MN HOUSE RESEARCH

Minnesota Department of Health Home Visiting Services

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Overview

The Minnesota Department of Health (MDH) supports voluntary home visiting services for pregnant women and families with young children. The services are funded with state and federal money. The publication outlines MDH responsibilities related to home visiting, specifies funding amounts and the sources of the funds, describes the home visiting models used in Minnesota, and provides data on the number of people in the state who receive MDH-supported home visiting services.

MDH Home Visiting

The Minnesota Department of Health (MDH) describes home visiting as:

> "a voluntary, home-based service ideally delivered prenatally through a child's first few years. During frequent, regularly scheduled visits, a family works with a trained home visitor to complete activities and curricula often provided by an evidence-based home visiting model. The home visitor also uses information from various health assessments to develop an individualized plan to assist the family in reaching their goals."[1]

Home visiting services seek to support pregnant women and families with young children by connecting them with appropriate medical and social services; providing information about healthy child development; promoting positive, responsive parenting; and by promoting family health and economic self-sufficiency.

MDH supports home visiting in several ways. MDH distributes state and federal money for home visiting services to community health boards (CHBs), Tribal governments, and nonprofit organizations. (See the "Funding" section of this brief for more details.) Additionally, MDH provides consultation, continuous quality improvement, and technical support to funding recipients; develops and provides training for home visiting program staff; establishes reporting requirements for home visiting programs; and collects data on home visiting services funded with certain state or federal funds. MDH uses the data collected to report on the value of home visiting services; monitor performance at the state, regional, and county levels; identify gaps in services and needs for additional training or technical assistance; and prioritize continuous

[1] Minnesota Department of Health, "Family Home Visiting Legislative Report," January 15, 2022, at https://www.health.state.mn.us/communities/fhv/reports.html.

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quality improvement projects. MDH also administers a family home visiting advisory group to improve communication among state and local participants in the home visiting system.

Funding

MDH distributes money from two state programs and two federal programs to CHBs, Tribal governments, and nonprofit organizations in the state for home visiting services (Table 1). The CHBs, Tribal governments, and nonprofit organizations may supplement any state and federal money with funding from other sources, including local money.

Table 1: State and Federal Money for MDH-Supported Home Visiting Services Fiscal Years 2022 – 2023

Home Visiting Program	Funding Source	Amounts by Fiscal Year (Dollars in thousands)	
		FY 22	FY 23
Home Visiting for Pregnant Women and Families with Young Children (Minn. Stat. § 145.87)	State general fund	$18,000	$18,000
Nurse-Family Partnership (Minn. Stat. § 145A.145)	State general fund	$2,000	$2,000
TANF Family Home Visiting (Minn. Stat. § 145A.17)	Federal TANF money	$8,557	$8,557
Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program (42 U.S.C. § 711)	Federal MIECHV grants	$8,827	$8,642

Sources: State law and communication with MDH.
Notes: The amounts in the table include money MDH may use for administration and evaluation and to provide technical assistance. See the body of the brief for more details.

State Funding

Total state general fund appropriations for MDH-supported home visiting are $20 million in each of fiscal years 2022 and 2023. Under the **Home Visiting for Pregnant Women and Families with Young Children** program, MDH awards competitive grants to CHBs, Tribal governments, and nonprofit organizations to start up, expand, and sustain home visiting programs that serve families with young children or pregnant women who have high needs or are high-risk.[2] Funding for the program is $18 million in each of fiscal years 2022 to 2024 and $16.5 million annually beginning in fiscal year 2025. MDH may use up to 7 percent of the annual appropriation for technical assistance, administration, and evaluation.

[2] Minn. Stat. § 145.87.

Under the **Nurse-Family Partnership** program, MDH awards competitive grants to CHBs, Tribal governments, and nonprofit organizations to start up, expand, or sustain nurse-family partnership home visiting programs.[3] The appropriation is $2 million each fiscal year. Statute does not specify an amount MDH may use for administrative purposes.

Federal Funding

States can use federal Temporary Assistance for Needy Families (TANF) block grant money for nonmedical home visiting services that meet the requirements of the TANF program. Minnesota opts to do so, allocating about $8.6 million for **TANF Family Home Visiting** services in each of fiscal years 2022 and 2023. MDH distributes the money, via formula, to CHBs and Tribal governments to pay for home visiting services for families at or below 200 percent of federal poverty guidelines[4] and other families determined to be at risk for child abuse, child neglect, juvenile delinquency, or other risks.[5] In each of fiscal years 2022 and 2023, MDH is allowed to use up to 6.23 percent of the allocation for administration, technical assistance, and evaluations.

The U.S. Department of Health and Human Services allocates money to MDH for home visiting services that target at-risk families under the federal **Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program**.[6] MDH received about $8.8 million in federal fiscal year 2022 to spend on MIECHV home visiting services and is expected to receive $8.6 million in federal fiscal year 2023. MDH distributes the money among communities based on the results of a statewide needs assessment. Federal law provides that MDH cannot spend more than 10 percent of the amount received on administration.[7]

Other Funding

CHBs, Tribal governments, and nonprofit organizations may also use other funding to support home visiting services, such as Medical Assistance funds,[8] grants from foundations, health insurance reimbursement, and local tax dollars. These funds are not distributed by MDH. A CHB or Tribal government may also choose to use a portion of its state local public health grant or federal maternal and child health block grant (both of which are distributed by MDH) for home visiting services. None of this funding is reflected in Table 1.

[3] Minn. Stat. § 145A.145.

[4] 200 percent of federal poverty guidelines is $55,500 for a family of four in 2022.

[5] Minn. Stat. § 145A.17.

[6] 42 U.S.C. § 711.

[7] 42 U.S.C. § 711(i)(2).

[8] Evidence-based home visiting services provided by public health nurses or registered nurses to Medical Assistance (MA)-eligible caregivers or children are reimbursed at $140 per visit from MA (Minn. Stat. § 256B.7635).

Home Visiting Models

When providing home visiting services, CHBs, Tribal governments, and nonprofit organizations select and implement one or more home visiting models based on the needs of their specific communities and the outcomes sought for the people who receive services. One way to characterize a home visiting model is the extent to which the model's design and outcomes are based on and supported by research and evidence. Several terms are used to describe home visiting models, including evidence-based, evidence-informed, promising practice, and traditional (or nonmodel) home visiting. A model's designation may determine the funding available for CHBs, Tribal governments, and nonprofit organizations using the model.

Models Defined

An **evidence-based home visiting model** is defined at Minnesota Statutes, section 145.187, as, "a program that:

1) is based on a clear, consistent program or model that is research-based and grounded in relevant, empirically based knowledge;
2) is linked to program-determined outcomes and is associated with a national organization, institution of higher education, or national or state public health institute;
3) has comprehensive home visitation standards that ensure high-quality service delivery and continuous quality improvement;
4) has demonstrated significant, sustained positive outcomes; and
5) either: (i) has been evaluated using rigorous randomized controlled research designs and the evaluation results have been published in a peer-reviewed journal; or (ii) is based on quasi-experimental research using two or more separate, comparable client samples."

The federal government also defines "evidence-based" for purposes of the MIECHV program and established the Home Visiting Evidence of Effectiveness (HomVEE) review to determine whether home visiting models meet the criteria to be considered "evidence-based."[9] The federal and state definitions are similar, and MDH currently supports seven home visiting models that are considered evidence-based under both definitions. The seven models are:

- Early Head Start,
- Family Connects,
- Family Spirit,
- Healthy Families America,
- Maternal Early Childhood Sustained Home-Visiting,
- Nurse-Family Partnership, and
- Parents as Teachers.

[9] As of July 2022, the HomVEE project has reviewed 50 home visiting models, and 22 were identified as meeting HHS criteria for being evidence-based. See U.S. Department of Health and Human Services, Administration for Children & Families, Home Visiting Evidence of Effectiveness, Model Reports, https://homvee.acf.hhs.gov/effectiveness.

The table on page 7 provides an overview of the theoretical basis of each model, the populations it serves, the length and intensity of the program, and the staff who provide services.

Minnesota Statutes, section 145.87, includes definitions for **evidence-informed home visiting models** and **promising practice models**. An **evidence-informed model** is defined as a program that: "(1) has data or evidence demonstrating effectiveness at achieving positive outcomes for pregnant women or young children; and (2) either: (i) has an active evaluation of the program; or (ii) has a plan and timeline for an active evaluation of the program to be conducted." A **promising practice model** is one that "has shown improvement toward achieving positive outcomes for pregnant women or young children." State statue does not define **traditional home visiting**. MDH describes it as relying on "nurse home visitor experience, nursing education, community needs, and findings from basic research."[10] In general, traditional home visiting does not have prescribed features, like a required number or frequency of visits, or a curriculum governing the visits.

Models in Use in Minnesota

Three of the four funding streams administered by MDH for home visiting require that at least a portion of the funding is used to implement evidence-based home visiting models.

- The appropriation for Pregnant Women and Families with Young Children home visiting requires that at least 75 percent of the grant money is to implement evidence-based home visiting models and up to 25 percent can be used to implement evidence-informed or promising practice models.
- The appropriation for Nurse-Family Partnership home visiting may be used only for Nurse-Family Partnership home visiting, which is an evidence-based model.
- The federal MIECHV program requires that at least 75 percent of its funding goes toward implementing evidence-based models, with up to 25 percent for promising practice models, but MDH currently allocates all federal MIECHV money for evidence-based programs.

The TANF Family Home Visiting funding stream is the only funding that does not require all or a portion of the appropriation to be used for one or more model types.

As a result of the requirements on the three funding streams, at least 65 percent of the home visiting money distributed by MDH must go toward evidence-based home visiting models. The remaining 35 percent may be spent on evidence-based models or other models, as determined by the recipients of the money.

[10] Minnesota Department of Health, "Family Home Visiting Legislative Report," January 15, 2022, at https://www.health.state.mn.us/communities/fhv/reports.html, page 10.

Enrollment

Table 2 provides information on the number of persons receiving MDH-supported home visiting services in calendar years 2017 through 2021. In calendar year 2021, about 6,600 children received MDH-supported home visiting services. Most of the children—about 84 percent—were under the age of three years at the time of enrollment for services. About 7,300 caregivers, including 1,705 pregnant women, also received home visiting services in calendar year 2021.

Enrollment in MDH-supported home visiting services was fairly consistent in calendar years 2017 through 2019. Between calendar years 2019 and 2020, enrollment declined by about 31 percent among children and by about 35 percent among caregivers. Enrollment continued to decline between calendar years 2020 and 2021, falling about 22 percent among children and about 20 percent among caregivers. MDH indicates that the decline in enrollment is likely because of the COVID-19 pandemic.[11]

Table 2: Participation in MDH-Supported Home Visiting Services Calendar Years 2017-2021

Participation in Home Visiting Services	2017	2018	2019	2020	2021
Children - Total	**12,316**	**12,350**	**12,434**	**8,541**	**6,637**
<1 year old	6,172	5,532	4,565	3,816	2,599
1-2 years old	4,470	4,436	4,427	3,648	2,968
3-4 years old	1,355	1,947	2,480	902	888
5 years and older	311	429	956	172	182
Caregivers - Total	**13,297**	**13,503**	**14,071**	**9,133**	**7,266**
Pregnant women	6,362	6,600	6,617	2,250	1,705
Other caregivers	6,930	6,895	7,435	6,833	5,561

Sources: Minnesota Department of Health, Family Home Visiting Report to the Minnesota Legislature for 2020 and 2022. Reports available at: https://www.health.state.mn.us/communities/fhv/reports.html.
Notes: The children's age is taken at the time of enrollment.
The total numbers of children and caregivers include small numbers of children and caregivers for whom data on age and pregnancy status are missing; see the source documents for details.
The numbers in the table include all individuals who consented to share data with MDH who participated in home visiting programs during the measurement year, as reported by local programs to MDH. The numbers may include clients served with funding sources other than money administered by MDH.

[11] Minnesota Department of Health, "Family Home Visiting Legislative Report," January 15, 2022, at https://www.health.state.mn.us/communities/fhv/reports.html.

Appendix: Evidence-Based Home Visiting Models Supported by MDH, as of August 2022

Model	Theoretical Model	Population Served	Length and Intensity of Program	Staff Providing Services
Early Head Start	Emphasizes parents as child's first and most important relationship. Comprehensive, two-generation initiative aimed at enhancing infant and toddler development, strengthening families, and respecting unique development of young children.	Designed for low-income pregnant women and families with children between birth and age 3. Most women and families must be at or below the federal poverty level, and a portion of enrollment must be available to certain children with disabilities.	Women may be enrolled prenatally or after a child's birth, and services continue until a child's 3rd birthday. Services include weekly home visits and two group socialization activities per month.	Home visitor child development associate or comparable credential
Family Connects	Brings families, community agencies, and health care providers together through nurse home visits to provide all families in a service area with support and resources to promote the well-being of newborns.	Designed to serve all families with newborns 2 to 12 weeks old in a defined service area; families with identified needs receive further support.	Universal, short-term home visiting targeted to a geographic area. Initial visit when newborn is 2 to 12 weeks old, but may reach families earlier or later when special needs are present. Families with identified needs receive more visits and referrals to services.	Bachelor-prepared registered nurse with specialized model training
Family Spirit	Designed to promote child's development through helping parents gain knowledge in domains of physical, cognitive, social-emotional, and language learning and self-help. Incorporates traditional Tribal teachings.	Designed for young Native American parents and their children; may also be used in non-Native populations with high parent and child health disparities.	Flexible design; recommended initiation at 28 weeks' gestation, continuing through child's 3rd birthday.	Paraprofessional, professional, or nurse, with specialized model training
Healthy Families America	Rooted in belief that early, nurturing relationships are the foundation for lifelong, healthy development. Interactions between providers and families are relationship-based, designed to promote positive relationships and healthy attachment, strengths-based, family-centered, culturally sensitive, and reflective.	Designed for parents facing challenges such as single parenthood, low-income, history of adverse childhood experiences, substance abuse, mental health issues, or domestic violence. HFA sites select specific characteristics to determine the population to serve.	Families are enrolled prenatally to within three months after a child's birth; services provided until child is between ages 3 and 5.	Paraprofessional, professional, or nurse, with specialized model training

Model	Theoretical Model	Population Served	Length and Intensity of Program	Staff Providing Services
Maternal Early Childhood Sustained Home-Visiting	Designed to enhance maternal and child outcomes by providing home visiting during and after pregnancy. Provides individualized, home-based services focused on parent education, maternal health and well-being, family relationships, and goal setting.	Designed for parents with children younger than two years old and pregnant women who are at risk of adverse parental and/or child health and development outcomes.	Ideally enrolls families prenatally but families may enroll up to eight weeks after an infant is discharged from a hospital. Provides a minimum of 25 visits for families that enroll prenatally and a minimum of 22 visits for other families. Visits continue until the child turns 2 years old.	Registered nurse with specialized model training.
Nurse-Family Partnership	Shaped by theories of human attachment, human ecology, and self-efficacy; client-centered and driven by client-identified goals. Goals include improved pregnancy outcomes, improved child health and development, and improved economic self-sufficiency.	Designed for first-time, low-income mothers and their children.	Pregnant women are enrolled early in pregnancy, first home visit no later than end of woman's 28th week of pregnancy; services available until child is age 2.	Bachelor-prepared registered nurse with specialized model training
Parents as Teachers	Based on the theory that affecting parenting knowledge, attitudes, behaviors, and family well-being impacts a child's developmental trajectory. Focuses on three areas: parent-child interaction, development-centered parenting, and family well-being.	Local affiliates select characteristics and eligibility of the population to be served. Eligibility criteria may include children with special needs, families at risk for child abuse, income-based criteria, teen or first-time parents, immigrant parents, or parents with low literacy or mental health or substance use issues.	Designed to serve families from pregnancy through a child's entry into kindergarten or through the kindergarten year. A local affiliate may choose to focus services on pregnant women and families with children between birth and age 3. Families can enroll at any point before age 5.	Paraprofessional, professional, or nurse, with specialized model training

Source: Adapted from HomVEE Model Overviews, at https://homvee.acf.hhs.gov/effectiveness and MDH model descriptions at https://www.health.state.mn.us/communities/fhv/homevisitor.html.