

Minnesota Family Home Visiting 2008 Community Health Board Plan Report

Introduction

The 2007 Legislature amended the Family Home Visiting (FHV) statute, M.S. §145A.17, and increased Temporary Assistance for Needy Families (TANF) funding to Community Health Boards (CHBs) and Tribal Governments to support the services provided under this statute. The amendment requires that CHBs and Tribal Governments submit a plan to the Commissioner of Health that addresses requirements outlined in the statute, including a description of a multidisciplinary approach to targeted home visiting for families. (See Appendix A.)

The Family Home Visiting Steering Committee provides the department of health with guidance to assure statewide implementation of the revised home visiting statute. The steering committee was integral to the development of the 2008 Community Health Board Plan Report (Plan). The members of the steering committee represent a broad range of state and local partners with an interest in home visiting and its outcomes. Participants include local public health directors, community health services 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 public health director and the Maternal and Child Health section manager of MDH co-facilitate the steering committee meetings.

A CHB made up of multiple local health public (LPH) departments could choose to submit one Plan combining the information for all of the LPH departments. Alternatively, it could choose to submit a separate Plan for each LPH department. If reporting as a multi-department CHB, information needed to be clearly identified as it related to each LPH department comprising the multi-department CHB. Plan information was received from 87 county/local health departments and four from city health departments. The Plan consists of narrative and statistical information. The information in this report is provided at the level of the LPH department.

For the purposes of the Plan, a FHV program was defined as any non-medical home visiting program for pregnant women and families with children that is administered and/or contracted by a LPH department in which a public health nursing (PHN) assessment is carried out during the initial home visit and the visits are provided by a trained home visitor to achieve the goals in the FHV statute. The goals of the FHV statute are: to foster healthy beginnings; to improve pregnancy outcomes; to promote school readiness; to prevent child abuse and neglect; to reduce juvenile delinquency; to promote positive parenting and resiliency in children; and to promote family health and economic self-sufficiency for children and families.

A LPH department may offer multiple FHV programs to the pregnant women and families that reside within its geographic area. It may have FHV programs that target different populations (e.g., pregnant teens, first time mothers), have different goals (e.g., prevention of child abuse and neglect, promotion of self-sufficiency), or are funded by different funding sources (e.g., TANF funds, grant funds). The Plan covered all of the FHV programs offered by a LPH department irrespective of funding source.

Two teleconference calls were held in January to provide guidance and technical assistance to LPH departments in completing and submitting the Plan. A Frequently Asked Questions fact sheet was posted on the MDH website to provide ongoing assistance.

Communities

LPH departments were asked to provide a description and highlight characteristics and needs of their communities, with particular attention to children and families with health risk factors and disparities.

FHV Clients

LPH departments were asked to describe the FHV clients served by their program. They were asked to address the following:

- The unique characteristics and needs of their FHV clientele, with particular attention to children and families with health risk factors and disparities
- The specific client needs that were addressed by their agency's FHV program(s)
- The process they went through to determine and prioritize the needs of their FHV clients

FHV Programs

LPH departments described each of the FHV programs that were administered or contracted by the LPH department highlighting the features that made it unique and different from other FHV programs. They were asked to describe:

- Population(s) served
- Initiation, intensity and duration of home visits
- Whether a targeted or universal approach was used
- Whether the FHV program was based on a national model, e.g., Nurse-Family Partnership or Healthy Families America
- Unique features
- Coordination to ensure non-duplication of services
- Promotion of continuity of services

Most of the Plans reported that two or three home visiting programs were implemented by the LPH departments.

The majority of the Plans described working with populations at risk for poor parenting outcomes. These populations included:

- Teen parents
- Low income, pregnant women
- Families involved with child protective services
- Families with children with developmental delays
- Parents at risk for child maltreatment
- Pregnant women with a history of chemical dependency
- Parents with mental health concerns

LPH departments identified the prenatal period or soon after a birth as the preferred time to engage and enroll clients. Most LPH departments reported offering a continuum of home visiting services to families. Plans described varied program intensity and duration. During the prenatal period, visits were reported to occur two to seven times with one or two visits after delivery depending on the family's need. Visits were reported by some LPH departments to occur weekly or more frequently after the birth of the child through age one or two depending on the LPH department's family home visiting protocol and/or family need.

All of the Plans submitted described having a targeted family home visiting program. Approximately 50 percent of the Plans described a program of providing universal contact. Universal contact was most described for populations receiving a postpartum or newborn visit. Universal contact occurred by visit, phone or mail contact. Some LPH departments discussed how their universal contact helped to identify those at risk for enrollment in their targeted FHV program.

Sixteen of the 91 LPH departments (18 percent) reported using the Nurse-Family Partnership (NFP) evidence-based model. Two LPH departments reported considering implementing NFP. Thirteen LPH departments (14 percent) reported using the Healthy Families America (HFA) model. One of the 13 LPH departments reporting using HFA is a credentialed HFA site. One LPH department reported considering becoming a HFA site. Sixty-two (68 percent) LPH departments did not report their FHV program was based on a national model.

LPH departments reported that as a result of the increased TANF funding they were able to enhance their programs by:

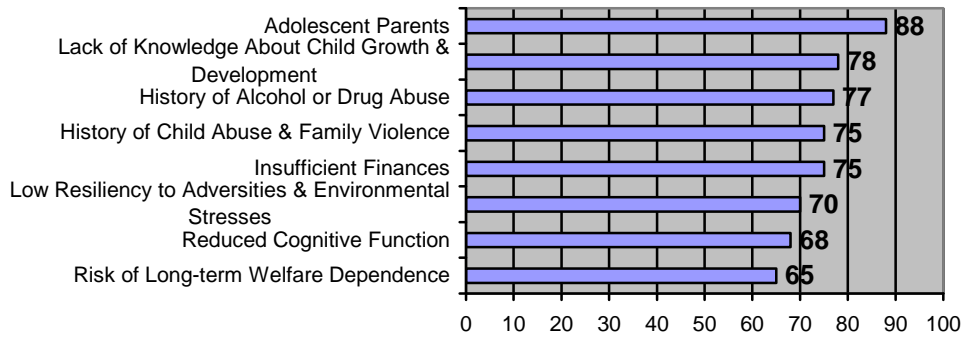
- Enrolling more families
- Providing services for a longer period of time
- Increasing the number of staff, including adding bi-lingual staff or CHWs
- Expanding opportunities for staff development

- Increasing capacity to outreach to and build relationships with community partners
- Updating website or outreach materials
- Purchasing evidence-based curricula or screening tools

High Risk Clients

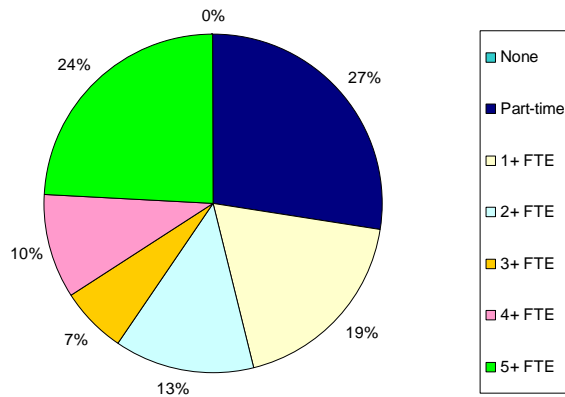
The FHV statute requires that families at or below 200 percent of federal poverty guidelines (TANF requirement) and families with specific risk factors be targeted. LPH departments reported on all of the risk factors that they were targeting in their communities. The following table describes the high risk clients targeted most frequently by the 91 LPH departments completing the Plan.

High Risk Clients Targeted



FHV Staff

The FHV statute requires FHV programs to carry out an assessment by a public health nurse in the initial visit and offer FHV visits by a trained home visitor. Twenty-seven percent of the LPH departments reporting in the Plan have less than one fulltime equivalent of PHN staff assigned to the family home visiting programs. Twenty-four percent of the LPH departments reported having five or more FTEs of PHN staff for home visiting. Some agencies identified they had difficulty hiring PHNs. This occurred primarily in greater Minnesota. The following chart (N=91) describes the PHN FTEs in the family home visiting programs.



Forty-nine percent of the LPH departments reported using RNs in their home visiting program. Other staffing categories utilized by LPH departments in their home visiting programs included social workers (8 percent), community health workers (19 percent) and parent educators (12 percent).

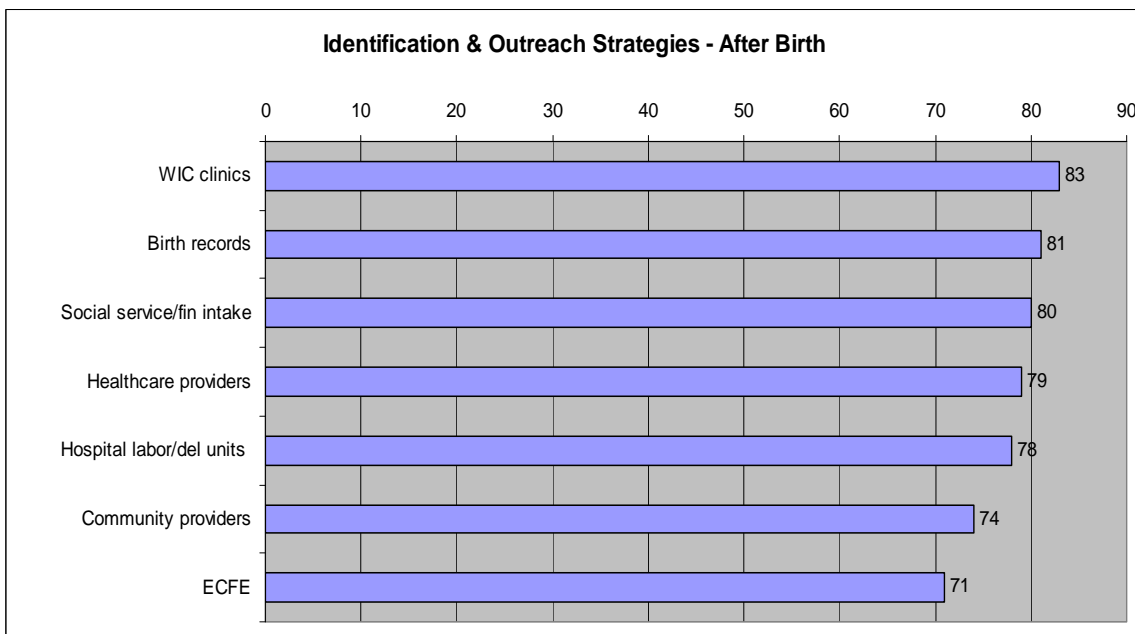
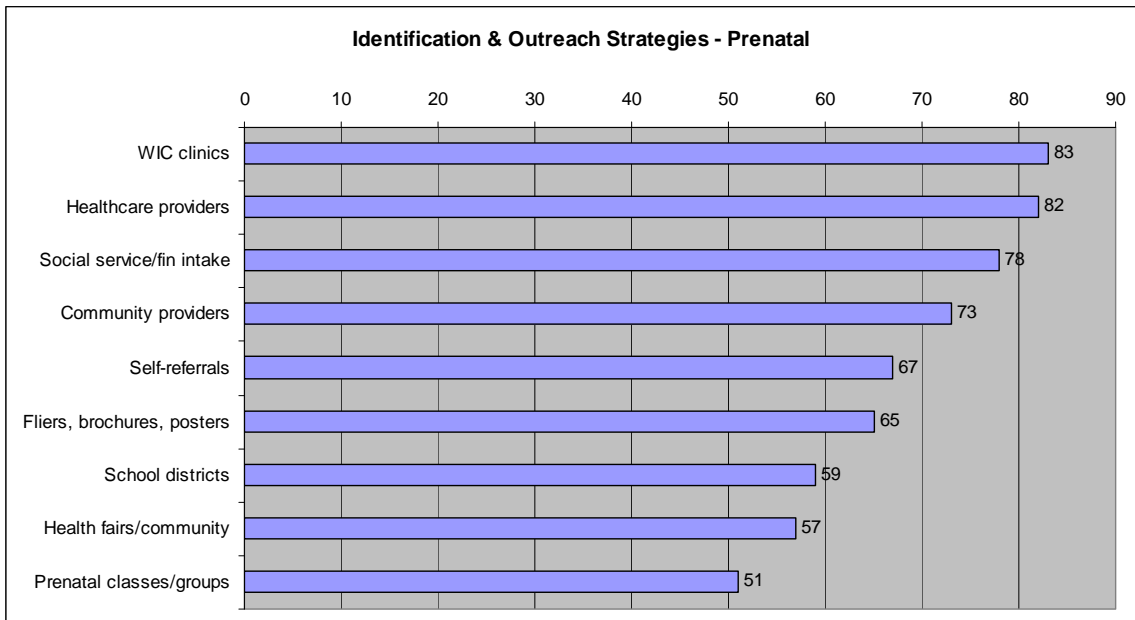
Diversity

LPH departments indicated in their Plans that they are seeing an increasing diversity of clients in their FHV programs reflecting changes in their communities. Some agencies indicated that they experience a greater diversity among the clients they were serving compared to those diverse populations in their community. FHV programs must, by statute, recruit home visitors who will represent, to the extent possible, the races, cultures and languages spoken by the families that may be served.

LPH departments reported attempting to hire staff reflective of the diversity in the client population or to hire multi-lingual staff. This is reported to be difficult to accomplish in some areas of the state. LPH departments reported staff attending trainings in cultural competency and utilization of materials available in multiple languages in their FHV programs.

Identification and Outreach

The Plans, according to the FHV statute, must include the descriptions of outreach strategies that will be used by LPH departments to reach families prenatally or at birth. The following two graphs (N=91) indicate the most common strategies used by LPH departments to identify and outreach to prenatal clients and clients after delivery of a child.



Screening and Assessment Tools

The FHV statute requires that the LPH departments describe strategies that will be used to ensure that children and families at greatest risk receive appropriate services. Screening or assessment tools are a strategy used by LPH departments to identify children and families that would benefit from additional referrals or resources. LPH

departments were asked in the Plan to describe tools that were used. The following table (N=91) describes the areas LPH departments reported on and the number of agencies using a standardized screening or assessment tool or one developed by their department:

Area for Screening and/or Assessment	Number of Tools	LPH Departments Using Tool	Percent of LPH Departments Screening
Infant-child growth and development	7	86	94.5
Infant-child social and emotional health	4	82	90.1
Home safety	1	79	86.8
Maternal depression	5	78	85.7
Parent-child interaction	1	61	79.1
Risk factors for abuse and neglect	5	44	67.0
Domestic violence	3	42	48.4
Substance use/abuse	4	40	44.0

Curricula Used and Training Needs

LPH departments reported using 15 different curricula in their family home visiting programs. The following table (N=91) identifies the number of agencies using the identified curriculum.

Curriculum	LPH Departments Using Curriculum	Percent of LPH Departments 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

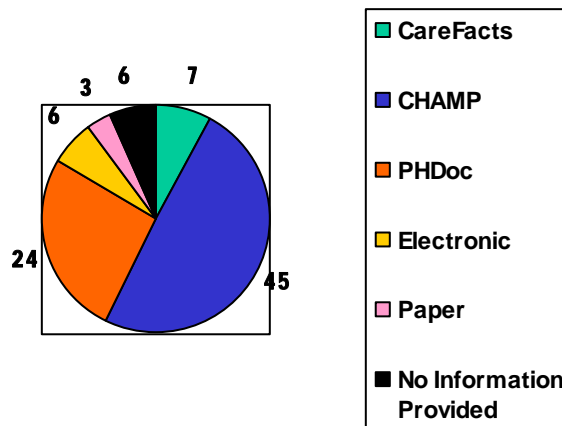
The Training and Education Work Group was interested in learning more about the training needs of family home visiting supervisors and home visitors. The information obtained from the Plans submitted by LPH departments informed the training work group and was incorporated into the Training and Education Work Plan. (See Appendix B, Training Plan.)

The following are the training areas identified by LPH departments for family home visitors and family home visiting supervisors. It is interesting to note that “Professional Boundaries and Prevention of Burnout” ranked high for both supervisors and family home visitors.

<u>Supervisors</u>	<u>Home Visitors</u>
Reflective Supervision (52)	Working with Families with Mental Health Issues (55)
Professional Boundaries and Prevention of Burnout (43)	Working with Families with Multiple Risk Factors (54)
Guided Case Conferencing (39)	Professional Boundaries and Prevention of Burnout (39)
Working with Families with Multiple Risk Factors (37)	Parent-Infant Attachment (37)
Working with Families with Mental Health Issues (33)	Parent-Child Interaction (37)
Personal Physical/Psychological Safety (23)	Infant Mental Health (35)
Infant Mental Health (17)	Maternal Mental Health (26)
Parent-Infant Attachment (16)	Personal Physical/Psychological Safety (23)
Maternal Mental Health (14)	Reflective Supervision (11)
Parent-Child Interaction (13)	Guided Case Conferencing (9)

Documentation System

The following graph (N=91) provides information on the type of documentation system that LPH departments are using.



Of the 91 LPH departments reporting, 40 of them reported utilizing the Omaha System for home visit charting. The Omaha System is a research-based, comprehensive practice and documentation system. The Omaha system includes an assessment component, an intervention component and an outcomes component.

Program Evaluation

LPH departments were asked in the Plan to submit short-term and long-term outcomes that they were using for evaluation of their local FHV program. Seventy-nine (87

percent) of the LPH departments submitted 415 outcomes and indicators that they were using for evaluation. The following table (N=91) describes the number of outcomes by goal area.

Goal	Number
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

The following table (N=91) identifies the number of outcomes by category regardless of goal area.

Category	Number	Category	Number
LBW/Preterm	49	Safe environment	13
Parental skills	35	Smoking	12
Checkups/screening	33	Medical home	12
Abuse	27	Home safety	11
Immunization	21	FAP	10
Prenatal care	21	Education	8
Work/school	20	Breast feeding	7
Mental health	17	Early education	7
Resources	15	Services	7
Teen births	13	Reading	6

The outcome and indicator information provided by LPH departments in the Plan informed the Evaluation Work Group. (See Appendix C, Evaluation Work Plan.)

Funding Sources

LPH departments use various funding sources to support their family home visiting programs. LPH departments identified all funding streams used for family home visiting. The following table (N=91) describes the funding streams and the number of LPH departments using that funding source.

Funding Source	Number of LPH Departments Using Funding Source	Percent of LPH Departments Using Funding Source
Temporary Assistance to Needy Families (TANF)	85	93.4
Title V/Maternal Child Health Block Grant (MCHB)	82	90.1
3 rd Party Reimbursement	66	72.5
State General Funds	65	71.4
County Levy	65	71.4
Grants	35	38.5
Other	36	39.6

The “other” category included:

- Foundation grants
- Non-profit or service organization grants
- Health plan grants
- Other funding from Minnesota agencies/departments (i.e. DHS, WIC)
- Schools: IEIC, LCTS, Part C, Part H
- Children’s and Mental Health Collaboratives
- Minnesota Organization for Fetal Alcohol Syndrome (MOFAS)
- March of Dimes
- Corporate grants
- City levy funding
- Community Development Block Grant

Program Partners

The FHV statute requires that FHV programs collaborate with multidisciplinary partners including other local public health departments, ECFE, Head Start, community health workers, social workers, community home visiting programs, school districts, and other relevant partners. FHV programs must 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.

In the Plan, LPH departments were asked to identify the level of their relationship with specific community partners. The categories and definitions for the levels of relationship were:

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.

The following table provides information shared by LPH departments in their Plans regarding the relationships they have with community partners.

Community Partner	Relationship (N=91)						
	None	Developing	Net-working	Coordina-tion	Coopera-tion	Collabor-ation	Multi-Sector Collaboration
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

Summary and Next Steps

The synthesis of the information provided by the LPH departments was presented to the Steering Committee and the family home visiting work groups. Presentations of the information have also been provided to other community partners, including Ready4K, the Local Public Health Association and the MCH Advisory Task Force.

The Steering Committee is currently working on determining whether the information provided by the LPH departments in the Plan fulfills the needs identified in the statute and by the Steering Committee. It is anticipated that there will be some modifications to the Plan in the future. The Steering Committee will also determine the frequency of submission of the Plan.

The Training and Education Work Group and the Evaluation Work Group used the information provided by the LPH departments in the Plan to inform their work. The work plans of those work groups reflect the information gathered as well as input from work group members and other key stakeholders.

Information regarding the activities of the Family Home Visiting Steering Committee, Training and Education Work Group and Evaluation Work Group, including the work plans is available at <http://www.health.state.mn.us/divs/fh/mch/fhv/advisory/index.html>. You may contact a family home visiting program consultant by calling the MCH Section at 651.201.3760.