Minnesota Family Home Visiting Program

Report to the Minnesota Legislature

August 2018

Minnesota Department of Health
Family Home Visiting Section
P.O. Box 64882, St. Paul, MN 55164-0882
(651) 201-4090
http://www.health.state.mn.us/fhv/

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Background

Need for Family Home Visiting

Families and the communities in which they live are central to the physical, social and emotional development of infants and young children. Opportunities for families to develop and maintain safe, stable, nurturing relationships and environments that support healthy development are impacted by adverse experiences. Moreover these adversities disproportionately affect pregnant and parenting families experiencing economic, structural and racial inequity. Exposure to adverse experiences in the absence of safe, stable, nurturing relationships and environments leads to poor health, education, and employment outcomes for children.

Family Home Visiting is a proven strategy to address the factors that impact relationships and environments for pregnant and parenting families with young children in the communities in which they live. National research has demonstrated that family home visiting results in improved prenatal health; fewer childhood injuries; fewer cases of neglect and maltreatment; fewer subsequent pregnancies; improved school readiness; and increased maternal employment. Family home visiting services have demonstrated significant impact on improving child well-being outcomes for families experiencing the greatest burden of health, economic, and racial inequities.

The need for Family Home Visiting services in Minnesota is supported by the following state statistics:

- In 2015 there were 109,000 children ages 0-4 in Minnesota living under 200% Federal Poverty Level (American Community Survey, 2016).
- 19.9 percent of women who gave birth were below 100% of the poverty level. (American Community Survey, 2016)
- 44.7 percent (n=31,182) of recorded births were paid for by Medicaid (MDH & DHS, 2016)
- 32.2 percent (n=22,458) of births were to unmarried mothers (MDH 2016)
- 10.4 percent (n=7,244) of recorded births are to mothers who have not completed high school/GED equivalent. (MDH, 2016)
- 10.9 percent (n=7,602) of birth mothers entered prenatal care late (third trimester) or not at all. (MDH, 2016);
- 6.9 percent (n=4,652) of singleton births were preterm births (less than 37 weeks gestation). (MDH, 2016)
- 4.9 percent (n=3,328) of singleton babies born are low birth weight (less than 2,500 grams). (MDH, 2016)
- 1,330 children are prenatally exposed to substances and alcohol. (DHS, Child Maltreatment Report, 2016)

- 8,630 children were determined through family investigations to be victims of maltreatment in 2015. (DHS, Child Maltreatment Report, 2016)The child maltreatment rate is 6.58 per 1,000 children. (DHS, Child Maltreatment Report, 2016)

Further, in 2016 there were 2,201 births to teens (ages 15-19) in the state of Minnesota. Providing services to pregnant and parenting teens is a priority area for home visiting services given the strong evidence of poor outcomes for both teen parents and children born to teen parents: higher rates of prematurity, low birthweight, and developmental delays, lower high-school graduation rates, as well as lifelong and intergenerational poverty. This is a critical time period to intervene to mitigate and eliminate adverse experiences in the family's life. Evidence-based home visiting is an effective upstream intervention that also serves as a key link to other early childhood interventions and community supports such as quality childcare, special education and other services that collectively will make a difference in the lives of parents and children.

What is Family Home Visiting?

Family home visiting (FHV) is a voluntary, home-based service ideally delivered prenatally through the early years of a child's life. It provides social, emotional, health-related and parenting support and information to families, and links them to appropriate resources. Home visiting is an evidence based multi-generational approach, benefiting pregnant and parenting families with young children through:

A teen mom *who was expecting her first child was sleeping on the couch in a two bedroom trailer with her mom, dad, brother and two nieces when she enrolled in FHV. The father of her baby was in jail. She was not in school and had only completed the 10th grade. Since becoming an FHV client, she has returned to school, found her own housing and has been accepted into a program that will help pay for her rent while she attends school.*

- Helping parents and caregivers to develop safe, stable nurturing relationships and environments that support healthy development;
- Connecting families to community services, such as referrals for pregnant women to prenatal care;
- Early support to parents in their role as a child's first teacher; and
- Education and support for parenting skills that decrease the risk of child abuse.

Depending on the goals identified by a family and based on developmental and risk assessments, a family may work with a home visitor from the prenatal period through a child's third birthday. Some programs serve families with children up to age five years. Through consistent and planned home visits,

parents and caregivers are connected to resources, are supported in learning essential parenting skills, and are able to provide opportunities for their children, which support healthy development.

Description of Programs and Funding Streams

Family Home Visiting is supported by a number of funding streams including state, federal and local sources. Table 1 shows the funding streams from SFY 2014 to 2019. The appropriation for state General Funds will increase by $10.5 million per year in SFY 2020 and 2021 (not shown in Table 1).

Table 1. Family Home Visiting Funding 2014 - 2019 (state fiscal years)

STATE & FEDERAL FUNDS FOR MDH HOME VISITING

	2014	2015	2016	2017	2018	2019
State General Funds Appropriation[#]	$289,000	$358,000	$1,001,368	$2,358,000	$8,289,000	$8,289,000
FEDERAL FUNDING						
TANF Family Home Visiting	$8,557,000	$8,557,000	$8,557,000	$8,557,000	$8,557,000	$8,557,000
MIECHV Formula Grant†**	$810,085	$1,367,680	$2,130,423	$4,127,010	$6,835,629	$8,435,468
MIECHV Expansion Grant†***	$6,956,952	$7,503,189	$7,928,995	$4,711,281	$909,677	0
Federal Subtotal	**$16,324,037**	**$17,427,869**	**$18,616,418**	**$17,395,291**	**$16,302,306**	**$16,992,468**
Total	**$16,613,037**	**$17,785,869**	**$19,617,786**	**$19,753,291**	**$24,591,306**	**$25,281,468**

NOTES

†MIECHV awards are prorated award on a monthly basis through the total award period and calculated on funding available on a state fiscal year.

**MIECHV Formula Grant anticipated to remain at $8.6 million/year going forward (based on HRSA changes for FFY16 funding)

***MIECHV Expansion Grant ends 09/30/2017; HRSA has discontinued this funding.

[#] The appropriation for state funds will increase by $10.5 million/year in SFY20 and SFY201 (not included in this chart)

Family Home Visiting Program

Since state fiscal year 2001, the Minnesota Legislature has authorized MDH to administer family home visiting services for families at or below 200 percent of poverty and who are at risk for poor maternal and child outcomes. Guided by a public health nursing assessment, interventions are designed to foster physical, social and emotional health, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families. Funding is distributed on a formula basis to local public health departments and tribal nations. New state funds are distributed on a competitive basis.

Minnesota Statutes Section 145A.17 governs the Family Home Visiting Program. The Minnesota Legislature provides funding of $7,827,300 annually to all local public health departments and tribal nations for services provided under the statute. Appendix A lists the amount awarded to each local public health agency for the time period 07/01/2017 through 6/30/2019, and Appendix B lists amounts awarded to tribal nations for 7/1/2017 through 6/30/2019. MDH is responsible for training and supervision standards, establishment of measures to determine the impact of Family Home Visiting programs funded under the statute, and for administering and monitoring grantees. Minnesota Statutes Section 145A.17 subdivision 8 also requires the Commissioner of Health to submit a report to the legislature on the Family Home Visiting Program in even numbered years. The purpose of this report is to describe the activities as mandated.

Family Home Visiting services are to be coordinated and delivered in partnership with multidisciplinary teams of public health nursing, social work and early childhood education professionals. Funded programs must begin prenatally whenever possible and focus on families with one or more of the following risk factors:

Unstable housing and attendance *at school were challenging for a 17 year old mom expecting her first baby. Since enrolling in FHV, she has found stable housing, is attending classes for her GED and is exclusively breastfeeding her 3 1/2 month old son.*

- Adolescent parents
- History of alcohol and drug abuse
- History of child abuse, domestic abuse, or other types of violence
- A history of domestic abuse, rape, or other forms of victimization
- Reduced cognitive functioning
- Lack of knowledge of child growth and development stages
- Low resiliency to adversities and environmental stresses
- Insufficient financial resources to meet family needs
- History of homelessness

- Risk of welfare dependence or family instability due to employment barriers
- Serious mental health disorder, including maternal depression

Federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV)

The federally funded Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, administered through MDH, targets high-risk families who are most likely to benefit from intensive home visiting services, through which trained professionals (often nurses, social workers, or parent educators) help parents acquire the skills to promote their children's development. In 2017, $14.6 million was provided to 13 grantees to provide evidence based home visiting services from March 2017 to September 30, 2019. Awardees were selected based on designation as an at-risk community in a statewide needs assessment. Home visiting services were provided to families through Nurse-Family Partnership (NFP) and Healthy Families America (HFA), two evidence-based home visiting models

MIECHV home visiting services seek to educate parents on child development and progress on developmental milestones and help families connect to necessary services, such as health care or community resources. Under the MIECHV program, Minnesota is accountable for meeting benchmarks in six areas: (1) improved maternal and newborn health; (2) prevention of child injuries, child abuse, neglect or maltreatment, and reduction of emergency department visits; (3) improvement in school readiness; (4) reduction in crime or domestic violence; (5) improvements in family economic security; and (6) improved coordination and referrals for other community resources and support.

State Nurse-Family Partnership Funding

The 2015 Minnesota Legislature authorized $575,000 in State Fiscal Year 2016, and $2,000,000 in State Fiscal Year 2017 and thereafter, to provide grants to local public health agencies and tribal nations to create or expand Nurse-Family Partnership (NFP) programs. In May 2016, grants were awarded to five CHBs to provide NFP home visiting services to families through the year 2020. Awardees include:

- Hennepin County Public Health
- Kanabec County Public Health
- Supporting Hands Nurse Family Partnership (fiscal host Kandiyohi-Renville County Public Health)
- City of Minneapolis Public Health
- St. Paul-Ramsey Public Health
- Polk-Norman-Mahnomen Public Health

State Evidence-Based Home Visiting Funding

In 2017, the MN Legislature appropriated $12 million in funding over the current biennium and $16.5 million per year starting in state fiscal year 2020. The Minnesota Department of Health (MDH) distributed the new state funding for evidence based home visiting services in two phases. *Phase 1* is

complete and allowed Minnesota to continue home visiting services to families and to sustain critical infrastructure built over the last six years. The five grantees awarded funding as part of *Phase 1* are providing evidence based home visiting services to over 300 families living in 19 counties and two tribal nations. Awardees were at risk of decreasing services or closing home visiting programs due to recent cuts in Minnesota's federal MIECHV award. All awardees are located in greater Minnesota. The *Phase 1* grantees are:

- Carlton and St. Louis County Public Health
- Mille Lacs Band of Ojibwe, Pine County Public Health and Mille Lacs County Public Health
- Mower County Public Health
- North Country Public Health, Beltrami County Public Health, Quin Community Health Board, and Leech Lake Band of Ojibwe
- Supporting Hands Nurse-Family Partnership (fiscal host Kandiyohi-Renville Public Health)

Phase 2 began on November 14, 2017 with the release of a competitive request for proposals for start-up or expansion of evidence based home visiting services. Local public health agencies, tribal nations, and non-profits are eligible to apply. The Minnesota Evidence-Based Home Visiting Grant program will distribute approximately $3.2 million per year for grantee funding under this RFP for the period of May 1, 2018 – December 31, 2022. MDH anticipates funding up to 12 applicants under this RFP to provide additional evidence-based home visiting services to families in Minnesota.

Evidence Based Home Visiting Models

Below is a description of the primary evidence-based home visiting (EBHV) models used by the Minnesota Family Home Visiting Program. Local public health agencies and Tribal Nations select which of these home visiting models best fit the needs of their communities. These EBHV models, among others, meet US Department of Health and Human Services criteria for evidence of effectiveness[1]. A map showing where each EBHV model funded by MDH is implemented in Minnesota is located at the end of the section in Figure 1. A listing of these programs is included in Appendix C.

Nurse-Family Partnership

Nurse-Family Partnership® (NFP) is an evidence-based, community health program that helps improve the lives of vulnerable mothers who are pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives regular nurse home visits that continue through her child's second birthday. Research has shown that every dollar invested in NFP

[1] Home Visiting Evidence of Effectiveness - HomVEE (http://homvee.acf.hhs.gov/)

yields a range of $2.88 to $5.70 in return[2]. Home visiting has been shown to results in reductions in child maltreatment, juvenile arrests, maternal convictions, emergency department use and cognitive and behavioral problems among children, contributing to cost savings at the community, state and federal levels.[3]

Goals of the NFP program include:

1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving diets and reducing use of cigarettes, alcohol and illegal substances;
2. Improve child health and development by helping parents provide responsible and competent care; and
3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.

Healthy Families America (HFA)

Healthy Families America (HFA) is an EBHV program model designed to work with families who are at-risk for adverse childhood experiences, including child maltreatment. It is the primary home visiting model best equipped to work with families who may have histories of trauma, intimate partner violence, and mental health and/or substance abuse issues. HFA services begin prenatally or right after the birth of a baby and are offered voluntarily, intensively and over the long-term (3 to 5 years after the birth of the baby).

Goals of the HFA program include:

1. Build and sustain community partnerships to systematically engage families in home visiting services prenatally or at birth.
2. Cultivate and strengthen nurturing parent-child relationships.
3. Promote healthy childhood growth and development.
4. Enhance family functioning by reducing risk and building protective factors.

Family Spirit

The Family Spirit Program is an evidence-based and culturally tailored home visiting intervention delivered by Native American paraprofessionals to support young Native parents from pregnancy to 3 years postpartum. Parents gain knowledge and skills to achieve optimum development for their infant

[2] Karoly, L.A., Kilburn, M.R., & Cannon, J.S. (2005). Early Childhood Interventions: Proven results, future promise. Santa Monica, CA: RAND Corporation

[3] Nurse-Family Partnership (2010). *Benefits and costs: A program with proven and measurable results.* Denver, CO: Nurse-Family Partnership.

through preschool age children across the domains of physical, cognitive, social-emotional, language learning, and self-help.

Goals of the Family Spirit program include:

1. Increase parenting knowledge and skills.
2. Address maternal psychosocial risks that could interfere with positive child rearing (low education and employment; drug and alcohol use; depression; domestic violence).
3. Promote optimal physical, cognitive, social/emotional development for children from zero to 3.
4. Prepare children for early school success.
5. Ensure children get recommended well-child visits and health care.
6. Link families to community services to address specific needs.
7. Promote parents' and children's life skills and behavioral outcomes across the lifespan.

Family Connects

Family Connects is an evidence based triage model of care, providing home visit to every family with a newborn age 2 to 12 weeks. The aim is to bring families, community agencies, and health care providers together to ensure parents have the resources they need to enhance the well-being of newborns. Families are screened for potential risk factors, and those with identified areas of concern receive additional visits, supports, and linkages to needed services.

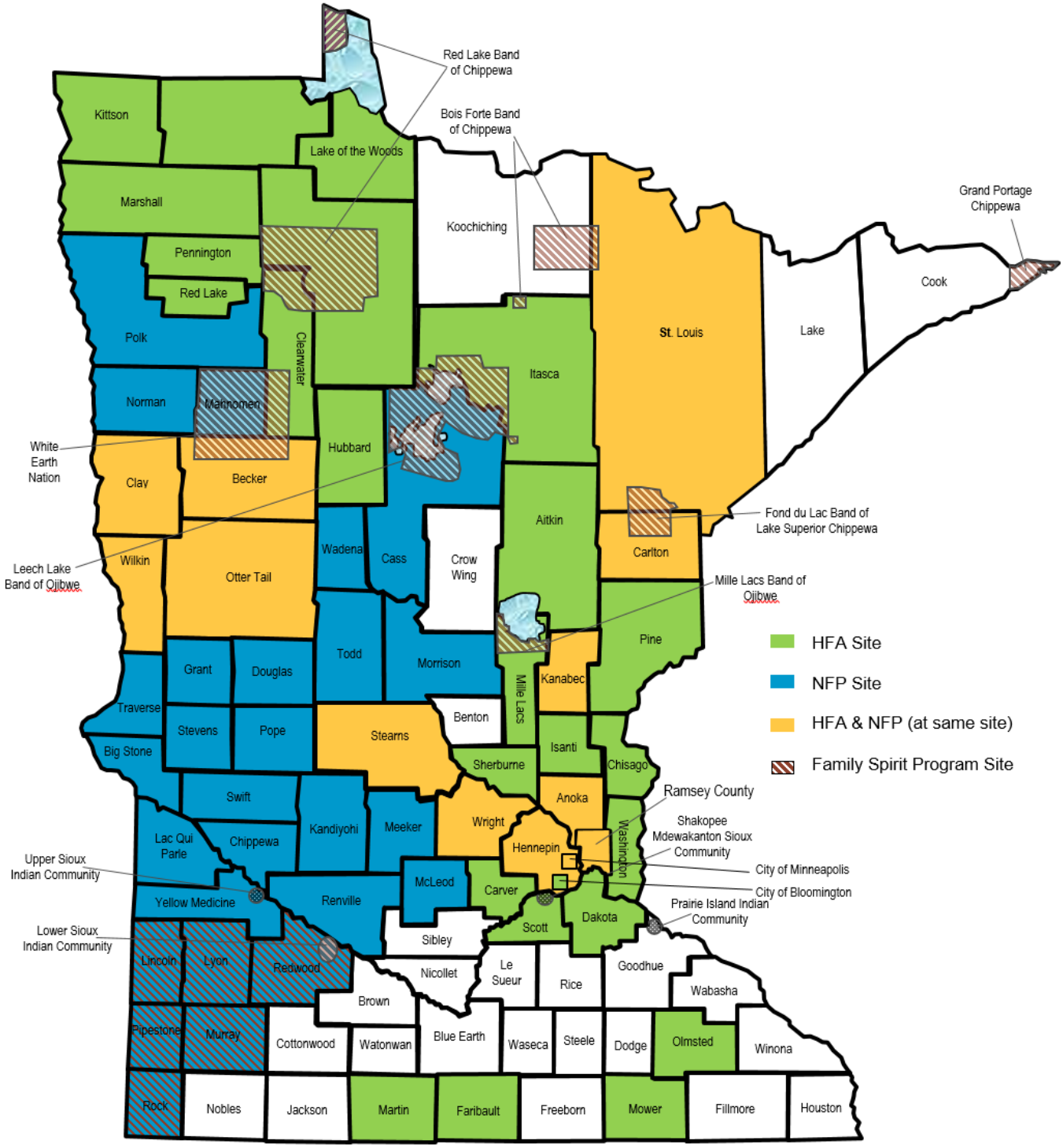
Goals of the Family Connects program are to enhance child health and well-being and reduce rates of child abuse and neglect through:

1. Improved connections to community resources
2. Connection to a primary medical home
3. Prevention of infant hospital readmissions
4. Prevention of unnecessary emergency care visits
5. Improved quality and safety of home environment, quality child care selection, and positive parenting behaviors
6. Reduce parental anxiety and depression.

Evidence Informed Home Visiting

A number of local public health agencies and tribal nations provide evidence informed home visiting services. These home visiting services range in length and intensity and are informed by best practices in home visiting. Some public health departments provide a single universal home visit shortly after birth, with additional visits if the family is found to be in need, while others provide intensive services to at-risk families.

Figure 1. Implementation of Evidence Based Home Visiting Models

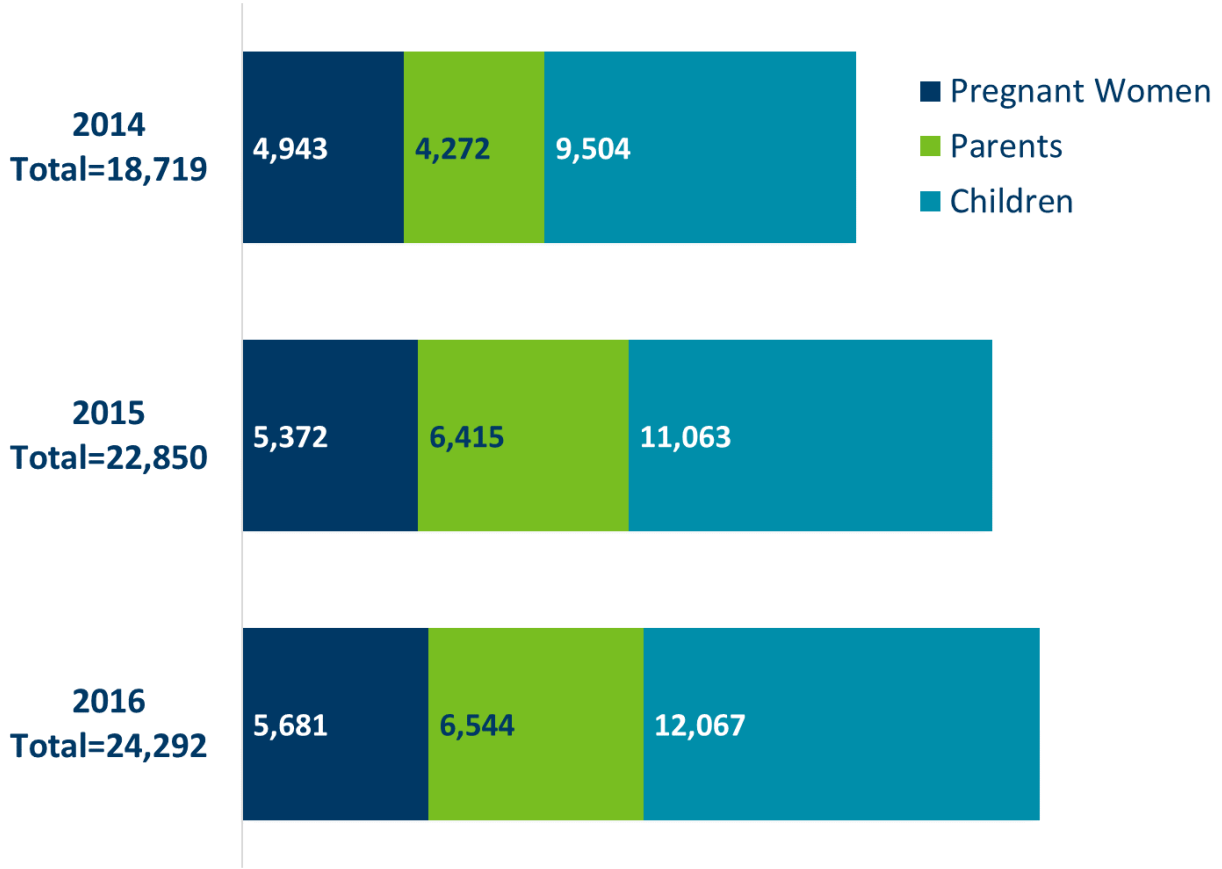


Program Evaluation

Program Demographics

Approximately 12,200 families were served through family home visiting in 2016 (based on data reported to MDH). Of adults served, 47 percent (5,681) were pregnant women and 53 percent (6,544) were parents and/or caregivers of young children. Just over 12,000 infants and children were served. Figure 2 shows the number of total clients (pregnant women, caregivers, infants and children) served over the past 4 years. MIECHV funds supported home visiting services to approximately 2,300 families in 2016. The remaining 9,900 families in 2016 were served with other funding sources including but not limited to TANF Family Home Visiting.

Figure 2. Number of Family Home Visiting Clients Served, Minnesota, 2014 - 2016



In 2016, home visiting programs served 1,217 pregnant or parenting teens under the age of 18. Of these, 1,138 were ages 15 to 17, and 79 were age 14 or younger. Slightly less than half of adult participants (5,965) were under the age of 25. Approximately 29 percent (3,540) adult clients had no high school diploma or GED when starting home visiting services.

The majority of adult participants identified as White (63 percent), 18 percent as Black or African-American, 3 percent as American Indian, and 6 percent as Asian. About 2,200 (18 percent) adult

participants indicated Hispanic ethnicity. Following a similar pattern but with a slightly different distribution, the majority of infants and children were identified as White (57 percent), 21 percent as Black or African-American, and 8 percent as Asian. Approximately 2,400 (20 percent) infants and children indicated Hispanic ethnicity.

Approximately 18% of adult participants and 22% of infants and children had no health insurance at the start of home visiting services. Additional demographic details are provided in Appendix D.

Methodology

Data for selected outcomes are presented on the following pages. Analysis was restricted to clients in long-term public health family home visiting programs. Long-term programs include NFP, HFA, and evidence informed public health nursing family home visiting programs. Data is presented for calendar year 2016.

Measures in this report differ from those included in the 2016 Report to the Legislature. Because of major changes in MIECHV data collection beginning October 2016, data needed for the calculation of measures in the 2016 report was not available for MIECHV-funded programs. Outcome measures in this report were selected based on the availability of data across all long-term public health family home visiting programs.

If data needed to determine inclusion in the numerator were missing (not reported to MDH), but all data needed to include the client or family in the denominator were available, the client or family was included in the denominator, but not included in the numerator. This methodology differs from that used in the 2016 Report to the Legislature. In the 2016 report, cases with missing data were excluded from the calculation of the measure.

Because of these differences in methodology, percentages should not be compared between this report and the 2016 Report to the Legislature.

Maternal and Newborn Health

Performance Measures:

- In 2016, 62% of mothers enrolled in home visiting were screened for postpartum depression before their baby was 3 months old.
- More than one-fourth (28%) of infants born to mothers who enrolled in home visiting while pregnant were still being breastfed at 6 months of age.

Why this is important

Breastfeeding provides health, social, and economic benefits to both mom and baby. Breast milk contains all of the nutrients that a baby needs and provides additional immunity protection against a host of illnesses and diseases.[4] Maternal health benefits include reduced risk for ovarian cancer and breast cancer. Breastfeeding also helps moms and babies bond and build a sense of closeness. In addition, more recent research indicates that breastfeeding may protect against post-partum depression and assist with faster recovery.[5]

The mental and physical health of mothers can also impact the well-being of the child. Postpartum depression can impair parent-child bonding, and have long-term consequences for the child's development and emotional health.[6]

How Family Home Visiting helps

Home visitors provide education, guidance and encouragement to moms on the benefits of breastfeeding and best ways to continue breastfeeding at home, school or work. Home visiting supports moms in problem-solving barriers to breastfeeding and refers them to community resources when there are significant needs. All of these efforts help to encourage breastfeeding in over 25% of home visiting families when the child is 6 months of age.

One of the measures that home visitors take to improve maternal and newborn health is to screen for postpartum depression and refer mothers who screen positive for depression to relevant services. In 2016, over 60% of mothers receiving home visiting were screened for post-partum depression.

[4] https://www.ncbi.nlm.nih.gov/books/NBK52687/

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4842365/

[6] http://developingchild.harvard.edu/wp-content/uploads/2009/05/Maternal-Depression-Can-Undermine-Development.pdf

Safety and Violence Prevention

Performance Measures:

- Half (50%) of mothers were screened for intimate partner violence during their 1st 6 months of home visiting.
- Among mothers with a positive screen for intimate partner violence, 65% were referred to services in 2016.

Why this is important

Domestic violence has a demonstrable, long-term impact on the adult victim as well as on children who witness violence. A history of adverse experiences in childhood, including exposure to violence and maltreatment, is associated with health risk behaviors such as smoking, alcohol and drug use, and risky sexual behavior, as well as obesity, diabetes, sexually transmitted diseases, attempted suicide, and other health problems later in life. Intimate partner violence (IPV) costs the United States $8.3 billion per year, including direct medical and mental health care costs and indirect costs from lost lives and lost work productivity. In addition to death or physical injury, IPV victims often experience adverse health outcomes due to chronic stress. Children in families where IPV is present are also more likely to experience maltreatment.[7]

How Family Home Visiting helps

Approximately half of mothers receiving home visiting services are screened for intimate partner violence. Of those who screen positive, over 60% are referred to services. MDH continues to do quality improvement with home visiting agencies to increase the level of screening and referral on all core elements. Family home visitors prevent child injuries by providing information on hazards in the home environment, coaching caregivers in positive parenting practices and providing guidance on when to seek out further medical care. Home visitors complete a Home Safety Checklist (HSC) with the caregiver to identify safety concerns in the home that may put the infant or toddler at risk for an unintentional injury. Family home visiting programs in Minnesota screen mothers and pregnant women for domestic violence using validated screening tools, and make appropriate referrals to domestic violence services. In addition to screening women for domestic violence, home visitors offer support and education regarding healthy relationships, and assist in the completion of safety plans for domestic violence, to help the mother strategize how to keep her and her children safe. In collaboration with the client, the home visitor promotes engaging other appropriate individuals in the client's family and social networks, promoting healthy relationships, nurturance, and care for the child.

[7] Intimate Partner Violence: Consequences (http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html)

Child Development and School Readiness

Performance Measures:

- In 2016, 54% of infants in home visiting were screened for developmental delays by 12 months of age.
- Of infants with a positive screen for developmental delay, 65% were referred to services in 2016.

Why this is important

Research demonstrates that early identification of developmental and social-emotional issues and the use of appropriate intervention supports and services significantly improve a child's early development, health, school readiness, academic success, and overall well-being. Investments in early identification and intervention often reduce the high costs and long-term consequences for health, education, child welfare, and juvenile justice systems.[8] However, many children enter school with significant delays and missed opportunities for intervention due to under identification and lack of timely referral to and receipt of necessary services. For example, less than 50% of children with developmental or behavioral disabilities are identified before children start school.[9]

How Family Home Visiting helps

Home visitors work with families in supporting healthy pregnancies by recognizing and reducing risk factors and by promoting prenatal health care, healthy diet, exercise, stress management and ongoing well-woman health care. Home visiting programs have a unique opportunity to reach vulnerable families and to incorporate evidence-based and practice-informed strategies to improve screening, referral and connection to services. Results above indicate that over 50% of children are screened for developmental delays by 12 months of age. Family home visitors screen young children using standardized instruments, discuss the results with parents to help them understand their child's developmental progress, and teach parents activities that they can do to support their child's development. Family home visitors refer and connect families to Early Intervention and other community services that support child development. In 2016 almost 2/3 of infants with a positive developmental delay screen were referred to additional resources. Through early identification and connection to services and resources, family home visitors play a role in improving development outcomes for at-risk families with young children.

[8] Birth to Five, Watch Me Thrive

[9] National Academy for State Health Policy. (2012). *Making the Case*.

Family Economic Self-Sufficiency

Performance Measures:

- Among caregivers without a high school diploma when starting home visiting, 70% were enrolled in or completed an educational program in 2016.
- Eighty-four percent of families in home visiting had health insurance in 2016.
- Seventy-eight percent of children in home visiting had health insurance in 2016.

Why this is important

Poverty has multiple, long-term effects on children's health and ability to learn because of the family's lack of access to resources and increased stress related to economic insecurity. Parents' increased educational attainment is associated with better outcomes for children.[10]

As stated by the Kaiser Commission on Medicaid and The Uninsured, lack of health insurance compromises the health of individuals because they are less likely to receive preventive care, more likely to be hospitalized for avoidable health problems, less likely to receive timely diagnoses, and more likely to delay needed treatment. In addition, lack of insurance also affects the financial wellbeing of families by increasing family exposure and vulnerability to the high cost of health care and out-of-pocket costs.[11]

How Family Home Visiting helps

Home visitors assist clients in setting personal goals for the future, including goals related to employment and education. The above graph show that close to 70% of home visiting clients participated in some form of further education beyond a high school diploma. Home visitors help their clients to seek out jobs, complete educational programs, and enroll in health insurance, by linking them to resources and helping to overcome barriers. Home visitors help the client envision how she would like life to be for herself and her child, and promote pregnancy planning, education and employment as a means of accomplishing the client's goals. Home visitors focus on promoting the client's abilities and behavior change to protect and promote her own health and well-being and that of her child. Home visitors also encourage parents to take their children to well-child visits and assist them in enrolling in health insurance. As the above charts indicate, approximately 80% of families and children receiving home visiting were successfully enrolled in health insurance.

[10] The Many Ways Mothers' Education Matters

[11] Key Facts about the Uninsured Population (http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/) Retrieved January 3rd, 2016.

Conclusion

Safe, stable, nurturing relationships and environments help set the stage for lifelong emotional, social, and physical health. Minnesota's continued investment in family home visiting assures that pregnant and parenting families living with the heaviest burdens of health, economic, and racial inequities have opportunities to support their children's positive health and development.

MDH is currently enhancing our state evaluation plan for home visiting. When completed this evaluation will allow us to gain further insight into the benefits and impacts of the expanded state funding. Key evaluation areas will address maternal and child health, screenings and referrals, as well as contextual information about what creates successful outcomes for families.

In partnership with local public health, Tribal Nations and other early childhood stakeholders, MDH will continue to promote the use of local, state and federal funds to increase statewide implementation of evidence-based Family Home Visiting models, practices, and other core components of effective early childhood systems. Ongoing implementation guidance, training opportunities and evaluation by MDH will continue to advance the outcomes as defined in statute 145a.17 and to improve the health and well-being of Minnesota's families.

Appendix A: Family Home Visiting Local Public Health Awards (7/01/18 to 6/30/19)

Local Public Health Agency	Amount of Award per year
Aitkin-Itasca-Koochiching Community Health Board	121,926
Anoka County Community Health Board	315,522
Beltrami County Community Health Board	53,860
Benton County Human Services	43,822
City of Bloomington Community Health Board	173,888
Blue Earth County Community Health Board	69,100
Brown-Nicollet Community Health Board	72,688
Carlton-Cook-Lake-St. Louis Community Health Board	389,512
Carver County Community Health Board	56,946
Cass County Health, Human & Veterans Services	41,252
Chisago County Community Health Board	45,394
Countryside Community Health Board	86,938
Crow Wing County Community Health Board	75,356
Dakota County Community Health Board	325,356
Des Moines Valley Health and Human Services	39,610
Dodge-Steele Community Health Board	65,310
Human Services of Faribault and Martin Counties	53,310
Fillmore-Houston Community Health Board	55,394
Freeborn County Community Health Board	44,266
Goodhue County Health and Human Services	47,462
Hennepin County, in its capacity as a Community Health Board	685,328
Horizon Public Health	99,332
Isanti County Community Health Board	30,958
Kanabec County Community Health Board	21,855
Kandiyohi-Renville Community Health Board	82,226

Local Public Health Agency	Amount of Award per year
Le Sueur-Waseca Community Health Board	58,458
Meeker-McLeod-Sibley Community Health Board	95,010
Mille Lacs County Community Health Board	46,438
City of Minneapolis Community Health Board	979,782
Morrison-Todd-Wadena Community Health Board	113,428
Mower County Community Health Board	50,814
Nobles County Community Health Board	30,998
North Country Community Health Board	68,550
Olmsted County Community Health Board	151,440
Partnership4Health Community Health Board	220,314
Pine County Community Health Board	46,441
Polk-Norman-Mahnomen Community Health Board	75,600
Quin County Community Health Board	84,412
St. Paul Ramsey County Community Health Board	994,732
Rice County Community Health Board	63,650
Scott County Community Health Board	76,566
Sherburne County Community Health Board	61,212
Southwest Health and Human Services Community Health Board	127,876
Stearns County Community Health Board	155,622
Wabasha County Community Health Board	27,872
Washington County Community Health Board	182,520
Watonwan County Community Health Board	21,176
Winona County Community Health Board	59,002
Wright County Community Health Board	90,476
Total Yearly Award	**$6,979,000**

Appendix B: Family Home Visiting Tribal Government Awards

Tribal Nation	Total Biennial Award July 1, 2017 – June 30, 2019
Bois Forte Reservation Tribal Council	113,359
Fond Du Lac Band of Lake Superior Chippewa	299,131
Grand Portage Reservation Council	50,321
Leech Lake Band of Ojibwe	363,318
Lower Sioux Indian Community	57,572
Mille Lacs Band of Ojibwe	128,395
Red Lake Band of Chippewa	316,502
Upper Sioux Community	42,336
White Earth Band of Ojibwe	325,666
Total Biennial	**$1,696,600**

Appendix C: Family Home Visiting Sites using Evidence-Based Home Visiting Programs in Minnesota, 2018

Healthy Families America

- Aitkin and Itasca Counties
- Becker, Otter Tail, Clay, and Wilkin Counties
- Faribault and Martin Counties
- Kanabec County
- Metro Alliance for Healthy Families (serving Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, and Washington Counties, and the City of Bloomington)
- Minnesota Visiting Nurse Agency (MVNA), serving City of Minneapolis
- St. Paul-Ramsey County
- Olmsted County
- Mower County
- Mille Lacs County
- Beltrami, Clearwater, Hubbard, and Lake of the Woods Counties
- Marshall, Pennington, Kittson, Roseau and Red Lake Counties
- Pine County
- Sherburne County
- St. Louis and Carlton Counties
- Stearns County
- Wright County

Family Spirit

- Bois Forte Band of Chippewa
- Mille Lacs Band of Ojibwe
- Lower Sioux Indian Community
- Red Lake Band of Chippewa

- Leech Lake Band of Ojibwe
- Grand Portage Chippewa
- Southwest Health and Human Services (serving Lincoln, Lyon, Murray, Pipestone, Redwood, and Rock Counties)
- Clearwater County

Nurse-Family Partnership

- Anoka County
- Otter Tail and Becker Counties
- Morrison, Todd, Wadena, and Cass Counties
- Clay, Wilkin, Norman, Mahnomen, and Polk Counties
- Carlton and St. Louis Counties
- Minnesota Visiting Nurse Agency (MVNA), serving City of Minneapolis and Hennepin County
- Kanabec County
- St. Paul-Ramsey County
- Stearns County
- Supporting Hands NFP (Big Stone, Douglas, Grant, McLeod, Meeker, Pipestone, Pope, Redwood, Renville, Traverse, Stevens, Yellow Medicine, Lac Qui Parle, Chippewa, Swift, Lincoln, Lyon, Murray, Kandiyohi, Rock Counties)
- Wright County
- Fond du Lac Band of Lake Superior Chippewa
- White Earth Nation

Appendix D: Data Tables

Demographic Characteristics

Number of Clients Enrolled by Client Type

Year	2016	
Client Type	**Number**	**Percentage**
Pregnant Women	5681	23%
Primary Caregivers (Parents)	6544	27%
Infants and Children	12067	50%
TOTAL	**24292**	**100%**

Age Group (Pregnant Women and Primary Caregivers Only)

Year	2016	
Age Group	**Number**	**Percentage**
14 and younger	79	1%
15 to 17	1138	9%
18 to 19	1473	12%
20 to 21	1362	11%
22 to 24	1913	16%
25 to 29	2966	24%
30 to 34	2029	17%
35 and older	1251	10%

Note: 18 missing cases excluded

Education Level (Pregnant Women and Primary Caregivers Only)

Year	2016	
Education Level	**Number**	**Percentage**
No High School Diploma or equivalent	3540	32%
High School Diploma or equivalent	3542	32%
Some Postsecondary education or college degree	4091	37%

Note: 11,056 other and missing cases excluded

Race (Pregnant Women and Primary Caregivers Only)

Year	2016	
Race	**Number**	**Percentage**
American Indian and Alaskan Native	346	3%
Asian	686	6%
Black and African-American	2233	19%
Native Hawaiian and Other Pacific Islander	37	0%
White	7661	65%
Multiple races reported	401	3%
Other	500	4%

Note: 365 missing cases excluded

Hispanic Ethnicity (Pregnant Women and Primary Caregivers Only)

Year	2016	
Hispanic Ethnicity	**Number**	**Percentage**
Hispanic	2177	18%
Not Hispanic	9641	82%

Note: 411 missing cases excluded

Race (Infants and Children Only)

Year	2016	
Race	**Number**	**Percentage**
American Indian and Alaskan Native	35	0%
Asian	965	8%
Black and African-American	2573	22%
Native Hawaiian and Other Pacific Islander	45	0%
White	6876	58%
Multiple races reported	111	1%
Other	619	5%

Note: 843 missing cases excluded

Hispanic Ethnicity (Infants and Children Only)

Year	2016	
Hispanic Ethnicity	**Number**	**Percentage**
Hispanic	2361	20%
Not Hispanic	9333	79%

Note: 373 missing cases excluded

Insurance Status at Intake (Pregnant Women and Primary Caregivers Only)

Year	2016	
Insurance Status	**Number**	**Percentage**
Has health insurance	9649	82%
Uninsured	2166	18%

Note: 414 missing cases excluded

Insurance Status at Intake (Infants and Children Only)

Year	2016	
Insurance Status	**Number**	**Percentage**
Has health insurance	8063	68%
Uninsured	2602	22%

Note: 1,402 missing cases excluded

Benchmark Evaluation Measures

Analysis was restricted to clients in long-term public health Family Home Visiting programs. Long-term programs include Nurse-Family Partnership (NFP), Healthy Families America (HFA), and evidence-informed public health family home visiting programs.

If data needed to determine inclusion in the numerator were missing (not reported to MDH), but all data needed to include the client or family in the denominator were available, the client or family was included in the denominator, but not included in the numerator. This methodology differs from that used in the 2016 Family Home Visiting Report to the Legislature; in which cases with any missing data were excluded from the calculation of the measure. Therefore, percentages should not be compared between these two reports.

Maternal and Newborn Health

Year	2016		
Measure Description	**Percentage**	**Numerator**	**Denominator**
Percentage of infants (born to mothers enrolled in home visiting prenatally) who were breastfed any amount at 6 months of age	28%	929	3354
Percentage of women who were screened for depression using a validated tool at least once between the birth of their child and 3 months postpartum	62%	3451	5576

Safety and Violence Prevention

Year	2016		
Measure Description	**Percentage**	**Numerator**	**Denominator**
Percentage of women who were screened for intimate partner violence with a standardized tool by 6 months of enrollment in home visiting	50%	2355	4685
Percentage of women with a positive screen for intimate partner violence who were referred to relevant IPV or domestic violence services	65%	114	175

Note: 285 NFP cases were excluded from the IPV Referral measure because of incomplete NFP referral data

Child Development and School Readiness

Year	2016		
Measure Description	**Percentage**	**Numerator**	**Denominator**
Percentage of children aged 9 to 12 months who received a screen for developmental delays using the Ages and Stages Questionnaire-3 (ASQ-3)	54%	2490	4606
Percentage of children aged 9 to 12 months with a positive screen for a developmental delay, who received a referral to relevant community resources	65%	121	185

Note: 39 NFP cases were excluded from the Developmental Referral measure because of incomplete NFP referral data

Family Economic Self-Sufficiency

Year	2016		
Measure Description	**Percentage**	**Numerator**	**Denominator**
Percentage of primary caregivers (pregnant women or parents) who did not have a high school diploma or equivalent on entry to home visiting, who subsequently completed a HS Diploma or equivalent, or enrolled in an educational program	70%	6013	8576
Percentage of primary caregivers (pregnant women or parents) who had health insurance coverage during the measurement year	84%	7162	8576
Percentage of infants and children who had health insurance coverage during the measurement year	78%	6764	8707