Minnesota Family Home Visiting Program

REPORT TO THE MINNESOTA LEGISLATURE

APRIL 2016

MDH Minnesota Department *of* Health

FAMILY HOME VISITING SECTION

Minnesota Family Home Visiting Program

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Contents

Executive Summary

Families are central to the healthy physical, social and emotional development of infants and young children. However, many Minnesota families face challenges that impact their ability to support the development of their children during the critical early years of life. Children and families in communities experiencing economic, social, and environmental disadvantages are disproportionately affected by stressors such as poverty and adverse experiences in early childhood, leading to the perpetuation of health disparities in later life.

Family Home Visiting services have been shown to effectively support at-risk families and improve outcomes for children and their families, and are a proven strategy to address the factors that create health inequity. This strategy has particular value for helping teen mothers and their children who face some of the highest risks for a host of negative outcomes and are often least equipped to seek out assistance. Family Home Visiting is a voluntary, home-based service ideally delivered prenatally through the early years of a child's life. It provides social, emotional, health-related and parenting support and information to families, and links families to appropriate resources.

This report summarizes outcomes from all Family Home Visiting programs that the Minnesota Department of Health (MDH) administered in calendar year 2014, the first year for which these data are available. These outcome data will provide baseline information for measurement of future progress.

The families served by Minnesota's Family Home Visiting programs in 2014 experienced notable impacts, particularly in the following key areas.

1. IMPROVED MATERNAL AND NEWBORN HEALTH

WHY THIS IS IMPORTANT: Regular, comprehensive well-child visits ensure that infant and child health problems are diagnosed and treated early, before they become more complex. Children in lower-income families experience a disproportionate burden of health problems, especially related to vision and hearing, behavior, elevated blood lead levels, and oral health. Left untreated, these problems can result in chronic conditions that adversely affect education, future productivity, and quality of life.

The mental and physical health of caregivers also impacts the well-being of the child. Postpartum depression can impair parent-child bonding and have long-term consequences for the child's development and emotional health.[1]

OUTCOMES: Baseline data from families served by Minnesota's Family Home Visiting programs indicate:

- Of 2,997 infants, 96 percent (n=2,872) completed at least half of the recommended number of well-child visits by 12 months of age.
- Of 3,283 new mothers, 82 percent (n=2,706) were screened for postpartum depression symptoms at least once by the time their child was 3 months old.
    - 25 percent (n=670) of new mothers screened had symptoms of postpartum depression.
    - 58 percent (n=389) of those with symptoms of postpartum depression agreed to be referred to relevant community resources.

2. REDUCTION IN CHILD INJURIES, CHILD ABUSE, NEGLECT, OR MALTREATMENT

WHY THIS IS IMPORTANT: A history of adverse experiences in childhood, including exposure to violence and maltreatment, is associated with health risk behaviors such as smoking, alcohol and drug use, and risky sexual behavior, as well as obesity, diabetes, sexually transmitted diseases, attempted suicide, and other health problems later in life.

OUTCOMES: Baseline data from families served by Minnesota's Family Home Visiting programs indicate:

- 4 percent of infants (136 out of 3,468) had one or more visits to the emergency department or an urgent care center for an injury by 6 months of age.
- Reports were made to Child Protection for suspected maltreatment for 4 percent of infants (133 out of 3,005) by 6 months of age.
    - Of those suspected maltreatment cases, 52 were substantiated.

3. IMPROVEMENTS IN SCHOOL READINESS AND PARENT-CHILD RELATIONSHIPS

WHY THIS IS IMPORTANT: A parent is a child's first and most important teacher. The strength of this first relationship significantly influences a child's ability to form and maintain subsequent

[1] http://developingchild.harvard.edu/wp-content/uploads/2009/05/Maternal-Depression-Can-Undermine-Development.pdf

healthy relationships. The quality of these first relationships greatly affects other aspects of a child's development. Positive social and emotional development in a very young child lays the foundation for lifelong physical health, mental health, and the capacity to learn.

OUTCOMES: Baseline data from families served by Minnesota's Family Home Visiting programs indicate:

- Of 5,157 eligible infants, 3,014 (58 percent) were screened for potential risk of developmental delay at 4 months of age.
  - 9 percent (273) scored below the referral cutoff score for communication, problem solving, or personal-social development.
- 461 caregivers were observed at least twice by home visitors who used standardized tools to measure changes in the quality of caregiver-child interaction by the time the child was 12 months old.
  - Of those caregivers, 62 percent (288 out of 461) had improved scores for one or more aspects of caregiver-child interaction at the second observation.

4. REDUCTION IN DOMESTIC VIOLENCE

WHY THIS IS IMPORTANT: Domestic violence has a demonstrable, long-term impact on the adult victim as well as on children who witness violence. Intimate partner violence (IPV) costs the United States $8.3 billion per year, including direct medical and mental health care costs and indirect costs from lost lives and lost work productivity. In addition to death or physical injury, IPV victims often experience adverse health outcomes due to chronic stress. Children in families where IPV is present are also more likely to experience maltreatment.[2]

OUTCOMES: Baseline data from families served by Minnesota's Family Home Visiting programs indicate:

- 2,556 women were screened for domestic violence by the time their child was 3 months old.
  - Of the women screened, 22 percent (n=561) screened positive for domestic violence.
  - 325 women with a positive screen completed a verbal or written safety plan with their home visitor.

[2] Intimate Partner Violence: Consequences (http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html)

5. FAMILY ECONOMIC SELF-SUFFICIENCY

WHY THIS IS IMPORTANT: Poverty has multiple, long-term effects on children's health and ability to learn because of the family's lack of access to resources increased stress related to economic insecurity.

Monitoring progress on the completion of educational programs or classes is one measure of movement toward increased self-sufficiency. Insurance coverage is another measure of progress toward self-sufficiency. As stated by the Kaiser Commission on Medicaid and The Uninsured, lack of health insurance compromises the health of individuals because they are less likely to receive preventive care, more likely to be hospitalized for avoidable health problems, less likely to receive timely diagnoses, and more likely to delay needed treatment. In addition, lack of insurance also affects the financial wellbeing of families by increasing family exposure and vulnerability to the high cost of health care and out-of-pocket costs.[3]

OUTCOMES: Baseline data from families served by Minnesota's Family Home Visiting programs indicate:

- Out of 860 primary caregivers enrolled in home visiting for 12 months, 39 percent (n=335) completed one or more educational programs or classes since enrolling in home visiting.
- At 12 months, 95 percent (954 out of 1,004) of families enrolled in home visiting had health insurance coverage.
    - This compares with 72 percent of families (1,890 out of 2,623) who were insured at the time of the first postpartum visit.

[3] Key Facts about the Uninsured Population (http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/) Retrieved January 3rd, 2016.

Introduction

Need for Family Home Visiting

Health, as defined by the World Health Organization, is "a state of complete physical, social, and mental well-being, and not merely the absence of disease or infirmity."[4] Health is created in the community through social, economic and environmental factors as well as individual behaviors and biology. When groups face serious social, economic and environmental disadvantages, such as structural racism and a widespread lack of economic and educational opportunities, health inequities are the result.[5]

Family Home Visiting services are one proven strategy to address the factors that create health inequity. National research has demonstrated that family home visiting results in improved prenatal health, fewer childhood injuries, fewer subsequent pregnancies, improved school readiness, increased intervals between births, and increased maternal employment. Family home visiting services provided to high-risk families have demonstrated significant impact on reducing child emergency room visits and the number of months a family needs welfare support.

The need for Family Home Visiting services in Minnesota is supported by the following state statistics:

- 15.5 percent of children ages 0-5 are living below the federal poverty level (American Community Survey, 2014);
- 43.1 percent of recorded births were paid for by Medicaid (MDH & DHS, 2013)
- 32.3 percent of babies were born to unmarried mothers (MDH, 2014);
- Teen Birth rate is 7.66 per 1,000 Teens ages 15-19 years old (MDH & American Community Survey, 2014)
- 4.6 percent of birth mothers have not completed high school/GED equivalent (MDH, 2014);

[4] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on July 22 1946 by the representatives of 61 states (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[5] Minnesota Department of Health. 2014. Advancing Health Equity in Minnesota, Report to the Legislature (http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf).

- 3.9 percent of birth mothers entered prenatal care late (third trimester) or not at all (MDH, 2014);
- 8.7 percent of births are premature, prior to 37 weeks gestation (MDH, 2014);
- 6.6 percent of babies born are low birth weight (under 2,500 grams) (MDH, 2014); and
- 4,183 children 17 years and younger are abused or neglected (DHS Child Maltreatment Report, 2013)

Further, in 2014 there were 2,733 births to teens in the state of Minnesota. Providing services to pregnant and parenting teens is a priority area for home visiting services given the strong evidence of poor outcomes for both teen parents and children born to teen parents: higher rates of prematurity, low birthweight, and developmental delays, lower high-school graduation rates, as well as lifelong and intergenerational poverty. This a critical time period to intervene in both the young mother's and the child's life. Evidence-based home visiting is an effective upstream intervention that can serve as a key link to other early childhood interventions and community supports such as quality child care, special education and other services that collectively will make a difference in the lives of parents and children.

What is Family Home Visiting?

Family Home Visiting is a voluntary, home-based service delivered ideally prenatally through the early years of a child's life. It provides social, emotional, health-related and parenting support and information to families, and links families to appropriate resources. Family home visiting services aim 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.

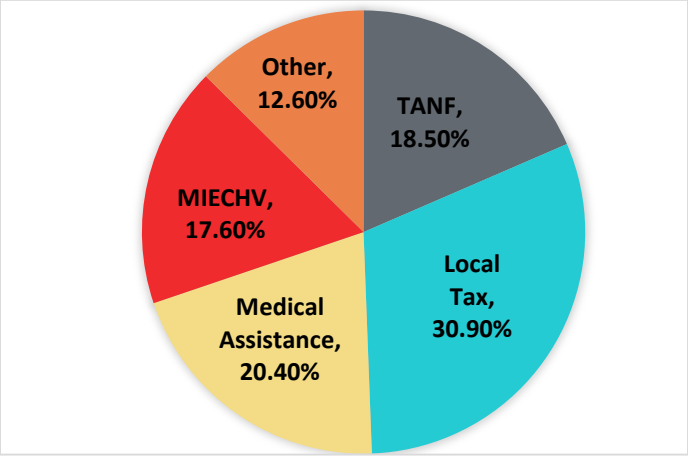
Depending on the goals identified by a family and based on assessments, a family may work with a home visitor for up to two years or longer. Through consistent and planned home visits, parents and caregivers learn how to improve their family's health and provide better opportunities for their children.

Description of Programs and Funding Streams

Family Home Visiting is supported by a number of funding streams including state, federal and local sources. Figure 1 shows the percent of funding by major funding stream. At the state level, the Minnesota Department of Health (MDH) oversees and distributes funding for home visiting services provided under Family Home Visiting (Temporary Assistance to Needy Families (TANF) funding), the federal Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV),

and Minnesota's Nurse Family Partnership legislation passed in 2015. Descriptions of each program are provided below.

Figure 1. Funding Sources for Family Home Visiting Programs in MN – 2014 based on survey responses to MDH from 45 local public health agencies representing 66 MN counties.



Family Home Visiting Program (TANF funded)

Since state fiscal year 2001, the Minnesota legislature has directed and MDH has administered federal TANF funds to support home visiting services to families at or below 200 percent of poverty and who are at risk for poor maternal and child outcomes. Interventions are designed to foster physical, social and emotional health, 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. Funding is distributed on a formula basis to local public health departments and Tribal Nations.

Minnesota Statutes Section 145A.17 (Appendix A) governs the Family Home Visiting Program (TANF funded). The Minnesota Legislature provides funding of $7,827,300 annually to all Community Health Boards (CHBs) and Tribal Nations for services provided under the statute. Appendix B lists the amount awarded to each CHB for the time period 07/01/2015 through 6/30/2017, and Appendix C lists amounts awarded to Tribal Nations for 7/1/2015 through 6/30/2017. The MDH is responsible for training and supervision standards, establishment of measures to determine the impact of Family Home Visiting programs funded under the statute, and for administering and monitoring grantees. Minnesota Statutes Section 145A.17 subdivision 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.

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. 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

Maternal, Infant, and Early Childhood Home Visiting (MIECHV)

The federally funded Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, administered through MDH, targets high-risk families who are most likely to benefit from intensive home visiting services, through which trained professionals (often nurses, social workers, or parent educators) help parents acquire the skills to promote their children's development. In 2014, $8,054,132 was provided to 19 Community Health Boards (CHBs) to provide evidence based home visiting services. These 19 CHBs were selected based on their coverage of counties designated as at-risk communities in a statewide needs assessment. MDH currently provides MIECHV funding to support 25 counties (within the 19 CHBs) provision of Nurse-Family Partnership (NFP) and Healthy Families America (HFA), two evidence-based home visiting models

MIECHV home visiting services help families connect to necessary services, such as health care or community resources, and monitor child development and progress on developmental milestones. Under the MIECHV program, Minnesota is accountable for meeting benchmarks in six areas: (1) improved maternal and newborn health; (2) prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits; (3) improvement in school readiness; (4) reduction in crime or domestic violence; (5)

improvements in family economic security; and (6) improved coordination and referrals for other community resources and support.

Nurse-Family Partnership Legislation

The 2015 Minnesota Legislature authorized $575,000 in State Fiscal Year 2016, and $2,000,000 in State Fiscal Year 2017 and thereafter, to provide grants to Community Health Boards (CHBs) and Tribal Nations to create or expand Nurse-Family Partnership (NFP) programs. Grants will be awarded in early 2016 to CHBs and Tribal Nations in both metropolitan and rural areas of the state, to either start a new NFP program or to expand an existing NFP program.

CHBs and Tribal Nations that expand services through rural regional partnerships will be given priority for funding. Priority will also be given to NFP programs that provide services through a Minnesota Health Care Programs (MHCP) enrolled provider that accepts Medical Assistance.

Evidence Based Home Visiting Models

Below is a description of the primary evidence-based home visiting (EBHV) models used by the Minnesota Family Home Visiting Program. Local public health agencies and Tribal Nations select which of these home visiting models best fit the needs of their communities. These EBHV models, among others, meet US Department of Health and Human Services criteria for evidence of effectiveness[6] and are supported by the MDH.

Nurse-Family Partnership

Nurse-Family Partnership® (NFP) is an evidence-based, community health program that helps improve the lives of vulnerable mothers who are pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives regular nurse home visits that continue through her child's second birthday. Research has shown that every dollar invested in NFP yields a range of $2.88 to $5.70 in return[7].

Goals of the NFP program include:

1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving diets and reducing use of cigarettes, alcohol and illegal substances;

[6] Home Visiting Evidence of Effectiveness - HomVEE (http://homvee.acf.hhs.gov/)

7 Karoly, L.A., Kilburn, M.R., & Cannon, J.S. (2005). Early Childhood Interventions: Proven results, future promise. Santa Monica, CA: RAND Corporation

2. Improve child health and development by helping parents provide responsible and competent care; and

3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

Healthy Families America (HFA)

Healthy Families America (HFA) is an EBHV program model designed to work with families who are at-risk for adverse childhood experiences, including child maltreatment. It is the primary home visiting model best equipped to work with families who may have histories of trauma, intimate partner violence, and mental health and/or substance abuse issues. HFA services begin prenatally or right after the birth of a baby and are offered voluntarily, intensively and over the long-term (3 to 5 years after the birth of the baby).

Goals of the HFA program include:

1. Build and sustain community partnerships to systematically engage families in home visiting services prenatally or at birth.

2. Cultivate and strengthen nurturing parent-child relationships.

3. Promote healthy childhood growth and development.

4. Enhance family functioning by reducing risk and building protective factors.

Family Spirit

The Family Spirit Program is an evidence-based and culturally tailored home visiting intervention delivered by Native American paraprofessionals as a core strategy to support young Native parents from pregnancy to 3 years postpartum. Parents gain knowledge and skills to achieve optimum development for their infant through preschool age children across the domains of physical, cognitive, social-emotional, language learning, and self-help.

Goals of the Family Spirit program include:

1. Increase parenting knowledge and skills.

2. Address maternal psychosocial risks that could interfere with positive child-rearing (low education and employment; drug and alcohol use; depression; domestic violence).

3. Promote optimal physical, cognitive, social/emotional development for children from 0 to 3.

4. Prepare children for early school success.

5. Ensure children get recommended well-child visits and health care.

6. Link families to community services to address specific needs.
7. Promote parents' and children's life skills and behavioral outcomes across the lifespan.

Family Connects

Family Connects is a triage model of care, providing one home visit to every family with a newborn age 2 to 12 weeks. The aim is to bring families, community agencies, and health care providers together to ensure parents have the resources they need to enhance the well-being of newborns. Families are screened for potential risk factors, and those with identified areas of concern receive additional visits, supports, and linkages to needed services.

Goals of the Family Connects program are to enhance:

Child health and well-being and reduce rates of child abuse and neglect through:

1. Improved connections to community resources
2. Connection to a primary medical home
3. Prevention of infant hospital readmissions
4. Prevention of unnecessary emergency care visits
5. Improved quality and safety of home environment, quality child care selection, and positive parenting behaviors

Reduce parental anxiety and depression.

Evidence Informed Home Visiting

A number of local public health agencies provide evidence informed home visiting services. These home visiting services range in length and intensity and are informed by best practices in home visiting. 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.

Over the past year, MDH has worked with Minnesota Coalition for Targeted Home Visiting (MCTHV), a statewide advocacy network of home visiting programs, to review home visiting standards used by other states with the goal of potentially identifying standards for Minnesota. MCTHV is currently finalizing a draft of standards for long term home visiting in Minnesota. While some home visiting programs may have additional or higher levels of standards based on models or curriculum used, this work will serve as a baseline for expectations for home visiting programs.

Program Evaluation

MDH uses the Family Home Visiting Evaluation Benchmark as a means of looking at outcomes related to home visiting services. The Family Home Visiting Evaluation Benchmark Plan is modeled after federal MIECHV performance measurement requirements. Benchmark measures are collected for MIECHV grantees in order to fulfill reporting requirements to the Health Resources and Services Administration (HRSA). Benchmark measures are also calculated for Minnesota public health home visiting programs more broadly for the state evaluation.

The Benchmark Plan includes six focus areas:

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

There are a total of 35 benchmark measures within these six areas. Each of these measures, along with how each is collected and calculated, is described in the Family Home Visiting Evaluation Benchmark Plan, which is published on the MDH website.

MDH also convenes a Family Home Visiting Evaluation Work Group to advise and collaborate on the evaluation of the Family Home Visiting program. Participants include local public health (LPH) home visitors and evaluation staff, data system vendor representatives, and model developers.

Program Statistics

Demographics

There were 18,719 clients in public health family home visiting programs statewide in 2014, according to data reported to MDH. Of these, 26 percent (4,943) were pregnant women, 23 percent (4,272) were parents and caregivers of young children, and 51 percent (9,504) were infants and children (Appendix H). Eighteen percent (3,428) of these clients were served using MIECHV funding, and the remainder were served with other funding sources including TANF Family Home Visiting.

Selected Outcomes

Data for selected outcomes under each of the six Family Home Visiting Evaluation Benchmark Plan areas are shown beginning on the following page. Analysis was restricted to 13,530 clients in long-term public health family home visiting programs, who were active between January 1, 2014, and December 31, 2014. Long-term programs include NFP, HFA, and other ongoing family home visiting programs.

Improved Maternal and Newborn Health

Outcomes

- Of 2,997 infants, 96 percent (n=2872) completed at least half of the recommended number of well-child visits by 12 months of age.
- Of 3,283 new mothers, 82 percent (n=2,706) were screened for postpartum depression symptoms at least once by the time their child was 3 months old.
  - 25 percent (n=670) of new mothers screened had symptoms of postpartum depression.
  - 58 percent (n=389) of those with symptoms of postpartum depression agreed to be referred to relevant community resources.

Why this is important

Regular, comprehensive well-child visits ensure that infant and child health problems are diagnosed and treated early, before they become more complex. Children in lower-income families experience a disproportionate burden of health problems, especially related to vision and hearing, behavior, elevated blood lead levels, and oral health. Left untreated, these problems can result in chronic conditions that adversely affect a child's education, future productivity, and quality of life.

The mental and physical health of caregivers also impacts the well-being of the child. Postpartum depression can impair parent-child bonding, and have long-term consequences for the child's development and emotional health.[8]

How Family Home Visiting helps

Home visitors work with clients in supporting healthy pregnancies by recognizing and reducing risk factors and by promoting prenatal health care, healthy diet, exercise, stress management and ongoing well-woman health care. Home visitors assess and promote positive infant and toddler healthy development and work with parents and community resources and providers to obtain supportive services. One of the measures that home visitors take to improve maternal and newborn health is to screen for postpartum depression and refer mothers who screen positive for depression to relevant services. They also encourage caregivers to take their children to well-child visits and assist them in enrolling in health insurance.

[8] http://developingchild.harvard.edu/wp-content/uploads/2009/05/Maternal-Depression-Can-Undermine-Development.pdf

Reduction in Child Injuries, Child Abuse, Neglect or Maltreatment; Emergency Department Visits

Outcomes

- 4 percent of infants (136 out of 3,468) had one or more visits to the emergency department or an urgent care center for an injury by 6 months of age.
- Reports were made to Child Protection for suspected maltreatment for 4 percent of infants (133 out of 3,005) by 6 months of age.
    - Of those suspected maltreatment cases, 52 were substantiated.

Why this is important

A history of adverse experiences in childhood, including exposure to violence and maltreatment, is associated with health risk behaviors such as smoking, alcohol and drug use, and risky sexual behavior, as well as obesity, diabetes, sexually transmitted diseases, attempted suicide, and other health problems later in life.

How Family Home Visiting helps

Family home visitors prevent child injuries by providing information on hazards in the home environment, as well as coaching caregivers in positive parenting practices. Home visitors complete a Home Safety Checklist (HSC) with the caregiver to identify safety concerns in the home that may put the infant or toddler at risk for an unintentional injury. The HSC is intended to be a non-threatening guide for parents to help them create a safe home for their children. Home visitors also work with parents to support positive parent-child interaction, safety planning in high risk situations, and appropriate navigation of the health care system.

Improvements in School Readiness and Achievement

Outcomes

- Of 5157 eligible infants, 3,014 (58 percent) were screened for potential risk of developmental delay at 4 months of age.
    - 9 percent (273) scored below the referral cutoff score for communication, problem solving, or personal-social development.
- 461 caregivers were observed at least twice by home visitors who used standardized tools to measure changes in the quality of caregiver-child interaction by the time the child was 12 months old.
    - Of those caregivers, 62 percent (288 out of 461) had improved scores for one or more aspects of caregiver-child interaction at the second observation.

Why this is important

A parent is a child's first and most important teacher. The strength of this first relationship significantly influences a child's ability to form and maintain subsequent healthy relationships. The quality of these first relationships greatly affects other aspects of a child's development. Positive social and emotional development in a very young child lays the foundation for lifelong physical health, mental health, and the capacity to learn.

How Family Home Visiting helps

Family home visitors screen young children using standardized instruments, and discuss the results with parents to help them understand their child's developmental progress. Home visitors also utilize standardized assessment tools to measure the quality of parent-child interaction. These assessments are then used to employ specific interventions that assist caregivers in enhancing their relationship with their infant/child. Home visitors work with caregivers to envision how they want to care for their child, and promote the caregiver's ability to accurately read and respond to infant cues, in order to promote infant trust and attachment, language skills, behavioral regulation, and emotional, physical and cognitive development.

Reduction in Domestic Violence

Outcomes

- 2,556 women were screened for domestic violence by the time their child was 3 months old.
  - Of the women screened, 22 percent (n=561) screened positive for domestic violence.
  - 325 women with a positive screen completed a verbal or written safety plan with their home visitor.

Why this is important

Domestic violence has a demonstrable, long-term impact on the adult victim as well as on children who witness violence. Intimate partner violence (IPV) costs the United States $8.3 billion per year, including direct medical and mental health care costs and indirect costs from lost lives and lost work productivity. In addition to death or physical injury, IPV victims often experience adverse health outcomes due to chronic stress. Children in families where IPV is present are also more likely to experience maltreatment.[9]

How Family Home Visiting helps

Family home visiting programs in Minnesota screen mothers and pregnant women for domestic violence using validated screening tools, and make appropriate referrals to domestic violence services. In addition to screening women for domestic violence, home visitors offer support and education regarding healthy relationships, and assist in the completion of safety plans for domestic violence, to help the mother strategize how to keep her and her children safe. In collaboration with the client, the home visitor promotes engaging other appropriate individuals in the client's family and social networks, promoting healthy relationships and nurturance and care for the child.

[9] Intimate Partner Violence: Consequences (http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html)

Family Economic Self-Sufficiency

Outcomes

- Of 860 primary caregivers enrolled in home visiting for 12 months, 39 percent (n=335) completed one or more educational programs or classes since enrolling in home visiting.
- 95 percent (954 out of 1,004) families enrolled in home visiting for 12 months had some type of health insurance coverage.
    - This compares with 72 percent of families (1,890 out of 2,623) who were insured at the time of the first postpartum visit.

Why this is important

Poverty has multiple, long-term effects on children's health and ability to learn because of the family's lack of access to resources increased stress related to economic insecurity.

Monitoring progress on the completion of educational programs or classes is one measure of movement toward increased self-sufficiency. Insurance coverage is another measure of progress toward self-sufficiency. As stated by the Kaiser Commission on Medicaid and The Uninsured, lack of health insurance compromises the health of individuals because they are less likely to receive preventive care, more likely to be hospitalized for avoidable health problems, less likely to receive timely diagnoses, and more likely to delay needed treatment. In addition, lack of insurance also affects the financial wellbeing of families by increasing family exposure and vulnerability to the high cost of health care and out-of-pocket costs.[10]

How Family Home Visiting helps

Home visitors assist clients in setting personal goals for the future, including goals related to employment and education. Home visitors help their clients to seek out jobs, complete educational programs, and enroll in health insurance, by linking them to resources and helping to overcome barriers. Home visitors help the client envision how she would like life to be for herself and her child, and promote pregnancy planning, education and employment as a means of accomplishing the client's goals. Home visitors engage in a therapeutic relationship with the client, focused on promoting the client's abilities and behavior change to protect and promote her own health and well-being and that of her child.

[10] Key Facts about the Uninsured Population (http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/) Retrieved January 3rd, 2016.

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 Nations and other early childhood stakeholders, MDH will continue to promote the use of local, state and federal funds to increase statewide implementation of evidence-based Family Home Visiting models, practices, and other core components of effective early childhood systems. Ongoing implementation guidance, training opportunities and evaluation 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

Appendix A: Minnesota Statutes 2015, Section 145A.17

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 8 s 32]

Subd. 3. **Requirements for programs; process.**

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

(1) a description of outreach strategies to families prenatally or at birth;
(2) provisions for the seamless delivery of health, safety, and early learning services;
(3) methods to promote continuity of services when families move within the state;

(4) a description of the community demographics;
(5) a plan for meeting outcome measures; and
(6) a proposed work plan that includes:
(i) coordination to ensure nonduplication of services for children and families;
(ii) a description of the strategies to ensure that children and families at greatest risk receive appropriate services; and
(iii) collaboration with multidisciplinary partners including public health, ECFE, Head Start, community health workers, social workers, community home visiting programs, school districts, and other relevant partners. Letters of intent from multidisciplinary partners must be submitted with the plan.

(b) Each program that receives funds must accomplish the following program requirements:
(1) use a community-based strategy to provide preventive and early intervention home visiting services;
(2) offer a home visit by a trained home visitor. If a home visit is accepted, the first home visit must occur prenatally or as soon after birth as possible and must include a public health nursing assessment by a public health nurse;
(3) offer, at a minimum, information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services available in the community;
(4) provide information on and referrals to health care services, if needed, including information on and assistance in applying for health care coverage for which the child or family may be eligible; and provide information on preventive services, developmental assessments, and the availability of public assistance programs as appropriate;
(5) provide youth development programs when appropriate;
(6) recruit home visitors who will represent, to the extent possible, the races, cultures, and languages spoken by families that may be served;
(7) train and supervise home visitors in accordance with the requirements established under subdivision 4;
(8) maximize resources and minimize duplication by coordinating or contracting with local social and human services organizations, education organizations, and other appropriate governmental entities and community-based organizations and agencies;
(9) utilize appropriate racial and ethnic approaches to providing home visiting services; and
(10) connect eligible families, as needed, to additional resources available in the community, including, but not limited to, early care and education programs, health or mental health services, family literacy programs, employment agencies, social services, and child care resources and referral agencies.

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

(d) Funds available under this section shall not be used for medical services. The commissioner shall establish an administrative cost limit for recipients of funds. The outcome measures established under subdivision 6 must be specified to recipients of funds at the time the funds are distributed.

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

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

Subd. 4. **Training.**

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

(1) effective relationships for engaging and retaining families and ensuring family health, safety, and early learning;
(2) effective methods of implementing parent education, conducting home visiting, and promoting quality early childhood development;
(3) early childhood development from birth to age five;
(4) diverse cultural practices in child rearing and family systems;
(5) recruiting, supervising, and retaining qualified staff;
(6) increasing services for underserved populations; and
(7) relevant issues related to child welfare and protective services, with information provided being consistent with state child welfare agency training.

Subd. 4a. **Home visitors as MFIP employment and training service providers.**

The county social service agency and the local public health department may mutually agree to utilize home visitors under this section as MFIP employment and training service providers under section 256J.49, subdivision 4, for MFIP participants who are: (1) ill or incapacitated under section 256J.425, subdivision 2; or (2) minor caregivers under section 256J.54. The county social service agency and the local public health department may also mutually agree to

utilize home visitors to provide outreach to MFIP families who are being sanctioned or who have been terminated from MFIP due to the 60-month time limit.

Subd. 5. **Technical assistance.**

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

Subd. 6. **Outcome and performance measures.**

The commissioner shall establish measures to determine the impact of family home visiting programs funded under this section on the following areas:

(1) appropriate utilization of preventive health care;
(2) rates of substantiated child abuse and neglect;
(3) rates of unintentional child injuries;
(4) rates of children who are screened and who pass early childhood screening;
(5) rates of children accessing early care and educational services;
(6) program retention rates;
(7) number of home visits provided compared to the number of home visits planned;
(8) participant satisfaction;
(9) rates of at-risk populations reached; and
(10) any additional qualitative goals and quantitative measures established by the commissioner.

Subd. 7. **Evaluation.**

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

Subd. 8. **Report.**

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

Subd. 9. **No supplanting of existing funds.**

Funding available under this section may be used only to supplement, not to replace, nonstate funds being used for home visiting services as of July 1, 2001.

History:

1Sp2001 c 9 art 1 s 53; 2002 c 379 art 1 s 113; 2007 c 147 art 17 s 1; 2009 c 79 art 2 s 8; 1Sp2011 c 9 art 2 s 22; 2013 c 108 art 12 s 49

Appendix B: Family Home Visiting (TANF) CHB Awards – 7/1/2015 through 6/30/2017

Community Health Board (CHB)	7/1/15 to 6/30/16	7/1/16 to 6/30/17
Aitkin Itasca Koochiching	$121,926	$121,926
Anoka	$315,522	$315,522
Benton	$43,822	$43,822
Blue Earth	$69,100	$69,100
Brown Nicollet	$72,688	$72,688
Carlton Cook Lake St. Louis	$389,512	$389,512
Carver	$56,946	$56,946
Cass	$41,252	$41,252
Chisago	$45,394	$45,394
Countryside (Big Stone, Chippewa, Lac Qui Parle, Swift, Yellow Medicine)	$86,938	$86,938
Crow Wing	$75,356	$75,356
Dakota	$325,356	$325,356
Des Moines Valley Health and Human Services (Cottonwood, Jackson)	$39,610	$39,610
Dodge Steele	$65,310	$65,310
Faribault Martin	$53,310	$53,310
Fillmore Houston	$55,394	$55,394
Freeborn	$44,266	$44,266
Goodhue	$47,462	$47,462
Hennepin Bloomington	$88,742	$88,742
Hennepin Edina	$39,996	$39,996
Hennepin Minneapolis	$979,782	$979,782
Hennepin Richfield	$45,150	$45,150
Hennepin Suburban	$685,328	$685,328
Horizon (Douglas, Grant, Pope, Stevens, Traverse)	$99,332	$99,332
Isanti Mille Lacs	$77,396	$77,396
Kanabec Pine	$68,296	$68,296
Kandiyohi Renville	$82,226	$82,226
Le Sueur Waseca	$58,458	$58,458
Meeker McLeod Sibley	$95,010	$95,010
Morrison Todd Wadena	$113,428	$113,428
Mower	$50,814	$50,814

Community Health Board (CHB)	7/1/15 to 6/30/16	7/1/16 to 6/30/17
Nobles	$30,998	$30,998
North Country (Beltrami, Clearwater, Hubbard, Lake of the Woods)	$122,410	$122,410
Olmsted	$151,440	$151,440
Partnership 4 Health (Becker, Clay, Ottertail, Wilkin)	$220,314	$220,314
Polk Norman Mahnomen	$75,600	$75,600
Quin	$84,412	$84,412
Ramsey	$994,732	$994,732
Rice	$63,650	$63,650
Scott	$76,566	$76,566
Sherburne	$61,212	$61,212
Stearns	$155,622	$155,622
Southwest (Lincoln, Lyon, Murray, Pipestone, Redwood, Rock)	$127,876	$127,876
Wabasha	$27,872	$27,872
Washington	$182,520	$182,520
Watonwan	$21,176	$21,176
Winona	$59,002	$59,002
Wright	$90,476	$90,476
Total	**$6,979,000**	**$6,979,000**

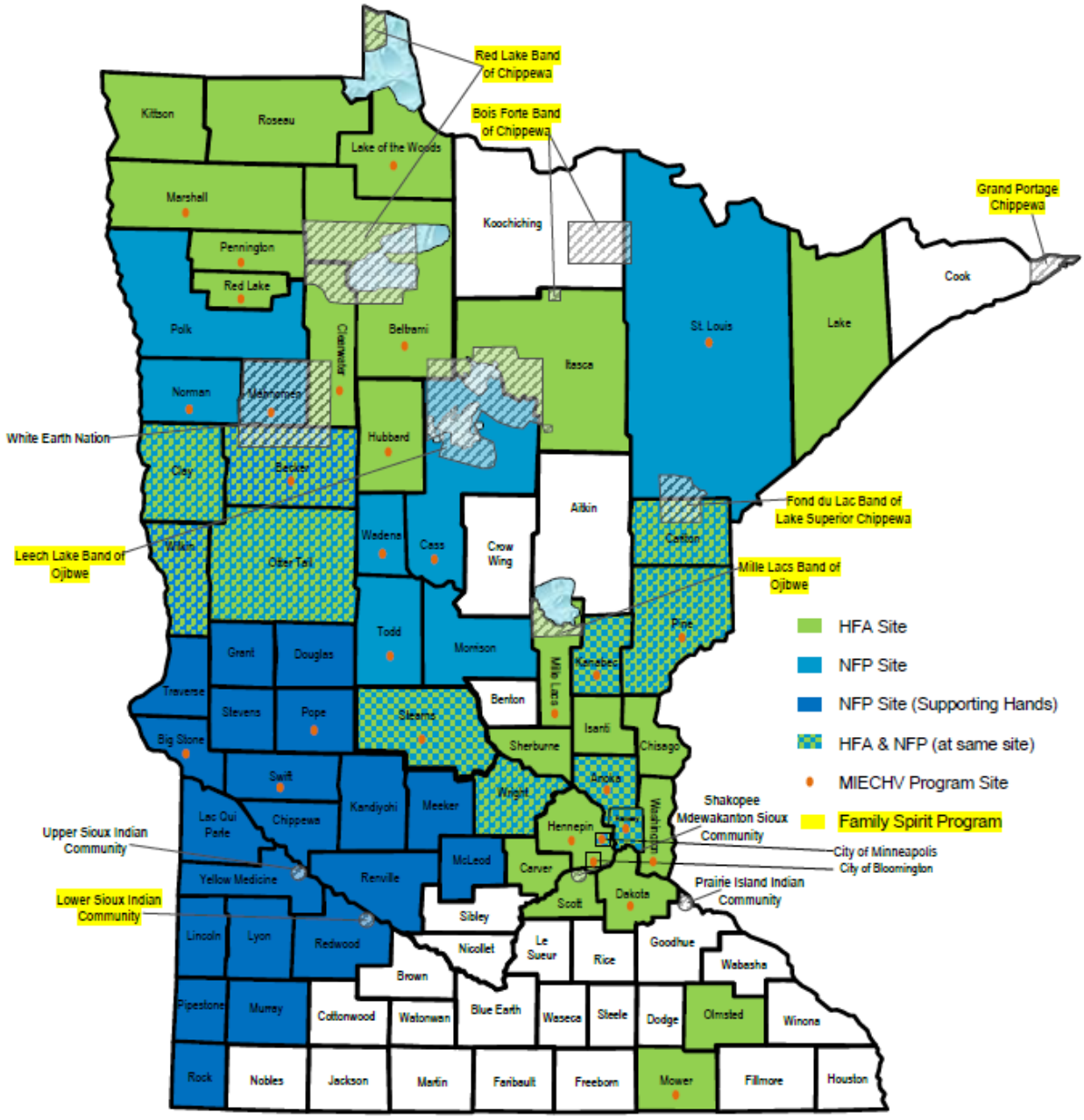
Appendix C: Family Home Visiting (TANF) Funding to Tribal Governments – 7/1/2015 to 6/30/2017

Tribal Governments	7/1/2015 to 6/30/2017
Bois Forte Reservation Tribal Council	$113,585
Fond Du Lac Band of Lake Superior Chippewa	$304,433
Grand Portage Reservation Council	$50,580
Leech Lake Band of Ojibwe	$368,822
Lower Sioux Indian Community	$57,983
Mille Lacs Band of Ojibwe	$132,469
Red Lake Band of Chippewa	$313,717
Upper Sioux Community	$42,356
White Earth Band of Ojibwe	$312,655
Total	**$1,696,600**

Appendix D: Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Community Health Board Awards – 1/1/2014 through 12/31/2014

Community Health Board	MIECHV Funding
Anoka	$436,500
Becker	$266,500
Bloomington	$194,380
Carlton, Cook, Lake St. Louis	$281,500
Cass	$91,000
Dakota	$369,617
Hennepin	$336,500
Isanti-Mille Lacs	$413,073
Kanabec Pine	$516,500
Meeker McLeod Sibley	$181,500
Minneapolis	$1,010,300
Morrison Todd Wadena	$91,000
Mower	$179,675
North Country (Clearwater)	$439,300
Polk Norman Mahnomen	$141,500
Partnership4health	$213,907
Quin (Marshall)	$266,500
St. Paul Ramsey	$1,634,000
Stearns	$724,380
Washington	$266,500
Total	$8,054,132

Appendix E: Map and List of Evidence-Based Home Visiting Programs, Minnesota, 2015



NFP Sites in MN:

- Anoka
- Becker
- Cass /Morrison / Todd / Wadena
- Mahnomen / Norman / Polk
- Partnership4Health (Clay/Wilkin/Otter Tail)
- Carlton / St. Louis
- City of Minneapolis (MVNA)
- Kanabec / Pine
- St. Paul-Ramsey
- Stearns
- Wright
- Big Stone
- Chippewa
- Douglas
- Grant
- Kandiyohi
- Lac Qui Parle
- Lincoln
- Lyon
- McLeod
- Meeker
- Murray
- Pipestone
- Pope
- Redwood
- Renville
- Rock
- Stevens
- Swift
- Traverse
- Yellow Medicine
- Fond du Lac Band of Lake Superior
- White Earth Nation

Family Connects Sites in MN:

- McLeod

Family Spirit Sites in MN:

- Bois Forte
- Mille Lacs
- Lower Sioux
- Fond du Lac
- Red Lake
- Leech Lake
- Grand Portage

HFA Sites in MN:

- Anoka
- Becker
- Beltrami / Clearwater / Hubbard / Lake of the Woods (North Country CHB)
- Mille Lacs
- Kittson / Marshall / Pennington / Red Lake / Roseau (Quin CHB)
- City of Minneapolis (Minnesota Visiting Nurse Association)
- Mower
- Olmsted
- Kanabec-Pine
- Stearns
- Carlton/Lake
- Itasca
- Partnership4Health (Clay/Wilkin/Otter Tail)
- Sherburne
- St. Paul-Ramsey
- Wright
- City of Bloomington
- Chisago
- Carver
- Dakota
- Hennepin
- Isanti
- Scott
- Washington

Appendix F: Family Home Visiting Program Coordination and Collaboration

In addition to the Family Home Visiting Advisory Group, MDH family home visiting staff and MDH Community & Family Health Division leadership participate in several groups that overlap with other providers of services for children and families. Examples include:

- Help Me Grow State Leadership Team
- Parent Aware work group
- Early Childhood Comprehensive Systems (ECCS) Steering Team
- Neonatal Abstinence Syndrome (cross-agency activities)
- Minnesota Developmental Screening Task Force
- Maternal and Child Health Advisory Task Force
- Sexual Violence Prevention Network
- Minnesota Coalition for Targeted Home Visiting, including Practice Matters work group
- Minnesota Coalition of Battered Women (joint trainings)
- Minnesota Early Learning Council
- Child Mortality and Sudden Unexpected Infant Death Reviews

Systems Collaboration and Impact

The Family Home Visiting Advisory Group provides guidance to MDH regarding implementation of Family Home Visiting within Minnesota's early childhood system. Representatives from local public health agencies, state agencies including Minnesota Departments of Education (MDE) and Human Services (DHS), and other home visiting stakeholders such as the Healthy Start and Head Start programs participate in the Family Home Visiting Advisory Group. MDE and DHS, which administer programs including Child and Teen Checkups, substance abuse and mental health services, child care assistance, the Minnesota Family Investment Program (MFIP), Early Head Start, Head Start, Early Childhood Family Education and Early Childhood Special Education chose representatives that provide guidance on behalf of those programs, as well as take information back from the Advisory Group to their agencies so that collaborative opportunities can be identified and an action plan developed.

The MDH Family Home Visiting staff are involved in a variety of activities to develop the state's early childhood system, including planning for implementation of the national Help Me Grow model in Minnesota. Work groups examined the resource and referral system for children at-risk for developmental and behavioral problems, and identified the important role that Family Home Visiting plays in assuring families have access to needed services.

MDH Family Home Visiting staff also participate in other system and interagency activities including the Minnesota Developmental Screening Task Force and Parent Aware activities, the

MN Coalition for Targeted Home Visiting, and the Interagency Council on Homelessness. The Community and Family Health Division Director is a member of the State Advisory Council on Mental Health, Subcommittee on Children's Mental Health. Family Home Visiting staff participate in the Multi-Generational Mental Health Work Group of the Subcommittee of Children's Mental Health. The work group was formed to make recommendations related to mental health issues of parents which impact the mental health of children.

Coordination and collaboration are also essential elements at the community level. Local public health agencies and Tribal Nations work within their communities, particularly their high risk communities, to develop collaborations with partners and service providers who will support implementation of family home visiting programs. All models being implemented require a community advisory board that supports implementation of the model. These advisory boards involve local stakeholders in planning, designing, and implementing the model. They also serve as a venue for community engagement and assuring that services are not duplicative.

Appendix G: Professional Development and Technical Assistance

In 2015, the MDH Family Home Visiting Section focused on making training more accessible, both geographically and financially, to its target audience of local public health and tribal health home visiting programs. Efforts have included: 1) continuing to offer a high level of quality training throughout various locations in the state; 2) opening training registration twelve months in advance to allow sites adequate planning time; and 3) increasing the use of technology, such as webinars and other e-learning programs, to reduce travel and time barriers to training. As a result, the Family Home Visiting Section provided over 1,000 hours of training through 70 training events in 2015. These trainings included topics such as maternal and infant assessment, developmental screening methods, implementation of evidence-based home visiting models, statewide data collection and continuous quality improvement.

MIECHV-funded efforts continue to strengthen reflective practice in evidence-based home visiting (EBHV). These efforts include mentoring of supervisors in the provision of reflective supervision and Infant Mental Health (IMH) consultation to home visiting teams. The goal of this effort is to ensure that supervisors are able to provide supervision that builds on capacities of home visitors and prevents burnout and staff turnover. IMH consultation to home visiting teams is available on an ongoing basis to support the reflective practice and relationship-based work of public health supervisors and staff providing intensive EBHV services to the families most at-risk for difficulties in caring for their children.

A related goal is to increase capacity across the state for IMH consultation to local public health programs offering EBHV. By mentoring and training locally-available mental health professionals, MDH has significantly increased the number and professional capacity of resources across the state. IMH consultation is unique in that it focuses on 1) the parent-child relationship, 2) the experience of the baby, and 3) how the parents' own childhood experiences impact their capacity to parent. The approach to consultation from an infant mental health frame utilizes a reflective stance; that is, it is empowers participants to reflect on their own experience in order to remain effective with families.

The Minnesota Legislature authorized $75,000 in state fiscal year 2016 for MDH to design baseline training for new home visitors to ensure statewide coordination across home visiting programs. The legislation indicates the project should be carried out in collaboration with DHS and MDE, CHBs, Tribal Nations, and other home visiting stakeholders. To meet the requirements of this legislation, MDH is continuing to partner with the Minnesota Targeted Home Visiting Coalition to identify the training needs of new home visitors and program supervisors across various types of home visiting programs (e.g. local public health, tribal health and Early Head Start), and using the core competencies for home visitors developed by the Coalition in 2013 as a basis for this work. Once the minimum training needs across all programs are identified, the project partners will begin to develop learning objectives and explore

training delivery methods (e.g. classroom, online or blended). The deadline for the baseline training design is June 30, 2016.

The MDH Family Home Visiting staff also contributed to a number of Community of Practice (CoP) activities in 2015. Building a CoP strengthens opportunities for face-to-face interaction, best-practice exchange, and ongoing professional development. It also assures excellence in home visiting practice and quality implementation of Minnesota's Healthy Families America (HFA) and Nurse Family Partnership (NFP) EBHV programs. Currently, MDH supports Communities of Practice for those implementing NFP and HFA evidence-based home visiting programs in Minnesota. CoP activities include:

- Quarterly NFP supervisor meetings with the Minnesota NFP State Nurse Consultants, who are MDH staff, and the NFP National Service Office (NSO) Nurse Consultant. The purpose of these meetings is to support NFP supervisors in Minnesota and surrounding single program states in successful implementation of the NFP model.

- Annual CoP events for NFP and HFA programs, which include activities for relationship-building and model-specific support in areas such as model fidelity, outcome data, enrollment and retention strategies, and training on topics identified by the respective CoP groups.

- HFA program supervisors and leads in the Twin Cities (Metro Alliance for Healthy families) and in Central Minnesota meet monthly to exchange best practices, discuss program implementation, share experiences in preparing for HFA model developer site visits, and to share resources.

- Bi-monthly phone consultations for HFA-affiliated programs using the Parent Survey assessment tool. These sessions provide participants with greater knowledge and experience using the Parent Survey through: 1) information on inter-rater reliability; 2) de-identified case scenarios; 3) step-by-step survey scoring; and 4) feedback about scoring at practice sessions.

In addition to the above, the MDH Family Home Visiting Section has made significant efforts to partner with other organizations in the early childhood system to offer professional development and training for home visiting staff. The following list highlights just a few of these partnerships:

- Partnership with DHS to lead a statewide initiative for community-based prenatal substance abuse recovery-oriented care. This work has included the provision of a statewide Summit on Prenatal Substance Use and Infant Exposure was hosted by MDH, DHS and other partners (i.e. Great Lakes Addiction Technology Transfer Center and the Minnesota Chapter of the March of Dimes) in May 2015 to raise awareness and encourage community collaborations around the issue. Over 350 people attended this Summit. Follow-up work from the Summit has included: 1) the convening of a core policy team that conducts bi-monthly meetings to address the rising issue of substance exposed infants in the state; 2) Minnesota's selection to participate as a pilot site for the creation of the Center for Excellence in Behavioral Health for Pregnant and Postpartum Women (PPW) and their Families; and 3) various CoP learning opportunities.

- Participation in the Maternal Wellbeing Innovation Lab. This project has included several community partners working in and with the early childhood system, as well as consumers, to develop a pilot project for organizations to address post-partum depression in a holistic, non-conventional way.
- Participation in the Early Childhood Professional Development Collaborative. This involves quarterly meetings with representatives from MDH, MDE, and DHS, as well as the University of Minnesota and private, non-profit groups to share information about their programs and training opportunities that are available for early childhood professionals.

Appendix H: Demographic Characteristics of Local Public Health Family Home Visiting Clients, Calendar Year 2014

NUMBER OF PERSONS ENROLLED BY CLIENT TYPE AND FUNDING SOURCE

Funding Source	All Clients		MIECHV funded		Other funded programs	
Client Type	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Prenatal Clients	4943	26%	1271	37%	3672	24%
Primary Caregivers	4272	23%	410	12%	3862	25%
Infants and Children	9504	51%	1747	51%	7757	51%
TOTAL	**18719**	**100%**	**3428**	**100%**	**15291**	**100%**

AGE GROUP (PRENATAL CLIENTS AND PRIMARY CAREGIVERS ONLY)

Funding Source	All Clients		MIECHV funded		Non-MIECHV funded	
Age Group	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
10-14	78	1%	21	1%	57	1%
15-17	1194	13%	342	20%	852	11%
18-19	1353	15%	315	19%	1038	14%
20-21	1219	13%	304	18%	915	12%
22-24	1516	16%	282	17%	1234	16%
25-29	1901	21%	237	14%	1664	22%
30-34	1248	14%	121	7%	1127	15%
35+	694	8%	56	3%	638	8%
Missing	12	0%	3	0%	9	0%
TOTAL	**9215**	**100%**	**1681**	**100%**	**7534**	**100%**

EDUCATION LEVEL (PRENATAL CLIENTS AND PRIMARY CAREGIVERS ONLY)

Funding Source	All Clients		MIECHV funded		Non-MIECHV funded	
Education Level	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
No High School Diploma/GED	3240	35%	736	44%	2504	33%
High School Diploma/GED	2076	23%	242	14%	1834	24%
Some Post-Secondary education or degree	2333	25%	427	25%	1906	25%
Missing	1566	17%	276	16%	1290	17%
TOTAL	**9215**	**100%**	**1681**	**100%**	**7534**	**100%**

RACE (PRENATAL CLIENTS AND PRIMARY CAREGIVERS ONLY)

Funding Source	All Clients		MIECHV funded		Non-MIECHV funded	
Race	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
American Indian and Alaskan Native	264	3%	60	4%	204	3%
Asian	609	7%	161	10%	448	6%
Black and African American	1644	18%	389	23%	1255	17%
Native Hawaiian and Other Pacific Islander	16	0%	4	0%	12	0%
White	5746	62%	893	53%	4853	64%
Multiple races reported	346	4%	88	5%	258	3%
Other	235	3%	17	1%	218	3%
Missing	355	4%	69	4%	286	4%
TOTAL	**9215**	**100%**	**1681**	**100%**	**7534**	**100%**

HISPANIC ETHNICITY (PRENATAL CLIENTS AND PRIMARY CAREGIVERS ONLY)

Funding Source	All Clients		MIECHV funded		Non-MIECHV funded	
Ethnicity	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Hispanic	1756	19%	271	16%	1485	**20%**
Not Hispanic	7139	77%	1372	82%	5767	**77%**
Missing	320	3%	38	2%	282	**4%**
TOTAL	**9215**	**100%**	**1681**	**100%**	**7534**	**100%**

INSURANCE STATUS AT INTAKE (PRENATAL CLIENTS AND PRIMARY CAREGIVERS ONLY)

Funding Source	All Clients		MIECHV funded		Non-MIECHV funded	
Insurance Status	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Has health insurance	7269	79%	1409	84%	5860	**78%**
Uninsured	632	7%	132	8%	500	**7%**
Missing	1314	14%	140	8%	1174	**16%**
TOTAL	**9215**	**100%**	**1681**	**100%**	**7534**	**100%**

INSURANCE STATUS AT INTAKE (INFANTS AND CHILDREN ONLY)

Funding Source	All Clients		MIECHV funded		Non-MIECHV funded	
Insurance Status	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Has health insurance	5515	58%	1084	62%	4431	**57%**
Uninsured	1266	13%	371	21%	895	**12%**
Missing	2723	29%	292	17%	2431	**31%**
TOTAL	**9504**	**100%**	**1747**	**100%**	**7757**	**100%**

RACE (INFANTS AND CHILDREN ONLY)

Funding Source	All Clients		MIECHV funded		Non-MIECHV funded	
Race	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
American Indian and Alaskan Native	227	2%	44	3%	183	2%
Asian	634	7%	175	10%	459	6%
Black and African American	1611	17%	344	20%	1267	16%
Native Hawaiian and Other Pacific Islander	10	0%	2	0%	8	0%
White	5285	56%	805	46%	4480	58%
Multiple races reported	715	8%	216	12%	499	6%
Other	353	4%	50	3%	303	4%
Missing	669	7%	111	6%	558	7%
TOTAL	**9504**	**100%**	**1747**	**100%**	**7757**	**100%**

HISPANIC ETHNICITY (INFANTS AND CHILDREN ONLY)

Funding Source	All Clients		MIECHV funded		Non-MIECHV funded	
Ethnicity	**Number**	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
Hispanic	2096	22%	335	19%	1761	**23%**
Not Hispanic	7021	74%	1384	79%	5637	**73%**
Missing	387	4%	28	2%	359	**5%**
TOTAL	**9504**	**100%**	**1747**	**100%**	**7757**	**100%**

Data Sources: Family Home Visiting Reporting and Evaluation System (FHVRES) and Nurse Family Partnership Efforts to Outcomes (NFP-ETO) system, as of December 07, 2015. Data are limited to clients in public health family home visiting programs, who were active during Calendar Year 2014.

Appendix I: 2014 Benchmark Data Tables

Note: The total number of persons reported for each measure varies because of missing data and differences in denominator definitions.

For details on each benchmark measure, including numerator and denominator definitions and the time point at which each measure is collected, see the Family Home Visiting Evaluation Benchmark Plan, on the MDH website.

Performance Indicators	Percentage	Numerator	Denominator
Benchmark 1.1: Average reported weeks of pregnancy at engagement in home visiting among women enrolled prenatally	**Mean=21 weeks**	n/a	2795
Benchmark 1.2: Percent of women enrolled prenatally who reported that they smoked cigarettes during their pregnancy at the 1st postpartum visit	**27%**	660	2412
Benchmark 1.3: Percent of postpartum women who reported that they currently take a vitamin containing folic acid at 6 months postpartum	**29%**	525	1799
Benchmark 1.4: Percent of postpartum women who reported that they have not been pregnant since the birth of their last (index) child at 12 months postpartum	**12%**	204	1675
Benchmark 1.5: Percent of postpartum women screened for postpartum depressive symptoms at least once between the birth of their infant and 3 months postpartum	**82%**	2706	3283
Benchmark 1.6: Average reported number of weeks of continued breast milk consumption at 6 months postpartum among infants for whom past breastmilk consumption was reported	**Mean=25.2 weeks**	n/a	1065
Benchmark 1.7: Percent of infants/children for whom the completion of at least 50% of	**96%**	2872	2997

Performance Indicators	Percentage	Numerator	Denominator
well-child visits was reported at 12 months postpartum			
Benchmark 1.8: Percent of mother-child dyads for whom some kind of health insurance coverage was reported at 6 months postpartum	**88%**	3120	3560
Benchmark 2.1: Percent of infants/children for whom one or more visits to the emergency department or urgent care center was reported by 12 months postpartum	**69%**	1927	2811
Benchmark 2.2: Percent of pregnant & postpartum women who reported that they had visit(s) to the emergency room or urgent care center by 12 months postpartum	**48%**	881	1840
Benchmark 2.3: Percent of primary caregivers enrolled who completed a Home Safety Checklist or equivalent by 6 months postpartum	**85%**	3063	3595
Benchmark 2.4: Percent of infants/children for whom one or more visits to the emergency department or urgent care center for an injury was reported by 6 months postpartum	**4%**	136	3468
Benchmark 2.5: Percent of all instances of reported suspected maltreatment among infants/children at 6 months postpartum	**4%**	133	3005
Benchmark 2.6: Percent of infants/children with substantiated child maltreatment at 6 months postpartum	**50%**	52	103
Benchmark 2.7: Percent of infants/children with substantiated child maltreatment who are first-time victims at 6 months postpartum	**90%**	47	52
Benchmark 3.1: Percent of parents with higher overall NCAST PCI Teaching Sub-Scale	**54%**	266	496

Performance Indicators	Percentage	Numerator	Denominator
Scores III & IV from time of first assessment to 12 months postpartum			
Benchmark 3.2: Percent of parents enrolled who discussed their child's ASQ-3 results (10/12 months scores) and ASQ:SE results (12 month score) with the home visitor at 12 months postpartum	**80%**	848	1065
Benchmark 3.3: Percent of parents with higher overall NCAST PCI Teaching Sub-Scale Scores I, II, V & VI from time of first assessment to 12 months postpartum	**50%**	251	502
Benchmark 3.4: Percent of parents screened positive for postpartum depression using the EPDS or PHQ-9 at least once between the birth of their infant and 3 months postpartum who were referred to relevant community resources	**58%**	389	670
Benchmark 3.5: Percent of infants meeting developmental milestones for communication, as measured by scoring above the referral cutoff score for Communication on the ASQ-3 at 4 months postpartum	**92%**	2792	3020
Benchmark 3.6: Percent of infants meeting developmental milestones for cognition, as measured by scoring above the referral cutoff score for Problem Solving on the ASQ-3 at 4 months postpartum	**92%**	2775	3023
Benchmark 3.7: Percent of infants meeting developmental milestones for cognition, as measured by scoring above the Personal-Social referral cutoff score on the ASQ-3 at 4 months of postpartum	**92%**	2773	3017
Benchmark 3.8: Percent of infants meeting social-emotional milestones, as measured by	**97%**	2000	2070

Performance Indicators	Percentage	Numerator	Denominator
scoring below the referral cutoff score on the ASQ:SE at 12 months postpartum			
Benchmark 3.9: Percent of infants/children who did not meet the classification for "underweight" or "obese" using WHO weight-for-length growth charts at 12 months postpartum	**84%**	1827	2179
Benchmark 4.1: Percent of prenatal and postpartum women who were screened for domestic violence using the NFP Relationship Assessment or HFA HARK-C Survey by 3 months postpartum	**77%**	2557	3330
Percentage of prenatal and postpartum women who screened positive for DV	**22%**	561	2549
Benchmark 4.2: Percent of prenatal and postpartum women identified for the presence of domestic violence using the NFP Relationship Assessment or HFA HARK-C Survey by 3 months postpartum who received a referral to relevant domestic violence services	**22%**	104	482
Benchmark 4.3: Percent of prenatal and postpartum women identified for the presence of domestic violence using the NFP Relationship Assessment or HFA HARK-C Survey by 3 months postpartum who completed an Intimate Partner Violence Safety Plan or equivalent	**60%**	326	542
Benchmark 5.1: Percent of primary caregivers who reported a higher category of annual household income & benefits from intake to 12 months post enrollment	**22%**	556	2537
Benchmark 5.2: Percent of primary caregivers who reported that they completed one or more educational programs or classes in the	**39%**	335	860

Performance Indicators	Percentage	Numerator	Denominator
past 12 months at 12 months post-enrollment			
Benchmark 5.3: Percent of primary caregivers and infants/children for whom some kind of health insurance coverage was reported at 12 months post-enrollment	**95%**	954	1004
Benchmark 6.1: Percent of infants who scored below the referral cutoff score for Communication, Gross Motor, Fine Motor, Problem Solving, or Personal-Social on the ASQ-3 at 12 months postpartum or who scored above the referral cutoff score on the ASQ:SE at 10/12 months postpartum	**16%**	310	1903
Benchmark 6.2: Percent of infants who scored below the referral cutoff score for Communication, Gross Motor, Fine Motor, Problem Solving, or Personal-Social on the ASQ-3 at 10/12 months postpartum or who scored above the referral cutoff score on the ASQ:SE at 12 months postpartum who received a referral to relevant community services	**100%**	63	63
Benchmark 6.3: Percent of infants scoring below the referral cutoff score for any developmental milestone, including the Communication, Gross Motor, Fine Motor, Problem Solving, or Personal-Social areas on the ASQ-3 at 10/12 months postpartum or scoring above the referral cutoff score for social-emotional milestones on the ASQ:SE who had an appointment made for further screening at 12 months postpartum	**100%**	51	51