DEPARTMENT OF HEALTH

Family Home Visiting Strong Foundations Grant Report, Year Two (2024)

MAY 2025

Report contents

Introduction

2024 Strong Foundations report

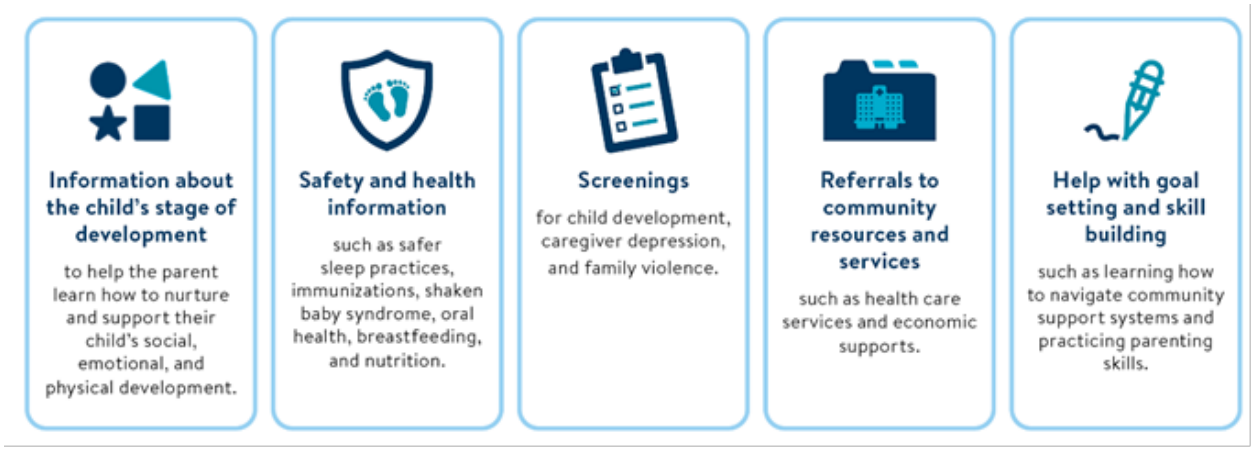
This report describes the key activities and outcomes for year two of the five-year Strong Foundations grant. It includes a description of:

- 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. $25 million is awarded annually 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 two of the Strong Foundations grant, 2024.

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 Family Home Visiting Annual Report, 2023 (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 visiting staff, representing a wide range of educational and lived experiences. To learn more about 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 participants 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 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 (including social-emotional development), caregiver depression, and intimate partner violence. Details of denominator and numerator calculations are provided in Appendices A1- A5. 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, 2024.
- Participants received services funded, in part or in whole 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 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, cognitive, self-help, and social interaction domains. Some screenings also assess gross and fine motor skills. Results for developmental screening and referral measures are displayed in Tables 1 and 2. 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 programs. Target children who had a concern identified prior to this reporting year and did not get re-screened this year are excluded from the measures.

Table 1. Developmental screening and referral, 2024

Measure	Children with a visit	Children screened	Children with concern identified	Children referred	Children received service
Count	3,828	2,170	388	124	63
Percent	--	**57%**	**18%**	**32%**	**51%**

Source: IHVE

Table 2. Social-emotional screening and referral, 2024

Measure	Children with a visit	Children screened	Children with concern identified	Children referred	Children received service
Count	4,117	1,840	96	27	14
Percent	--	**45%**	**5%**	**28%**	**52%**

Source: IHVE

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 depression (including postpartum depression) that should be shared with their health care provider.
- Referring caregivers to local community resources and helping to connect families with a warm hand-off.

Screening and referrals presented here include only those offered by 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 3 shows the depression screening and referral data for primary caregivers in 2024. The following depression screening tools were used: Edinburgh, PHQ-9, PHQ-4, and PHQ-2. Referrals are those to mental health services or the Mothers and Babies curriculum.

Table 3. Caregiver depression screening and referral measures, 2024

Measure	Caregivers with a visit	Caregivers screened	Caregivers with concern identified	Caregivers referred	Caregivers received service
Count	4,633	2,391	712	232	104
Percent	--	**52%**	**30%**	**33%**	**45%**

Source: IHVE

Perinatal depression screenings

Table 4 summarizes three perinatal depression screening measures specifically for caregivers who enrolled into the home visiting program prenatally. Among all Strong Foundations caregivers who were enrolled prenatally, 61% received a depression screen before the birth of their child, 64% were screened during their first three months postpartum, and 50% were screened when their child was 4 to 12 months of age.

Table 4. Perinatal depression screening for caregivers enrolled prenatally, 2024

Caregivers received a depression screen before the child's birth			Caregivers received a depression screen between the birth of the child and 3 months after the birth			Caregivers received a depression screen between the child reaching 3 and 12 months		
Numerator	Denominator	%	Numerator	Denominator	%	Numerator	Denominator	%
518	844	**61%**	562	873	**64%**	320	636	**50%**

Source: IHVE

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 caregivers in identifying and accessing social support (e.g., trusted family/friend).
- 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 5 shows the results of IPV screening and referral measures that were calculated for caregivers who were enrolled in home visiting for at least six months. There are several considerations to note when interpreting these measures. First, the percentage of caregivers who received a referral (26%) only includes those provided by a family home visitor; caregivers who participate in home visiting may receive 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, in 2024, 42% of all referrals for IPV were made without a screener.

Table 5. Strong Foundation grantee IPV screening and referral, 2024

Measure	Caregivers with a visit	Caregivers screened	Caregivers with concern identified	Caregivers referred
Count	1,617	829	108	28
Percent	--	**51%**	**13%**	**26%**

Source: IHVE

Strong Foundations participant characteristics

The Strong Foundations grant served 5,055 families across 86 counties in 2024. Participant demographic characteristics and household risk factors for primary caregivers and target children are described in the following section. See Appendix B for full counts and percents for these characteristics, including caregiver age and military service.

Caregiver characteristics

Table 6. Strong Foundations caregiver ethnicity, 2024

Ethnicity	Total	Strong Foundations percent
Other	2,876	57%
Hispanic or Latino/a/x	1,810	36%
Client declines	175	3%
Somali	131	3%
Hmong	69	1%

Source: IHVE

**Totals counts may be above total caregivers as multiple ethnicities may be reported; they are represented in each respective ethnicity category.*

Table 7. Strong Foundations caregiver race, 2024

Race	Total	Strong Foundations percent
White	2,473	49%
Black or African American	1,055	21%
Client described	688	14%
Client declines	483	10%
American Indian or Alaska Native	284	6%
Asian	279	6%
Native Hawaiian or Other Pacific Islander	22	0%

Source: IHVE

**Totals counts may be above total caregivers as multiple races may be reported; they are represented in each respective race category.*

Table 8. Strong Foundations other caregiver characteristics, 2024

Under 25 Years	Employed	Insured	High school completion
32%	42%	82%	65%

Source: IHVE

Table 9. Strong Foundations household risk factors, 2024

Characteristic	Count	Percent	Percent missing
Low income	2,036	63%	36%
Pregnant and under 21	354	7%	0%
Food insecurity	963	38%	30%
Currently experiencing homelessness	216	4%	1%
Household has a child with developmental delays or disabilities	488	11%	14%
Participant has a history of child abuse or neglect or has had interactions with child welfare services	1,206	37%	36%
History of substance abuse	561	14%	21%
Experience with incarceration	216	6%	28%

Source: IHVE

**Across grantees, percent missing ranges from 1-36%. Percent missing includes clients who decline to answer and those who did not report. All were removed from the denominator; missing data can artificially inflate or deflate percentages.*

Child characteristics

Table 10. Strong Foundations target child ethnicity, 2024

Ethnicity	Total	Strong Foundations percent
Other	2,616	55%
Hispanic or Latino/a/x	1,726	37%
Client declines	162	3%
Somali	142	3%
Hmong	81	2%

Source: IHVE

**Totals counts may be above total children as multiple ethnicities may be reported; they are represented in each ethnicity.*

Table 11. Strong Foundations child race, 2024

Race	Total	Strong Foundations percent
White	2,473	49%
Black or African American	1,055	21%
Client described	688	14%
Client declines	483	10%
American Indian or Alaska Native	284	6%
Asian	279	6%
Native Hawaiian or Other Pacific Islander	22	0%

Source: IHVE

**Totals counts may be above total children as multiple races may be reported; they are represented in each respective race.*

Table 12. Strong Foundations language spoken in the child's home, 2024

Languages
English
Spanish
Other language

Source: IHVE

Table 13. Strong Foundations child age, 2024

Child Age	Total	Percent
< 1 year	1,945	41%
1-2 years	2,309	49%
3-4 years	350	7%
5-6 years	110	2%
> 6 years	4	0%

Source: IHVE

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. Here, grantees were asked to rank their top strategies in supporting the following topics:

- Enrolling families prenatally
- Achieving target caseload
- Promoting reflective supervision
- Facilitating advisory committees
- Engaging with CQI
- Supporting screenings and assessments
- Supporting community of practice participation
- Informing early childhood systems coordination

The tables in following sections display results from these rankings. Each grantee indicated their top, second, and third strategy from a set of responses compiled from a previous progress monitoring report. To capture both the top strategies as well as the range of responses, we calculated weighted scores by weighting the first choice with a factor of one, the second choice with a factor of 0.5, and the third choice with a factor 0.25. The top three choices are presented for all Strong Foundations grantee.

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.

Strategies to promote referrals, recruitment, and enrollment

Strong Foundation grantees shared any new or innovative strategies that support family referrals, recruitment, and enrollment in the year-end progress monitoring report. Below is a summary of reported new or innovative strategies.

Community partnership and relationship development

Grantees continually build community partnerships through participating in local events, interacting with partner agencies, and facilitating regional communities of practice.

"We hosted a Family Wellness Resource Fair, we focused on outreach to providers and invited them to host resource tables at the event. This event served as a valuable platform for raising awareness about our services and foster collaboration with community partners."

"We are currently exploring other ways to reach the target population for referrals/recruitment such as having PHNs meet with potential clients in-person at the WIC clinic."

"We initiated a regional MECSH group with neighboring counties, bringing together other nurses working in MECSH to share resources and strategies for increasing referrals and engagement. This collaboration allows us to leverage collective expertise and enhance our efforts to connect with families and build stronger community ties."

Home visiting agency infrastructure

Grantees continually update their programs and to better recruit and refer families.

"We had been discussing the possibility of having a "lead home visitor" position. We wanted to offer more leadership and career advancement within the home visitor role. The lead home visitor would take the lead on relationships with other community sites and maintain contacts to strengthen recruitment efforts and ensure more involvement in community events."

"Local clinic has shifted from an opt-in to an opt-out process. We have also attempted to connect with the other local clinic to discuss the possibility of this process."

"We have added a new staff person who has a background in Indigenous foods and medicines. We will eventually be making our own natural remedies and introducing Indigenous foods via meal kits. We hope this leads to a healthier lifestyle for our families and program retention."

Outreach materials and approaches

Grantees engage more families by translating materials, increasing accessibility, updating materials, and by using social media to distribute home visiting agency information.

"Developed an outreach flyer insert with pictures of our two home visitors with a message to families to promote a higher response rate to our phone calls. We hope that by seeing our faces, it will entice families to be more willing to talk with us about the home visiting program."

"We have utilized digital advertising, program informational video, outreach meetings with partner agencies, billboards, and model outreach materials."

"…started sending out handwritten cards for current client's birthdays, milestone achievements, and thank you's to clients for participating in the program."

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 14 displays the number of newly enrolled families each quarter, overall and prenatally, and the percentage of prenatal enrollment. In 2024, Strong Foundations grantees' prenatal recruitment goals ranged from 5% to 100% of newly enrolled families, with an average of 53%.

Table 14. Prenatal enrollment percentage of new families, 2024

Measure	Q1	Q2	Q3	Q4	Cumulative
Prenatal enrollment	340	315	312	233	1,200
Newly enrolled clients	579	561	566	443	2,149
Prenatal enrollment %	59%	56%	55%	53%	56%

Sources: IHVE, Progress Monitoring Report

Grantees ranked their top choices for partners that strengthen and promote prenatal enrollment. Table 15 includes the top three choices for all Strong Foundations grantees.

Table 15. Strategies to recruit prenatally ranked by grantees

Strong Foundations grantees
1. WIC
2. Healthcare systems and payers
3. Community resources

Source: Progress Monitoring Report

Target caseload

Strong Foundations grantees steadily increased their caseloads during years one and two of the grant. Table 16 displays the total households as reported in the Strong Foundations quarterly report along with the percentage of target caseload met.

Table 16. Strong Foundations caseload by quarter, 2024

Measure	Q1	Q2	Q3	Q4	2024
Total households	3,134	3,329	3,432	3,309	13,204
Target caseload	3,335	3,335	3,335	3,335	13,340
Percent	106%	100%	97%	101%	101%

Source: Quarterly Report

Grantees ranked their top choices for strategies that are most impactful to increase or achieve target caseload. Table 17 includes the top three choices for all Strong Foundations grantees.

Table 17. Strategies impacting target caseload ranked by grantees

Strong Foundations grantees
1. In-person interactions
2. Strong referral partnerships
3. Staff retention

Source: Progress Monitoring Report

Promoting health for all

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.[12]

During the grant application period, each 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.

Resources and supports to meet the needs of families

In the fall of 2024, Strong Foundations grantees were asked what resources and supports would better help them adapt and individualize their programs to meet the needs of families. Below is a summary of their responses and individual grantee examples.

Language supports (translation and interpretation) and cultural resources

Offering in-person interpretation, translating curriculum and resources (e.g., webinars, videos), and offering other culturally specific services would help reduce language and cultural barriers.

"home visitors who are able to speak the language of the families we serve. Language support is very important to ensure that families are participating in lesson and discussions."

"… we are consistently looking for ways to provide deep cultural relevance and responsiveness in our programming."

"A cultural resource to be able to incorporate more cultural traditions into the lessons I am providing and to be able to start doing group lessons and activities. A resource to incorporate crafts, cooking, spiritual practices, etc."

"Having model specific home visiting materials and resources available in all languages that families speak or read."

Skill building and developing community partnerships

Continued professional development would allow grantees to support families in their communities and further develop relationships with community partners.

"Regular access to a social worker to answer complex questions when resource needs arise."

"Tips and tricks from other home visiting programs that can be similar to a menu of options for home visitors."

"Staff training for learning about the many issues they perceive daily. FASD, Drug related training, Curriculums, Doula training, Suicide Prevention, Traumatic Brain injuries, Domestic abuse, MMIR, case management, ...teenage pregnancy... trauma focused work, engaging fathers and couples counseling."

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. Grantees ranked their top choices for strategies that are most impactful to promote reflective supervision. Table 18 includes the top three choices for all Strong Foundations grantees.

Table 18. Strategies to promote reflective supervision ranked by grantees

Strong Foundations grantees
1. Plan for consistent, protected time
2. Open-door policy
3. Organizational and leadership buy-in and training and expertise

Source: Progress Monitoring Report

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. Grantees ranked their top choices for strategies that are most impactful to facilitating advisory committees. Table 19 includes the top three choices for all Strong Foundations grantees.

Table 19. Strategies to facilitate advisory committees ranked by grantees

Strong Foundations grantees
1. Variety of members of the community
2. Plan for specific topics
3. In-person and virtual participation

Source: Progress Monitoring Report

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

Continuous quality improvement

Continuous quality improvement (CQI) is a systematic approach to identifying and addressing areas of improvement in a program. It involves regularly collecting and analyzing data, implementing changes, and evaluating impact, with the goal of enhancing effectiveness and efficiency.

CQI is essential for family home visiting, allowing for ongoing assessment and refinement of services to ensure they meet the evolving needs of families, resulting in more impactful interventions. CQI 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. Grantees ranked strategies that are most impactful to engage with CQI. Table 21 includes the top three choices for all Strong Foundations grantees.

Table 21. Ranked factors that are most impactful to engage with CQI

Strong Foundations grantees
1. Using home visitor and staff feedback
2. Collaborating with MDH family home visiting staff
3. Model-specific CQI efforts

Source: Progress Monitoring Report

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. Grantees ranked their top choices for strategies that are most impactful to support screening and assessments. Table 22 includes the top three choices for all Strong Foundations grantees.

Table 22. Strategies to support screening and assessments ranked by grantees

Strong Foundations grantees
1. Reports, checklists, schedules
2. Team meetings
3. Staff trainings

Source: Progress Monitoring Report

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, 88% of grantees reported participating in at least one CoP in 2024. Grantees ranked their top choices for partners that strengthen and promote CoP participation. Table 23 includes the top three choices for all Strong Foundations grantees.

Table 23. Strategies that support CoP participation ranked by grantees

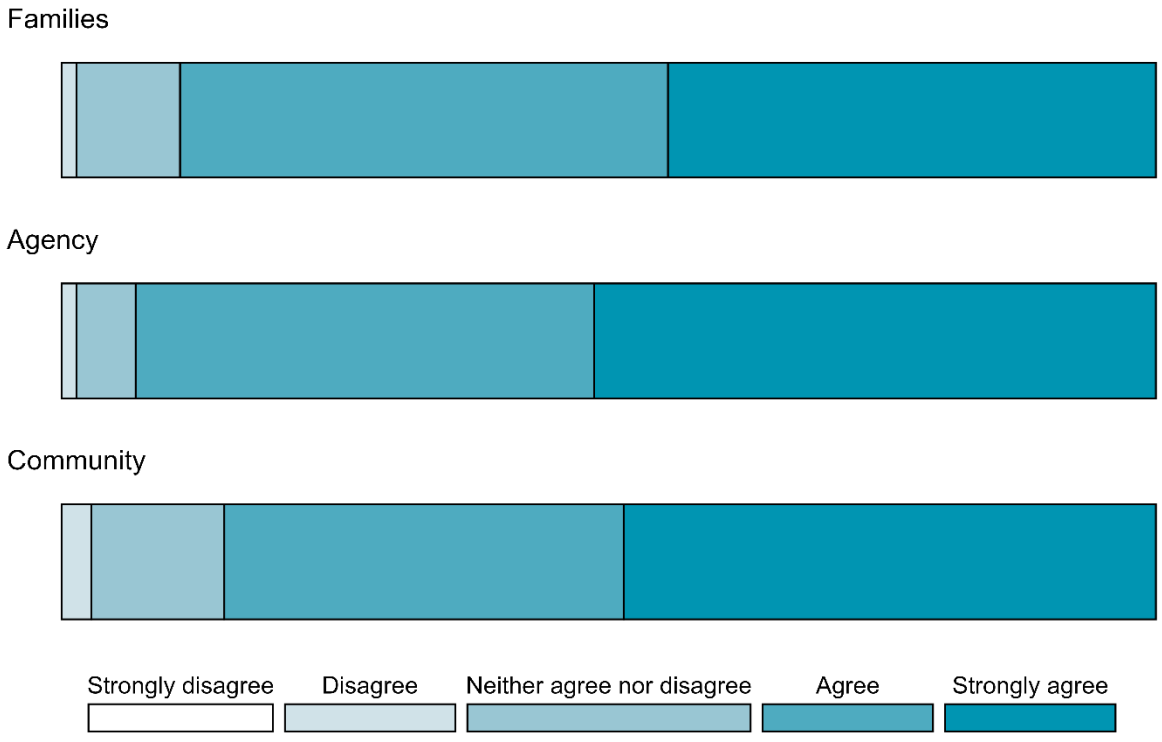
Strong Foundations grantees
1. Include various types of CoPs
2. Apply CoP content and materials
3. Increase options to find and access CoPs

Source: Progress Monitoring Report

Model satisfaction

Grantees rated how well the models they implement met the needs of their families, agency, and communities. Results from all grantees are shown in Figure 1.

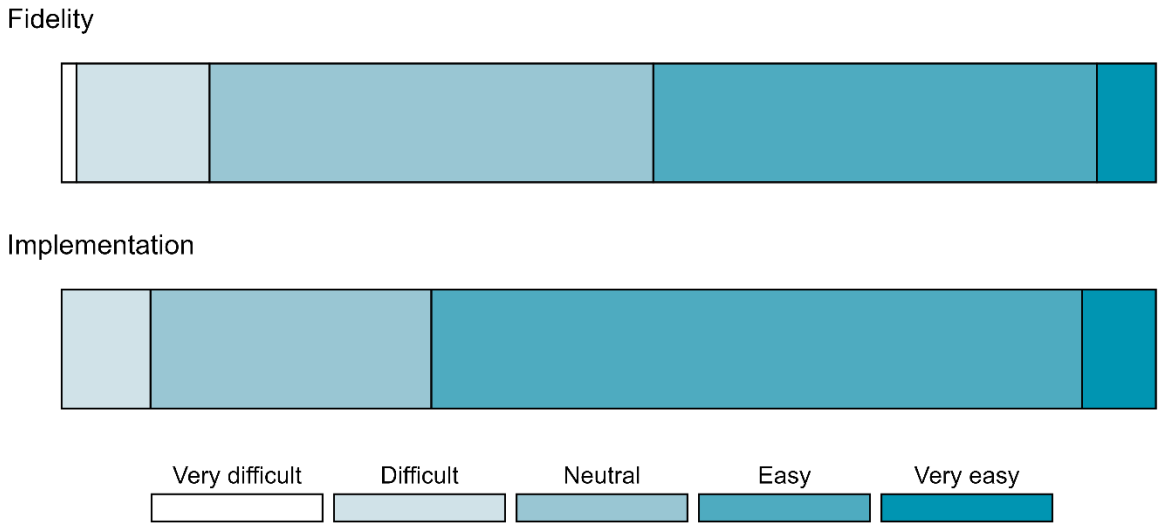
Figure 1. How well does your model meet the needs of your families, agency, and community?



Source: Progress Monitoring Report

Grantees rated the ease of implementation of their models as well and the ease in meeting model fidelity requirements. Results from all grantees are shown in Figure 2.

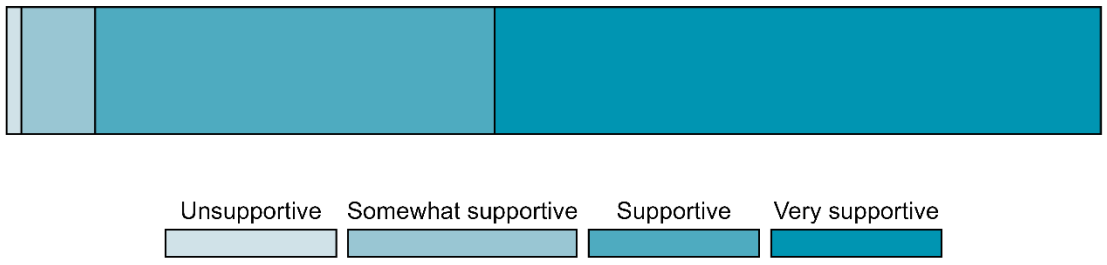
Figure 2. Ease of model implementation and meeting model fidelity



Source: Progress Monitoring Report

Grantees rated the support they receive from MDH in implementing their models and results for all grantees are summarized in Figure 3.

Figure 3. How supportive is MDH in your agency's model implementation?



Source: Progress Monitoring Report

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. Figure 4 displays the types of professional development that staff members participate in, and Figure 5 shows the types of trainings that staff are interested in attending.

Figure 4. What types of professional development do your staff members participate in?

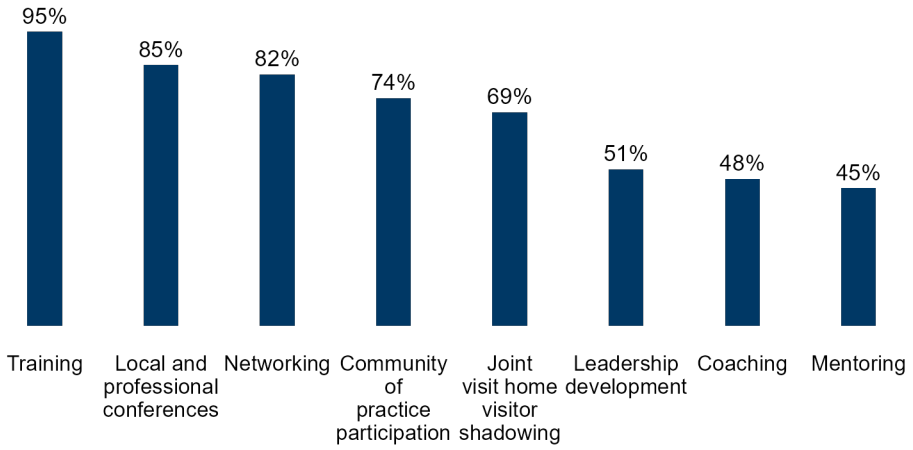
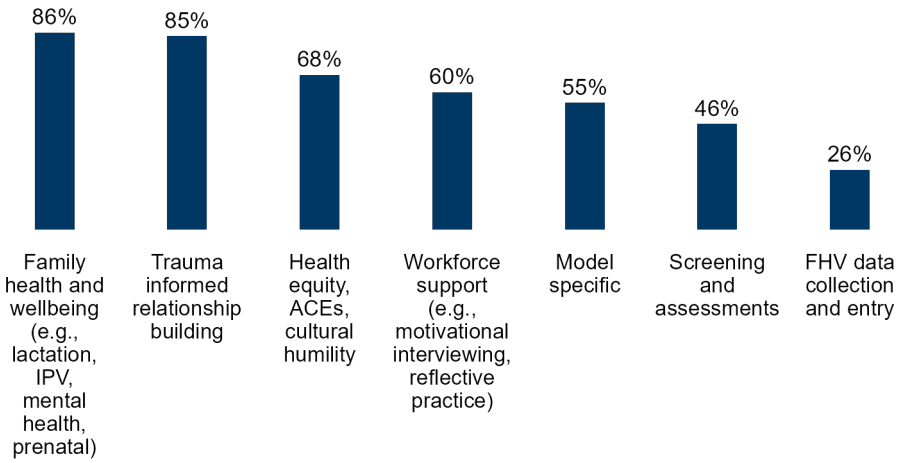


Figure 5. What trainings/training topics is your staff interested in seeing offered?



Top training topics of interest for 2024-2025

1. Family health and wellbeing (e.g., lactation, IPV, mental health, prenatal)
2. Trauma-informed/relationship building
3. Health equity (e.g., ACEs, cultural humility)

Top technical assistance topics of interest for 2024-2025

1. Recruitment and enrollment
2. Target caseload
3. Advancing health equity

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 24, home visitor staffing vacancies varied between 11-17% across quarters in 2024. Figures 6, 7, 8, and 9 display the degree to which staff recruitment and retention are issues, along with a list of the biggest issues that affect staff recruitment and/or retention. Table 24 describes several strategies that Strong Foundations grantees use to promote staff recruitment and retention.

Table 24. Percent of Strong Foundations grantees with staff vacancies, 2024

Position	Q1	Q2	Q3	Q4
Home visitors	17%	11%	11%	13%
Supervisors	5%	4%	2%	1%
Other staff	1%	1%	1%	0%

Source: Quarterly Report

Figure 6. To what degree is staff *recruitment* an issue with your agency?

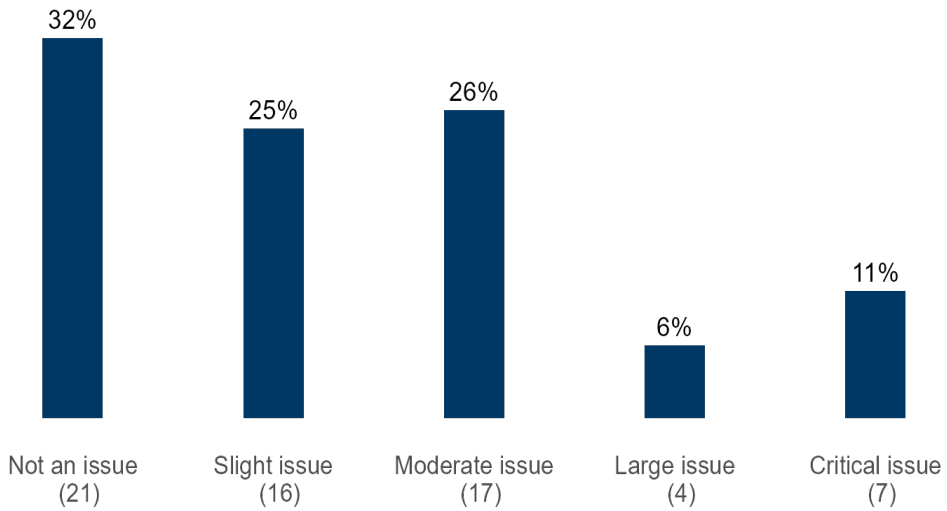


Figure 7. What are the biggest issues affecting staff *recruitment*?

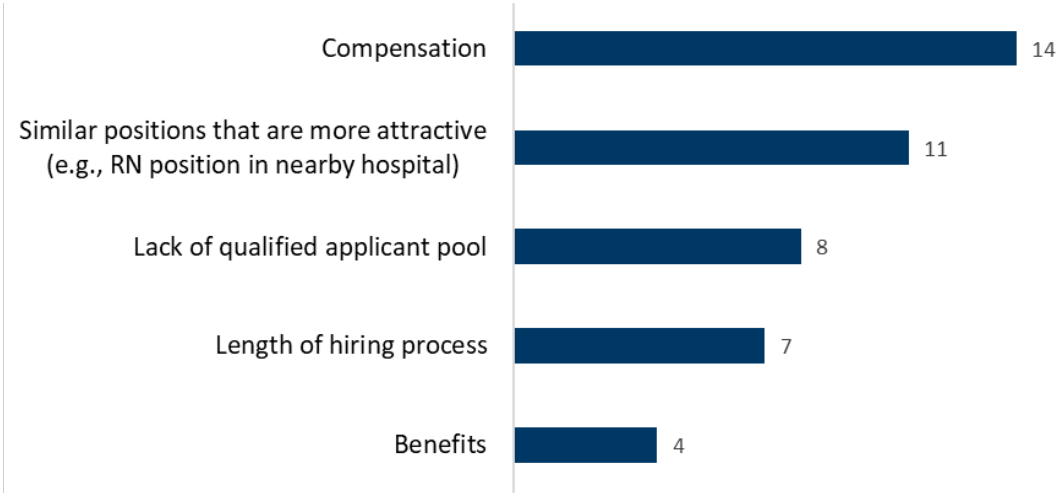


Figure 8. To what degree is staff *retention* an issue with your agency?

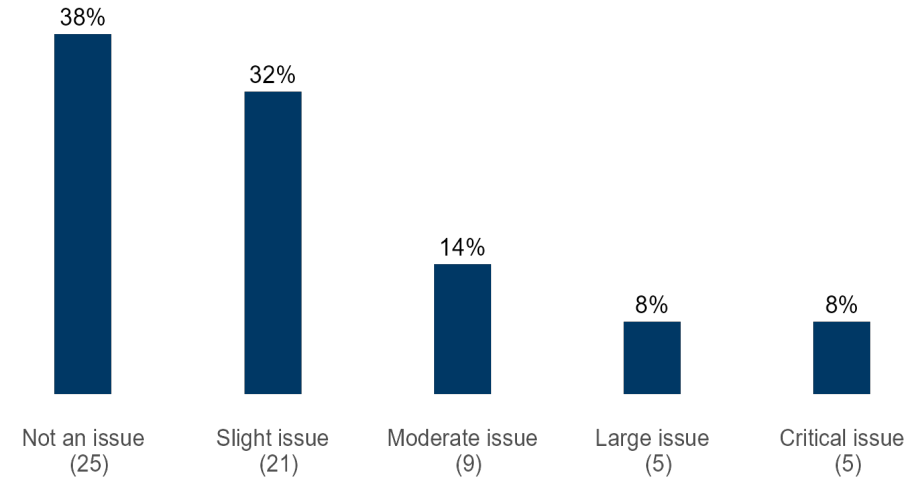


Figure 9. What are the biggest issues affecting staff *retention*?

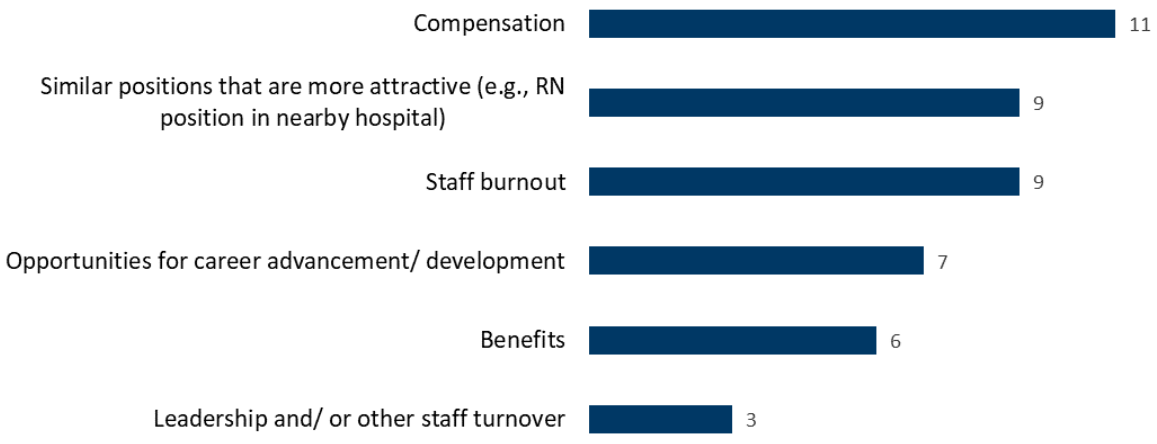


Table 25. Strong Foundations grantees' use of strategies that promote staff recruitment and retention

Strategy	Current strategy	Not interested/ not applicable to our program	Not sure	Planned strategy	Would like to learn more
Use performance reviews as professional development tool	89%			2%	9%
Supervisors/ leadership provide informal feedback on home visitor performance	92%	2%		5%	2%
Support staff to set and track professional development goals	75%	5%	3%	11%	6%
Provide peer mentors	46%	15%	5%	11%	23%
Use annual performance reviews for salary and promotion decisions	46%	38%	5%	6%	5%
Collect home visitor input in setting policies (e.g., staff safety, physical work environment, service improvement, hiring decisions)	80%	3%	3%	8%	6%
Support professional development that leads to credentials and or degrees	62%	12%	5%	8%	14%
Provide job flexibility and autonomy	94%		2%	2%	3%
Provide leadership opportunities for home visitors	71%	5%	3%	9%	12%
Provide opportunities for home visitors to meet informally for staff building	77%	5%	2%	9%	8%
Recognize outstanding staff recognition (e.g., thank you notes to award ceremony)	60%	6%	6%	17%	11%

Source: Progress Monitoring Report

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.

Successful early childhood systems work relies on collaborative relationship building with partners. Grantees ranked their top choices for strategies to support early childhood systems coordination. Table 26 includes the top three choices for all Strong Foundations grantees.

Table 26. Strategies to support early childhood systems coordination ranked by grantees

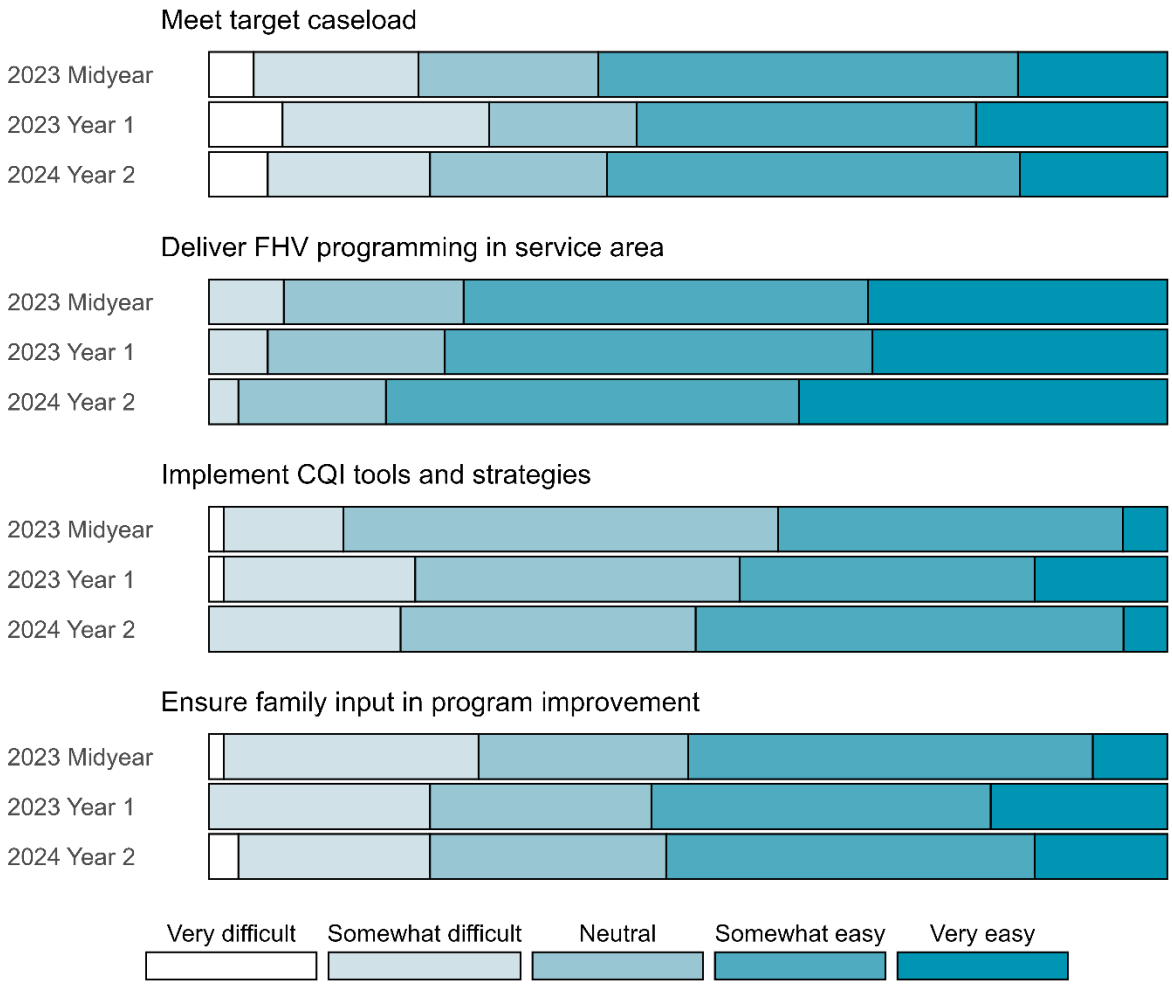
Strong Foundations grantees
1. Screening, referral, and co-intervention
2. Community outreach
3. Meeting and advisory board coordination

Source: Progress Monitoring Report

Grant agreement compliance

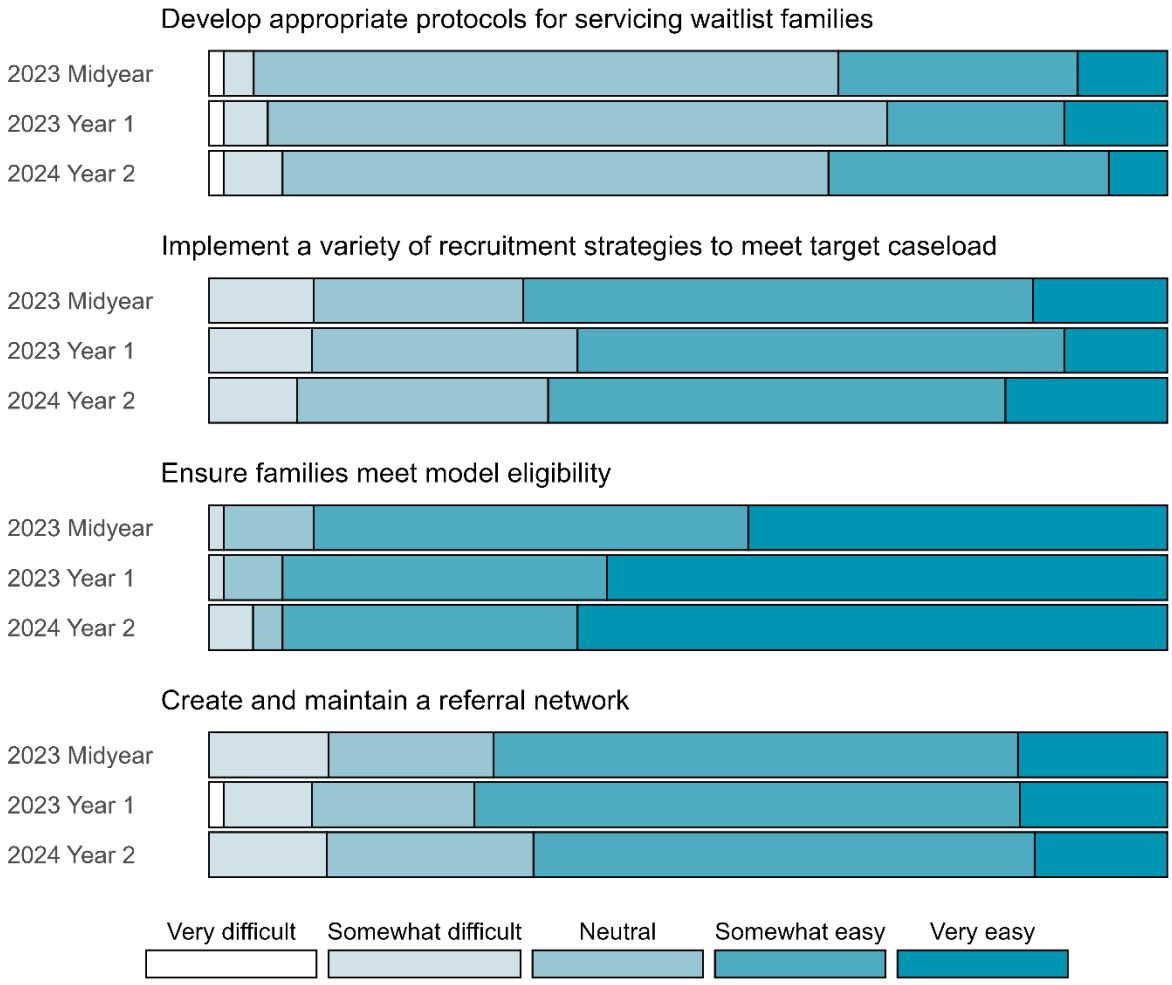
Grant compliance indicates that a grantee can ensure their promised deliverables are achieved. Demonstrating compliance is an important indicator in securing and maintaining grant funding. This includes fiscal responsibilities, work plan deliverables, and progress/data reporting. The figures below display Strong Foundations grantees' self-reported ease or difficulty in meeting key grant activities over three time periods (midyear 2023, year-end 2023, and year-end 2024).

Figure 10. Strong Foundations grantees' ease in implementing grant requirements outlined in workplan: Part I



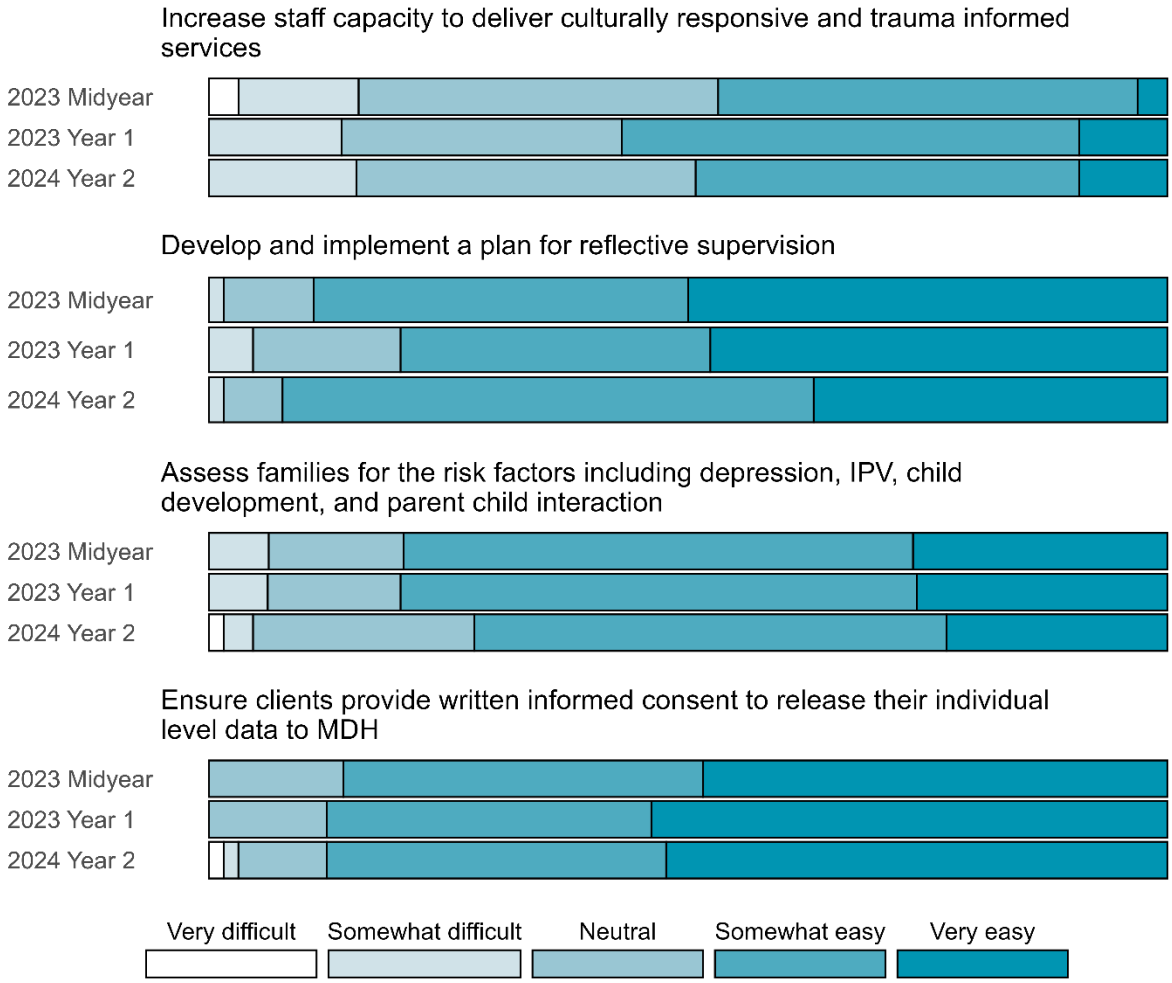
Source: Progress Monitoring Report

Figure 11. Strong Foundations grantees' ease in implementing grant requirements outlined in workplan: Part II



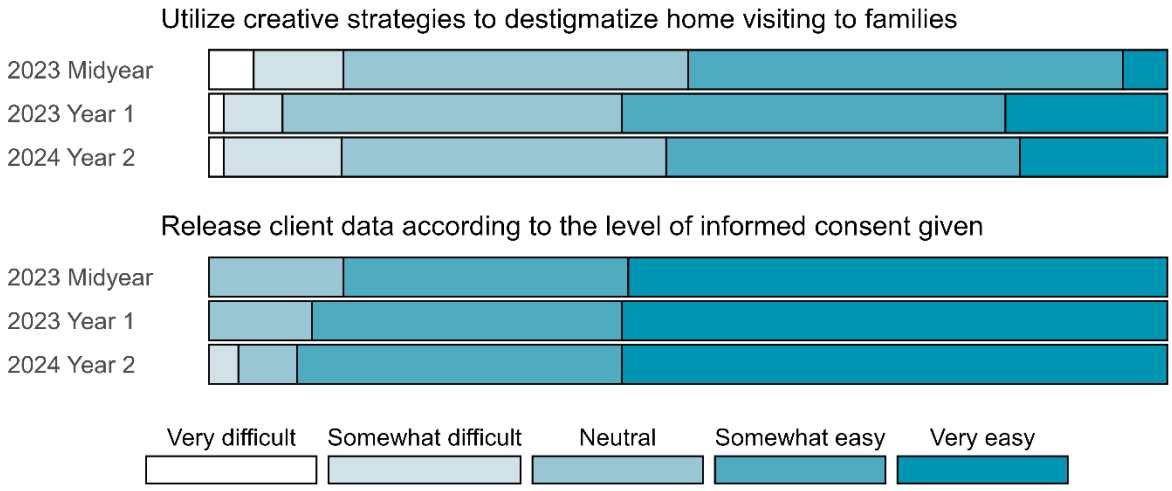
Source: Progress Monitoring Report

Figure 12. Strong Foundations grantees' ease in implementing grant requirements outlined in workplan: Part III



Source: Progress Monitoring Report

Figure 13. Strong Foundations grantees' ease in implementing grant requirements outlined in workplan: Part IV



Source: Progress Monitoring Report

Appendix

Appendix A: Outcome measure descriptions

A1. 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, Brigance, DRDP).	Target children who received home visiting during reporting year and were between 1-66 months during the reporting year. Target children that had a concern identified prior to this reporting year are excluded if they did not get re-screened this 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 1-66 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 screening. Referrals include Early Intervention/Part C, Early Childhood Family Education, Early Childhood Mental Health, Head Start/Early Head Start, School Readiness or Preschool program, Home Visitor Support for Child Development, Primary Care Provider, Health Care Specialist Provider, Mental Health Services, or Other Provider or Community Service.	Target children who received home visiting during reporting year and were between 1-66 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 within 45 days of the referral.	Target children who received home visiting during reporting year and were between 1-66 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.

A2.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 1-66 months during the reporting year. Target children that had a concern identified prior to this reporting year are excluded if they did not get re-screened this 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 1-66 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. Referrals include Early Intervention/Part C, Early Childhood Family Education, Early Childhood Mental Health, Head Start/Early Head Start, School Readiness or Preschool program, Home Visitor Individualized Support for Child Development, Primary Care Provider, Health Care Specialist Provider, Mental Health Services, or Other Provider or Community Service	Target children who received home visiting during reporting year and were between 1-66 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 within 45 days of the referral	Target children who received home visiting during reporting year and were between 1-66 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.

A3. 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. Referrals include referral to mental health services or referral to other provider or community service where "Mothers and Babies" is specified in the referral type.	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.

A4. 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.

A5. 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.

Appendix B. Participant demographic characteristics

B1. Caregiver age

Caregiver age	Total	Percent
<= 17	120	2%
18-19	242	5%
20-21	459	9%
22-24	810	16%
25-29	1,335	26%
30-34	1,123	22%
35-44	902	18%
45-54	52	1%
55-64	10	0%
>= 65	2	0%

B2. Caregiver employment

Caregiver employment	Total	Percent
Not employed	2,778	55%
Employed full-time (30+ hours/week)	1,177	23%
Employed part-time (less than 30 hours/week)	940	19%
Unknown/did not report	110	2%
Declines to answer	50	1%

B3. Caregiver insurance status

Caregiver insurance	Total	Percent
Medicaid or CHIP	3,621	72%
Unknown/did not report	512	10%
Private or other	496	10%
No Insurance coverage	421	8%
Tricare	5	0%

B4. Caregiver education

Caregiver education	Total	Percent
High school diploma or GED	1,681	33%
Less than high school diploma	1,162	23%
Some college or post high school training	707	14%
Bachelor's degree or higher	548	11%
Declines to answer	346	7%
Unknown/did not report	218	4%
Associate's degree	194	4%
Technical training or certificate	156	3%
Other	43	1%

B5. Household miliary service

Household miliary service	Total	Percent
No	4,347	86%
Unknown/did not report	577	11%
Yes	131	3%

B6. Languages spoken in child's household

Language	Total	Percent
English	2,992	63%
Spanish	1,251	27%
Other language	181	4%
Somali	90	2%
Karen	70	1%
Hmong	51	1%
Oromo	28	1%
Arabic	19	0%
Amharic	18	0%
Burmese	7	0%
Client declines to answer	7	0%
Nepalese	4	0%

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)

Minnesota Statutes, section 145.87 (https://www.revisor.mn.gov/statutes/cite/145.87)

Minnesota Statutes, section 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)

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