DEPARTMENT OF HEALTH

MIECHV Needs Assessment 2020 Summary: Identifying Communities Most in Need & Assessing Early Childhood Services

Background

What is Family Home Visiting?

Family Home Visiting (FHV) is a **proven approach** in empowering pregnant women and families with young children by providing social, emotional, health-related, and parenting supports. FHV services have consistently demonstrated improvements in outcomes for caregivers and children in families experiencing the greatest burden of health, economic, and racial inequities.

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program in Minnesota

A significant funder of family home visiting in Minnesota is the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. The Minnesota Department of Health (MDH) is the state MIECHV awardee for Minnesota. MDH uses MIECHV funding to provide family home visiting grants to local implementing agencies to serve at-risk communities identified through a statewide needs assessment. Local implementing agencies select and implement evidence-based home visiting models that match the unique needs of their communities.

MIECHV Needs Assessment

The Family Home Visiting program at the Minnesota Department of Health (MDH-FHV) conducted the original MIECHV Needs Assessment at the beginning of the MIECHV program in 2010. MDH-FHV conducted an updated MIECHV Needs Assessment in 2020 to better understand the current state of home visiting in Minnesota and to identify communities who may most benefit from these early childhood and family support services.

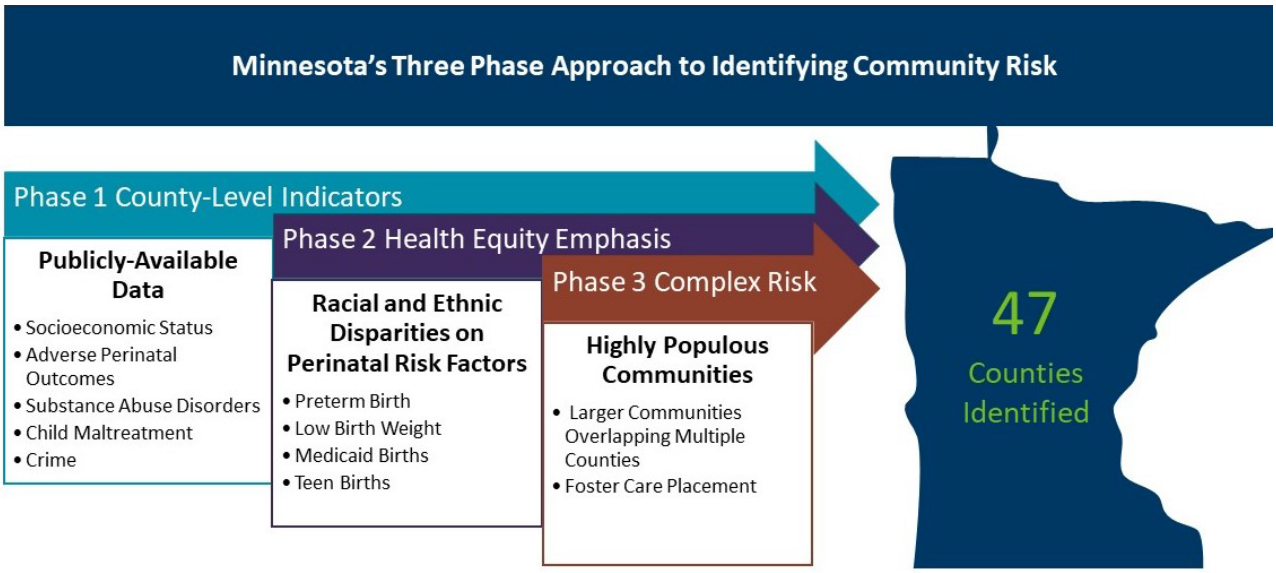
This summary provides an overview and general description of findings from the 2020 MIECHV Needs Assessment. Major activities in this needs assessment include: a) identification and description of Minnesota communities most in need, b) assessments of the quality and capacity of existing home visiting programs, c) evaluation of the state's capacity for providing substance use disorder treatment and counseling services, and d) an overview of the coordination activities with other early childhood agencies and needs assessments.

Identifying Communities Most in Need

A major activity of the MIECHV Needs Assessment was to identify Minnesota communities of individuals with the greatest risk factors for health and well-being. **Every community in Minnesota has families with young children who would undoubtedly benefit from family home visiting**; MDH was tasked with identifying those communities with the **highest concentrations of risk**. MDH-FHV implemented a three-

phase approach, starting with defined risk indicators aligned with MIECHV statute, to identify and target communities in Minnesota.

Process



A three phrase approach was used to comprehensively evaluate and determine communities in Minnesota most at risk:

Phase 1: Communities (defined as counties) were quantitatively assessed using publicly-available indicators (e.g., state agency and U.S. Census data). Data from five domains that align with statutorily-defined risk factors were provided to MDH: low socioeconomic status, adverse perinatal outcomes, substance abuse disorders, crime, and child maltreatment. Each domain consisted of one or more indicators, see the 2020 MIECHV Needs Assessment Narrative for a full description. Counties that met or exceeded the risk threshold in at least two of the five domains were considered a county "at-risk".
Results: 17 counties across Minnesota were identified.

Minnesota MIECHV Domains and Indicators

MIECHV Domain	Indicator
Socioeconomic Status	• High School Dropout • Income Inequality • Unemployment • Poverty • Childhood Poverty • Medicaid Births
Adverse Perinatal Outcomes	• Preterm Birth • Low Birth Weight

MIECHV Domain	Indicator
Substance Abuse Disorder	• Alcohol • Marijuana • Opioids • Methamphetamines
Child Maltreatment	• Determined Maltreatment
Crime	• Total Crimes • Juvenile Arrests

Phase 2: Health Equity Emphasis. Some of Minnesota's largest health disparities are seen in perinatal health outcomes in individuals from different races and ethnicities. Further, county level rates often mask significant health disparities among groups of people that live in the same county. For these reasons, county rates of preterm birth, low birth weight, Medicaid-funded births, and births to teen parents were examined by race and ethnicity. Counties with the largest differences in rates among racial or ethnic groups were considered at-risk in Phase 2.

Results: Twenty-two additional counties across Minnesota were combined with Phase 1 of the Needs Assessment.

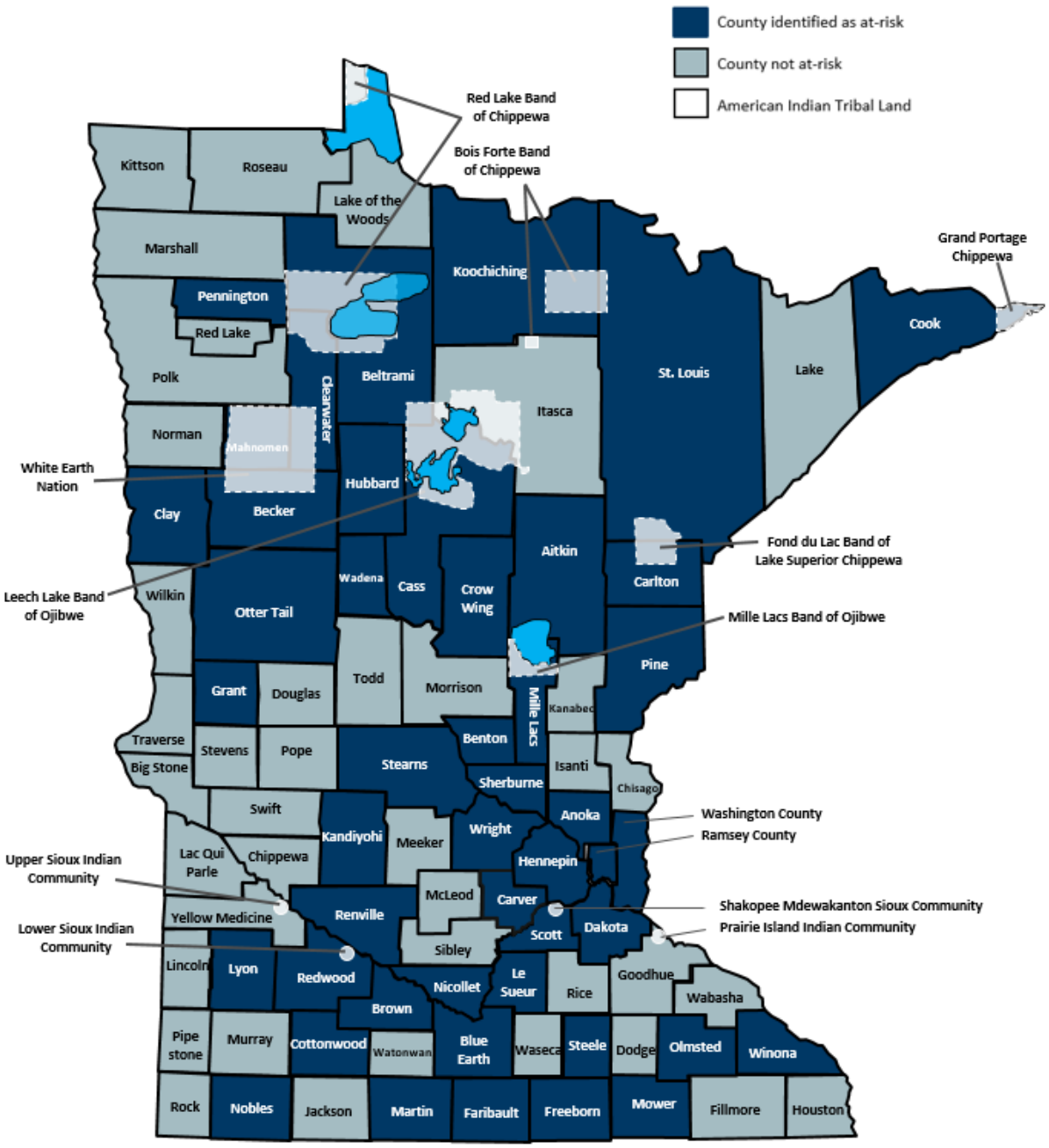
Phase 3: Complex Risk. Because some metropolitan areas in Minnesota overlap multiple counties, higher risk indicators for metropolitan areas may be masked when only using county-level data. Phase 3 used city-level poverty data to identify counties with metropolitan areas at greater risk. Counties with highly populous metropolitan communities also often include communities who regularly experience historical and present trauma. Foster care placement rates also contribute to risk associated with young children.

Results: An additional six counties were added to account for two larger cities with higher levels of poverty. Two more counties were added after including foster care placement rates.

This multiple phased approach allowed MDH-FHV to identify Minnesota counties with concentrations of families experiencing risks, for the purpose of targeting MIECHV funds for home visiting. The second and third phases highlighted and identified the racial and ethnic disparities experienced by communities of color across our state.

Improving the wellbeing of families with young children in our state must explicitly address racial and ethnic health disparities.

Minnesota Counties Identified as At-Risk Communities in MIECHV Needs Assessment, 2020



Quality & Capacity of Home Visiting in Minnesota

A second task of the MIECHV Needs Assessment was to describe the availability and subsequent quality of existing home visiting services. This section includes information on financial commitments, outstanding needs and gaps in family home service delivery, current family home visiting participant demographic characteristics, and finally, home visitor workforce and development.

Investments in Family Home Visiting

There has been a significant financial commitment to family home visiting in Minnesota in recent years. From 2014-2020, there has been an eight million dollar increase in evidence-based home visiting funded by the state legislature. This funding, combined with nearly $9 million dollars dedicated to TANF funding and stable MIECHV funding, has supported home visiting **in all 87 counties and 11 tribes across Minnesota**.

Further, Minnesota is uniquely positioned to promote sustainability: Many home visiting providers are able to bill for Medical Assistance reimbursement for home visiting services, which helps state and federal grant funds go farther and support more families.

Despite sizable investments, the need for family home visiting services continually and greatly outpaces its current availability.

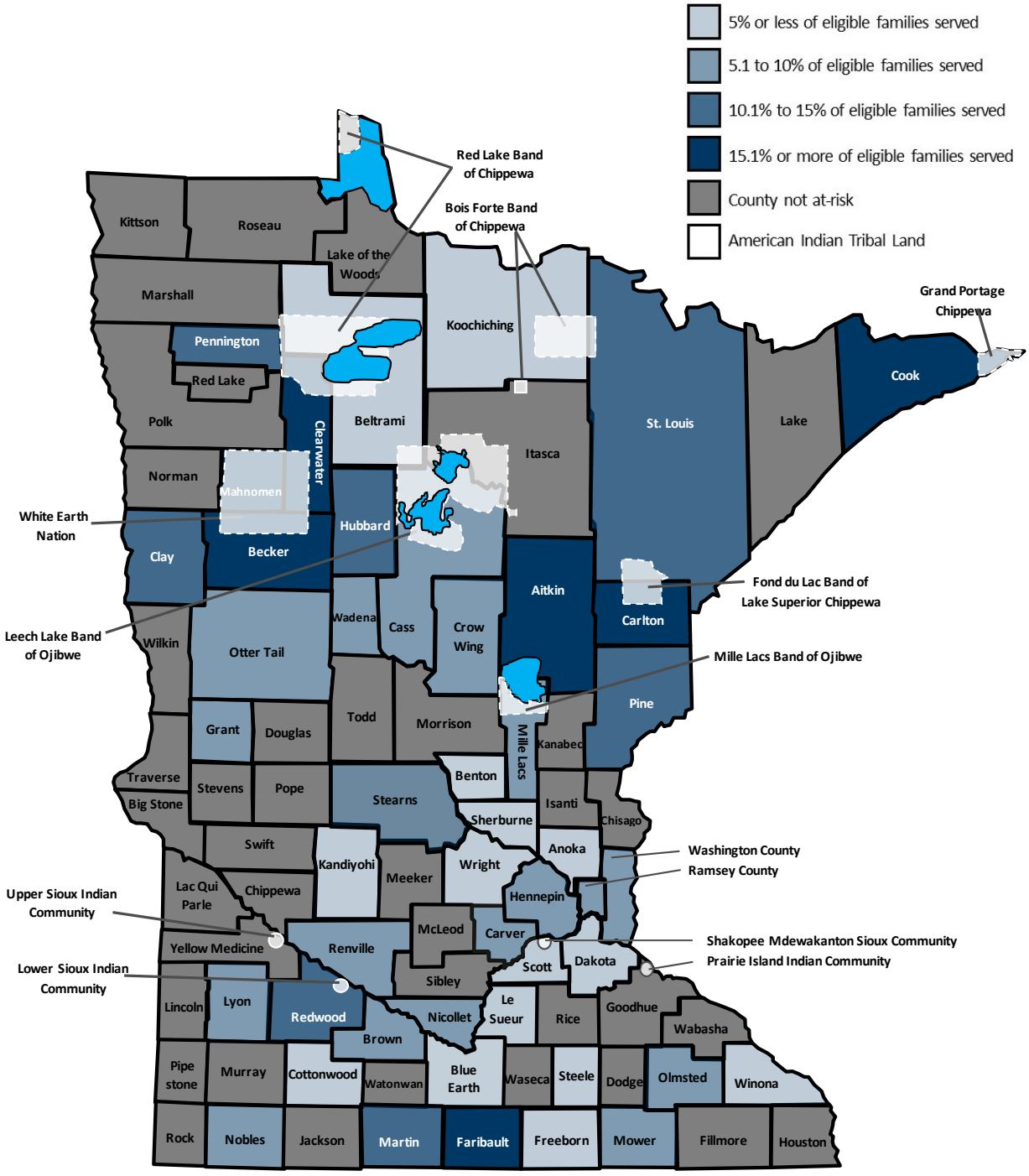
Need for Family Home Visiting & Gaps in Service Delivery

Families At Risk in Minnesota

For each county, the number of families in need of family home visiting was calculated by counting the number of families living below 185% of the Federal Poverty Level (FPL) who also had children under the age of five using U.S. Census data. Using these data, there are an estimated 76,000 Minnesota families in need of family home visiting services. Of those, nearly 65,000 (85%) families reside within counties identified as at risk by the MIECHV Needs Assessment.

Only one in 10 families in need of family home visiting actually received these services, despite significant investments where local agencies operate with full or nearly full caseloads.

Proportion of Eligible Families Served in At-Risk Counties in Minnesota, 2019



Gaps & Opportunities

While gaps in services for home visiting remain, MDH-FHV continually uses state investments to strategically address unequal access to quality home visiting services. Unfortunately, these gaps disproportionally impact families who already **face persistent inequities,** including those living in rural

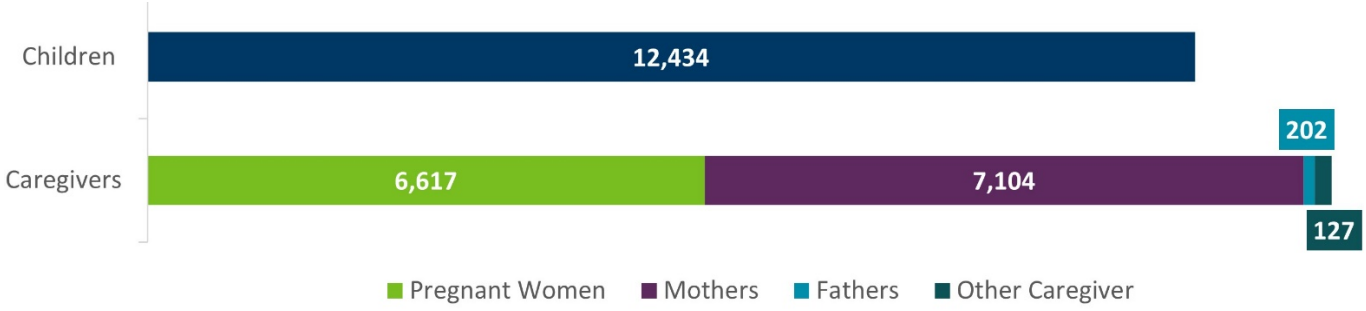
areas; families who speak a language other than English; recently arrived immigrants or refugees; Black, Indigenous and People of Color (BIPOC) families; and communities who have historically not have had access to public services. Below are strategies used by MDH and FHV grantees to support the effective implementation of home visiting services to meet the unique needs of families across Minnesota:

- **Additional funding opportunities prioritize communities** where home visiting services, particularly evidence-based home visiting has had a limited reach to specific populations. These areas include rural and frontier counties, tribal nations, and community and culturally specific non-profits. Effective implementation in new programs requires time and robust technical assistance and support to develop sustainable infrastructure, to recruit and retain staff, engage and serve families, and to connect, refer, and partner with other critical community services.
- Minnesota's Home Visiting workforce is predominately White yet home visiting programs in Minnesota serve diverse populations, including American Indians, Black or African Americans, Asian Americans, and Hispanic or Latinx people. Minnesota is also home to a large community of first- and second-generation immigrants, many of whom are refugees. MDH recognizes the importance of funding grantees **that hire culturally-competent staff and make adaptations to existing models to better serve diverse communities.** Minnesota is the home of 11 federally-recognized American Indian nations representing unique communities with distinct cultural traditions. Many of these **communities have developed partnerships** with various community and social service programs to better support American Indian families. Several American Indian communities implement Family Spirit, an evidence-based home visiting program developed by and for American Indians. A Family Spirit Community of Practice has garnered widespread support and participation from communities throughout the state.

Minnesota Families Served by Family Home Visiting

In 2019, 14,071 primary caregivers received FHV services, of which 7,104 were postpartum mothers, 127 were fathers, 6,617 were pregnant persons, and 204 were other caregivers. A total of 12,434 children were enrolled during this same time. A little less than half of both caregivers and children were Black or African American, American Indian, or people of color. Nearly a third of caregivers speak a language other than English as their primary language. Nearly a quarter of caregivers did not have a high school or general equivalency diploma at the time of enrollment.

Demographic Characteristics of Family Home Visiting Participants, 2019



Workforce and Development

Home Visitors in Minnesota

The majority of MDH-funded home visitors in Minnesota identify as female (93%) and White (77%). Home visitors have an average of nine years of experience, with a range of zero to 41 years. Almost half of home visitors are 40 years old or older, and three quarters have earned at least a bachelor's degree. Almost 7 in 10 home visitors have a nursing license and over 80% of home visitors are trained in an evidence-based model.

Based on a review of MDH grantee budgets, home visitor compensation depends primarily on location, credentials, and length of experience or tenure with the organization. Compensation is generally lower in rural areas; credentialed nurses tend to earn more than home visitors without credentials.

Professional Development & Continuous Quality Improvement

Providing adequate support and development for both home visitors and supervisors is instrumental to promoting effective organizations and delivering high quality programming to families.

Professional Development

All evidence-based FHV models implemented in Minnesota require model-specific training for both home visitors and supervisors. MDH FHV provides training on a variety of topics via in-person workshops, online webinars, or hybrid instruction. Grantees have indicated the following topics as top training priorities (in descending order):

- Trauma-informed care
- Infant mental health/attachment
- Working with families in poverty, and
- Adverse Childhood Experiences (ACEs) & resilience.

Continuous Quality Improvement Learning Collaborative

MDH FHV has facilitated three Continuous Quality Improvement (CQI) learning collaboratives in recent years: 1) family engagement, enrollment, and retention; 2) caregiver depression screening & child development screening; and 3) breastfeeding. Training, coaching, technical assistance, and learning sessions support local programs while they test strategies, collect data, learn from peers, and evaluate effectiveness. A cohort of Minnesota grantees recently participated in a nationwide Intimate Partner Violence (IPV) CQI initiative.

Capacity for Providing Substance Use Treatment

Substance Abuse Disorder in Minnesota

While the state has made significant improvements to the system of substance use disorder (SUD) treatment in recent years, most people who need substance abuse treatment do not receive it, including pregnant women and parents of young children.

Worse, substance abuse has **disproportionately affected some Minnesotans**: American Indians are five times as likely and Black or African Americans are twice as likely to die from a drug overdose than their White counterparts.[1]

State Substance Abuse Disorder Support Mechanisms

The Minnesota Department of Human Services (DHS) provides a number of strategies to prevent and address the impact of drug and alcohol abuse by providing services in: (a) prevention; (b) early intervention; (c) detoxification; (d) treatment; (e) continuing care; and (f) recovery support. Services are provided by individual and population-based programs that are delivered across many settings with a focus on culturally specific activities for groups, such as those defined by gender, race, age, and sexual orientation.

SUD Treatment for Pregnant Women and Families with Young Children

The Women's Recovery Services (WRS) program (as part of DHS) partners with 11 treatment providers to provide comprehensive, women-specific and family-centered services focused on helping pregnant and parenting women who have SUDs and are in treatment to remain alcohol and drug free.

Gaps & Barriers in Treatment of Pregnant Women and Families with Young Children

Despite critical investments to treatment programs that provide gender-responsive care for pregnant and parenting women, **demand for these types of services continues to surpass available services**, particularly in Greater Minnesota. In fact, many counties identified as at-risk in the substance use domain that do not have gender-responsive treatment programs for pregnant and parenting women.

FHV is uniquely positioned to partner with SUD treatment providers and parents struggling with SUD to promote family wellbeing. Streamlined service coordination for services that support pregnant women and families with young children provides both tailored treatment and wraparound supports and resources to the family.

Coordination with Other Needs Assessments

In conducting the MIECHV needs assessment, the Family Home Visiting team coordinated with other recent needs assessments in our state, including Title V, Head Start, and the Preschool Development Grant (PDG) to identify common barriers across the system of programs and opportunity for service coordination serving families with young children.

Title V & MIECHV Coordination

The Title V and MIECHV needs assessments created opportunity for collaboration and information sharing. FHV staff participated on several teams convened to develop strategies to address Title V priorities, providing input on ways that home visiting programs currently reach families, services provided, and potential opportunities for growth of home visiting programs. Findings from the Title V needs assessment were used to inform both the selection of at-risk indicators as well as to provide qualitative data for the MIECHV needs assessment narrative.

Head Start Findings

MDH was able to glean important information from the regional Head Start needs assessments that are conducted every five years. Surveys of parents involved in Early Head Start (EHS) highlight the **importance of including parents in early childhood education programs**. Parents expressed the need for education and employment support, often sharing that their greatest need and challenge was **affordable housing**. Findings from available EHS community needs assessments reflected the benefit and need for early childhood development programs in many of the at-risk service areas, as identified by the MIECHV needs assessment.

Preschool Development Birth Through Five Grant (PDG)

Findings from the PDG needs assessment indicate the most pressing issue for early childhood programs is **lack of a centralized process** for accessing programs and resources, including Family Home Visiting (FHV). To address this gap, community-based grants will be used to develop Implementation Hubs (Hubs) across Minnesota. Hubs will support pregnant and parenting families with young children up to age eight by:

- Developing brick and mortar, mobile, and virtual access points for families coupled with relationship-based, culturally appropriate navigation of programs and systems.
- Increasing access to systems through pilot testing the state's Help Me Connect (based on the national Help me Grow model) system.
- Growing individualized community engagement and support community-developed solutions.

Final Thoughts

Commitment to Health Equity

This needs assessment was purposefully conducted with a health equity lens, with the goal of identifying and addressing disparities as they exist in the FHV landscape within Minnesota.

Continued funding to organizations serving communities of color will provide opportunities for innovative implementation of evidence-based home visiting programs and improve access to culturally-appropriate FHV services.

Recruiting, training, and retaining home visitors who are Black or African American, American Indian, or people of color, and continuing to invest in culturally-informed home visiting models is critical to this endeavor.

Meeting the Needs of Minnesota's Most Vulnerable

Family Home Visiting is an effective and demonstrated lever in supporting Minnesota families by providing appropriate community resources and skills that promote family and child wellbeing. Even with significant investments in FHV, MDH-funded programs are still serving only a fraction of the families who could benefit from them. Most at-risk counties are serving less than 20% of eligible families, despite many programs having nearly full caseloads.

With the COVID-19 pandemic and the resulting economic impact on families, particularly for BIPOC communities who have been disproportionately impacted, there is a **current and critical opportunity** to better fund and subsequently scale family home visiting services.

[1] Minnesota Department of Health. (2020, January). *Drug and Alcohol Abuse in Minnesota: A Biennial Report to the Legislature*. Retrieved from: https://www.leg.state.mn.us/docs/2020/mandated/200125.pdf