DEPARTMENT OF HEALTH

Family Home Visiting Program

REPORT TO THE MINNESOTA LEGISLATURE 2020

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Family Home Visiting Program: Report to the Minnesota Legislature 2020

Minnesota Department of Health
Family Home Visiting Section
PO Box 64882
St. Paul, MN 55164-0882
651-201-5000
health.homevisiting@state.mn.us
www.health.state.mn.us/communities/fhv

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Contents

Background

Family Home Visiting is a voluntary, preventive intervention that supports pregnant women and families with young children through a two-generation approach. By strengthening families in their communities, family home visiting has repeatedly demonstrated powerful impacts on multiple family and child outcomes, including positive pregnancy outcomes, school readiness, child abuse prevention, and family self-sufficiency.[1,2] **Minnesota Statutes Section 145A.17 subdivision 8** 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 including:

- Rationale for and importance of home visiting
- Description of home visiting in Minnesota, including systems, programs, and family activities
- Minnesota-specific outcomes related to systems, programs, and families
- Future directions for state and program development

Need for Family Home Visiting

Family Home Visiting (FHV) helps ensure pregnant women receive adequate prenatal care, learn about healthy development in utero, in infancy, and beyond, and promotes responsive relationships. As children and families develop, FHV helps ensure families with young children receive individualized social, emotional, health-related, and parenting supports, and are connected with community resources that help stabilize and empower families.

***Babies and young children thrive in caring and stimulating environments**. Even more, supportive and predictable relationships with parents and caregivers lay the groundwork for lifelong wellbeing and learning.*

*In particular, babies' brains develop at a remarkable rate—more than **1 million new neural connections form every second** during the first few years.[3]*

Appropriate prenatal care is critical for babies: brain development begins well before birth and is heavily affected by malnutrition, environmental pollutants, and infections (e.g., rubella).[4,5,6] Stressors and traumatic experiences in early childhood can disrupt normal brain development and lead to poorer physical health and worse emotional, behavioral, cognitive, and language developmental outcomes.[7,8]

Chronic stressors, such as poverty, can actually change the way the brain looks, develops, and functions.[9] The effects of poverty can be detected in brain development as early as 6 to 9 months of age.[10]

These adverse experiences and stressors unevenly impact pregnant women and families who also experience **economic, structural,** and **racial inequities**. Minnesota is one of the healthiest places to live, yet health disparities continue to significantly impact many Minnesotans.

For example, Minnesota's infant mortality rate is well below the U.S. average,[11] yet differences among racial groups persist: Births to African-American/Black and American Indian mothers have twice the rate of infant mortality compared to births of non-Hispanic white mothers.[12] This difference in birth outcomes between white

mothers and mothers of color is a health inequity. Health inequities are avoidable, unjust, and systematic differences between two groups. They occur for a variety of reasons and are a result of historical trauma, racial discrimination, structural racism, and social disadvantage.[13]

FHV 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. FHV services have demonstrated significant impact on improving child well-being outcomes for families experiencing the greatest burden of health, economic, and racial inequities.

What is Family Home Visiting?

FHV is a voluntary, home-based service ideally delivered prenatally through a child's first few years. Using information from developmental and risk assessments, a trained home visitor visits the family every week or so and works with the family on goals they have established. Home visiting uses a multi-generational approach, benefiting pregnant and parenting families with young children through:

- Helping parents and caregivers 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;
- Supporting parents as a **child's first teacher**; and
- Fostering **parenting skills** that decrease the risk of child abuse.

Risk Factors

Families who present the greatest needs are prioritized to receive visits from family home visitors who have extensive training and expertise. FHV begins prenatally when possible and recruits families with one or more of the following risk factors:

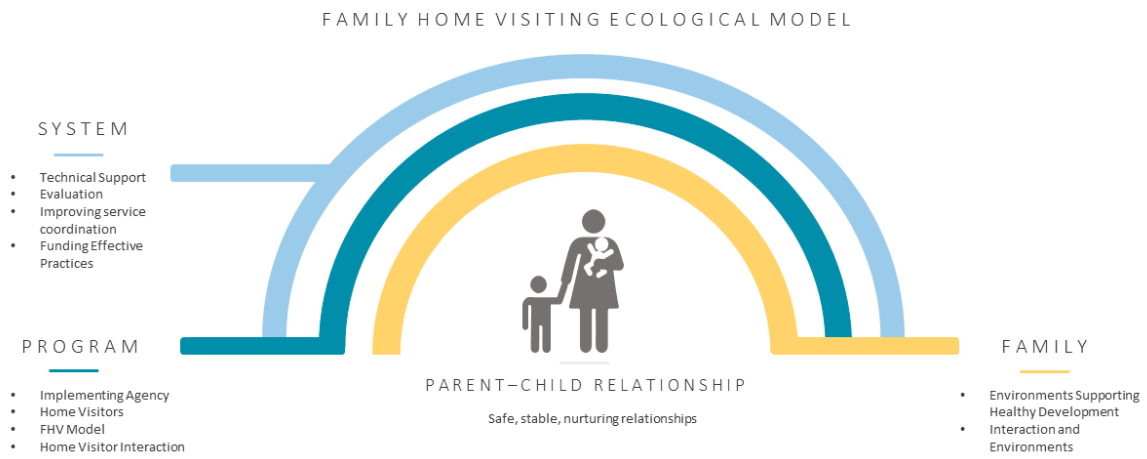
- Adolescent parents
- History of child or domestic abuse, or other types of violence including victimization
- History of homelessness or low resiliency to adversities and environmental stressors
- Mental health disorders including maternal depression or reduced cognitive function
- History of alcohol or substance use
- Insufficient financial resources and economic instability due to employment barriers

Ecological Systems

An adapted ecological systems lens is well suited to illustrate the positive impacts of FHV on maternal and child health and wellbeing.[14] Children and families develop and thrive within several layers of influences, where closer influences to the family have greater impacts on well-being. At the very core is the parent/child dyad and their relationship. Through the parent/child relationship, babies develop and are supported by multiple influences, including quality interactions, attachment, and wellness.

FHV in Minnesota uses an ecological framework with two layers around the family: the first, closer influence is direct FHV programming. This includes the implementing organization, the home visitor, the home visiting model selected, and the actual home visits. Surrounding this is a systems layer (i.e., Minnesota Department of Health) that affects the family but more directly influences home visiting programs. Technical assistance and support, research and evaluation, improving service coordination, and funding effective practices are examples of how systems support families via strengthening home visiting programs and implementing agencies.

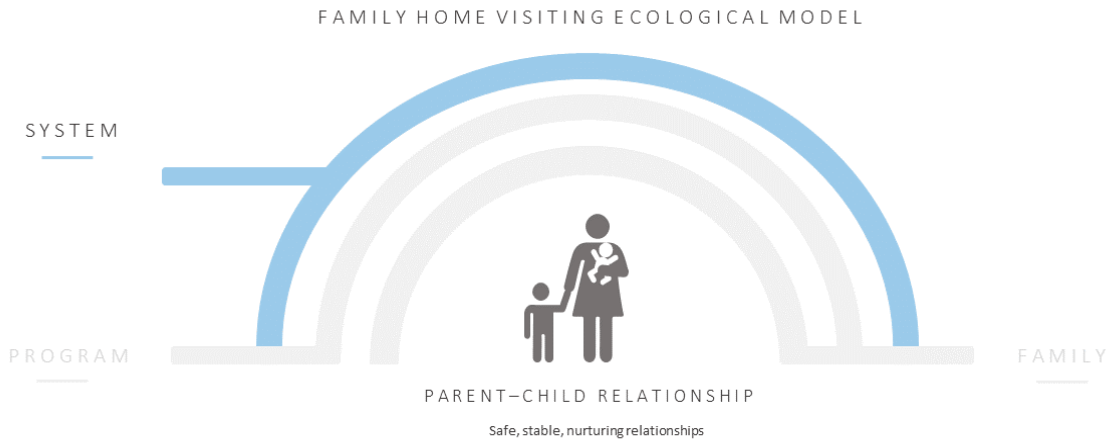
Each of these layers influences the parent, child, and their relationship, and are critical in ensuring that pregnant women and families with young children can access and benefit from quality FHV services. Additionally, these levels are points of entry to support health equity and healthy development for all Minnesotans.



Family Home Visiting Overview

This section presents an overview of family home visiting using the ecological framework:

- Systems: state-level funding and supports from MDH
- Programs: local programs providing FHV services
- Families: description of families participating in FHV



Systems

The Family Home Visiting (FHV) program at the Minnesota Department of Health (MDH) provides systems-level supports to grantees and local implementing agencies through the work of three units. This section presents an overview of the MDH FHV program, a description of FHV's integral role in supporting health equity, an overview of past and current investments, and the rationale for supporting evidence-based home visiting.

MDH FHV Program Organization

In January of 2017, the MDH FHV program re-organized the staffing structure to enhance expertise and focus areas. The program created three units: **1) Practice**, **2) Capacity Building**, and **3) Evaluation**. This new structure enhanced alignment and coordination of internal and external work with local implementing agencies (LIAs) and key partners.

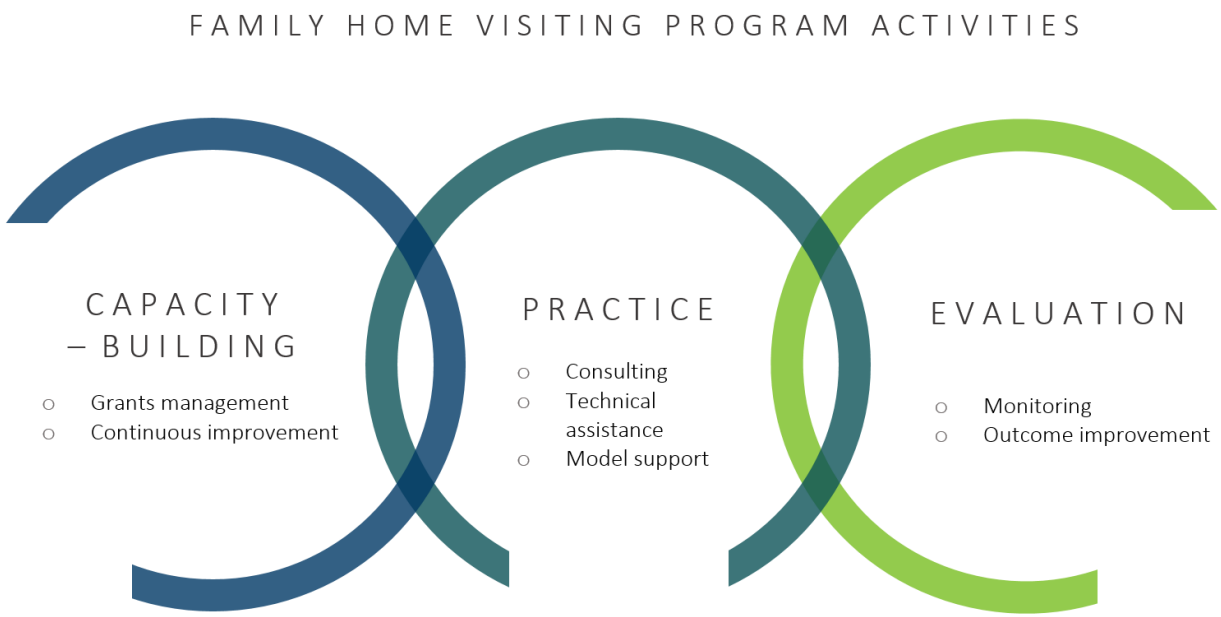
The Practice Unit oversees the direct consultation to local implementing agencies regarding home visiting infrastructure, home visiting practice, and regional/local coordination. Staff in this unit are responsible for connecting with home visiting model developers, providing practice-related technical assistance to LIAs, and overseeing model fidelity.

The Capacity Building unit plays a strategic role in planning, implementing, and monitoring related to state and federal family home visiting initiatives. They lead activities related to the expansion of evidence-based home visiting models and adoption of best practices, including program development, continuous quality improvement, early childhood systems integration, and grants management.

The Evaluation Unit oversees reporting of process and outcome measures to meet state and federal requirements. This includes tracking 19 federal benchmark measures, as well as developing and monitoring Minnesota-specific evaluation measures. They provide technical assistance for data collection and reporting to LIAs and respond to information requests.

Work within the MDH FHV program is collaborative and interactive—the success of one area relies on the support and expertise of the others as seen in Figure 1.

Figure 1. MDH FHV Program Structure



MDH Family Home Visiting Program Key Functions

- **Distributing funds** to local home visiting service providers through grant awards.
- **Monitoring** of work plans, budgets, and fidelity to home visiting models.
- Providing programmatic and budget **technical assistance**.
- **Coordinating with other state agencies** to build a stronger and more integrated early childhood systems.
- **Evaluating program effectiveness** through outcome measurement.
- **Continuous Quality Improvement** to improve programs and outcomes for families.

Health Equity and Family Home Visiting

Families are central to the healthy physical, social, and emotional development of infants and young children. However, many Minnesota families face challenges that impact their children's development during the critical early years of life. Stressors such as poverty and adverse experiences disproportionately affect children and families in economically, socially, and environmentally disadvantaged communities. Frequent exposure to these stressors leads to likelihood of facing **health disparities** later in life.

Health disparities are preventable differences in health outcomes that negatively affect socially disadvantaged populations, such as populations defined by race, gender, education, or geographic region.[15] The 2014 MDH report *Advancing Health Equity in Minnesota* describes these disparities as "neither random nor unpredictable. The groups that experience the greatest disparities in health outcomes also have experienced the greatest inequities in the social and economic conditions that are such strong predictors of health."[16]

FHV is uniquely positioned to **promote health equity** by addressing disparities, especially for pregnant women and families with young children. It provides social, emotional, health, and parenting supports to families, and links them to appropriate resources. FHV's emphasis of meeting families where they are, connecting pregnant women with appropriate prenatal care, and empowering parents with skills are just a few key activities that address the social and economic factors that drive these disparities.

The MDH FHV Program has adopted the following **strategic planning values** to guide this work:

- Transparent
- Inclusive
- Collaborative
- Adaptable
- Data-Informed
- Honoring Cultural & Community Wisdom

The MDH FHV Program puts these values into **policies and strategies that promote health equity** by:

- Supporting tribal home visiting and tribal public health by maximizing grants and streamlining application processes. Further, tribal home visiting frequently uses Family Spirit, an evidence-based FHV model that uses culture as an asset and prevention framework.
- Requiring Request for Proposal awardees to demonstrate they serve diverse and priority populations.
- Prioritizing grantees that work with smaller organizations that can meet the diverse needs of their communities.
- Promoting continuity of care for highly mobile families by strengthening local collaborations.
- Investing in programs that serve priority populations that historically have not accessed Family Home Visiting.

Past and Current Investments

State and federal grants (Table 1) fund Family Home Visiting across Minnesota. State allocated TANF (Temporary Assistance for Needy Families) funding supports non-model and evidence-based home visiting (EBHV) in local public health agencies and tribal nations. Competitive state grant funding, including state Nurse-Family Partnership (NFP) and Evidence-Based Home Visiting (EBHV), and the federal Maternal, Infant, Early Childhood Home Visiting (MIECHV) program finance the expansion and start-up of EBHV services.

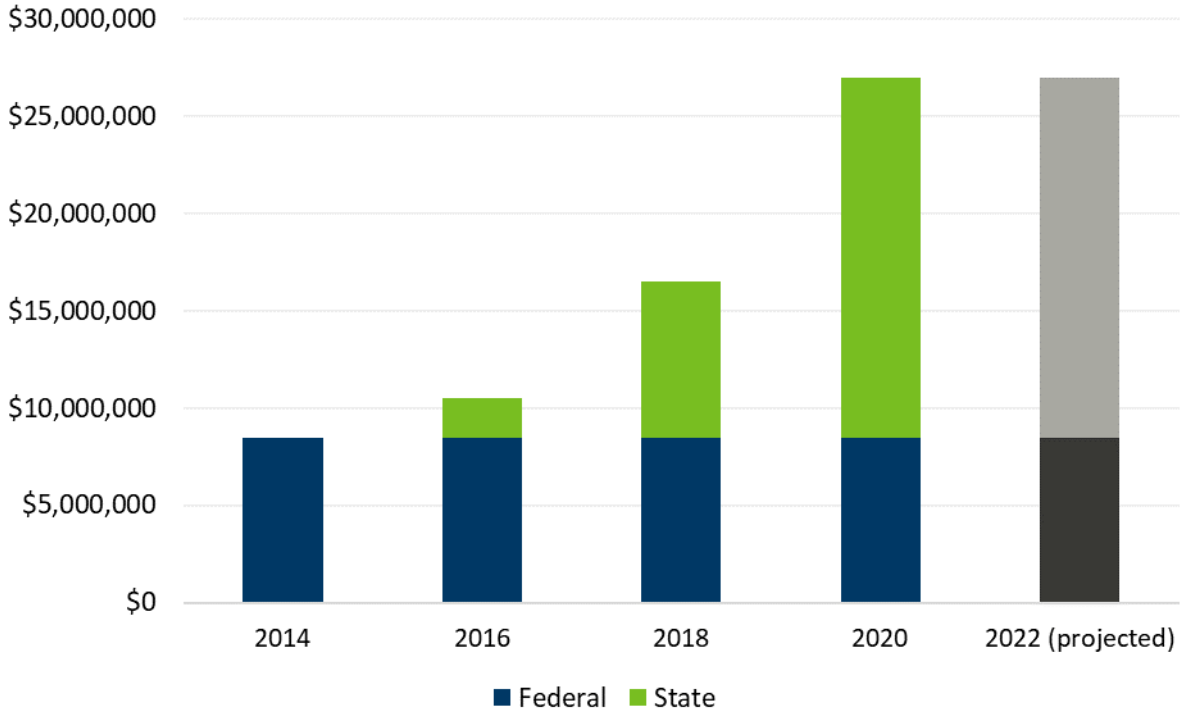
Table 1. MDH Family Home Visiting Funding at a Glance

Funding Source	Key Characteristics
Evidence-Based Home Visiting (EBHV) Grant	▪ State funded ▪ Competitive ▪ Distributed to community health boards (CHBs), tribal nations, & non-profits ▪ Evidence-based home visiting model required ▪ Serve high-need populations
Maternal, Infant, Early Childhood Home Visiting (MIECHV) Grant	▪ Federally funded ▪ Highest risk counties are eligible to receive funding ▪ Evidence-based home visiting model required ▪ Serve at-risk communities ▪ Promote early childhood system partnerships and coordination
Nurse-Family Partnership (NFP) Grant	▪ State funded ▪ Competitive ▪ Distributed to CHBs and tribal nations ▪ Exclusively use NFP model
Temporary Assistance for Needy Families fund (TANF) Block Grant	▪ State allocation of federal funding ▪ Not competitive ▪ Distributed by formula to Community Health Boards (CHBs) & tribal nations ▪ Traditional and evidence-based home visiting ▪ Participants meet 200% federal poverty guideline or MFIP eligibility

Since 2016, state funding for evidence-based home visiting has increased (see Figure 2), reflecting national trends of investing in validated home-based interventions that support pregnant women and families with young children.

In addition, the Minnesota Legislature and the Governor's Office continue to show bipartisan support for the family home visiting programs outlined in MN Statutes Section 145A.17, allocating $8.56 million each year for family home visiting programs in community health boards and tribal nations. For more information on individual awards to local public health and tribal communities, see Appendices A1 and A2 or visit the **Minnesota Department of Health-Family Home Visiting's Funding and Grants Management website.**

Figure 2. Investments in Evidence-Based Home Visiting 2014 - Present



Evidence-Based Family Home Visiting

Six different evidence-based home visiting models are implemented across Minnesota and vary in focus, intensity, and duration. To be considered evidence-based, a model must demonstrate positive impacts on child and family wellbeing through rigorous research.

Early Head Start, Family Spirit, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers are long-term, targeted home visiting models, serving families for 2-5 years; Family Connects is a short-term, universal home visiting model that provides families an average of 2-5 visits. All models use a two-generation approach for supporting parents and children yet vary slightly in audience, eligibility, and content focus.

See Appendix B for more detail on individual models, including target audience, theoretical foundation, and personnel requirements. Appendix C lists agencies that provide MDH-funded evidence-based home visiting services by model and service area. Each of the six models has demonstrated effects on maternal and child outcomes, and other measures that support family well-being. Table 2 describes the impacts of models implemented in Minnesota by outcome measure type, compiled by the Home Visiting Evidence of Effectiveness (HomVEE) review within the U.S. Department of Health & Human Services. Visit the **HomVEE Executive Summary** for more information.

Return on Family Home Visiting Investments

There is an estimated $6.40 return/gain on public investments for each dollar spent on evidence-based home visiting through the reduction in need for public services.[17]

Table 2. Positive Impacts on Primary or Self-Reported Outcome Measures for Home Visiting Models Implemented in Minnesota

X Meets Criteria | Does not meet criteria or not measured

	Early Head Start	Family Connects	Family Spirit	Health Families America	Nurse-Family Partnership	Parents As Teachers
Child Development & School Readiness	x	x	x	x	x	x
Child Health				x	x	
Family Economic Self-Sufficiency	x			x	x	x
Linkages/Referrals	x			x		
Maternal Health			x	x	x	
Positive Parenting Practices	x		x	x	x	x
Reduction in Child Maltreatment	x			x	x	x
Reductions in Juvenile Delinquency, Family Violence, & Crime				x	x	

Source: U.S. Department of Health & Human Services , Home Visiting Evidence of Effectiveness (HomVEE)

Traditional Family Home Visiting

Traditional public health home visiting is widely implemented across Minnesota. This type of home visiting is often guided by practitioner experience, nursing education, community needs, and findings from basic research.

A number of local public health agencies, tribal nations, and non-profits provide traditional home visiting services. They range in length and intensity. 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 ongoing, intensive services to families at risk.

Home Visiting Highlight: Simpson Housing Services

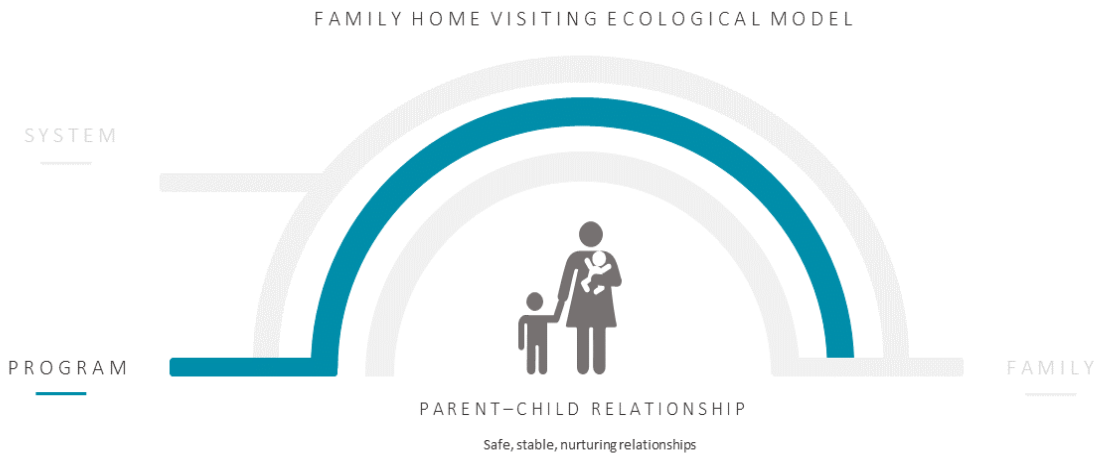
Adapting a Family Home Visiting Model to Serve a Population within a Cultural Context

As an agency that has a long history serving families experiencing homelessness, Simpson Housing Services was well aware of the challenges that both homeless children and their parents face. Children in homeless families have increased rates of developmental delays, learning disabilities, and emotional and behavioral problems, including anxiety and depression.[18]

Simpson's approach to serving families combines stable housing, agency expertise, building trusting relationships with families, and effective early childhood intervention and support strategies. The program serves families with high levels of trauma and instability who may not have access to or have distrust of traditional early childhood programs. Recognizing this critical need for the families they serve, Simpson Housing applied for and received the new state evidence-based home visiting funding to fill gaps in the early childhood home visiting system and increase home visiting services to families experiencing homelessness.

In the fall of 2019, Simpson Housing Services began implementing the Family Spirit home visiting model and adapting it to support primarily African American families in their supportive housing programs who have experienced homelessness. The Family Spirit model was designed through a cultural lens with recognition of communities that have experienced significant personal and historical trauma. Staff at Simpson Housing chose Family Spirit for its emphasis on cultural strengths and balance of proven outcomes with flexibility to address the needs of highly mobile families.

Simpson Housing currently works with over 290 families in supportive housing. They will be targeting home visiting services to pregnant women or families that have children younger than 18 months of age.



Programs

Local programs (community health boards, tribal communities, and nonprofits) provide and implement Family Home Visiting services in Minnesota. Staff development is an integral component in the success of these programs.

Family Home Visiting Grantees

FHV grantees receive state and federal funds to deliver home visiting services to families. The agencies conducting the home visits use their knowledge of the community they serve, community needs, and resources that best serve their priority population(s) to determine the desired outcomes from home visiting. Selecting appropriate home visiting models and curricula, managing operations, hiring and supporting home visiting staff, and meeting reporting requirements are a few key responsibilities of local FHV programs.

The MDH FHV Program has a long history of supporting community health boards and tribal nations in Minnesota to provide home visiting services. With the infusion of new state funding, MDH has expanded support to non-profits and regional collaborations to implement evidence-based home visiting programs. As a result, FHV is able to reach communities and priority populations in new and innovative ways.

Home Visiting Highlight: City of Minneapolis Family Connects

Family Connects: A Universal Approach to Family Home Visiting

An integral goal of the Minneapolis Health Department is to aid populations with greater risk for adverse health outcomes, including low-income individuals and families, communities of color and American Indians, first time mothers, and teen parents. To help reach this goal, Healthy Families America and Nurse-Family Partnership, two long-term family home visiting models, have been implemented in Minneapolis over the past decade through their partnership with MVNA.

Minneapolis, however, identified a critical gap in services: Many families are not eligible or interested in long-term home visiting services. In fact, MVNA received nearly 1,500 referrals for families in 2017 that were not eligible for the long-term models but were interested in short-term home visiting.

The Minneapolis Health Department, in coordination with Hennepin Healthcare and MVNA, is delivering the first large-scale universal home visiting program in Minnesota. Family Connects, an evidence-based, short-term model delivered by nurses, operates under the theory that every family is vulnerable at the birth of a child and community-wide eligibility is the best route to population-level change.

MVNA invites all new mothers who reside in Minneapolis and deliver their baby at Hennepin County Medical Center (HCMC) to elect a Family Connects home visit after the birth of their child. These women reflect the needs and risks of the target population: high poverty (75% HCMC birth families live at or below 200% Federal Poverty Level); women at risk for poor birth outcomes, such as low birth weight (9.5% at HCMC) and premature delivery (10.4% at HCMC); teens; homeless; and underserved racial/ethnic communities (based on 2017 Hennepin Healthcare Community Health Assessment).

Their goal is to is to improve the health and wellbeing of children and their families through early access to postpartum and well-child care, teaching positive parenting techniques, lowering maternal anxiety and depression, reducing emergency medical care for infants, lowering rates of child protection investigations for abuse and neglect, and linking families to community resources, including long-term home visiting.

Staff Development & Support

Supporting and developing staff is critical for delivering strong program activities to families and promoting stable and effective organizations. FHV services are often delivered in partnership with multidisciplinary teams of public health nursing, social work, early childhood education professionals, and family educators.

Each of the FHV models has specific training requirements for home visitors and their supervisors. There are also trainings and topics that local implementing agencies and home visitors seek out to build knowledge and skills. Beyond the core requirements of each home visiting model, FHV agencies have discretion in selecting trainings specific to the needs of their home visitors and communities.

Two online professional development resources are currently being supported by the MDH FHV Program. **Achieve OnDemand** is an online training resource aimed specifically at home visitors and their supervisors. Through these online resources, family home visitors can access and participate in self-paced learning modules. **Institute for the Advancement of Family Support Professionals (“The Institute”)** is a free online training resource that offers family support professionals the opportunity to learn new skills and develop their careers**.**

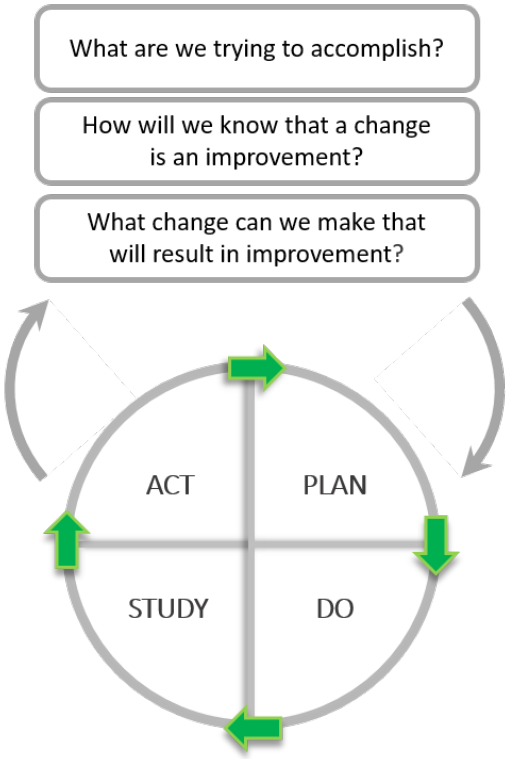
Spotlight On: Continuous Quality Improvement

What is CQI?

Continuous Quality Improvement (CQI) is a deliberate, defined process of focusing on activities that are responsive to community needs and improving population health. It is a continuous and ongoing effort to achieve measurable improvements in efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality.

The MDH FHV Program utilizes the Model for Improvement[19] (Figure 3) to build capacity within local FHV programs for continuous quality improvement and to improve outcomes at the state and local levels. The Model for Improvement is a simple, yet powerful change model used to accelerate learning and improvement.

Figure 3. Model for Improvement

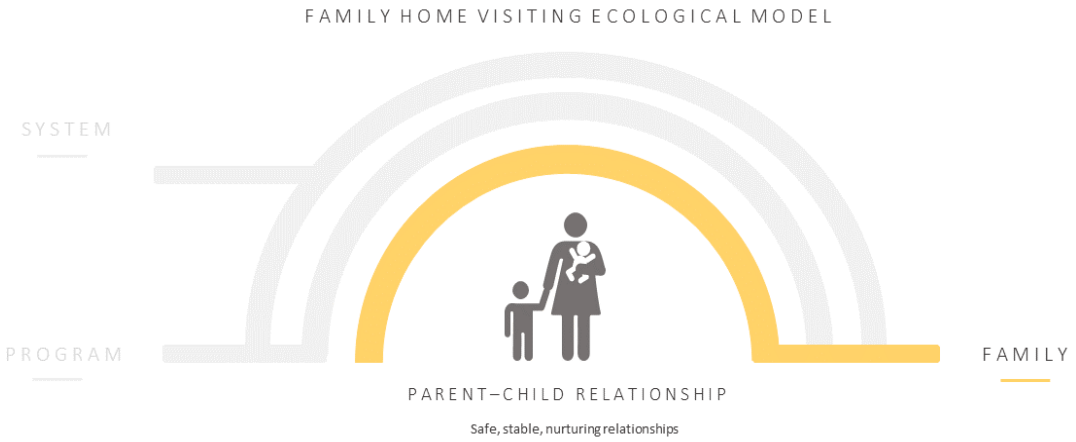


Since 2017, MDH has been using the Institute for Healthcare Improvement Breakthrough Series Collaborative[20] model to improve family and program outcomes.

A Collaborative is a time-limited effort of multiple organizations from throughout Minnesota that come together with leaders and experts to learn about and to create improved processes in a specific topic area.

Key Collaborative features include:

- "All teach, all learn" where everyone is involved in sharing expertise
- **Rapid testing for improvement** allows real time changes to practice
- Minnesota programs have a platform to **share best practices** with one another
- Reproducing what works by **scaling tested interventions**
- **Reporting, monitoring, and interpreting data** as part of everyday practice



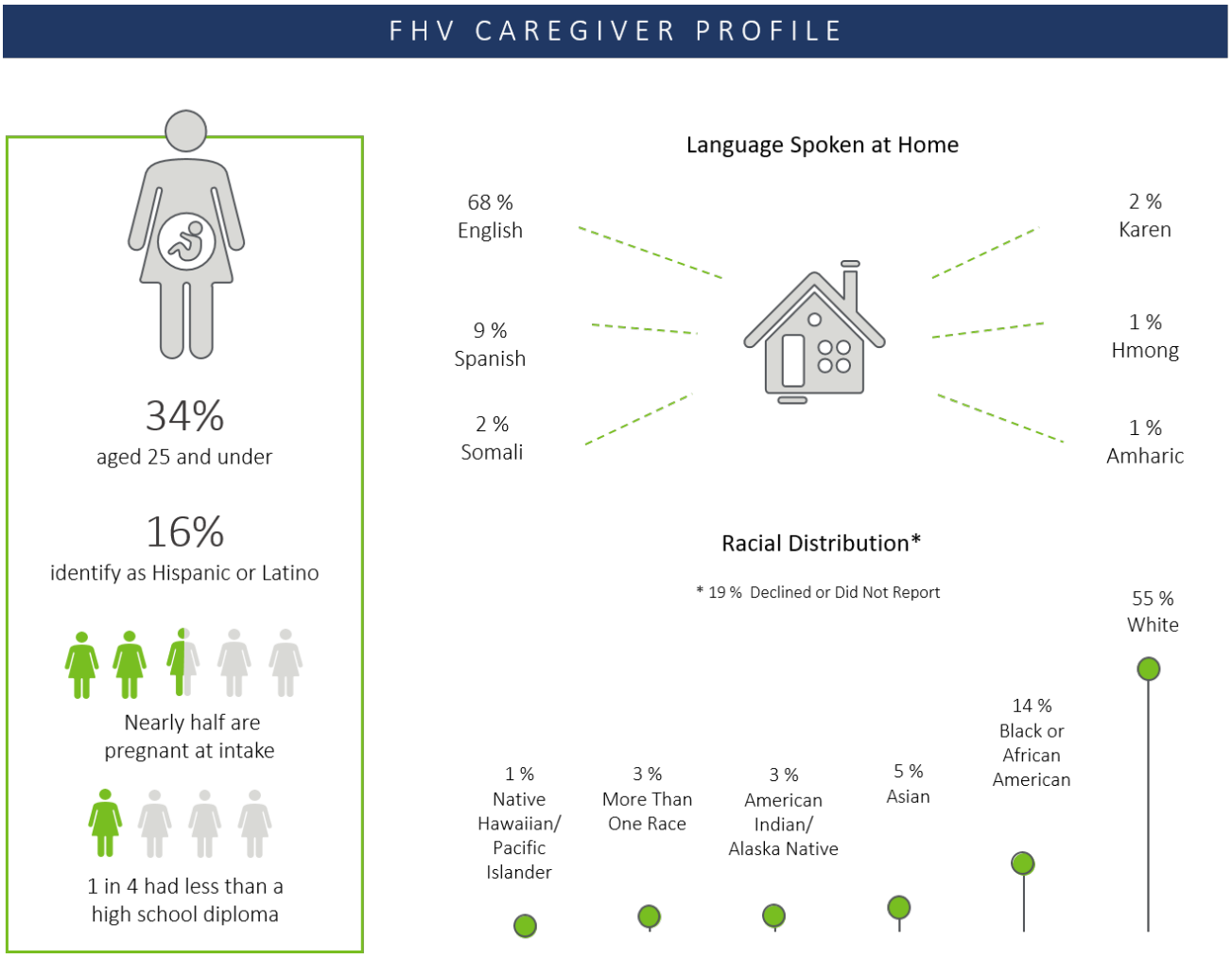
Families

Families who participate in family home visiting are diverse and represent different ages, education levels, languages, and races.

Family Home Visiting Caregiver Demographic Characteristics 2017-2019

As seen in Figure 4, over one-third of caregivers participating in FHV were under 25 years old, 16% identified as Hispanic or Latino, and one in four had less than a high school diploma. A variety of languages are spoken, including English, Spanish, Somali, Karen, Hmong, and Amharic. Over half of the FHV caregivers are White, followed by Black or African American (14%), Asian (5%), American Indian/Alaska Native (3%), those who identify as more than one race (3%), and Native Hawaiian/Pacific Islander (1%). For complete demographic counts and averages for 2017, 2018, and 2019, along with 3-year averages, see Appendix D. Data were provided for caregivers enrolled during each fiscal year and averaged across all three years.

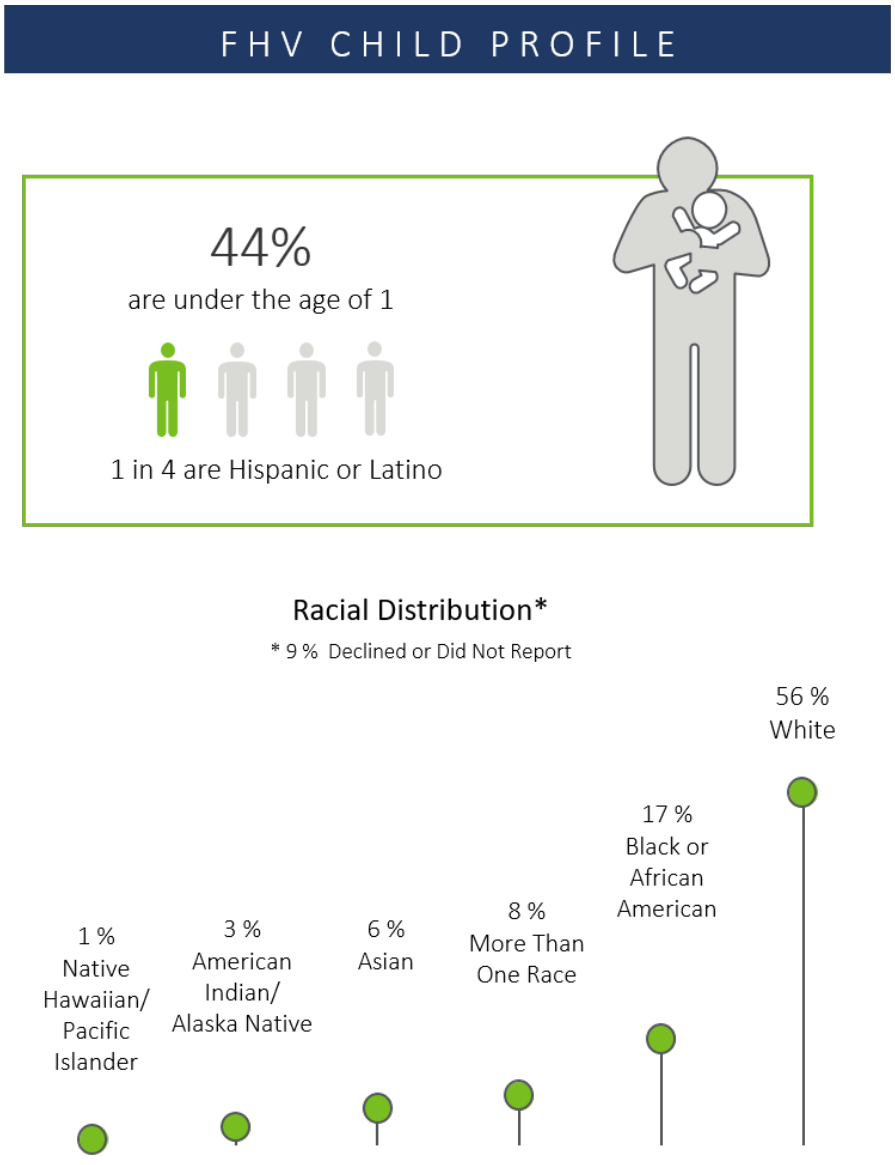
Figure 4. Profile of Caregivers Participating in Family Home Visiting for State Fiscal Years 2017-2019



Family Home Visiting Children Demographic Characteristics 2017-2019

As seen in Figure 5, over 40% of the children served by FHV were under 12 months old and one in four children is Hispanic or Latino. Over half of the children are White (56%), followed by Black or African American (17%), more than one race (8%), Asian (6%), American Indian/Alaska Native (3%), and Native Hawaiian/Pacific Islander (1%). For complete demographic counts and averages for 2017, 2018, and 2019, along with 3-year averages, see Appendix D. Data were provided for children enrolled during each fiscal year and averaged across all three years.

Figure 5. Profile of Children Participating in Family Home Visiting for State Fiscal Years 2017-2019



Tribal Family Home Visiting

Family Home Visiting (FHV) is a two-generation intervention that supports healthy families through parent support and education as well as focusing on child development and school readiness. FHV can be especially successful for American Indian families in models that utilize a culture as strength and prevention framework. Historical trauma and systemic racism have perpetuated ongoing health disparities in Minnesota's American Indian population and have had especially harmful effects on mothers and young children. [21,22,23]

Home Visiting Builds Capacity in Tribal Communities

Family Home Visiting empowers families by emphasizing:

- People are the experts on their own life
- The power of meeting people where they are
- Relationships are key
- The value in connecting families to resources to build their support network and reinforce community infrastructure

Tribal communities in Minnesota are building local home visiting capacity with the financial and technical support of the MDH FHV Program. MDH is improving tribal grant coordination by working to de-silo funding opportunities, encouraging collaborations across grantees, and leveraging related resources that support pregnant mothers and families of young children.

The MDH FHV Program helps support home visiting programs in American Indian communities by providing model expertise, providing technical assistance around reporting, assisting in funding/grants management, and facilitating training opportunities.

Family Spirit Overview

Family Spirit is an evidence-based home visiting model that is designed for pregnant women and families with young children in American Indian communities. It was developed around indigenous beliefs systems and encourages using healthy traditions to guide parenting behavior and goals.

Visits can be as often as weekly to deliver the model's 63 lessons across six parenting and healthy living domains. The format encourages using healthy indigenous traditions of the participant's community to guide parenting and personal behavior.

Sharing Our Expertise with a National Audience

In February 2019, representatives from MDH, the Leech Lake Band of Ojibwe, and the Family Spirit home visiting model led a panel discussion at the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) All Grantee Meeting in Baltimore, Maryland. They reviewed local experiences, cultural adaptations, best practices, and lessons learned from a five-year, multi-level collaboration to support Family Spirit implementation in Minnesota's tribal nations.

They focused on implementation efforts aimed at prioritizing authentic partnerships and supporting cultural enhancements that incorporate considerations at the community, state, and model levels. The panel blended brief activities focused on developing programmatic, infrastructure, and skill building around cultural enhancements and adaptations.

In addition, panelists presented different community-based approaches to developing culturally informed interventions. These approaches included non-adaption/surface-structure cultural adaptation, deep-structure cultural adaptation, and culturally grounded prevention.

Karla Decker-Sorby (MDH), Birdie Lyons (Leech Lake Band of Ojibwe), and Crystal Kee (Family Spirit at Johns Hopkins Center for American Indian Health) presenting at the 2019 MIECHV All Grantee meeting in Baltimore, MD.

Family Spirit Community of Practice

In May 2018, staff from MDH and the Johns Hopkins Center for American Indian Health hosted a two-day event that began with an opening drum ceremony, smudging with sage and cedar, and traditional Ojibwe and Dakota welcoming prayers. Twenty-two staff from seven Family Spirit sites across Minnesota were involved in event planning and helped to develop learning objectives. These included innovative ways to embed American Indian cultural elements into home visits, improve father involvement, implement retention strategies, and work with families experiencing substance use. Breakout sessions allowed MDH and Family Spirit staff to meet individually with each Family Spirit site to discuss successes and challenges.

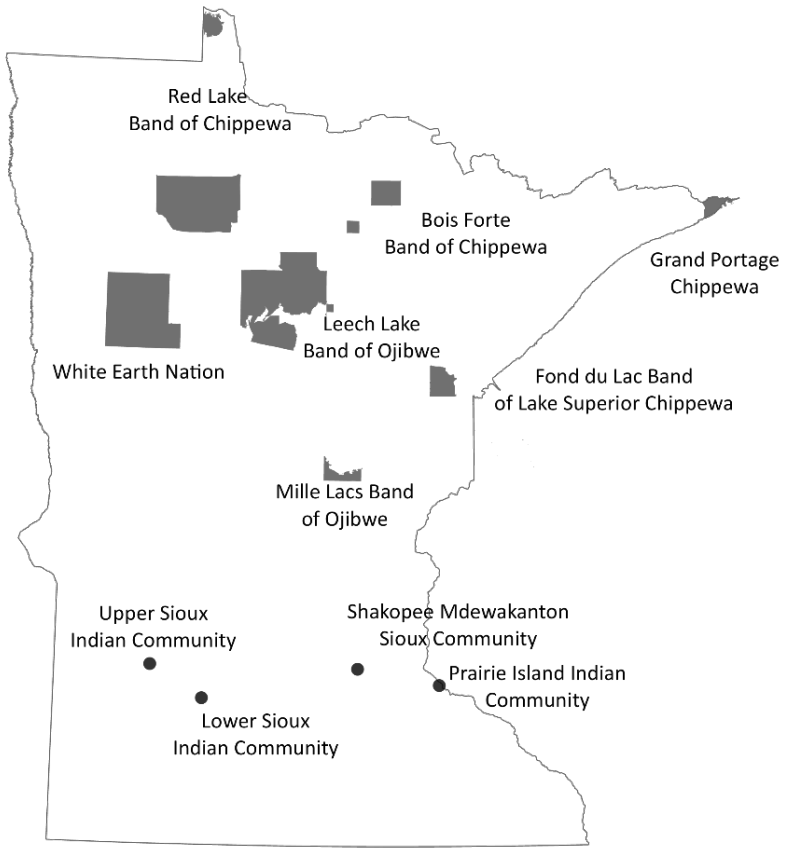
Carol DeMars and Crystal Roeschlein from the Mille Lacs Band of Ojibwe at the Family Spirit training in Bemidji, MN.

What's Next for Tribal Home Visiting in Minnesota?

In 2020, there will be a gathering of all of Minnesota's Family Spirit and tribal home visiting sites for a yearlong, three-part Community of Practice series. The Community of Practice will support agencies and home visitors by connecting them to others doing the same work and learning from best practices. Focus groups will guide the development of self-identified professional development needs and areas where more support from the MDH FHV Program would be helpful.

Highlights of Tribal Home Visiting in Minnesota

Minnesota's eleven tribal nations are distinct, separate communities. Each community has unique strengths and challenges. Geographically, the tribes are located throughout Minnesota with four small Dakota (Sioux) tribes south of Interstate 94 and seven larger Ojibwe (Anishinaabe, Chippewa) tribes across the northern tier. Below are a few examples of how Family Home Visiting is building stronger communities and families across Minnesota.



Bois Forte

Minnesota's First Family Spirit Site

Bois Forte became the first Family Spirit site in Minnesota in 2014. They have continued to grow their program and strengthen the community one family at a time. In fact, their newest home visitor was one of the first graduates of their Family Spirit program.

Fond Du Lac Band of Lake Superior Chippewa

Tagwii Recovery Program Education

Family Home Visiting has collaborated with the Tagwii Recovery Program, a program that focuses on the treatment of alcoholism, opioid addiction, other substance abuse, and mental health disorders. They have reached 19 adolescents and 57 adults in these programs and engaged them in educational group topics like STIs, birth control, and sexuality.

Grand Portage Band of Chippewa Indians

Engaging Families with Healthy Options

Grand Portage has a small population yet utilizes a variety of programs to help engage families in Family Home Visiting. For example, the Healthy Cents program hosts parent-child education events that center on education and engagement with nutrition, especially with WIC resources and other healthy foods.

Leech Lake Band of Ojibwe

Breastfeeding Support Fostered Tribe-wide

Family Home Visiting in LLBO has modified the continuous quality improvement initiative on breastfeeding to increase buy-in for breastfeeding across the whole tribe. By supporting policy changes that promote breastfeeding, mothers can feel more accepted and supported in their breastfeeding journey. This initiative also increases breastfeeding rates to at least the first six months of the child's life.

Lower Sioux Indian Community

Collaboration with Early Head Start Programs

Family Spirit home visiting collaborates with the Lower Sioux Early Head Start, an early childhood program, to host events and workshops, such as the moccasin making workshop and traditional teaching. Participants learn how to make moccasins for their children while childcare is provided. They also host year-end celebrations that include information on the importance of breastfeeding. Lower Sioux Community Health staff participate in home visits with Lower Sioux Early Head Start family home visitors as requested for support. This collaboration works to strengthen and support each other as a community versus competing with one another.

Mille Lacs Band of Ojibwe

Building Trust One Family at a Time

MLBO Family Home Visiting's goal is to build trust in the community. They visit participants at a local treatment center that allows mothers to keep their babies with them during treatment. Home visitors also provide education that includes cultural traditions at various community events.

Red Lake Band of Chippewa

Public Health Nursing Partnerships

Family Home Visiting collaborates with WIC public health nurses. These public health nurses join Family Home Visitors on visits to new moms and babies to provide a continuity of care between programs.

Upper Sioux Indian Community

Utilizing Traditional Dakota Teachings to Promote Health

Family Home Visiting uses traditional Dakota teachings and language with a focus on health, like Planting Traditional Gardens and using the Dakota name for each seed that is planted. These programs allow families to learn more about healthy options for the family while nurturing the sense of community and the sense of identity in the Dakota culture.

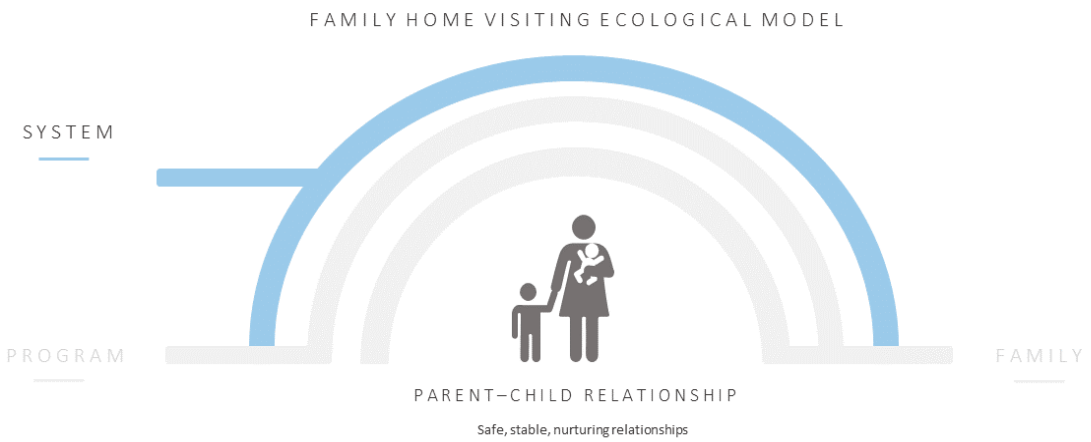
White Earth Reservation

Putting Family Home Visiting into a Cultural Context

Family home visitors promote culturally appropriate safe sleep practices by providing dream catchers and cribettes, and sharing safe sleep information from the Healthy Native Babies Project. They also provide items for smudging (abalone shells, sage, sweetgrass, tobacco, cedar) when discussing the home environment and share the culturally relevant pregnancy book, "The Coming of the Blessing."

Activities and Outcomes

This section describes activities and outcomes related to the implementation of Family Home Visiting services. Following the ecological model, systems-level activities and results, program activities, and family outcomes are presented.



Systems

The Family Home Visiting (FHV) program at the Minnesota Department of Health (MDH) has expanded the availability of FHV in Minnesota and continued to support local partnerships and collaborations.

Expansion of Evidence-Based Home Visiting Services since 2012

Evidence-based home visiting has dramatically increased across the state as the MDH FHV Program has emphasized the importance of implementing proven models that support pregnant women and families with young children. Forty-seven counties were implementing an EBHV model in 2012. That number grew significantly in 2015 to 59 counties. Tribal nations have also had success implementing evidence-based home visiting models that meet their community values and needs. In Minnesota, eight of the eleven tribal nations implement Nurse-Family Partnership or Family Spirit.

By 2019, 94% (n = 81) of counties are using an evidence-based home visiting model that has demonstrated positive results for families. Figures 6-8 illustrate the expansion of evidence-based home visiting services across Minnesota from 2012, 2015, and 2019, respectively.

Figure 6. Minnesota Counties with Evidence-Based Home Visiting, 2012

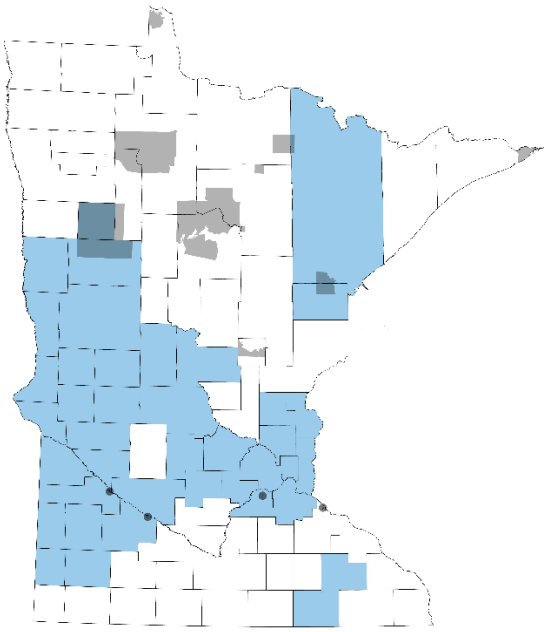


Figure 7. Minnesota Counties with Evidence-Based Home Visiting, 2015

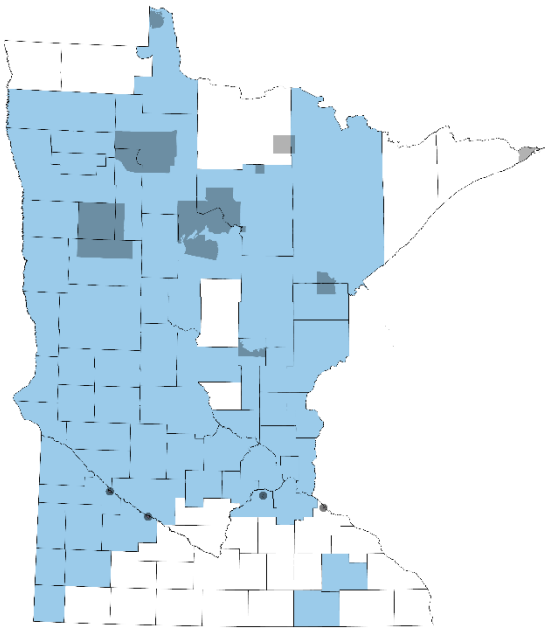
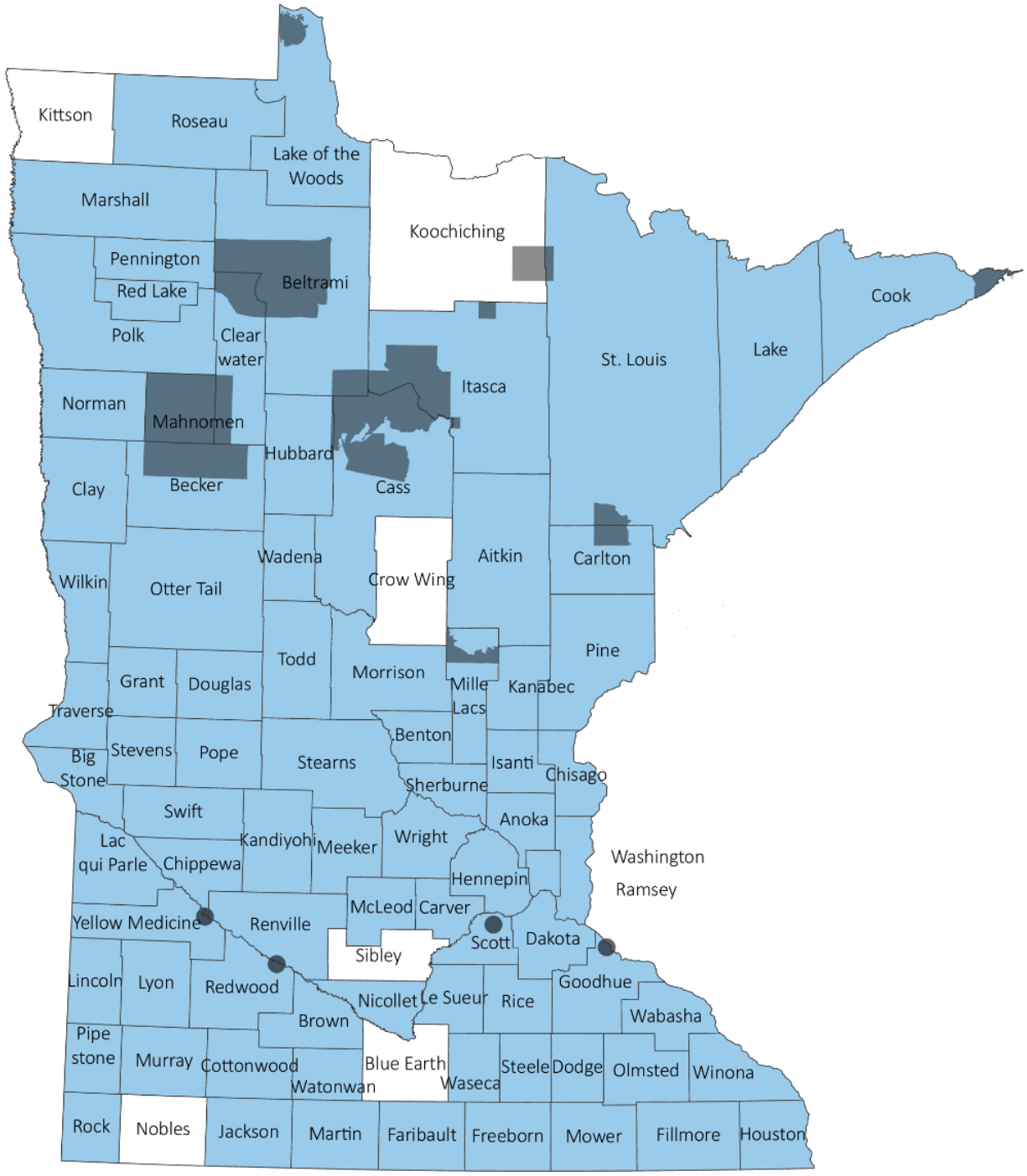


Figure 8. Minnesota Counties with Evidence-Based Home Visiting, 2019



See Appendix C for tables listing counties within the service area of specific local FHV provider agencies, listed by evidence-based model.

Home Visiting Highlight: Lakes & Prairies Community Action Partnership

Data-Driven Programming

Lakes & Prairies Early Head Start recognizes that parents are the most significant individuals in a child's life. They have extensive experience working with families at-risk and provide a solid foundation for effectively addressing the diverse needs presented by families living in both urban and rural communities in the Upper Midwest.

To understand and respond to the unique needs of families and individuals, Lakes & Prairies has developed a series of Child and Family assessment data collection processes. Adult education, health outcomes, housing, child development, and parent engagement data are just a few measures they use to support families in their program.

Lakes & Prairies recently hosted a Self-Assessment Data Sharing Day, inviting community members to attend. Lakes & Prairies shared feedback on health, enrollment, nutrition, family services, and education data. Participants looked for trends and offered strategies for improvement.

Continuous Quality Improvement (CQI) Initiatives

The MDH FHV program is implementing a comprehensive CQI plan, offering support to LIAs by providing:

- Consultation
- Training
- Facilitation
- Coaching
- Peer learning opportunities
- Technical assistance
- Data collection, reporting, and analysis

Coaching Capacity: The MDH FHV program has strategically developed internal capacity to support more LIAs in their improvement efforts. In addition to formal training received by the FHV CQI Coordinator, three FHV Nurse Consultants and two CQI Student Workers also participated in the Quality Improvement Essentials training through Institute for Healthcare Improvement. An internal CQI Workgroup collaborates to provide appropriate expertise and tailored support to LIAs focusing on improvement areas.

Peer Learning: Peer learning is a key component of FHV CQI plan. Since 2017, the MDH FHV Program has utilized the Institute for Healthcare Improvement Breakthrough Series Collaborative model to promote peer learning among home visiting programs throughout the state. MDH makes year-over-year improvements to the Collaborative by regularly seeking and applying feedback from CQI participants. This has been instrumental in helping teams understand the value, building buy-in, gaining support, and acknowledging MDH's own commitment to the CQI process.

Partner and Parent Perspective: The MDH FHV program has formed a CQI Advisory Group comprised of local home visiting administrators, supervisors, and home visitors to provide input into CQI initiatives. These leaders help select topics, set goals, create driver diagrams, develop measures, create resources, address challenges, champion changes, and celebrate successes. MDH is utilizing the Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) Parent Leadership Toolkit to help local programs do the same with their clients. MDH works with LIAs to set small goals for building parent leadership using the Toolkit and helps them identify opportunities to engage parents in a wide variety of ways.

MDH FHV Quality Improvement Objectives

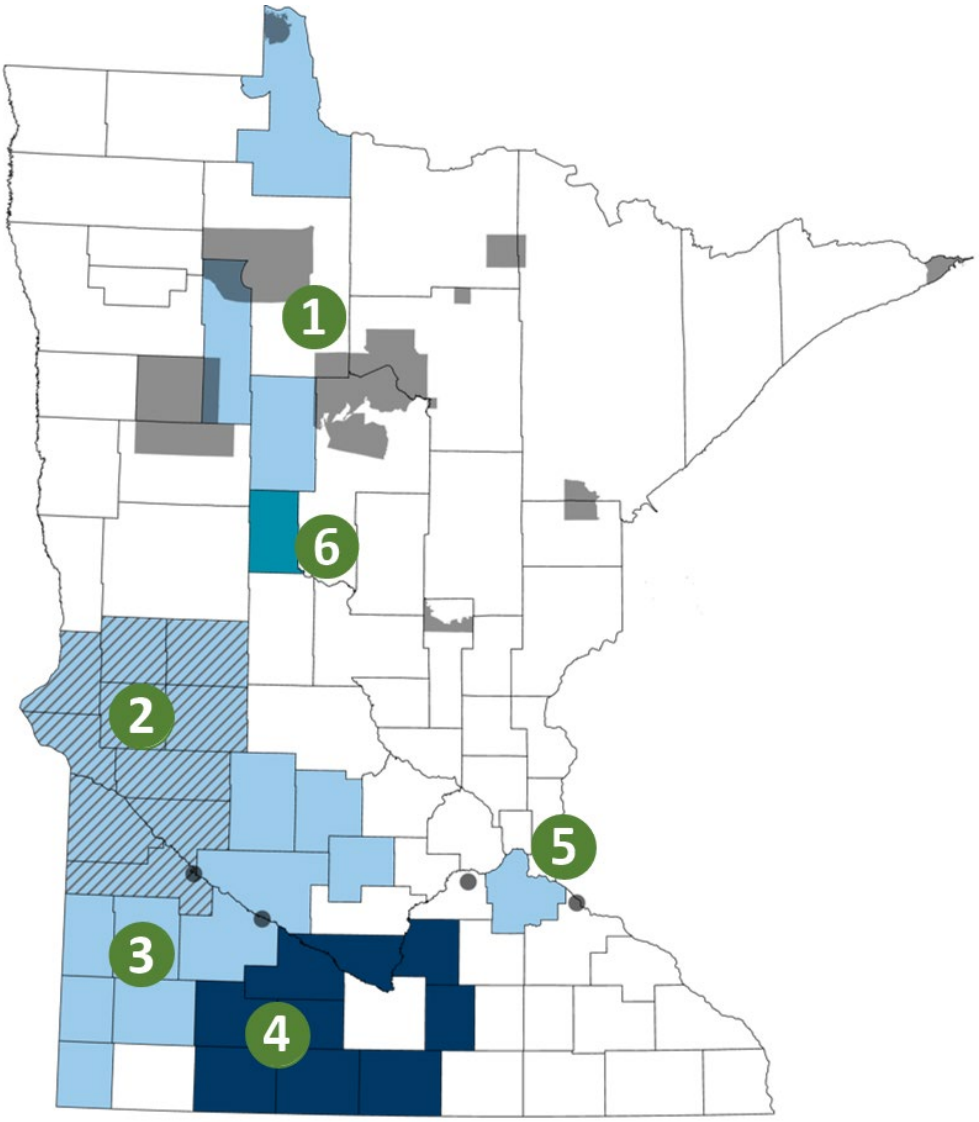
- Improve outcomes for families served by local home visiting programs
- Build capacity of Local Implementing Agencies (LIAs) to use consistent and planned quality improvement methods.
- Continually improve state methods for supporting LIAs in quality improvement efforts.

Strengthening Collaborations

The MDH FHV Program prioritizes regional, county, and tribal collaborations for grant applicants. These partnerships encourage broader geographic coverage and cross-county collaborations that reduce gaps and duplication of services. Funding local partnerships that include smaller grantees also promotes health equity as smaller, culturally based agencies are often better suited to meet the diverse needs of communities and create a more seamless home visiting service delivery for highly mobile families. These regional and community collaborations strengthen home visiting by extending grant dollars, stabilizing programs, and better reaching and supporting families.

These collaborations represent a host of developing relationships including: cross-county, tribal-county, local partnerships across programs, and local FHV programs to other early childhood systems. On the following pages are a few examples of effective home visiting partnerships across Minnesota.

Effective Partnerships across Family Home Visiting in Minnesota



1 Tribal and County Coordination to Serve Region

North Country Public Health, Quin County Community Health Board, Beltrami County Public Health, and Leech Lake Band of Ojibwe are collaborating to better serve the Native American population in the area. Leech Lake home visiting serves as a leader in supporting Family Spirit, an evidence-based model that uses Native teachings for Beltrami and Clearwater County Public Health Nursing. This partnership also uses a universal referral form and coordinates with local school districts, social service agencies, Head Start, medical clinics and hospitals, and WIC.

2 Family Home Visiting and Child Welfare Collaborate

Horizon Public Health and Countryside Public Health are implementing the Healthy Families America (HFA) model with the Child Welfare Adaptation, an adaptation that allows enrollment of families referred from Child

Welfare whose children are up to 2 years of age instead of the normal requirement to enroll shortly after birth. By increasing the number of families served by home visiting, they capitalize on preventive services that help reduce parental substance abuse, incarceration rates, child maltreatment, and out-of-home placements. They also improve both child and adult mental health by reducing Adverse Childhood Experiences (ACEs). County Human Service partners, WIC, hospitals, and Public Health work together to identify and recruit eligible families.

3 20 Counties Collaborate to Reach Those in Need

Supporting Hands Nurse-Family Partnership in west central and southwestern Minnesota provides home visiting services across 20 counties. The largest home visiting collaboration in Minnesota, Supporting Hands has supported healthy pregnancy outcomes, child health and development, and economic self-sufficiency to over 1,200 currently enrolled women. This collaboration is also one of the longest: 13 of the counties joined together in 2007 and have graduated nearly 350 families. To support this effective partnership, supervisors handle central intake and make assignments throughout the region. Supporting Hands has an active recruiting presence in the community and coordinates services with WIC, Head Start, Lower Sioux home visiting, and school districts' Early Childhood Family Education/Special Education programs.

4 Leveraging Experience to Spread Evidence-Based Home Visiting

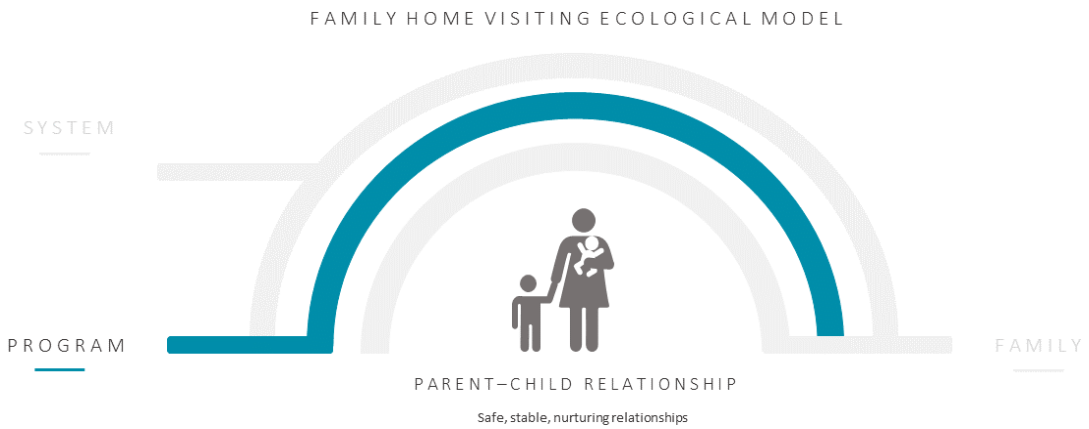
When state evidence-based funds became available, nine counties in south central Minnesota knew it was the right opportunity to work together to expand availability of evidence-based home visiting services in their region. By leveraging the experience and success of the current HFA program in Faribault and Martin counties, services and infrastructure were expanded to Brown, Cottonwood, Jackson, Le Sueur, Nicollet, Waseca, and Watonwan counties. They formed a partnership to implement Healthy Families America (HFA) for at-risk prenatal women and women with children up to age three. Through their expanded partnership, the nine counties have implemented an active referral system to reach their intended target population, ensure timely referrals, and identify appropriate community resources for client referrals.

5 Birth to Age 8 Collaborative-Early Childhood Systems Coordination

Dakota County Community Services (including Family Home Visiting and WIC), local school districts, 360 Communities (nonprofit), and Head Start are partnering to coordinate early childhood services so all children reach reading proficiency by spring of third grade and families receive the necessary supports to succeed. Key activities include: Ensuring all eligible children receive preschool screening, implementing a collaborative referral process that connects families with services, and identifying and tracking risk indicators for strategic intervention. For example, a data sharing portal is in development that will allow home visiting nurses to collaborate with school district staff and surround a child and family with support as needed. The portal will promote data sharing related to specified developmental milestones and referrals that have been offered to the family.

6 Cross-Agency Collaboration Promotes Information Sharing

The **Wadena County Early Childhood Coalition** focuses on supporting the health and wellbeing for children birth to age five, empowering families, and providing educational opportunities for early learning providers. Wadena County Public Health, school districts, clinics, and childcare share information, participate in joint planning, and provide strategic opportunities for cross referrals to Family Home Visiting and other services.



Program Outcomes

Core activities that promote Family Home Visiting at the program level include: program expansion, staff development & support, participant retention activities, and an ever-increasing number of families served by FHV.

Program Expansion

As the MDH FHV Program expands evidence-based home visiting across the state, current FHV grantees are identifying strategies to better reach families in their communities. MDH continues to support existing programs to leverage initial investments and further build capacity. Program expansion activities emphasize the implementation of evidence-based home visiting models with demonstrated effects on pregnant women and young children and their families.

Staff Development and Support

FHV programs use a variety of methods to build home visitors' knowledge, skills, and abilities. The MDH FHV Program offers a variety of topics as well as different training delivery options. The training needs of home visiting staff vary by geography, FHV model, community need, and priority areas.

Spotlight: Promoting Maternal Mental Health Community of Practice 2018-2019

The kickoff event for the Promoting Maternal Mental Health Community of Practice (CoP) took place in August, 2018 with a daylong virtual training on "Mental Health and Wellness during Pregnancy."

Over 260 home visitors attended the training at seven sites across the state. The training highlighted interventions that home visitors can implement with pregnant women to promote mother/baby attachment. The training also presented the impact of maternal factors, such as stress and depression, on the pregnancy and fetus.

Additional CoP events continued throughout 2019. Five live webinars were offered in April, May, July, August, and November. The webinars highlighted perinatal depression, perinatal anxiety, and other serious perinatal mental health concerns. Each webinar featured a didactic presentation from an expert and showcased local home visitors who shared their experiences and expertise working with families. Resources were highlighted related to maternal mental health, screening protocols, and client education.

The information that was presented in the live CoP webinars was also available through the MDH FHV weekly electronic newsletter, Tuesday Topics. All webinars, presentation materials, and resources were recorded or saved and uploaded to the FHV Basecamp site.

Home Visiting Highlight: Mower County Book Sharing

Fostering Caregiver-Child Interactions through Books

Mower County's Healthy Families America home visiting program collaborates with several organizations that serve Mower County families. One innovative area of partnership supports caregiver-child interactions by providing developmentally-appropriate books and toys. The local library received a grant from the United Way of Mower County to provide families with developmental materials. Austin's local Community Learning Center also applied for and received a book grant for Mower County's family home visiting program. The home visiting program also participates in Leadership Austin, a program that educates future leaders about the community.

These innovative partnerships represent successful, non-traditional collaborations to serve their community's most vulnerable families. These mutually-beneficial relationships highlight the level of collaboration that can happen in a community outside of traditional public health connections.

Professional Development

Trainings are available on a variety of topics for FHV grantees. These trainings are available as an in-person workshop, online, or a hybrid of the two. In 2019, the MDH FHV Program offered a new opportunity for FHV grantees to find content suitable to the unique needs of their program using The Ounce of Prevention's **Achieve OnDemand (AOD)**. AOD is an online training portal that offers self-paced courses for home visitors and supervisors. Over 220 licenses have been distributed to FHV programs across the state. Online learning is an especially effective tool in supporting and developing staff and programming for smaller, rural organizations.

Futures Without Violence/Healthy Moms, Happy Babies is a curriculum developed for home visiting programs that provides best practice training, tools, and resources to support screening and referral for Intimate Partner Violence (IPV) during a home visit. Participants learn about the curriculum's validated scripts and safety cards, and gain skills on making referrals for families experiencing violence. Over the past five years, this training has been offered twice a year in partnership with Violence Free Minnesota. It is available across various locations and also uses virtual technology. In 2019 alone, over 150 home visitors attended these trainings.

Introduction to Using the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire: Social Emotional (ASQ:SE). MDH offers live webinars quarterly for home visitors who want an introduction to the developmental and social-emotional screening tools. Participants learn how to accurately choose, score, and interpret the screening questionnaires. They also begin to develop an approach to share the child's strengths and any identified concerns with caregivers. Annually, approximately 100 home visitors are trained on each of these tools.

Home Visiting Highlight: Kanabec Treatment Facility

Supporting Moms in Nontraditional Settings

Kanabec County Community Health (KCCH) has a long-standing history of successfully providing Family Home Visiting (FHV) services within the county and surrounding communities. They focus outreach to mothers early in the prenatal process to establish relationship-based care that leads to improved prenatal outcomes.

To better support community needs, KCCH FHV has partnered with Recovering Hope Treatment Center, a treatment facility for women who struggle with drug and alcohol addiction. This treatment center allows women to bring their children (up to age five) to live at the facility and provides on-site childcare while mom is working on recovery.

Since mothers at the center face enormous barriers to parenting success, FHV provides a valuable service while they reside in this non-traditional location. In addition to visits, KCCH FHV nurses have offered a parenting class at the center that helps the resident mothers continue to create a healthy life for themselves and their children.

As the treatment center has grown, Public Health has transitioned to a supportive role for Recovering Hope staff who teach the parenting groups. Recovering Hope is very open to input and advocacy from KCCH regarding policies and procedures that support key bonding, attachment, and breastfeeding for new moms and their infants.

The partnership between KCCH and Recovering Hope is innovative and effectively reaches families where they are during this critical time.

Many of the clients do not come from Kanabec County and will return to their county of residence upon completion of treatment. The Family Home Visitors work diligently to connect the mothers and children with home visiting programs where they live.

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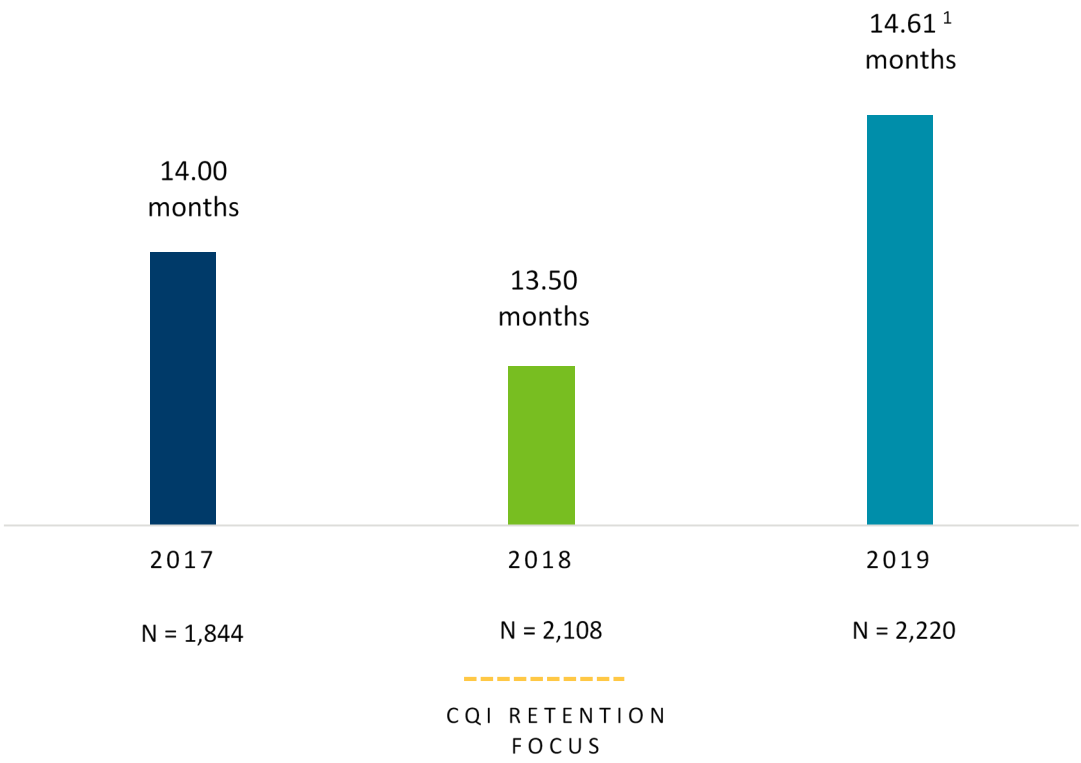
Retention

The longer a family participates in Family Home Visiting, the better they do across a variety of outcomes, including adverse pregnancy outcomes,[24] family engagement,[25] lower parenting stress and positive discipline skills,[26]and improved language and literacy environments.[27] That said, families often face many barriers that impede their ability to fully participate in FHV. Figure 9 illustrates the average number of months a typical family participated in a long-term home visiting model. In 2018, Continuous Quality Improvement (CQI) activities prioritized family engagement and retention. As described below, home visiting clients in 2019 participated, on average, one month longer than the previous year.

Figure 9. Average Months Participating in Long-Term Family Home Visiting



[1] FHV clients in 2019 had statistically significant higher participation rates compared to those in 2017.
A Kruskal Wallis test with Wilcoxon pairwise comparison showed a significant difference in participation length between 2018 to 2019, $H(2) = 7.01$, $p = .03$.

Spotlight on: Continuous Quality Improvement (CQI)

Each year, the MDH FHV Program selects a performance measure that has opportunity for improvement. Training, coaching, technical assistance, and learning sessions support local programs while they test strategies, collect data, learn from peers, and evaluate effectiveness.

- Gaining momentum: From 2018 to 2019, there was a 200% increase in participation in MDH-FHV led CQI activities.

2018	2019
16 Programs	31 Programs
57 Participants	156 Participants

- MDH was one of just six state MIECHV programs invited to participate in a national CQI initiative focused on Intimate Partner Violence. This 18-month effort is developing innovative strategies and change ideas that will influence home visiting programs throughout the United States.
- Supporting staff development: 71% of CQI respondents report gaining skills or knowledge that will increase effectiveness in their job. Four in 5 (82%) of CQI respondents report being satisfied with CQI quality. (CQI Learning Collaborative Evaluation Survey Report, November 27, 2018).

Year	CQI Objectives	Results
2017	Improve referrals to and follow-up from community services after a developmental, social-emotional, and/or caregiver depression screening and finding	At least 95% of clients are referred to community services following a developmental, social-emotional, or caregiver depression screening and finding
2018	Increase family enrollment, engagement, and retention in FHV	Baseline: **15** days from referral to first face-to-face contact Result: **7** days from referral to first face-to-face contact Baseline: **22** days between referral and enrollment Result: **9** days between referral and enrollment
2019	Increase number and duration of babies receiving human milk	Process activities include: Approximately 202 home visitors, 2,617 families served, 1,067 infants less than 12 months of age, 429 clients reached by CQI activities. Testing high-impact changes including advanced lactation training, breastfeeding assessment, infant feeding toolkit, father engagement, returning to work/school transition plan, and cultural responsiveness

Home Visiting Highlight: Carlton-Cook-Lake-St. Louis Family Celebration Event

Family Celebration Event: Great Turnout, Greater Benefits for Program

In September 2019, Public Health Nurses from the Carlton-Cook-Lake-St. Louis Nurse-Family Partnership (NFP) and Healthy Families America (HFA) programs hosted the first Family Celebration Event at the Great Lakes Aquarium in Duluth, MN. The event recognized and celebrated families enrolled in the NFP and HFA family home visiting programs. It also honored their commitment to being the best caregivers they can be and their dedication to family home visiting.

Over 100 individuals (approximately 40 families) attended the event. The celebration included several hands-on activities that promote caregiver-child interactions. In one interactive activity, clients played a "go-fish" game where they found a partner (another caregiver with a child of a similar age) and completed a brief questionnaire together for a chance to win a grocery store gift card. The event also included a catered lunch, a professional photographer taking family photos, and full access to the aquarium.

The idea to host a Family Celebration Event originally came as part of the continuous quality improvement (CQI) work facilitated by MDH FHV Program staff. The CQI project's focus on client recruitment, engagement, and retention led staff to wonder if hosting a family recognition and celebration event would help recruit, retain, and engage clients in NFP and other home visiting programs.

Because of extremely positive client feedback, the NFP and HFA teams will continue to host bi-annual Family Celebration Events for clients and families. These events have also provided an excellent opportunity for team building and a chance to celebrate the nurses and all of their hard work!

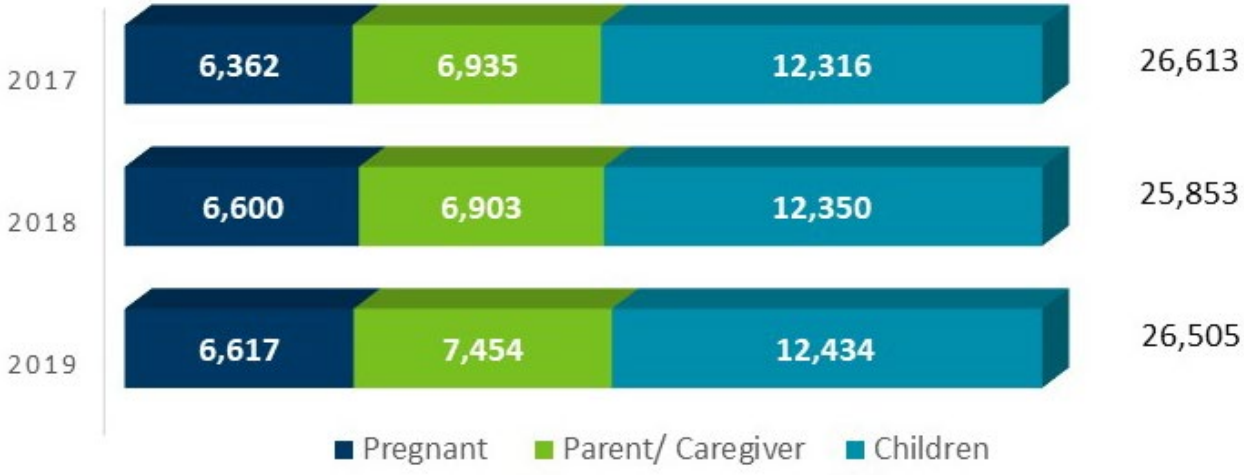
Families Served by Family Home Visiting

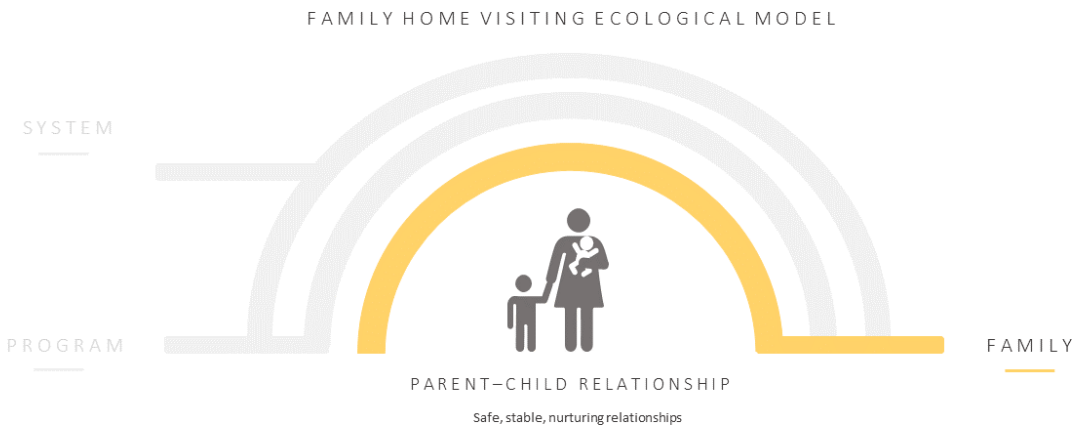
As Family Home Visiting expands across Minnesota, more pregnant mothers, caregivers, and young children have access to and benefit from this effective early childhood intervention. Due to increased investments in state funding, 892 more individuals were served in FHV in 2019 from 2017. Figure 10 highlights the steadily increasing number of Minnesotans accessing FHV with over 6,000 pregnant women, nearly 7,000 caregivers, and 12,000 children each year.

~900

more caregivers, children, and pregnant individuals were served by FHV from 2017 to 2019

Figure 10. Numbers of Family Home Visiting Participants, 2017-2019





Family Measures of Wellbeing

This section presents Family Home Visiting outcome measures related to Maternal and Newborn Health, Safety and Violence Prevention, Child Development and School Readiness, and Family Economic Self-Sufficiency.

Methodology

Outcome data for selected measures are presented on the following pages. Analysis was restricted to clients in long-term FHV programs. Long-term programs include MDH-funded Early Head Start, Family Spirit, Healthy Families America, Nurse-Family Partnership, Parents as Teachers, and traditional public health family home visiting programs.

Full counts and averages statistics for caregivers and children for years 2017, 2018, and 2019 can be found in Appendix E.

- Data are presented for calendar years 2017, 2018, and 2019. Measures in this report differ from those included in the 2016 and 2018 Reports to the Legislature.
- Outcome measures in this report were selected based on the availability of data across all long-term FHV programs.
- There are known quality issues in some data sources used in this report. These quality issues (e.g., missing data) were due to the limitations of the data systems used to collect and report data to MDH.
- In some cases, screenings and referrals may have been provided by home visitors but not entered into MDH FHV evaluation data reporting systems. Data on these services are not available for this report.
- Because not all MDH FHV evaluation data that is shared with MDH includes personal identifiers, MDH cannot de-duplicate clients among FHV sites. Therefore it is possible that individuals are counted more than once for some measures (for example, if a client transferred between sites).

Because of these limitations, percentages should not be compared between this report and previous Reports to the Legislature.

Please note that data quality issues will be significantly reduced with the rollout of the new MDH Family Home Visiting data collection system, Information for Home Visiting Evaluation (IHVE), in early 2020. This system will have robust controls for data quality and will collect consistent data across all FHV grantees.

Maternal and Newborn Health

Maternal and newborn health refers to the health of the mother, both during pregnancy and after, and young children. It includes physical, mental, and behavioral health and health-related habits. For young infants, it also includes developmental milestones. Improving the health and wellbeing of women and children is a top goal of Family Home Visiting. Two measures are used to assess maternal and newborn health in FHV in Minnesota: Breastfeeding and postpartum depression screening rates.

Breastfeeding

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.[28] Maternal health benefits include reduced risk for ovarian cancer and breast cancer.[29] Benefits to baby include lower risks of Sudden Infant Death Syndrome, asthma, obesity, and type 2 diabetes.[30] Breastfeeding also helps moms and babies bond and build a sense of closeness.[31] In addition, more recent research indicates breastfeeding may protect against post-partum depression.[32]

Breastfeeding Data

Average breastfeeding rates for Family Home Visiting participants, 2017-2019 have remained steady with 26-27% of babies receiving breastmilk at six months of age each year. See Appendix E1 for counts and averages for 2017-2019 and 3-year averages. Breastfeeding was reported as a percentage of infants who were breastfed any amount at 6 months of age, excluding infants whose mothers cannot breastfeed because of medical contraindications.

Breastfeeding Home Visiting Supports

Home visiting helps by:

- Providing education and encouragement to moms on the benefits of breastfeeding.
- Communicating best ways to continue breastfeeding at home, school, and work.
- Supporting moms in problem solving barriers to breastfeeding.
- Referring mothers to community resources when there are significant needs.

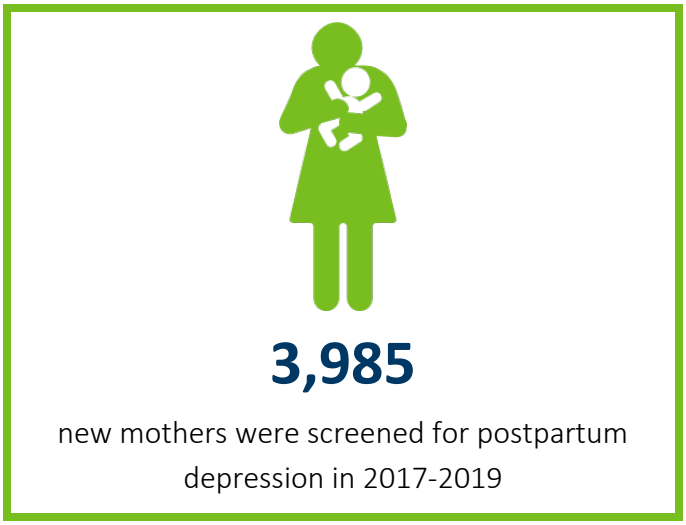
Postpartum Depression Screening

The mental and physical health of mothers impacts children's wellbeing. Postpartum depression (PPD) can impair parent-child bonding and have long-term consequences for the child's cognitive and emotional development.[33] Children's early exposure to maternal depression may impede brain development by changing brain architecture[34] and stress response systems.[35] Fortunately, improvements in mother's mental health are associated with reductions in children's depressive symptoms.[36] Screening mothers for PPD can effectively support their mental health by facilitating potential diagnosis and treatment referral.[37]

Postpartum Depression Screening Data

One of the interventions used by home visitors to improve maternal and newborn health is to screen for postpartum depression and refer mothers who screen positive for depression to relevant services.

Nearly 4,000 caregivers (46%) received a depression screening from their family home visitor by 3 months postpartum during 2017, 2018, and 2019. Appendix E2 provides annual counts and averages along with 3-year averages.



Postpartum Depression Screening Supports

Home visitors help by:

- Completing depression and anxiety screenings with mom during both prenatal and postpartum periods.
- Describing common feelings women experience after giving birth.
- Educating women on signs and symptoms of postpartum depression that should be shared with their health care provider.
- Referring caregivers to local community resources and helping to connect families via warm hand-off.

Safety and Violence Prevention

Family Home Visiting (FHV) focuses on keeping children safe in the home. Home visitors help prevent child injuries by screening for hazards in the home environment, coaching caregivers in positive parenting practices, and providing guidance on when to seek out further medical care.

Intimate Partner Violence (IPV) Screening

Family Home Visitors screen caregivers for whether they experience intimate partner violence (IPV) and provide support for healthy relationships. IPV has long-term negative impacts on both the caregiver and any children in the home.[38] IPV includes 4 different types of violence and aggression: physical violence, sexual violence, stalking, and psychological aggression. [39] IPV screening and referral data are collected by MDH for the primary caregiver.

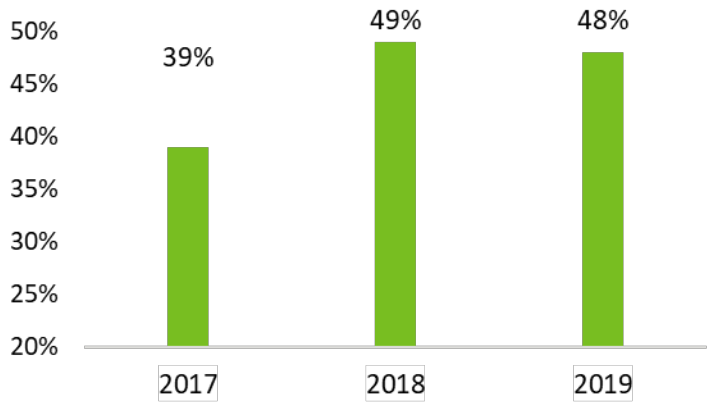
IPV Screening Importance

IPV is a significant risk to the health of many Minnesota families. More than one in three women have experienced sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime.[40] MDH has identified screening for IPV using validated tools as a best practice, and provides support to this practice by offering trainings to home visitors. Because of the trust developed between home visitors and caregivers, home visitors have a unique opportunity to connect caregivers to resources when IPV occurs.

IPV Screening Data

Figure 11 displays the percentage of caregivers who received an IPV screening within 6 months of enrolling in FHV. For full counts and 3-year average of IPV screening and referral rates (those who screen positive and are offered a referral), see Appendices E3 and E4, respectively.

Figure 11. Percentage of Caregivers Screened for IPV 2017–2019



IPV Screening Supports

Family home visiting uses a validated screening tool for domestic violence with the FHV families. In addition to screening women for domestic violence, home visitors offer support and education regarding healthy relationships to help caregivers identify the characteristics of a healthy relationship.

Child Development and School Readiness

Cognitive, behavioral, socio-emotional, verbal, and fine and gross motor skills develop early and set the stage for school readiness and lifelong wellbeing. Interactions with caregivers and environments heavily impact child development and provide opportunities for home visitors to support families of young children. Promoting child development and school readiness skills for young children are key components in all home visiting models implemented in Minnesota.

Developmental Screening

Early identification and intervention are crucial in catching and supporting potential developmental delays and concerns. Family home visitors play a key role in supporting developmental outcomes for families at risk with young children through early identification and connection to services and resources. Two measures were assessed in this domain: developmental screening and developmental referrals. Due to significant quality issues in data for one home visiting model, only developmental screening data are presented here.

Developmental Screening Data

Over 40% of babies receiving Family Home Visiting services received a developmental screening between 9-12 months of age during 2017-2019. These rates only account for developmental screenings that were conducted during this relatively short period. To see annual counts and percentages for developmental screenings and referrals (those screened positive and offered a referral between the ages of 9-12 months) for 2017, 2018, and 2019, see Appendices E5 and E6, respectively.

Developmental Screening Supports

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. 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 and model parent activities that they can do to support their child's development. Family home visitors also refer and connect families to Early Intervention and other community services that support child development.

Family Economic Self-Sufficiency

Family economic self-sufficiency refers to the educational and economic opportunities for families to improve self-sufficiency. Families who have access to preventative care, a steady income, and other basic needs can then begin to focus on individual improvement and skill development. Family economic self-sufficiency is a common goal across FHV models. In this report, three measures are used to assess this: child health insurance coverage, caregiver health insurance coverage, and level of caregiver education.

Health Insurance Coverage

Access to health insurance allows families to get preventive care, avoid using the emergency room as a primary care provider, and keep medical debt at bay. Preventive care for children can help caregivers avoid having to skip work or school to care for sick children. Caregivers who are getting regular medical care can get timely and accurate diagnoses and treatment for health conditions and establish trust with their primary care provider. This allows for more effective treatment and coordination of care.

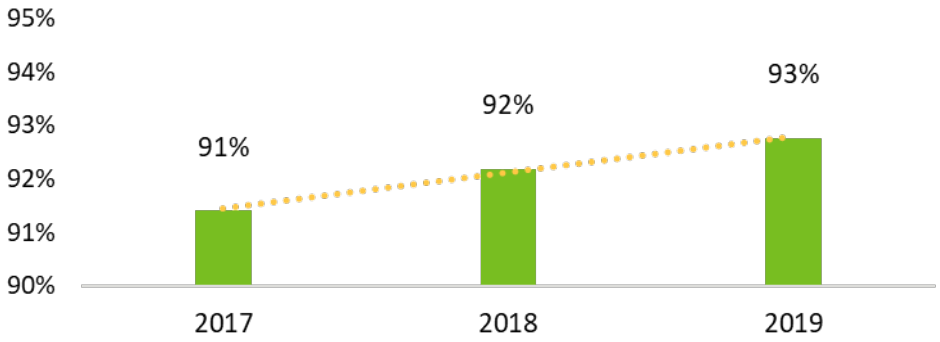
Child Health Insurance Data

Over 90% of children receiving FHV services had health insurance in years 2017-2019, as seen in Figure 12. Health insurance rates for children steadily increased from 91% in 2017 to 93% in 2019.[2] These values include only children whose health insurance status was known; children with missing data were not included in this analysis.

See Appendix E7 for annual and 3-year counts and percentages of children with health insurance as of the most recent data collection for that measurement year. Appendix E8 provides a breakdown of health insurance type. The majority of children served by FHV were insured by MN Health Care Programs (Medical Assistance or MinnesotaCare).

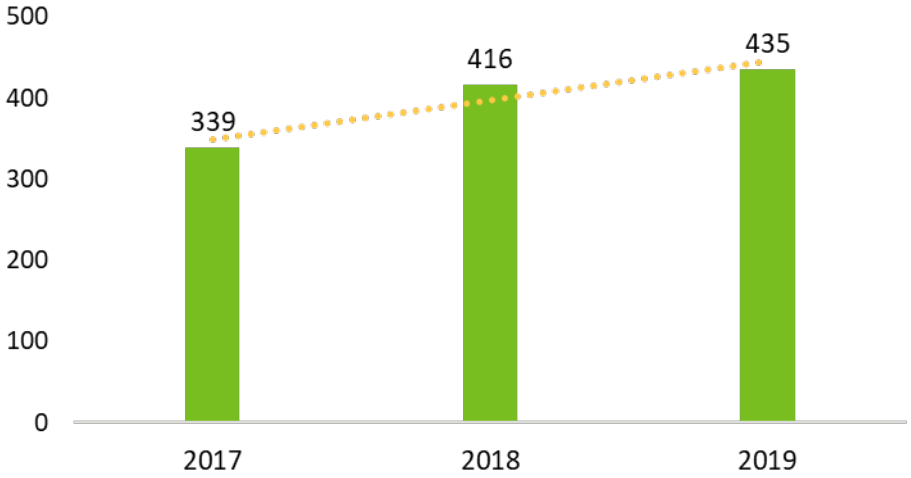
[2] There is a statistically significant higher percentage of children with health insurance in 2019 than in 2017, X^2 (2) = 9.55, $p < .01$. These values include only children whose health insurance status was known; children with missing data were not included in this analysis.

Figure 12. Percentage of Children with Medical Insurance, 2017-2019



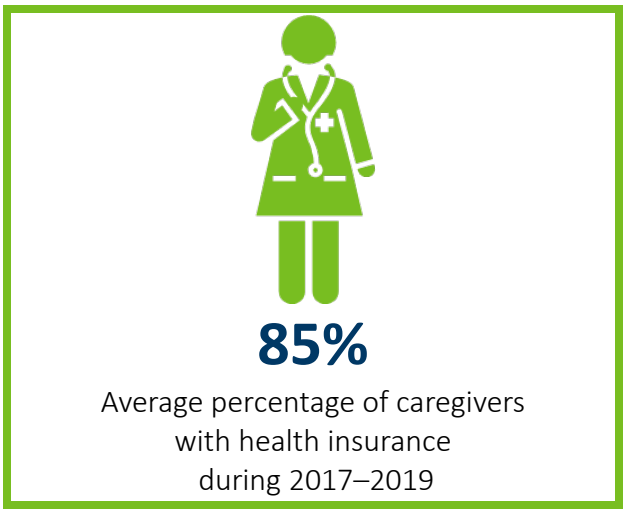
Many children entered the Family Home Visiting program without insurance but gained it while participating. As illustrated in Figure 13, over 1,000 FHV children gained health insurance during years 2017, 2018, and 2019. These values reflect children who entered FHV without insurance and subsequently gained insurance while enrolled.

Figure 13. Number of children who gained health insurance while enrolled in Family Home Visiting



Caregiver Health Insurance Data

The rate of caregivers who have health insurance has remained steady across years 2017, 2018, and 2019. Approximately 85% of caregivers have access to health insurance while participating in Family Home Visiting. For full counts and averages for each year along with a 3-year average, see Appendix E9. Appendix E10 describes the type of health insurance for caregivers participating in Family Home Visiting for years 2017-2019. Similar to children, the majority of caregivers were enrolled in Medical Assistance or MinnesotaCare.



Health Insurance Supports

Home visitors are a key referral source for families. Family home visitors help families attain health insurance by:

- Inquiring about health insurance coverage.
- Referring all clients who lack health insurance to county financial services.
- Assisting families with application process.
- Monitoring insurance coverage and potential lapses in coverage.
- Assessing family financial status and making referrals to all potential financial resources (such as WIC, food pantries, housing assistance).

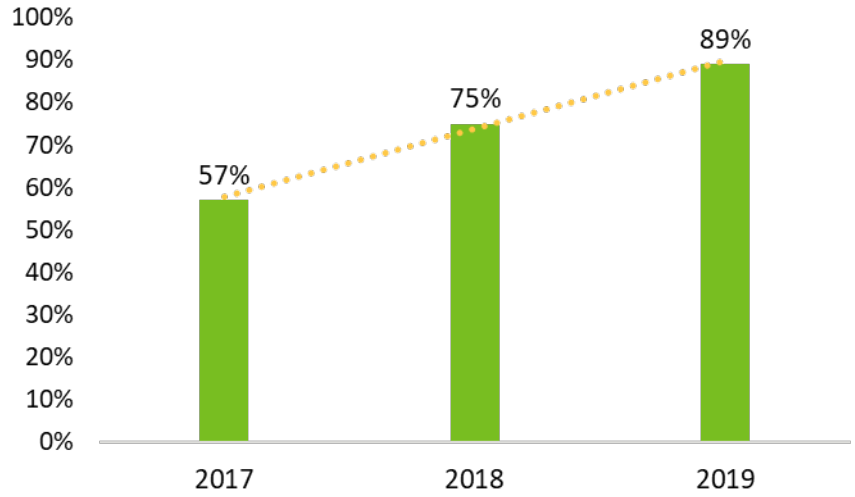
Caregiver Education

Caregivers who have at least a GED have a larger earning potential and lower unemployment than those who do not.[41] There is strong positive association between education attainment and health, including mental and physical outcomes.[42] Both family income and parental education levels are positively associated with children's developmental outcomes.[43] Economic self-sufficiency is easier to achieve with a higher salary and greater qualifications for jobs.

Caregiver Education Data

More caregivers are getting a high school diploma or GED while enrolled in Family Home Visiting (FHV). As described in Figure 14, 57% of caregivers who started the FHV program without a degree earned one or were currently enrolled in a program while participating in FHV in 2017. These percentages rose in 2018 and 2019 to 75% and 89%, respectively. To see caregiver education status at enrollment for years 2017-2019, see Appendix E11. Note: The values in the Appendix E11 represent caregivers of all ages.

Figure 14. Percentage of FHV Caregivers Aged 19+ Who Did Not Have a High School Diploma at Intake and Completed High School or GED at the End of the Year



Caregiver Education Supports

Our home visitors support this goal by assessing readiness to go to school or get a GED, helping caregivers make a plan to continue their education, and referring them to programs that can provide support and work with their schedules.

Home Visiting Highlight: YWCA Mankato's New American Families Program

Expanding Home Visiting Services to Immigrant and Refugee Families

YWCA Mankato's New American Families Program recognizes that immigrant and refugee women and their families suffer disparate maternal and child health outcomes, healthcare access, and poverty representation. Their effects in rural communities are exacerbated by distance, transportation barriers, and limited availability of culturally-competent workers in systems of care meant to serve all in need.

To address these systemic problems and improve developmental health components and access to resources, the New American Families Program is implementing the Parents as Teachers (PAT) home visiting model. PAT was chosen for its focus on serving the entire family, comprehensive child health screening, and school readiness.

To recruit families, the New American Families Program is creating 1) an interagency referral network, 2) referral agreements with health and social service providers to improve coordination across services, and 3) linguistically and culturally appropriate materials. While they have a strong word-of-mouth referral system, they seek to recruit families from immigrant groups from communities that have demonstrated higher rates of low infant birth weight. Hiring culturally competent staff is a priority: First-hand knowledge of the immigrant experience and language critically supports home visiting and families.

These services will supplement home visiting services provided by Early Head Start, Nicollet and Blue Earth Health Departments, Greater Mankato Area United Way, and Mankato school district Early Childhood Family Education.

Next Steps for Family Home Visiting

The MDH FHV Program will plan strategically for funding and expansion, continue to build cross department coordination, develop and execute evaluation activities using a new data collection system, and support grants management development and technical assistance.

Funding/Expansion

The MDH FHV Program will continue to prioritize and fund home visiting services with three focal areas:

- **Innovation.** There is much to be learned about how to effectively support and implement FHV across Minnesota. Building statewide capacity requires innovative solutions at both the state and local levels. MDH will continue to address health equity by prioritizing funding to agencies that can implement evidence-based home visiting programs and adapt them to creatively and successfully recruit, engage, retain, and serve families.
- **Priority populations.** Large health disparities exist across Minnesota. Family Home Visiting is one proven strategy in addressing the needs of families and communities who have historically not had access to these effective interventions.
- **Geographic areas with limited or no evidence-based home visiting.** A goal of MDH is to ensure Family Home Visiting is available in all regions of the state. As FHV continues to expand, extra attention is being given to those areas without evidence-based home visiting.

Cross-Department Work

The MDH works with the Departments of Education and Human Services and early childhood partners around the state on multiple initiatives aimed at building the state's early childhood system. MDH has been actively involved in two specific initiatives: The Minnesota Preschool Development Birth through Five (PDG B-5) grant and the development of Help Me Connect.

Minnesota Preschool Development Birth through Five (PDG B-5) Grant

Minnesota's PDG B-5 grant focuses on supporting families with young children who are experiencing racial, geographic, and economic inequities. During the reporting period, MDH FHV Program staff worked with an interagency team to plan and conduct over 150 community engagement meetings statewide, including all 11 tribal nations. In addition to a strategic plan and needs assessment, grant activities included:

- Planning and contracting for the creation of a trauma-informed toolkit
- Exploration of data sharing across state agencies
- Transition toolkit
- Parent communications strategy work
- Expanding a Knowledge and Competency Framework

In December 2019, Minnesota was awarded a three-year $26.7 million Preschool Development Renewal Grant. The federal funding from the PDG B-5 will support the ongoing work of Help Me Connect by funding a series of regional hubs and an online system that will link families to a multitude of community services. The Minnesota Departments of Education, Health, and Human Services continue to collect extensive stakeholder and community feedback. They are implementing improvements to government systems, including coordinating with the MDH federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) needs assessment.

Help Me Connect

Help Me Connect builds on the success of Help Me Grow, a referral mechanism that provides a one-stop option to help families and providers find and connect to a wide range of prenatal and early childhood services. These early childhood services support healthy child development and family well-being including basic needs. The aim is to improve equitable access and outcomes to early identification and services for developmental and behavioral health, particularly for communities most affected by racial, economic, and geographic disparities.

Recent accomplishments include integrating statewide partners' recommendations by developing an early childhood resource database and a one-stop way to navigate these resources based on need. This online resource navigator currently focuses on local referring providers across family/child-serving systems. Local focus groups with rural, tribal, and diverse urban areas will help shape the navigator— it will be tested in local communities in fall 2020.

Next steps for Help Me Connect include engaging local communities in testing emerging referral systems and evaluating access to evidence-based services that target prenatal to age 8 services. State infrastructure development and provider training will continue under the leadership of the statewide partners. State-level staffing will be needed for consultation and training to support local providers who will connect pregnant and parenting Minnesotans to what they need for optimal well-being. Minnesota's Preschool Development Renewal grant will support this work.

Evaluation Planning

As evidence and support for FHV grows, the MDH FHV Program is updating processes for collecting and interpreting program data. Evaluation activities will inform local and state level programming and policy. In conjunction with research partners at the University of Minnesota, this process will be iterative and comprehensive, and will address relevant aspects of FHV in Minnesota:

- **Process evaluation** focuses on implementation and seeks to identify opportunities to improve processes and policies at the visit, program, local, and state level. How is FHV being implemented? Who is being served, and importantly, who is not being reached? How to promote best practices in FHV implementation, for example, referring families? What are effective ways to share and reproduce findings in one Minnesota community to another?
- **Outcome and impact questions** will provide information on how well FHV worked across Minnesota. For whom did it work? In what ways? And in which contexts? What are the long-term benefits of FHV for Minnesotan families? What are the costs and returns when investing in FHV?

Information for Home Visiting Evaluation

The new MDH FHV data collection system, **Information for Home Visiting Evaluation (IHVE)**, will provide data to answer questions about FHV effectiveness and opportunities for improvement. IHVE is going into production in January 2020 and is replacing previous systems for collecting FHV evaluation data.

Features of IHVE include:

- Consistent, **standardized data collection** across all FHV programs;
- Data collection forms embedded in electronic health record systems used by local public health agencies, so that **data entry is streamlined and efficient** for home visitors;
- **Near real-time data submission**, so that information is more up-to-date; and
- **Automatic data validation**, so that evaluation data is correct and complete.

A priority of future FHV evaluation activities is to support grantees as local experts on their own data. The IHVE system will enable the construction of a secure data portal for FHV grantees to access information about their own program. MDH FHV evaluation staff will provide grantees with technical assistance to use this data for reporting, communicating results with constituents and stakeholders, and driving local programming.

Though they vary widely in scope, all evaluation activities have one thing in common: a focus on how to best support family well-being. By examining the moving parts of Family Home Visiting, MDH can learn how to strategically invest in FHV activities for the best results.

Grant Monitoring and Technical Assistance Innovations

Several state-funded non-profits, tribal nations, and community health boards are implementing evidence-based models that had not been previously funded, including Early Head Start, Parents as Teachers, Family Spirit, and Family Connects. With the expansion in the types of models and types of programs that are funded, there is an increased opportunity to **serve a greater variety of families**, utilize **a more diverse workforce**, and increase the availability of **culturally based home visiting services**.

To better support the new types of agencies that are implementing newly funded models, MDH-FHV has identified improvements to sub-recipient monitoring and technical assistance (TA) strategies. During the reporting period, the MDH FHV Program identified the need to develop a revised grants management TA plan and implement a tiered monitoring approach.

Technical Assistance (TA)

The Capacity Building unit within the MDH FHV Program has been working to evaluate the needs of these new programs, understand their strengths and assets, and identify ways to provide TA. MDH uses a tailored approach to providing TA for new grantees by scheduling orientation site visits with new programs, conducting check-in calls more regularly, and encouraging an open door policy for all questions. MDH also posts many of the most commonly used grants management resources on the MDH FHV Funding and Grants Management website for ease of access.

In addition, MDH is developing a series of webinars to provide TA on topics relevant to all local implementing agencies (LIAs). Sample webinar topics include:

- Basic grant requirements, including reporting requirements and revising budgets and work plans
- Adapting evidence-based home visiting models to culturally and linguistically diverse populations
- Working with families with serious mental illness and substance use
- Maximizing third party reimbursement for home visiting

As part of these webinars, MDH will partner with local programs that have expertise in topic areas and highlight best practice.

Tiered Monitoring

In 2020, the MDH FHV Program will begin implementing a monitoring plan that assigns LIAs to one of three tiers based on their level of risk. This tiered monitoring plan will enable grants management staff to focus their most robust level of support to LIAs with the highest need. Annually, grants managers will use a standardized tool to assess risk for each LIA based on their previous year's performance in key categories such as fiscal compliance, program fidelity, and organizational capacity.

Programs with low risk will receive the base level of monitoring with individualized technical assistance as needed. Programs with medium risk will receive additional monitoring and technical assistance. High risk programs will receive the most frequent monitoring activities and comprehensive technical assistance. This tiered monitoring approach will ensure LIAs successfully carry out the outcomes of their grant through the most appropriate support from MDH.

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.

In partnership with local public health, tribal nations, community-based organizations, and other early childhood stakeholders, the MDH Family Home Visiting Program 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 Minnesota Statutes 145A.17 and to improve the health and well-being of Minnesota's families.

Appendices

Appendix A. Family Home Visiting TANF Grant Allocations FY20-21

A1. Family Home Visiting Tribal Government Awards

Tribal Nation	Amount of Award from 7/01/19 to 6/30/20	Amount of Award from 7/01/20 to 6/30/21
Bois Forte Reservation Tribal Council	55,932	55,932
Fond Du Lac Band of Lake Superior Chippewa	147,949	147,949
Grand Portage Reservation Council	25,272	25,272
Leech Lake Band of Ojibwe	181,671	181,671
Lower Sioux Indian Community	27,913	27,913
Mille Lacs Band of Ojibwe	65,670	65,670
Red Lake Band of Chippewa	169,029	169,029
Upper Sioux Community	22,373	22,373
White Earth Band of Ojibwe	162,493	162,493
Total	**848,300**	**848,300**

A2. Family Home Visiting Local Public Health Awards

Local Public Health Agency	Amount of Award from 7/01/19 to 6/30/20	Amount of Award from 7/01/20 to 6/30/21
Aitkin-Itasca-Koochiching Community Health Board	121,926	121,926
Anoka County Community Health Board	315,522	315,522
Beltrami County Community Health Board	53,860	53,860
Benton County Human Services	43,822	43,822
City of Bloomington Community Health Board	173,888	173,888
Blue Earth County Community Health Board	69,100	69,100
Brown-Nicollet Community Health Board	72,688	72,688
Carlton-Cook-Lake-St. Louis Community Health Board	389,512	389,512

Local Public Health Agency	Amount of Award from 7/01/19 to 6/30/20	Amount of Award from 7/01/20 to 6/30/21
Carver County Community Health Board	56,946	56,946
Cass County Health, Human & Veterans Services	41,252	41,252
Chisago County Community Health Board	45,394	45,394
Countryside Community Health Board	86,938	86,938
Crow Wing County Community Health Board	75,356	75,356
Dakota County Community Health Board	325,356	325,356
Des Moines Valley Health and Human Services	39,610	39,610
Dodge-Steele Community Health Board	65,310	65,310
Human Services of Faribault and Martin Counties	53,310	53,310
Fillmore-Houston Community Health Board	55,394	55,394
Freeborn County Community Health Board	44,266	44,266
Goodhue County Health and Human Services	47,462	47,462
Hennepin County, in its capacity as a Community Health Board	685,328	685,328
Horizon Public Health	99,332	99,332
Isanti County Community Health Board	30,958	30,958
Kanabec County Community Health Board	21,855	21,855
Kandiyohi-Renville Community Health Board	82,226	82,226
Le Sueur-Waseca Community Health Board	58,458	58,458
Meeker-McLeod-Sibley Community Health Board	95,010	95,010
Mille Lacs County Community Health Board	46,438	46,438
City of Minneapolis Community Health Board	979,782	979,782
Morrison-Todd-Wadena Community Health Board	113,428	113,428
Mower County Community Health Board	50,814	50,814
Nobles County Community Health Board	30,998	30,998
North Country Community Health Board	68,550	68,550
Olmsted County Community Health Board	151,440	151,440
Partnership4Health Community Health Board	220,314	220,314
Pine County Community Health Board	46,441	46,441
Polk-Norman-Mahnomen Community Health Board	75,600	75,600

Local Public Health Agency	Amount of Award from 7/01/19 to 6/30/20	Amount of Award from 7/01/20 to 6/30/21
Quin County Community Health Board	84,412	84,412
St. Paul Ramsey County Community Health Board	994,732	994,732
Rice County Community Health Board	63,650	63,650
Scott County Community Health Board	76,566	76,566
Sherburne County Community Health Board	61,212	61,212
Southwest Health and Human Services Community Health Board	127,876	127,876
Stearns County Community Health Board	155,622	155,622
Wabasha County Community Health Board	27,872	27,872
Washington County Community Health Board	182,520	182,520
Watonwan County Community Health Board	21,176	21,176
Winona County Community Health Board	59,002	59,002
Wright County Community Health Board	90,476	90,476
Total	**$6,979,000**	**$6,979,000**

Appendix B. Evidence-Based Home Visiting Models Supported by the Minnesota Department of Health[3]

Model	Theoretical Model	Population Served	Length and Intensity of Program	Staff Providing Home Visiting Services
Early Head Start	Emphasizes parents as child's first and most important relationship. Comprehensive, two-generation initiative aimed at enhancing infant and toddler development, strengthening families, and respecting unique development of young children.	Designed for low-income pregnant women and families with children between birth-3 months old. Most women and families must be at or below the federal poverty level, and a portion of enrollment must be available to certain children with disabilities.	Women may be enrolled prenatally or after a child's birth, and services continue until a **child's 3rd birthday**. Services include weekly home visits and two group socialization activities per month.	Home visitors much be a Home Visitor Child Development Associate or have comparable credentials.
Family Connects	Brings families, community agencies, and health care providers together through nurse home visits to provide all families in a service area with support and resources to promote the well-being of newborns.	Designed to serve all families with newborns 2 to 12 weeks old in a defined service area; families with identified needs receive further support.	Universal short-term home visiting targeted to a geographic area. Initial visit when **newborn is 2 to 12 weeks old**, but may reach families earlier or later when special needs are present. Families with identified needs receive more visits and referrals to services.	Home Visitors receive specialized model training; Home Visitors must be bachelor prepared Registered Nurses.

[3] Descriptions provided by MDH-FHV staff, December 11, 2018

Model	Theoretical Model	Population Served	Length and Intensity of Program	Staff Providing Home Visiting Services
Family Spirit	Designed to promote child's development through helping parents gain knowledge in domains of physical, cognitive, social-emotional, and language learning and self-help. Incorporates traditional tribal teachings.	Designed for young Native American parents and their children; may also be used in non-Native populations with high parent and child health disparities.	Flexible design; recommended initiation at 28 weeks gestation, continuing **through child's 3rd birthday.**	Home Visitors receive specialized model training; Home visitors can be paraprofessionals, professionals, and/or nurses.
Healthy Families America (HFA)	Rooted in belief that early, nurturing relationships are the foundation for life-long, healthy development. Interactions between providers and families are relationship-based, designed to promote positive relationships and healthy attachment, strengths-based, family-centered, culturally sensitive, and reflective.	Designed for parents facing challenges such as single parenthood, low income, history of adverse childhood experiences, substance abuse, mental health issues, or domestic violence. HFA sites select specific characteristics to determine the population to serve.	Families are enrolled prenatally to within 3 months after a child's birth; **services provided until child is between ages 3 and 5.**	Home Visitors receive specialized model training; Home visitors can be paraprofessionals, professionals, and/or nurses.
Nurse-Family Partnership (NFP)	Shaped by theories of human attachment, human ecology, and self-efficacy; client-centered and driven by client-identified goals. Promotes health of the mother during pregnancy, care of the child, and the mother's personal growth and development.	Designed for first-time, low-income mothers and their children.	Pregnant women are enrolled early in pregnancy, first home visit no later than end of woman's **28th week of pregnancy; services available until child is age 2.**	Home Visitors receive specialized model training; home visitors must be bachelor prepared Registered Nurses.

Model	Theoretical Model	Population Served	Length and Intensity of Program	Staff Providing Home Visiting Services
Parents as Teachers (PAT)	Based on the theory that affecting parenting knowledge, attitudes, behaviors, and family well-being impacts a child's developmental trajectory. Focuses on three areas: parent-child interaction, development-centered parenting, and family wellbeing.	Local affiliates select characteristics and eligibility of the population to be served. Eligibility criteria may include children with special needs, families at risk for child abuse, income-based criteria, teen or first-time parents, immigrant parents, or parents with low literacy or mental health or substance use issues.	Designed to serve families from pregnancy through a child's entry into kindergarten or through the kindergarten year. A local affiliate may choose to focus services on pregnant women and families with **children between birth and age 3.** Families can enroll at any point before age 5.	Home Visitors receive specialized model training; Home visitors can be paraprofessionals, professionals, and/or nurses.

Appendix C. Family Home Visiting Models by Provider Agency and Service Area

Note: The following tables include agencies that provide MDH-funded FHV services using an evidence-based home visiting model. Tables do not include agencies that implement evidence-based home visiting models in Minnesota using non-MDH funding sources.

Service Areas include the county or counties in which the provider agency offers the home visiting model. Please note that a provider agency may target home visiting services to particular communities within their service area.

C1. Early Head Start Provider Agencies

Provider Agency	Service Area
Families First of Minnesota	Fillmore Freeborn Goodhue Mower Olmsted Rice Wabasha
Inter-County Community Council Inc	Clearwater Pennington Polk Red Lake
Lakes and Prairies Community Action Partnership Inc	Clay Wilkin
Semcac Head Start	Fillmore Freeborn Goodhue Mower Olmsted Rice Wabasha
Three Rivers Community Action Inc	Fillmore Freeborn Goodhue Mower Olmsted Rice Wabasha

C2. Family Connects Provider Agencies

Provider Agency	Service Area
MVNA	Hennepin

C3. Family Spirit Provider Agencies

Provider Agency	Service Area
Bois Forte Band Tribal Government	Itasca Koochiching St. Louis
Division of Indian Work	Hennepin Ramsey
Headway Emotional Health Services	Hennepin Ramsey
Leech Lake Band of Ojibwe	Beltrami Cass Hubbard Itasca
Mille Lacs Band of Ojibwe	Aitkin Mille Lacs Pine
Minnesota Indian Women's Resource Center	Hennepin Ramsey
Northwest Indian Community Development Center	Beltrami
Red Lake Comprehensive Health Services	Beltrami Clearwater Lake of the Woods
Simpson Housing Services Inc	Hennepin
Southside Family Nurturing Center	Hennepin

C4. Healthy Families America Provider Agencies

Provider Agency	Service Area
Anoka County Human Services	Anoka
Becker County Public Health	Becker
Beltrami County Public Health	Beltrami
Brown County Public Health	Brown
Carlton County Public Health and Human Services	Carlton
Carver County Public Health	Carver
Catholic Charities	Hennepin
CHI St. Joseph's Health	Hubbard
Chisago County Health and Human Services	Chisago
City of Bloomington Community Services	Hennepin
Clay County Social and Health Services	Clay
Clearwater County Public Health/Nursing Services	Clearwater
Cook County Public Health	Cook
Countryside Public Health	Big Stone Chippewa Lac qui Parle Swift Yellow Medicine
Dakota County Public Health	Dakota
Des Moines Valley Health and Human Services	Cottonwood Jackson
Dodge County Public Health	Dodge
Fillmore County Community Services	Filmore
Freeborn County Public Health	Freeborn
Goodhue County Health and Human Services	Goodhue
Headway Emotional Health Services	Hennepin
Horizon Public Health	Douglas Grant Pope Stevens Traverse
Houston County Public Health	Houston
Human Services of Faribault and Martin Counties	Faribault Martin
Inter-County Nursing Service	Pennington Red Lake
Isanti County Public Health	Isanti
Kanabec County Community Health	Kanabec
Lake County Health and Human Services	Lake
LakeWood Health Center	Lake of the Woods
Le Sueur County Public Health	Le Sueur
LifeCare Public Health	Roseau

Provider Agency	Service Area
Mille Lacs County Public Health	Mille Lacs
Mower County Health and Human Services	Mower
MVNA	Hennepin
Nicollet County Public Health	Nicollet
North Valley Public Health	Marshall
Olmsted County Public Health Services	Olmsted
Otter Tail County Public Health	Otter Tail
Pillager Family Council	Cass
Pine County Public Health	Pine
Rice County Public Health	Rice
Scott County Public Health	Scott
Sherburne County Health and Human Services	Sherburne
St. David's Center for Child and Family Development	Hennepin
St. Louis County Public Health and Human Services	St. Louis
St. Paul-Ramsey County Public Health	Ramsey
Stearns County Human Services	Benton Stearns
Steele County Community Services	Steele
The Family Partnership	Hennepin
Wabasha County Public Health	Wabasha
Waseca County Public Health Services	Waseca
Washington County Public Health and Environment	Washington
Watonwan County Human Services	Watonwan
Wilkin County Public Health	Wilkin
Winona County Community Services	Winona
Wright County Human Services	Wright

C5. Nurse-Family Partnership Provider Agencies

Provider Agency	Service Area
Anoka County Human Services	Anoka
Becker County Public Health	Becker
Carlton County Public Health and Human Services	Carlton
Cass County Health Human and Veterans Services	Cass
Clay County Social and Health Services	Clay
Kanabec County Community Health	Kanabec
Morrison County Public Health	Morrison
MVNA	Hennepin
Norman-Mahnomen Public Health	Mahnomen Norman
Otter Tail County Public Health	Becker Otter Tail
Polk County Public Health	Polk
St. Louis County Public Health and Human Services	St. Louis
St. Paul-Ramsey County Public Health	Ramsey
Stearns County Human Services	Benton Stearns
Supporting Hands Nurse-Family Partnership	Big Stone Chippewa Douglas Grant Kandiyohi Lac qui Parle Lincoln Lyon McLeod Meeker Murray Pipestone Pope Redwood Renville Rock Stevens Swift Traverse Yellow Medicine
Wadena County Public Health	Wadena
Wilkin County Public Health	Wilkin
Wright County Human Services	Sherburne Wright

C6. Parents as Teachers Provider Agencies

Provider Agency	Service Area
Catholic Charities	Hennepin
Communidades Latinas Unidas En Servicio Inc	Hennepin Ramsey
Greater Minneapolis Crisis Nursery	Hennepin
Jeremiah Program	Fillmore Freeborn Goodhue Mower Olmsted Rice Wabasha
Lifetrack Resources Inc	Ramsey
St. David's Center for Child and Family Development	Hennepin
St. Paul-Ramsey County Public Health	Ramsey
Way To Grow	Hennepin
WellShare International	Hennepin Ramsey
YWCA Mankato	Blue Earth Le Sueur Nicollet

Appendix D. Family Home Visiting Participant Demographic Characteristics, 2017-2019

Note: Some percent values may not total 100% due to rounding.

D1. Table of Caregiver Education Level at Intake

	2017		2018		2019		
Caregiver Education Level at Intake	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
Less than HS Diploma	3,736	28%	3,613	27%	3,393	24%	26%
HS Diploma/GED	3,931	30%	3,875	29%	3,870	28%	29%
Some College/Training	2,307	17%	2,311	17%	2,240	16%	17%
Technical Training or Certificate	84	1%	109	1%	134	1%	1%
Associate's Degree	879	7%	928	7%	918	7%	7%
Bachelor's Degree or Higher	1,122	8%	1,157	9%	1,156	8%	8%
Other	135	1%	114	1%	126	1%	1%
Unknown/Did Not Report	1,103	8%	1,396	10%	2,234	16%	12%
Total	**13,297**	**100%**	**13,503**	**100%**	**14,071**	**100%**	**100%**

D2. Table of Caregiver Insurance Status at Intake

	2017		2018		2019		
Caregiver Insurance at Intake	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
Insured	11,339	85%	12,016	89%	12,571	89%	88%
Uninsured	757	6%	771	6%	837	6%	6%
Unknown/Did Not Report	1,201	9%	716	5%	594	4%	6%
Applied for Insurance (Pending)	0	0%	0	0%	69	0%	0%
Total	**13,297**	**100%**	**13,503**	**100%**	**14,071**	**100%**	**100%**

D3. Table of Caregiver Insurance Type at Intake

Caregiver Insurance Type at Intake	2017		2018		2019		Three Year Average
	Count	Percent	Count	Percent	Count	Percent	
No Insurance Coverage	757	6%	771	6%	837	6%	6%
MN Health Care Programs	9,011	68%	9,602	71%	10,097	72%	70%
Tri-Care	49	0%	48	0%	53	0%	0%
Private Insurance	2,179	16%	2,224	16%	2,256	16%	16%
Other Insurance Type	59	0%	86	1%	98	1%	1%
Unknown/Did Not Report	1,242	9%	772	6%	730	5%	7%
Total	**13,297**	**100%**	**13,503**	**100%**	**14,071**	**100%**	**100%**

D4. Table of Caregiver Primary Language at Intake

Caregiver Primary Language at Intake	2017		2018		2019		Three Year Average
	Count	Percent	Count	Percent	Count	Percent	
English	8,988	68%	9,152	68%	9,496	67%	68%
Hmong	95	1%	89	1%	114	1%	1%
Somali	264	2%	217	2%	217	2%	2%
Spanish	1,174	9%	1,130	8%	1,243	9%	9%
Amharic	57	0%	74	1%	78	1%	1%
Arabic	30	0%	28	0%	25	0%	0%
Burmese	11	0%	7	0%	12	0%	0%
Karen	212	2%	219	2%	247	2%	2%
Nepalese	10	0%	11	0%	16	0%	0%
Oromo	24	0%	27	0%	49	0%	0%
Other	424	3%	471	3%	529	4%	3%
Unknown/Client Declines to Answer	2,008	15%	2,078	15%	2,045	15%	15%
Total	**13,297**	**100%**	**13,503**	**100%**	**14,071**	**100%**	**100%**

D5. Table of Caregiver Ethnicity at Intake

Caregiver Ethnicity at Intake	2017		2018		2019		Three Year Average
	Count	Percent	Count	Percent	Count	Percent	
Hispanic or Latino	2,083	16%	1,988	15%	2,297	16%	16%
Not Hispanic or Latino	9,156	69%	9,353	69%	9,821	70%	69%
Unknown/Did Not Report	2,058	15%	2,162	16%	1,953	14%	15%
Total	**13,297**	**100%**	**13,503**	**100%**	**14,071**	**100%**	**100%**

D6. Table of Caregiver Race at Intake

Caregiver Race at Intake	2017 Count	2017 Percent	2018 Count	2018 Percent	2019 Count	2019 Percent	Three Year Average
American Indian or Alaska Native	384	3%	465	3%	532	4%	3%
Asian	642	5%	665	5%	781	6%	5%
Black or African American	1,933	15%	1,816	13%	2,044	15%	14%
Native Hawaiian or Other Pacific Islander	69	1%	124	1%	140	1%	1%
White	7,308	55%	7,400	55%	7,608	54%	55%
More Than One Race	357	3%	394	3%	462	3%	3%
Declined/Unknown/Did Not Report	2,604	20%	2,639	20%	2,504	18%	19%
Total	**13,297**	**100%**	**13,503**	**100%**	**14,071**	**100%**	**100%**

D7. Table of Caregiver Type at Intake

Caregiver Identification at Intake	2017 Count	2017 Percent	2018 Count	2018 Percent	2019 Count	2019 Percent	Three Year Average
No Data	5	0%	8	0%	19	0%	0%
Pregnant Women	6,362	48%	6,600	49%	6,617	47%	48%
Postpartum Mother	6,622	50%	6,593	49%	7,104	50%	50%
Father	134	1%	123	1%	127	1%	1%
Other Caregiver	174	1%	179	1%	204	1%	1%
Total	**13,297**	**100%**	**13,503**	**100%**	**14,071**	**100%**	**100%**

D8. Table of Caregiver Age at Intake

Caregiver Age at Intake	2017 Count	2017 Percent	2018 Count	2018 Percent	2019 Count	2019 Percent	Three Year Average
No Data	86	1%	97	1%	109	1%	1%
<=17	413	3%	373	3%	386	3%	3%
18-19	920	7%	859	6%	718	5%	6%
20-21	1,367	10%	1,282	9%	1,144	8%	9%
22-24	2,084	16%	2,129	16%	2,105	15%	15%
25-29	3,527	27%	3,600	27%	3,717	26%	27%
30-34	2,750	21%	2,895	21%	3,119	22%	21%
35-44	2,016	15%	2,119	16%	2,558	18%	16%
>=45	134	1%	149	1%	215	2%	1%
Total	**13,297**	**100%**	**13,503**	**100%**	**14,071**	**100%**	**100%**

D9. Table of Child Insurance Status at Intake

Child Insurance at Intake	2017		2018		2019		Three Year Average
	Count	Percent	Count	Percent	Count	Percent	
Insured	9,550	78%	9,810	79%	9,479	76%	78%
Uninsured	1,470	12%	1629	13%	1,547	12%	13%
Unknown/Did Not Report	1285	10%	861	7%	753	6%	8%
Applied for Insurance (Pending)	11	0%	50	0%	655	5%	2%
Total	**12,316**	**100%**	**12,350**	**100%**	**12,434**	**100%**	**100%**

D10. Table of Child Insurance Type at Intake

Child Insurance Type at Intake	2017		2018		2019		Three Year Average
	Count	Percent	Count	Percent	Count	Percent	
No Insurance Coverage	1,470	12%	1,629	13%	1,547	12%	13%
MN Health Care Programs	7,289	59%	7,984	65%	8,103	65%	63%
Tri-Care	35	0%	34	0%	38	0%	0%
Private Insurance	1,387	11%	1,432	12%	1,421	11%	11%
Other Insurance Type	48	0%	51	0%	57	0%	0%
Unknown/Did Not Report	2,087	17%	1,220	10%	1,268	10%	12%
Total	**12,316**	**100%**	**12,350**	**100%**	**12,434**	**100%**	**100%**

D11. Table of Child Ethnicity at Intake

Child Ethnicity at Intake	2017		2018		2019		Three Year Average
	Count	Percent	Count	Percent	Count	Percent	
Hispanic or Latino	3,156	26%	3,120	25%	2,968	24%	25%
Not Hispanic or Latino	8,769	71%	8,897	72%	9,157	74%	72%
Unknown/Did Not Report	391	3%	333	3%	309	2%	3%
Total	**12,316**	**100%**	**12,350**	**100%**	**12,434**	**100%**	**100%**

D12. Table of Child Race at Intake

	2017		2018		2019		
Child Race at Intake	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
American Indian or Alaska Native	340	3%	386	3%	395	3%	3%
Asian	752	6%	766	6%	854	7%	6%
Black or African American	2,113	17%	2,003	16%	2,028	16%	17%
Native Hawaiian or Other Pacific Islander	90	1%	173	1%	194	2%	1%
White	7,004	57%	6,977	56%	6,775	54%	56%
More Than One Race	966	8%	1,022	8%	1,107	9%	8%
Declined/Unknown/Did Not Report	1,051	9%	1,023	8%	1,081	9%	9%
Total	**12,316**	**100%**	**12,350**	**100%**	**12,434**	**100%**	**100%**

D13. Table of Child Age at Intake

	2017		2018		2019		
Child Age at Intake	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
No Data	8	0%	6	0%	6	0%	0%
<1 year	6,172	50%	5,532	45%	4,565	37%	44%
1-2 Years	4,470	36%	4,436	36%	4,427	36%	36%
3-4 Years	1,355	11%	1,947	16%	2,480	20%	16%
5-6 Years	246	2%	334	3%	757	6%	4%
7+ Years	65	1%	95	1%	199	2%	1%
Total	**12,316**	**100%**	**12,350**	**100%**	**12,434**	**100%**	**100%**

Appendix E. Family Home Visiting Participant Outcome Measures, 2017-2019

Note: Some percent values may not total 100% due to rounding.

E1. Table of Child Breastmilk Status at Six Months of Age

	2017		2018		2019		
Child Receives Any Breastmilk at 6 Months	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
Yes	768	26%	801	27%	687	26%	26%
No	2,169	74%	2,218	73%	1,921	74%	74%
Total	**2,937**	**100%**	**3,019**	**100%**	**2,608**	**100%**	**100%**

E2. Table of Caregiver Depression Screening

	2017		2018		2019		
Caregiver Depression Screening	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
Had Depression Screening	1,320	43%	1,427	46%	1,238	48%	46%
No Depression Screening	1,717	57%	1,642	54%	1,327	52%	54%
Total	**3,037**	**100%**	**3,069**	**100%**	**2,565**	**100%**	**100%**

E3. Table of Caregiver Intimate Partner Violence (IPV) Screening by 6 Months of FHV Program Enrollment

	2017		2018		2019		
Caregiver IPV Screening	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
Had IPV Screening	1,092	39%	1,444	49%	1,224	48%	45%
No IPV Screening	1,734	61%	1,497	51%	1,302	52%	55%
Total	**2,826**	**100%**	**2,941**	**100%**	**2,526**	**100%**	**100%**

E4. Table of Caregiver Intimate Partner Violence (IPV) Referral for Positive Screen

	2017		2018		2019		
Caregiver IPV Referral	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
Had IPV Referral	67	55%	71	52%	52	51%	53%
No IPV Referral	54	45%	66	48%	50	49%	47%
Total	**121**	**100%**	**137**	**100%**	**102**	**100%**	**100%**

E5. Table of Child Developmental Screening at 9 to 12 Months of Age

	2017		2018		2019		
Child Developmental Screening	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
Had Developmental Screening	1,206	43%	1,194	42%	996	40%	42%
No Developmental Screening	1,575	57%	1,658	58%	1,468	60%	58%
Total	**2,781**	**100%**	**2,852**	**100%**	**2,464**	**100%**	**100%**

E6. Table of Child Developmental Referral for Positive Screen

	2017		2018		2019		
Child Developmental Referral	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
Had Developmental Referral	46	58%	62	62%	59	76%	65%
No Developmental Referral	34	43%	38	38%	19	24%	35%
Total	**80**	**100%**	**100**	**100%**	**78**	**100%**	**100%**

E7. Table of Child Insurance Status

	2017		2018		2019		
Child Insurance Status	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
Insured	6,705	81%	7,205	82%	7,162	79%	81%
Uninsured	632	8%	613	7%	561	6%	7%
Unknown/Did Not Report	956	12%	927	11%	1,007	11%	11%
Applied for Insurance (Pending)	0	0%	8	0%	286	3%	1%
Total	**8,293**	**100%**	**8,753**	**100%**	**9,016**	**100%**	**100%**

E8. Table of Child Insurance Type

	2017		2018		2019		
Child Insurance Type	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
No Insurance Coverage	632	8%	613	7%	561	6%	7%
MN Health Care Programs	5,823	70%	6,420	73%	6,567	73%	72%
Tri-Care	21	0%	28	0%	23	0%	0%
Private Insurance	613	7%	605	7%	602	7%	7%
Other Insurance Type	42	1%	44	1%	52	1%	1%
Unknown/Did Not Report	1,156	14%	1,043	12%	1,211	13%	13%
Total	**8,293**	**100%**	**8,753**	**100%**	**9,016**	**100%**	**100%**

E9. Table of Caregiver Insurance Status

	2017		2018		2019		
Caregiver Insurance Status	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
Insured	7,346	80%	8,363	86%	8,913	87%	85%
Uninsured	659	7%	720	7%	780	8%	7%
Unknown/Did Not Report	1,149	13%	631	6%	543	5%	8%
Applied for Insurance (Pending)	0	0%	0	0%	33	0%	0%
Total	**9,154**	**100%**	**9,714**	**100%**	**10,269**	**100%**	**100%**

E10. Table of Caregiver Insurance Type

	2017		2018		2019		
Caregiver Insurance Type	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
No Insurance Coverage	659	7%	720	7%	780	8%	7%
MN Health Care Programs	6,187	68%	7,050	73%	7,554	74%	71%
Tri-Care	30	0%	32	0%	34	0%	0%
Private Insurance	1,051	11%	1,156	12%	1,198	12%	12%
Other Insurance Type	50	1%	81	1%	81	1%	1%
Unknown/Did Not Report	1,177	13%	675	7%	622	6%	8%
Total	**9,154**	**100%**	**9,714**	**100%**	**10,269**	**100%**	**100%**

E11. Table of Caregiver Educational Attainment

	2017		2018		2019		
Caregiver Education Attainment	**Count**	**Percent**	**Count**	**Percent**	**Count**	**Percent**	**Three Year Average**
Has HS Diploma or GED	1,304	43%	1,177	38%	1,029	35%	39%
Does Not have HS Diploma or GED	1,716	57%	1,930	62%	1,874	65%	61%
Total	**3,020**	**100%**	**3,107**	**100%**	**2,903**	**100%**	**100%**

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