DEPARTMENT OF HEALTH

Pregnancy Assistance Fund Implementation Evaluation Report

MINNESOTA EXPECTANT AND STUDENT PARENTING PROGRAM

July 1, 2017 – June 30, 2018

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Implementation Evaluation Summary

Minnesota Expectant and Parenting Student Program-MEPSP

Grantee: Minnesota Department of Health

Program Name: Minnesota Expectant and Parenting Student Program

Program Description:

The Minnesota Expectant and Parenting Student Program (MEPSP) provided coordinated, case management and referrals to health, education and social services for females and males, ages 10-24, who were expectant and parenting, as well as to their children. The primary focus was to improve health outcomes and education attainment for at-risk populations such as youth in the foster care or corrections systems, people with disabilities or who are homeless or immigrants, and members of the LGBTQ community. Social workers, public health nurses and/or community health representatives recruited program participants, assessed their health, educational and social needs, made referrals to services, and used motivational interviewing techniques to address any unmet needs. Services were provided in high schools, institutions of higher education (IHE) and community service centers (*e.g.*, non-profits).

Settings: (Also referred to as grantee organizations or grantees)

1. Minneapolis Health Department (serving Hennepin County) in collaboration with Hennepin Healthcare, MVNA
2. Kandiyohi County
3. Northwest Indian Community Development Center, located in Bemidji and primarily serving Beltrami and Cass counties, the White Earth Nation, Leech Lake Band of Ojibwe (MN Chippewa Tribe) and the Red Lake Nation.

Implementation Evaluation Questions:

Primary Evaluation Question: How well was the MEPSP implemented?

Secondary Evaluation Questions:

Were the intended target populations reached?

How satisfied were the participants with the MEPSP intervention or services?

Did the Pregnancy Assistance Fund (PAF) grantees create new multi-sectoral partnerships in Minnesota?

To what extent did the professional development trainings in adolescent mental health and adolescent brain development increase grantees' knowledge?

Evaluation Design and Data Collection:

MDH designed the implementation evaluation questions and indicators in March 2017. The design was re-assessed in July 2017. The implementation evaluation is a single group, non-experimental, pre and post-evaluation design. Qualitative and quantitative data were collected and analyzed.

Implementation Evaluation Highlights:

1. **The intended MEPSP target population was served.**

   The program served 430 adult participants: fifteen percent were White, 76% were Non-White, and 9% were not reported. Eighty-six percent of program participants were parenting, 5% were expectant and parenting, 8% were expecting their first child, and 1% were non-reported. In addition, four hundred and forty seven (447) children were served.

2. **Program participants were very satisfied with MEPSP services.**

   Of the 172 program participants who completed a self-report survey, 68% indicated they were "very satisfied" with the MEPSP they received.

3. **The number of MEPSP multi-sectoral partnerships increased amongst the grantees.**

   According to the three grantee organizations, the total number of informal and formal partnerships increased from 61 to 70 by June 30, 2018.

4. **Grantees' staff indicated their knowledge of adolescent brain development and adolescent mental health increased.**

   The site capacity assessment, administered in a pre and post-format, given to the grantee organizations' staff indicated that they were "quite confident" or "extremely confident" about their knowledge of adolescent brain development and mental health.

I. Introduction

Report Focus

This report focuses on program implementation for the period July 1, 2017 through June 30, 2018.

Intended Target Population and Assessment Process

In order to identify and respond to the needs of expectant and parenting teens and young adults, ages 10 to 24, males and females, MDH conducted a thorough needs assessment in January 2017. MDH analyzed birth certificate data, teen pregnancy focus group results, and the results of a 2016 *Listening Session* with health care providers. Phone meetings with public health, secondary education and higher education experts also occurred. Staff reviewed several public health journal articles and reports. These assessments revealed health, social, and educational needs for pregnant and parenting people, and their children, in three communities.

Description of Need

While Minnesota's measures of health, education, social and economic indicators of well-being are among the best in the nation, the three MEPSP communities have disproportionate inequities for these indicators for expectant and parenting teen and young adult students. For example, disparities in pregnancy, birth and Sexually Transmitted Infections (STI) persist among Minnesota youth. For example, in 2015, the rate of births per 1,000 females for teens 15-17 years of age by race and ethnicity were African American/Black 14, American Indian 20.3, Asian/Pacific Islander 7.3, Hispanic 16.3, and White 3.2. Of the top ten counties in Minnesota for teen birth rates in 2013-2015, Kandiyohi County was number five with a rate of 32, and four of counties which include Tribal reservations were in the top ten (Mahnomen 56.6, Cass 36.4, Beltrami 29.8 and Pennington 29). Teen and young adult mothers had lower education levels, and disparities by race, ethnicity and geographic region.

Even though graduation rates have improved over the years, more emphasis is needed to increase timely graduation rates for American Indians, African American, and Hispanic students. In 2015, on-time high school graduation rates for American Indians students was 51.9%, and for African American students it was 62% compared to 82% for all MN students. In MN, 2011 to 2015 data showed that approximately 18% of birth mothers between 18-24 had less than high school education. These inequities, along with other indicators of Adverse Childhood Experiences, indicated a need for targeted investments in the social determinants of health impacting populations of color and American Indians (i.e., poverty, racism, education, access to health care, etc.)

Local Areas

MDH identified these three partner communities based on the needs assessment analyses and their organizations' readiness and capacity to achieve the MEPSP goal and objectives. MDH prioritized forming partnerships with organizations and agencies that had the capacity to meet the complex and comprehensive needs of the target population. In order to address issues related to health inequities, MDH also carefully considered collaborating with under-resourced rural communities. These pilot communities serve American Indians, Black/African-American, and Hispanic/Latino teens and young adults.

II. Program Description

The MEPSP services were an appropriate fit for the intended target population because they were designed to connect at-risk individuals to health, social and educational services and resources to improve health and education outcomes. The Community HUB Model (https://www.pchubi.com) was studied while developing the Minnesota Expectant and Parenting Student Program (MEPSP). A social worker, care coordinator, community health worker and/or nurse, met with the program participant in trusted locations (e.g., high schools, community service centers, etc.) to discuss barriers to education completion and optimal health. These barriers may include lack of transportation, access to quality prenatal care or health insurance, or basic living needs such as safe housing or food. Table 1 lists the sites where MEPSP services were provided.

Table 1: MEPSP Settings and Sites

Setting	Sites
City of Minneapolis, including serving Hennepin County	High Schools/alternative high schools and one Institution of Higher Education
Kandiyohi County	High Schools/alternative high schools and Community Service Centers
Northwest Indian Community Development Center Located in Bemidji and primarily serving Beltrami and Cass counties, the White Earth Nation, Leech Lake Band of Ojibwe (MN Chippewa Tribe) and the Red Lake Nation.	Community Service Centers

The following two programmatic objectives were designated to measure participants' outcomes:

- MEPSP grantees will achieve a 5% increase of participating expectant and parenting teens and young adults, enrolled in the MEPSP, who successfully complete at least one semester of high school /GED, their higher education goals or vocational preparation goals.
- Seventy-five percent of participating expectant and parenting teens and young adults, enrolled in the MEPSP, will successfully complete at least two health-related services.

The following table lists some of the program's main components. A more detailed description of the MEPSP's services is available in Appendix A.

Table 2: Program Components: Only Describes Direct Services

Program Component	Format of Service	Dosage	Content Delivered
Program intake	Confidential communication between staff and program participant, in-person.	Once	Reviewed and answered questions about program participants' eligibility for services: number of children, housing status, educational level, etc. If qualify for services, staff discussed program participants' health, education and/or social needs.
Referrals	Confidential communication between staff and program participant, in-person.	On-going	Using the "warm referral" approach, staff identified providers who can assist program participants with their health, education or social needs at community agencies, clinics or within the agency. Staff provided phone numbers, contact names and other important details to program participants.
Case Management	Staff maintain relationship with program participants via email, phone, and/or in-person.	On-going	They discussed existing or newly identified health, social or education barriers. Staff also used motivational interviewing techniques to motivate program participants to stay enrolled in high school or college.
Community Supports (To address social determinants of health)	Staff receive requests from program participants via email, phone and/or in-person.	Available only upon request. Maximum dosage of once per academic semester.	Limited, financial assistance was provided to some families for emergencies and basic needs such as homelessness, short-term child care and food insecurity.

III. Implementation Evaluation

Evaluation activities are very important to the Minnesota Department of Health (MDH) because it ensures MEPSP is accomplishing the program goals, and providing information to guide program management, and sustainability planning. MDH designed the implementation evaluation questions and indicators in March 2017, and they were re-examined in July 2017. The implementation evaluation is a single group, non-experimental, pre and post-evaluation design. Table 3 depicts the evaluation design process. Both qualitative and quantitative data were collected and analyzed.

The inclusion criteria for participants enrolled in MEPSP helped grantees target the intended population for participation. The criteria for participants were:

- A resident of the county or tribal nation served by each MEPSP site
- Recipients of at least one program service (*e.g.*, referral, case management, etc.)
- Expectant and/or parenting people; self-identified as male or female
- Between the ages of 10 to 24.

Table 3: Evaluation Design Process

	Pre-test: Baseline Measurement	Intervention: Exposure to program	Post-test: Measurement After Intervention
Single group pre- and post-test	0_1	X	0_2

The MDH created four data tools to capture the federal performance measures, answer the evaluation questions, and to assess attainment of program's short- and long-term objectives.

The tools include:

1. **Student Enrollment Form (SEF):** New participants are administered the enrollment surveys at intake or within 2 weeks of enrollment. This baseline data is stored in the database.
2. **MEPSP REDCap Database (MRD):** The data manager or evaluator from each site complete the MEPSP database via REDCap software for each participant served at the three sites. MDH created a REDCap database to collect grantees' data for reporting OAH's performance measures and CQI activities. The REDCap database has a longitudinal design that allows for repeated observations of the same variables during each semester of the grant year. The longitudinal design is valuable because MDH can track the program participants' progress and departures from the program, their high school/GED and/or college graduations, and their re-enrollment in their schools each semester. Grantees entered data at any time, making it user-friendly and flexible, and MDH accessed the data at any time to assess the attainment of the implementation objectives.
3. **Student Parent Experience Survey (SPES):** Online surveys to assess students' experiences with the program. The SPES data were collected to ensure the immediate impact of the program. The SPES measures attitudes, knowledge and behavior of current MEPSP participants; perceived program experience, general challenges, childcare, financial, parenting, and social and health needs. Survey included both closed and open-ended questions. A pre-survey was administered during the Fall semester and post-survey during the Spring semester.
4. **Site Capacity Assessment (SCS):** Survey collected information about each site's program services, referral system, and partners to assess the program's capacity to implement activities relevant to program sustainability. The pre-capacity survey was administered during the Fall semester and the post-capacity survey during the Spring semester.

IV. Implementation Results

1. Were the intended target populations reached?

Answer: Yes, MEPSP services were provided to the intended target population of expectant and parenting teens and young adults, in the three settings, and multiple sites, during the Fall 2017 and Spring 2018 semesters[1].

Evidence:

The program served 430 adult participants and 447 children. During the Fall and Spring semesters, the majority of program participants identified as female (92% Fall and 93% Spring) and 7 to 8 percent identified as males, respectively. According to 2018 Spring semester data, the majority of participants ranged in ages between 13 through 25. Almost 72% of these participants were ages 18 to 24 years old, 27% were 15 to 17 years old, and less than 1% were ages 13 and 14. Only one person older than 25 received services. According to the participants, the majority of first pregnancies occurred when they were 15 to 17 years old. In its 2017 MEPSP grant application to OAH, MDH proposed serving pregnant or parenting youth ages 10 to 12. The Fall 2017 and Spring 2018 data reveal that no one in the 10 to 12 age category received services.

During the first year of MEPSP services, the majority of program participants (89% Fall semester and 86% Spring semester) were parenting, and not pregnant. Eight percent were expecting their first child, and 5% of program participants were parenting and expecting, and 1% were non-reported.

MEPSP program participants received services at various sites in their respective communities. The Fall 2017 and Spring 2018 data report that almost 36% of participants were in high school, almost 23% were in alternative high school (*e.g.*, juvenile detention centers, etc.) and approximately 4% were enrolled at an IHE, such as vocational school or two-year colleges. MEPSP services were also provided in conjunction with an ESL program (*i.e.*, English as a Second Language) and ABE (*i.e.*, Adult Basic Education) programs. ESL and ABE program participants received remedial education to assist with GED testing or entry to an IHE. People enrolled in either program most likely were members of immigrant communities, which was another targeted population for MEPSP.

2. How satisfied were the participants with the MEPSP intervention or services?

Answer: Yes.

Evidence:

All program participants were asked to complete a self-report survey about their overall experiences with MEPSP. This survey evaluated how effective MEPSP was in helping program participants reach their academic goals, improve their health and well-being, and address the risk and protective factors affecting them. Of the 172 program participants who responded to "*What is your overall experience with the student parent program*?" in

1 Minnesota Department of Health, Minnesota Expectant and Parenting Student Program, REDCap database, 2017-2018.

the Fall survey, 95% indicated they were "*very satisfied/satisfied*" with the services they received.[2]

MDH examined a second indicator to evaluate the program participants' satisfaction with MEPSP. An analysis of the Fall 2017 and Spring 2018 results revealed there was an 12% increase in the number of program participants who believed that MEPSP helped them become more self-sufficient by setting goals, planning for their future, and improving other life skills. In Fall 2017, 17 respondents indicated they had these skills, and in Spring 2018, 27 respondents said they had these skills. The increase in skills can be interpreted as a proxy measure for evaluating participants' satisfaction with the program.

MDH also reviewed qualitative data describing the program participants' satisfaction with MEPSP. The participants' comments were rich in detail about the MEPSP services they received:

- *My nurse always made sure I stayed on the right track and moved forward no matter what.*
- *The program staff are my biggest support system.*
- *They are always there for me. They are very helpful and useful.*

The relationships formed between the program participants and the nurses/social workers/community health representatives appear to be critical to the students' overall satisfaction with the program, and their success in achieving their goals. Program participants' satisfaction will be a very important indicator to monitor and evaluate in the future two years (2018-2020) of MEPSP.

3. Did the Pregnancy Assistance Fund (PAF) grantees create new multi-sectoral partnerships in Minnesota?

Answer: Yes.

Evidence:

The Site Capacity Assessment (SCS) administered in the Fall 2017 to all three grantee organizations indicated there were 61 informal and formal partnerships; by June 30, 2018, that number had increased to 70. This slight increase was a result of the MEPSP grantees talking and collaborating with childcare centers, behavioral health centers, tribal nations and tribal leadership, and government agencies providing workforce services.

Furthermore, linkages with Institutions of Higher Education continued during the implementation of the PAF program. For example, one grantee, the Northwest Indian Community Development Center (NWICDC) strengthened its verbal communication and referral process with Bemidji State University (*i.e.*, BSU). NWICDC explained how its MEPSP services were available to any expectant or parenting students enrolled at BSU and how they could work tandemly to help expectant and parenting student remain enrolled in college, while receiving MEPSP coordinated, case management services. The Minneapolis Health Department established a new partnership with the University of Minnesota, Twin

2 Minnesota Department of Health, Minnesota Expectant and Parenting Student Program, Site Capacity Assessment, 2017.

Cities campus to provide more academic supports to the expectant and parenting youth and young adult enrolled in MEPSP.

These partners are critical not only because their services augment MEPSP, but they will also be approached to assist with program sustainability planning.

4. To what extent did the professional development trainings in adolescent mental health and adolescent brain development increase grantees' knowledge?

   Answer:

   In the Site Capacity Assessment, three grantees' staff indicated their knowledge of adolescent brain development and adolescent mental health increased.

   Evidence:

   MDH trained 37 MEPSP grantees' staff and other state agency partners about adolescent brain development and adolescent mental health. A post-training assessment given to the grantee organizations indicated that training participants were "quite confident" or "extremely confident" about their knowledge of adolescent brain development and mental health.

A separate, detailed evaluation summary of the MEPSP's Adolescent Brain Development training, conducted by Dr. Nimi Singh in March 2018, is available in Appendix B.

V. Conclusion and Lessons Learned

With the the PAF grant, the Minnesota Department of Health increased the capacity of the MEPSP site to serve expectant and parenting teens, mothers and fathers. The MEPSP site provided coordinated, case management and referrals to health, education and social services for females and males, ages 10-24, to expectant and parenting teens, mothers, and fathers, as well as to their children.

The Site Capacity Assessment provided a comprehensive picture of the services provided by the MEPSP site. MDH was able to assess implementation strategies, services provided, new partners, resources and professional development training needs, and implementation challenges specific to each site. Even though the duration of the grant was shortened, making it difficult for the sites to hire staff and implement the program planned for three years, the capacity assessment showed increases in multi-sectoral local and state partners to support expectant and parenting, mothers and fathers in achieving their academic and self-sufficiency goals while maintaining their health.

Participants' responses to the Student Parent Experience Survey (SPES) indicated an overall satisfaction of the student parent program to help them meet their academic, health, and self-sufficiency goals. Although the SPES responses supported the idea that MEPSP implementation sites were effective in providing resources to student parents to help them reach their goals, there is still room for improvement when it comes to systems, policies, and program structure. Having knowledge of the student experiences was extremely helpful to the program and its sites and can be used when modifying and improving program implementation during 2018-2019 grant years.

Despite the short period, the robust MEPSP evaluation implementation plan enabled the MEPSP to answer the evaluation questions, assess attainment of program short- and long-term objectives, and engage community partners in various adolescent health training sessions and advisory group discussions to improve the quality of services at the three MEPSP sites. The lessons learned during the implementation of the MEPSP during the 2017-2018, has provided MEPSP with the information and tools needed to modify and improve upon the services during the next grant year. During the 2018-2019 grant year, the Minnesota Department of Health will continue to monitor the target audience served, the impact of professional development workshops, the growth and maintenance of local partnerships, and the program participants' satisfaction with MEPSP services.

Evaluation Implementation Report: Appendix A

Summary of Services Delivered by the MEPSP Grantees to Program Participants*

July 1, 2017- June 30, 2018

Funded by the Office of Adolescent Health and administered and evaluated by the Minnesota Department of Health

1. **Program Recruitment**
   - Informal methods: In the American Indian community, "word of mouth" was used as a recruitment strategy because peer-to-peer support and trust are always critical. NWICDC has programs such as Basic Education, GED tutoring and traditional community gatherings and participants were recruited from these activities to MEPSP.
   - Formal recruitment methods:
     - Staff gave presentations to public and private service providers.
     - Local colleges and alternative high schools made referrals.
2. **Intake Enrollment and Engagement**
   - Initial intake was conducted in a confidential location, such as on site at high school, IHE or community service. Some intakes were conducted at program participant's home.
   - A social worker/care coordinator, community health worker, or nurse was the primary contact for program participant.
   - Assessed the parents' and the children's physical, social and emotional needs and educational goals, and the barriers to their educational goals. Staff used motivational interviewing with participants to determine current level of education and which credits/degrees/classes are needed to graduate.
3. **Care Coordinator/nurse/social worker/Community Health Worker (staff) and participant develop an action plan. Staff made warm referrals to education, health, and social services providers.**

   These may include helping a participant with sliding fee childcare assistance or TANF/MFIP assistance forms and other barriers.
   - If material needs (cribs, diapers, etc.) are identified by a client as barrier, MEPSP staff made referrals for these supports.
   - Note: If safety is an issue for the program participant, providers implemented a safety protocol. For example, the City of Minneapolis' process looks involves these steps:

     MVNA secures a waiver that makes it more challenging for the economic assistance (TANF/MFIP in MN) case to go into sanction. MVNA is obligated to have the client meet with a domestic violence advocate and complete a safety plan in writing. The Safety Plan and Waiver are sent to the County to have their case coded as Family Stabilization Services (FSS). Sometimes, the program participant will decide to file an order for

protection and go into safe, secure housing. The MEPSP staff help the program participant find housing.

- At NWICDC: Services available on site

  If a program participant identified job training or ABE needs, the MEPSP staff walked the program participant over to the person who coordinates these program sessions on site, within the agency. If program participant identifies stress, anxiety or depression, they are referred to culturally-based mindfulness and stress reduction services on site.

- The program participant identifies daily-living needs (housing/rent, food, utilities, and gas to get to an internship or school) as a barrier MEPSP staff assist them to access emergency funds from available program resources or options to meet the need.

4. **After the intake and initial meeting, determine next meeting.**
5. **Staff entered data into REDCap, MDH database.**
6. **MEPSP staff followed up with program participants (by telephone and/or in person) to discuss barriers and identify next steps to successfully complete goals.**
7. **MEPSP staff meet frequently and as needed to reassess progress and goals.**

*Note: This list does not include the other activities staff perform, such as participating in MDH trainings, spearheading their Continuous Quality Improvement projects and creating systems' improvements with partner agencies.

Implementation Evaluation Report: Appendix B

2018 Adolescent Mental Health Training, Minnesota Department of Health

The Minnesota Department of Health, Minnesota Expectant and Parenting Student Program hosted a day-long Adolescent Mental Health Training on March 23, 2018. Dr. Nimi Singh, Adolescent Medicine Physician, M Health, University of Minnesota, Family Medicine and Primary Care, was the expert speaker for the workshop. Public health nurses, sexual health program managers and health educators attended.

The following information is a summary of the 12 evaluation forms collected at the end of the training. Approximately 15 people attended the event.

Question 1. The objectives of the training were clearly identified:		
Answer options	**Response count**	**Response percent**
Agree strongly	9	75%
Agree	3	25%
Disagree	0	0%
Disagree strongly	0	0%
Skipped question	0	
Total answered	**12**	**100%**

Question 2. The objectives of the training were met:		
Answer options	**Response count**	**Response percent**
Agree strongly	8	66.6%
Agree	4	33.3%
Disagree	0	0%
Disagree strongly	0	0%
Skipped question	0	
Total answered	**12**	**100%**

Question 3. The most important thing I heard and/or learned during the training was:	
Lots of good resources, given hands on examples so not all lecture, good interactions	
How importannt our own mindfulness can be in maintaining relationships with our clients	
Mindfullness - what it is. Stress and how it affects all of us (mind, soul, body)	
All of it was wonderful. Validation of all I have been learning about mindfulness and other approaches to helping those we serve.	
The informal examples	
To recognize and validate past traumas, but to not let them define us.	
Practice what you preach	
ADHD is usually a sign of anxiety and PTSD. Very interesting - changes how I'm going to think	
The importance of balance and sleep	
Geeze, I can't think of listing all of it. Every moment felt valuable for my job and personal life	
Mindfullness, sleep and meditation, letting go of stories	
How to more effectively be "present" to help my clients.	
Skipped question	0
Answered question	12
Total	**12**

Question 4. Something that could have been left out of the training was:	
N/A	
It was all excellent	
It was good as is	
Nothing - keep it all. The non-scripted stuff was the best	
Love the tie back to research but basics was needed	
I liked it all	
N/A	
Honestly, I thought is was all goo. The room was kind of cold, though.	
Nothing, maybe need more :)	
Skipped question	3
Answered question	9
Total	**12**

Question 5. Something that I would like to include in the next training was:	
More client/worker interactions and how to use mindfulness to elicit change	
Would love to have more of her presentation and wisdom and expertise!	
I like the non violence topic coming up. For part 2 - more deeper dive into nutrition and physioloy of approach	
More time to practice M.I. (maybe M.F.?)	
More meditation tecniques and small group interactions	
Different practical skills for mindfulness	
Further diver into the material	
Maybe a few breaks to get up and move around. Hard to sit still for awhile.	
More experimental learning.	
More practical exercises, less sitting	
More detailed examples of patients/clients dealing with intense emotional traumas and socioeconomic barriers.	
Skipped question	1
Answered question	11
Total	**12**

Question 6. Other comments:	
Enjoyed Nimi!	
Very, very good!	
I really enjoyed today - thank you!	
I think that the training went well and that I was able to learn a lot!	
Awesome	
I would come again if there was a part 2.	
Thank you. A follow up session would be KEY!	
Great training	
Skipped question	4
Answered question	8
Total	**12**

Summary:

- The training was very well liked by those who attended.
- Those who attended the training believe it will be very helpful to them in their respective fields.
- Learning about mindfulness was an important piece for many individuals.
- Several individuals found the informal, real-life examples to be valuable and relatable.
- Most individuals really enjoyed Dr. Singh's presentation and many are interested in attending a follow-up session.

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