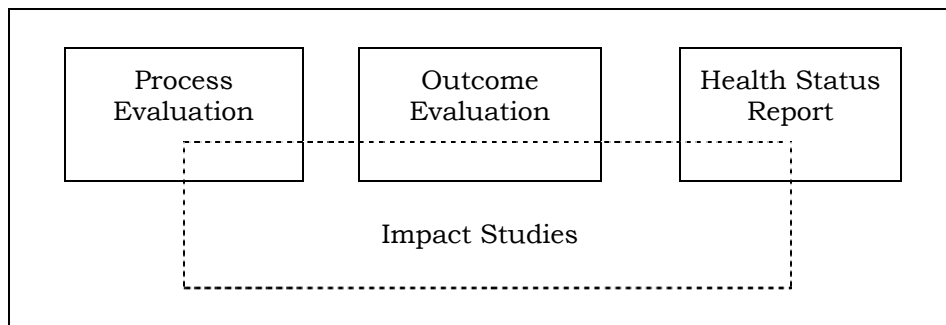


# Minnesota Family Home Visiting

## Evaluation Plan 2008



**Submitted by;**  
**Minnesota Center for Health Statistics**  
**Division of Health Policy**

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We would like to acknowledge the contributions of the Evaluation Work Group for their time and input in creating this plan.

Community and LPH Representatives:

Gyda Anderson, Clay County Public Health

Gay Bakken, Metro Alliance for Healthy Families & Dakota Healthy Families

Laurie Brovold, Anoka County Community Health & Environmental Services

Marilyn Deling, Olmsted County Public Health Services

Linda Harris, Evaluation Consultant

Chery Johnson, Kandiyohi County Public Health

Sue Mitchell, St. Paul-Ramsey County Department of Public Health

Julie Myhre, Carlton-Cook-Lake-St. Louis Community Health Board

Carmen Reckard, Human Services of Faribault-Martin Counties

Minnesota Department of Health staff:

Mary Jo Chippendale

Jan Jernell

Allison LaPointe

Junie Svenson

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# Introduction

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For the past several months, MDH staff from the Center for Health Statistics and Community and Family Health Division coordinated the development of a statewide outcome evaluation plan for the Minnesota Family Home Visiting Program. With direction from the FHV Steering Committee, MDH staff worked with the Family Home Visiting Evaluation Work Group to develop this plan. The FHV Evaluation Work Group included home visiting staff from local public health agencies, MDH staff with evaluation expertise and others with interest in home visiting and expertise in evaluation. This group met monthly to provide feedback and direction in developing this plan including identifying stakeholders, reviewing evaluation questions, analyzing outcomes reported by local public health departments in the FHV Detailed Plans, and guiding the development of statewide outcomes and indicators. In addition, MDH worked with an evaluation consultant to conduct a Delphi process to identify FHV outcomes. The results of this work are outlined in this summary and presented in detail in subsequent sections of this plan.

Home visiting to improve the health and well-being of families and children has been a part of the framework of maternal child health at the national, state, and local levels for many years. From 1992 to the present day, Minnesota has funded and administered targeted and universal home visiting for families with children that utilize public health nurses (PHNs) for the initial assessment with ongoing visits carried out by PHNs or other trained home visitors as appropriate. These programs have had as their goals, the prevention of abuse and neglect and out-of-wedlock births and the promotion of positive parenting, healthy children, and economic self-sufficiency. The current Family Home Visiting program is a targeted program for families at or below 200 percent poverty and families with specific risk factors. It incorporates the work and focus of many of these home visiting programs with some changes and expansions.

This document is divided into three sections. **Section I** provides a historical summary of universal and targeted home visiting in Minnesota. Also included in this section is an overview of current home visiting in Minnesota as described by local programs. Local FHV programs are funded with Federal Temporary Assistance to Needy Families (TANF), Title V Maternal Child Health (MCH) Block Grant funds, state general funds, local levies, and third party reimbursement and various grants and other sources. As Section I indicates, FHV programs in Minnesota use a multitude of program models and curricula with services provided universally or targeted to families with selected risk factors. They use a variety of home visiting approaches and strategies. There are, of course, both strengths and limitations to this complex approach of providing home visiting services. One particular area of strength is that this diversity of approaches allows the local community to design and implement its 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 home visiting statewide.

**Section II** summarizes evaluation requirements referred to in the most recent legislation (MS 145.7A) including the identification of statewide outcomes, description of local programs, documentation of funds allocation, and communication to stakeholders on lessons learned, challenges, and successes. This section includes a description of several evaluation challenges and issues that became apparent in the planning process and may be inherent in an evaluation of this scale and complexity. It also provides a conceptual framework for the evaluation and a description of the Evaluation Work Group composition and work in identifying common outcomes and measurable indicators for statewide reporting.

The evaluation model included in this section presents the evaluation questions and the components of the model that respond to these questions. The evaluation model includes Process and Outcome evaluation components that meet the accountability and learning functions of the evaluation. The Process evaluation component results in a description of the services, recipients of services and results of home visiting services in Minnesota. The Outcome Evaluation component identifies statewide outcomes and indicators that are required reporting for all FHV programs in the state. In addition, several outcomes are identified that will be required reporting for programs that direct resources to specific areas. A third set of outcomes needing further research and development are included because of their significance to home visiting. These may be required reporting for local programs at some time in the future.

An Impact Studies component is included in the model and is described more fully in this section. The Impact Studies component is designed to document longer term outcomes of home visiting and provide opportunity for special home visiting evaluation and research projects. A Health Status Reporting component completes the model description. The Health Status Reporting component involves development of a plan for reporting on several health status indicators for women and children.

**Section III** provides a next steps plan for implementation of a statewide evaluation. Evaluation implementation will take place in year two and subsequent years.

## **Section I: FHV History and Background**

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### ***History***

For at least 100 years, nurse home visiting has been used as a service delivery strategy to improve the health and well-being of families. Home visiting is an intervention where services are delivered in the home in an effort to influence parental skills and behaviors, and improve the environment in which children spend most of their time. Trained home visitors provide education and anticipatory guidance to families and link them to resources that support expectant parents or parents with young children. The relationship between the family and home visitor is integral to the success in achieving the goals set together by the family and the home visitor. The following section describes the history of home visiting in Minnesota from the early 90's to present.

#### **Home Visiting Program to Prevent Child Abuse & Neglect, 1992-2001**

In 1992, MDH implemented a home visiting program to prevent child abuse and neglect. The program offered intense home visiting services to families with identified risk factors for child abuse and neglect. This was a competitive grants program offered to local public health agencies. Twenty-two agencies provided home visiting to over 2,000 households throughout Minnesota until the program ended in 2001.

#### **Minnesota Healthy Beginnings (MHB), 1999-2003**

In 1999, MDH began the Universal Home Visiting Program to strengthen families and to promote positive parenting and healthy child development. Home visits were offered to all families with a new baby in geographic area irrespective of income, age or risk status. MHB funding was offered to local public health departments and other agencies through a competitive grants program. The funding for MHB ended in 2003.

#### **Family Home Visiting Program, 2001 - present**

The Family Home Visiting Program, originally called the TANF PHN Home visiting Program, began in 2001. The program's goal was to improve the health and well-being of children and families, to promote economic self-sufficiency, and to reduce out-of-wedlock pregnancies in TANF-eligible families ( < 200% of federal poverty guidelines and US citizens or eligible non-citizens) including pregnant women. Home visits could be offered prenatally through a child's 18th year (19 if still in school). The funding was offered to all local public health departments on a formula-basis.

In 2002, the state renamed the Public Health Nurse Home Visiting Program to the Family Home Visiting Program (FHV) and the funding was offered to all 52 Community Health Boards and all 11 tribal governments statewide on a formula basis.

In 2004, under the Minnesota Local Public Health Act, the FHV program was blocked together with a number of other grant programs. Three funding sources support the services provided through the Local Public Health Act: State general funds, Federal MCH Block Grant funds, and Federal TANF funds. By blocking these programs and funds, the Act allows Community Health Boards (CHBs) and Tribal Governments to determine their own priorities for the use of these funds and all three funding sources can be used to provide Family Home Visiting services.

The program's goal was to improve the health and well-being of children and families, to promote economic self-sufficiency, and to reduce out-of-wedlock pregnancies in TANF-eligible families including pregnant women ( 200% of federal poverty guidelines and US citizens or eligible non-citizens). Statewide formula-based funding for this program was available to all 52 Community Health Boards and all 11 Tribal Governments.

Minnesota Statute, section 145A.17 governs the Minnesota's Family Home Visiting program. In 2007, the Legislature amended the statute to add new program requirements, expand target populations and goal areas, institute training requirements and establish measures to determine the impact of family home visiting programs funded under the statute. It also increases TANF funding to CHBs and Tribal governments in order to support the services provided under statute. Changes to the statute include:

Community Health Boards (CHBs) and Tribal Governments are required to submit a plan to the commissioner of health describing a multidisciplinary approach to targeted home visiting for families with identified risk factors;

New program requirements must be implemented, such as visits must begin prenatally whenever possible and families must be connected to additional community services and programs as needed and to center-based or group meetings for families when available; and  
The commissioner of health is now required to provide training for home visitors on specific topics; and

The commissioner of health is also required to establish measures to determine the impact of family home visiting programs funded under the statute.

FHV legislation identifies several broad goals and outcomes that laid out the groundwork for developing the evaluation plan. The goals in the legislation expand the scope of family home visiting programs in the following areas:

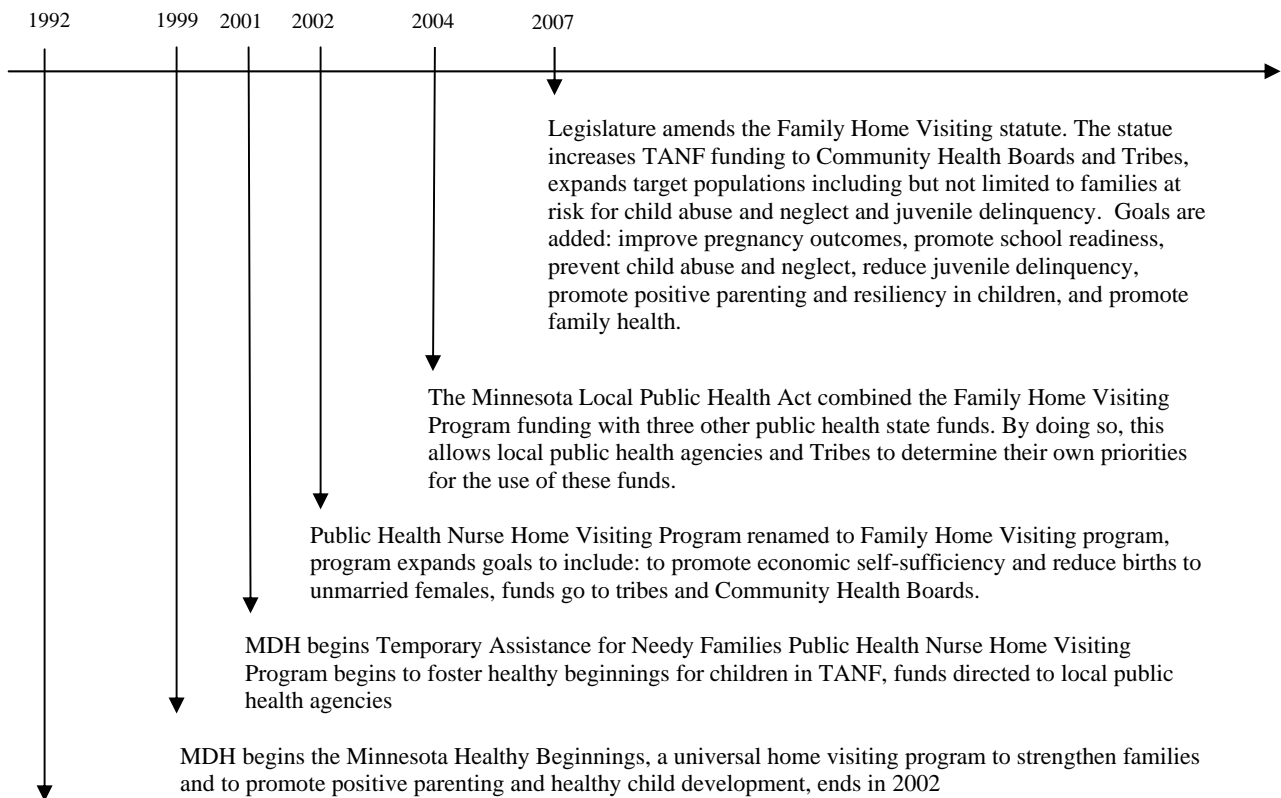
- Healthy beginnings
- Pregnancy outcomes
- School readiness
- Child abuse and neglect
- Juvenile delinquency
- Positive parenting and resiliency in children
- Family health and economic self-sufficiency for children and families.

In addition, the legislation lists several outcome and performance areas where it mandates the establishment of measures to determine program impact.

- Appropriate utilization of preventive health care
- Rates of substantiated abuse and neglect
- Rates of unintentional injuries
- Rates of children who are screened and who pass early childhood screening
- Rates of children accessing early care and education services
- Program retention rates
- Number of home visits provided compared to the number planned
- Participant satisfaction
- Rates of at-risk populations reached

All of the above goals and areas for which measures are required have been incorporated into the evaluation plan and data collection efforts described in this document. The statute provides direction for the development of the evaluation plan as well as the identification of the recommended statewide outcomes and indicators.

**Figure 1: History of Home Visiting in Minnesota, 1992 to Present**



MDH implements a home visiting program to prevent child abuse and neglect, ends in 2001

## Current Home Visiting Programs in Minnesota

Currently, 87 counties and 4 urban family home visiting programs receive increased funding through the MN Family Home Visiting statute (Minnesota Statutes, section 145A.17). Minnesota home visiting programs throughout the state are multi-faceted and far-reaching. Each home visiting program is unique – no two programs are exactly alike. The amended 2007 FHV statute required Community Health Boards (CHBs) to complete a detailed plan that describes a multidisciplinary approach to targeted home visiting for families. The detailed plans that were submitted by CHBs in June, 2008 describe home visiting target populations, the home visiting program models, assessment tools, funding sources and staff. The Detailed Plan will serve as a primary data source for the process evaluation component of the FHV Evaluation Model discussed in the Section II. This section provides a general description of current home visiting programs in Minnesota and the heterogeneous nature of home visiting.

### Program Models and Curricula

There are many different types of home visiting models being used for programs including national models such as Nurse Family Partnership (NFP) and Healthy Families America (HFA). Seventeen of the 91 local public health departments reported use of the NFP or NFP-like model and 11 reported use of the HFA or HFA-like model in their detailed plans. Sixty-three departments did not identify a specific national program model they were using.

Local public health departments reported use of 14 different curricula in their FHV programs. The most often used curricula are *Promoting Maternal Mental Health during Pregnancy*, *Bright Futures*, *Positive Parenting*, and *Keys to Caregiving* (Figure 2).

**Figure 2: Curricula Used by Minnesota Family Home Visiting Agencies, 2008 Detailed Plan**

Rank	Curriculum	Number of Programs	Percent
1	Promoting Maternal Mental Health During Pregnancy	59	64.8
2	Bright Futures	44	48.4
3	Positive Parenting	38	41.8
4	Keys to Caregiving	32	35.2
5	Healthy Families America-San Angelo	20	22.0
6	Promoting First Relationships	20	22.0
7	Young Family Parenting Information (MELD)	20	22.0
8	Seeing Is Believing	15	16.5
9	Partners in Parenting Education (PIPE)	14	15.4
10	Growing Great Kids	13	14.3
11	The Incredible Years	10	11.0
12	Partners for a Healthy Baby	10	11.0
13	Steps Toward Effective & Enjoyable Parenting (STEEP)	8	8.8

14	Parents as Teachers	1	1.1
14	Chicago Parent Program	1	1.1

## Populations Served

The populations that Minnesota FHV programs serve are mostly targeted, based on selected risk factors. They serve teen parents, low income pregnant women, families involved in child protection services, children with developmental delays, parents at risk for child maltreatment, pregnant women with a history of chemical dependency, and parents with mental health issues among others.

## Initiation, Intensity and Duration of Family Home Visiting

The majority of local public health departments identified prenatal initiation as preferred time to engage and enroll clients and offer a continuum of home visiting services to families. Most departments described program intensity and duration varying from 2-7 visits during pregnancy and 1-2 visits after delivery depending on family needs to weekly and frequent visits after delivery through age 1 or 2. The types of visits vary from program to program and client to client. Many departments offer both one on one home visits and group educational sessions. Some examples of unique services provided include support groups for chemically dependent mothers and providing fluoride varnishing.

## Screening and Assessment Tools

Screening and assessment is an essential component of FHV programs. Local public health departments reported using screening and assessment tools to screen for eight major categories (Figure 3). Almost all departments (94.5%) screen for infant growth and development. These departments used seven different types of screening tools including Ages and Stage Questionnaires and Brigance. The majority of departments screened for infant-child social and emotional health, home safety, maternal depression, and domestic violence. Two-thirds of the departments reported using screening tools for parent-child interaction. Finally, less than half of the departments used tools to screen for risk factors for abuse/neglect and substance abuse.

**Figure 3: Screening and Assessment: Number of Tools Used by Screening Category for Minnesota Family Home Visiting Agencies, 2008 Detailed Plan**

Rank	Category for Screening/Assessment	Number of Tools	Number of Programs	Percent
1	Infant Growth & Development	7	86	94.5
2	Infant-Child Social & Emotional Health	4	82	90.1
3	Home Safety	1	79	86.8
4	Maternal Depression	5	78	85.7
5	Domestic Violence	1	72	79.1
6	Parent-Child Interaction	5	61	67.0
7	Risk Factors for Abuse/Neglect	3	44	48.4
8	Substance Use/Abuse	4	40	44.0

## Documentation Systems

Another important aspect of FHV programs is the documentation of the visits. The majority of Minnesota local public health departments reported using one of the Omaha System-based documentation systems: CHAMP (45), PHDoc (24), CareFacts (7), six reported using an electronic system other than the CHAMP, PHDoc and CareFacts, and three reported using a paper system only.

## Funding

FHV programs are funded through several mechanisms. The majority of programs receive at least part of their funding from Federal TANF and Title V MCH Block Grant funds. Two-thirds of the FHV programs received some of their funding from State general funds, county levies and third party reimbursements. One third of the agencies receive some of their funding from grants or other sources (e.g. schools, state agencies). The 2008 detailed plan did not collect information on what proportion of the funding comes from each source.

**Figure 4: Funding Sources for Minnesota Family Home Visiting Agencies, 2008 Detailed Plan**

Rank		Number of Programs	Percent
1	Temporary Assistance to Needy Families (TANF)	85	93.4
2	Title V and Maternal and Child Health Block Grant (MCHB)	82	90.1
3	State General Funds	65	71.4
4	County Levy	65	71.4
5	3rd Party Reimbursement	66	72.5
6	Grants*	35	38.5
7	Other*	36	39.6

\*Includes foundation, health plan, and corporate grants, and funding from city levies, other state agencies and schools

## Summary

Minnesota's Family Home Visiting Program viewed at the state level is a homogenous program. However, it is really an amalgam of many heterogeneous programs designed specifically to fit the needs of communities at the local level. There are 91 public health departments that provide FHV services throughout Minnesota with the type of home visit varying from department to department. Among the 91 departments there are 14 curricula used, nine documentation systems employed, and at least six different funding sources. Twenty-eight agencies use a national home visiting model while 63 use other types of programming. All agencies screen and assess their clients for risk factors and development levels. However, the purpose for screening varies from agency to agency as does the tool used to screen. The intensity level for home visits range from two to seven visits prenatally to weekly visits up to age two.

The lack of uniformity at the local program level is intentional and necessary. However, it also makes a statewide evaluation challenging. This evaluation plan attempts to recognize the heterogeneity of Minnesota's home visiting program.

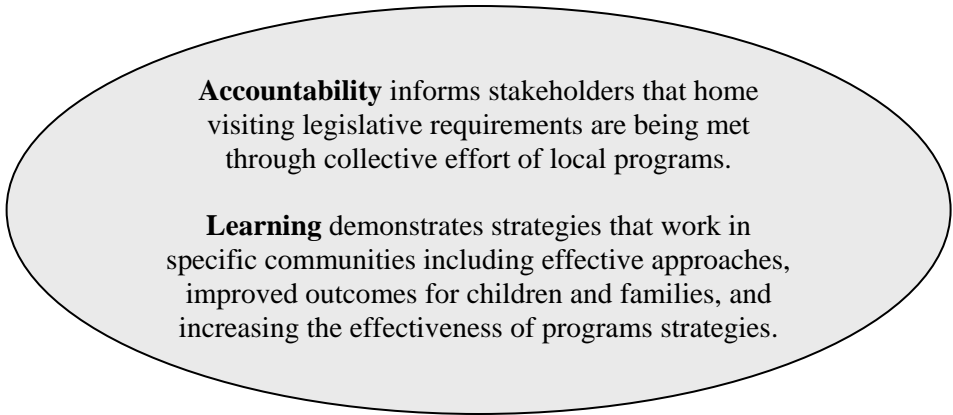
## Section II: FHV Evaluation Model

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### *Purpose of the Evaluation*

The 2007 revised Family Home Visiting statute (MS145A.17) requires that the Minnesota Department of Health implement a comprehensive evaluation for the FHV program. The statute states that the statewide evaluation will measure statewide outcomes; describe the local programs; document allocation of funds; and, inform stakeholders on lessons learned, challenges and successes.

The evaluation plan answers questions about the “why” and “how” of FHV as well as the contribution of FHV 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 FHV is meeting the intent of the legislation and learning involves gathering data and information to improve home visiting programs and contribute to the literature of what works in home visiting to enhance the lives of women, children, and families.



**Accountability** informs stakeholders that home visiting legislative requirements are being met through collective effort 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.

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.

The remainder of this section of the document describes the proposed evaluation model for FHV and includes the evaluation questions, logic model, conceptual framework of the evaluation, a description of the work of the Evaluation Work Group, identifies key family home visiting stakeholders, and issues and challenges confronted in the planning process. Finally, this section describes the four components of the Evaluation model, how each fits with the two primary functions of the evaluation (accountability and learning), the evaluation questions that each component will respond to, and the primary individuals or groups responsible for data collection and dissemination.

## ***Evaluation Questions***

Consistent with these purposes for the evaluation several questions are posed to assess both the accountability and learning functions. The questions are intended to frame the assessment of the efforts of local programs meeting the legislation requirements by documenting the process and activities conducted by the FHV 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 primary questions being asked of this evaluation are:

What is being done in FHV in Minnesota?

Who and how many are being served?

What results are being achieved?

What are results overall at the local level and the long term?

What is the impact of FHV services on families?

What can we learn about strategies and approaches in home visiting to improve the results?

## Guiding Principles

The Minnesota Family Home Visiting Steering Committee (SC) recommended that MDH form the Family Home Visiting Evaluation Work Group (EWG) consisting of home visiting staff from local public health agencies across the state, MDH staff and evaluation experts. The SC asked that the EWG develop a plan for evaluation that *“will provide the legislature with meaningful outcomes that will demonstrate the impact of home visiting.”*

Since fall of 2007, the EWG has been meeting to develop a plan to evaluate the overall effectiveness of the Family Home Visiting program. The EWG developed guiding principles for the evaluation (Figure 5), reviewed the 2007 FHV legislation and previous home visiting evaluation efforts, identified stakeholders, reviewed evaluation questions, analyzed outcomes from the 2008 detailed plans submitted by local public health departments and developed FHV statewide outcomes.

### Figure 5: Home Visiting Evaluation Guiding Principles 2007 FHV Evaluation Work Group

The evaluation will:

- be useful to state and local public health;
- be meaningful for all stakeholders;
- be consistent with the statute;
- not be burdensome;
- recognize the differences in home visiting programs and build on these differences;
- keep pace with changes in funding and programming; and
- be simple and practical.

## Evaluation Stakeholders

The EWG identified numerous stakeholders at both local and state levels, including FHV staff and clients, Minnesota Departments of Health, Education and Human Services, schools, Early/HeadStart, Early Childhood Family Education, child development advocates (e.g. Ready4K), legislators, prospective funders, and health plans. Once stakeholders were identified, the EWG discussed the different needs and expectations each stakeholder may have regarding evaluation. For example, local public health departments would want to know how the implementation of the evaluation would impact their work; while MDH staff would want to know about the evaluation capacities of local public health agencies. After discussions with the EWG, it is assumed that all stakeholders would want to know:

- Who and how many are being served?
- How much is being spent and on what?
- Who is providing services?
- Is Minnesota Family Home Visiting efficient?
- What results are being achieved?

## Challenges in FHV Evaluation Planning

The MDH Center for Health Statistics and Family Home Visiting staff reviewed documents, worked with the EWG, the SC, the FHV Training Work Group, and consulted with staff in Community and Family Health to develop a plan for the evaluation. Throughout this process, there were several recurring evaluation issues and challenges mentioned. FHV in Minnesota is multifaceted and complex. Currently, 87 counties and 4 city FHV programs received increased funding through this initiative. Each of these are diverse in programming and approaches as well as the populations they serve, making it difficult to capture and accurately reflect the status and overall effect of home visiting at the state level. In addition, other issues that make overall evaluation a challenge include the following:

**Different approaches to local evaluation and measurement:** As indicated in the background, local agencies use many different models to implement 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:** Departments vary in staff size from over 100 to less than 5. Smaller agencies do not have the staff resources to conduct an extensive evaluation. Regardless of size, 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 FHV programming started, comparing statewide outcomes to comparison group and baseline data are 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 home visiting by parceling out the specific contributions of 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.

## ***Logic Model***

The logic model for the statewide FHV program provides the rationale behind program inputs and activities and the relationship to the program outcomes. The purpose of the logic model is to communicate the underlying assumptions or hypotheses that program proponents have about why the program will work or lead to the intended outcomes. The family home visiting logic model in Figure 6 shows the following information for each component:

**Program Inputs** are the resources that are dedicated to or consumed by programs. In this model, the inputs include both resources, such as trained and supervised home visiting staff and the attributes of the home visiting programs as defined by Minnesota Statute 145A.17 (Family Home Visiting Programs).

**Activities** are the actions that are carried out and which are intended to have a direct impact on children and families. For example, assessment and screening are primary home visiting activities.

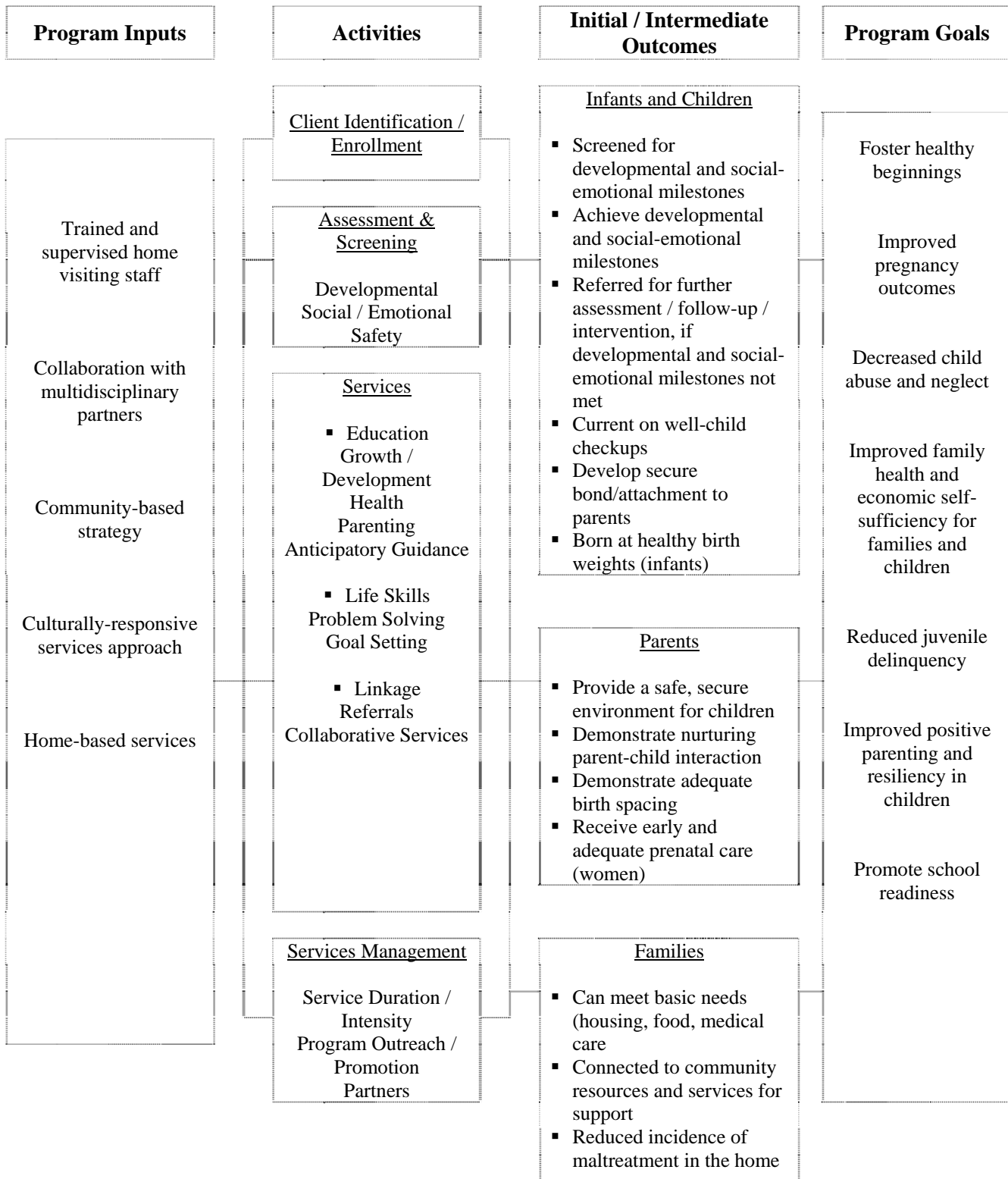
**Outcomes** are the benefits derived by children and families that are served by the program. Outcomes can occur during or after participation in the Family Home Visiting Programs and can include changes in knowledge, skills, attitudes, or behavior. Outcomes can be divided into two categories:

*Initial outcomes* are the first changes for participants, and are very closely influenced by the program. Initial outcomes are often changes in knowledge, attitudes, or skills.

*Intermediate outcomes* are changes in behavior that result from the acquisition of new knowledge and skills.

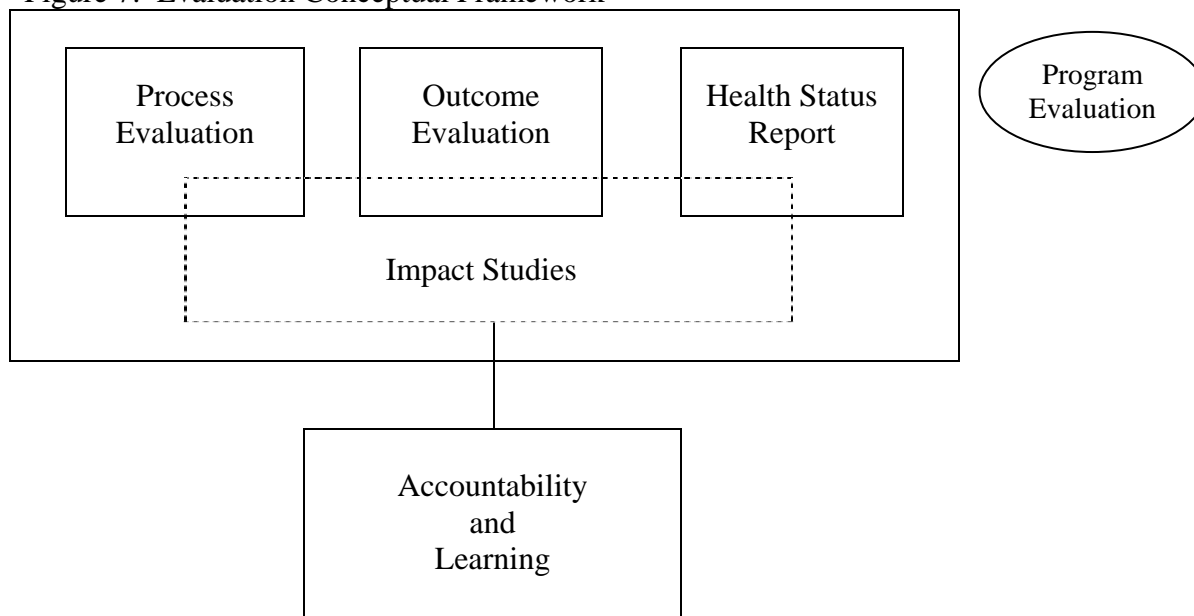
**Program Goals** are the ultimate outcomes a program wants to achieve. These goals are defined in Minnesota Statute 145A.17 (Family Home Visiting Programs) and include fostering health beginnings or improved pregnancy outcomes.

**Figure 6: Minnesota Family Home Visiting – Logic Model**



## Conceptual Framework

Figure 7: Evaluation Conceptual Framework



The evaluation model for FHV consists of distinct components (Figure 7). The model includes a process and an outcome evaluation, impact studies and a system for monitoring the health status women and families.

The **process evaluation** will document program activities and describe clients reached. This component will determine if the FHV statewide program is meeting the intent of the home visiting legislation. Data collected in the process evaluation component can also contribute to our learning about what works in FHV. 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 FHV programs and provide opportunity for local FHV programs to learn from the experience of others.

The **outcome evaluation** will provide results on set of outcomes that result from FHV activities and define the purposes of family home visiting in Minnesota, childhood screening and assessment, child development, referral, access to services and services utilization. The outcome evaluation is responsive to questions in the learning function of the FHV model.

**Health Status Reporting** is an important component of this plan. The reporting will inform the various stakeholders about the health status and trends of groups that are targeted for future home visiting services. A plan for reporting on a selected group of indicators for women, infants, and children will be developed and made available to stakeholders. While the Health Status Reporting component does not entirely reflect the impacts of the FHV programs, it provides a tool to monitor the health status of the target populations to inform the adequacy of resource inputs.

**Impact Studies** are a major component of the evaluation model. Impact Studies are in-depth evaluations or studies allowing for greater understanding of specific program services. There are many topic areas that could be included for further study, the agenda for this group will allow for increased knowledge of FHV with selected or multiple programs areas (e.g. comparison of national model results).

**Figure 8: Model Components Description**

Components	Description
Process Evaluation	Required reporting for all FHV programs Describes individuals enrolled in home visiting and FHV programs (demographics and descriptive reporting) Provides information for accountability and learning
Outcome Evaluation	Required reporting of selected outcomes for all FHV programs Required reporting of selected outcomes for programs directing resources to specific areas (e.g. child maltreatment) Outcomes for further development Describes the impact FHV has on Minnesota children and families Provides information for accountability and learning
Health Status Reporting	MDH reports using existing data to monitor health status of children and families Reporting useful for FHV staff and interested stakeholders Uses could include comparison data or inform policymakers Provides information for learning
Impact Studies	Selected FHV 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
Program Level Evaluation*	Program level outcomes, indicators, analysis and reporting Provides information for accountability and learning

\*In addition to the data gathered at the statewide level to describe home visiting services, clients, strategies and activities, local programs are expected to conduct their own process evaluation. While this evaluation function is not a part of the overall evaluation, local evaluation is required. Programs identify goals, outcomes, indicators, and report on progress toward these outcomes. The Evaluation Work Group and the Impact Studies group will further discuss local level evaluation and consider ways to document the reporting of local evaluation results. Technical assistance will be incorporated into the training schedule where needed.

## **Process Evaluation**

The process evaluation component of the evaluation model will identify outputs to FHV Program at the statewide level. Process evaluation responses address the accountability and learning function of the FHV evaluation to its various stakeholders.

Process evaluation results will describe 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. There are many descriptors that have been included in previous home visiting data collection activities. For purposes of this evaluation, the Detailed Plan will serve as the primary data source for the process evaluation. *The EWG will work with the SC and MDH staff to review and revise the Detailed Plan assure that the data collected are meaningful and useful for evaluation or sharing purposes.* Figure 9 provides examples of the type of questions that could be posed in the process component of the evaluation.

As expected, all FHV programs will report in this area.

### **Figure 9. Examples of Process Evaluation Data**

#### Description/Intensity of Home Visit

- Enrollments and exits completed this reporting period
- 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 FHV 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: 2008 Minnesota Family Home Visiting Detailed Plan

## **Outcome Evaluation**

The Outcome Evaluation component requires statewide reporting for an initial number of intermediate and long term outcomes. The indicators measure changes in statewide outcomes of health and well-being of children and families that occur as a result of home visiting.

The Outcome Evaluation monitors broad overall trends and answers several questions including: the extent that FHV interventions meet the program goals identified in legislation; the results that are being achieved; and the impact of home visiting on children and families.

### **Figure 10: Outcome Selection Questions**

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

## **Identifying Statewide Outcomes**

The EWG worked with MDH staff to engage a statewide group of experts to identify statewide outcomes for the FHV Program. A Delphi process, a consensus development process designed to gather information from a panel of experts, was carried out to first identify and then prioritize outcomes that that were most important to assess for FHV across eight goal areas. A panel of 86 experts was identified to assist in this process including representatives of state agency departments, local public health, SC members, community partners, foundations, academic institutions, researchers, and community members. Experts represented all regions of Minnesota, including those in the urban area and in greater Minnesota. In the first round of this process, over 400 outcomes were identified by the forty-seven Experts who participated. 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 were most important to home visiting.

## **Reporting Requirements for Outcomes and Indicators**

Along with the completion of the Delphi process and a review by the EWG and MDH staff a total number of twenty-two outcomes were identified. These outcomes were divided into three groups: outcomes that all FHV programs are required to report; outcomes that are required for selected FHV programs directing resources to specific areas; and outcomes needing further development to facilitate measurement across the diverse programs and populations served by the programs.

The first set of outcomes -- required for all FHV programs, cover several goals identified in the 2007 legislation including the areas of school readiness, healthy beginnings, and positive parenting. The second set of outcomes -- required for selected FHV programs, fall under the legislative goal areas of pregnancy outcomes, economic self-sufficiency, and child abuse and neglect.

The third set of outcomes -- those requiring further development, cover the legislative goal areas of positive parenting, juvenile delinquency and family health. It is recommended that the EWG continue to work on this third set of outcomes to develop indicators for these outcomes. The EWG will consider several approaches to identify indicators in this outcome areas as well as usable data collection tools.

This schema of reporting recognizes the diversity of family home visiting programs where FHV 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 FHV programs and another set of programs that focus resources in certain areas not common to all programs such as prenatal visits will be required to report on outcomes specific to those activities.

## **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 in FHV program 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 in FHV program 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 FHV 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 FHV 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 FHV 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 FHV 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: 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: The percent of infants/children that are current with the periodicity schedule for early and periodic screening

## **Outcomes for 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.

## **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.

The outcomes identified through this process are preliminary.

## ***Health Status Reporting***

The primary function of the Health Status Reporting component is 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 FHV stakeholders including policy makers, local public health FHV program staff, health care providers and others interested in the health of families. Biannual reports will be available for FHV staff statewide and will contribute to the work of FHV 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 program to compare common outcomes (e.g. birthweight) for targeted groups and serve as a resources for future planning at the state and local levels.

Initially, Health Status reports would include several health status indicators for women and children listed in Figure 11.

**Figure 11: Health Status Indicators**

<b>Pregnancy and Birth</b>	<b>Violence</b>
Birthweight	Injury (unintentional)
Gestational age	Maltreatment
Infant mortality	
Prenatal care (initiation and adequacy)	<b>Socioeconomic</b>
Teen birth and pregnancy	Poverty
	School lunches (free and reduced fees)
<b>Well Child Care</b>	Population growth
Immunization	
Screening	<b>Risk Behaviors</b>
	Smoking
<b>Protective Factors</b>	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), Behavioral Risk Factor Surveillance System (BRFSS), Minnesota Center for Crime Victim Services (MCCVS), Minnesota State Demographic Center, Minnesota Student Survey (MSS), and U. S. Census Bureau. Gathering and compiling the data for the Health Status Reporting component will be the primary responsibility of MDH research and evaluation staff. This group will get stakeholder input to identify the indicators and get feedback on layout and design. This group will also work closely with MDH staff to develop and implement a communication and dissemination plan for reports.

### ***Impact Studies***

The Impact Studies, a critical component of the evaluation, facilitates the accountability and learning dimensions of the FHV 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. It is 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. An important role for the group will be the communication of the statewide process and outcomes results to local programs to improve programming and share strategies and provide policy direction and recommendations to the SC.

**Figure 12: Impact Studies Group Functions/Activity Examples**

Develops Strategic Research and In-depth Evaluation Agenda	Initial agenda could include client/family satisfaction of family home visiting/visitors. Agenda could also include comparisons with state, national findings in home visiting, comparisons of results of similar program approaches.
Reviews Results of Local Evaluations	Provides feedback to Steering Committee about the investment, value, significance of results for home visiting reporting after review of program results
Conduct In-depth Case Study Research	Group can elect to conduct individual studies to further document/demonstrate successful program results
Advise on conducting Intensive/Longitudinal Studies	Some FHV programs provide services for longer periods of time allowing sufficient time for studies to be conducted. Impact studies group could initiative and implement longer term studies (e.g. a study of meeting developmental milestones for children who are long term home visiting clients) or a study of juvenile delinquency among children and youth who received home visiting services).

The group will 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 FHV services on children and families served? Perhaps an initial focus for the group would be to address the question of client satisfaction with home visits and/or home visitors.

There are several sources of data for the Impact Studies Group including the results of local FHV evaluations, state, national, local data sources, and additional data collection. The Impact Studies Group would include MCH and CHS staff, EWG members, and special consultants/advisors from other regions/states.

## Section III: Implementation of Evaluation

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### Tasks

Task	Staff Responsible		Target Completion Dates		
	Lead	Support	Stage 1 9/2008- 3/2009	Stage 2 3/2009- 3/2010	Stage 3 3/2010- 9/2013
<b>PROCESS EVALUATION</b>					
Develop list of indicators needed to adequately describe "What family home visiting looks like in Minnesota."	CFH	MCHS, EWG			
Review detailed plan data based on list of indicators, determine what is already included and needs to be added to future FHV detailed plans.	CFH	MCHS, EWG			
Determine method of collecting and reporting these indicators	CFH	MCHS, EWG, OPHP			

FH FHV: Family Health – Home Visiting & Epi, MCHS: Center for Health Statistics, EWG: Evaluation Work Group, OPHP: Office of Public Health Practice

Task	Staff Responsible		Target Completion Dates		
	Lead	Support	Stage 1 9/2008- 3/2009	Stage 2 3/2009- 3/2010	Stage 3 3/2010- 9/2013
<b>OUTCOME EVALUATION</b>					
<b>Finalize outcomes and indicators</b> Reconvene Evaluation Work Group (EWG) Define remaining indicators Determine numerators and denominators Obtain EWG input and SC approval of outcomes and indicators	FHV	MCHS, EWG			
<b>Develop data collection plan<sup>1</sup></b> Determine reporting period for each outcome and indicator Determine variables to be collected at the local level (e.g. demographics, length in program, type of program) Establish submission deadline Determine method of transmission of indicator data from LPH to MDH (see “Data Collection System”) Develop guidelines for reporting and generating data at the local level Develop training for reporting and transmission of data (transmission is defined as submitting data to MDH)	FHV	MCHS, EWG, OPHP, ISTM			
<b>Pilot test data collection and submission systems with FHV agencies</b> Are outcomes and indicators feasible to collect? Do documentation systems need to be modified to collect data on these indicators Is the submission system easy to use? How much time does it take to collect and submit these data?	FHV	MCHS, EWG, LPH			
<b>Develop an analysis plan</b> Identify standards or comparison targets for outcomes (e.g. national data, research in the field, specified goals or targets and or surveillance data) Determine characteristics of program (state, regional, model type) to be analyzed Determine characteristics of client to be reported (age, race, county of residence etc.) to be analyzed	FHV	MCHS, EWG			

<sup>1</sup>The assumption is that each FHV agency uses assessment tools (e.g. ASQ) and documentation systems (PHdoc). If they do not have these in place, MDH FHV must recommend assessment tools and documentation systems.

FH: FHV: Family Health – Home Visiting & Epi, MCHS: Center for Health Statistics, EWG: Evaluation Work Group, OPHP: Office of Public Health Practice, LPH: Local Public Health Departments, ISTM: Information Systems and Technology Management

Task	Staff Responsible		Target Completion Dates		
	Lead	Support	Stage 1 9/2008- 3/2009	Stage 2 3/2009- 3/2010	Stage 3 3/2010- 9/2013
<b>HEALTH STATUS REPORTING</b>					
Develop list of indicators	MCHS	FHV, EWG			
Develop data collection and analysis plan	MCHS	FHV, EWG			
Report on health status indicators	MCHS	FHV, EWG			

<b>IMPACT STUDIES</b>					
Create and facilitate an Impact Studies Workgroup	MCHS	FHV, EWG			
Develop long range research plan (e.g. what will be studied and when) Possible topics: client satisfaction, outcomes by race/ethnicity and income, comparison of outcomes by model	MCHS	FHV, EWG			
Select FHV agencies for participation in studies	MCHS	FHV, EWG			
Establish funding sources (MDH & outside sources)	MCHS	FHV, EWG			
Conduct studies	MCHS	FHV, EWG			

<b>PRODUCTS</b>					
List of outcomes and indicators with instructions on how to collect, when to collect and how to submit	FHV	MCHS, EWG			
Trainings – two on Webex (outcome and indicator collection process and data transmission)	FHV	TWG, MCHS			
Data analysis and reporting plan	FHV	MCHS, EWG			
Evaluation results report	FHV	EWG, MCHS			

FHV: Family Health – Home Visiting & Epi , MCHS: Center for Health Statistics, EWG: Evaluation Work Group, OPHP: Office of Public Health Practice, ISTM: Information Systems and Technology Management, TWG: Training Work Group

## **Data collection system**

The recommended data collection system for collecting data on the FHV statewide outcomes is the Local Health Planning and Performance Measurement System (PPMRS). The PPMRS is a system currently used by all local public health agencies in Minnesota to report financial and statistical information, performance measures and Title V/TANF federal measures. FHV outcomes and process measures would be added as an additional data entry section. The advantages of using PPMRS are:

- It is an existing system used by LPH, so training on system would not be required (training would still be needed for reporting data)
- LPH can use same login and passwords for FHV component/
- Architecture is already in place, so time and money should be less than starting from scratch
- Pilot testing the system would not be needed
- Data collection would be done electronically, expediting the collection and reporting process
- Demonstrates coordination between MDH offices

PPMRS was developed by MDH Information Systems and Technology Management (ISTM) and Office of Public Health Practice (OPHP) staff. ISTM will develop and implement the FHV component of the PPMRS with the guidance of FHV staff (one staff person should be designated) and OPHP staff. The development and implementation of the system will depend on ISTM available and FHV ability to pay for the services.

The initial steps for developing this data collection system are:

- 1) Contact ISTM to determine availability
- 2) Conduct a business process analysis (ISTM & FHV)
- 2) Develop site prototype (ISTM & FHV)
- 3) Generate cost estimate and timeline (cost is currently estimated at less than \$100,000)

Note: These steps must be taken immediately so that there will be enough time to develop the site or determine an alternative data collection system.

### **Training Needs**

Because this data collection system is already being used by local public health staff, the training on how to use FHV data collection system should be minimal and coordinated with training that OPHP might conduct.

## **Limitations**

There are several limitations that need to be addressed before FHV data collection system is put into place including:

The regional method used to report their PPRMS data should be used for reporting their FHV data. Counties who do not normally report their FHV data together may need to take an extra step to aggregate.

FHV will be dependent on ISTM's schedule and availability to make updates and changes on system.

FHV data may get lost in large system.

## ***Next Steps***

The FHV Evaluation Plan is a proposed approach for a comprehensive evaluation of Family Home Visiting. The FHV Evaluation plan was developed with the support and guidance of the Steering Committee, the Evaluation Work Group, and a review of FHV literature and evaluation reports. Minnesota Home Visiting is a large and complex configuration of multiple approaches, models, outcomes, targeted groups and outcomes. The evaluation must reflect these differences to effectively convey the impact of FHV in Minnesota. There are several key next steps in implementing an evaluation plan for FHV. These steps must be immediate and straightforward to build on the momentum around evaluation and home visiting. To begin, the following next steps are being proposed:

- Steering Committee approves the continuation of the Evaluation Work Group
- Steering Committee reviews and provides feedback on the Evaluation Plan
- Evaluation Work Group reconvenes to review Evaluation Plan including the implementation roles
- Staff and Evaluation Work Group begin implementation tasks

Each of these activities is necessary for a smooth transition into an implementation phase of the FHV evaluation.