Family Home Visiting Strong Foundations Grant Report, Year One (2023)

July 2024

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Introduction

2023 Strong Foundations Report

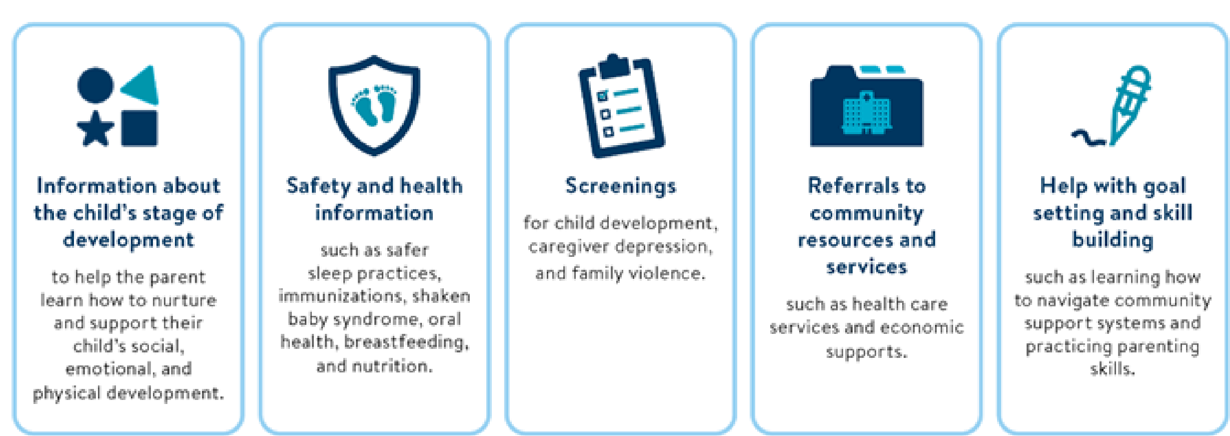
This report describes the key activities and outcomes for year one of the five-year Strong Foundations grant. It includes a description of:

- Family home visiting and its benefits.
- Essential program activities that promote health equity.
- Demographic characteristics of home visiting participants.
- Implementation of key home visiting activities.
- Key participant screening and referral measures.

What is family home visiting?

Family home visiting is a voluntary service for pregnant people and families with young children. It typically begins before birth, or soon after birth and continues through the early years of a child's life. A trained home visitor provides individualized services, in the home or another location, to meet the unique needs of each family. Local home visiting programs across the state seek to reach all families with young children and pregnant individuals who would benefit from family home visiting. As seen in the graphic below, families receive various types of information based on their unique needs.

What do families receive during a family home visit?



Family home visiting has shown powerful impacts on family and child well-being, including positive pregnancy outcomes, school readiness, child abuse prevention, and family self-sufficiency by strengthening families in their communities.[1,2,3]

Strong Foundations grant

The Strong Foundations grant, beginning January 2023, reflects state and federal efforts to expand home visiting services to more families across Minnesota. Annually $25 million is awarded to local grantees who provide evidence-based home visiting for pregnant people and families with young children.

Strong Foundations funding originates from three sources: 1) the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, 2) state general funds appropriated under Minnesota Statutes, section 145.87, and 3) state general funds for Nurse-Family Partnership programs appropriated under Minnesota Statutes, section 145A.145.

At Minnesota Department of Health (MDH), the Strong Foundations grant is part of a comprehensive approach to strategically serve as many families as possible and meet the unique needs of communities across the state. Two other grants in Minnesota, Promising Practices and Temporary Assistance for Needy Families (TANF), also provide family home visiting services but vary in length, intensity, target populations, and use of models and curricula. To learn more about MDH's comprehensive family home visiting programming, visit Family Home Visiting Annual Report, 2023 (PDF).

This report describes activities, program implementation, and select outcomes for year one of the Strong Foundations grant, 2023.

Models supported

MDH supports the implementation of seven evidence-based models in Minnesota with Strong Foundations funding. All models use a two-generation approach for supporting parents and children yet vary slightly in audience, eligibility, content focus, and duration. Early Head Start, Family Spirit, Healthy Families America, Maternal Early Childhood Sustained Home-Visiting (MECSH), 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. For more information, visit the [2023 Family Home Visiting Annual Report [PDF].

According to Minnesota Statutes section 145.87, evidence-based home visiting means a "program that has data or evidence demonstrating effectiveness at achieving positive outcomes for pregnant women or young children; and either has an active evaluation of the program or has a plan and timeline for an active evaluation of the program to be conducted."

Each Strong Foundations grantee maintains an active license with their selected home visiting model(s), apart from MECSH. MDH is the state license holder for the MECSH model. MDH ensures MECSH model fidelity through ongoing implementation support via trainings and practice consultation and accurate data collection and monitoring.

Strong Foundations grantees

Through 2027, 65 grantees (44 community health boards (CHBs), 17 nonprofit organizations, and 4 tribal nations) are funded through the Strong Foundations program. Together, these local

implementing agencies serve 86 counties and four tribal nations. The Strong Foundations grant has a collective caseload of 3,800 families.

These organizations vary in size and serve small and large priority populations with a range of target caseloads. Wabasha County CHB in southeast Minnesota is the smallest with a caseload of nine families; St. Paul-Ramsey CHB has a caseload of 333. The mean and median caseload across Strong Foundations grantees is 50 and 30, respectively.

In the Strong Foundations program, there are the full-time equivalent of over 200 home visitors. They represent a wide range of educational and lived experiences. To learn more about their demographic characteristics, visit the Family Home Visiting Annual Report, 2023 (PDF).

Strong Foundations screening assessment and referral outcomes

Methodology

Screening assessments provide home visitors an opportunity to identify potential problems or conditions early with their clients and intervene accordingly. Based on the results of screenings, home visitors can make a referral and connect families to the appropriate support services. Family home visiting is a part of a larger, comprehensive, and coordinated early childhood system where partners seek to identify potential health, developmental, or safety issues with a timely and preventative approach to as many families as possible.

Several screening assessments and referral measures are presented in the following section: child development, child social-emotional development, caregiver depression, intimate partner violence, and tobacco cessation.

For each section, the following inclusion/exclusion criteria were used:

- Primary caregivers and/or target children received one or more home visits between Jan. 1 – Dec. 31, 2023.
- Participants received services funded by Strong Foundations grant using an evidence-based model.
- Programs and individuals consented to share client-level data with MDH.

Child development screening assessment and referral

Cognitive, behavioral, socio-emotional, verbal, and fine and gross motor skills develop early and set the stage for school readiness and lifelong well-being. Interactions with caregivers and environments heavily impact child development and provide opportunities for home visitors to support families of young children. Early identification and intervention are crucial in catching and supporting potential developmental delays and concerns.

Family home visitors play a key role in supporting developmental outcomes by:

- Screening young children using standardized instruments.
- Discussing the results with parents to help them understand their child's developmental progress.
- Teaching and modeling activities to support their child's development.
- Referring families to services and resources as needed.

Developmental screenings assess a child's skills and abilities in communication, gross and fine motor, problem-solving, self-help, and social interaction domains. For both general development and social-emotional development, the following screening and referral measures were calculated for children between 1 and 66 months of age:

1. Percentage of children who received a developmental screening.
2. Percentage of children who had a concern identified from a developmental screening.
3. Percentage of children who received a referral within 45 days of a screening that identified a concern.
4. Percentage of children who received services for developmental concerns within 45 days of a referral.

Results for developmental screening and referral measures are displayed in Table 1. Note that referrals include only those offered by family home visiting. Family home visiting is part of a comprehensive early childhood system where families may receive screening assessments and related referrals from local school districts, Early Head Start, or local public health. Further, some children who had a concern identified from a screening may be already receiving services. Details of denominator and numerator calculations as well as counts are provided in Appendix B1 and Appendix B2.

Table 1. Developmental Screening and Referral Measures, Strong Foundations Grantees, 2023

Measure	Children with a visit	Children screened	Children with concern identified	Children referred	Children received services
General development – count/percent	3,735	58%	23%	29%	50%
Social-emotional development– count/percent	3,735	45%	8%	15%	47%

Depression screening and referral

Caregiver mental and physical health can impact child well-being. Caregiver depression, particularly maternal depression, can impair caregiver-child bonding and have long-term consequences for the child's cognitive and emotional development.[4,5] Children's early exposure to maternal depression may impede brain development by changing brain architecture[6] and stress response systems.[7] Fortunately, improvements in maternal mental health are associated with reductions in mental health disorder symptoms in their children.[8] Screening caregivers for depression can effectively support their mental health by facilitating referrals for potential diagnosis and treatment.[9]

Family home visitors help by:

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

Note screening assessments and referrals presented here include only those offered by family home visiting. Caregivers may receive screenings and referrals to services from their primary healthcare provider. Some caregivers who have a concern identified in a screening are already receiving services.

Depression screenings and referrals for all caregivers

Table 2 shows the results of the following depression screening and referral measures that were calculated for all primary caregivers served by Strong Foundations home visiting in 2023:

1. Percentage of caregivers who received a depression screening.
2. Percentage of caregivers who had a concern identified from a depression screening.
3. Percentage of caregivers who were referred to services after a depression screening that identified a concern.
4. Percentage of caregivers who received services for depression concerns after a referral.

Depression screening tools used include the Edinburgh, PHQ-9, PHQ-4, and PHQ-2. Referrals include referrals to mental health services. Details of denominator and numerator calculations as well as counts are provided in Appendix B3.

Table 2. Caregiver depression screening and referral measures, Strong Foundations grantees, 2023

Measure	Caregiver with a visit	Caregiver screened	Caregiver with concern identified	Caregiver referred	Caregiver received services
Count/percent	4,202	53%	34%	30%	45%

Perinatal depression screenings

Table 3 summarizes three perinatal depression screening measures that were calculated specifically for caregivers that enrolled into the home visiting program prenatally. These measures show the percentage of caregivers enrolled prenatally who received a depression screen from their home visitor during these timeframes:

1. Prenatally, between the caregiver's enrollment into home visiting and the birth of their child.
2. During the first three months after the birth of the child.
3. Between 3 and 12 months postpartum.

Among caregivers who were enrolled prenatally into home visiting, 63% received a depression screen before the birth of their child, 64% were screened during their first three months postpartum, and 57% were screened when their child was 4 to 12 months of age. Details of denominator and numerator calculations as well as counts are provided in Appendix B4.

Table 3. Perinatal depression screening for caregivers enrolled prenatally, 2023

Measure	Screened before child's birth	Screened between 0-3 months	Screened between 3-12 months
Percent	63%	64%	57%

Intimate partner violence screening and referral

Family home visitors screen caregivers for whether they experience intimate partner violence (IPV) and provide support for healthy relationships. IPV has long-term negative impacts on both the caregiver and any children in the home.[10]

IPV is a significant risk to the health of many Minnesota families. Nearly one in three women have experienced sexual violence, physical violence, and/or stalking by an intimate partner in their lifetime.[11] 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 visitors help by:

- Providing education and resources on healthy relationships, consent, and safety.
- Universally screening all caregivers using validated tools when it is safe to do so.
- Connecting caregivers to resources as soon as possible.
- Assisting caregiver in identifying and accessing social support (e.g., trusted family or friends).
- Planning for follow up visit and make follow up calls using model recommendations or agency protocol.
- Incorporating family-centered decision-making into follow-up expectations.

Table 4 shows the results of the following IPV screening and referral measures that were calculated for caregivers who were enrolled in home visiting for at least six months:

1. Percentage of caregivers who received an IPV screening.
2. Percentage of caregivers who had a concern identified from an IPV screening.
3. Percentage of caregivers who were referred to services after an IPV screening that identified a concern.

Details of denominator and numerator calculations as well as counts are provided in Appendix B5.

Table 4. IPV screening and referrals

Measure	Caregivers with a visit	Caregivers screened	Caregivers with concern identified	Caregivers referred
IPV – count/percent	1,644	48%	13%	27%

There are several considerations to note when interpreting these measures. First, the percentage of caregivers who received a referral (27%) only includes those provided by a family home visitor; caregivers who participate in home visiting may have received a referral from another source. Next, caregivers may already be receiving services when they are screened; in

the event of a positive screening the home visitor will work with the caregiver to determine if an additional referral is needed. Finally, a caregiver may disclose they are experiencing IPV to a home visitor outside of a screening. Notably, of the referrals related to IPV that were made by home visitors to caregivers served by Strong Foundations in 2023, over a third (38%) were made for caregivers that did not receive an IPV screening.

Tobacco cessation referral

Smoking commercial tobacco is the leading cause of preventable death in the U.S. and causes 90% of all deaths from lung cancer.[12] Smoking during pregnancy is also connected to adverse perinatal outcomes, including preterm birth,[13] stillbirth,[14] and sudden infant death syndrome.[15]

Home visitors build strong relationships with families and through that relationship can gauge an appropriate time to introduce tobacco cessation options when families are ready to start this process.

As shown in Table 5, 11% of caregivers served by Strong Foundations in 2023 who used commercial tobacco were provided with referrals to tobacco cessation services. Details of denominator and numerator calculations as well as counts are provided in Appendix B6.

Table 5. Tobacco cessation referrals

Measure	Caregivers enrolled for 6 months who use commercial tobacco	Caregivers referred
Tobacco cessation-count/percent	170	11%

Commitment to advancing health equity

Every individual should have the opportunity to live their healthiest life, yet many experience health disparities due to systemic health and racial inequities. Socially disadvantaged populations, such as communities of color, American Indians, LGBTQ+ communities, the disability community, rural communities, and low-income communities experience the highest disparities across Minnesota.[16]

Family home visiting is a proven strategy to promote health equity and reduce health disparities among pregnant individuals and parenting families with young children—and doing so directly in the communities in which they live.

MDH

MDH continually finds opportunities to embed strategies that promote health equity into family home visiting. MDH also collects semiannual updates from grantees where they describe their progress in meeting health equity goals. Finally, one of the strongest mechanisms MDH uses to promote health equity is embedded throughout the grant lifecycle (e.g., health equity prompts within grant applications, compensation for community grant reviewers, and building relationships). To learn more, visit the Family Home Visiting Annual Report, 2023 (PDF).

Grantee

During the grant application period, each of the 65 Strong Foundations grantees defined their priority populations and chose evidence-based home visiting models that best meet their populations' needs. Grantees also tailor approaches, practices, and policies to promote health equity. Figure 1 highlights strategies that Strong Foundations grantees reported that effectively reach, recruit, and retain priority populations.

Figure 1. Strategies to Reach, Recruit, and Retain Priority Populations Across All Strong Foundations Grantees

Strategy	Percent of Strong Foundations grantees
Ongoing staff development and training	94%
Interpretative services are available	77%
Home visiting materials are translated	70%
Evidence-based model was selected with priority populations in mind	64%
Recruit and retain home visitors who represent community	62%
Evidence-based model enhancements model is adapted while ensuring fidelity as needed	53%
Recruit and retain support staff, e.g. paraprofessionals who represent community	47%
Parent participation in Advisory Committee	17%
Parent participation in home visiting community meetings	17%

Percent of Strong Foundations grantees

Individualization

Strong Foundations grantees described modifications to home visiting materials, curricula, and resources to make them more meaningful for families.

Effective Strategies that Support Individualization

Below is a summary of the strategies that support equitable access and reduce barriers to resources for all families. Examples were provided by individual Strong Foundations grantees.

Adapted materials **simplify the concepts** and meets families where they are.

"Meeting families where they are at and adapting information and learning materials as needed."

"Our teams have found that often materials consist of higher reading level and word density than our families are able to utilize well. They often use the lower reading-level materials and adjust teaching to simplify the concepts meeting families where they are at."

Tailor materials to meet individual family needs**.**

"We are currently adapting our curriculum and changing how some of it will best provide a better support to the communities we serve... We have noted NOT all communities have the same needs."

"We have an internal FHV Health Education Workgroup that looks at materials, handouts, etc. to ensure we are meeting the needs of staff and clients in the best way possible, keeping things up to date, and finding reputable resources in many languages."

Adjust modes of delivery based on family needs.

"Materials are provided either written or electronic based on participant preference."

"We use digital and printed materials for families participating in the program. We utilize in person home visits as much as possible to have verbal discussions about the curriculum."

"For a pregnant mom, we do virtual visits at her request until after she gives birth. For a family with several children under 5, we split the home visit to a virtual with parents followed by in a home visit a couple days later."

Participant referrals

If a family has a positive experience with a home visitor, they are more likely to share it with members of their community. From there, trust can be established between the family and home visiting program and relationships are then developed. Strong Foundations grantees report that family referrals or "word of mouth" is often an effective recruitment strategy as it builds trust of the home visiting program in all communities.

> *"We have had cousins, friends, and other relatives that have referred to FHV [family home visiting]. They* ***speak highly of their nurse*** *and want others to experience the same support. NHVs [nurse home visitors] keep confidentiality and this ensures clients to continue to refer their friends and relatives."*
>
> *"Periodically, we include a* ***'Refer a Friend'*** *blurb in our monthly family newsletters reminding participants how to connect families to services."*
>
> *"Word of mouth is* ***important in small communities****. If one family enjoys the program, they tend to spread the message."*
>
> *Strong Foundations grantees*

Cultural and language representation

Strong Foundations grantees also described cultural adaptations to implementation, materials, curricula, and resources to make them more meaningful for families. These adaptations support participants' belonging in part of the program and demonstrate programs' understanding of diversity of the participants in the program and their unique needs and barriers.

Effective Strategies to Support Cultural Representation

Grantees accommodate varying **language** needs of families participating in family home visiting.

"We talk with all families about preferred language as well as literacy. For families who learn best visually or auditorily, we have videos from approved sources to share on specific health and parenting topics."

"All our materials are translated in the languages of the families we serve, and we have bilingual staff and cultural navigators that help support our home visitors."

"If serving Spanish speaking clients, nurses use as many resources as are available in Spanish and use either staff or contracted Spanish interpretation. For Somali clients, we utilize Somali staff or contracted interpretation."

Grantees continuously weave in **community representation**.

"Adapt materials to include local Ojibwe language. Provide resources developed by tribal members."

"Ongoing evaluation of community representation for cultural and equity needs through planning and when/if changes are needed."

Adapting materials helps grantees ensure materials better represent their families.

"Adjusted pictures on outreach materials to be more inclusive."

"We recently updated our program flyers and trifolds to mirror people from our community."

"We purchase and provide children's books in various languages and cultural representations."

Strong Foundations participant characteristics

The Strong Foundations grant served 4,621 families across 87 counties in 2023. Participant demographic characteristics and household risk factors for primary caregivers and target children are described in the following sections.

Caregiver characteristics

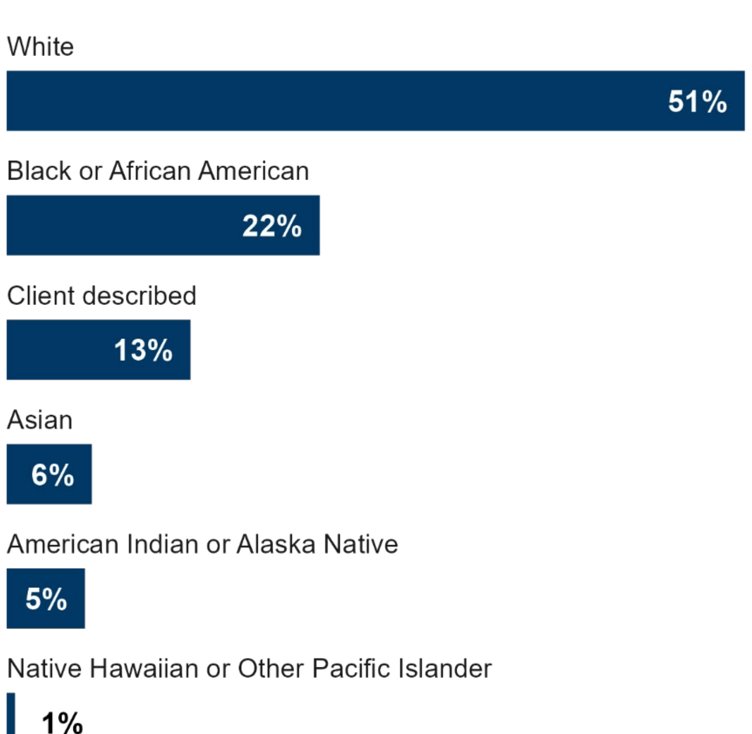
Over a third (34%) of Strong Foundations primary caregivers are under 25 years old. Primary caregivers also reported their ethnicity: Thirty-two percent of primary caregivers identify as Hispanic or Latino/a/x, 3% as Somali, and 1% as Hmong, as seen in Table 6.

Table 6. Caregiver Ethnicity

Caregiver ethnicity	Count	Percent
Other	2,764	60%
Hispanic or Latino/a/x	1,497	32%
Client declined to answers	154	3%
Somali	142	3%
Hmong	68	1%

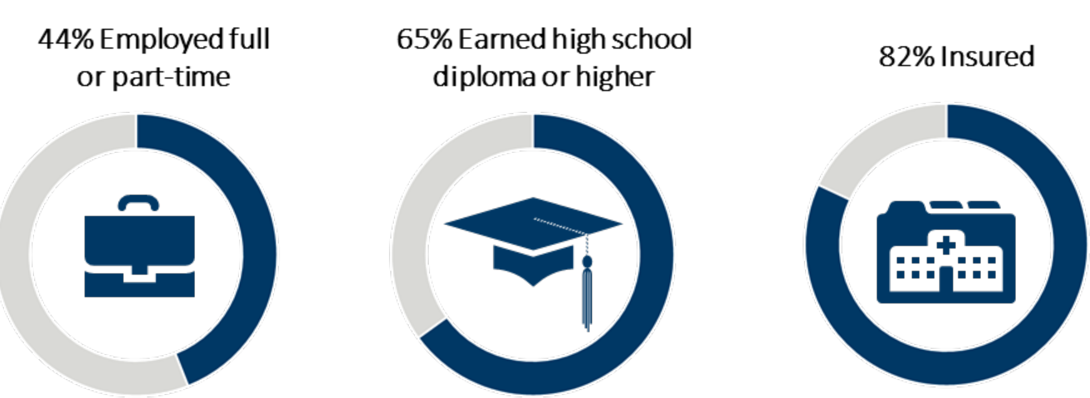
Caregiver race identity includes: 51% white, 22% Black or African American, 13% another race, 6% Asian, 5% American Indian or Alaska Native, and 1% Native Hawaiian or other Pacific Islander, as seen in Figure 2. Additional details of caregiver age and race are provided in Appendices A1 and A2. The summary of race does not include a catchall group for people who identify with more than one race.

Figure 2. Caregiver Race



Almost half of caregivers participating in home visiting are employed either full or part-time (44%); 65% have a high school degree or higher, and 82% were insured, as highlighted in Figure 3. Counts and percentages of these demographic characteristics, including military service are provided in Appendices A3, A4, A6, and A7.

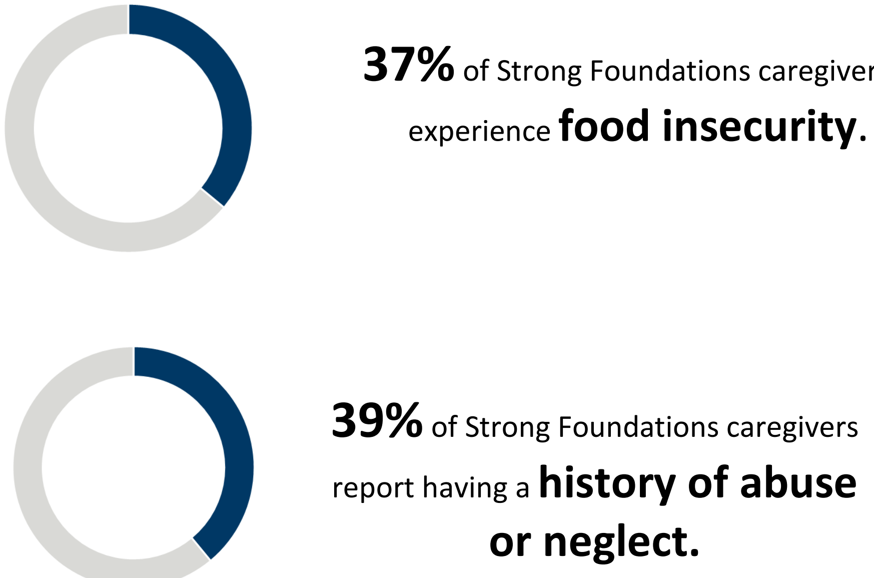
Figure 3. Additional Primary Caregiver Characteristics



Family home visitors play a crucial role in supporting families, particularly those facing risk factors associated with poorer health outcomes. Families participating in home visiting experience numerous risk factors, including:

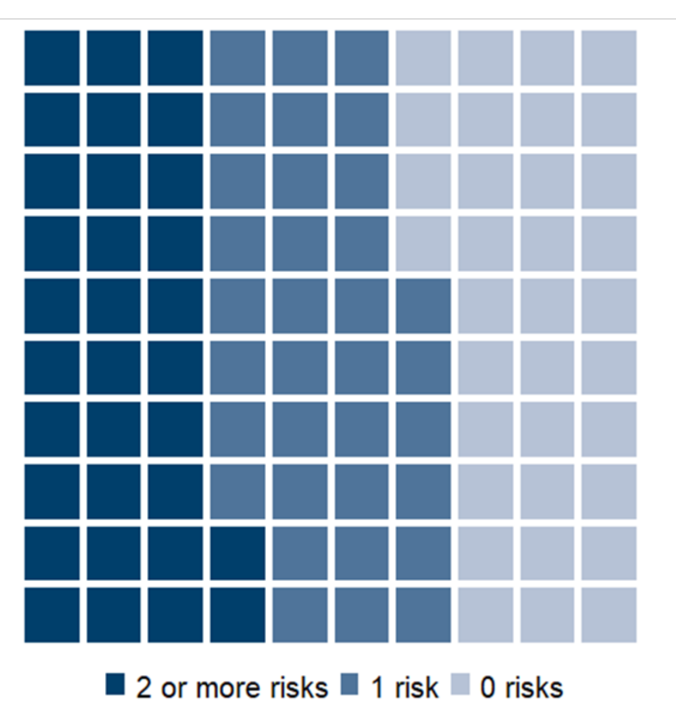
- Low income
- Pregnancy at a young age (under 21)
- Food insecurity
- Homelessness
- Household has a child with developmental delays or disabilities
- History of child abuse or neglect, or interactions with child welfare services
- Substance abuse
- Incarceration

Counts and percentages for these risk factors are presented in Appendix A7.



In 2023, 66% of primary caregivers reported experiencing at least one of the risk factors listed above and 32% reported experiencing two or more risk factors. Additional details including counts and percentages are provided in Appendix A7. Figure 4 displays the proportion of families who report they have experienced one, two, or more risk factors.

Figure 4. Percent of Households with Risk Factors



Child characteristics

Below is a summary of the demographic characteristics of target children served with Strong Foundations funding. Almost half of target children (46%) are under 12 months old. Across target children, their ethnicity was reported as 33% Hispanic or Latino/a/x, 3% Somali, and 2% Hmong, as seen in Table 7.

Table 7. Target Child Ethnicity

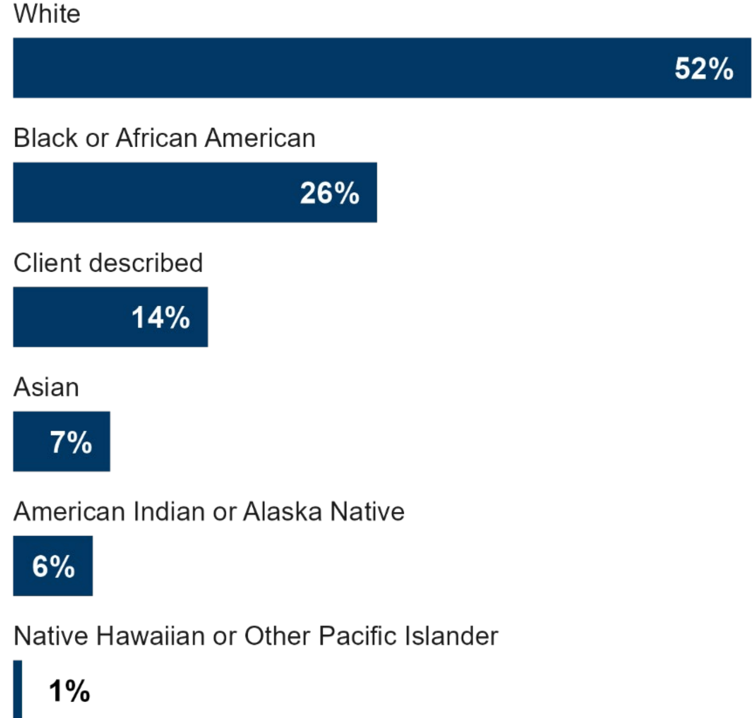
Child ethnicity	Count	Percent
Other	2,474	59%
Hispanic or Latino/a/x	1,379	33%
Client declines	147	3%
Somali	144	3%
Hmong	87	2%

A variety of languages are spoken in their homes (Figure 5): 66% speak English, followed by Spanish (22%), Somali (3%), Karen (2%), Hmong (1%), and Oromo (1%).

Figure 5. Most Frequent Languages Spoken at Home

Like the caregiver characteristics, over half (52%) of children's race is reported as white, followed by Black or Black or African American (26%), Asian (7%), American Indian or Alaska Native (6%) and Native Hawaiian or Other Pacific Islander (1%), as displayed in Figure 6. Like the race category for primary caregivers, children whose caregivers report their race as more than one race are represented in each respective race category. Full counts and percentages are provided in Appendices A8, A9, and A10.

Figure 6. Child Race



Strong Foundations grant implementation

Annually, each of the 65 grantees completes a structured workplan where they describe how they plan to address key implementation topics. This section presents a grant-wide description of how each activity was implemented, along with grantee-compiled strategies that supported their successful implementation.

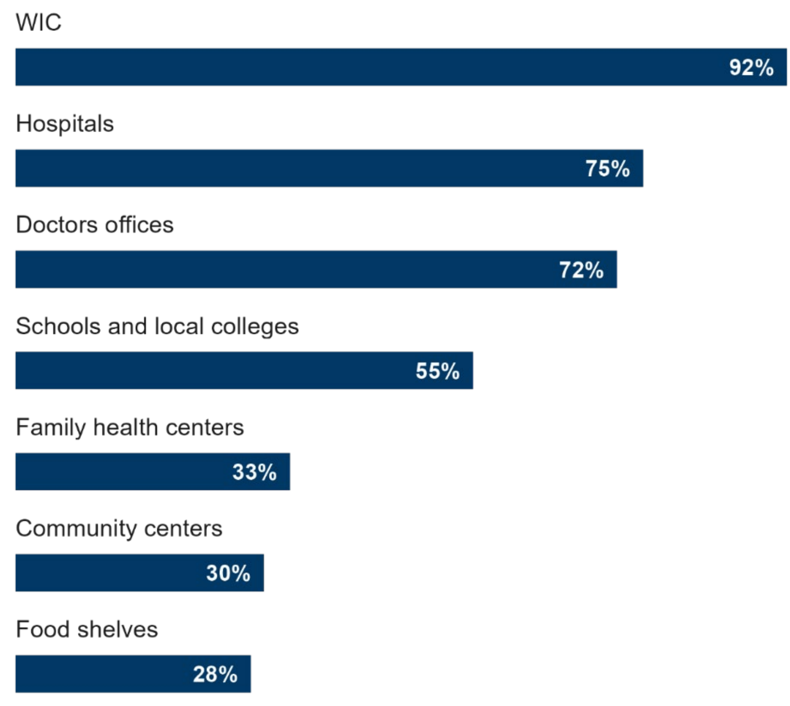
Three data sources were used to complete this section: 1) participant-level data submitted to MDH's data system, Information for Home Visiting Evaluation (IHVE), 2) grantee progress monitoring reports, and 3) grantee quarterly reports. In the year-end progress monitoring report, grantees responded to a set of open-ended questions for each implementation topic; summaries of the emergent themes for each topic area are presented with examples.

Increase access to evidence-based home visiting services

Referral, recruitment, and enrollment

Improving the efficiency and convenience of referral and enrollment processes increases recruitment and enrollment of new families. Ongoing efforts to build partnerships with other agencies that support caregivers and young children help sustain home visiting programs. These collaborations provide a continuity of care and link families to important resources that support their overall health and well-being. Figure 7 presents the resources and partners most often used by Strong Foundations grantees.

Figure 7. Resources and Partners that Strengthen Recruitment



Other common resources and partners that support referral and recruitment efforts include child protection, human and social services, non-profit organizations, and pregnancy resource centers.

Innovative recruitment and enrollment strategies

- Centralized intake process.
- In-person outreach: “Attending various public facing events in the communities we serve, has been helpful to promote and increase awareness of the program.”
- Creating and sharing promotional videos.
- Developing partnerships: “Community education has been wonderful for getting information out about our programs. We also get a lot of provider introductions to families. We have also had word of mouth in the community to help assist with referrals in.”

Prenatal enrollment

By enrolling families prenatally, family home visiting programs can maximize home visiting benefits and outcomes. Prenatal enrollment provides opportunities to promote adequate prenatal care, encourage breastfeeding initiation, and connect families to resources early.

Table 8 displays the number of families newly enrolled in family home visiting each quarter, both overall and prenatally, as well as the percentage of prenatal enrollment. In 2023, Strong Foundations grantees' prenatal recruitment goals ranged from five to 100% of newly enrolled families, with an average of 44%. Figure 8 displays the critical partners that help support prenatal recruitment into family home visiting programming.

Table 8. Prenatal Enrollment Percentage of New Families

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	2023 Total
Number of prenatal clients enrolled	342	328	302	273	1,245
Total number of new clients enrolled	610	565	570	469	2,214
Prenatal enrollment percent	56%	58%	53%	58%	56%

*"…the most impactful component is **finding a 'champion' of home visiting** in these settings to really develop a supportive referral network."*

Strong Foundations grantee

Figure 8. Partners that Strengthen and Promote Prenatal Enrollment

WIC

- Warm hand-offs
- Prenatal visits provide early engagement and support

"WIC outreach and partnership has significantly strengthened prenatal enrollment."

County Social Services

- Parent Support Outreach Program
- Chemical health
- Adult mental health
- Corrections

"Home visitors work closely with social workers though their county social services to gather referrals, of which some of these are prenatal."

Healthcare Systems and Payers

- Medical providers
- OB/GYN partners
- Health plan referrals via text or phone

"Having team members meet with clinic and hospital providers has made a monumental leap in strengthening partnerships and it is only with this collaboration that increased prenatal enrollment has been able to be achieved."

Community Resources

- OB prenatal educators
- Local schools
- Health Resource Centers

"Having the face-to-face conversations with our community partners has also helped."

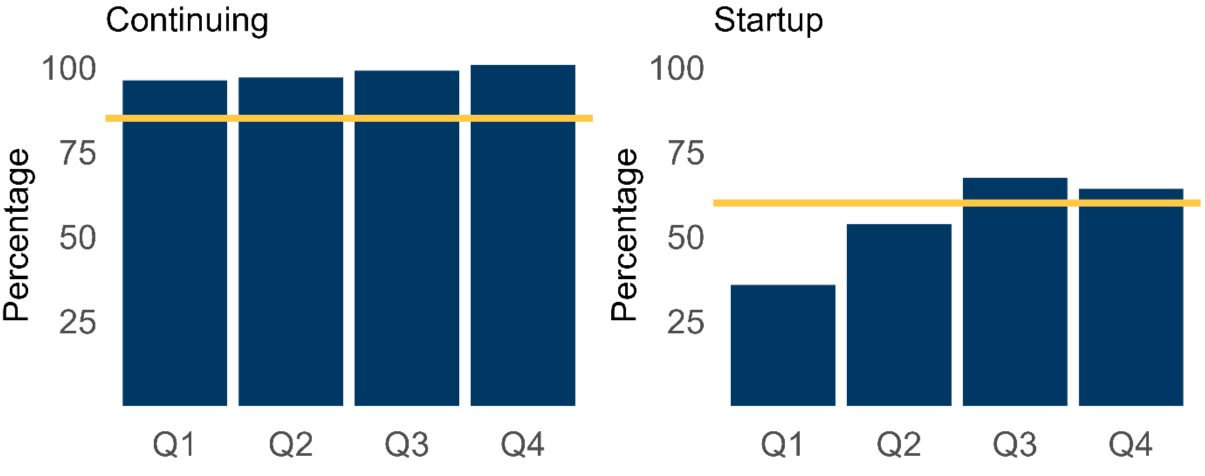
Target caseload

Strong Foundations grantees steadily increased their caseloads during year one of the grant. Grantees who previously received evidence-based home visiting funding from MDH ("sustaining grantees") had a year-end goal of reaching 85% of their total caseload. Newly-funded or "start-up" grantees' caseload goal was 60% by December 31, 2023. Table 9 displays the total current households as reported in the Strong Foundations quarterly report along with the percentage of target caseload met. Figure 9 presents this information, along with year-end goals, across quarters for both sustaining and start-up grantees.

Table 9. Strong Foundations Caseload by Quarter, 2023

Blank	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Total households	3,128	3,171	3,250	3,301
Target caseload	3,310	3,310	3,310	3,310
Percent	95%	96%	98%	100%

Figure 9. Percentage of Target Caseload Met by Quarter*



*Yellow line denotes the caseload goals for continuing (85%) and sustaining (60%) grantees.

Effective Strategies in Reaching Target Caseload

Strong Foundations grantees described strategies that have helped increase enrollment and, in turn, reach their target caseload. Below is a summary of their responses with examples.

In-person interactions at recruitment and in home visits are valuable. They provide opportunities to build relationships between families and home visitors.

"Face-to-face interactions between families and our home visitors have worked well for enrolling families."

"Face to face contact at WIC appointments and scheduling the first visit at that time."

Strong referral partnerships help achieve target caseloads. For example, WIC, local clinics, and community resources are partnerships that assisted grantees.

"Collaborating with community leaders and organizations assisted in developing and strengthening trust and provided an avenue for reaching a broader audience."

"The large number of referrals that we do get from clinics, hospitals, WIC, and at times other community agencies helps us to constantly be able to talk about and offer services."

Outreach and marketing efforts, such as social media and posting flyers, help recruit families and build caseloads.

"Social media presence to make the public aware of and how to make referrals/access the program."

"This includes creating outreach materials such as flyers, posters, and postcards with QR codes to access county webpages and online referral links."

Staff retention or extended staff vacancies significantly impact caseload.

"Supporting our current staff and building the capacity for a strong program foundation over the past year has proven successful based on meeting our target caseload and maintaining a waitlist."

"We have retained our staff with zero turnover which strengthens our program, and families see increased benefits. They then share their success and satisfaction with the program, increasing referrals."

Using data in decision making supports programs’ ability to recruit and retain families.

“… utilizing data to identify high-need areas can guide targeted efforts for recruitment and support. Regularly evaluating and adjusting strategies based on feedback and outcomes is crucial for sustained success.”

“As a group, we use collected data in order to review caseloads, referral acceptance, and engagement quarterly.”

Family retention helps in achieving target caseloads.

“Family visiting staff have retained families at a high rate. This reduces the pressure to recruit and engage new families. It also allows for a deeper impact on the parent-child dyads we're retaining.”

“It has been a two-pronged approach: strong family retention, and successful recruitment of new families. Family visiting staff have retained families at a high rate.”

*“The **CQI project was helpful** in giving us the tools and providing a structure for us to focus on engagement. We also intentionally **aligned our project with our Work Plan goals** which provided a structure for reviewing our referral partners.*

*We brought forth key learnings and updates to our **Community Advisory Committee** which also includes many referral partners and community resources.”*

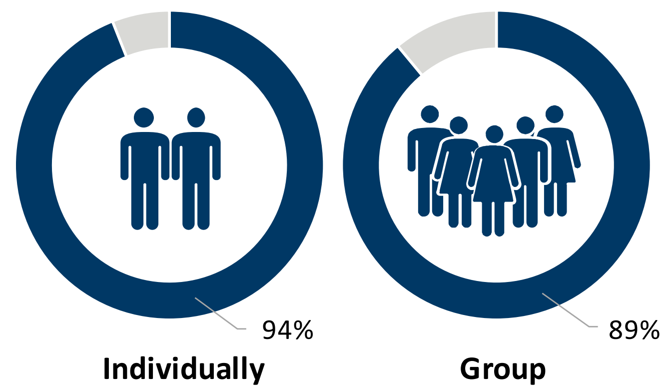
Strong Foundations grantee

Increasing infrastructure to support staff to provide evidence-based home visiting services with model fidelity

Reflective supervision

Reflective supervision can help support the challenging work of being a home visitor, increase their overall feelings of job satisfaction, which, in turn, may promote staff retention. The consistent, reliable experience of reflective supervision clarifies goals and areas of intervention. Reflective supervision may be facilitated individually or in groups. As seen in Figure 10, 94% of Strong Foundations grantees provide individual reflective supervision to their home visitors; 89% facilitate it in a group setting. Supervisors also benefit from reflective supervision: Across the Strong Foundations grant, 88% of grantees report that supervisors also receive reflective supervision.

Figure 10. How is Reflective Supervision Facilitated?



Effective Strategies that Support Reflective Supervision

Strong Foundations grantees provided several strategies that support reflective supervision for their home visitors and supervisors. Below are the main themes with specific examples.

Plan for consistent, protected time for reflective supervision

"Consistency is key to supporting the practice of reflective supervision."

"Reflective supervision is seen as a 'sacred' time that needs to be saved each week, meaning it shouldn't be cancelled and rescheduled often."

Organizational and leadership buy-in

"Directors are very supportive of reflective supervision and make sure it is a priority for staff."

"FHV has continued financial and staffing support so that reflective practice and supervision meets model recommendations via 1:1 supervisor and staff meetings."

Training and expertise of facilitator

"Our monthly group reflective [sessions] are also helpful in supporting reflective…it's carried out by an infant mental health specialist and allows staff to connect over similar issues."

"Our agency partners with [another] county to receive monthly group reflective practice sessions with a trained facilitator."

Utilizing tools and resources

"…looking over curriculum items such as Hole in the Ground and Promoting First Relationships to support our RS [reflective supervision] practice."

"We also have brought in an infant mental health specialist to provide presentations on reflective practice and the U of M "RIOS" tool."

Open-door policy

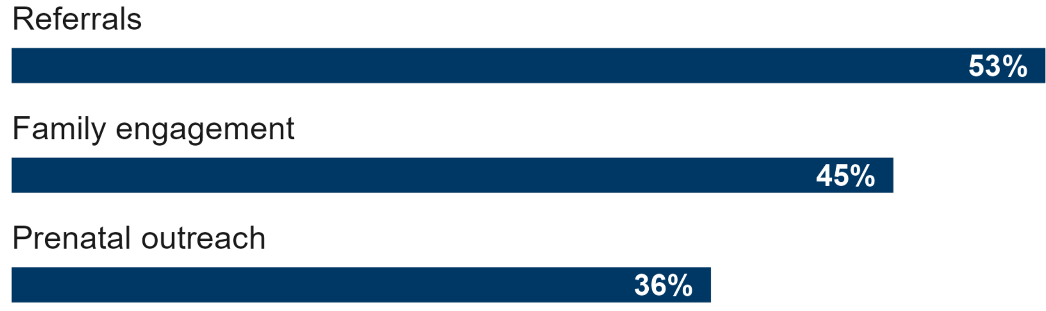
"Being available for 'impromptu reflective supervision' when public health nurses need to talk soon after a challenging or emotionally taxing visit."

"…family home visiting team implemented an open-door process with their supervisor for one-on-one reflective practice sessions which allowed staff to request RP [reflective practice] sessions as they needed."

Advisory committee

Community advisory boards or committees aim to improve home visiting services through planning, evaluation, outreach efforts, and quality improvement initiatives. Support and partnership with an advisory committee can be instrumental to the success and sustainability of home visiting programs. In the first six months of the Strong Foundations grant, nearly two-thirds (64%) of grantees facilitated at least one advisory committee meeting; 36% hosted two or more. The leading topics of the advisory committees included referrals, family engagement, and prenatal outreach, as seen in Figure 11.

Figure 11. Top Topics Presented in Advisory Committee Meetings



Other advisory committee topics included: training opportunities, model-specific requirements and outcomes, family and home visitor satisfaction survey results, fidelity and program data reporting, and health equity and intersectionality.

Effective Strategies that Support Advisory Committee Facilitation

Strong Foundations grantees identified strategies that effectively support the facilitation of an advisory committee. Below is a summary of the grantees' descriptions with direct examples from individual grantees.

Opportunity to **develop and vet materials**.

"Working on a marketing campaign to update logos, materials, and increase outreach efforts."

"We assist with recruiting parents and bring content to the advisory group for input/feedback."

Designated time to **plan for specific topics.**

Prenatal, referrals, 'how program fits the community,' cultural humility.

"… staff were interested in gaining knowledge about area history and expanding their knowledge of cultural practices. One of our committee members provided input on different resources to reach out to, to gain insight to specific cultures such as the Native American population in the area."

Consists of a **variety of members of the community**, including families.

"We rely on home visitors' positive relationships with current and former families to ensure essential family representation, and we have tried to ensure geographic representation…"

"We have a health advisory committee that meets two times a year that consists of members from public health, mental health, program participants, and staff."

"… we feel family participation is essential to the quality of input we are looking for."

Offer **in-person and virtual participation.**

"...staff have really enjoyed having a hybrid option, so that they can also connect in-person."

"We share a meal together and work cooperatively to adapt the curriculum to current needs, and discuss challenging topics and concerns."

> *Attending Advisory Committee meetings on a regular basis to **build and maintain relationships with community partners has been imperative** to maintain a steady referral base and creates an opportunity for continued collaboration between agencies.*
>
> *Strong Foundations grantee*

Participating in MDH evaluation and continuous quality improvement activities to enhance home visiting services

Continuous quality improvement (CQI)

CQI is a systematic approach to identifying and addressing areas of improvement in a program or service and involves regularly collecting and analyzing data, implementing changes, and evaluating their impact, with the goal of enhancing effectiveness and efficiency.

CQI is essential for public health family home visiting because it allows for ongoing assessment and refinement of services to ensure they meet the evolving needs of families, resulting in more effective and impactful interventions. This approach fosters data-driven decision-making, promotes innovation, and helps achieve better outcomes in maternal and child health, early childhood development, and overall family well-being.

Change ideas implemented to improve family engagement and retention:

- Creating videos with participants and referral partners to improve referrals and enrollment.
- Talking to internal teams to increase referrals, showing examples of what family home visiting looks like.
- Using incentives to retain families.
- Home visitors shadowing each other to learn new ideas for recruitment, especially the first contact.
- Scheduled planned activities to celebrate Spanish heritage month.
- Using the HOPE (Health Outcomes from Positive Experiences) framework to focus on promoting positive childhood experiences.

*"**Weekly team huddles, monthly team meetings,** and **regular check-ins** [about CQI] have helped greatly. Monthly meetings with MDH and model developer have been **very helpful in filling gaps** in knowledge and making sure we are on track."*

Strong Foundations grantee

Strategies and Partnerships that Strengthen Continuous Quality Improvement

Strong Foundations grantees described the strategies and partnerships that helped strengthened their CQI efforts. Below is a summary of the grantees' responses with examples from individual grantees.

Collaborating with MDH family home visiting staff

"This annual CQI project that MDH facilitates for LIAs is extremely helpful. We have appreciated the opportunity to provide input on topics of interest, receive guidance on CQI activities, and collaborate with other LIAs to learn about their work."

"Monthly meetings with MDH have been very helpful in filling gaps in knowledge and making sure we are on track."

Local community advisory boards

"The local advisory committee give us insight into other home visiting programs and potential partnerships."

"Monthly staff meetings help identify and monitor CQI strategies that work and need to be changed. These areas are also presented to the CAB (advisory committee) for review..."

Community partnerships

"… community partners are integral to our process and work."

"We have established quarterly meetings with [hospital/clinic] OB/High Risk RNs to staff clients, discuss referrals, and review processes."

Model-specific CQI efforts

"MECSH team consultation meetings to plan for how to review data sent from MDH evaluation team and for setting CQI plans going forward."

"...Family Spirit will have its own CQI project tailored to engagement and enrollment."

Using home visitor and staff feedback

"Our team is informally engaged in [C]QI all the time through modifications being made to documentation, recruitment, ordering materials, etc."

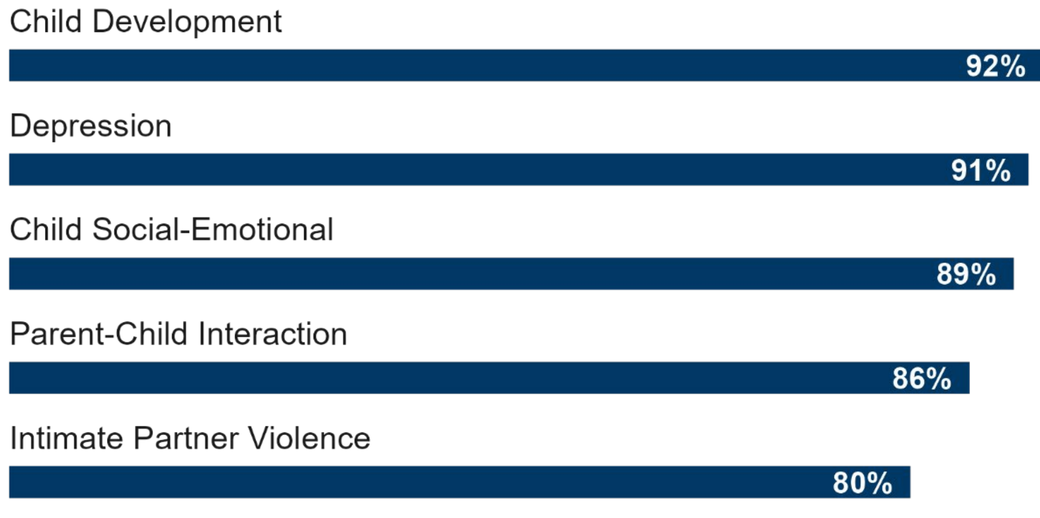
"In 2023, our full team engaged in some brainstorming around ways to increase family retention and engagement."

Model fidelity

Screenings and assessments

Screenings and assessments are standardized tools that assist in identifying potential safety, health, or developmental concerns in home visiting clients. They can reinforce parent and child strengths and support the home visitor in strategizing interventions. Figure 12 displays the types of screenings and assessments used by Strong Foundations grantees.

Figure 12. Types of Screening and Assessment Administered Across Strong Foundations Grantees



Strategies that Support Screening and Assessment Administration

Strong Foundations grantees described strategies that have helped ensure families receive model-required screening and assessments. Below is a summary of the grantees' responses with examples from individual grantees.

Strategies that incorporate data ensure effective and timely administration.

"Building some reports and chart-audit check lists to support home visitor and supervisor review of clients completed screenings & assessments."

"Our department has access to MIIC [Minnesota Immunization Information Connection] through the [electronic health record] system which has assisted greatly in meeting the fidelity requirements of ensuring families receive model required assessment and referral."

Reports, checklists, schedules monitor when screening and assessments are due.

"PHNs [public health nurses] follow a forms and collection time schedule which has descriptions of what screenings and topics should be provided to the client at that visit. PHNs provide updates to the client's PCP [primary care provider] if a screening is abnormal or if there is a concern."

"We use the service alert reports available in the PAT Penelope database to track when screenings and assessments need to be completed."

Time during **team meetings** to discuss screenings and assessments.

"We review our [parent-child interaction] tool biannually at our [evidence-based home visiting] staff meetings."

"Staff have the opportunity to discuss screenings and assessments at team meetings."

Partnerships with MDH and other programs assist with guidelines.

"… the partnership with our MDH implementation coach and grant specialist, as well as PAT implementation specialist, has been essential. This year, we identified several areas for improvement, especially in ensuring families receive the required screenings and assessments."

Staff trainings help all staff complete screenings and assessments in-person.

"Ensuring completion of the screening is a key component of the integrated home visit. The supervisors do a quarterly joint visit to ensure compliance."

"Trainings helped new and existing staff for completing screenings and assessments. For example, advertising training updates and opportunities have proved beneficial for staff."

Communities of Practice

Communities of Practice (CoP) enhance knowledge and skill in family home visiting by sharing information and experiences across home visitors and home visiting programs. These regular forums lead to enhanced collaboration and problem solving across grantees. Across the Strong Foundations grant, 91% of grantees reported participating in Communities of Practice in 2023.

Strategies that Support Participation in Communities of Practice

Grantees described the strategies and partnerships that have worked well in supporting Community of Practice facilitation and participation. Below is a summary of their responses with examples from individual grantees.

Various types of CoPs are available to grantees.

CoP examples: model specific, supervisor, home visitor, and regional or topical (e.g., African American Babies Coalition).

Increase options to find and access CoPs.

Including: calendar invites, Tuesday Topics newsletter, MDH Basecamp reminders, providing meeting dates in advance, and recordings of previous COPs.

Address **barriers to participation.**

- Scheduling conflicts.
- Topic applicability.
- Other participants' participation: *"Day of the week initially was a poor fit for our schedule, but that has been adjusted and FHV supervisor has been able to attend."*

Opportunities to effectively **apply CoP content and materials**.

- CoP materials and discussions are reviewed in team meetings.
- Cross-county discussions.
- Attending CoPs as a team: "CoP material and discussions are reviewed in team meetings, both individual county meetings with home visitors and cross-county discussions in our monthly Supervisor meetings as a standing agenda item."
- Providing opportunity to problem solve and strategize content or topics: "Our monthly group reflective [sessions] are also helpful in supporting reflective, because it's carried out by an infant mental health specialist and allows staff to connect over similar issues."

Staffing and workforce development

Home visiting staff development

Supporting and developing staff is critical for promoting stable and effective organizations and delivering strong program activities to families. Ongoing learning and training are imperative to build skills in the home visiting workforce. These investments equip home visitors with knowledge and tools to support families effectively and confidently.

Strategies that Support Ongoing Home Visiting Staff Professional Development

Strong Foundations grantees report several strategies and partnerships that support the ongoing staff development for home visitors, supervisors, and staff. Below is a summary of the main themes of the strategies that grantees found successful along with specific examples.

Model trainings and other learning opportunities are regularly available.

"Our models have various training requirements, some for specific training and others for general ongoing training. We built training expenses into each of our budgets to support this."

"Priority is placed on trainings required by FHV [family home visiting] models such as NFP required trainings (FAN, Cultural Consciousness, DANCE), and MECSH Foundation training."

"The nursing teams incorporate regular opportunities for professional development into our regular model specific team meetings or into our monthly joint team meeting across models."

"Family Spirit has regular office hours and ongoing digital curriculum training and support."

Grantees engage with **local networking coalitions and partners** to share resources and monitor emerging trends in home visiting.

- Participating in Breastfeeding Coalition, Doula Support, Community Health Worker Alliance, regional and model collaboratives.
- Partnering with local public health and hospitals, neighboring counties.
- Attending local and national trainings and conferences (e.g., Black and Brown Summit).

Specific skills are developed by offering various training topics:

- Screening and assessment (e.g., PICCOLO, ASQ, Intimate Partner Violence)
- Workforce support (motivational interviewing, reflective supervision)
- Family health and wellbeing (e.g., lactation, vaping, blood born pathogen training)
- Technical support was also provided (e.g., EHR/REDCap training, cybersecurity)
- Health equity (e.g., bias in home visiting, cultural consciousness, ACEs)

Agencies support staff development through offering **trainings of interest** as well as **requiring trainings** that all home visiting staff should attend.

“Staff are encouraged to participate in trainings of interest that pertain to their work for professional development. The department has a training budget to support this.”

“During reflective supervision, home visitors and supervisor identify areas for support and seek out trainings in those areas.”

“We conduct an annual needs assessment from the home visiting staff to gather training needs that they feel are a priority.”

“PHN [public health nursing] staff have a list of required trainings that is provided during orientation to ensure all required training is completed.”

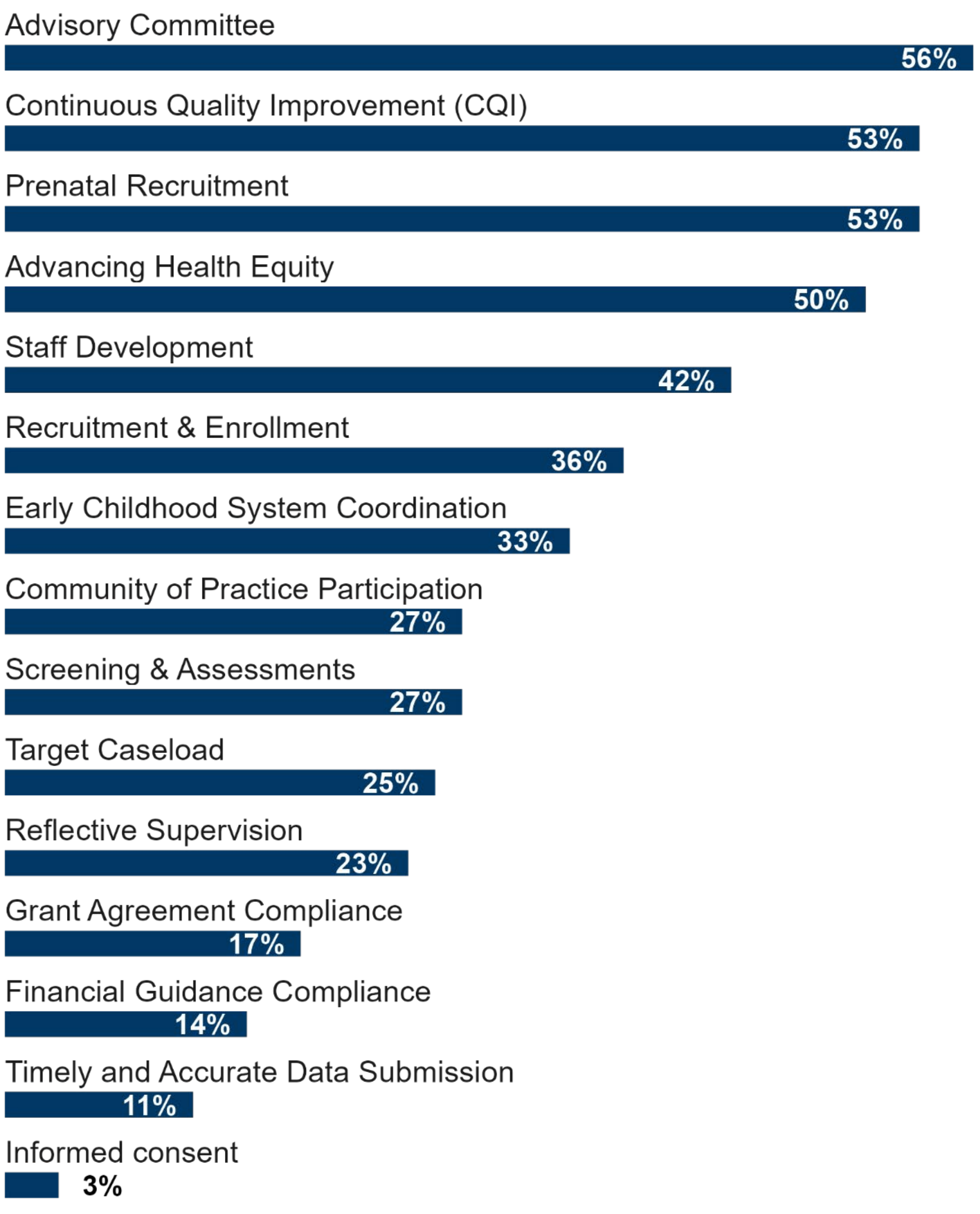
“[Grantee] requires 2 hours of diversity and inclusion trainings annually. Managers/Supervisors supports ongoing training for staff when necessary.”

Grantees provide training opportunities in **several formats** including:

- Virtual meetings
- Individual check-ins
- Internal team meetings
- Cross-agency meetings
- MDH-facilitated events
- Webinars
- National conferences

Figure 13 displays the top training or technical assistance topics of interest across grantees in 2023.

Figure 13. Top Requested Training / Technical Assistance Topics Across Strong Foundations Grantees



Staffing

An essential component in every home visiting program is its workforce. By ensuring staff positions are filled promptly, programs can better reach and serve more families. Filling vacancies can often be accompanied with significant challenges but using innovative strategies in recruiting and hiring qualified staff can expedite staffing transitions and promote retention. As seen in Table 10, home visitor staffing vacancies varied between 15-26% across quarters in 2023.

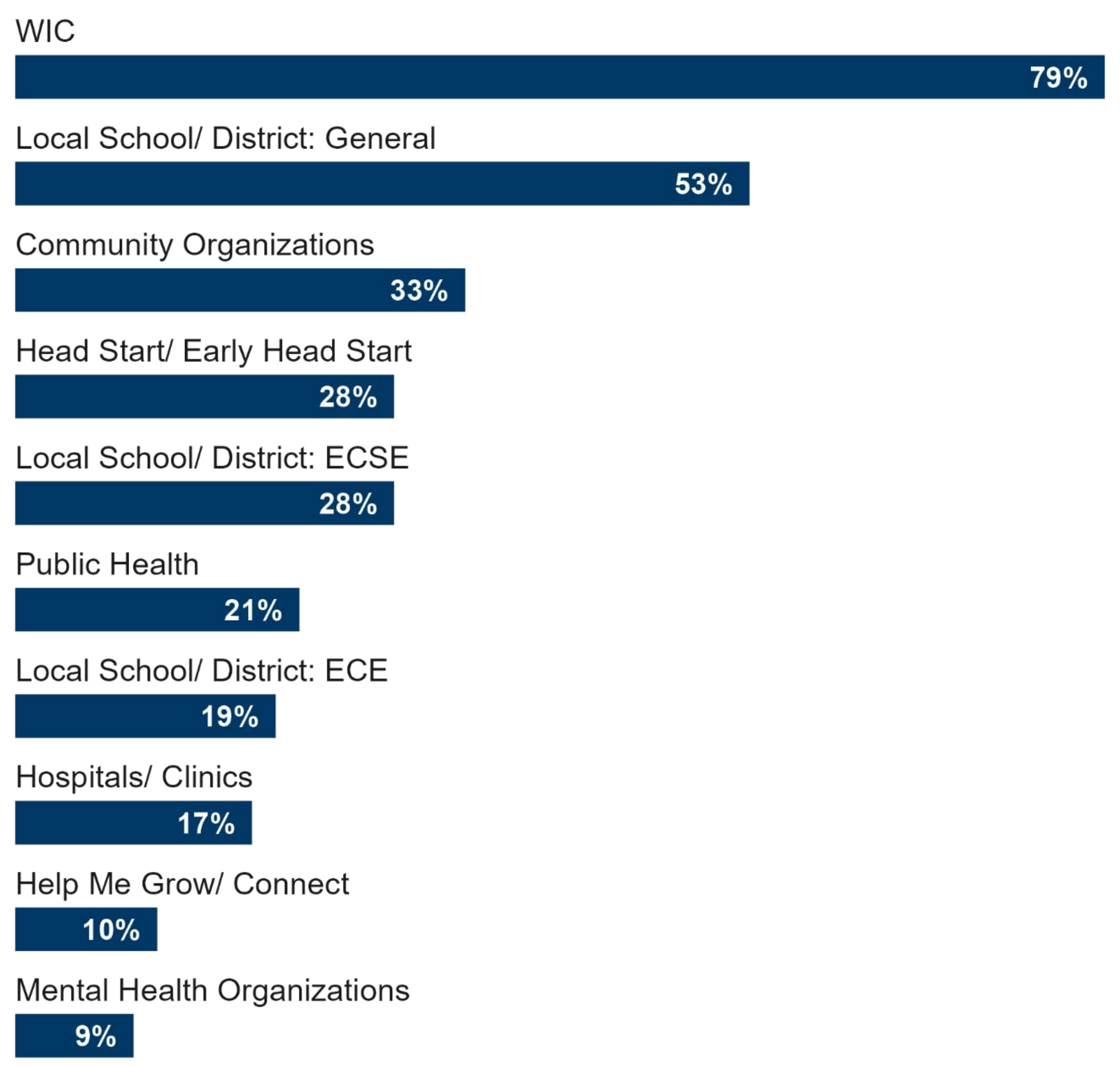
Table 10. Percent of Strong Foundations Grantees with Staff Vacancies, 2023

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Home visitors	24%	26%	23%	15%
Supervisors	7%	6%	9%	5%
Other staff	3%	2%	2%	2%

Early childhood system coordination

Services for pregnant and parenting families should integrate health care, social services, and community programming to promote a holistic approach of family support. Service coordination promotes overall family well-being and includes a multi-generational approach, both key elements of family home visiting. Figure 14 highlights the main early childhood systems partners across Strong Foundations grantees.

Figure 14. Top Early Childhood Partners Reported Across Strong Foundations Grantees



Strategies that Build and Support Systems-level Coordination Across Early Childhood Partners

Successful early childhood systems work relies on collaborative relationship building with partners, particularly those mentioned in the above chart. Strong Foundations grantees shared different strategies that help build systems-level coordination across early childhood partners

Screening, referral, and co-intervention with other direct service staff.

- Participate in joint visits with early intervention agencies.
- Share developmental assessments with partners.
- Work on collaborative case management with early intervention.
- Communicate with district special education specialists if working with the same client.

Meeting and advisory board coordination may look like:

- Participation in local interagency early intervention committees (IEIC).
- Inviting community partners to team meetings.
- Communication with partners via meetings, calls, emails, and regular connections.
- Invite others to participate in advisory boards.

Linking families through **community outreach.**

"Prioritizing events has been a key component in agency recognition, relationship development, and outreach, including summer events, back to school/kindergarten roundups, and readiness events."

"We hosted a large family event with a resource fair made up of other EC [early childhood] programs/organizations."

*"The **teamwork with our partners** is core and essential to **strengthening the coordination** of early childhood programs and systems. Over time, we have built and strengthened these relationships, and we believe it is a **mutual benefit with all of our partners**."*

Strong Foundations grantee

Grant agreement compliance

Grant compliance indicates that a grantee can ensure their promised deliverables are achieved. Demonstrating compliance is an important indicator in securing and maintaining grant funding. This includes fiscal responsibilities, work plan deliverables, and progress/data reporting. The figures below, Figure 15**,** Figure 16**,** and Figure 17 display Strong Foundations grantees' self-reported ease or difficulty in meeting key grant activities.

Figure 15. Strong Foundations Grantees' Ease in Implementing Grant Requirements Outlined in Workplan: Part I.

Assess families for the risk factors including depression, IPV, child development, and parent child interaction
2023 Mid-year
2023 Year 1
Create and maintain a referral network
2023 Mid-year
2023 Year 1
Deliver FHV programming in service area
2023 Mid-year
2023 Year 1
Develop and implement a plan for reflective supervision
2023 Mid-year
2023 Year 1
Develop appropriate protocols for servicing waitlist families
2023 Mid-year
2023 Year 1
Very difficult
Somewhat difficult
Neutral
Somewhat easy
Very easy

Figure 16. Strong Foundations Grantees' Ease in Implementing Grant Requirements Outlined in Workplan: Part II.

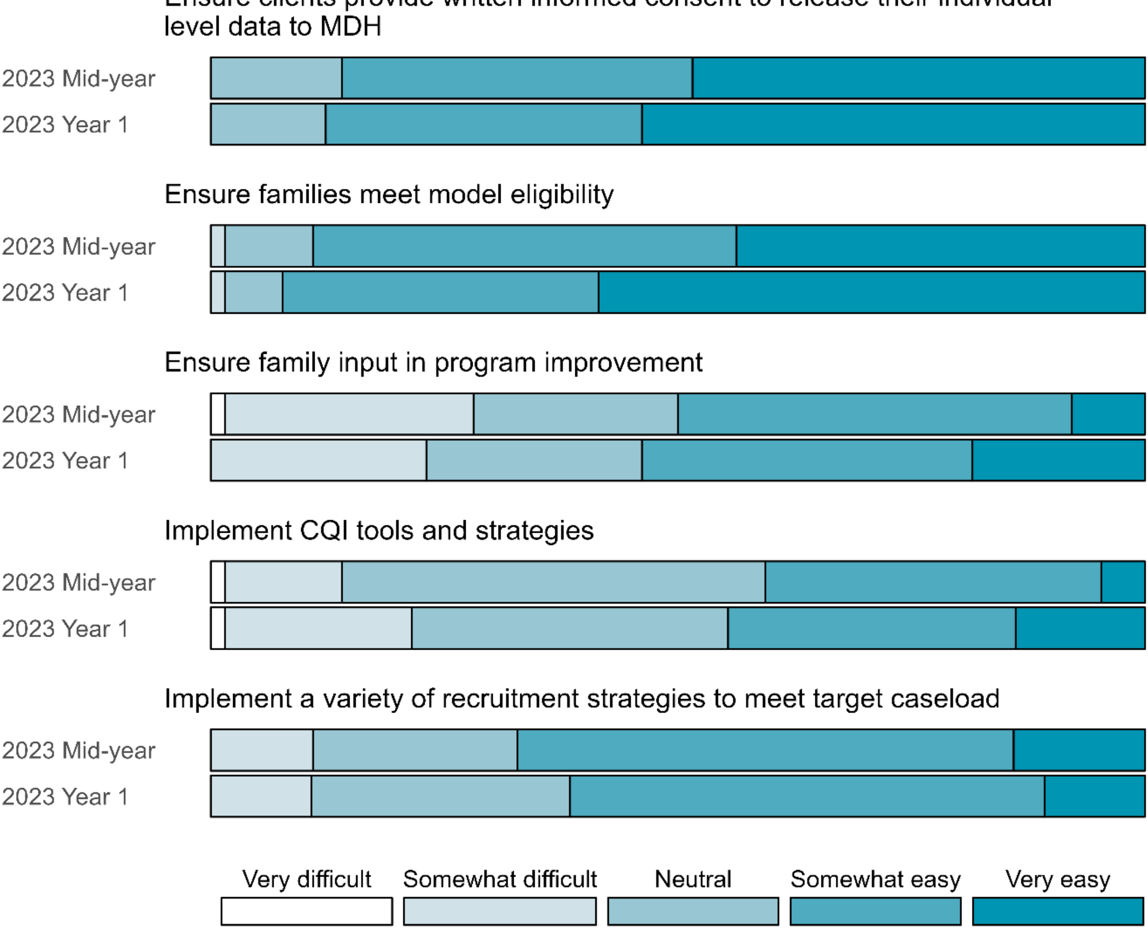


Figure 17. Strong Foundations Grantees' Ease in Implementing Grant Requirements Outlined in Workplan: Part III.

Increase staff capacity to deliver culturally responsive and trauma informed services

2023 Mid-year

2023 Year 1

Meet target caseload

2023 Mid-year

2023 Year 1

Release client data according to the level of informed consent given

2023 Mid-year

2023 Year 1

Utilize creative strategies to destigmatize home visiting to families

2023 Mid-year

2023 Year 1

Very difficult | Somewhat difficult | Neutral | Somewhat easy | Very easy

Appendices

Appendix A: Participant demographic characteristics

A1. Primary Caregiver Age

Caregiver age	Count	Percent
≤= 17	107	2%
18-19	274	6%
20-21	419	9%
22-24	772	17%
25-29	1,197	26%
30-34	1,013	22%
35-44	799	17%
45-54	35	1%
55-64	4	0%
> = 65	1	0%

A2. Caregiver Race

Caregiver race	Count	Percent
White	2,352	51%
Black or African American	1,002	22%
Client described	589	13%
Client declined to answer	327	7%
Asian	273	6%
American Indian or Alaska Native	250	5%
Native Hawaiian or Other Pacific Islander	27	1%

Note. Total counts are larger than total caregivers because multiple races were reported across some caregivers.

A3. Caregiver Employment

Employment Status	Count	Percent
Not employed	2,483	54%
Employed full-time (30+ hours/week)	1,121	24%
Employed part-time (Less than 30 hours/week)	910	20%
Unknown/did not report	64	1%
Declines to answer	43	1%

A4. Caregiver Education

Educational attainment	Count	Percent
Less than high school diploma	1,064	23%
High school diploma or GED	1,532	33%
Some college or post high school training	686	15%
Bachelor's degree or higher	491	11%
Associate degree	170	4%
Technical training or certificate	142	3%
Declined to answer	336	7%
Other	38	1%
Unknown/did not report	162	4%

A5. Caregiver Insurance

Insurance status	Count	Percent
Yes	3,792	82%
Unknown/did not report	520	11%
No	309	7%

A6. Household Military Service

Household includes individuals who are serving or served in the U.S. armed forces	Count	Percent
Yes	135	3%
No	3,971	86%
Unknown/did not report	515	11%

A7. Household Risk Factors

Characteristic	Count	Percent	Percent Unknown*
Low income	2,005	65%	33%
Pregnant and under 21	398	9%	
Food insecurity	784	37%	29%
Currently experiencing homelessness	166	4%	1%
Household has a child with developmental delays or disabilities	455	11%	12%
Participant has a history of child abuse or neglect or has had interactions with child welfare services	1,157	39%	36%
History of substance abuse	585	16%	21%
Experience with incarceration	209	6%	26%

**Percent unknown includes clients who decline to answer and those who did not report. These clients were removed from the denominator.*

A8. Child Age

Child age	Count	Percent
< 1 year	1,928	46%
1-2 years	1,876	44%
3-4 years	330	8%
5-6 years	85	2%
> 6 years	4	0%

A9. Child Race

Child race	Count	Percent
White	2,187	52%
Black or African American	1,082	26%
Client described	580	14%
Asian	289	7%
American Indian or Alaska Native	236	6%
Client declined to answer	179	4%
Native Hawaiian or Other Pacific Islander	27	1%

Note. Totals counts are above total children as multiples races may be reported

A10. Languages Spoken in Child's Home

Language spoken in child's household	Count	Percent
English	2,796	66%
Spanish	940	22%
Somali	108	3%
Karen	77	2%
Hmong	57	1%
Oromo	27	1%
Arabic	20	0%
Amharic	10	0%
Burmese	6	0%
Nepalese	4	0%
Other	169	4%
Client declined to answer	9	0%

Appendix B: Outcome measure descriptions

B1. Outcome: Developmental screening and referral

The measures for developmental screening were calculated using the following definitions for denominator and numerator.

Measure	Numerator	Denominator
Children screened	Target children in the denominator that received a developmental screen during the reporting year (ASQ-3, PEDS, PEDS:DM).	Target children who received home visiting during reporting year and were between 1 month and 66 months during the reporting year.
Children with concern identified	Target children in denominator with a concern identified from a developmental screen administered during the reporting year.	Target children who received home visiting during reporting year and were between 1 month and 66 months during the reporting year and received a developmental screen during the reporting year.
Children referred	Target children in denominator and received a referral within 45 days of the screening	Target children who received home visiting during reporting year and were between 1 month and 66 months during the reporting year and received a developmental screen with a concern identified during the reporting year.
Children received service	Target children in the denominator that received services for Early Intervention/Part C, Home Visitor Individualized Support for Child Development, Primary Care Provider, Health Care Specialist Provider, or Other Provider or Community Service within 45 days of the referral.	Target children who received home visiting during reporting year and were between 1 month and 66 months during the reporting year and received a developmental screen with a concern identified during the reporting year and received a referral within 45 days of the screening.

Measure	Children with a visit	Children screened	Children with concern identified	Children referred	Children received service
Count	3,735	2,158	493	144	72
Percent		58%	23%	29%	50%

B2. Outcome: Social-emotional screening and referral

The measures for social-emotional screening were calculated using the following definitions for denominator and numerator.

Measure	Numerator	Denominator
Children screened	Target children in the denominator that received a social-emotional screen during the reporting year (ASQ-SE or PSC).	Target children who received home visiting during reporting year and were between 1 month and 66 months during the reporting year.
Children with concern identified	Target children in denominator with a concern identified from a social-emotional screen administered during the reporting year.	Target children who received home visiting during reporting year and were between 1 month and 66 months during the reporting year and received a social-emotional screen during the reporting year.
Children referred	Target children in denominator and received a referral within 45 days of the screening	Target children who received home visiting during reporting year and were between 1 month and 66 months during the reporting year and received a social-emotional screen with a concern identified during the reporting year.
Children received service	Target children in the denominator that received services for Early childhood mental health, Home Visitor Individualized Support for Child Development, Primary Care Provider, Health Care Specialist Provider, or Other Provider or Community Service within 45 days of the referral.	Target children who received home visiting during reporting year and were between 1 month and 66 months during the reporting year and received a social-emotional screen with a concern identified during the reporting year and received a referral within 45 days of the screening.

Measure	Children with a visit	Children screened	Children with concern identified	Children referred	Children received service
Count	3,735	1671	127	19	9
Percent		45%	8%	15%	47%

B3. Outcome: Depression screening and referral

The measures for depression screening and referral were calculated using the following definitions for denominator and numerator.

Measure	Numerator	Denominator
Caregivers screened	Primary caregivers in the denominator that received a depression screen during the year.	All primary caregivers that received at least 1 home visit
Caregivers with concern identified	All primary caregivers who were served during the year that were screened for depression during the year and have a concern identified.	All primary caregivers who were served during the year that were screened for depression during the year
Caregivers referred	All primary caregivers in the denominator that received a referral during the year.	All primary caregivers that received at least 1 home visit and received a depression screen and have a concern identified.
Caregivers received service	All primary caregivers in the denominator that had a completed depression referral.	All primary caregivers that received at least 1 home visit and received a depression screen and had a concern identified and received a referral during the year.

Measure	Caregivers with a visit	Caregivers screened	Caregivers with concern identified	Caregivers referred	Caregivers received service
Count	4,202	2,244	756	225	102
Percent		53%	34%	30%	45%

B4. Outcome: Perinatal depression screening

The measures for perinatal depression screening were calculated using the following definitions for denominator and numerator.

Measure	Numerator	Denominator
Primary caregivers who enrolled prenatally and received a depression screen before the child's birth.	Primary Caregivers who are in the denominator who received a screening between the first visit and the child's birth.	Primary Caregivers who enrolled before the child's birth and had first visit before child's birth. Only caregivers open on or after child's birth are included.
Primary caregivers who enrolled prenatally and received a depression screen between the birth of the child and 3 months after the birth.	Primary Caregivers who are in the denominator who received a screening between the child's birth and 3 months after the child's birth.	Primary Caregivers who are enrolled before the child's birth and had first visit before child's birth and were open at 3 months after the child's birth.
Primary caregivers who were enrolled prenatally and received a depression screen between the child reaching 3 and 12 months.	Primary Caregivers who are in the denominator who received a screening between the 3 months and 1 day after the child's birth and 12 months after the child's birth.	Primary Caregivers enrolled before the child's birth and had first visit before child's birth and were open at 12 months after the child's birth.

Measure	Numerator	Denominator	Percent
Primary caregivers who enrolled prenatally and received a depression screen before the child's birth.	552	870	63%
Primary caregivers who enrolled prenatally and received a depression screen between the birth of the child and 3 months after the birth.	564	883	64%
Primary caregivers who were enrolled prenatally and received a depression screen between the child reaching 3 and 12 months.	314	555	57%

B5. Outcome: IPV screening and referral

The measures for IPV screening and referral were calculated using the following definitions for denominator and numerator.

Measure	Numerator	Denominator
Caregivers screened	Primary caregivers in the denominator that received an IPV screen (HARK, HARK-C, HITS, RAT, CTS).	Primary caregivers who reached 6 months of enrollment during the reporting year.
Caregivers with concern identified	Primary caregivers in the denominator that received a referral the day of screen.	Primary caregivers who received home visiting services during the year and were enrolled for at least 6 months that received an IPV screen.
Caregivers referred	Primary caregivers in the denominator that received a referral for IPV services during the reporting year.	Primary caregivers who received home visiting services during the year and were enrolled for at least 6 months that received an IPV screen and a concern identified with that screen.

Measure	Caregivers enrolled for 6 months	Caregivers screened	Caregivers with concern identified	Caregivers referred
Count	1,644	793	103	28
Percent	--	48%	13%	27%

B6. Outcome: Tobacco cessation referral

The measure for tobacco cessation referral was calculated using the following definitions for denominator and numerator.

Measure	Numerator	Denominator
Tobacco referral	Referred for tobacco cessation within 6 months of enrollment	Caregivers who were enrolled for 6 months where the anchor date (enrollment + 6 months) occurred during the year, who used tobacco, and were not enrolled in a tobacco cessation program.

Measure	Caregivers enrolled 6 months	Caregivers referred
Number	170	19
Percent	--	11%

Resources

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program (https://mchb.hrsa.gov/programs-impact/programs/home-visiting/maternal-infant-early-childhood-home-visiting-miechv-program)

Minn. Stat. § 145.87 (https://www.revisor.mn.gov/statutes/cite/145.87)

Minn. Stat. § 145A.145 (https://www.revisor.mn.gov/statutes/cite/145A.145)

Family Home Visiting Annual Report, 2023 (PDF) (https://www.health.state.mn.us/communities/fhv/fhvannualreport.pdf)

Healthy Outcomes from Positive Experiences (HOPE) framework (https://positiveexperience.org/)

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