- Adequate staffing and resources to ensure consistent, ongoing staff access to:
  - participation in HFA and NFP Communities of Practice,
  - reflective supervision of home visitors as required by HFA and/or NFP,
  - reflective supervision mentoring for supervisors,
  - motivational Interviewing training and coaching, and
  - community-based infant mental health consultation.
- Capacity to collect and report to MDH data on 35 benchmark constructs.
- Participation in an evaluation conducted by the University of Minnesota's Center for Early Education and Development to assess the impact of reflective practice mentoring.

**Budget**

The budget includes a total of over \$6 million to support CHBs in their implementation of HFA and/or NFP and other funding for EBHV training and technical assistance, reflective practice mentoring, data collection and data systems development, CQI activities, and the University of Minnesota reflective practice evaluation.



## Appendix G: 2011-12 Local Public Health Family Home Visiting Demographic Characteristics<sup>1</sup>

Indicator/Category	N <sup>2</sup>	Percent <sup>3</sup>
<b>Total Enrollment</b>	<b>27,430</b>	<b>100%</b>
Primary Caregivers	9,872	36.0%
Prenatal Clients	4,217	15.4%
Infants and Children	13,341	48.6%

<b>Age Group: Primary Caregivers &amp; Prenatal Clients</b>	<b>14,089</b>	<b>100%</b>
<15	91	0.6%
15-17	1,077	7.6%
18-19	1,438	10.2%
20-21	1,606	11.4%
22-24	2,201	15.6%
25-34	5,388	38.2%
35+	1,546	11.0%

<b>Race: Primary Caregivers &amp; Prenatal Clients</b>	<b>14,089</b>	<b>100%</b>
White	9,054	64.3%
Black/ African American	2,438	17.3%
American Indian/ Alaskan Native	348	2.5%
Asian	916	6.5%
Native Hawaiian/ Other PI	19	0.1%
1+ Race Reported	245	1.7%

<b>Race: Infants &amp; Children</b>	<b>13,341</b>	<b>100%</b>
White	8,162	61.2%
Black/ African American	2,185	16.4%
American Indian/ Alaskan Native	318	2.4%
Asian	940	7.0%
Native Hawaiian/ Other PI	11	0.1%
1+ Race Reported	701	5.3%

<b>Hispanic Ethnicity: Primary Caregivers &amp; Prenatal Clients</b>	<b>2,319</b>	<b>16.5%</b>
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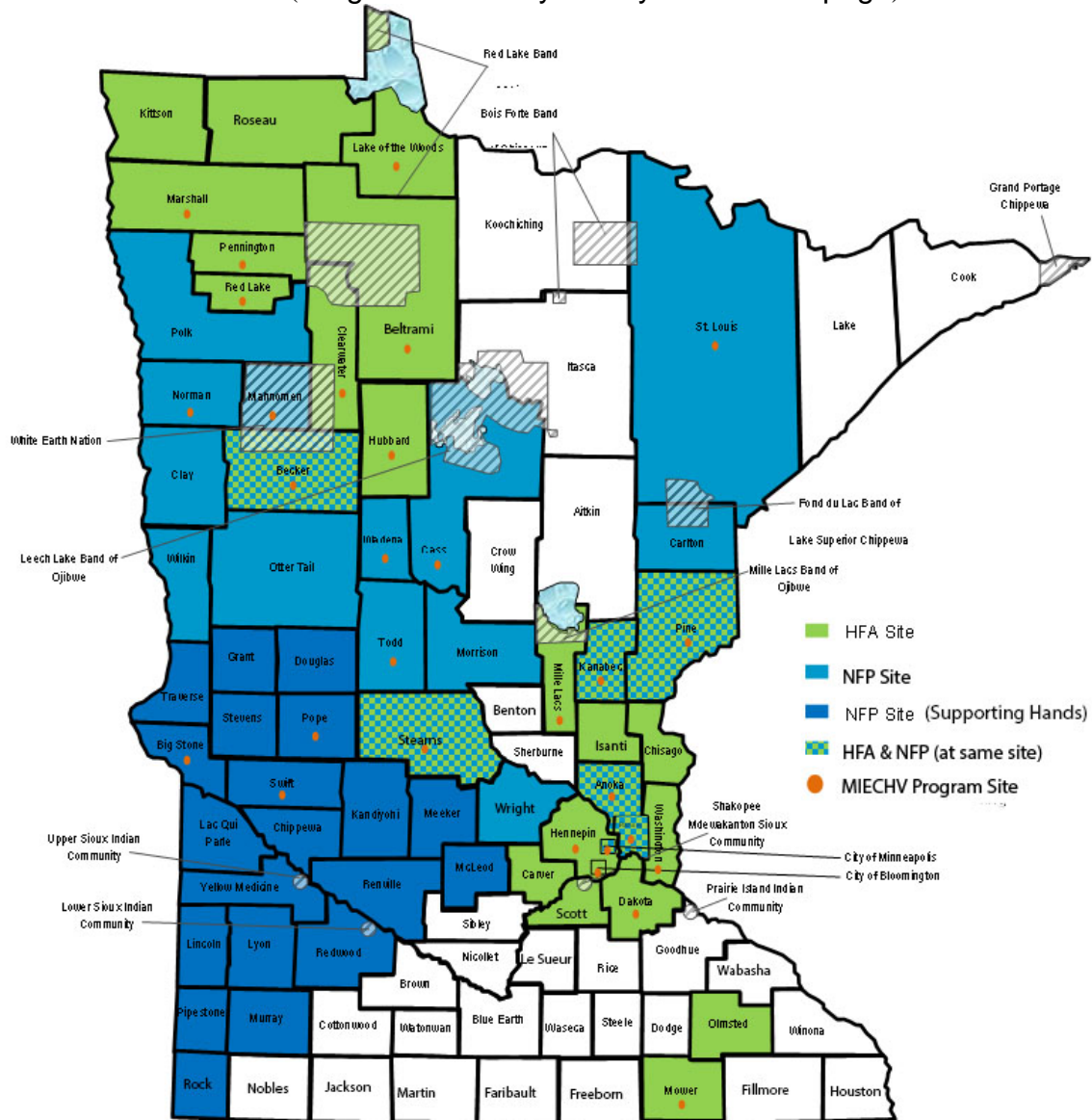
<b>Education – Primary Caregivers &amp; Prenatal Clients</b>	<b>14,089</b>	<b>100%</b>
No high school diploma/GED	4,091	29.0%
High school diploma/GED	3,866	27.4%
Some post-secondary education or degree	3,703	26.3%

- 1 Includes data from reporting period January 1 – December 31, 2012. Data is reported by Community Health Board (CHB) or county. These data do not reflect tribal home visiting programs. The Minnesota Department of Health (MDH) continues to work with tribal programs on identifying data collection activities that meet the needs of tribal communities.
- 2 Children who received services in more than one county (transfers) may be counted more than once.
- 3 Column totals not equaling 100 percent are due to missing, other, or unknown values. These values are included in the denominator of the calculation.

*SOURCE: Local Public Health Planning and Performance Measurement Reporting System (LPH PPMRS), MDH, 2012*

# Appendix H: 2013 Evidence Based Home Visiting Programs Healthy Families America (HFA) and Nurse-Family Partnership (NFP)

(Programs listed by county on the next page)



**Nurse-Family Partnership (NFP) and Healthy Families America (HFA)  
Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV)  
Sites in Minnesota 2014**

**NFP Sites in MN:**

Anoka  
Becker / Otter Tail  
Cass / Morrison / Todd / Wadena  
Clay / Mahnomen / Norman / Polk / Wilkin  
Carlton / St. Louis  
City of Minneapolis (MVNA)  
Kanabec / Pine  
St. Paul-Ramsey  
Stearns  
Wright

**Supporting Hands NFP Sites:**

Big Stone  
Chippewa  
Douglas  
Grant  
Kandiyohi  
Lac Qui Parle  
Lincoln  
Lyon  
McLeod  
Meeker  
Murray  
Pipestone  
Pope  
Redwood  
Renville  
Rock  
Stevens  
Swift  
Traverse  
Yellow Medicine

**HFA Sites in MN:**

Becker  
Beltrami / Clearwater / Hubbard / Lake of the Woods (North Country CHB)  
Mille Lacs  
Kittson / Marshall / Pennington / Red Lake / Roseau (Quin CHB)  
City of Minneapolis (MVNA)  
Mower  
Olmsted  
Kanabec-Pine  
Stearns

**Tribal MIECHV Program Site in MN:**

White Earth Nation (NFP)

**Metro Alliance for Healthy Families:**

Anoka (also an Independent HFA site)  
City of Bloomington  
Chisago  
Carver  
Dakota  
Hennepin  
Isanti  
St. Paul-Ramsey (also an independent HFA site)  
Scott  
Washington

**Tribal NFP Sites in MN:**

Fond du Lac Band of Lake Superior  
White Earth Nation

**HFA & NFP (at same site):**

Anoka  
Becker  
City of Minneapolis (MVNA)  
Kanabec / Pine  
St. Paul-Ramsey  
Stearns

**MIECHV Program Sites in MN:**

Anoka (NFP & HFA)  
Becker (NFP & HFA)  
Beltrami / Clearwater / Hubbard / Lake of the Woods (HFA)  
Big Stone / Pope / Swift / Traverse (NFP)  
City of Bloomington (HFA)  
Cass (NFP)  
Dakota (HFA)  
Hennepin (HFA)  
Mille Lacs (HFA)  
Mower (HFA)  
Kanabec / Pine (NFP & HFA)  
Mahnomen / Norman (NFP)  
Marshall / Pennington / Red Lake (HFA)  
City of Minneapolis (NFP & HFA)  
St. Louis (NFP)  
St. Paul-Ramsey (NFP & HFA)  
Stearns (NFP & HFA)  
Todd / Wadena (NFP)  
Washington (HFA)



## Appendix I: Minnesota Family Home Visiting Evaluation Benchmarks

### Improved Maternal and Newborn Health

- Prenatal care
- Parental use of tobacco
- Preconception care
- Inter-birth intervals
- Screening for maternal depressive symptoms
- Breastfeeding
- Well-child visits
- Maternal and child health insurance status

### Child Injuries, Abuse, Neglect or Maltreatment and Reduction of Emergency Department Visits

- Visits of infants/children to the emergency department from all causes
- Visits of pregnant and postpartum women to the emergency department from all causes
- Information provided or training of pregnant and postpartum women, and other caregivers, on prevention of child injuries
- Incidence of infant/child injuries requiring medical treatment
- Reported suspected maltreatment among infants/children – reports: i.e., allegations, not substantiated/determined
- Substantiated maltreatment cases among infants/children
- First-time victims of maltreatment among infants/children

### Improvements in School Readiness and Achievement

- Parent support for children's learning & development
- Parent knowledge of child development & of their child's developmental progress
- Parenting behaviors & parent-child relationship - e.g., discipline strategies, play interactions
- Parent emotional well-being or parenting stress
- Infant/child communication, language, and emergent literacy
- Child's general cognitive skills
- Child's positive approaches to learning including attention
- Child's social behavior, emotion regulations, and emotional well-being
- Child's physical health & development

### Domestic Violence

- Screening for domestic violence
- Of postpartum women identified for the presence of domestic violence, number of referrals made to relevant domestic violence services
- Of postpartum women identified for the presence of domestic violence, number of families for which a verbal or written safety plan was completed
- Household income & benefits
- Education of adult members of the household
- Insurance coverage of pregnant women, mothers, infants/children

## Coordination of Referral for Other Community Resources and Supports

- Number of families identified for necessary services
- Number of families that required services & received a referral to available community resources
- Number of formal agreements (including MOUs) with community-based agencies in the collaborating community at level of reporting entity
- Number of agencies which home visitor has a clear point of contact at the community level
- Number of completed referrals

## References

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- <sup>i</sup> Nurse-Family Partnership (June 2010). *Benefits and Costs: A Program with Proven and Measurable Results*. Denver, CO: Nurse-Family Partnership.
- <sup>ii</sup> <http://www.cdc.gov/ace/findings.htm>
- <sup>iii</sup> 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.
- <sup>iv</sup> 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.
- <sup>v</sup> Karoly, L., Kilburn, M., Cannon, J.; *Early Childhood Interventions: Proven Results, Future Promise*; RAND Corporation; 2005.
- <sup>vi</sup> Miller, T. (February 2011). *Cost Offsets of Nurse-Family Partnership in Minnesota*. Calverton, MD: Pacific Institute for Research and Evaluation.
- <sup>vii</sup> Supporting Evidence-Based Home Visiting to Prevent Child Maltreatment: Cross-Site Evaluation Cost Study Background and Design Update.
- <sup>viii</sup> Minnesota MIECHV Expansion Program Grant period program data, March 31, 2013 – March 31, 2014.