

# Minnesota Department of Health Home Visiting Programs

December 2018

## Executive Summary

This publication provides information on home visiting programs supported by the Minnesota Department of Health (MDH) and funded with money administered by MDH. The publication describes the evidence-based home visiting models used in Minnesota, specifies funding amounts and the sources of those funds, outlines MDH responsibilities related to home visiting, and provides data on the number of people in the state who have received home visiting services.

## Home Visiting Described

The Minnesota Department of Health (MDH) describes home visiting as “a voluntary, home-based service ideally delivered prenatally through the early years of a child’s life . . . [that] provides social, emotional, health-related and parenting support and information to families, and links them to appropriate resources.”<sup>1</sup> Home visiting programs use visits by nurses, home visiting professionals, or trained personnel to support pregnant women and parents and connect them with appropriate medical and social services, promote child health and school readiness, and prevent child abuse, neglect, and juvenile delinquency.

## Home Visiting Models

### Evidence-Based and Evidence-Informed Models

When providing home visiting services, community health boards, tribal governments, and nonprofit organizations select and implement a home visiting service model based on the needs of their specific communities and the outcomes sought for the people who receive services. One way to characterize a home visiting model is the extent to which the model’s design and outcomes are based on and supported by research and evidence. A home visiting model may be evidence-based or evidence-informed. An evidence-informed model may be further characterized as based on promising strategies or as an emerging model. A model’s designation as evidence-based or evidence-informed may determine the funding available for programs using that model. Minnesota does not have definitions in state law for these terms. MDH uses definitions for these terms that are used and applied in social sciences.<sup>2</sup>

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<sup>1</sup> Minnesota Department of Health, “Minnesota Family Home Visiting Program Report to the Minnesota Legislature,” August 2018.

<sup>2</sup> Definitions for these terms were provided by MDH staff and are taken from Smoky Mountain Research Institute and the North Carolina Partnership for Children, “The Smart Start Resource Guide of Evidence-Based and

**Evidence-based model.** An evidence-based model is one that has repeatedly and consistently demonstrated desired outcomes through the application of scientific research methods. Characteristics of such a model include:

- clearly identified outcomes and the activities related to those outcomes;
- a manual or training that describes components of the service and how to administer it;
- clinical practices that are generally accepted as appropriate for children and parents receiving family support services;
- rigorous, randomized trials that are conducted in care or practice settings; demonstrate the model to be superior to an appropriate comparison practice; and the results of which are published in peer-reviewed literature;
- demonstration of a sustained effect;
- reliable, valid outcome measures that are consistently and accurately administered;
- the weight of the evidence of outcomes studies supporting the model's effectiveness;
- ongoing evaluation and continuous quality improvement activities; and
- adherence to the model in program implementation at the local level.

Specific state or federal funding initiatives use their own criteria and processes to determine whether a model is considered evidence-based. For instance, federal law governing the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program<sup>3</sup> requires 75 percent of federal MIECHV funding available to states, territories, and tribal governments for home visiting services to be awarded to home visiting programs that meet federal criteria for an evidence-based model.<sup>4</sup> These criteria require the model to:

- have been in existence for at least three years and be grounded in empirically based knowledge, be linked to program-determined outcomes, be associated with a national organization or institution of higher learning with comprehensive program standards, and have been proven to be effective through rigorous research;
- have undergone a review process under the federal Home Visiting Evidence of Effectiveness (HomVEE) project in the Department of Health and Human Services; and
- be designated by HomVEE as evidence-based.

As of October 2018, 46 home visiting models have been reviewed by the HomVEE project, and 20 were identified as evidence-based.<sup>5</sup> MIECHV funds administered by MDH must be used for home visiting programs that are designated as evidence-based by HomVEE.

**Evidence-informed model.** An evidence-informed home visiting model is guided by child development theory, practitioner experience, qualitative studies, and findings from basic research, and has written implementation guidelines, a strong logic model, and a history of demonstrating positive

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Evidence-Informed Programs and Practices," May 2015; and Ohio Department of Jobs and Family Services, "Evidence Based, Evidence Informed, Promising Practices and Emerging Program and Practices" (undated).

<sup>3</sup> The MIECHV program was established in March 2010 and is a federal program that provides funding to states, territories, and tribal governments for home visiting services in at-risk communities, as identified by each jurisdiction.

<sup>4</sup> U.S.C., title 42, sec. 711(d)(3).

<sup>5</sup> U.S. Department of Health and Human Services, Administration for Children & Families, Home Visiting Evidence of Effectiveness Model Reports, found at <https://homevee.acf/hhs.gov/models.aspx>.

results. Characteristics of such a model are similar to those of an evidence-based model, except more variation is permitted in the types of studies used to demonstrate model efficacy, the settings where those studies may be conducted, and how study results are published.

One category of evidence-informed model is a **model using promising practices** or a **model using promising strategies**. With this model, at least one study using a comparison group must have established the model's efficacy, with the results published in a formal, independent report. Another category, an **emerging model** or **model using emerging practices**, is a model evaluated with a less rigorous evaluation without a comparison group, or a model for which an evaluation is still in process.

## Evidence-Based Models Supported by MDH

Six evidence-based home visiting models supported by MDH are in use or being implemented in Minnesota: Early Head Start, Family Connects, Family Spirit, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers. All of these models have been designated as evidence-based by HomVEE. Table 1 (on page 4) provides an overview of the theoretical basis of the model, the populations it serves, the length and intensity of the program, and the staff who provide services.

## Family Home Visiting

MDH distributes TANF funds to pay for home visiting services to families at or below 200 percent of federal poverty guidelines and other families determined to be at risk for child abuse, child neglect, juvenile delinquency, or other risks. Funding is distributed to community health boards and tribal nations based on a formula. Services must be initiated prenatally whenever possible and must be targeted to families with adolescent parents, a history of alcohol or other drug abuse, a history of child or domestic abuse or other violence, reduced cognitive functioning, lack of knowledge of child growth and development, low resiliency, insufficient financial resources, a history of homelessness, employment barriers, a serious mental health disorder, or other risk factors. The first home visit must include a public health nurse assessment and must be conducted by a public health nurse. These home visiting services are governed by [Minnesota Statutes, section 145A.17](#).

**Table 1: Evidence-Based Home Visiting Models Supported by MDH**

Model	Theoretical Model	Population Served	Length and Intensity of Program	Staff Providing Services
Early Head Start	Emphasizes parents as child's first and most important relationship. Comprehensive, two-generation initiative aimed at enhancing infant and toddler development, strengthening families, and respecting unique development of young children.	Designed for low-income pregnant women and families with children between birth and age 3. Most women and families must be at or below the federal poverty level, and a portion of enrollment must be available to certain children with disabilities.	Women may be enrolled prenatally or after a child's birth, and services continue until a child's 3rd birthday. Services include weekly home visits and two group socialization activities per month.	Home visitor child development associate or comparable credential
Family Connects	Brings families, community agencies, and health care providers together through nurse home visits to provide all families in a service area with support and resources to promote the well-being of newborns.	Designed to serve all families with newborns 2 to 12 weeks old in a defined service area; families with identified needs receive further support.	Universal, short-term home visiting targeted to a geographic area. Initial visit when newborn is 2 to 12 weeks old, but may reach families earlier or later when special needs are present. Families with identified needs receive more visits and referrals to services.	Bachelor-prepared registered nurse with specialized model training
Family Spirit	Designed to promote child's development through helping parents gain knowledge in domains of physical, cognitive, social-emotional, and language learning and self-help. Incorporates traditional tribal teachings.	Designed for young Native American parents and their children; may also be used in non-Native populations with high parent and child health disparities.	Flexible design; recommended initiation at 28 weeks gestation, continuing through child's 3rd birthday.	Paraprofessional, professional, or nurse, with specialized model training
Healthy Families America	Rooted in belief that early, nurturing relationships are the foundation for life-long, healthy development. Interactions between providers and families are relationship-based, designed to promote positive relationships and healthy attachment, strengths-based, family-centered, culturally sensitive, and reflective.	Designed for parents facing challenges such as single parenthood, low income, history of adverse childhood experiences, substance abuse, mental health issues, or domestic violence. HFA sites select specific characteristics to determine the population to serve.	Families are enrolled prenatally to within 3 months after a child's birth; services provided until child is between ages 3 and 5.	Paraprofessional, professional, or nurse, with specialized model training
Nurse-Family Partnership	Shaped by theories of human attachment, human ecology, and self-efficacy; client-centered and driven by client-identified goals. Promotes health of the mother during pregnancy, care of the child, and the mother's personal growth and development.	Designed for first-time, low-income mothers and their children.	Pregnant women are enrolled early in pregnancy, first home visit no later than end of woman's 28th week of pregnancy; services available until child is age 2.	Bachelor-prepared registered nurse with specialized model training
Parents as Teachers	Based on the theory that affecting parenting knowledge, attitudes, behaviors, and family well-being impacts a child's developmental trajectory. Focuses on three areas: parent-child interaction, development-centered parenting, and family wellbeing.	Local affiliates select characteristics and eligibility of the population to be served. Eligibility criteria may include children with special needs, families at risk for child abuse, income-based criteria, teen or first-time parents, immigrant parents, or parents with low literacy or mental health or substance use issues.	Designed to serve families from pregnancy through a child's entry into kindergarten or through the kindergarten year. A local affiliate may choose to focus services on pregnant women and families with children between birth and age 3. Families can enroll at any point before age 5.	Paraprofessional, professional, or nurse, with specialized model training

Sources: HomVEE Model Overviews, found at <https://homvee.acf.hhs.gov/models.aspx>; model descriptions provided by MDH staff, December 11, 2018

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## Funding for Home Visiting

Community health boards and tribal governments pay for home visiting programs using federal, state, and local money and funds from other sources. MDH distributes state general fund money, federal Temporary Assistance to Needy Families (TANF) funds, and federal MIECHV funds as grants for home visiting programs in the state.

- State general fund appropriations for MDH home visiting programs are used to establish new programs or expand existing programs that use an evidence-based home visiting model. Separate general fund appropriations are used to establish new programs or expand existing programs that use the Nurse-Family Partnership (NFP) model.
- MDH distributes federal TANF funds using a formula, for family home visiting programs that serve families at or below 200 percent of federal poverty guidelines and families at risk, including risks for child abuse, child neglect, or juvenile delinquency.
- MDH distributes federal MIECHV Program money to home visiting programs that use an evidence-based home visiting model to target at-risk families. Communities receiving MIECHV funds are chosen using the results of a statewide needs assessment.
- Home visiting programs are also funded using medical assistance funds, grants from foundations, insurance reimbursement, and local tax dollars. These funds are not distributed by MDH. A community health board or tribal nation may also choose to use a portion of its state local public health grant or federal maternal and child health block grant (both of which are distributed by MDH) for home visiting.

**Table 2: Home Visiting Grants Administered by MDH, by State Fiscal Year**

Funding Source	Program	FY 16	FY 17	FY 18	FY 19
State General Fund	Nurse-Family Partnership Programs	\$575,000	\$2,000,000	\$2,000,000	\$2,000,000
	Evidence-Based Programs	0	0	5,580,000	5,580,000
Federal Funds	TANF	8,557,000	8,557,000	8,557,000	8,557,000
	MIECHV	10,059,000	8,838,000	7,745,000	8,435,000

Sources: MDH, "Minnesota Family Home Visiting Program Report to the Minnesota Legislature," August 2018; communication with MDH Budget Office, December 10, 2018.

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## Roles of MDH in Home Visiting

MDH distributes federal and state funds for home visiting services, through formulas and grants, to community health boards, tribal governments, and nonprofit organizations. The agency also provides consultation, continuous quality improvement, and technical support to grant recipients operating home visiting programs; develops and provides training for home visiting program staff; establishes reporting requirements for home visiting programs; and collects data on home visiting services funded with certain state or federal funds. MDH uses the data collected to report on the value of home visiting services; monitor performance at the state, regional, and county levels; identify gaps in services and

needs for additional training or technical assistance; and prioritize continuous quality improvement projects. Additionally, MDH administers a family home visiting advisory group to improve communication among state and local participants in the home visiting system.

## Availability of Home Visiting Services

As of 2018, 76 counties and eight tribal nations have evidence-based home visiting services provided in the jurisdiction of the county or tribe, with funding administered by MDH.<sup>6</sup>

Table 3 provides information on the number of persons served by home visiting programs in calendar years 2014, 2015, and 2016. These numbers:

- include all open clients in home visiting programs during the measurement year, as reported by local programs to MDH;
- do not include clients served by tribal home visiting programs funded through MDH;
- do not include clients who declined to share individual-level data with MDH; and
- may include clients served with funding sources other than grants administered by MDH.

**Table 3: Home Visiting Clients Served in Minnesota in Calendar Years 2014-2016**

Category	2014	2015	2016
Prenatal Clients	4,943	5,372	5,681
Parents/Other Caregivers	4,272	6,415	6,544
Infants and Children	9,504	11,063	12,067
Total	18,719	22,850	24,292

Source: MDH, "Minnesota Family Home Visiting Program Report to the Minnesota Legislature," August 2018.

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<sup>6</sup> Communication with MDH staff, November 26, 2018.