Family Home Visiting Legislative Report

01/15/2022

Minnesota Family Home Visiting Report to the Legislature

Minnesota Department of Health
Family Home Visiting
PO BOX 64882
St. Paul, MN 55164-0882

health.homevisiting@state.mn.us
health.state.mn.us/communities/fhv

As requested by Minnesota Statute 3.197: This report cost approximately $19,228 to prepare, including staff time, printing, and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille, or audio recording. Printed on recycled paper.

Executive Summary

Through countless family testimonies and rigorous empirical research, Family Home Visiting (FHV) has long demonstrated its ability to be a powerful lever at supporting and empowering pregnant individuals and families with young children.

Family Home Visiting helps connect pregnant women with adequate prenatal care, learn about healthy child development in utero, infancy, and the early childhood years, and promotes responsive relationships. As children and families develop, FHV ensures families with young children receive individualized social, emotional, health-related, and caregiving supports, and are referred to community resources that help stabilize families. In 2021, over 7,000 families connected with their home visitors to find resources and learn health and wellbeing information for themselves and their families.

Over the course of the past two years, family home visitors have been a critical lifeline for families trying to navigate the abrupt health, economic, and social fallout brought on by the COVID-19 pandemic.

The pandemic has had a disproportionately negative impact on the communities that FHV seeks to serve. Health, economic, social, and psychological burdens have been exacerbated in the communities that were already unevenly impacted by structural and racial inequities.

COVID-19 has also had a crippling effect on every FHV implementing agency, directly and indirectly impacting staffing, planning, recruitment, and implementation.

The biennial Family Home Visiting (FHV) Report to the Legislature highlights the dual realities Family Home Visiting programming has faced over the past two years: COVID-19 has impacted every aspect of FHV service delivery while at the same time confirming FHV's irreplaceable role in promoting health and wellbeing for pregnant women and families with young children most in need.

Family home visiting continues to be a concrete and measurable mechanism to ensure safe, stable, and nurturing environments for Minnesota's children.

> *"During the pandemic, challenges have layered on and our nurses, like the families they serve,* ***continue to be resilient as they have adapted to new ways of working and being****. Many of families they work with already face extremely difficult circumstances that may include a* ***history of trauma, poverty, abuse, and/or addiction, which can be compounded by the pandemic.***
>
> *They (nurses) are* ***working together to share creative ideas*** *and resources to maintain connections with families and while providing important essential services in the midst of a historic pandemic."*
>
> *—FHV Grantee*

Contents

Introduction

Family Home Visiting Benefits

Family Home Visiting (FHV) 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, FHV 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]

Appropriate prenatal care is critical for babies: brain development begins well before birth and is heavily affected by malnutrition, environmental pollutants, and infections.[3,4,5] 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.[6,7]

Chronic stressors, such as poverty, can actually change the way the brain looks, develops, and functions.[8] The effects of poverty can be detected in brain development as early as 6 to 9 months of age.[9]

These adverse experiences and stressors unevenly impact pregnant women and families who also experience **economic, structural,** and **racial inequities**. On average, Minnesota has good health outcomes, but those **outcomes hide significant health inequities** for Minnesotans who are Black, Indigenous, and People of Color (BIPOC).

Family Home Visiting is a proven strategy in addressing the factors that impact relationships and environments for pregnant and parenting families with young children—and doing so directly in the communities in which they live. FHV services have demonstrated significant and replicated impacts on improving child and family wellbeing.

What is Family Home Visiting?

Family Home Visiting (FHV) is a voluntary, home-based service ideally delivered prenatally through a child's first few years. During frequent, regularly scheduled visits, a family works with a trained home visitor to complete activities and curricula often provided by an evidence-based home visiting model. The home visitor also uses information from various health assessments to develop an individualized plan to assist the family in reaching their goals. Home visiting uses a multi-generational approach, benefiting pregnant and 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 appropriate prenatal care;
- Supporting parents and caregivers as a **child's first teacher**; and

- Fostering **parenting and caregiving skills** that decrease the risk of child abuse.

Additional Need for Family Home Visiting in Minnesota

Despite sizable financial commitments, the need for Family Home Visiting (FHV) services continually and greatly outpaces its current availability. In 2021, over 7,000 households participated in FHV, yet according to a recent statewide assessment, an estimated 76,000 Minnesota families would benefit from FHV services. Across Minnesota, **only one in 10 families in need** of Family Home Visiting receive these services, despite significant local, state, and federal investments.

Family Home Visiting Participants

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

- Teen 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

COVID-19

On March 13th, 2020, Minnesota Governor Tim Walz declared a peacetime emergency to combat COVID-19, an infectious disease that had been detected in 42 states, including Minnesota. Since then, the COVID-19 pandemic has negatively impacted the social, economic, and health & wellbeing of Minnesotans. The impact of COVID-19 has been unevenly experienced: families who already face systemic health and racial disparities have been disproportionally affected by COVID-19 and its subsequent financial, health, and social fallout. While the long-term impact of this health crisis is yet to be learned, COVID-19 has upended family social supports, financial and employment security, housing stability, school and work environments, and health & wellbeing.

Despite Family Home Visiting programs across the state being impacted with staffing reassignments, and numerous other barriers that affect recruitment, participation, and retention, **home visitors have served a critical function of assisting pregnant women and families with young children during this exceptional crisis**.

Jesse was pregnant and in rehab for alcohol addiction when the pandemic hit. Her older children were temporarily in custody with a family member while she completed the rehab program. Because of the pandemic, CPS policies changed overnight and she was suddenly not allowed to see her children (ages 2 and 9) at all. Understandably, she was quite distressed by this. She had limited access to phone or email due to the policies at her facility, but her home visiting nurse was able to advocate for her with CPS and help find COVID-safe ways for her to visit with the children. Jesse and the kids did so much better once they could see each other regularly!*

Eventually, she was able to move to her own apartment together with her children (while continuing her outpatient therapy). Her nurse helped her get furniture for the apartment and brought donated winter coats, clothing, and toys for the kids since most stores were closed due to lockdown. The nurse also delivered a car seat and pack and play for her new baby - a healthy baby boy! Jesse is now thriving and has regained full custody of her older kids.

FHV Grantee

Health Equity

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 equity means every individual has a fair opportunity to attain the individual's full health potential and **no individual is disadvantaged** from achieving this potential.[10]

FHV is uniquely positioned to **promote health equity** by providing social, emotional, health, and caregiving supports to families, and linking them to appropriate resources. FHV's emphasis on 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 **health disparities**.

Health disparities are preventable differences on health outcomes that negatively affect socially disadvantaged populations, such as populations defined by race, gender, education, or geographic region.[11] The Minnesota Department of Health's Center for Health Equity (CHE) 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."[12]

The MDH-FHV section promotes health equity by:

- Supporting Tribal home visiting and Tribal public health by maximizing grants and streamlining application processes.
    - Each year, nine Tribal Nations receive TANF funds to implement evidence-based and/or traditional home visiting programs.
    - Beginning in 2017, four Tribes and five non-profit organizations that serve Indigenous families have received state Evidence-Based Home Visiting (EBHV) grants to implement Family Spirit and Nurse-Family Partnership home visiting programs.
- Advancing the implementation of Family Spirit, an evidence-based FHV model that uses culture as an asset and prevention framework. Specifically designed for Native American parents, caregivers, and their children, Family Spirit incorporates traditional Indigenous parenting and self-care concepts and uses a strengths-based curriculum to improve maternal and child health.
- Requiring Request for Proposal (RFP) awardees to demonstrate they serve populations impacted by health disparities.
- Prioritizing grantees that work with smaller organizations that can meet the unique needs of their communities. For example, Hennepin County strategically redirects part of their funding to smaller non-profit organizations that have existing and trusting relationships within the communities they serve.
- Promoting continuity of care for highly mobile families by strengthening local collaborations.
- Investing in programs that serve populations that historically have not accessed Family Home Visiting, including Black, Indigenous, and People of Color (BIPOC), immigrant, geographically-isolated populations as well as communities whose first language is not English. Examples include:
    - CLUES, a Latino-led organization, delivers FHV programming **to Latino and new immigrant families**;
    - The Family Partnership implements FHV services to **African-American families** in primarily North Minneapolis;
    - Pillager Family Council supports a **100% rural community** with families facing poverty and other risk factors;
    - Simpson Housing Services serves largely **African American families experiencing homelessness;**
    - Way to Grow supports communities with **high percentage of immigrant families and English Language Learners (ELL)**, African-American, African, Native American, Hmong, White and Latino families;
    - WellShare International's program works primarily with **Somali families**; and

- YWCA-Mankato seeks to serve **immigrant and refugee families**.

FHV is well positioned to drive health equity in Minnesota by empowering families through building relationships and connecting them to community resources. Coupled with the devastating impact that COVID-19 has had on the families who already experience health disparities, Minnesota's investment in family home visiting services is an essential component to promote health equity for all Minnesotans.

Family Home Visiting in Minnesota

Family Home Visiting incorporates local, state, and federal partners and investments to effectively implement family-based interventions to pregnant women and families with young children across the state. This section provides descriptions of evidence-based and traditional home visiting, state and federal investments, local implementing partners, and a 2021 Minnesota legislative update, including home visiting initiatives that were codified into statute.

Traditional & Evidence-Based Home Visiting

Across Minnesota, both evidence-based home visiting and traditional public health home visiting are implemented with funding from MDH-FHV. Evidence-based home visiting models have demonstrated and replicated positive impacts on child and family wellbeing through rigorous research. Home visitors trained in these models go through extensive training and accreditation processes to effectively implement the model's core components. Traditional home visiting (both long- and short-term) relies on nurse home visitor experience, nursing education, community needs, and findings from basic research.

Seven different evidence-based home visiting models are supported by MDH and implemented across Minnesota. Early Head Start, Family Spirit, Healthy Families America, Maternal Early Childhood Sustained Home-Visiting, 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 caregivers and children yet vary in eligibility, intensity, length, and content focus.

Evidence-Based Home Visiting Expansion

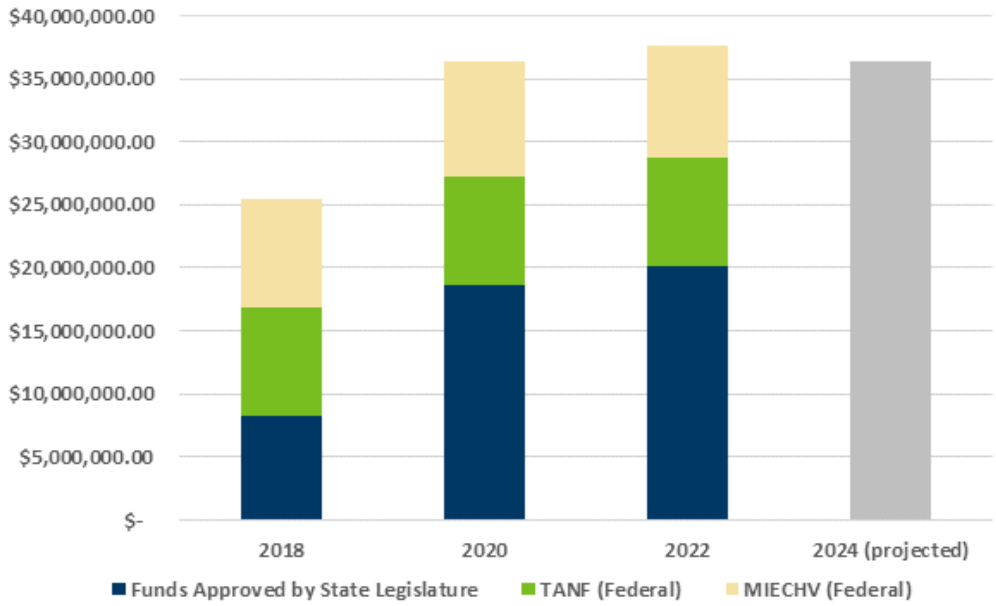
Evidence-based (EB) home visiting has dramatically increased across the state as the MDH-FHV program has emphasized the importance of implementing **proven models** that support pregnant women and families with young children. In 2012, over half of counties (n = 47, 54%) were implementing an EB model. By 2019, the number jumped to 81 counties (94%). In 2021, 98% of counties are implementing an EB home visiting model.

Some counties and communities choose to implement multiple evidence-based home visiting models to better meet the needs of specific populations within their communities. Tribal nations have also had great success implementing EB models that meet their community values and needs.

Investments

MDH-FHV uses a combination of state and federal dollars to fund local home visiting programming across the state, awarding grants to local public health, Tribal Nations, and non-profit organizations. As seen in Figure 1, there has been increased investment in FHV in recent years, reflecting national momentum of supporting evidence-based interventions that yield positive outcomes for families.

Figure 1. Investments in Evidence-Based Home Visiting 2018 - Present



Minnesota Department of Health-Family Home Visiting's Funding and Grants Management website to view individual TANF awards to local public health and Tribal governments.

State allocations provide over half (52%) of FHV funding, followed by MIECHV (24%), and TANF (24%). Many local counties also leverage local funds to expand services and reach to communities across the state. Combinations of the funds mentioned above, along with other local, state, and federal resources, allow local agencies to sustainably provide home visiting services to as many eligible families as possible. Further, local home visiting programs that employee public health nurses can seek third party reimbursement for eligible home visiting services using Medical Assistance for participants enrolled in Medicaid.

Local Home Visiting Programs

Local implementing agencies use their knowledge of the community they serve, community needs, and resources that best serve their priority population(s) to determine an appropriate home visiting model and curriculum. Managing operations, hiring and supporting home visiting staff, and meeting reporting requirements are a few key responsibilities of local FHV programs.

Three distinct grantee types use MDH funds to deliver Family Home Visiting services in Minnesota: community health boards (CHBs), non-profit organizations, and Tribal governments. Home visitors in CHBs most often are public health nurses. Non-profit organizations are an emerging home visiting implementer and have demonstrated their ability to meet the unique needs of the communities in which they serve. Tribal governments implement Family Home Visiting as a method to support and empower Tribal community members with young children, often using a home visiting model that emphasizes culture as a protective factor.

For a current family home visiting program inventory, including MDH-awarded programs, visit Help Me Connect, an online early childhood resource navigator. Search results can be filtered by evidence-based model, specialization, or service area (ZIP code, city, or county).

Legislative Update

During the 2021 Legislative session, two home visiting initiatives that were initially approved by the Legislature in 2017 were codified into statute, MN Stat 145.87 (Home Visiting for Pregnant Women and Families with Young Children) and MN Stat 145A.145 (Nurse-Family Partnership Programs). A change that occurred during the codification of MN Stat 145.87 added flexibility to use up to 25% of state home visiting funds to support evidence-informed or promising practices. The legislation requires that a minimum of 75% of funding must be distributed to evidence-based home visiting programs. The increased flexibility is intended to support the advancement of community-driven home visiting solutions aimed at decreasing health disparities for American Indians and families of color in Minnesota.

MDH as Minnesota's Family Home Visiting Hub

The Family Home Visiting Section in the Minnesota Department of Health works collaboratively to oversee **key functions**:

- **Distribute funds** to local home visiting service providers through grant awards.
- **Monitor** work plans, budgets, and fidelity to home visiting models.
- Provide programmatic and budgeting **technical assistance and training**.
- Organize **Continuous Quality Improvement initiatives** to improve programs and outcomes for families.
- **Coordinate with other state agencies** to build a stronger and more integrated early childhood systems.
- **Evaluate program effectiveness** through outcome measurement.

Staff & Program Development

Professional Development

Supporting and developing staff is critical for promoting stable and effective organizations and delivering strong program activities to families. Each of the FHV models has specific training requirements for home visitors and their supervisors. MDH also provides ongoing trainings to local programs that build capacity and promote connections across home visiting programs. 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.

Continuous Quality Improvement (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. Recruitment & retention of families, breastfeeding, intimate partner violence (IPV), and most recently screening for depression have been recent CQI initiatives facilitated by MDH-FHV.

Technical Assistance

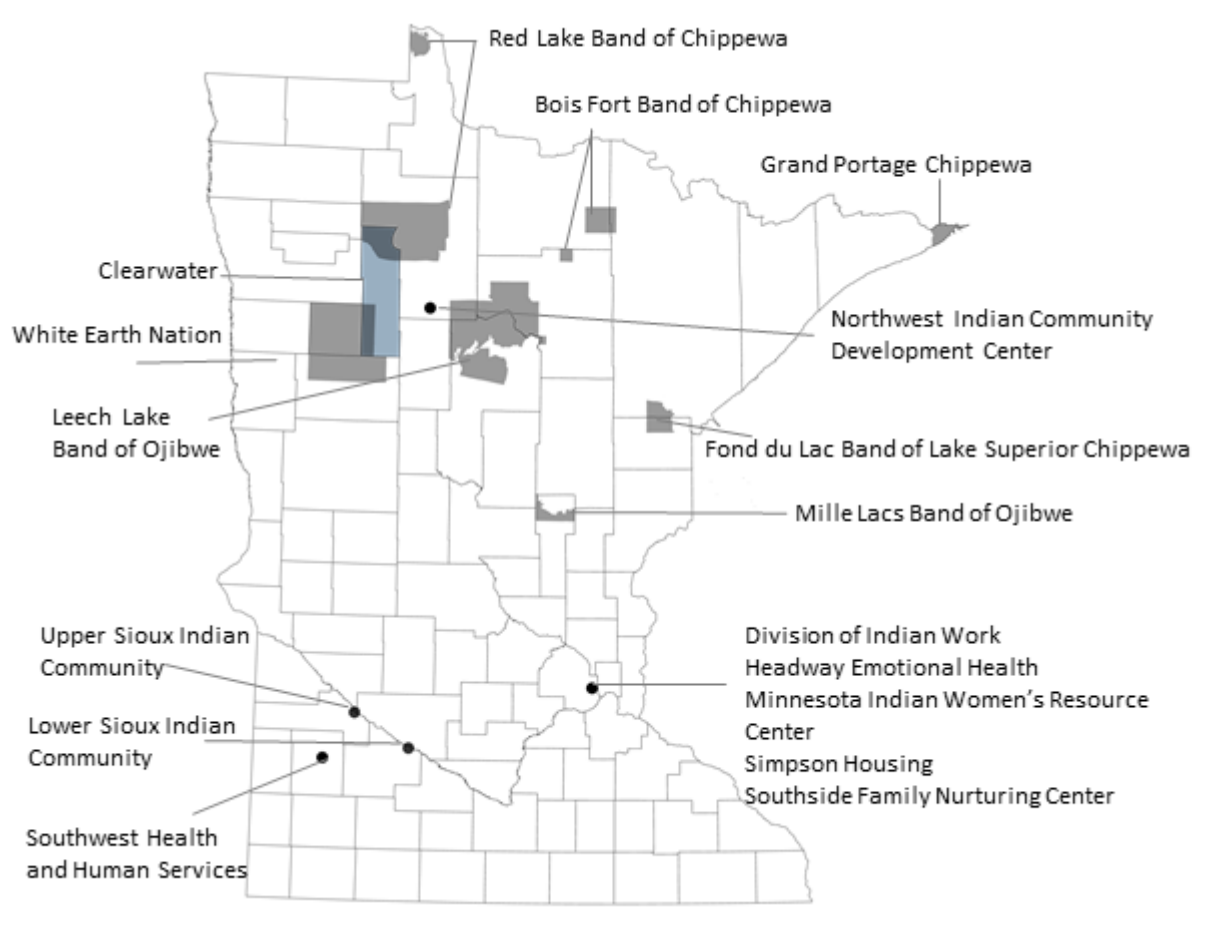
Providing accurate, timely technical assistance is an essential function at MDH-FHV. MDH-FHV staff work collaboratively to provide consultation to local implementing agencies on budgeting, grants management, funding, model support, data entry & evaluation, and more. MDH-FHV provides resources, tools, and individualized support to improve service delivery and promote program capacity.

Family Spirit Learning Collaborative/Community of Practice

Beginning 2020, Minnesota Department of Health facilitated a yearlong, three-part Community of Practice (CoP) series for home visiting programs implementing **Family Spirit**, an evidence-based home visiting model. Family Spirit was developed around Indigenous belief systems and encourages the use of healthy traditions to guide parenting behavior and goals. Seventeen agencies (Tribal Nations, nonprofit organizations, and community health agencies) participated in in the CoP where model expertise and training were provided by Family Spirit developer **Johns Hopkins Center for American Indian Health (JHCAIH)**.

Across the state, there is widespread commitment to advance culturally relevant family home visiting services by promoting collaboration, enhancing networking opportunities, and providing technical assistance. Lieutenant Governor Peggy Flanagan, a member of the White Earth Nation, joined the kick-off and closing events to share the **state's commitment to addressing the stark health disparities experienced by the American Indian population**. She applauded the efforts of family home visitors and gave examples from her own work about the difference these services make.

Participating Agencies



Community of Practice participants (mostly home visitors) attended webinars, group and individual coaching sessions, and other virtual trainings and presentations by national experts and JHCAIH staff. Due to COVID-19, nearly all activities were facilitated virtually. Topics included:

- Strengthening home visiting programming (e.g., how to effectively use incentives, creating meaningful referrals for resources, incorporating culture into Family Spirit delivery)
- Motivational Interviewing
- Trauma-informed approaches to home visiting
- Supporting home visitors who experience vicarious trauma.

CoP Participant Perspective: Birdie Lyons, Family Spirit Coordinator

Birdie Lyons, member of the Leech Lake Band of Ojibwe and Family Spirit coordinator, has worked in home visiting for over 38 years, the last six implementing Family Spirit. She shared her reflections as a participant of the Community of Practice (CoP). Birdie enjoyed the CoP because it provided a framework to look at how she did her work just a bit differently. The year-long process also allowed her "to reflect,

and put into practice and see what did and didn't work" with input from other Tribal home visitors from across the state.

One of the most impactful aspects of the CoP was the focus on family-led practice: "It reminded me that my role is to listen to the participant and follow their lead. We spend so much time thinking about curriculum and reports that a home visitor might forget about the people you're serving and what they need versus what you think they need." Another aspect of the CoP that was very valuable was, "the information was presented in a way that made sense to me, I could see how what I was learning could be adapted to my Ojibwe community."

Birdie looks forward to additional CoPs, including those that focus on both Indigenous Communities and more broadly on Black, Indigenous, and People of Color (BIPOC) communities. "CoPs need to include a foundation of understanding of the issues Indigenous communities encounter as they rebuild their Nations and culture." She also would like to have the opportunity to learn more about other cultures, and build understanding on how to work with other cultures. "We need more of this training. It helps everybody, not just Indigenous communities."

Project Evaluation Findings

At the conclusion, JHCAIH conducted an evaluation of the Family Spirit Community of Practice. Evaluation findings indicate the CoP was positive and informative. The speakers and presenters were effective, and the CoP provided opportunities for participants to learn and address personal and professional goals. Additionally, participants appreciated the opportunity to learn and connect with other programs.

Embedding Native Belief Systems

Family Spirit facilitators adapted a traditional Continuous Quality Improvement process with elements from a Community of Practice approach that acknowledged and elevated the importance of traditional practices, shared learning, and peer connections.

COVID Adaptations

COVID-19 upended regularly- planned CoP topics and processes. In response to home visitor feedback, a workshop was created to focus on remote home visiting guidance. Subsequent sessions were held virtually, and facilitators regularly provided space and time for home visitors to debrief and receive support in response to their demanding COVID-19 response work.

Intentional Opportunities for Connection

Home visitor feedback highlighted the importance of designating time for group discussions and informal conversations. While some presentations embedded small group discussions, additional opportunity for making and building connections is sacred to home visitors.

Networking at Multiple Levels

Home visitors developed professional and social relationships with one another, the Department of Health, and Family Spirit team. They used this time to exchange information with one another (e.g., reflective supervision resources) and created the opportunity for sites to communicate their needs or to ask questions.

Next Steps

At the end of the Community of Practice, future Family Spirit projects at MDH were identified. Potential topics include:

- Re-introducing in-person home visitation post-COVID
- Reflective practice/consultation and debrief
- Fathers and male role models
- Addressing risk factors such as suicide, homelessness, and substance abuse
- Working with the incarceration system and parents recently released.

Grants Monitoring

Grants managers oversee all areas of FHV grants, including the grant agreement, work plan, budget, invoices, monitoring, and reporting requirements. They provide technical assistance throughout all stages of a grant: Pre-Award, Award, & Post-Award. They use several resources, including work plans, progress reports, check-ins, and site visits to assess and guide effective implementation and successful completion of grant activities. Equally important, grants managers have a fiduciary responsibility to ensure the investments made from Minnesotans are spent responsibly and in accordance with all relevant statutes.

Data Management & Evaluation

The Family Home Visiting evaluation team collects, analyzes, and reports on data related to the impact of FHV services in Minnesota. Evaluation activities inform local and state level programming and policy as well as meet grant and model requirements for reporting. **Information for Home Visiting Evaluation (IHVE)**, the MDH-FHV data collection system, provides data to answer questions about FHV effectiveness and opportunities for improvement.

Building & Strengthening Collaborations

The Minnesota Department of Health uses collaborations to promote innovation, engage individuals and organizations, and communicate and disseminate findings and best practices. This includes a focus on promoting local partnerships, sharing information with local and national partners, and participating in inter-agency initiatives.

Promoting Local Partnerships

MDH-FHV prioritizes regional, county, and tribal collaborations for grant applicants. These partnerships encourage broader geographic coverage and multi-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.

Early Childhood System Building

The Minnesota Department of Health 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-FHV has been actively involved in three specific initiatives: The Minnesota Preschool Development Birth through Five (PDG B-5) grant, the development of Help Me Connect, and MFIP Collaboration for Teen Moms.

FHV Program Outcomes

COVID Impact on Family Home Visiting

The COVID-19 pandemic has impeded Family Home Visiting (FHV) at every level of service delivery. Despite its acute impact on the state health department, and local nonprofit, Tribal, and county health agencies, **family home visitors have effectively connected with families and provided invaluable resources** during this particularly devastating time for so many Minnesotans. Home visiting supervisors, other support staff, and FHV staff within MDH continued to create systems of support for program delivery.

COVID-19 Impact on Family Home Visiting Grantees

While all programs faced a similar need to adapt, local public health and Tribal health partners were additionally burdened with COVID-19 staff reassignments in their home communities. These local agencies took the lead in their community's response and were required to prioritize local COVID-19 support activities, such as vaccine planning & distribution, contact tracing & case investigation, and providing essential services for quarantined and isolated individuals and families.

Family Home Visiting Implementation & Adaptations

In Spring 2020, MDH and evidence-based home visiting model developers recommended an immediate switch to virtual from in-person visits. This shift required home visitors to acquire new technological

skills literally overnight. According to a biannual FHV progress report completed in December 2020, **96% of FHV grantees were providing telehealth or video conferencing to FHV participants** while 67% continued to offer some in-person visits. Local public health agencies that bill for third party reimbursement were required to meet or update telehealth policies and requirements while striving to engage families in virtual visits.

Programs needed to change policies and procedures to keep their staff and families safe. Staff and families alike were impacted by the added stress that accompanied concerns for their personal health and safety, and the general societal discord. MDH-FHV staff worked with MDH's Incident Command System to provide over 20,000 masks to home visiting programs so that home visiting staff and the families could stay safe amidst a nationwide shortage in supply.

Programs also sought out creative ways to stay connected with families through window visits, group video conferences focusing on a particular topic (e.g., nutrition, cultural healing), and a myriad of other innovative strategies. In December 2020, FHV grantees reported several adaptive and effective recruitment and retention strategies, including sending text messages, dropping off activity packets, and offering virtual telehealth visits. Nearly 95% of FHV grantees rated in-person visits (e.g., outdoor visits) as either very or extremely effective in supporting recruitment and retention efforts.

'T' was 17 and pregnant when she started experiencing signs of pre-eclampsia. Her home visitor referred her to a clinic immediately after a telehealth video visit. She ended up being transferred to a larger hospital setting, was monitored for one week, and then delivered her infant at 33 weeks gestation during the COVID pandemic.

The nurse home visitor was able to facilitate WIC certification by phone and support her in following up with her local clinic for questions and concerns. The home visitor also provided a scale for mom to weigh infant when her transportation options prevented her from getting infant into clinic for a weight check.

—FHV Grantee

MDH's COVID-19 Role

The Minnesota Department of Health has indisputably been the epicenter of Minnesota's COVID-19 response. During the surge in COVID-19 cases in late Fall/Winter 2020-21, nearly two-thirds of FHV staff were reassigned in some capacity. FHV staff contributed their unique sets of expertise to the response by working as Tribal and local public health liaisons, staffing the public hotline, assisting with case investigations and data entry, and eventually vaccine planning & distribution.

Home Visiting Workforce, 2021

MDH collects data from home visitors about their demographic and professional characteristics in the Information for Home Visiting Evaluation (IHVE) data system. Reporting of demographic characteristics is optional and home visitors may decline to respond to those questions. This section describes home visitors who provided Family Home Visiting (FHV) services to families during State Fiscal Year 2021.

FHV services are delivered by home visitors with a range of professional experiences, including public health nursing, social work, child development, and family education. A large number of home visitors (85%) have at least a bachelor's degree and 9 in 10 have at least one license or specialized training. Home visitors hold a variety of licenses and credentials, including Certified Public Health Nurse (34%), Registered Nurse (RN) (34%), Certified Lactation Consultant (11%), and Child Passenger Safety Technician (5%). The average length of experience as a home visitor is 8.5 years (range of zero to 41 years). Eighty-five percent are trained in at least one evidence-based home visiting model.

Like national trends[13,14], most of the home visiting workforce funded by MDH is female (98%) and White (80%). Four percent of home visitors are Hispanic or Latino/a/x, four percent are Hmong, and three percent are Somali. Nearly half of home visitors (48%) are 40 years old or older. Appendix B presents detailed characteristics of home visitors in State Fiscal Year 2021.

Six percent of home visitors are Black or African American, five percent are Asian, two percent are American Indian or Alaska Native, and less than one percent are Native Hawaiian or Other Pacific Islander. Two percent of home visitors identify as more than one race, and one percent reported their race as not listed. Most home visitors deliver home visiting services in English (85%). Home visitors also offer home visits in Spanish, Hmong, Somali, and Amharic. Over one in ten home visitors can provide home visits in more than one language.

Anecdotally, home visitors serving Indigenous communities report using Ojibwe and Dakota concepts and vocabulary with families, and in speaking their "first languages", they can better align their beliefs and behaviors with participants' core values and culture. For example, a Tribal elder shared an example of using Dakota vocabulary to highlight the importance of Indigenous language in parenting:

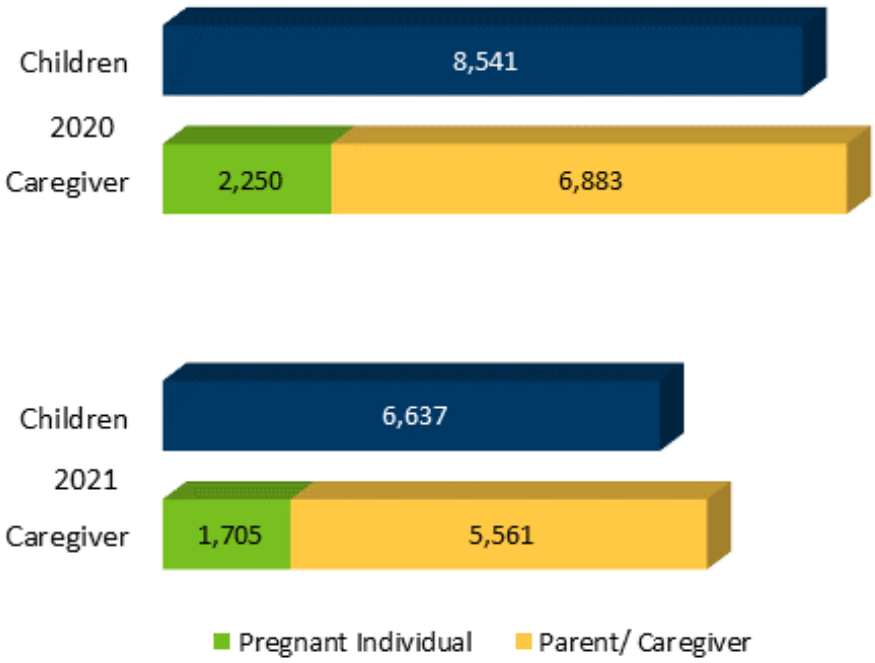
> *We have watched our children being taken from us, first it was the residential schools and then it was the child protection system. Our Nations have people who need to relearn the way of life Creator intended them to live. Teaching this involves using our language. For example, a word for 'discipline' in Dakota has the same conceptual meaning as the word 'respect'. We teach families that we don't punish in anger, we guide in respect. The word explains it all. Our language is key in reclaiming our health and our culture.*
>
> *—Dakota Tribal Elder and Scholar*

A limitation to these data is that not all home visitors who provided FHV services in State Fiscal Year 2021 are included. Home visitors are not required to answer demographic questions on the form used to collect this data. Additionally, a small number of FHV grantees were not able to submit home visitor data to IHVE in time to be included in this report. As a result, home visitor data reported here may underrepresent individuals who identify as BIPOC (Black, Indigenous, or People of Color). Despite these caveats, MDH continues to use data to help identify and address opportunities to improve programming for all Minnesotans, particularly those who experience the greatest health disparities.

Families Participating in Family Home Visiting

As Family Home Visiting expands across Minnesota, more pregnant individuals, caregivers, and young children have access to and benefit from this effective early childhood intervention. About one in four caregivers participating in FHV were pregnant women in State Fiscal Years 2020 and 2021, as seen in Figure 2. There were 9,133 caregivers and 8,541 children participating in family home visiting in 2020; in 2021, there were 7,266 caregivers with 6,637 children.

Figure 2. Family Home Visiting Participants for State Fiscal Years 2020, 2021



Likely as a result of the ongoing COVID-19 pandemic, 1,275 fewer children and 1,337 fewer caregivers received FHV services in 2021 than 2020. Nearly 25% fewer pregnant women participated in FHV in 2021 compared to 2020. Note that this data is reported for state fiscal years (SFY 2020: 7/1/19-6/30/20; SFY 2021: 7/1/20-6/30/21). For complete counts for 2020, 2021, and a 2-year average, see Appendix C1.

FHV Caregiver Demographic Characteristics, 2020-2021

Nearly two in five (38%) caregivers who participate in FHV are under 25 years old. Twenty percent of caregivers identify their ethnicity as Hispanic or Latino/a/x, four percent as Somali, and one percent as Hmong. Across 2020 and 2021, 57% of caregivers participating in FHV indicated an ethnicity not listed in IHVE. The majority of caregivers identified as White (54%), followed by Black or African American (23%), Asian (7%), American Indian or Alaska Native (4%), and Native Hawaiian or Other Pacific Islander (<1%). Three percent reported more than one race, 6% reported their race was not listed, and 3% of caregivers declined to answer.

Caregivers enter the program with a range of educational experiences: 24% have less than a high school diploma and a third have additional college or training. Two in five (42%) FHV participants are employed at program entry either full or part-time. Annually, an average of 250 families enrolled in FHV experience homelessness, and 16% report owning their own home, condominium, or apartment. See Appendix C for full counts for 2020, 2021, and 2-year averages.

Family Home Visiting specifically aims to reach families who are exposed to risk factors associated with poorer health outcomes. Among participants who provided this information, seven in 10 families report residing in a low-income household. Nearly a third (31%) of participants had a history or child abuse or neglect or interacted with child welfare services. Thirteen percent of households reported having a child with developmental delays or disabilities. Fourteen percent participants reported having had attained low student achievement or having a child with low student achievement. One in five (20%) reported a history of substance abuse or needs substance abuse treatment.

Our client is working to overcome many barriers in her life including history of past abuse, struggles with mental health and poverty. The ***home visiting nurses have walked alongside her*** *these past several months to support her with goals.* ***The client has shown amazing strength and fortitude and has a strong work ethic****- she is working full time and has plans to continue with her education this fall so that she can provide a better life for her and her child.*

The nurses have supported her by providing information about community resources, child growth and development, and bonding. This had led to her ***becoming more confident as a parent*** *and she has been* ***bonding with her baby and meeting her child's needs****.*

—FHV Grantee

Child Demographic Characteristics, 2020-2021

Over 85% of children who receive Family Home Visiting services are less than two years old (half of whom are less than a year old). One in five (22%) children are reported as Hispanic or Latino/a/x, four percent as Somali, and one percent as Hmong. Over half (54%) reported an ethnicity not listed in IHVE. Almost half of the children participating in FHV are White (49%), followed by Black or African American (23%), Asian (7%), American Indian or Alaska Native (3%), and Native Hawaiian or Other Pacific Islander (<1%). Seven percent of children are reported to have more than one race and 6% are reported as a race not listed. The race of five percent of children was not reported. Numerous languages are spoken in FHV children's homes, most commonly English (75%), Spanish (12%), Somali (3%), Karen (3%), and Hmong (1%).

> *Since July, many families with young children have **struggled to find a balance with work, emotional support in parenting, self-care, and financial burdens**. The regular check-ins with a home visitor have been an important stress reduction tool. One mom said she knows who **she can ask for help and resource ideas** every week- **'It's such a relief'.***
>
> *—FHV Home Visiting Grantee*

Retention

The longer a family participates in Family Home Visiting (FHV), the better they do across a variety of outcomes, including adverse pregnancy outcomes,[15] family engagement,[16] lower parenting stress and positive discipline skills,[17] and improved language and literacy environments.[18] That said, families often face barriers that impede their ability to fully participate in FHV, such as frequent moves, employment, or school constraints.

Approximately 40% of families enrolled in long-term Family Home Visiting participated for more than one year, with an average length of 13.7 months during State Fiscal Years (SFY) 2020 & 2021. The average length in Minnesota's FHV programs is almost four months longer than the findings that were presented as part of a national evaluation of federal MIECHV-funded home visiting programs.[19] Close to 15% of families participate until program completion (length determined by model) or until established goals have been met. Beyond the family's decision or factors impacting their wellbeing (e.g., changes to housing), the length in FHV participation can be also affected by a child's age at intake and model type. Further, COVID-19 has likely affected family retention, in both service delivery (e.g., prompt transition to limited virtual home visits, agency reassignments to support the COVID-19 response) and family factors (e.g., economic instability, changes to housing).

"Thank you for being the ONE person who really saw me and helped me. I know I'm a better person - and a better mom – because of our time together and all I have learned in this Program. You have inspired me to finish high school and I want to go to college to become a nurse.

Today, I know that I am a person of value and worth. I know relationships should not be abusive. And, I know that there are people in the world who REALLY DO care for others. You will always be a role model for me, and I will never forget you."

—NFP Graduate, speaking to her home visitor

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. Family wellbeing, and subsequently, family outcome measures have been credibly affected by the COVID-19 pandemic, starting with a broad review of COVID-19 impacts described below.

COVID-19 Impact on Family Wellbeing

Emerging evidence highlights the immediate and short-term impact of COVID-19 on family wellbeing. The pandemic has led to a decrease in breastfeeding rates, compared with mother-baby dyads prior to 2020.[20] Extended stay-at-home orders, coupled with other economic and stressors, such as job losses and isolation from social networks, have intensified the incidence of intimate partner violence (IPV) in pregnant women and families with young children, as described in the IPV Screening section of this report.[21,22]

In the face of COVID-19 and its resulting impact on the social and emotional wellbeing of women who recently delivered, it is more imperative than ever to screen for postpartum depression. Emerging evidence suggests, however, women who delivered during the pandemic were far less likely to have a postpartum depression screening, compared to women who delivered prior to the COVID-19 pandemic.[23]

Compared to pre-pandemic deliveries, women who delivered during the COVID-19 pandemic were also more likely to have other health issues, including gestational diabetes, hypertensive disorders of pregnancy, and poor fetal growth.[24] Stillbirth, maternal death, and maternal depression have also worsened during the pandemic.[25]

Methodology

Data from selected measures are presented for State Fiscal Years 2020 (July 1, 2019-June 30, 2020) and 2021 (July 1, 2020-July 30, 2021). Analyses are restricted to clients in long-term Family Home Visiting (FHV) programs. Long-term programs include MDH-funded Early Head Start, Family Spirit, Healthy Families America, Maternal Early Childhood Sustained Home-Visiting, Nurse-Family Partnership, Parents as Teachers, and traditional public health family home visiting programs.

- These data represent individuals who consented to share data with MDH. Privacy concerns as well as mistrust of government institutions due to historical data misconduct affect who consented. These data may underrepresent those who have disproportionately been affected by data misuse or abuse, including Black, Indigenous, and People of Color (BIPOC).
- Comparability across Legislative Reports is limited as a new data collection system (IHVE) was launched in January 2020. The 2022 FHV Legislative Report crosses the transition to IHVE and subsequently both historical data and data sent directly to IHVE are reported.
- Measures in this report were selected based on both 1) relevance to outcome and performance measures outlined in Minnesota Statute 145A.17 and 2) the availability of data across all long-term FHV programs.
- Because not all MDH-FHV evaluation data that is shared with MDH includes direct personal identifiers, MDH-FHV cannot fully de-duplicate clients between FHV sites. Therefore, it is possible that individuals are counted more than once for some measures (i.e., a client transferred between sites).
- Due to the COVID-19 pandemic, the number of visits was greatly reduced and subsequently, less data were collected. Further, we presume that during the limited visits that were completed, supporting families in real time was prioritized over data collection.

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 priority of Family Home Visiting. Five measures are used to assess maternal and newborn health in FHV: Breastfeeding, preterm birth, postpartum depression screening, well-child visits, and postpartum care.

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.[26] Maternal health benefits include reduced risk for ovarian cancer and breast cancer.[27] Benefits to baby include lower risks of Sudden Infant Death Syndrome, asthma, obesity, and type 2 diabetes.[28] Other long-term benefits include healthier eating habits and better behavioral and cognitive development.[29] Breastfeeding also helps moms and babies bond and build a sense of closeness.[30] In addition, more recent research indicates breastfeeding may protect against post-partum depression.[31]

Over one in ten home visitors in Minnesota are credentialed as a Certified Lactation Consultant as seen in Appendix B2. Home visiting strategies directly support breastfeeding by sharing the benefits of breastfeeding, providing strategies that support breastfeeding at home, school, & work, supporting parents in problem solving barriers to breastfeeding, and referring parents to community resources when needed.

Breastfeeding was reported as the percentage of infants who were fed any amount of breastmilk at 6 months of age, excluding infants whose mothers cannot breastfeed because of medical contraindications. Average breastfeeding rates for Family Home Visiting participants increased from 2020 to 2021. Sixty-eight percent of babies received breastmilk at six months of age in 2021 compared to 50% in 2020. See Appendix D1 for complete counts and averages for State Fiscal Years (SFY) 2020-21 and 2-year averages.

*After giving birth, one of our mothers shared some frustration **around breastfeeding** with her home visitor during a visit call. Her home visitor assisted the mother by using advice she received from the lactation consultant and was able to further explain some of the advice that had been difficult for the mother to understand.*

*Through persistence and openness with her lactation consultant and the home visitor, the **mother gained confidence in her breastfeeding, and her child's latching improved**. The child is now breastfeeding successfully, and the family is staying healthy.*

—FHV Grantee

Preterm Birth

A preterm birth, also called a premature birth, is one where a baby is delivered three or more weeks before the mother's expected due date. The final weeks of pregnancy are particularly important for brain, lung, and liver development. Preterm birth is the leading cause of death globally among children under 5 years of age[32] and increases the risk of serious lifelong health issues, including breathing problems, feeding difficulties, cerebral palsy, developmental delays, and vision and hearing problems.[33] Regular home visits that include education and connections to community-resources can help promote healthy births, particularly for individuals who are greater risk of experiencing socioeconomic, racial, and ethnic health disparities.

Preterm birth rates for FHV participants for 2020 and 2021 were 20% and 13%, respectively. Appendix D2 presents detailed characteristics, including counts and percentages for SFYs 2021-2022.

While higher than the state's 2019 average of 7.6% [34], comparability is limited. The preterm birth data during the COVID-19 pandemic for the entire population is not yet available. Further, because FHV strives to recruit and serve families who experience greater health disparities and are already at greater risk for adverse perinatal outcomes, higher rates are expected compared with the entire population.

Caregiver Depression Screening

The mental and physical health of caregivers impact child wellbeing. Caregiver depression, particularly maternal depression can impair caregiver-child bonding and have long-term consequences for the child's cognitive and emotional development.[35,36] Children's early exposure to maternal depression may impede brain development by changing brain architecture[37] and stress response systems.[38] Fortunately, improvements in maternal mental health are associated with reductions in mental health disorder symptoms in their children.[39] Screening caregivers for depression can effectively support their mental health by facilitating referral for potential diagnosis and treatment.[40]

Home visitors complete depression screenings with caregivers, describe common feelings parents experience after giving birth, educate on the signs and symptoms of depression, and make referrals to local resources via a warm hand-off.

One of the interventions used by home visitors to improve maternal and newborn health is to screen for depression and refer caregivers who screen positive to relevant services. In 2020, almost one third (32%) of caregivers received a depression screening from their home visitor within the first 3 months of enrollment; for those enrolled prenatally, a screening was administered within 3 months of delivery. The number increased to 48% in 2021, likely a result of a coordinated Continuous Quality Improvement (CQI) initiative that occurred in 2020-21. During this CQI initiative, MIECHV grantees participated in a yearlong effort to increase the use of evaluation data to identify viable strategies to improve depression screening rates. Appendix D3 provides annual counts and percentages for SFYs 2020, 2021 along with 2-year averages.

Well-Child Visits

Well-child visits are regularly scheduled visits with a child's health care provider that include physical exams, immunizations, and assessments to measure and monitor growth and development. These preventative visits also provide an opportunity for caregivers to ask questions and raise concerns. Home visitors can help foster the relationship between caregivers and a child's primary doctor and can highlight the importance of these visits, particularly around timely vaccine schedules.

The frequency at which children should visit a doctor changes as they age. The American Academy of Pediatrics (AAP) recommends ten well-child visits in a child's first two years. Younger children are seen more frequently to receive recommended vaccinations and promptly address potential concerns during this time of rapid development. In 2018, over 90% of U.S. children ages zero to four received at least one well-child checkup over 12 months.[41]

The evaluation measure used in this report is stricter than national comparison data, reporting the percentage of children who received the last recommended well-child visit based on the AAP schedule. In both years 2020 and 2021, about one in ten children received a visit at the appropriate interval. The COVID-19 pandemic and the resulting stay-at-home orders have led to a decline in child preventative health services, including vaccine delivery [42, 43], particularly for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP).[44] Family Home Visiting can and should be used as an effective strategy at increasing well-child rates to pre-pandemic levels. Appendix D4 provides annual counts and percentages for SFYs 2020, 2021 along with 2-year averages.

Postpartum Care

In the days and weeks after giving birth, postpartum care visits provide the time-sensitive opportunity to assess the physical, social, and psychological well-being of the new parent. Physical exams with lab work, mental health screenings, breastfeeding and feeding evaluations, and assessing the risk for potential chronic medical conditions & life-threatening birth complications are often central topics of care. Home visitors can help parents schedule postpartum visits, discuss their importance, and support parents as they navigate this new time.

Postpartum care visit rates are estimated to range from 20 to 90 percent[45] but vary between subgroups (e.g., those who used prenatal care[46] or experience social inequities such as unstable housing or limited transportation).[47]

In Minnesota, on average one in 100 mothers enrolled in FHV reported that they received a postpartum visit with their health care provider within 8 weeks of delivery in 2020 and 2021. Reasons for the low percentage may include missing data: as noted in the Methodology section, home visitors have prioritized family supports over evaluation data collection during the pandemic. Additionally, the COVID-19 pandemic has disrupted parents' access to postpartum care: Women who delivered during the pandemic (compared to those who delivered pre-pandemic) are less likely to attend a postpartum care visit.[48] Appendix D5 presents a detailed count and percentage for SFYs 2020, 2021 as well as two-year averages.

Safety and Violence Prevention

Family Home Visiting (FHV) focuses on keeping children safe in the home. Two measures related to safety and violence prevention are reported here: Intimate partner violence (IPV) screening and safe sleep practice.

Intimate Partner Violence (IPV) Screening

Family Home Visitors screen caregivers for experiences with intimate partner violence (IPV) and provide support for healthy relationships. IPV has long-term negative impacts on both the caregiver and children in the home.[49] IPV includes 4 different types of violence and aggression: physical violence, sexual violence, stalking, and psychological aggression including coercion.[50]

IPV is a significant risk to the health of many families. More than one in three women have suffered sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime.[51] Further, over 20% of women and 15% of men have experienced severe physical violence by an intimate partner.[52][51]

Because of the trust developed between home visitors and caregivers, home visitors have a unique opportunity to connect caregivers to resources when IPV occurs. Family Home Visiting uses a validated screening tool for IPV with FHV families. Home visitors also use CUES (Confidentiality, Universal Education & Empowerment, Support), an evidence-based intervention, as a safer alternative to screening when privacy can not be guaranteed. In addition to screening caregivers for IPV, home visitors offer support and education regarding healthy relationships to help caregivers identify the characteristics of a healthy relationship.

> *Our client was a single pregnant woman who had experienced violence. She was homeless and in an unplanned pregnancy without support from the father or her family. She **worked on a safety plan, mental health support, financial assistance, and medical services.** She secured employment **and a safe place to live** and delivered the baby at full term. She breastfed the baby, bonded with the baby, and graduated from NFP when the toddler turned two years old. Mom is no longer on financial assistance and enrolled at the technical college.*
>
> *—NFP Home Visitor*

In comparison with other home visiting activities, screening for IPV has been especially affected by COVID-19 and its use of virtual technology for home visits. Best practice specifies it is critically important that the client's partner is not in proximity when screening to ensure confidentiality, privacy, and client safety. Because they could not assess the location of other family members during a virtual home visit, home visitors were discouraged from screening for IPV unless privacy could be guaranteed.

With safety considerations in place, one third of FHV caregivers received a screening for IPV within 6 months of enrollment in 2020, compared to 27% in 2021. For detailed counts and a 2-year average of IPV screening for State Fiscal Years 2020 and 2021, see Appendix D6.

Safe Sleep

The safest way for babies to sleep is on their backs, in their own space or crib, and without bedding. In Minnesota, over 50 babies die each year while sleeping in unsafe sleeping conditions.[53] Sudden unexpected infant death (SUID) is the sudden and unexpected death of an infant and is the most common cause of death in babies. There are three categories of SUID: 1) SIDS (Sudden Infant Death Syndrome), 2) accidental suffocation and strangulation, and 3) unknown causes.[54]

Home visitors can play an integral role in providing knowledge to new caregivers on recommended safe sleep practices, particularly if the home visitor observes unsafe practices and is subsequently able to intervene. They can also provide educational materials, screen families for safe sleep behaviors and environments, and connect families to resources, such as portable cribs and appropriate sleepwear.

Over one in four (26%) infants receiving FHV services were *always* placed on their backs, without bed-sharing, and without soft bedding in 2020. The percent increased to 56% in 2021. Appendix D7 provides complete counts and percentages for State Fiscal Years 2020, 2021 along with 2-year averages.

Child Development and School Readiness

Cognitive, behavioral, socio-emotional, verbal, and fine and gross motor skills begin developing in utero 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 home visiting models. Measures of developmental screening and caregiver-child interactions are included in this report.

> *Our client delayed taking childbirth classes and **felt ill-prepared for giving birth**. She also did not have the necessities for bringing home a newborn baby. Her nurse home visitor was able to connect Mom to online childbirth classes, help her get diapers, clothes, and a car seat. Mom and the home visitor also did activities to **promote prenatal bonding**. Mom had the birth she hoped for, had the things she needed before bringing baby home, **shares many laughs and stories with her baby**, and has been breastfeeding.*
>
> *—FHV Grantee*

Developmental Screening

Early identification and intervention are crucial in preventing the potential poor outcomes associated with developmental delays. Family home visitors play a key role in supporting positive developmental outcomes for the young children in the families they serve through early identification and connection to services and resources.

Home visiting programs have a unique opportunity to reach families and 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 caregivers to help them understand their child's developmental progress, and teach and model parent activities that support their child's development. Family home visitors also partner with families to make referrals and connections to Early Intervention and other community services that support child development.

Nearly one third (31%) of babies participating Family Home Visiting services received a developmental screening within age groups defined by the American Academy of Pediatrics (9, 18, and 24 months of age) during 2020 and 2021. These rates only account for developmental screenings that were conducted during these specific age intervals. To see annual counts and percentages for developmental screenings for 2020, 2021, and a two-year average, see Appendix D8.

When I met 'E' he was 26 months old and didn't have any words yet. Through getting to know the family more, they let me know that they didn't have any books for their child in their home language. I worked on getting several books for the family in their home language and with the mom's help, made a referral to Help Me Grow. He now has several words that he is using often to communicate and the family has a whole shelf of books. —FHV Home Visitor

Caregiver-Child Interaction

Interactions between caregivers and children create a lifelong framework for children to communicate, learn, socialize, and self-regulate. These interactions are the behaviors that establish the relationships between a child and caregiver. Caregiver-child interactions look differently during different developmental stages: In infancy, responsive interactions create secure bonds and attachment with primary caregivers; toddlers often learn social cues, language, and self-regulatory strategies from interactions; and older preschoolers learn to express themselves and use what they've learned from caregiver-child interactions to explore their world.

Home visitors have the unique opportunity to help facilitate positive and healthy interactions between a caregiver and child. Many caregivers enrolled in FHV have significant stressors (e.g., housing instability) that impede their ability to facilitate responsive and developmentally appropriate interactions. Home visitors can help families find resources to help stabilize these stressors. Equally significant, as trusted partners with caregivers, home visitors can share the importance of quality interactions and the

underlying impact on child development. Home visitors provide specific strategies, model engaging and developmentally appropriate interactions, and provide feedback to caregivers in real time.

Family home visitors use a caregiver-child interaction (CCI) tool that has demonstrated validity evidence. In 2020, nearly a quarter (23%) of caregivers received an observation using a CCI tool within the appropriate target age range of the child. In 2021, 14% of FHV caregivers were observed with a CCI tool. The transition to virtual home visiting due to COVID-19 required additional consideration in how to meaningfully connect with families and administer required screening tools. As a likely result of the pandemic, fewer families were observed. Model and tool developers, policy centers, and federal programs responsively created guidance to support home visitors conducting virtual CCI observations. Appendix D9 presents State Fiscal Years 2020, 2021 counts and averages, along with two- year averages.

Family Economic Self-Sufficiency

Family economic self-sufficiency refers to the educational and economic opportunities for families to improve their 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. In this report, two measures are used to assess this: Continuous health insurance coverage and caregiver education.

> *A client was living with friends and did not know the steps to find proper housing for her and her baby. Through their lessons, she made a referral to housing and expressing her need for a home. The client appreciated the support from family education and has been a routine client. She is now about to move into her own home! She has learned to budget, grocery shop, have a safe and clean home because of the program.*
>
> *—FHV Grantee*

Continuous 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. 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.

Home visitors are a key referral source for families. Family home visitors refer clients who lack health insurance to county financial services, assist families with application process, monitor insurance coverage and potential lapses in coverage, and assess family financial status & make referrals to all potential financial resources (e.g., WIC, food pantries, housing assistance).

The percentage of caregivers who have health insurance remained steady across State Fiscal Years 2020 and 2021. Ninety percent of caregivers had access to health insurance while participating in Family

Home Visiting. For full counts and averages for each year along with a 2-year average, see Appendix D10.

Caregiver Education

Caregivers who have at least a GED have a larger earning potential and lower unemployment than those who do not.[55] There is strong, positive association between educational attainment and both physical and mental health outcomes.[56] Both family income and parental education levels are positively associated with children's developmental outcomes.[57] Economic self-sufficiency is easier to achieve with a higher salary and greater qualifications for jobs. Home visitors support this goal by assessing readiness to go to school or complete a GED, helping caregivers make a plan to continue their education, and referring them to programs that can work with their schedules.

The rate of caregivers who either enrolled, maintained, or completed high school (or equivalent) remained steady between years 2020 and 2021 at 44% and 45%, respectively. Appendix D11 presents caregiver education status at enrollment for State Fiscal Years 2020, 2021 and a two-year average.

"Our client was a young pregnant mother, scared to reach out for help from the community resources. Her NFP home visiting nurse listened to her goals of ***wanting to go back to college and be able to provide for her growing family****. The NFP nurse helped guide her with support and encouraged her to gain the strength to call local resources in order for the client to reach her end goals. The client now has a 6-month-old, is going to school full time, and was on the presidents list for perfect grades her first semester. The client and NFP nurse are both very proud of her accomplishments." – FHV Grantee*

Family Outcomes Summary

Encouragingly, the data reported represent both the resiliency of FHV families, as well as home visitors' persistent effort in supporting families during this unprecedented time. While there is always opportunity for growth, particularly as FHV families continue to navigate through the pandemic, engaging families where they are yields benefits for both caregivers and children.

Family home visiting strengthens families by providing resources to caregivers and working with them to establish goals. As a result, we see healthier caregivers and children, safer home environments, children better prepared for lifelong learning, and more self-sufficient families.

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 ensures 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.

The COVID-19 pandemic has exacerbated Minnesota's health disparities and has had a devastating impact on the health, social, economic, and psychological wellbeing of families across the state. It has equally tested Minnesota's public health ecosystem and system of resource delivery designed to support and empower families.

In partnership with local public health, Tribal nations, community-based organizations, and other early childhood stakeholders, Minnesota Department of Health-Family Home Visiting 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 early childhood systems that emphasize health equity.

By developing relationships with families most in need and providing community resources, local family home visiting programs have proven to be an invaluable lifeline during this crisis.

Appendices

Appendix A.
Family Home Visiting TANF Grant Allocations SFY22-23

A1. Family Home Visiting Tribal Government Awards

Tribal Nation	Amount of Award from 07/01/21 to 6/30/22	Amount of Award from 07/01/22 to 6/30/23
Bois Forte	$112,392	$112,392
Fond Du Lac	$298,632	$298,632
Grand Portage	$50,575	$50,575
Leech Lake	$371,349	$371,349
Lower Sioux	$48,998	$48,998
Mille Lacs	$128,592	$128,592
Red Lake	$317,096	$317,096
Upper Sioux	$43,448	$43,448
White Earth	$325,520	$325,520
Total	$1,696,602	$1,696,602

A2. Family Home Visiting Local Public Health Awards

Local Public Health Agency	Amount of Award from 7/01/21 to 6/30/22	Amount of Award from 7/01/22 to 6/30/23
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

Local Public Health Agency	Amount of Award from 7/01/21 to 6/30/22	Amount of Award from 7/01/22 to 6/30/23
Brown-Nicollet Community Health Board	$72,688	$72,688
Carlton-Cook-Lake-St. Louis Community Health Board	$389,512	$389,512
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

Local Public Health Agency	Amount of Award from 7/01/21 to 6/30/22	Amount of Award from 7/01/22 to 6/30/23
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
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.
Home Visitor Characteristics, 2021

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

B1. Home Visitor Education, 2021

Education	Count	Percent
Less than high school diploma	1	<1%
High school diploma or GED	4	1%
Some college or post-high school training	9	2%
Technical training or certificate	9	2%
Associate degree	41	8%
Bachelor's degree or higher	467	85%
Other	13	2%
Decline to answer	6	1%
Total	**550**	**100%**

B2. Home Visitor Certifications & Licenses, 2021

Type of License	Count	Percent
Certified Public Health Nurse (PHN)	367	34%
Registered Nurse (RN)	364	34%
Certified Lactation Counselor (CLC)	116	11%
Child Passenger Safety Technician (CPST)	51	5%
Licensed Social Worker (LSW)	16	2%
Child Development Associate (CDA) + Home Visitor CDA	11	1%
Infant Family Associate (1-4)	10	1%
Community Health Worker (CHW)	8	1%
Other certificate or license	72	7%
None	33	3%
Decline to answer	9	1%
Missing	7	1%
Total	**1,064**	**100%**

Note: Total exceeds number of home visitors due to multiple credentials

B3. FHV Model Implemented by Home Visitors, 2021

Model	Count	Percent
Early Head Start	10	2%
Family Connects	7	1%

Family Spirit	14	3%
Healthy Families America	237	43%
Maternal Early Childhood Sustained Home-Visiting (MECSH)	35	6%
Nurse-Family Partnership	75	14%
Parents As Teachers	48	9%
Other Evidence-Based Model	39	7%
None	82	15%
Decline to answer	3	1%
Total	**550**	**100%**

B4. Home Visitor Gender, 2021

Gender	Count	Percent
Female	536	98%
Male	3	1%
Does not identify as male or female	2	<1%
Decline to answer	9	2%
Total	**550**	**100%**

B5. Home Visitor Race, 2021

Race	Count	Percent
American Indian or Alaska Native	9	2%
Asian	26	5%
Black or African American	35	6%
Native Hawaiian or Other Pacific Islander	2	<1%
More than one race	12	2%
Race category not listed	4	1%
Decline to answer	18	3%
Missing	7	1%
Total	**550**	**100%**

B6a. Languages Utilized by Home Visitors, 2021

Language	Count	Percent
English	531	85%
Spanish	35	6%
Hmong	15	2%
Somali	15	2%
Amharic	3	1%
Language not listed	15	2%
Decline to Answer	10	2%
Total	**624**	**100%**

Note: Total exceeds number of home visitors due to multiple languages reported

B6b. Number of Languages Utilized by Home Visitors, 2021

Number of Languages	Count	Percent
1	469	85%
2	55	10%
3	9	2%
6	1	<1%
Decline to answer	10	2%
Missing	6	1%
Total	**550**	**100%**

B7. Home Visitor Ethnicity, 2021

Ethnicity	Count	Percent
Hispanic or Latino/a/x	21	4%
Hmong	19	4%
Somali	17	3%
Ethnicity not listed	397	72%
Decline to answer	88	16%
Missing	8	2%
Total	**550**	**100%**

B8. Age Groups of Home Visitors, 2021

Education	Count	Percent
Under 25	14	3%
25 to 29	68	12%
30 to 34	89	16%
35 to 39	91	17%
40 to 44	73	13%
45 to 49	53	10%
50 to 54	41	8%
55 to 59	50	9%
60 to 64	38	7%
65 and older	11	2%
Decline to Answer	22	4%
Total	**550**	**100%**

Appendix C.
Participant Enrollment & Demographic Characteristics, 2020-2021

C1a. Number of Children Participating in Family Home Visiting, 2020- 2021

	2020	2021	Two Year Average
Children	8,541	6,637	7,589

C1b. Type of Caregivers Participating in FHV, 2020- 2021

	2020		2021		
Caregiver Type	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
Pregnant	2,250	25%	1,705	23%	24%
Caregiver	6,833	75%	5,561	77%	76%
Total	9,133	100%	7,266	100%	100%

C2. Primary Caregiver Age at Enrollment, 2020- 2021

	2020		2021		
Age	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
≤17	342	4%	249	3%	4%
18-19	708	8%	525	7%	7%
20-21	991	11%	742	10%	11%
22-24	1,539	17%	1,140	16%	16%
25-29	2,412	26%	1,928	27%	26%
30-34	1,752	19%	1,455	20%	20%
35-44	1,292	14%	1,149	16%	15%
45-54	78	1%	66	1%	1%
55-64	15	0%	11	0%	0%

≥65	4	0%	1	0%	0%
Total	**9,133**	**100%**	**7,266**	**100%**	**100%**

C3. Primary Caregiver Ethnicity at Enrollment, 2020- 2021

	2020		2021		
Ethnicity	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
Hispanic or Latino/a/x	1,754	19%	1,522	21%	20%
Hmong	105	1%	109	2%	1%
Somali	241	3%	318	4%	4%
Multiple ethnicities reported	9	0%	4	0%	0%
Ethnicity not listed	4,145	45%	5,009	69%	57%
Decline to answer	2,879	32%	304	4%	18%
Total	**9,133**	**100%**	**7,266**	**100%**	**100%**

**Caregiver ethnicity response options were redefined in 2020 to Hispanic or Latino/a/x, Hmong, Somali, Multi-ethnic, and Ethnicity not listed.*

C4. Primary Caregiver Race at Enrollment, 2020- 2021

	2020		2021		
Race	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
American Indian or Alaska Native	319	3%	274	4%	4%
Asian	596	7%	509	7%	7%
Black or African American	2,066	23%	1,761	24%	23%
Native Hawaiian or Other Pacific Islander	60	1%	15	0%	<1%
White	5,049	55%	3,766	52%	54%
More than one race	251	3%	217	3%	3%
Race category not listed	472	5%	503	7%	6%
Decline to answer	320	4%	221	3%	3%

Total	**9,133**	**100%**	**7,266**	**100%**	**100%**

C5. Primary Caregiver Educational Attainment, 2020- 2021

	2020		2021		
Educational Attainment	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
Less than HS diploma	2,171	24%	1,798	25%	24%
HS Diploma/GED	2,780	30%	2,247	31%	31%
Some college or training	1,598	17%	1,179	16%	17%
Technical training or certification	317	3%	244	3%	3%
Associate degree	397	4%	244	3%	4%
Bachelor's Degree or higher	743	8%	603	8%	8%
Other	62	1%	27	0%	1%
Unknown or Decline to answer	1,065	12%	924	13%	12%
Total	**9,133**	**100%**	**7,266**	**100%**	**100%**

C6. Primary Caregiver Employment Status at Enrollment, 2020- 2021

	2020		2021		
Employment Status	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
Employed Full Time	2,134	23%	1,646	23%	23%
Employed Part-Time	1,792	20%	1,268	17%	19%
Not employed	4,671	51%	3,947	54%	53%
Unknown or Decline to answer	536	6%	405	6%	6%
Total	**9,133**	**100%**	**7,266**	**100%**	**100%**

C7. Primary Caregiver Age at Enrollment, 2020- 2021

	2020		2021		
Housing Status	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
Owns or shares own home, condominium, or apartment	1,480	16%	1,197	16%	16%
Rents or shares own home or apartment	3,140	34%	3,280	45%	40%
Lives in public housing	145	2%	127	2%	2%
Lives with parent or family member	1,334	15%	1,292	18%	16%
Some other arrangement	318	3%	348	5%	4%
Total Not Homeless	**6,417**	**70%**	**6,244**	**86%**	**78%**
Homeless and sharing housing	108	1%	102	1%	1%
Homeless and living in an emergency or transition shelter	59	1%	77	1%	1%
Some other arrangement	100	1%	54	1%	1%
Total Homeless	**267**	**3%**	**233**	**3%**	**3%**
Unknown or Decline to answer (could not determine Homeless vs. Not Homeless)	2,449	27%	789	11%	19%
Grand Total	**9,133**	**100%**	**7,266**	**100%**	**100%**

C8. Primary Caregiver Priority Population* Characteristics at Enrollment, 2020-2021

	2020			2021			
Characteristic	**Count**	**Percent**	**Percent Missing**	**Count**	**Percent**	**Percent Missing**	**Two Year Average**
Low-income household	4,013	70%	37%	3,438	69%	32%	70%
Participant is an enrollee who is pregnant and under age 21	607	7%	0%	457	6%	0%	7%
Participant has a history of child abuse or neglect or has had interactions with child welfare services	2,134	31%	26%	2,022	30%	6%	31%
Participant has a history of substance abuse or needs substance abuse treatment	1,093	20%	40%	1,115	19%	20%	20%
Participant uses tobacco products in the home	954	16%	34%	968	15%	11%	16%
Participant in the household has attained low student achievement or has a child with low student achievement	823	14%	35%	778	14%	23%	14%
Household has a child with developmental delays or disabilities	932	14%	26%	780	12%	11%	13%
Household includes individuals who are serving or formerly served in the US armed forces	262	3%	10%	188	3%	14%	3%
*Priority population is a federal definition for eligibility for Maternal, Infant, Early Childhood Home Visiting programming							

C9. Child Age at Enrollment, 2020- 2021

	2020		2021		
Age	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
<1 year	3,816	45%	2,599	39%	42%
1-2 years	3,648	43%	2,968	45%	44%
3-4 years	902	11%	888	13%	12%
5-6 years	137	2%	170	3%	2%
Over 7 years	35	0%	12	0%	0%
Missing	3	0.04%	0	0%	0%
Total	**8,541**	**100%**	**6,637**	**100%**	**100%**

C10. Child Ethnicity, 2020- 2021

	2020		2021		
Ethnicity	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
Hispanic or Latino/a/x	1,797	21%	1,492	22%	22%
Hmong	113	1%	125	2%	2%
Somali	265	3%	333	5%	4%
Multiple ethnicities reported	20	0%	15	0%	0%
Ethnicity not listed	3,598	42%	4,388	66%	54%
Decline to answer	2,748	32%	284	4%	18%
Total	**8,541**	**100%**	**6,637**	**100%**	**100%**

** Child ethnicity response options were redefined in 2020 to Hispanic or Latino/a/x, Hmong, Somali, Multi-ethnic, and Ethnicity not listed.*

C11. Child Race, 2020- 2021

	2020		2021		
Race	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
American Indian or Alaska Native	248	3%	210	3%	3%
Asian	567	7%	448	7%	7%
Black or African American	1,790	21%	1,620	24%	23%
Native Hawaiian or Other Pacific Islander	38	0%	16	0%	<1%
White	4,135	48%	3,284	49%	49%
More than one race	614	7%	441	7%	7%
Race category not listed	471	6%	438	7%	6%
Decline to answer	678	8%	180	3%	5%
Total	**8,541**	**100%**	**6,637**	**100%**	**100%**

C12. Primary Language Spoken at Home, 2020- 2021

	2020		2021		
Language	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
English	6,443	75%	4,943	74%	75%
Spanish	981	11%	816	12%	12%
Karen	268	3%	223	3%	3%
Somali	263	3%	249	4%	3%
Hmong	115	1%	102	2%	1%
Other	400	5%	300	5%	5%
Unknown orDecline to answer	71	1%	4	1%	1%
Total	**8,541**	**100%**	**6,637**	**101%**	**100%**

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

Appendix D.
Family Home Visiting Participant Outcome Measures, 2020-2021

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

D1. Child Breastmilk Status at Six Months of Age

	2020		2021		
Breastfeeding	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
Yes	353	50%	456	68%	59%
No	354	50%	212	32%	41%
Total	**707**	**100%**	**668**	**100%**	**100%**

Percent Missing. 2020: 37%; 2021: 20%

D2. Infants Born Prenatally before 37 Weeks

	2020		2021		
Preterm Birth	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
Yes	243	20%	104	13%	17%
No	953	80%	667	87%	83%
Total	1,196	100%	771	100%	100%

Percent Missing. 2020: 22%; 2021: 16%

D3. Caregivers Screened for Depression Within 3 Months of Enrollment or within 3 Months of Delivery

	2020		2021		Two Year Average
Depression Screening	**Count**	**Percent**	**Count**	**Percent**	
Yes	971	32%	866	48%	40%
No	2,043	68%	932	52%	60%
Total	**3,014**	**100%**	**1,798**	**100%**	**100%**

Percent Missing. 2020: 0%; 2021: 0%

D4. Well-Child Visit on American Academy of Pediatrics Schedule

	2020		2021		Two Year Average
Well-Child Visit	**Count**	**Percent**	**Count**	**Percent**	
Yes	685	10%	540	10%	10%
No	6,085	90%	4,654	90%	90%
Total	**6,770**	**100%**	**5,194**	**100%**	**100%**

Percent Missing. 2020: 0%; 2021: 0%

D5. Postpartum Care Visit within 8 Weeks after Delivery

	2020		2021		Two Year Average
Postpartum Care	**Count**	**Percent**	**Count**	**Percent**	
Yes	18	2%	9	1%	1%
No	1,047	98%	792	99%	99%
Total	**1,065**	**100%**	**801**	**100%**	**100%**

Percent Missing. 2020: 26%; 2021: 41%

D6. Intimate Partner Violence Screening within 6 months of Enrollment

	2020		2021		Two Year Average
IPV Screening	**Count**	**Percent**	**Count**	**Percent**	
Yes	855	33%	614	27%	30%
No	1,761	67%	1,643	73%	70%
Total	**2,616**	**100%**	**2,257**	**100%**	**100%**

Percent Missing. 2020: 0%; 2021: 0%

D7. Safe Sleep Practice for Infants

	2020		2021		Two Year Average
Safe Sleep	**Count**	**Percent**	**Count**	**Percent**	
Yes	772	26%	1,363	56%	39%
No	2,236	74%	1,069	44%	59%
Total	**3,008**	**100%**	**2,432**	**100%**	**100%**

Percent Missing. 2020: 34%; 2021: 22%

D8. Developmental Screening

	2020		2021		Two Year Average
Developmental Screening	**Count**	**Percent**	**Count**	**Percent**	
Yes	1,014	28%	932	34%	31%
No	2,561	72%	1,843	66%	69%
Total	**3,575**	**100%**	**2,775**	**100%**	**100%**

Percent Missing. 2020: 0%; 2021: 0%

D9. Caregiver-Child Interaction Observation

	2020		2021		
Parent-Child Interaction	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
Yes	711	23%	309	14%	19%
No	2,321	77%	1,955	86%	81%
Total	**3,032**	**100%**	**2,264**	**100%**	**100%**

Percent Missing. 2020: 0%; 2021: 0%

D10. Health Insurance Coverage for 6 Consecutive Months

	2020		2021		
Continuity of Insurance Coverage	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
Yes	3,552	90%	2,901	90%	90%
No	392	10%	321	10%	10%
Total	**3,944**	**100%**	**3,222**	**100%**	**100%**

Percent Missing. 2020: 20%; 2021: 18%

D11. Caregiver Enrolled, Maintained, or Completed High School or Equivalent

	2020		2021		
Primary Caregiver Education	**Count**	**Percent**	**Count**	**Percent**	**Two Year Average**
Yes	838	44%	698	45%	44%
No	1,083	56%	842	55%	56%
Total	**1,921**	**100%**	**1,540**	**100%**	**100%**

Percent Missing. 2020: 28%; 2021: 13%

[1] Kaminski, Jennifer & Valle, Linda & Filene, Jill & Boyle, Cynthia. (2008). A Metaanalytic Review of Components Associated with Parent Training Program Effectiveness. Journal of abnormal child psychology. 36. 567-89. 10.1007/s10802-007-9201-9.

[2] Lee, E., Mitchell-Herzfeld, S., Lowenfels, A. A., Greene, R., Dorabawila, V., & DuMont, K. A. (2009). Reducing low birth weight through home visitation: A randomized controlled trial. *American Journal of Preventive Medicine, 36*(2), 154–160.

[3] Cordeiro, C. N., Tsimis, M., & Burd, I. (2015). Infections and Brain Development. *Obstetrical & Gynecological Survey, 70*(10), 644-655.

[4] Cusick, & Georgieff. (2016). the Role of Nutrition in Brain Development: The Golden Opportunity of the "First 1000 Days". *The Journal of Pediatrics, 175*, 16-21.

[5] Friedrich, M. (2018). Air Pollutants Undermine Infant Brain Development. *JAMA, 319*(7), 648.

[6] Blair, C., & Raver, C. (2016). Poverty, Stress, and Brain Development: New Directions for Prevention and Intervention. *Academic Pediatrics, 16*(3), S30-S36.

[7] Hair, N., Hanson, J., Wolfe, B., & Pollak, S. (2015). Association of Child Poverty, Brain Development, and Academic Achievement. *JAMA Pediatrics, 169*(9), 822-829.

[8] Lawson, G., Duda, J., Avants, B., Wu, J., & Farah, M. (2013). Associations between children's socioeconomic status and prefrontal cortical thickness. *Developmental Science, 16*(5), 641-652.

[9] Tomalski, P., Moore, D., Ribeiro, H., Axelsson, E., Murphy, E., Karmiloff-Smith, A. . . . Kushnerenko, E. (2013). Socioeconomic status and functional brain development – associations in early infancy. *Developmental Science*, *16*(5), 676-687.

[10] https://www.senate.mn/conference_committee/2021-2022/1504_Conference_Committee_on_H.F._2128/HHS-Health.pdf

[11]Centers for Disease Control and Prevention. [CDC Health Disparities and Inequalities Report—United States, 2013. MMWR 2013;62.

[12] Minnesota Department of Health (2014). Advancing Health Equity in Minnesota: Report to the Legislature [PDF]. Retrieved from https://www.health.state.mn.us/communities/equity/reports/ahe_leg_report_020114.pdf

[13] Schaack, D., Molieri, A., Franko, M., Roberts, A., Wacker, A., Estrada, M., & Gann, H. (2019). The Region X Home Visiting Workforce Study: Brief 1. Denver, CO: Butler Institute for Families, Graduate School of Social Work, University of Denver.

[14] Sandstrom, Heather, Sarah Benatar, Rebecca Peters, Devon Genua, Amelia Coffey, Cary Lou, Shirley Adelstein, and Erica Greenberg. 2020. Home Visiting Career Trajectories: Final Report. OPRE Report #2020- 11, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[15] Goyal, N. K., Hall, E. S., Meinzen-Derr, J. K., Kahn, R. S., Short, J. A., Van Ginkel, J. B., & Ammerman, R. T. (2013). Dosage effect of prenatal home visiting on pregnancy outcomes in at-risk, first-time mothers. *Pediatrics*, 132 Suppl 2(2), S118–S125. doi:10.1542/peds.2013-1021J

[16] Hughes-Belding, K., Peterson, C., Clucas Walter, M., Rowe, N., Fan, L., Dooley, L. . . . Goodman, K. (2019). Quality home visits: Activities to promote meaningful interactions. *Infant Mental Health Journal*, 40(3), 331-342.

[17] Nygren, P., Green, B., Winters, K., & Rockhill, A. (2018). What's Happening During Home Visits? Exploring the Relationship of Home Visiting Content and Dosage to Parenting Outcomes. *Maternal and Child Health Journal*, 22(1), 52-61.

[18] Raikes, H., Green, B., Atwater, J., Kisker, E., Constantine, J., & Chazan-Cohen, R. (2006). Involvement in Early Head Start home visiting services: Demographic predictors and relations to child and parent outcomes. *Early Childhood Research Quarterly*, 21(1), 2-24.

[19] Anne Duggan, Ximena A. Portilla, Jill H. Filene, Sarah Shea Crowne, Carolyn J. Hill, Helen Lee, and Virginia Knox. (2018). Implementation of Evidence-Based Early Childhood Home Visiting: Results from the Mother and Infant Home Visiting Program Evaluation. OPRE Report 2018-76A. Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

[20] Latorre, G., Martinelli, D., Guida, P. *et al.* Impact of COVID-19 pandemic lockdown on exclusive breastfeeding in non-infected mothers. *Int Breastfeed J* **16,** 36 (2021). https://doi.org/10.1186/s13006-021-00382-4

[21] Boserup, B., McKenney, M., & Elkbuli, A. (2020). Alarming trends in US domestic violence during the COVID-19 pandemic. *The American Journal of Emergency Medicine*, *38*(12), 2753–2755. https://doi.org/10.1016/j.ajem.2020.04.077.

[22] Cannon, C. E. B., Ferreira, R., Buttell, F., & First, J. (2021). COVID-19, Intimate Partner Violence, and Communication Ecologies. *American Behavioral Scientist*, *65*(7), 992–1013. https://doi.org/10.1177/0002764221992826.

[23] Sakowicz, Allie & Imeroni, Sidney & Matovina, Chloe & Daiter, Maya & Grobman, William & Miller, Emily. (2021). 590 Postpartum depression screening during the COVID-19 pandemic. American Journal of Obstetrics and Gynecology. 224. S371-S372. 10.1016/j.ajog.2020.12.611.

[24] Sun S, Savitz DA, Wellenius GA. Changes in Adverse Pregnancy Outcomes Associated With the COVID-19 Pandemic in the United States. *JAMA Netw Open.* 2021;4(10):e2129560. doi:10.1001/jamanetworkopen.2021.29560

[25] Chmielewska B, Barratt I, Townsend R, Kalafat E, van der Meulen J, Gurol-Urganci I, O'Brien P, Morris E, Draycott T, Thangaratinam S, Le Doare K, Ladhani S, von Dadelszen P, Magee L, Khalil A. Effects of the COVID-19 pandemic on maternal and perinatal outcomes: a systematic review and meta-analysis. Lancet Glob Health. 2021 Jun;9(6):e759-e772. doi: 10.1016/S2214-109X(21)00079-6. Epub 2021 Mar 31. Erratum in: Lancet Glob Health. 2021 Jun;9(6):e758. PMID: 33811827; PMCID: PMC8012052.

[26] Agostoni, C. F., Decsi, T., Fewtrell, M., Goulet, O., Kolacek, S., Koletzko, B., . . . Van Goudoever, J. (2008). Complementary Feeding: A Commentary by the ESPGHAN Committee on Nutrition. *Journal of Pediatric Gastroenterology and Nutrition*, 46(1), 99-110.

[27] Breast Cancer and Breastfeeding: Collaborative Reanalysis of Individual Data from 47 Epidemiological Studies in 30 Countries, Including 50 302 Women With Breast Cancer and 96 973 Women Without the Disease. (2003*). Obstetrical & Gynecological Survey*, 58(2), 94-95.

[28] American Academy of Pediatrics. (2012). Breastfeeding and the use of human milk. *Pediatrics, 129(3)*, e827–e841. Retrieved November 19, 2019, from https://pediatrics.aappublications.org/content/129/3/e827

[29] Couto G, Dias V, Oliveira I. Benefits of exclusive breastfeeding: An integrative review. NPT. 2020;7(4):245-254.

[30] Feldman-Winter, L., & Goldsmith, J. (2016). Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns. *Pediatrics*, 138(3), E20161889-e20161889.

[31] Figueiredo, B., Canário, C., & Field, T. (2014). Breastfeeding is negatively affected by prenatal depression and reduces postpartum depression. *Psychological Medicine*, 44(5), 927-936.

[32] Liu L, Oza S, Hogan D, Chu Y, Perin J, Zhu J, et al. Global, regional, and national causes of under-5 mortality in 2000-15: an updated systematic analysis with implications for the Sustainable Development Goals. Lancet. 2016;388(10063):3027-35

[33]Centers for Disease Control and Prevention: Reproductive Health. Preterm Birth. Retrieved November 15th, 2021. https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm

[34]Minnesota Department of Health, Minnesota Center for Health Statistics. (2019). 2019 Minnesota County Health Tables. https://www.health.state.mn.us/data/mchs/genstats/countytables/MNCountyHealthTables2019.pdf

[35] Ashman SB, Dawson G, Panagiotides H. Trajectories of maternal depression over 7 years: relations with child psychophysiology and behavior and role of contextual risks. Dev Psychopathology. 2008 Winter;20(1):55-77. doi: 10.1017/S0954579408000035. PMID: 18211728.

[36] Murray, L., & Cooper, P. (1997). Effects of postnatal depression on infant development. *Archives of Disease in Childhood*, 77(2), 99-101.

[37] Diego, M. A., Field, T., Jones, N. A., & Hernandez-Reif, M. (2006). Withdrawn and intrusive maternal interaction style and infant frontal EEG asymmetry shifts in infants of depressed and non-depressed mothers. *Infant Behavior and Development*, 29, 220-209.

[38] Ronsaville, D.S., Municchi, G., Laney, C., Cizza, G., Meyer, S.E. & Haim, A. (2006). Maternal and environmental factors influence the hypothalamic-pituitary adrenal axis response to corticotropin-releasing hormone infusion in offspring of mothers with or without mood disorders. *Development & Psychopathology*, 18, 173-194.

[39] Weissman, M., Pilowsky, D, Wickramaratne, P., Talati, A., Wisinewski, S, Fava, M., …STAR*D-Child Team. (2006). Remissions in Maternal Depression and Child Psychopathology: A STAR*D-Child Report. *JAMA, 295*(12), 1389-1398. doi:10.1001/jama.295.12.1389

[40] Chaudron, L., Szilagyi, P., Kitzman, H., Wadkins, H., & Conwell, Y. (2004). Detection of postpartum depressive symptoms by screening at well-child visits. *Pediatrics, 113*(3), 551-558.

[41] *QuickStats:* Percentage of Children Aged <18 Years Who Received a Well-Child Checkup in the Past 12 Months, by Age Group and Year — National Health Interview Survey, United States, 2008 and 2018. MMWR Morb Mortal Wkly Rep 2020; 69:222. DOI: http://dx.doi.org/10.15585/mmwr.mm6908a5

[42] Center for Translational Neuroscience (2020, October 13). Health (Still) Interrupted: Pandemic Continues to Disrupt Young Children's Healthcare Visits. *Medium.* https://medium.com/rapid-ec-project/health-still-interrupted-pandemic-continues-to-disrupt-young-childrens-healthcare-visits-e252126b76b8

[43] DeSilva MB, Haapala J, Vazquez-Benitez G, et al. Association of the COVID-19 Pandemic with Routine Childhood Vaccination Rates and Proportion Up to Date With Vaccinations Across 8 US Health Systems in the Vaccine Safety Datalink. *JAMA Pediatrics.* Published online October 07, 2021. doi:10.1001/jamapediatrics.2021.4251

[44] Centers for Medicare and Medicaid Services. Service use among Medicaid and CHIP beneficiaries age 18 and under during COVID-19: Preliminary Medicaid and CHIP data snapshot. Retrieved December 22, 2021. https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-18-under-COVID-19-snapshot-data.pdf

[45] American Academy of Pediatrics and American College of Obstetricians and Gynecologists, in *Guidelines for Perinatal Care*, pp. 170–171, AAP, Elk Grove Village, Ill, USA; ACOG, Washington, DC, USA, 6th edition, 2007.

[46] Kogan, M. D., Leary, M., & Schaetzel, T. P. (1990). Factors Associated with Postpartum Care Among Massachusetts Users of the Maternal and Infant Care Program. *Family Planning Perspectives*, *22*(3), 128–130. https://doi.org/10.2307/2135644.

[47] Bryant, A.S., Haas, J.S., McElrath, T.F. *et al.* Predictors of Compliance with the Postpartum Visit among Women Living in Healthy Start Project Areas. *Matern Child Health J* **10,** 511–516 (2006). https://doi.org/10.1007/s10995-006-0128-5

[48] Sakowicz, Allie & Imeroni, Sidney & Matovina, Chloe & Daiter, Maya & Grobman, William & Miller, Emily. (2021). 590 Postpartum depression screening during the COVID-19 pandemic. American Journal of Obstetrics and Gynecology. 224. S371-S372. 10.1016/j.ajog.2020.12.611.

[49] Mcmahon, S., Huang, C., Boxer, P., & Postmus, J. (2011). The impact of emotional and physical violence during pregnancy on maternal and child health at one year post-partum. *Children and Youth Services Review*, 33(11), 2103-2111.

[50] Breiding, M.J., Basile, K.C., Smith, S.G., Black, M.C., & Mahendra, R. (2015). Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements. [PDF]. Retrieved from https://www.cdc.gov/violenceprevention/pdf/ipv/intimatepartnerviolence.pdf

[51] Smith, S.G., Zhang, X., Basile, K.C., Merrick, M.T., Wang, J., Kresnow, M., Chen, J. (2018). The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief – Updated Release. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

[52] Black, M.C., Basile, K.C., Breiding, M.J., Smith, S.G., Walters, M.L., Merrick, M.T., Chen, J., & Stevens, M.R. (2011). The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

[53] Minnesota Department of Health. Sudden Unexpected Infant Deaths (Includes SIDS and Sleep-Related Infant Deaths) and Safe Sleep. Retrieved December 8th, 2021. https://www.health.state.mn.us/people/womeninfants/infantmort/suids.html

[54] Centers for Disease Control and Prevention: Sudden Unexpected Infant Death and Sudden Infant Death Syndrome. Retrieved December 8th, 2021. https://www.cdc.gov/sids/about/index.htm

[55] Labor, U. S. (2019, September 4). Unemployment rates and earnings by educational attainment. Retrieved from Bureau of Labor Statistics: https://www.bls.gov/emp/tables/unemployment-earnings-education.htm

[56] Montez, J. K., & Friedman, E. M. (2015). Educational attainment and adult health: Under what conditions is the association causal? *Social Science & Medicine*, 127, 1-7. doi: 10.1016/j.socscimed.2014.12.029

[57] Hosokawa, R., & Katsura, T. (2017). A longitudinal study of socioeconomic status, family processes, and child adjustment from preschool until early elementary school: the role of social competence. *Child and Adolescent Psychiatry and Mental Health*, 11, 62. doi:10.1186/s13034-017-0206-z