Family Home Visiting Program

Report to the Minnesota Legislature 2010

Minnesota Department of Health

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Family Home Visiting Program

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Executive Summary

The goal of the Minnesota Family Home Visiting Program is 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 2007 Minnesota legislature amended the Family Home Visiting Program statute [M.S. 145A.17] and increased Temporary Assistance for Needy Families (TANF) funding to community health boards and tribal governments to support the services provided under the statute. The statute identifies program requirements and directs the commissioner of health to establish training requirements and evaluation measures to determine the impact of family home visiting programs funded under this statute.

In each even-numbered year, the commissioner of health is required to submit a report to the legislature on the Family Home Visiting Program funded by this statute and the results of the evaluation of the program. The purpose of this report is to fulfill that requirement for 2010. This document describes the activities mandated by the revisions to the Family Home Visiting Program statute and may not be a complete picture of family home visiting programming in Minnesota.

Activities and Accomplishments

The Minnesota Department of Health (MDH) provides statewide oversight, guidance, training and evaluation of the Family Home Visiting Program that is administered locally by community health boards and tribal governments. Over the past two years, MDH has developed the program in three major areas.

1. Targeted Home Visiting Plans
2. Training and Technical Assistance
3. Evaluation of Outcomes

1. Targeted Home Visiting Plans

In 2008, MDH required the 53 community health boards (91 local health departments) and 10 tribal governments funded under this statute to submit a plan describing seven components. These components include:

1. Outreach strategies;
2. Delivery of health, safety and early learning services;
3. Continuity of services;
4. Community demographics;
5. Outcome measures;
6. Work plan; and
7. Collaboration and coordination.

The majority of local health departments and tribal governments describe a continuum of family home visiting services that they provide in their communities. The programs vary in intensity and duration. A public health nursing assessment is required for the initial home visit for the Family Home Visiting Program. Ongoing visits are conducted by nurses and/or trained home visitors. Families receive information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services available in the community. These diverse programs are designed specifically to meet the needs of the local communities. Among the 91 local health departments there are 15 different curricula used, nine documentation systems employed and at least six different funding sources. Twenty-eight local health departments use a nationally recognized family home visiting model while 63 use other types of programming.

The Family Home Visiting Program serves families at or below 200 percent of federal poverty guidelines. All of the local health departments and tribal governments reported targeting clients with the following risk factors:

- Adolescent parents
- Lack of knowledge about child grown and development
- History of alcohol and drug abuse
- History of child abuse and family violence
- Insufficient finances
- Low resiliency to adversities and environmental stresses
- Reduced cognitive function
- Risk of long-term dependence.

2. Training and Technical Assistance

MDH is required to train family home visitors and provide technical assistance to programs. During the past two years, training and technical assistance has been provided in the following areas.

- Effective relationships for engaging and retaining families and ensuring family health, safety, and early learning.
- Effective methods of implementing parent education, conducting home visiting, and promoting quality early childhood development.
- Early childhood development from birth to age five.
- Diverse cultural practices in child rearing and family systems.
- Recruiting, supervising and retaining qualified staff.
- Increasing services for underserved populations.
- Relevant issues related to child welfare and protective services, with information provided being consistent with state child welfare agency training.

3. Evaluation of Outcomes

MDH developed a statewide outcome evaluation plan for local health department activities under the Family Home Visiting Program. Tribal governments are currently working with MDH to formalize their evaluation approach. Their progress will be reported in future legislative reports.

The evaluation plan addresses questions about the "why" and "how" of family home visiting as well as the contribution of family home visiting to the healthy development of children and families. The purposes of the evaluation are two-fold – accountability and learning. Accountability informs stakeholders that the Family Home Visiting Program legislative requirements are being met through collective efforts of local programs. Learning demonstrates strategies that work in specific communities including effective approaches, improved outcomes for children and families, and increasing the effectiveness of program strategies.

The evaluation plan for the Family Home Visiting Program includes four distinct components: Process Evaluation; Outcome Evaluation; a system for monitoring the Health Status of children and families; and Impact Studies. Outcomes and performance measures are reported by local health departments through the Planning and Performance Measurement Reporting System (PPMRS). MDH conducted a statewide feasibility assessment of these measures from January 1, 2009 to June 30, 2009.

The Family Home Visiting Program statute outlines ten outcome measures (listed below) to be reported by local health departments. This report describes the results of these outcome measures as reported by local health departments for the period January 1, 2009 to June 30, 2009.

1. Appropriate utilization of preventive health care.
2. Rates of substantiated child abuse and neglect.
3. Use of the home safety check list by family home visiting to reduce the rate of unintentional child injuries.
4. Rates of children who are screened and who pass early childhood screening for developmental and social-emotional milestones.
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.
10. Other qualitative goals and quantitative measures:
    a) Rates of preterm birth
    b) Rates of low birth weight
    c) Rates of subsequent births within 12 months of a previous birth.
    d) Rate of pregnant and parenting teens working towards a high school diploma or GED
    e) Promotion of economic self-sufficiency
    f) Parent-child interaction.

The evaluation was modified to include additional outcome measures for the January 2010 through December 2010 reporting period.

Conclusions

Local family home visiting programs report that as a result of the increased TANF funding they were able to enhance their local programs by:

- Enrolling more families
- Providing services for a longer period of time
- Increasing the number of staff, including adding bilingual staff or community health workers
- Expanding opportunities for staff development
- Increasing capacity to outreach to and build relationships with community partners
- Updating website or outreach materials
- Purchasing evidence-based curricula or screening tools.

The Family Home Visiting Program positively influences the lives of at risk pregnant women, infants and children. Family home visiting serves a large, low-income population of prenatal clients, primary caregivers, infants and children targeting the at-risk populations identified by the statute. Family home visitors connect families to community resources for health care, insurance, parenting, chemical dependency issues, employment, housing, education, financial and food. Family home visitors are successful at promoting appropriate utilization of preventive health care services, including well child and prenatal care. The close monitoring of at risk pregnancies by family home visitors potentially contributes to the lower premature birth rates of family home visiting prenatal clients compared to the rest of the state. Family home visitors work with families to achieve economic self-sufficiency through encouraging completion of a high school diploma or GED and utilizing local employment counseling resources. Working with women to successfully space pregnancies contributes to economic stability and improved health for the mother and child. Programs actively promote community partnerships and collaborations. Early identification of infants and children not meeting developmental or social-emotional milestones and referring these children to community resources for further assessment and intervention is a critical role played by family home visiting. The close relationship of family home visiting with these early childhood organizations facilitates early intervention and reduces duplication of services.

Background

Statutory Requirements

The 2007 Minnesota legislature amended the Family Home Visiting Program statute [M.S. 145A.17] and increased Temporary Assistance for Needy Families (TANF) funding to community health boards and tribal governments to support the services provided under the statute. Community health boards and tribal governments are required to submit a plan to the commissioner of health describing a multidisciplinary approach to targeted home visiting for families. The statute identifies program requirements and directs the commissioner of health to establish training requirements and evaluation measures to determine the impact of family home visiting programs funded under the statute. (See Appendix A: Family Home Visiting Program Statute)

In each even-numbered year, the commissioner of health is required to submit a report to the legislature on the Family Home Visiting Program funded by this statute and the results of the evaluation of the program. The purpose of this report is to fulfill the requirement for 2010. This document describes the activities mandated by the revisions to the Family Home Visiting Program statute and may not be a complete picture of family home visiting programming in Minnesota. Over the past two years, the Minnesota Department of Health (MDH) has developed the program in three major areas: **1) Targeted Home Visiting Plans; 2) Training and Technical Assistance; and 3) Evaluation of Outcomes.**

Goal of the Program

The goal of the Minnesota Family Home Visiting Program is 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 Family Home Visiting Program statute requires that programs must begin prenatally whenever possible and must be targeted to families with:

- adolescent parents;
- a history of alcohol or other drug abuse;
- a 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;
- a lack of knowledge of child growth and development stages;
- low resiliency to adversities and environmental stresses;
- insufficient financial resources to meet family needs;
- a history of homelessness;
- a risk of long-term welfare dependence or family instability due to employment barriers; or
- other risk factors as determined by the commissioner.

Program Development

MDH provides oversight, guidance and statewide evaluation of the Family Home Visiting Program and administers the funds provided to community health boards and tribal governments. Approximately $8,000,000 in TANF funding is allocated to the Family Home Visiting Program. MDH retains $498,000 for statewide training and technical assistance and $249,000 targeted for evaluation of program outcomes.

MDH convened a steering committee to provide the department with guidance for statewide implementation of the Family Home Visiting Program statute. The steering committee represents state and local partners with an interest in family home visiting and the outcomes of the program. Members include local health department directors, community health administrators and supervisors from both metro and non-metro areas, the Local Public Health Association of Minnesota, the Minnesota Departments of Education and Human Services, tribal governments, Head Start and Ready4K. A local health department director and the MDH Maternal and Child Health Section manager co-chair the steering committee. See Appendix B: Family Home Visiting Steering Committee Members.

Targeted Home Visiting Plans

Community health boards and tribal governments receiving funding under the Family Home Visiting Program statute are required to submit a plan to the commissioner of health describing a multidisciplinary approach to targeted home visiting for families [M.S. 145A.17, subd. 3]. The community health boards and tribal governments submitted their plans to MDH in March of 2008. Minnesota's local public health system consists of 53 locally governed community health boards that include 28 single county, 21 multi-county and four city health departments. The community health boards chose to report their plans as distinct 87 county and four city health departments thus totaling the number 91 seen in this report. Throughout this report, community health boards will be referred to as local health departments. The complete Minnesota Family Home Visiting 2008 Community Health Board Plan Report is available on the web at http://www.health.state.mn.us/divs/fh/mch/fhv/reports/chbplanreport.pdf.

A summary of the tribal government Family Home Visiting Program plans can be seen in Appendix C: Tribal Government Family Home Visiting Plans.

The plans were required by statute to include seven components. These components included:

1. Outreach strategies
2. Delivery of health, safety and early learning services
3. Continuity of services
4. Community demographics
5. Outcome measures
6. Work plan
7. Collaboration and coordination.

1. Outreach strategies: The plans provided descriptions of outreach strategies used to reach families prenatally or at birth. Table 1 shows the most common strategies used by local health departments to identify and provide outreach to prenatal clients and clients after the delivery of a child.

Table 1

PRENATAL Identification and Outreach Strategies	Number of LHD	AT BIRTH Identification and Outreach Strategies	Number of LHD
WIC clinics	83	WIC clinics	83
Healthcare providers	82	Birth Records	81
Social service/financial intake	78	Social service/financial intake	80
Community providers	73	Healthcare providers	79
Self-referrals	67	Hospital labor and delivery units	79
Fliers, brochures, posters	65	Community providers	74
School districts	59	ECFE	71
Health fairs/community	57		
Prenatal classes/groups	51		

2. Delivery of health, safety and early learning services: Local health departments and tribal governments are expected to provide seamless delivery of health, safety and early learning services in their communities by partnering with other community providers serving families with young children. These collaborative efforts occur through case consultations, partner meetings, shared case plans or joint home visits to families.

3. Continuity of services: When families move within the state, family home visiting programs link to family home visiting providers in the new community to which the family is moving. Permission granted by the family allows providers to share pertinent information and assure the continuity of service.

4. Community demographics: The local family home visiting programs described the unique characteristics and needs of their clientele, with particular attention to children and families with health risk factors and health disparities. The plans also described the process they went through to determine and prioritize the needs of their clients.

5. Outcome measures: Local health departments submitted the short-term and long-term outcomes they were using for evaluation of their programs. Over 400 outcomes and indicators were submitted. Table 2 illustrates the number of outcomes identified by each component of the Family Home Visiting Program goal.

Table 2

Family Home Visiting Program Goal	Number of Outcomes
Foster healthy beginnings	75
Improve pregnancy outcomes	62
Promote family health	55
Promote school readiness	51
Reduce child abuse and neglect	50
Promote positive parenting and resiliency in children	46
Promote economic self-sufficiency for children and families	43
Reduce juvenile delinquency	9
Other	24

6. Work plan: Each local health department submitted a work plan that included a description of their family home visiting programs and approaches; a description of the strategies they use to reach families at greatest risk; and the tools they use in family education. Each of these is described in greater detail below.

Types of Family Home Visiting Programs. The majority of local health departments reported that they provide several different family home visiting programs to meet the needs of their community. Twenty-eight local health departments use a nationally recognized family home visiting model (i.e. Nurse Family

Partnership or Healthy Families America) while 63 use other types of programming. MDH encourages and supports the use of evidence-based models and provides training and technical assistance for local program development. Evidence-based family home visiting practice is supported by research findings and/or demonstrated as being effective through a critical examination of current and past practices.

Family Home Visiting Approaches. Local health departments and tribal governments employ a variety of family home visiting approaches. A public health nursing assessment is required for the initial home visit for the Family Home Visiting Program. The programs then vary in intensity and duration. Ongoing visits are conducted by nurses and/or trained family home visitors. All families, regardless of the approach used, receive information on infant care, child growth and development, positive parenting, preventing diseases, preventing exposure to environmental hazards, and support services available in the community.

Reaching At-Risk Families. Most local health departments report that the prenatal period or soon after a birth is the optimal time to engage and enroll families. Between two to seven visits occur during the prenatal period. Visits may occur weekly or more frequently after the birth of the child through age one or two, depending on the family home visiting protocol and/or family need.

All local health department and tribal government plans described having a targeted family home visiting program (i.e. targeting families at highest risk). Approximately 50 percent of the plans described a program of contacting *all* parents of newborns in their community. This universal contact occurred by visit, phone or mail. Programs discussed how their universal contact helped to identify at-risk families for enrollment in their targeted home visiting program.

Teaching Tools for Families. Local health departments reported using 15 different teaching curricula with families in their family home visiting programs. Table 3 shows the number and percentage of local health departments using each curriculum.

Table 3

Curriculum	Number of LHD Using Curriculum	Percent of LHD Using Curriculum
Promoting Maternal Mental Health During Pregnancy	59	64.8
Bright Futures	44	48.4
Positive Parenting	38	41.8
Keys to Caregiving	32	35.2
Healthy Families – San Angelo	20	22.0
Promoting First Relationships	20	22.0
Young Family Parenting Information (MELD)	20	22.0
Seeing Is Believing	15	16.5
Partners in Parenting Education (PIPE)	14	15.4
Growing Great Kids	13	14.3
The Incredible Years	10	11.0
Partners for a Healthy Baby	10	11.0
Steps Toward Effective & Enjoyable Parenting (STEEP)	8	8.8
Parents as Teachers	1	1.1
Chicago Parent Program	1	1.1

Minnesota has several culturally-specific curricula that are used by tribal government family home visiting programs. They include:

- The Minnesota Department of Education, Office of Indian Education "Positive Indian Parenting" curriculum is an adaptation of the model developed by the National Indian Child Welfare Association. Lessons are based on traditional values to assist parents in culturally-appropriate child rearing practices.

- The “Cherish the Children” curriculum was developed by the Minnesota Indian Women’s Resource Center. This curriculum focuses on parenting skills for Indian mothers.
- National programs, such as Healthy Native Babies, provide risk-reduction templates that encourage personalization and adaptation for individual communities.
- Non-native curricula such as Bright Futures and the Nursing Child Assessment Satellite Training (NCAST) and Promoting Maternal Mental Health during Pregnancy are also identified in the tribal plans.

7. Collaboration and coordination: The Family Home Visiting Program statute requires that programs collaborate with multidisciplinary partners including other local health departments, Early Childhood Family Education (ECFE), Head Start, community health workers, social workers, other home visiting programs, school districts, and other community partners.

In their plans, local health departments were asked to identify the level of the relationship they have with specific community partners. The levels of relationship were described as: none; developing; networking; coordination; cooperation; collaboration; and multi-sector collaboration. The definition of the levels and a table describing the level of the relationship for the community partners is included in Appendix D: Community Partnerships. The local health departments and tribal governments were also asked to gather, and keep within their agency, letters of intent from multidisciplinary partners demonstrating collaboration and seamless delivery of services within their communities.

Training and Technical Assistance

The Family Home Visiting Training Work Group was formed to advise MDH on the development of the training requirements for family home visitors described in the Family Home Visiting Program statute [M.S. 145A.17, subd. 4]. The training work group consists of 19 members representing local health departments, the Minnesota Departments of Education and Human Services, tribal governments and Head Start. The training work group met from November 2007 through August 2008 and developed the Family Home Visiting Training Plan. Four principles guide training and technical assistance:

1. Building and strengthening relationships with families, planning and conducting effective home visits;
2. Strengthening parent/child relationships, positive parenting, early learning and school readiness;
3. Promoting health family functioning, self-sufficiency, family health and safety; and
4. Developing strong home visiting programs, leadership, supervision and program administration.

The complete Family Home Visiting Program Training Plan can be viewed at http://www.health.state.mn.us/divs/fh/mch/fhv/advisory/tewg/fhvtrainingplan_june2008.pdf. The training categories in the plan directly relate to the requirements outlined in the statute.

Following approval of the training plan, the Training Work Group met twice to discuss and make recommendations regarding the implementation of the training plan. Discussions focused on an overall structure for developing the trainings and determining priority areas for implementation. An implementation plan for September 2008 through December 2009 was developed and is available at http://www.health.state.mn.us/divs/fh/mch/fhv/advisory/tewg/fhvtrainingplan_oct2008.pdf.

Plans submitted by the tribal governments were used to identify their training and technical assistance needs. Extensive research was conducted to identify culturally appropriate materials and curriculums. Twelve curriculums, written by Native Americans and designed to strengthen Native families, were identified.

Table 4 summarizes the implemented training activities by MDH for local health departments and tribal communities for the years 2008 and 2009.

Table 4

2008-2009 Family Home Visiting Training Activities	
Parent-Child Interaction	NCAST Parent Child Interaction (PCI) trainings were held throughout the state and will continue to be offered three to four times per year. NCAST PCI scales measure parent-child interactions and can be used by family home visitors as an effective method of parent education to promote early learning.
What About the Baby?	MDH partnered with the Minnesota Organization for Adolescent Pregnancy Prevention and Parenting to provide two *What About the Baby?* trainings. These trainings provided research-based information on strategies to promote relationships leading to healthy development for both the adolescent parent and their child.
Recognizing Chemical Dependency	*Recognizing Chemical Dependency* trainings were held seven times throughout the state to promote family health and safety. Learning objectives included exploring the impact of substances upon a developing fetus, understanding the biological basis for chemical dependency, developing awareness of screening tools and learning ways to effectively support clients in changing their chemical dependency behaviors.
Motivational Interviewing	Two trainings were held in 2009 on basic principles of motivational interviewing. Skills learned in these trainings allow family home visitors to effectively engage and retain families and promote behavior change.
Comprehensive Family Assessment and Care Planning	*Comprehensive Family Assessment and Care Planning* provides less experienced home visitors with the knowledge and tools to effectively conduct a family assessment and develop a care plan to promote family health and safety.
Promoting Relationships with Relationships	*Promoting Relationships with Relationships* increases the knowledge of home visitors on the importance of secure and responsive relationships on child growth and development. It also addresses how to support parents in a diverse range of child rearing and family systems by focusing on the parents' relationships with their children.
Wellbriety	In collaboration with Minnesota Tribal communities, a two-day Native specific *Wellbriety* training for Minnesota tribal home visitors. *Wellbriety* training explores historical trauma, relationships, conflict management and the development of trust and respect.
Live It Teen Pregnancy Prevention	MDH partnered with the Division of Indian Work, Minneapolis, to hold a train the trainer session for the *Live It Teen Pregnancy Prevention* curriculum in July 2009. The training was held on the Fond du Lac reservation and home visitors from three other Tribal communities, Leech Lake, Upper Sioux and White Earth, attended the training.

Appendix E: Training and Technical Assistance Activities provides additional information on the training and technical assistance activities that address the statutory requirements for family home visiting.

Evaluation

Background

The 2007 revised Family Home Visiting Program statute required that MDH implement a comprehensive evaluation for the Family Home Visiting Program. MDH convened a Family Home Visiting Evaluation Work Group to develop a statewide outcome evaluation plan for community health board activities under the Family Home Visiting Program. Tribal governments are currently working with MDH to formalize their evaluation approach. Their progress will be reported in future legislative reports. The following section reflects the evaluation plan designed for local health departments.

The Evaluation Work Group, under the direction of the steering committee, included family home visiting staff from local health departments, MDH staff with evaluation expertise and others with interest in family home visiting and expertise in evaluation. The charge of the work group was to provide feedback and direction in developing a Family Home Visiting Program evaluation plan, including identifying stakeholders, reviewing evaluation questions, analyzing outcomes reported by local health departments in their detailed plans and guiding the development of statewide outcomes and indicators to be collected. This group met monthly from the fall of 2007 until their final report was presented to the steering committee in September 2008. In addition, MDH worked with an evaluation consultant to conduct a Delphi process (a consensus development process designed to gather information from a panel of experts) to assist in the identification of key Family Home Visiting Program outcomes.

One of the challenges faced by the work group is that family home visiting programs in Minnesota use a multitude of program models and curricula with services provided universally to all families or targeted to families with selected risk factors. These diverse programs are designed specifically to meet the needs of local communities. As noted previously, among the 91 local health departments there are 15 different curricula used, nine documentation systems employed and at least six different funding sources. Twenty-eight departments use a national home visiting model while 63 use other types of programming. All local health departments screen and assess their clients for risk factors and development levels. However, the purpose for screening varies as does the tool used to screen. The intensity level for family home visits range from two to seven visits prenatally to weekly visits up to age two.

There are both strengths and limitations to this complex approach of providing family home visiting services. One particular area of strength is that this diversity of approaches allows the local community to design and implement its family home visiting services in response to the unique qualities and needs of its local communities. In turn, this creates a major challenge for the evaluation to document the impact of the Family Home Visiting Program statewide. The evaluation plan recommended by the work group attempts to recognize the diversity of Minnesota's family home visiting programs while taking into account the following factors.

- **Different approaches to local evaluation and measurement:** As indicated in the background, local health departments use many different models to implement family home visiting. These models use different evaluation tools to measure, therefore aggregating data collected with a variety of tools will be challenging.

- **Varying capacities to conduct evaluation:** Local health departments vary in staff size from over 100 to less than five. Smaller departments do not have the staff resources to conduct an extensive evaluation. Regardless of size, local health departments have different levels of evaluation ability, making it essential to create an evaluation that is easy to conduct and does not consume too much staff time.

- **Lack of comparison groups, baseline and targets:** An evaluation uses comparison groups, baselines and targets to determine the effectiveness of the program. Because this evaluation will begin after the Family Home Visiting Program has started, comparing statewide outcomes to comparison group and baseline data is not possible. Therefore other standards and targets for comparison need to be selected such as evaluation results from other states and national programs.

- **Need to provide information on return on investment:** There is intense scrutiny both at the local and state level to justify the resources invested in family home visiting by tracking the specific contributions of family home visiting, apart from other efforts. This can be very difficult to document because funding is coming from different sources, clients often receive services from many programs, clients are transient thus hard to track, and outcomes are not seen immediately.

For these reasons, the Evaluation Work Group determined that evaluation activities would be broader than that of families that could be served by state-appropriated funding. It was determined that data collected and reported by local health departments would include all non-medical home visiting activities for pregnant women and families that was administered and/or contracted by a local health department in which a public health nursing assessment is carried out during the initial home visiting and the visits are provided by a trained family home visitor to achieve the goals listed under the Family Home Visiting Program statute [M.S. 145A.17]. This evaluation covers all local health department family home visits, irrespective of funding sources.

Evaluation Plan and Framework

Accountability informs stakeholders that Family Home Visiting Program legislative requirements are being met through collective efforts of local programs.

Learning demonstrates strategies that work in specific communities including effective approaches, improved outcomes for children and families, and increasing the effectiveness of programs strategies.

The evaluation plan addressed questions about the “why” and “how” of family home visiting as well, as the contribution of family home visiting to the healthy development of children and families. The purposes of the evaluation are two-fold – **accountability** and **learning**. Accountability is the extent to which the Family Home Visiting Program is meeting the intent of the legislation. Learning involves gathering data and information to improve family home visiting programs and contribute to the literature of what works in family home visiting to enhance the lives of women, children, and families. In addition, the evaluation can help to determine the strategies or approaches that work best with targeted groups in order to fine tune and capitalize on the strengths of the program to make them most effective and to assess the short and long-term outcomes of the project.

Consistent with these purposes for the evaluation, several questions were posed in the work group to assess both the accountability and learning functions. The questions were intended to frame the assessment of the efforts of local programs meeting the statutory requirements by documenting the process and activities conducted by family home visiting programs. In addition, the evaluation questions focus on the need to document the effects including the results or outcomes achieved for children, families, communities, and/or systems.

The evaluation plan for Family Home Visiting Program includes four distinct components: Process Evaluation; Outcome Evaluation; a system for monitoring the Health Status of children and families; and Impact Studies. Each component is described in Table 5.

Table 5

Model Components Description	
Components	Description
1. Process Evaluation	▪ Required reporting for all family home visiting programs ▪ Describes individuals enrolled in family home visiting programs (demographics and descriptive reporting) ▪ Provides information for accountability and learning
2. Outcome Evaluation	▪ Required reporting of selected outcomes for all family home visiting programs ▪ Required reporting of selected outcomes for programs directing resources to specific areas (e.g. child maltreatment) ▪ Outcomes for further development ▪ Describes the effects family home visiting has on Minnesota children and families ▪ Provides information for accountability and learning
3. Health Status Reporting	▪ MDH reports using existing data to monitor health status of children and families ▪ Reporting useful for family home visiting staff and interested stakeholders ▪ Uses could include comparison data or inform policymakers ▪ Provides information for learning
4. Impact Studies	▪ Selected family home visiting programs participate ▪ Could include a comparison of results of national models for targeted demographic groups (e.g. race, mothers' age) ▪ Could also include a cross agency effort to convert to a common documentation system that could be integrated into PPMRS type reporting system ▪ Describes how results can inform policies and programs ▪ Provides information for learning

1. Process Evaluation: The process evaluation is being used to determine if the program is meeting the intent of the Family Home Visiting Program statute and describes services, recipients of services and the results of services. The questions include who receives services, the number served, the purpose for being served and a description of interventions and strategies that are designed to develop strengths and competencies in the families served. The results of the process evaluation are primarily "counts" of a set of descriptors. Data collected in the process evaluation component contributes to the learning about what works in family home visiting. For example, recruitment strategies, client retention approaches, program techniques and strategies that are targeted to teen parents, all of which can be shared with other local programs and provide opportunity for local family home visiting programs to learn from the experience of others. Table 6 provides examples of the type of information that could be collected in the process component of the evaluation.

Table 6

Examples of Process Evaluation Data
Description/Intensity of Home Visit
Enrollments and exits completed this reporting period Family home visits completed in first, second, and third trimester Children 0-3 year in household opened during reporting period Average number of home visits that were completed between dates of first visit billed to the family home visiting program and date of closure to home visiting services.
Demographics
Race/ethnicity of primary caregivers opened during reporting period Education level of caregiver Age of caregiver MFIP assistance (per caregiver)
Source: Minnesota Family Home Visiting 2008 Community Health Board Plan Report

2. Outcome Evaluation: The outcome evaluation will provide information on a set of outcomes that result from family home visiting activities and define the purposes of family home visiting in Minnesota, including: childhood screening and assessment, child development, referral, access to services and services utilization. The outcome evaluation monitors broad overall trends and answers several questions including: the extent that home visiting interventions meet the program goals identified in legislation; the results that are being achieved; and the impact of home visiting on children and families. The indicators measure changes in statewide outcomes of health and well-being of children and families that occur as a result of home visiting.

Identification of Statewide Outcomes

The Evaluation Work Group and MDH engaged a statewide group of experts to identify statewide outcomes for the Family Home Visiting Program. A Delphi process was carried out to first identify and then prioritize outcomes that were most important to assess for family home visiting. A panel of 86 experts was identified to assist in this process, including representatives of state agencies, local health departments, Family Home Visiting Steering Committee members, community partners, foundations, academic institutions, researchers, and community members. Experts represented all regions of Minnesota, including the metro area and greater Minnesota. In the first round of this process, over 400 outcomes were identified by the participants. In the second round of this process, the expert panel was asked to prioritize the most commonly cited set of 40 outcomes by selecting a small number of outcomes that they felt were most important to family home visiting. Table 7 provides the criteria by which potential outcome measures were evaluated.

Table 7

Outcome Selection Questions
▪ Is the outcome useful to the state and local public health (e.g. decision-making and program improvement)? ▪ Is the outcome common across multiple home-visiting programs? ▪ Is the outcome consistent with the statute? ▪ Is the outcome critical to healthy families (or the end result of home visiting)? ▪ Is the outcome long or short term (or what is a reasonable amount of time to expect to see change in the target population?) ▪ Can the outcome be reasonably measured (what are common indicators)? ▪ Is there a way to measure and collect data with limited burden on local programs?

Reporting Requirements for Outcomes and Indicators

With the completion of the Delphi process and a review by the Evaluation Work Group and MDH staff, a total of twenty-two outcomes were identified. These outcomes were divided into three groups:

- **Group 1:** Outcomes that all family home visiting programs would be required to report;
- **Group 2:** Outcomes that would be required for selected family home visiting programs directing resources to specific areas; and
- **Group 3:** Outcomes needing further development to facilitate measurement across the diverse programs and populations served by the programs.

The first group of outcomes (required for all family home visiting programs) covers several goals identified in the 2007 legislation including the areas of school readiness, healthy beginnings, and positive parenting. The second group of outcomes (required for selected family home visiting programs) fall under the legislative goal areas of pregnancy outcomes, economic self-sufficiency, and child abuse and neglect. The third group of outcomes (requiring further development) covers the legislative goal areas of positive parenting, juvenile delinquency and family health.

This plan for reporting recognizes the diversity of family home visiting programs, where family home visiting programs are directing resources, providing services, or using strategies and approaches that differ. Using this approach, there will be required reporting on a specific set of indicators for all family home visiting programs and another set of indicators for programs that focus resources in certain areas not common to all programs such as birth or pregnancy, economic self-sufficiency, or child maltreatment. The following is a list of the outcomes identified and indicators that will be used to monitor the Family Home Visiting Program.

Group 1: Statewide Outcomes for *All* Family Home Visiting Programs

Early Childhood Development

Outcome 1: Infants and children are screened for developmental and social-emotional milestones using recommended standardized tools.

Indicators:

a) The percent of infants and children (born or newly enrolled within the reporting period) with three or more visits who were screened for developmental milestones with a recommended standardized tool within six months of birth or enrollment.
b) The percent of infants and children (born or newly enrolled within the reporting period) with three or more visits who were screened for social-emotional milestones with a recommended standardized tool within six months of birth or enrollment.
c) If the family received services longer than six months (during the reporting period), the percent of infants and children screened for developmental milestones according to the recommended schedule for the tool used.
d) If the family received services longer than six months (during the reporting period), the percent of infants and children screened for social-emotional milestones according to the recommended schedule for the tool used.

Outcome 2: Infants and children achieve developmental and social-emotional milestones.

Indicators:

a) The percent of infants and children that meet developmental milestones at their first screening with a recommended standardized tool within six months of birth or enrollment.
b) The percent of infants and children that meet social-emotional milestones at their first screening with a recommended standardized tool within six months of birth or enrollment.

c) If the family received services longer than six months (during the reporting period), the percent of infants and children that meet developmental milestones for their age at the last time they were screened with recommended standardized tools.
d) If the family received services longer than six months (during the reporting period), the percent of infants and children that meet social-emotional milestones for their age at the last time they were screened with recommended standardized tools.

Outcome 3: Infants and children who do not meet developmental and social-emotional milestones are referred for further assessment, follow-up, and/or additional intervention.

Indicator:
a) The percent of infants and children that do not meet developmental and social/emotional milestones that are referred for further assessment, follow-up, and/or additional intervention.

Access, Utilization of Services, Resources and Supports
Outcome 1: Parents and their infants/children are connected to the community resources and/or services for parenting and family support.

Indicators:
a) The percent of parents and infants/children referred to community resources and/or services.
b) The percent of parents and infants/children who are using community resources and/or services who were referred to these resources/services.

Outcome 2: Infants and children are current on well-child checkups.

Indicator:
a) The percent of infants/children that are current with the periodicity schedule for early and periodic screening.

Group 2: Outcomes for Family Home Visiting Programs Directing Resources to Specific Areas

Birth or pregnancy
Outcome 1: Babies are born at healthy birth weights (2500 – 4000 grams).
Outcome 2: Pregnant women receive early and adequate prenatal care.

Economic self-sufficiency
Outcome 1: Families can meet basic needs of family (e.g. adequate housing, food, medical care).
Outcome 2: Subsequent births to parents occur no earlier than two years from previous birth.

Child maltreatment and abuse
Outcome 1: No maltreatment is occurring in the home.
Outcome 2: Parents provide a safe, secure environment for their children.

Group 3: Outcomes for Further Research/Development

Parenting Skills, Nurturing Family Environment, Attachment & Bonding
Outcome 1: Parents consistently demonstrate nurturing parent-child interactions.
Outcome 2: Parents and infant have developed a secure bond/attachment.

3. Health Status Reporting: Health status reporting is an important component of the evaluation plan with the primary function of monitoring and reporting on the health status of women, children, and families. Health status reporting addresses the learning function of the evaluation. Data gathered and compiled in health status reports on the health of women, children, and infants will be useful to many family home visiting stakeholders including policy makers, local health department staff, health care providers and others interested in the health of families. Biannual reports will be available for family home visiting staff statewide and will contribute to the work of family home visitors by helping define and understand the health status of targeted populations, identify health and illness determinants, recognize health patterns and trends. The data will also allow local programs to compare common outcomes (e.g. birth weight) for targeted groups and serve as a resource for future planning at the state and local levels.

While the health status reporting component does not entirely reflect the impacts of the family home visiting programs, it provides a tool to monitor the health status of the target populations to inform the adequacy of resource inputs. Initially, health status reports would include several health status indicators for women and children listed in Table 8.

Table 8

Health Status Indicators	
Pregnancy and Birth	**Violence**
Birth weight	Injury (unintentional)
Gestational age	Maltreatment
Infant mortality	
Prenatal care (initiation and adequacy)	**Socioeconomic**
Teen birth and pregnancy	Poverty
	School lunches (free and reduced fees)
Well Child Care	Population growth
Immunization	
Screening	**Risk Behaviors**
	Smoking
Protective Factors	Alcohol/drug use
Nutrition	Children dropping out of school
Physical activity	Juvenile delinquency
Parents care about them	

The data sources for health status reporting include, but are not limited to, Minnesota vital records (birth and death records), Pregnancy Risk Assessment Monitoring System, Behavioral Risk Factor Surveillance System, Minnesota Center for Crime Victim Services, Minnesota State Demographic Center, Minnesota Student Survey, and the U.S. Census Bureau.

4. Impact Studies: Impact studies are the final component of the evaluation plan and facilitate both the accountability and learning dimensions of the Family Home Visiting Program. Impact studies are in-depth, focused evaluations or studies (e.g. comparison studies, longitudinal studies, case studies) of selected programs or multiple programs to provide richer insight into services and approaches. There are many topic areas that could be included for further study. It has been recommended that an impact studies group be established to develop and implement a research and evaluation agenda and to manage, analyze and communicate statewide results and outcomes at the state level.

This group would recommend an agenda for focused evaluations or strategic research, or advise and conduct case studies of home visiting programs. Impact studies can respond to questions that could include: How do health status outcomes compare to various outcomes identified at the local level? What are the characteristics of a home visit (e.g. length and initiation, intensity, topics discussed)? What

characterizes a successful and productive relationship between the home visitor and client? What is the local impact of family home visiting services on the children and families served? This group would address the question of client satisfaction with home visits and/or home visitors. This will be an area of future work.

Data Collection and Preliminary Evaluation Results

The Evaluation Work Group developed and vetted a form for collection of family home visiting data through the MDH Planning and Performance Measurement Reporting System (PPMRS). This data collection system is used by all local health departments to report to MDH. A module was developed specifically for the Family Home Visiting Program. The data collection form is included in Appendix F: Family Home Visiting Data Collection Form.

The MDH then conducted a statewide feasibility assessment of these measures from January 1, 2009 to June 30, 2009. Data were reported in aggregate numbers online by local health departments. Additional qualitative information was also collected describing challenges facing family home visiting clients and programs and strategies used to overcome those problems. Data, both quantitative and qualitative, from this testing period were used by MDH and the Evaluation Work Group to improve and streamline the data collection for July 2009 through December 2009 reporting period. The evaluation was again modified to include further outcome measures for the January 2010 through December 2010 reporting period.

A statewide network analysis survey of early childhood partners was conducted from May 2009 to September 2009 to measure the Family Home Visiting Program's connectivity to community resources. Additionally, 75 stories describing interventions provided by family home visitors were collected from June 1, 2008 to October 30, 2009 and were analyzed for the evaluation themes outlined in the statute.

As noted earlier, the data analyzed for this evaluation includes all non-medical family home visiting program activities for pregnant women and families with children that is administered and/or contracted by a local public heath department to achieve the goals listed under the Family Home Visiting Program statute, irrespective of funding source.

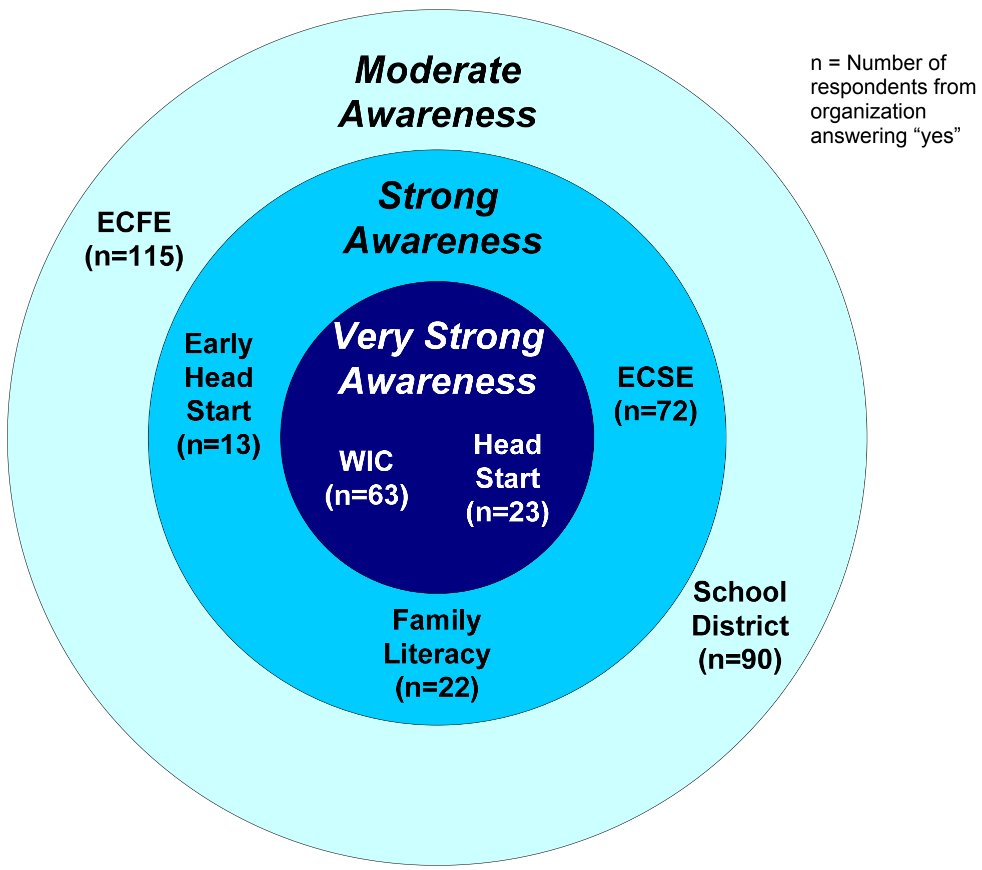
Promotion of Community Partnerships and Collaborations

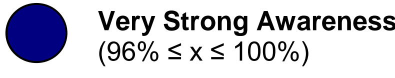
The Family Home Visiting Program statute emphasizes the connection of clients to resources and collaboration with multidisciplinary partners including early childhood organizations. To evaluate the promotion of partnerships and collaboration, a statewide network analysis survey involving 350 representatives (77% response rate) from early childhood organizations including Head Start, Early Head Start, Early Childhood Family Education (ECFE), Early Childhood Special Education (ECSE), School Districts and WIC was conducted from May 2009 to September 2009.

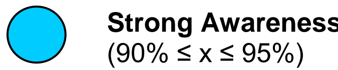
Family home visiting programs are well connected to early childhood services. There was a high level of awareness, referrals, and contact between early childhood organizations and family home visiting programs. Most programs reported a "cooperative partnership" with family home visiting, which was defined as sharing information and working together to meet common goals. Figures 1 through 3 show the network diagrams and questions for awareness, contact, and relationship between family home visiting programs and early childhood organizations.

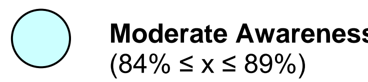
Figure 1. Awareness Diagram

Are you aware of your local health department's family home visiting program and the services they provide to families expecting a child or to families with young children? Answers: Yes/No







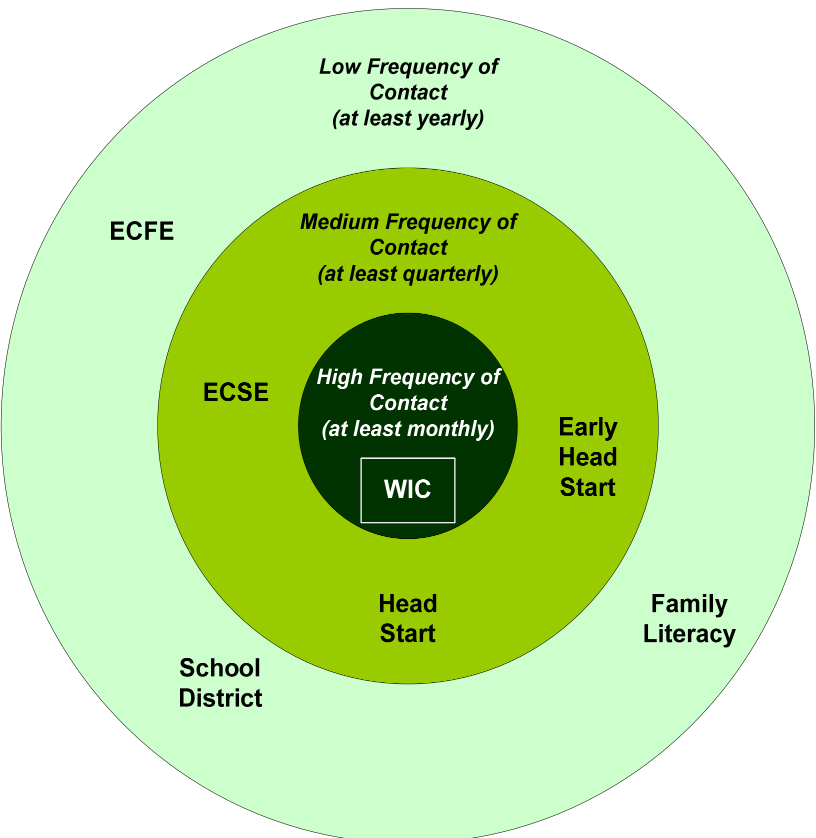


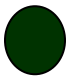
Key Findings:

- Overall, there was a high level of awareness in the community with the lowest percentage of awareness being 84%.
- WIC and Head Start had the highest level of awareness.
- School District and ECFE had the lowest level of awareness.

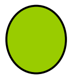
Figure 2. Frequency of Contact Diagram

In the past year, what frequency of contact (such as meetings, phone calls or emails) has your organization had with your local health department's family home visiting program? Answers: No Contact; Yearly; Quarterly; Monthly; Weekly; Daily

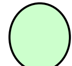




High Frequency of Contact
75% have family home visitor contact monthly or more



Medium Frequency of Contact
75% have family home visitor contact quarterly or more



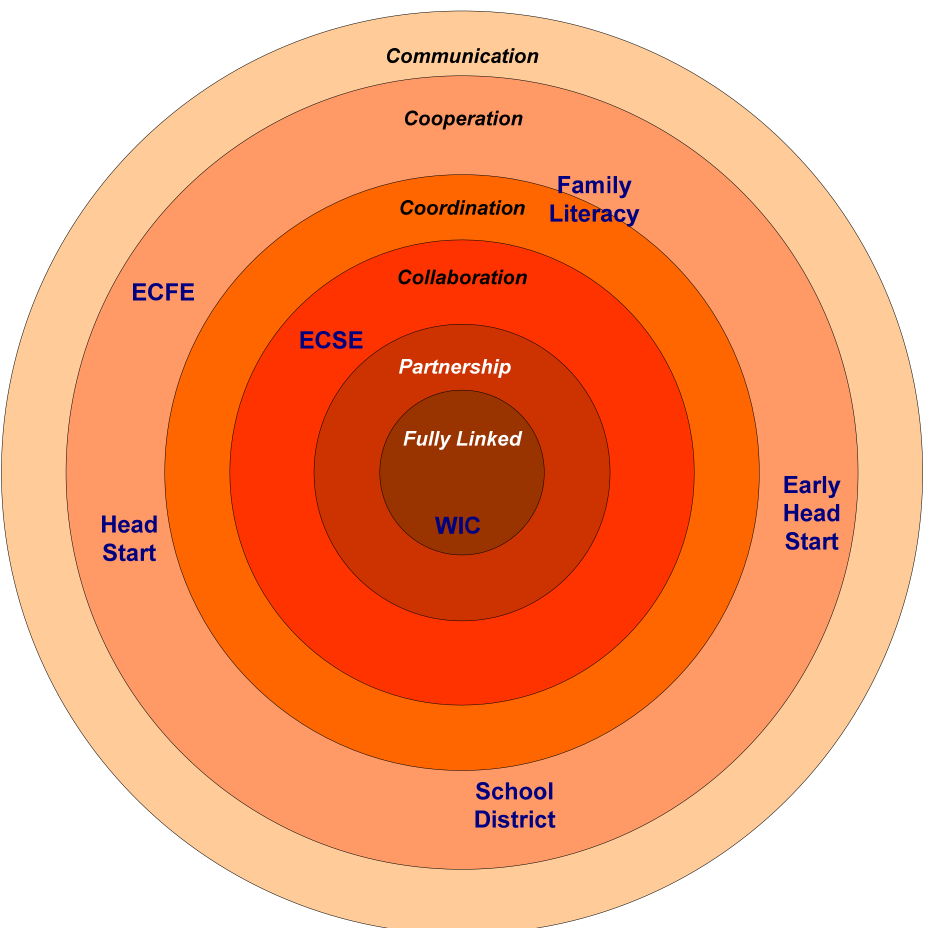
Low Frequency of Contact
75% have family home visitor contact yearly or more

Key Findings:

- All organizations had some level of contact with family home visiting.
- More than half had contact with family home visiting at least on a quarterly basis.
- WIC had the highest frequency of contact.
- Organizations with the next highest frequency of contact were Head Start, Early Head Start and Early Childhood Special Education.

Figure 3. Relationship Diagram

Placement in the diagram reflects the type of relationship reported most frequently by individuals representing the organization in response to the question, "Please choose the response that best describes the current relationship between your organization and your local health department's family home visiting program.



DEFINITIONS:
Communication: We share information only when it is advantageous to either or both programs.
Cooperation: We share information and work together when any opportunity arises.
Coordination: We work side-by-side as separate organizations to achieve common program goal.
Collaboration: We work side by side and actively pursue opportunities to work together as an informal team.
Partnership: We work together as a formal team with specified responsibilities to achieve common program goals.
Fully linked or integrated: We mutually plan, share staff and/or funding resources and evaluate activities to accomplish our common goals.

Key Findings:
- The majority of organizations report having a "cooperation" relationship with family home visiting (i.e. they share information and work together when the opportunity arises).
- ECSE and WIC had the strongest relationship with family home visiting.

Target Populations

Data measuring the population served was collected by MDH from January 1, 2009 to June 30, 2009. These data are reported in detail in Appendix G: Summary of Population Served. Local health departments and tribal government family home visiting programs served 27,300 primary caregivers, prenatal clients and children under the age of six during the first half of 2009 representing 80,800 visits. Over 15% of the populations served were prenatal clients, 21% of those prenatal clients were adolescents.

Thirty percent of families served experienced household hunger or food insecurity which is three times the average for Minnesota and 2.5 times that of the United States as a whole.[1] Fifteen percent of families served by family home visiting experienced housing insecurity measured by two or more moves within the previous year. This rate is three times the rate found in other low-income populations. Housing insecurity, a precursor to homelessness, has been linked to child growth and development concerns.[2]

Other at-risk populations targeted by family home visiting programs include low-income first time mothers and disparate populations. Low-income, first time mothers are a primary target group for evidenced-based home visiting programs. Over 56% of prenatal clients served were first time mothers. In 2007, 40% of all births in Minnesota were to first time mothers.[3] Approximately 40% of infants and children and 37% of primary caregivers and prenatal clients were of non-white race and 17% of infants and children and 16% of primary caregivers and prenatal clients were of Hispanic ethnicity. Live birth data for Minnesota indicates that approximately 25% of Minnesota's births are to non-white mothers and 8% are to Hispanic mothers.[3] Over 20% of families served by family home visiting identified a language other than English as their primary language.

Local health departments report the risk factors they target in their communities. Table 9 shows the number of local health departments that target families with the specific risk factors listed in the Family Home Visiting Program statute.

Table 9

Risk Factors	Number of LHD
Adolescent parents	88
Lack of knowledge about child growth and development	78
History of alcohol and drug abuse	77
History of child abuse and family violence	75
Insufficient finances	75
Low resiliency to adversities and environmental stresses	70
Reduced cognitive function	68
Risk of long-term welfare dependence	60
Source: Minnesota Family Home Visiting 2008 Community Health Board Plan Report	

Outcome and Performance Measures

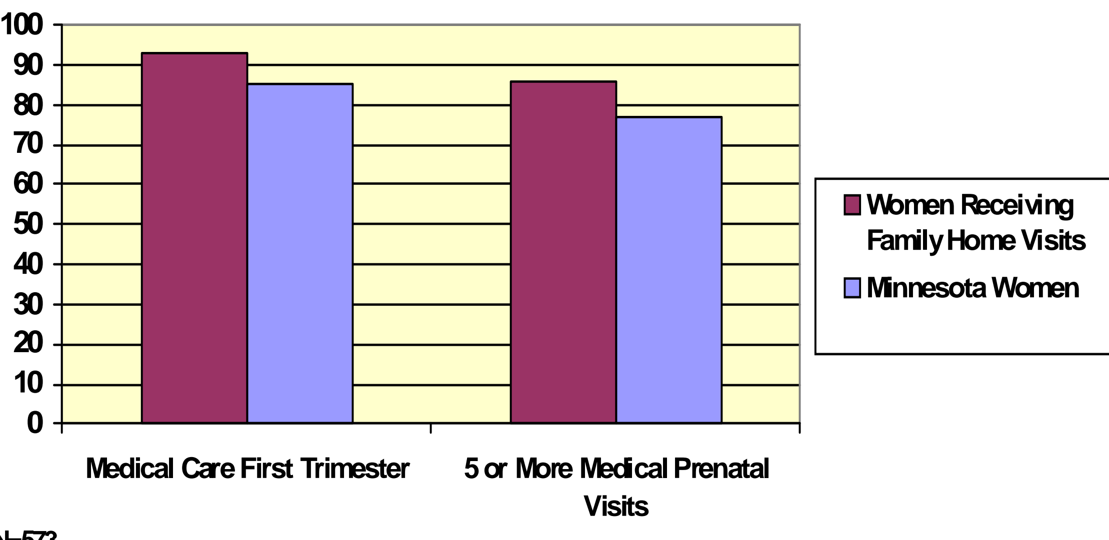
The Family Home Visiting Program statute outlines ten outcome and performance measures that are addressed below.

1. **Appropriate utilization of preventive health care.**
   Of the 4,633 children with three or more family home visits, 79% were current on well-child care visits. This well-child care rate compares favorably to the 2008 Minnesota Child and Teen Check-Ups rate of 75% of eligible children ages 0 to 5 years receiving at least one initial or periodic screen[4] and a national rate of 71% for low-income children.[5] Over 88% of children seen for three or more family home visits had a consistent primary medical care provider. This rate is significantly higher than the

Minnesota health care home rates of 71%[6] and the national rate of 64% for children 0 to 5 years of age.[6]

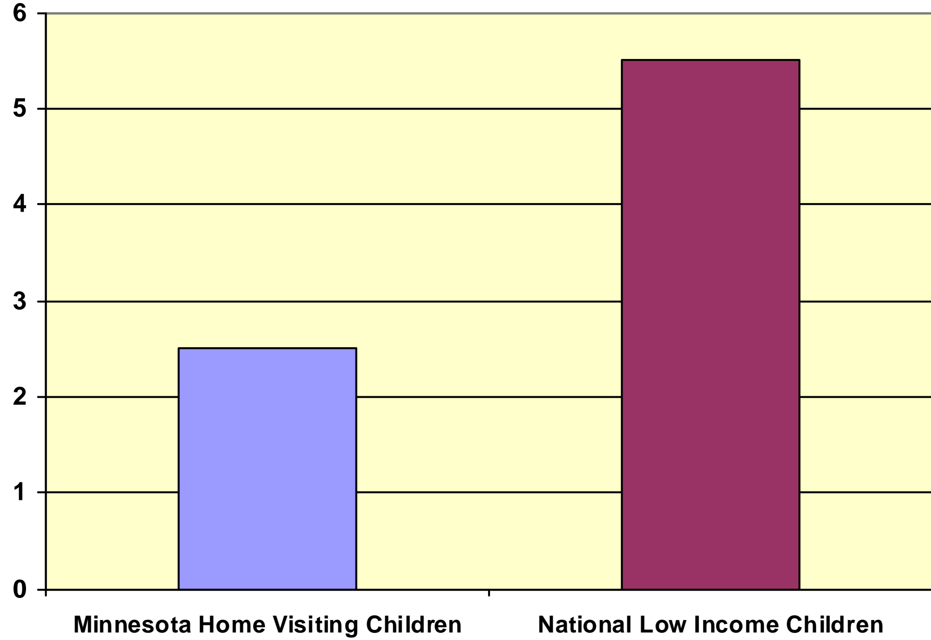
As seen in Figure 5, of the 573 women receiving three or more home visits during their first trimester, 93% received medical care during their first trimester which is significantly higher than the 2006 Minnesota rate of 87%.[7] Over 86% of the family home visiting prenatal clients had five or more medical prenatal visits, which also is higher than the 2006 Minnesota rate of 77%.[7] The comparison data of Minnesota women are based on prenatal care started before the fourth month of gestation and with five or more prenatal visits.

Figure 5. Percentage of Women with Three or More Parental Family Home Visits Who Initiated Medical Care in the First Trimester and Had Five or More Medical Prenatal Care Visits



2. **Rates of substantiated child abuse and neglect.**
   Infants and children served by family home visiting had a lower rate of substantiated child abuse and neglect when compared with national rates for similar low-income populations (Figure 6). From January 1, 2009 to June 30, 2009, 280 children (2.5%) had substantiated child maltreatment reports during the time they were served by family home visiting. Low-income populations, such as those served by family home visiting, have higher rates of child maltreatment. Although the national rate of substantiated child maltreatment for all income levels during 2007 was 1.1%[8] and the Minnesota rate was 0.5%[8], the national rate in low income populations was 5.5% which is a better comparison number for the population served by Minnesota's family home visiting population.[9]

Figure 6. Rates of Substantiated Child Maltreatment for Infants and Children During the Time Served by Family Home Visiting Compared with National Rates for Low Income Children



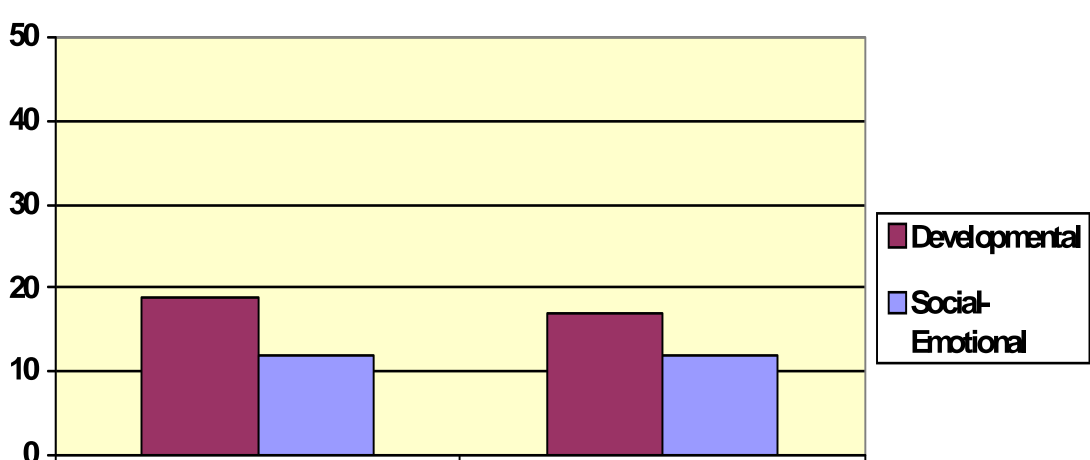
3. **Use of the home safety checklist by family home visiting to reduce the rate of unintentional child injuries.**
   From January 1, 2009 to June 30, 2009, 79% of the 3,387 primary caregivers with three or more home visits had a home safety checklist completed and concerns addressed by the family home visitor. Rates of childhood injuries will be measured during 2010.

4. **Rates of children who are screened and who pass early childhood screening for developmental and social-emotional milestones.**
   From January 1, 2009 to June 30, 2009, family home visitors conducted developmental screenings for 68% (3,432) and social-emotional screenings for 38% (1,900) of infants and children within the first six months of enrollment. For those infants and children seen for six more months, 74% (2,055) received a subsequent developmental and 61% (1,712) received a subsequent social- emotional screen according to the periodicity schedule for the instrument that was used. Only infants and children with three or more home visits were included.

   As shown in Figure 7, 19% of initial developmental and 12% of initial social-emotional screens failed to meet developmental milestones. On the subsequent screens, the percentages are similar with 17% not meeting developmental and 12% not meeting social-emotional milestones.

> Approximately one out of five infants and children screened by family home visitors did not meet developmental milestones and one out of ten did not meet social-emotional milestones. Early identification and referral of these children for additional assessment and intervention is an essential service of Family Home Visiting Programs.

Figure 7. Percentage of Children Not Meeting Developmental or Social/Emotional Milestones at Initial and Subsequent Screens



5. **Rates of children accessing early care and educational services.**
   1,131 infants and children were identified as not meeting one or both of developmental or social-emotional milestones over 83% (940 children) were referred and 62 % (583 children) of those referred received follow-up by the home visitor.

6. **Program retention rates.**
   At the first visit of the January 1, 2009 to June 30, 2009 reporting period, 55% of home visiting clients, including primary caregivers, prenatal clients, and infants and children had been served for more than six months.

7. **Number of home visits provided compared to the number of home visits planned**.
   The rate of completed visits compared to visits planned from January 1, 2009 to June 30, 2009 was 93%.

8. **Participant satisfaction**.
   A formal statewide satisfaction survey will be completed during 2010 and 2011. Existing satisfaction surveys used by local health departments for family home visiting clients have been gathered and these will be used to develop a statewide survey.

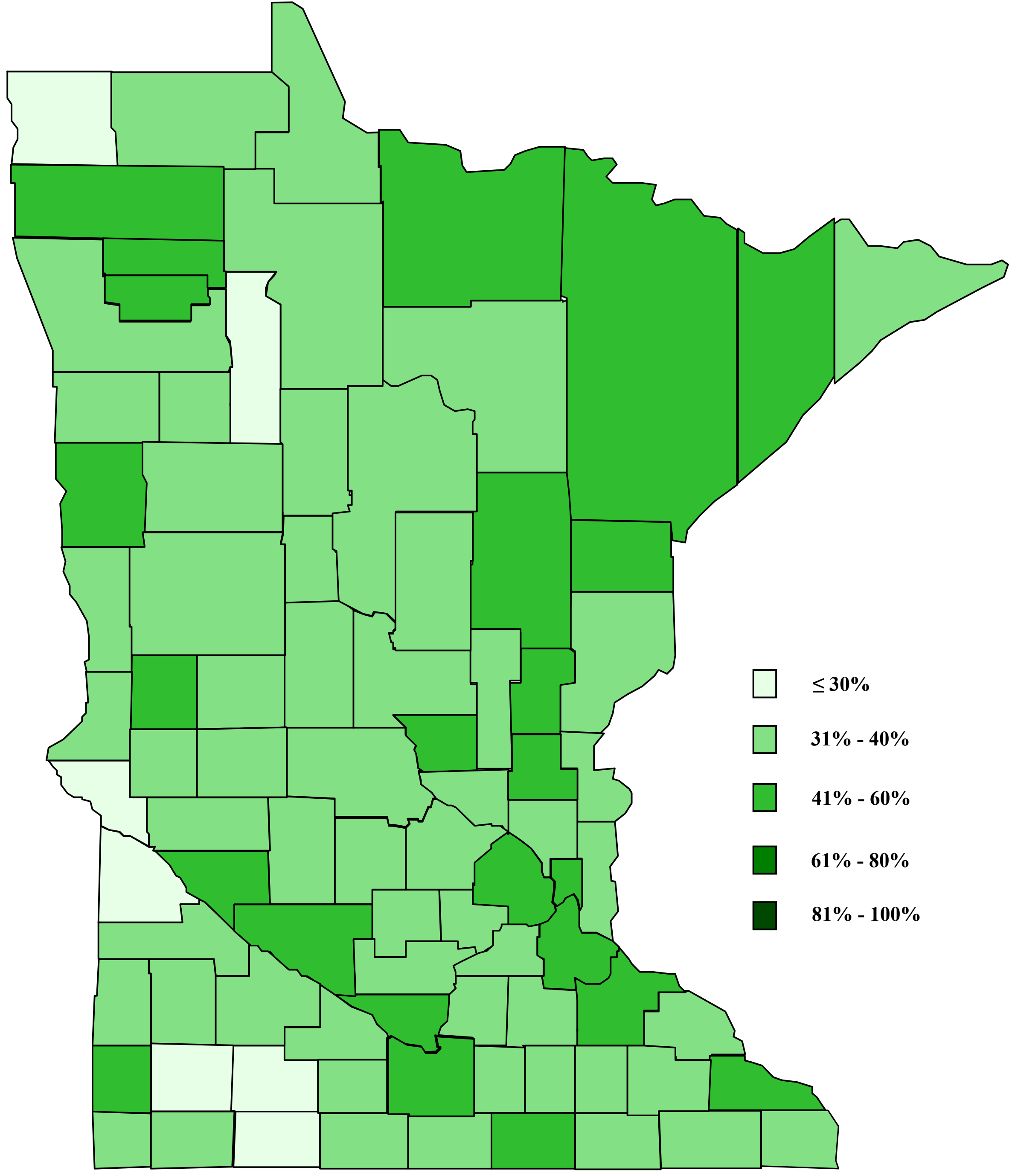
9. **Rates of at-risk populations reached.**
   Rates of at-risk populations will be calculated during 2010, the first full year of evaluation data to be collected. First time mothers are a target group for many family home visiting programs. Several of the evidenced-based family home visiting programs such as Nurse-Family Partnership and Healthy Families America enroll only first time mothers. Of those served during the reporting period, 56 percent were first time mothers compared to the Minnesota rate of 40% during 2007. Figure 8 shows the percentage of family home visiting prenatal clients who are first time mothers by county during the reporting period and Figure 9 shows the percent of all first time mothers delivering during 2007 by county. The actual percentages show in Figures 8 and 9 can be found in Appendix H: First Time Mothers by County.

   Darker shading on the maps indicates a higher percentage of first time mothers served. In general, most counties serve a higher percentage of first time mothers in the family home visiting population than the percentage in the general population.

Figure 8. Family Home Visiting Population First Time Mothers (%) Jan-June 2009

≤ 30%
31% - 40%
41% - 60%
61% - 80%
81% - 100%

Figure 9. Minnesota First Time Mothers by County (%)



10. Other qualitative goals and quantitative measures.

Rates of preterm birth. Family home visiting programs target women who are at higher risk for premature birth and low birth weights than the Minnesota population as a whole. Despite this, the rate of premature births for women delivering from January 2009 to June 2009 was 6.4% compared to the 2007 state rate of 10%.[3]

Rates of low birth weight. The rate of low birth weight infants (<2500g excluding preterm and multiple births) born to women from January 2009 to June 2009 was 4.6% compared to a state rate of 1.8%.[3] Premature births and multiple births were excluded from these data in order to show the rate of intrauterine growth retardation. Family home visitors provide education, referrals, resources and support to pregnant women in order to decrease the risk factors for intrauterine growth retardation including hypertension, poor nutrition, smoking and alcohol use.

Rates of subsequent births within 12 months of a previous birth. Pregnancy spacing is important for both physical and economic health for the parent and the child. Of the 1,106 women served by family home visiting for 12 or more months, 96% did not have a subsequent birth within 24 months.

Rate of pregnant and parenting teens working towards a high school diploma or GED. Family home visitors work with teens to set goals which include achieving a high school diploma or GED. Of the 1,102 pregnant and parenting teens served by family home visiting for three or more visits from January to June 2009, 80% were either attending school, working towards a GED or had achieved their high school diploma or GED.

Promotion of economic self-sufficiency. Of the 75 stories submitted by family home visitors in 2009, 59% describe educating parents about economic self-sufficiency goal setting and identification and reduction of barriers. In 2010 outcome evaluation measures describing changes in economic self-sufficiency including changes in food insecurity, housing insecurity, education and income will be implemented.

Preparing for Self–Sufficiency and Successful Parenting

"Jamie had a high-risk pregnancy due to her young age and limited support network. The public health nurse's primary goal for Jamie was to insure that she had a healthy pregnancy through frequent nursing visits, prenatal information and infant care follow-up. The secondary goal for was to serve as her mentor to keep Jamie in school and on target for graduation. Frequent visits prior to delivery identified preterm labor symptoms requiring medical attention. Throughout the visits, Jamie identified her dreams for a cohesive family, a nice home, and a solid job that allowed flexibility to raise her baby and give her child the very things that she did not have growing up. Her academic grades improved to achieve the B Honor Roll prior to delivery and she beamed with pride. Following her second semester, Jamie delivered a very healthy, full term baby girl. She is now on target for graduation and plans on attending school following her high school graduation. Her daughter is thriving, has a stable life style, and is developing ahead of schedule. The mother does not participate in any welfare programs, except for medical assistance, and is moving toward self-sufficiency."

Parent-Child Interaction. In 2010, parent-child interaction measures will be included in the statewide evaluation. Of the 75 stories reported during 2009, 19% reported interventions for improving parent-child interaction.

Promoting Positive Parent-Child Interaction

"One of my moms had been having a tough couple of days, feeling as though all her son did was cry. She was obviously exhausted and at the end of her rope. She was having a hard time responding to him when he cried. During our conversation about why babies cry and ways to comfort a crying baby, her son began to fuss and cry. I asked her if it would be okay if I picked him up. With her permission, I picked up her son and began to soothe him, using the '5 S's of calming a baby', that we had previously discussed. As he began to quiet and calm, she asked me, 'Do you know how to read babies minds or something?' I explained to her that I wasn't a mind reader, but that babies give us certain cues that mean different things. This started a whole discussion about baby cues, and ways to respond appropriately. By the end of the visit, it was like a switch had been flipped on for her…her body language was more relaxed, and she was holding her son, trying out some of the calming techniques we had discussed. It wasn't until the next visit that I really saw how much this visit had helped her. Both she and her son seemed to be enjoying each other very much. She commented she had been using some of the techniques, and that it was amazing."

Conclusions

Minnesota Family Home Visiting Program actively promotes community partnerships and collaborations. Early identification of infants and children not meeting developmental or social-emotional milestones and referring these children to community resources for further assessment and intervention is a critical role played by family home visiting. The close relationship of family home visiting with these early childhood organizations facilitates early intervention and reduces duplication of services.

Family home visiting serves a large, low-income population of prenatal clients, primary caregivers, infants and children targeting the at risk populations identified by the statute. Family home visitors connect families to community resources for health care, insurance, parenting, chemical dependency issues, employment, housing, education, financial and food. Family home visitors are successful at promoting appropriate utilization of preventive health care services, including well child and prenatal care. The close monitoring of at risk pregnancies by family home visiting potentially contributes to the lower premature birth rates of family home visiting prenatal clients compared to the rest of the state.

Family home visitors work with families to achieve economic self-sufficiency through encouraging completion of a high school diploma or GED and utilizing local employment counseling resources. Working with women to successfully space pregnancies contributes to economic stability and improved health for mother and child.

References

1. Nord, Mark, Margaret Andrews, and Steven Carlson. Household Food Security in the United States, 2008. ERR-83, U.S. Dept. of Agriculture, Econ. Res. Serv. November 2009. http://www.ers.usda.gov/publications/err83/. Accessed Dec 14, 2009.
2. Cutts, DB et al. Hennepin County Medical Center, Minneapolis, MN, Article in press 2009.
3. Minnesota Center for Health Statistics, Minnesota Department of Health.
4. Child and Teen Checkups Program. State of Minnesota Participation Reports FFY 2008. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_018157# Accessed Feb 10, 2010.
5. U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Child Health USA 2008-2009.* Rockville, Maryland: U.S. Department of Health and Human Services, 2009, p 61. http://mchb.hrsa.gov/chusa08/hsfu/pages/307phcv.html Accessed Feb 10, 2010.
6. Child and Adolescent Health Measurement Initiative. Minnesota medical home performance profile for all children. Data Resource Center for Child & Adolescent Health, 2007. http://medicalhomedata.org/ViewDocument.aspx?item=463 Accessed Feb 10, 2010.
7. National Center for Health Statistics, final natality data. March of Dimes peristats. http://www.marchofdimes.com/peristats/ Accessed Feb 10, 2010.
8. U.S. Department of Health and Human Services, Administration on Children, Youth and Families. Child Maltreatment 2007 (Washington, DC: U.S. Government Printing Office, 2009). http://www.acf.hhs.gov/programs/cb/pubs/cm07/insidecover.htm. accessed January 15, 2010.
9. Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., and Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, p 5-15. http://www.acf.hhs.gov/programs/opre/abuse_neglect/natl_incid/nis4_report_congress_full_pdf_jan2010.pdf Accessed Feb 10, 2010.

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APPENDIX A. Family Home Visiting Program Statute

145A.17 FAMILY HOME VISITING PROGRAMS.

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

(1) adolescent parents;

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

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

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

(5) reduced cognitive functioning;

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

(7) low resiliency to adversities and environmental stresses;

(8) insufficient financial resources to meet family needs;

(9) a history of homelessness;

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

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

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

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

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

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

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

(4) a description of the community demographics;

(5) a plan for meeting outcome measures; and

(6) a proposed work plan that includes:

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

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

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

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

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

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

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

(4) provide information on and referrals to health care services, if needed, including information on and

assistance in applying for health care coverage for which the child or family may be eligible; and provide information on preventive services, developmental assessments, and the availability of public assistance programs as appropriate;

(5) provide youth development programs when appropriate;

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

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

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

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

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

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

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

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

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. 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*

APPENDIX B: Family Home Visiting Steering Committee Members

Family Home Visiting
Steering Committee 2009

Committee Co-Chairs

Sandy Tubbs
Douglas County Public Health

Laurel Briske
Maternal and Child Health Section
Minnesota Department of Health

Committee Members

Mary Jo Chippendale
Maternal and Child Health Section
Minnesota Department of Health

Doriscile Everett-O'Neal
Twin Cities Healthy Start

Rob Fulton
St. Paul-Ramsey County Department of Public Health

Joni Geppert
Community and Family Health Division
Minnesota Department of Health

Shelly Griffin
Becker County Human Services

Eileen Grundstrom
Office of Minority and Multicultural Health
Minnesota Department of Health

Eric Haugee
Ready 4 K

Laurel Hoff
Anoka County Community Health

Chery Johnson
Kandiyohi County Public Health

Julie Ring
Local Public Health Association

Sharon T. Smith
Office of Minority and Multicultural Health
Minnesota Department of Health

Junie Svenson
Maternal and Child Health Section
Minnesota Department of Health

Judy Voss
Olmsted County Public Health Services

Dave Thompson
MN Dept of Human Services

Mary Vanderwert
Head Start
Minnesota Department of Education

Eileen Nelson
Early Childhood Family Education
Minnesota Department of Education

APPENDIX C: Tribal Government Family Home Visiting Plans

Summary of Tribal Government Home Visiting Detailed Plans

Population Background

There are eleven federally-recognized tribal communities in Minnesota, seven Chippewa/Ojibwe and four Sioux. These eleven tribes encompass a diverse group of peoples, with communities ranging in size from 322 American Indians to enrolled populations of nearly 10,000. As Sovereign Nations their members are dually part of their independent Indian Nations as well as citizens of the state of Minnesota. Many reservations are spread out geographically across large spans of land and are organized into districts or sub-communities who often have their own cultures and resources. As a whole the American Indian population is quite mobile, especially when it comes to childbirth and child rearing. Personal stories from enrolled members tell of returning home to the reservation when it comes time to have and raise a family after years of living in large cities and even in other parts of the country.

Home Visiting Background

Ten of the eleven federally-recognized MN tribes receive funding for TANF family home visiting and/or healthy youth development. Funding began in 2001 and has grown and adapted to meet the needs of the community over the past seven years. Tribal home visiting programs are quite well-connected to maximize resources in the community and are very community/client-centered.

Summary of Detailed Plans

2007 Program Expansion: In June of 2007, following the expansion of TANF home visiting funding, tribes were asked to indicate the areas in which their programs would expand in response to this additional funding. Of the topic areas mentioned in the legislation, tribes indicated focusing most frequently on the following topics:

- Improving pregnancy outcomes
- Promoting family health and economic self-sufficiency
- Promoting positive parenting and resiliency in children
- Targeting of adolescent parents.

Reaching High Risk Populations: To assure families at greatest risk receive appropriate services, several approaches were mentioned, including coordination with WIC and receiving referrals from other tribal or local/county services.

Community Partnerships: There were strong community partnerships already in existence as of 2007, including partnerships with:

- Community Health Representatives
- Mental health professionals
- School districts
- Head Start
- Foster care
- Indian Child Welfare
- Other county public health and tribal health agencies
- Follow Along
- ECFE

2008 Program Expansion: In their 2008 plans, tribes indicated a focus on the following issues:

- Pre-conception care with an expected impact on infant mortality,
- Maternal depression
- Doula programs
- Increasing the intensity and duration of visits to fit more with existing models such as the Nurse Family Partnership
- Offering reflective supervision
- Hiring of additional staff or expanding of FTEs
- Enhancing staff trainings
- Targeting of teenage boys to address the prevention of teen pregnancy.

Technical Assistance Needs: Tribes were asked to identify which areas their staff and supervisors most needed training and technical assistance from the MDH. The areas most requested for home visitors were:

- Working with families with multiple risk factors
- Parent-infant attachment
- Parent-child interaction
- Professional boundaries and prevention of burnout
- Maternal mental health
- Adolescent parenting support
- White Bison curricula focusing on promoting the Wellbriety Movement
- NCAST training.

Providing Support to Empower Clients to Make Positive Life Changes

"(This mother) has several other children, all out of her care due to her drug abuse. Her last child was born just 9 months ago. She was adopted by an Indian family. She decided that she also wanted to choose an adoptive family for the child she was carrying. The Public Health Nurse (PHN) met with her twice weekly, discussing her options, healthy behaviors during pregnancy, how she could nurture herself within her pregnancy, and anticipatory guidance on both self care and adoption processes after the birth. The PHN got her in touch with the 'right people;' an adoption agency experienced with American Indian adoptions, a mental health counselor, and a parent mentor group.

Upon the birth of her child, she gazed into her baby's eyes and decided to parent her child. The PHN met with her and her baby in the hospital. With the experienced help of the tribal birth parent advocate, the PHN and the mother discussed what this would entail and she decided she was ready for this life change. The PHN assisted her with getting on the section 8 housing list. She would reside in the halfway house until housing could be established. Within this wait time, the PHN got her connected with the Young Parent Group, which holds weekly outings and parenting education for young parents. She continued to attend AA group meetings and sobriety feasts. She was honest about her struggle to keep from abusing drugs and alcohol, and was able to stay sober. After several months, the mother secured housing. The PHN encouraged her to look into the future and try to see what it may look like. They talked about possible jobs and childcare options. The PHN brought her some information on an upcoming Nursing Assistant course, and told her 'you can do this.' By the next visit, she had already attended a full week of classes!

Throughout the visits, the PHN wrote the mother letters in the 'voice of the baby.' These letters highlighted what they talked about during the visits, offered encouraging words and sentiments of thanks from the baby for all of the hard work she has been doing. At one visit, the mother invited the PHN to her back bedroom. She showed her a graded test that she had taken for her training. It was an 'A', 100% correct. She said, 'I've never been 100% good at anything in my life. Thank you for making me think I can do this.' The PHN asked her what helped her keep going when times got tough. She led the PHN into a small, adjoined room, and with tears in her eyes, said 'These. These letters are everything.' She pointed to all the letters sent from her PHN that were written in the voice of baby James. She has each and every letter taped up, filling an entire wall. 'When I feel like using, I stand here and look at them. They give me strength I didn't know I had.'"

APPENDIX D: Community Partnerships

The following table provides information from local health departments (N=91) in their details plans regarding their relationships with community partners. The categories and definitions for the levels of relationship are included below.

Community Partner	Relationship						
	None	Develop-ing	Network-ing	Coordina-tion	Coopera-tion	Collabora-tion	Multi-Sector Collabora-tion
Other LPH	11	1	32	5	5	14	23
Tribal Health Department	50	0	15	1	8	3	2
Community Home Visiting Program	49	6	9	6	3	8	8
ECFE	0	0	15	4	31	23	18
Early/Head Start	9	1	14	13	12	34	8
School Districts	2	0	5	13	13	37	21
Child Care Providers	5	3	44	1	27	8	3
Intake/Financial Workers	7	1	35	17	13	15	3
Social Workers	1	2	9	18	12	34	15
Community Health Workers	50	5	6	3	4	6	4
Mental Health Providers	7	8	30	12	7	16	11
OB Providers	10	4	43	13	14	6	1
Labor and Delivery Providers	14	4	39	10	14	6	4
Pediatric Providers	14	5	42	11	13	5	1

Developing – These are relationships that are currently being developed. This involves becoming aware of the role these partners may play and their interest in the program.

Networking – Involves an exchange of information in order to help each other do a better job. Networking requires the least amount of commitment and time and can be a good starting point for organizations to work together.

Coordination – Involves a relationship where partners "modify their activities" so that they can provide better services to constituents. Coordination involves more commitment, time, and trust than networking.

Cooperation – Involves sharing information and making adjustments in services to help each other do a better job. Cooperation involves more trust and greater time investment than networking or coordination.

Collaboration – Involves organizations helping each other to expand or enhance their capacities to do their jobs. Collaboration involves a much greater commitment in time, resources, and trust compared to networking, coordination or cooperation.

Multi-sector Collaboration – Is similar to collaboration but has a greater potential for change as well as greater challenges, e.g., in multi-sector collaboration, private, public, and nonprofit organizations form a partnership to solve system problems in the community. Multi-sector collaboration is more complex and challenging than other relationships with the greatest amount of commitment, time, resources, and trust.

APPENDIX E: Training and Technical Assistance Activities

Training and technical assistance activities that address the statutory requirements for family home visiting include:

1. *Effective relationships for engaging and retaining families and ensuring family health, safety, and early learning*
   - Parent-Child Interaction
   - What About the Baby?
   - Recognizing Chemical Dependency
   - Comprehensive Assessment and Care Planning
   - Promoting Relationships with Relationships
   - Pediatric Home Safety Checklist
   - Wellbriety
   - American Indian Home Safety Checklist
   - Family-Based Approach to Promoting Health in American Indian Communities
   - Leading the Next Generations Healthy Relationships, Native Wellness Institute
2. *Effective methods of implementing parent education, conducting home visiting, and promoting quality early childhood development*
   - Parent-Child Interaction
   - What About the Baby?
   - Motivational Interviewing
   - Comprehensive Assessment and Care Planning
   - Promoting Relationships with Relationships
   - Live It Teen Pregnancy Prevention
   - Spring 2010 Conference
   - Evidence-based American Indian Strengthening Families Program
   - Evidence-based American Indian Lifeskills
   - Language of Life – Bringing Traditional Parenting Skills Back to Our Parents
   - Native American Parenting Traditions Revisited
   - Nurse Family Partnership Home Visiting program with adaptations for tribal communities being considered in 2010
3. *Early childhood development from birth to age five*
   - Parent-Child Interaction
   - Comprehensive Assessment and Care Planning
   - Promoting Relationships with Relationships
   - Language of Life – Bringing Traditional Parenting Skills Back to Our Parents
4. *Diverse cultural practices in child rearing and family systems*
   - What About the Baby?
   - Comprehensive Assessment and Care Planning
   - Promoting Relationships with Relationships
   - Pediatric Home Safety Checklist
   - American Indian Home Safety Checklist
   - Spring 2010 Conference
   - Evidence-based American Indian Strengthening Families Program
   - Family-Based Approach to Promoting Health in American Indian Communities
   - Evidence-based American Indian Lifeskills
   - Language of Life – Bringing Traditional Parenting Skills Back to Our Parents
   - Native STAND
   - Native American Parenting Traditions Revisited
   - Nurse Family Partnership Home Visiting program with adaptations for tribal communities being considered in 2010

5. *Recruiting, supervising and retaining qualified staff*
    - Motivational Interviewing
    - Leading the Next Generations Healthy Relationships, Native Wellness Institute
    - Nurse Family Partnership Home Visiting program with adaptations for tribal communities being considered in 2010
6. *Increasing services for underserved populations*
    - What About the Baby?
    - Live It Teen Pregnancy Prevention
    - Spring 2010 Conference
    - Evidence-based American Indian Strengthening Families Program
    - Language of Life – Bringing Traditional Parenting Skills Back to Our Parents
    - Native STAND
    - Native American Parenting Traditions Revisited
    - Nurse Family Partnership Home Visiting program with adaptations for tribal communities being considered in 2010
7. *Relevant issues related to child welfare and protective services, with information provided being consistent with state child welfare agency training*
    - Comprehensive Assessment and Care Planning
    - Promoting Relationships with Relationships
    - Evidence-based American Indian Strengthening Families Program

APPENDIX F: Family Home Visiting Data Collection Form

Family Home Visiting Population Description	
Total Family Home Visits	**Number**
Total home visits completed during reporting period *(include enrolled primary caregiver, women seen prenatally, and children)*	
Total home visits planned but not home/not found during reporting period	
Total length of enrollment *(at first visit of reporting period)*	
< 6 months (<180 days)	
7 months - 12 months (181 days to 364 days)	
13-24 months (365 days to 727 days)	
>24 months (> 727 days)	
Infants and Children (Ages 0-6)	
Total enrollment of infants and children during reporting period	
Newly enrolled during reporting period	
Primary Caregiver/Women Served Prenatally Information	
Total enrollment of primary caregivers/Women served prenatally during reporting period	
Newly enrolled during reporting period	
Female Gender	
Marital status at first visit of reporting period	
Single (never married)	
Separated or divorced	
Married	
Widowed	
Unknown	
Education Attainment at first visit of reporting period	
No high school diploma	
High school diploma or GED	
Some post secondary education	
College degree	
Unknown	
Primary Language	
English	
Hmong	
Somali	
Spanish	
Other (specify)	
Unknown	
Employment at first visit of reporting period *(includes full or part-time)*	
1 employed adult in household	
2 or more employed adults in household	
No employed adults in household	
Unknown	

Women Served Prenatally	Number
Total enrollment of prenatal clients*	
First time mothers (no previous live or still births)	
Mothers delivering	

* *Include clients who delivered and those undelivered during this reporting period. Count clients who were pregnant twice during the reporting period as two clients.*

Race and Age of Participants: Number Served-Count Enrolled Clients (at first visit of reporting period)							
Age Group	**White**	**Black or Afr Amer**	**Am. Indian/ Nat Alaskan**	**Asian**	**Nat Hawaiian /Other PI**	**>1 Race Reported**	**Other & Unknown**
Primary Caregiver or Woman Seen Prenatally Age							
<15							
15-17							
18-19							
20-21							
22-24							
25-34							
35 +							
Unknown							
Child Age							
<1 yrs							
1-2 yrs							
3-4 yrs							
5-6 yrs							
Unknown							

Hispanic	
Primary Caregiver or Woman Seen Prenatally Age	**Number**
<15	
15-17	
18-19	
20-21	
22-24	
25-34	
35+	
Age Unknown	
Child Age	
<1 yrs	
1-2 yrs	
3-4 yrs	
5-6 yrs	
Age Unknown	
*Hispanics should be recorded under Race as well as here.	

Please describe any challenges you had in collecting these descriptive data and methods you used to overcome these challenges.

Indicators for Evaluating Outcomes

Provide number of enrolled FHV participants for each indicator

I. Early Childhood Development: *To be completed by all FHV programs.*

(Include only those with 3 or more family home visits.) **Number**

Denominators	
Infants/children with ≥3 family home visits	
Infants/children with ≥3 family home visits served 6 or more months	
Outcome/Indicator A.1 Infants and children screened with a recommended standardized instrument within 6 months of enrollment for:	
a) Developmental milestones	
b) Social-emotional milestones	
Outcome/Indicator A.2 Infants and children receiving FHV services longer than 6 months screened with a	

recommended standardized instrument according to the recommended schedule for:	
a) Developmental milestones	
b) Social-emotional milestones	
Outcome/Indicator B.1 Infants and children who at their first screening with a recommended standardized tool within six months of enrollment:	
a) Meet developmental milestones	
b) Meet social-emotional milestones	
Outcome/Indicator B.2 Infants and children receiving FHV services longer than six months infants and children who for their age at the last time they were screened with recommended standardized tools:	
a) Meet developmental milestones	
b) Meet social-emotional milestones	
Outcome/.Indicator C.1 Infants and children not meeting developmental or social emotional milestones identified during reporting period who:	
a) Are referred to community resources and/or services.	
b) Receive follow up by a family home visitor on that referral.	
What challenges are families experiencing regarding developmental and social emotional screening and follow-up?	
What lessons were learned regarding developmental and social emotional screening and connecting families to developmental services?	
What would help increase the capacity of FHV to provide developmental and social emotional screening, referral and follow-up services?	
Please describe any challenges you had in collecting these Early Child Development outcome data and methods you used to overcome these challenges.	

II. Access, Utilization of Services, Resources and Supports: *To be completed by all programs for FHV participants.*	
Outcome A: Parents and their infants/children are connected to community resources and/or services for parenting and family support. *Include all enrolled primary caregivers, women seen prenatally, and infants/children served during the reporting period. Include those with 1 or more family home visit.*	**Number**
Indicator A1: Parents, infants and children referred to community resources and/or services. *Referrals can be written or verbal.*	
Indicator A2: Receive follow-up by a family home visitor on that referral. *(2010)*	
Outcome B: Infants and children are current on well-child checkups. *Include those with three or more family home visits by the end of the reporting period. 'Current' refers to within 1 month for children 18 months and younger and within 3 months for children older than 18 months.*	
Indicator B1: Infants/children current with the periodicity schedule for Well Child Care (i.e., Child and Teen Check Up, American Academy of Pediatrics or the child's health care provider).	
Indicator B2a: If not current, are referred to Well Child Care. *(2010)*	
Indicator B2b: Receive follow up by a family home visitor on that referral. *(2010)*	
What challenges are families experiencing in attaining community resources and/or services?	
What lessons were learned regarding community resources?	
What would increase the capacity of Family Home Visiting to provide community resource referral and follow-up services?	
Please describe any challenges you had in collecting these Access, Utilization of Services, Resources and Supports data and methods you used to overcome these challenges.	

III. Birth or Pregnancy: *To be completed by FHV programs directing resources to this area (i.e., Does your Family Home Visiting program provide outreach to pregnant women? Does your FHV program target pregnant women?)*	
Denominators	**Number**

Women delivering during the reporting period with 3 or more prenatal family home visits.	
Births to mothers delivering during the reporting period. *Include all births (e.g., twins=2) to women with >3 prenatal family home visits.*	
Women served during the 1st trimester by FHV. *Only include women with* 3 or more *prenatal family home visits delivering during the reporting period)*	
Outcome/Indicator A: Infants born at healthy birth weight (2500 grams or 5.5 lbs and higher). *Exclude multiple births (i.e., twins) and infants less than 37 weeks gestation delivered by mothers during the reporting period with 3 or more prenatal family home visits.*	
Outcome/Indicator B: Infants born at greater than or equal to 37 weeks gestation (full term) during the reporting period. *Only include all births to mothers with 3 or more prenatal family home visits. Twins=2 births.*	
Outcome C: Pregnant women receive adequate prenatal care. *Do not count a visit that was only for a pregnancy test or only for WIC. Only include women with 3 or more prenatal family home visits starting in the 1st trimester. Include only women delivering during the reporting period.*	**Number**
Indicator C1: Women who received medical prenatal care within their 1st trimester.	
Indicator C2: Women who received prenatal care within their 1st trimester who had at least 5 medical visits.	
What challenges are women experiencing in attaining early and adequate prenatal care?	
What lessons were learned regarding women attaining early and adequate prenatal care?	
What would increase the capacity of FHV to help women attaining early and adequate prenatal care?	
Please describe any challenges you had in collecting these Birth or Pregnancy data and methods you used to overcome these challenges.	

IV. Economic Self-sufficiency: *To be completed by FHV programs directing resources to this area (i.e., Does your FHV program target interventions to meet these areas?, Does your FHV program have an agreement either formal or informal with the county human service agency to provide MFIP services that are part of a participant's employment or education plan?, Does your FHV program provide information to the county human services agency that may result in sanctions to an MFIP participant?)*

Denominators	**Number**
Primary Caregivers with 3 or more family home visits by the first visit of the reporting period.	
Infants and Children with 3 or more family home visits by the first visit of the reporting period	
Pregnant and parenting teens (up to age 20) with 3 or more family home visits by the first visit of the reporting period.	
Outcome A: Families can meet basic needs of family (e.g., adequate housing, food, medical care). *Include those with three or more family home visits by the first visit of the reporting period. Indicator is measured on the first visit of the reporting period for enrolled clients.*	
Indicator A1: Major Medical Care Resource Available for Medical Services	
a) Enrolled prenatal clients or primary caregiver whose Major Medical Care Resource is:	
1) Private Insurance	
2) Medical assistance	
3) Minnesota Care	
4) Other Sources (grants, etc)	
5) Self-Pay (uninsured)	
6) Unknown insurance status	
b) Enrolled prenatal clients or primary caregiver who do not have insurance who:	
1) Are referred to insurance resources. *(2010)*	
2) Receive follow up by a family home visitor on those referrals. *(2010)*	
c) Enrolled infants/children whose Major Medical Care Resource is:	
1) Private Insurance	

2) Medical assistance	
3) Minnesota Care	
4) Other Sources (grants, etc)	
5) Self-Pay (uninsured)	
6) Unknown insurance status	
d) Enrolled infants/children who do not have insurance who:	
1) Are referred to insurance resources. *(2010)*	
2) Receive follow up by a family home visitor on those referrals. *(2010)*	
What challenges are families experiencing in attaining health insurance?	
What lessons were learned regarding assisting families attaining health insurance?	
What would increase the capacity of FHV to help families attain health insurance?	
Indicator A2: Medical Home	**Number**
a) Children with a consistent primary medical care provider	
b) Children served who do not have a consistent primary medical care provider who:	
1) Are referred to healthcare resources. *(2010)*	
2) Receive follow up by a family home visitor on those referrals. *(2010)*	
What challenges are families experiencing in attaining and maintaining a medical home?	
What lessons were learned regarding families attaining and maintaining a medical home?	
What would increase the capacity of FHV to help families attain and maintain a medical home?	
Indicator A3: Housing Stability	**Number**
a) Families who moved more than two times within the past 12 months. Measure at the first visit of the reporting period.	
b) Families who moved more than two times within the past 12 months who:	
1) Are referred to financial or housing resources. *(2010)*	
2) Receive follow-up by a family home visitor on those referrals. *(2010)*	
What challenges are families experiencing in attaining and maintaining stable housing?	
What lessons were learned regarding families attaining and maintaining stable housing?	
What would increase the capacity of FHV to help families attain and maintain stable housing?	
Indicator A4: Food Insecurity	**Number**
a) Families who are food insecure as indicated by two or more affirmative responses using the following three questions from the USDA Food Insecurity Scale. These questions include: "Within the last 12 months: 1.We worried whether our food would run out before we got money to buy more (Often True, Sometimes True, Never True); 2.The food that we bought just didn't last, and we didn't have money to get any more (Often True, Sometimes True, Never True); 3. Did you or other adults in your family ever cut the size of your meals or skip meals because there wasn't enough money for food? (Yes, No)"	
b) Families who are food insecure who:	
1) Are referred to financial or food resources. *(2010)*	
2) Receive follow up by a family home visitor on those referrals *(2010)*	
What challenges are families experiencing in attaining and maintaining food security?	
What lessons were learned regarding families attaining and maintaining food security?	
What would increase the capacity of FHV to help families attain and maintain food security?	
Indicator A5: School Attendance by Pregnant and Parenting Teens	**Number**
a) Pregnant and parenting teens who attend school or are working towards or have received their GED: *Include up to age 20 years.*	
What challenges are pregnant and parenting teens having in attending school or achieving their GED?	
What lessons were learned regarding pregnant and parenting teens attending school or achieving their GED?	
What would increase the capacity of FHV to help pregnant and parenting teens attend school or achieving their GED?	
Outcome B: Subsequent births to women occur no earlier than two years from previous birth. *Include those served by FHV for >12 months or >364 days. Indicator is measured on the first visit of the reporting period for enrolled clients.*	**Number**
Denominator: Women served by FHV for > 12 months or >364 days by the first visit of the reporting period.	

Indicator B1: Women who did not have a subsequent birth (live or stillbirth) within 24 months or 728 days from birth of their last child.	
What challenges are women experiencing regarding pregnancy spacing?	
What lessons were learned regarding assisting women to space pregnancies?	
What would increase the capacity of Family Home Visiting to help women space pregnancies?	
Please describe any challenges you had in collecting these Economic Self-Sufficiency data and methods you used to overcome these challenges.	

V. Child Maltreatment: *To be completed by Family Home Visiting Programs directing resources to this area (i.e., Is the primary goal of your Family Home Visiting program to prevent child maltreatment and abuse?, Do you have an agreement (informal or formal) with the county human services agency to receive referrals screened out for child abuse/neglect?, Do you work with your human services agency to provide services to prevent child abuse and neglect with families participating in the county's Family Assessment Response (FAR), Parent Support Outreach Program, or other parent outreach program?)*

Outcome A: No maltreatment is occurring in the home. *Include enrolled children ages 0-6 with 1 or more family home visits.*	**Number**
Indicator A1: Children 0-6 years experiencing substantiated child maltreatment during the time enrolled in Family Home Visiting.	
Please describe any challenges you had in collecting these Child Maltreatment data and methods you used to overcome these challenges.	

VI. Injury Prevention: *To be completed by Family Home Visiting programs directing resources to this area (i.e, Do family home visitors do an assessment of hazards for childhood injury in the home?, Does your Family Home Visiting program use the home safety checklist tool?) Measure at the first visit of the reporting period.*

Denominator: Primary Caregivers with 3 or more family home visits by the first visit of the reporting period.	
Outcome A: Parents provide a safe environment for their children. *Include primary caregivers with three or more family home visits by the first visit of the reporting period.*	**Number**
Indicator A1: Primary caregivers who have had a home safety checklist completed and safety concerns addressed by a family home visitor.	
What challenges are families experiencing in attaining and maintaining a safe environment?	
What lessons were learned regarding assisting families in attaining and maintaining a safe environment?	
What would increase the capacity of Family Home Visiting to help families obtain and maintain a safe environment?	
Please describe any challenges you had in collecting these Injury Prevention data and methods you used to overcome these challenges.	

APPENDIX G: Summary of Population Served

Total Number Served by Home Visiting and Visit Completion Rate, Household Food Insecurity and Housing Insecurity January 1, 2009 to June 30, 2009	
	# or %
Total Enrollment	27,300
Total Number of Home Visits Planned	86,882
Total Number of Visits Completed	80,800
Visit Completion Rate (planned/completed)	93.0%
Type of Participant	
Infants and Children	49%
Primary Caregivers	36%
Prenatal Clients	15%
Length of Service at First Visit of Reporting Period	
< 6 months	61%
7 to 12 months	25%
13 to 24 months	9%
> 24 months	5%
Household Food Insecurity	30%
Housing Insecurity (More than 2 moves in past year)	15%

Characteristics of Enrolled Infants and Children and Primary Caregivers and Prenatal Clients January1, 2009 –June , 2009		
Characteristic	**Infants and Children %**	**Primary Caregivers and Prenatal Clients %**
Newly Enrolled	49	67
Age Group		
< 1 year	72	
1 to 2 years	19	
3 to 4 years	7	
5 to 6 years	2	
< 15 years		1
15 to 17 years		8
18 to 19 years		12
20 to 21 years		12
22 to 24 years		17
25 to 34 years		42
35+		8
Race		
African American	13	15
American Indian/ Alaska Native	6	7
Asian	5	4
Native Hawaiian/ Other Pacific Islander	<1	<1
White	60	63
> 1 race reported	4	2
Other and Unknown	11	8
Hispanic Ethnicity	16	18
Primary Language Spoken in the Home		
English		79
Hmong		3
Somali		2
Spanish		14
Other		2
Marital Status		
Unmarried		60
Married		40
Insurance Status		
Private	12	15
Medical Assistance	76	68
Minnesota Care	3	3
Other	1	3
Uninsured	8	11

APPENDIX H: First Time Mothers by County

Percentage of Births to First Time Mothers in 2007 by County Compared to Percentage of First Time Mothers Served by Home Visiting Jan-Jun 2009

Local Health Department	2007 Births	Home Visiting	Local Health Department	2007 Births	Home Visiting	Local Health Department	2007 Births	Home Visiting
Aitkin	45	75	Hennepin	45	77	Meeker-	39	28
Anoka	40	65	Bloomington		83	McLeod-	39	
Becker	37	52	-Richfield			Sibley	33	
Beltrami	37	54	-Edina			Nicollet	43	100
Benton	44	50	Minneapolis		61	Nobles-	37	56
Blue Earth	43	100	Goodhue	42	41	Rock	37	
Brown	35	22	Houston	38	36	Norman-	31	18
Carlton	41	*	Hubbard	34	100	Mahnomen	37	
Carver	35	73	Isanti	42	100	Olmsted	40	47
Cass	33	*	Itasca	39	69	Otter Tail	37	100
Chisago	39	73	Kanabec	43	44	Pennington	46	80
Clay	48	94	Kandiyohi	36	19	Pine	39	50
Clearwater	24	50	Kittson	29	100	Polk	35	89
Cook	40	33	Koochiching	43	84	Ramsey	43	40
Cottonwood-	28	53	Lake	43	25	Red Lake	46	71
Jackson	30		Lake of the	39	100	Redwood-	34	63
Countryside		58	Woods			Renville	41	
Big Stone	24		Le Sueur	36	31	Rice	37	53
Chippewa	42		Lincoln-	37	77	Roseau	35	91
Lac Qui Parle	27		Lyon-	40		St. Louis	42	22
Swift	33		Murray-	30		Scott	38	54
Yellow	36		Pipestone	43		Sherburne	38	79
Medicine			Marshall	42	40	Stearns	38	56
Crow Wing	39	*	Mid-state		63	Todd	32	50
Dakota	41	58	Grant	43		Wabasha	38	87
Dodge-	38	69	Pope	32		Wadena	37	50
Steele	37		Stevens	36		Waseca	32	69
Douglas	37	86	Traverse	33		Washington	40	52
Faribault-	38	33	Mille Lacs	38	83	Watonwan	35	*
Martin	34		Morrison	35	68	Wilkin	37	50
Fillmore	36	86	Mower	37	63	Winona	41	71
Freeborn	44	42				Wright	37	73

* No data provided

Source for 2007 Birth Data – Minnesota Center for Health Statistics, Minnesota Department of Health.