DEPARTMENT OF HEALTH

Family Home Visiting Strong Foundations Grant Report, Year Three (2025)

MAY 2026

Contents

Introduction

2025 Strong Foundations report

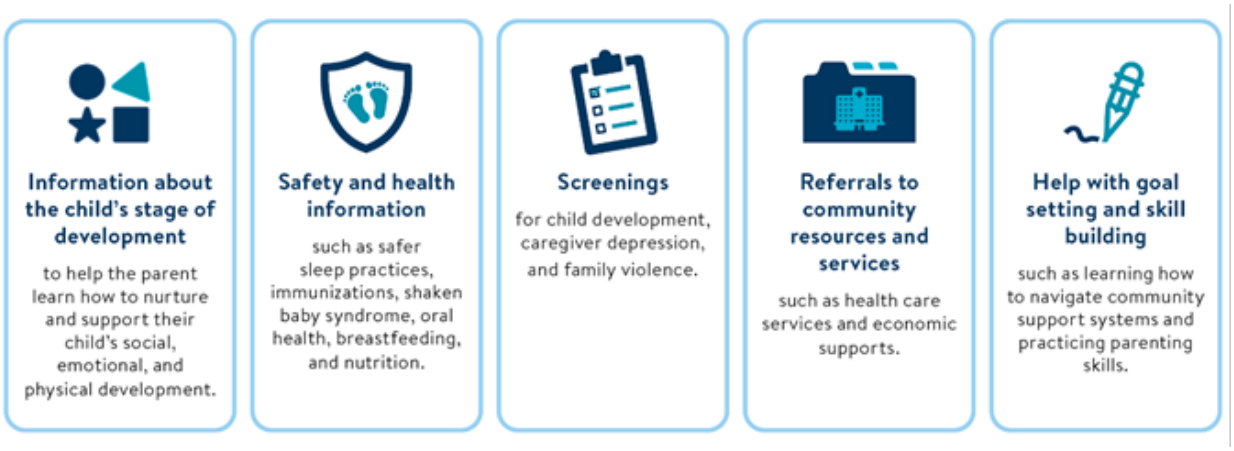
This report describes the key activities and outcomes for year three of the five-year Strong Foundations grant. It includes a description of:

- Family home visiting and its benefits.
- 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.[i,ii,iii]

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 three of the Strong Foundations grant, 2025.

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

In 2025, 66 grantees (45 community health boards (CHBs), 17 nonprofit organizations, and 4 Tribal nations) are funded through the Strong Foundations program. Together, these local implementing agencies serve 85 counties and four Tribal nations. The Strong Foundations grant has a collective caseload of approximately 3,700 families. An additional 500 families participate in short-term evidence-based home visiting.

The organizations that implement long-term evidence-based home visiting 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 383. The mean and median caseload across Strong Foundations grantees is 56 and 36 respectively.

In the Strong Foundations program, there are the full-time equivalent of over 170 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, 2025.
- Participants received services funded, in part or entirely, 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 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. Appendix A includes full details of measure calculations. The screening percentages for 2023-2025 for all Strong Foundations grantees are displayed in Figures 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, 2025

Measure	Children with a visit	Children screened	Children with concern identified	Children referred	Children received service
Count	3,847	2,367	396	127	50
Percent	--	**62%**	**17%**	**32%**	**39%**

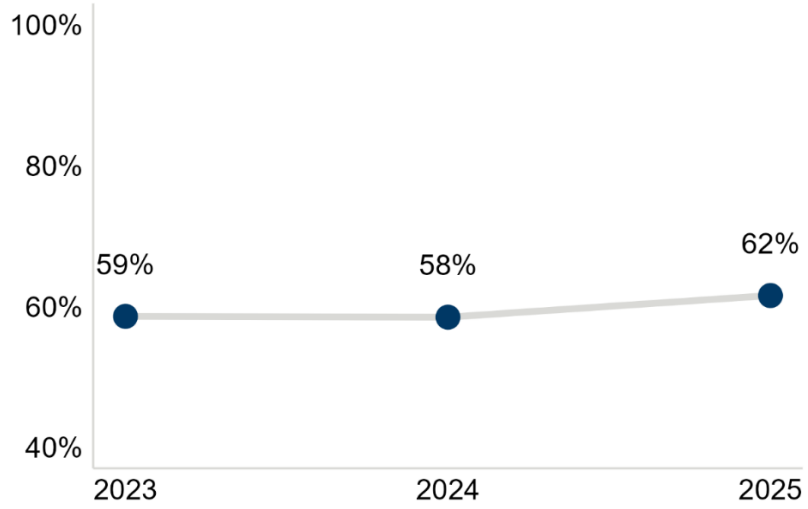
Source: IHVE

Table 2. Social-emotional screening and referral, 2025

Measure	Children with a visit	Children screened	Children with concern identified	Children referred	Children received service
Count	4,136	1,998	119	26	11
Percent	--	**48%**	**6%**	**22%**	**42%**

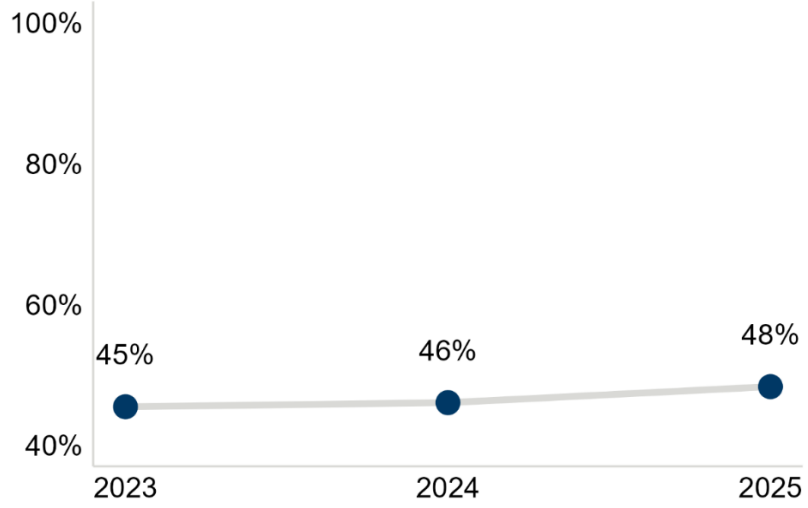
Source: IHVE

Figure 1. Developmental screening trends, 2023-2025



Source: IHVE

Figure 2. Social emotional screening trends, 2023-2025



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.[iv,v] Children's early exposure to maternal depression may impede brain development by changing brain architecture[vi] and stress response systems.[vii] Fortunately, improvements in maternal mental health are associated with reductions in mental health disorder symptoms in their children.[viii] Screening caregivers for depression can effectively support their mental health by facilitating referrals for potential diagnosis and treatment.[ix]

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 healthcare provider.
- Referring caregivers to local community resources and helping to connect families with a warm hand-off.

Screening assessments and referrals presented here include only those offered by family home visiting. Caregivers may receive screenings and referrals 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

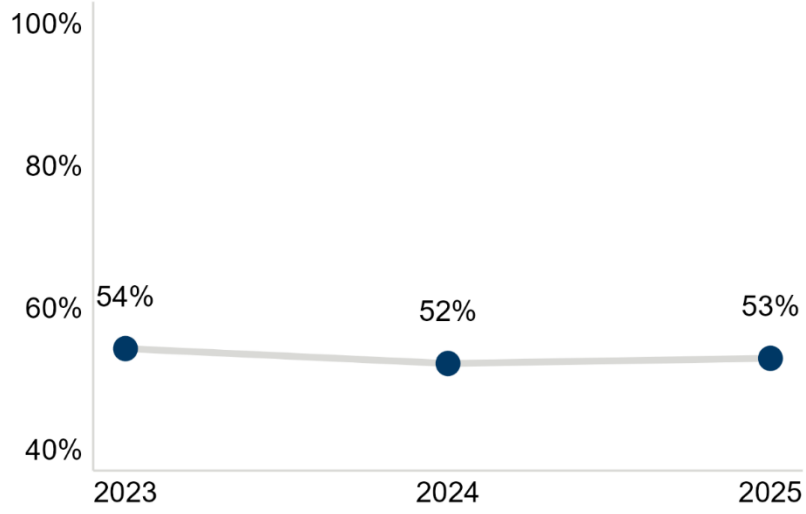
Table 3 shows the depression screening and referral data for primary caregivers in 2025. Appendix A includes full details of measure calculations. The screening percentages for 2023-2025 for all Strong Foundations grantees and individual grantees are displayed in Figure 3.

Table 3. Caregiver depression screening and referral measures, 2025

Measure	Caregivers with a visit	Caregivers screened	Caregivers with concern identified	Caregivers referred	Caregivers received service
Count	4,766	2,517	704	296	137
Percent	--	**53%**	**28%**	**42%**	**46%**

Source: IHVE

Figure 3. Caregiver depression screening trends, 2023-2025



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, 67% received a depression screen before the birth of their child, 73% were screened during their first three months postpartum, and 57% were screened when their child was 4 to 12 months of age.

Table 4. Perinatal depression screening for caregivers enrolled prenatally, 2025

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	%
583	870	**67%**	581	792	**73%**	304	531	**57%**

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.[x]

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.[xi] Because of the trust developed between home visitors and caregivers, home visitors have a unique opportunity to connect caregivers to resources when IPV occurs.

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 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 (29%) 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 2025, 67% of all referrals for IPV were made without a screener.

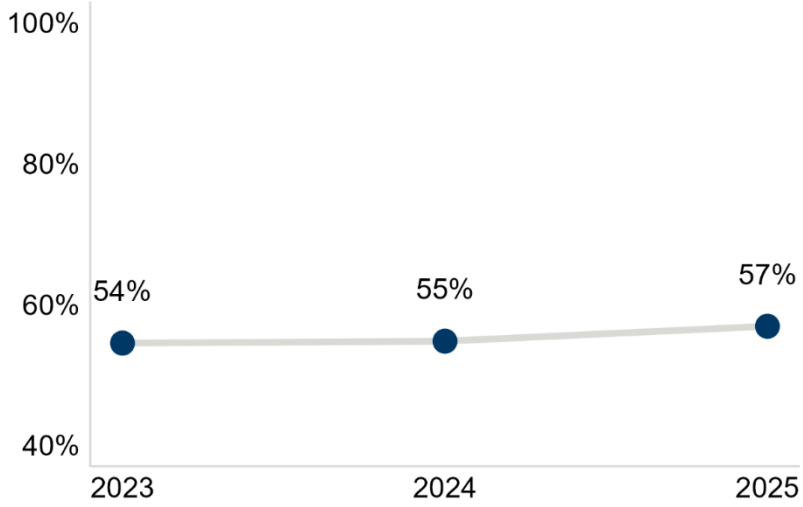
The screening percentages for 2023-2025 for all Strong Foundations grantees and individual grantees are displayed in Figure 4.

Table 5. IPV screening and referral, 2025

Measure	Caregivers with a visit	Caregivers screened	Caregivers with concern identified	Caregivers referred
Count	1,315	748	75	22
Percent	--	**57%**	**10%**	**29%**

Source: IHVE

Figure 4. IPV screening trends, 2023-2025



Source: IHVE

Strong Foundations participant characteristics

The Strong Foundations grant served 5,111 families across 85 counties in 2025. Note that these are limited to families that consent to share data with MDH. 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. Caregiver ethnicity

Ethnicity	Total	Strong Foundations Percent
Other	2,864	56%
Hispanic or Latino/a/x	1,854	36%
Client declines	195	4%
Somali	119	2%
Hmong	87	2%

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. Caregiver race

Race	Total	Strong Foundations Percent
White	2,465	48%
Black or African American	1,056	21%
Client described	717	14%
Client declines	477	9%
American Indian or Alaska Native	298	6%
Asian	284	6%
Native Hawaiian or Other Pacific Islander	21	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. Other caregiver characteristics

Under 25 Years	Employed	Insured	High school completion
30%	42%	85%	66%

Source: IHVE

Table 9. Household risk factors

Characteristic	Count	Percent	Percent missing
Low income	2,002	61%	36%
Pregnant and under 21	281	5%	0%
Food insecurity	1,078	37%	29%
Currently experiencing homelessness	180	4%	1%
Household has a child with developmental delays or disabilities	486	11%	13%
Participant has a history of child abuse or neglect or has had interactions with child welfare services	1,191	35%	34%
History of substance abuse	515	13%	22%
Experience with incarceration	217	6%	28%

Source: IHVE

Note. Across Strong Foundations grantees, percent missing ranges from 1-36% across characteristics. Percent missing includes clients who decline to answer and those who did not report. These clients were removed from the denominator. Missing data can artificially inflate or deflate percentages.

Child characteristics

Table 10. Target child ethnicity

Ethnicity	Total	Strong Foundations Percent
Other	2,557	54%
Hispanic or Latino/a/x	1,813	38%
Client declines	163	3%
Somali	132	3%
Hmong	98	2%

Source: IHVE

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

Table 11. Child race

Race	Total	Strong Foundations Percent
White	2,465	48%
Black or African American	1,056	21%
Client described	717	14%
Client declines	477	9%
American Indian or Alaska Native	298	6%
Asian	284	6%
Native Hawaiian or Other Pacific Islander	21	0%

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

Table 12. Language spoken in the child's home

Languages
English
Spanish
Other language

Source: IHVE

Table 13. Child age

Child Age	Total	Percent
< 1 year	1,895	40%
1-2 years	2,329	49%
3-4 years	407	9%
5-6 years	116	2%
> 6 years	8	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 midyear and year-end progress monitoring reports, grantees responded to a set of closed- and open-ended questions for each implementation topic and results from the report are included in each section.

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 supporting 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 Foundations grantees shared 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.

Innovative approaches to outreach to traditional referral partners

Grantees described activities and updates, for example electronic referrals, that improve outreach to traditional referral partners.

"Our current focus is on creating a short, interactive presentation for some of our programs that are under-referring that includes real life examples of how we work with families enrolled at this time."

"We also expanded medical provider outreach efforts in 2025, including delivering Family Home Visiting informational baskets to local delivery hospitals, OB/GYN clinics, Family Practice, and pediatric providers to strengthen referral pathways and awareness of services."

Relational engagement

Grantees describe innovations around communication, developing community events, and creating participant recognition activities to improve recruitment and enrollment.

"Hosted a [M]other's & Father's Day event in June for all FHV participating families, and plan to continue this annually."

"Working with internal communications team on FHV outreach and advertising -Started 'Moms walking group'."

Client centered outreach

Grantees describe innovations in outreach including updating social media, improving ease for self-referrals and referrals from family and friends.

"Updates to video social media campaign for self referrals; self referrals now 2nd most common referral source. Relationships with ECFE drop-in programs to support chest/breastfeeding and do outreach about HV program. Ongoing WIC outreach increasing in 2026. Outreach to Vietnamese cultural community from birth records."

"We have continued to use the brochure with the flyer handout with the nurse's pictures and phone numbers to provide clients with a visual picture of who will be calling them or visiting them in the MECSH program."

"Lastly, we've been encouraging families to refer folks who they know (some already do this on their own)."

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.

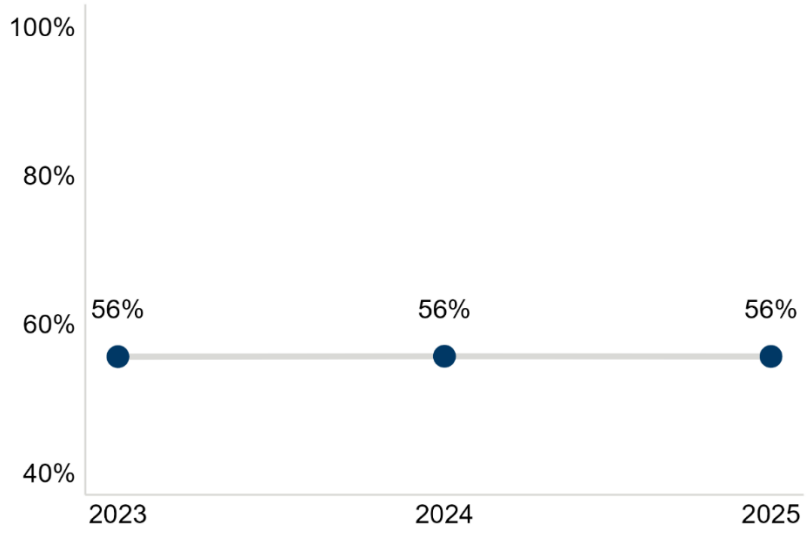
Table 14 displays the number of families newly enrolled in family home visiting each quarter, both overall and prenatally, as well as the percentage of prenatal enrollment. In 2025, Strong Foundations grantees' prenatal recruitment goals ranged from five to 100% of newly enrolled families, with an average of 51%. Figure 5 depicts the prenatal enrollment percentage by implementation year for all Strong Foundations grantees.

Table 14. Prenatal enrollment percentage of new families, 2025

Measure	Q1	Q2	Q3	Q4	Cumulative
Prenatal Enrollment	331	321	339	262	1,253
Newly Enrolled Clients	609	560	579	505	2,253
Prenatal Enrollment %	54%	57%	59%	52%	56%

Source: IHVE

Figure 5. Prenatal enrollment of new families by implementation year



Source: IHVE

Target caseload

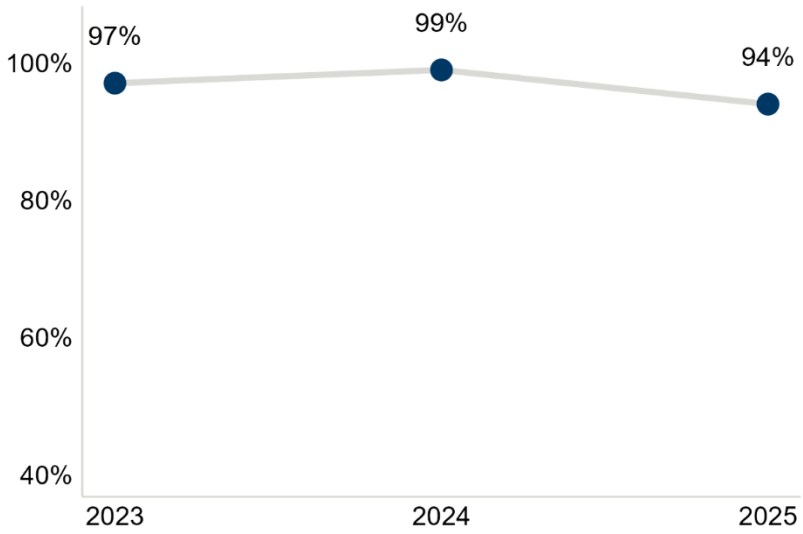
Strong Foundations grantees consistently served over 90% of their caseloads during the first three years of the grant. Table 15 displays the total households as reported in the Strong Foundations quarterly report along with the percentage of target caseload met. Figure 6 depicts the average target caseload for all Strong Foundations grantees across years.

Table 15. Strong Foundations caseload by quarter

Measure	Q1	Q2	Q3	Q4	2025
Total Households	3,469	3,492	3,507	3,507	--
Target Caseload	3,742	3,742	3,728	3,728	--
Percent	93%	93%	94%	94%	94%

Source: Quarterly Report

Figure 6. Average percent of target caseload by implementation year



Source: IHVE

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. Below is a summary of reported new or innovative strategies.

Strategies to promote reflective supervision

Tools

Grantees use various tools such as the Facilitated Attuned Interactions (FAN): a parent interaction tool, as part of their reflective supervision practice.

"We use a structured supervision task list to consistently address parent-child interactions and intentionally follow up on every CHEERS [parent-child interaction] assessment, regardless of concerns, to support ongoing reflection and strengths-based discussion."

"Split teams into smaller groups"

Training staff in reflective supervision

Grantees train staff, or contract staff, or both to run reflective supervision.

"To strengthen reflective supervision, our Public Health Nurse Lead completed I and II trainings RIOS [reflective supervision training] in 2025 and has begun providing reflective supervision to staff. This internal capacity has allowed for increased accessibility for staff."

"Supervisor plans to obtain IMH [Infant Mental Health] Endorsement Level II in 2026."

Prioritization of reflective supervision

Grantees share how prioritizing reflective supervision supports staff well-being and professional growth.

"[W]e intentionally schedule dedicated time for these sessions, ensuring they remain a protected space for professional growth."

"We continue to plan ahead and have consistent times scheduled and offer an open-door policy to staff."

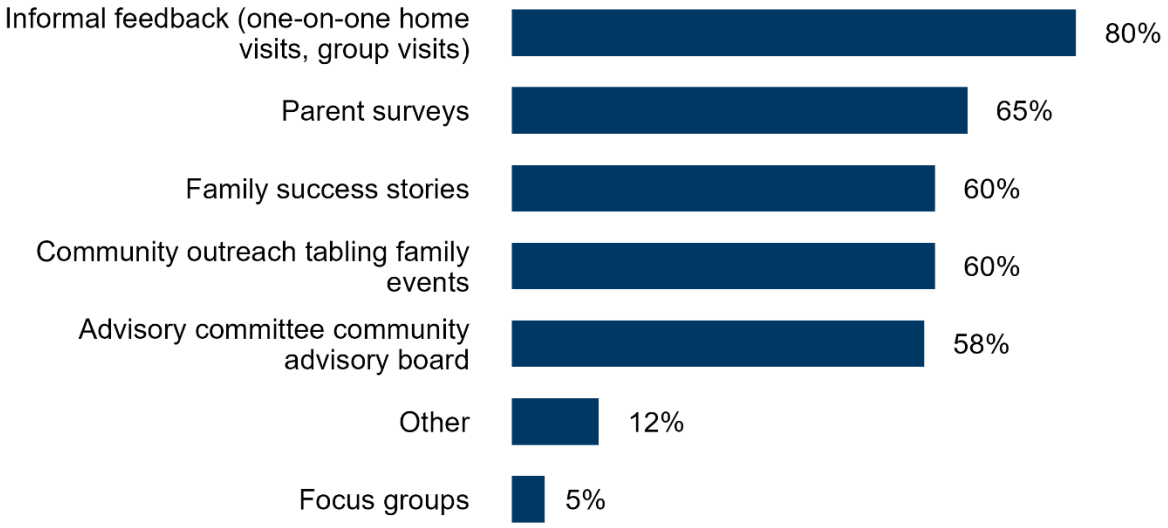
"Our team places a strong emphasis on reflective supervision and has implemented intentional strategies to ensure its consistency and impact. We dedicate protected time for these sessions, recognizing their critical role in supporting staff well-being and professional development. Guided by a highly trained Infant Mental Health Specialist, Home Visitors engage in meaningful, in-depth reflective discussions that enhance both the quality of practice and the level of support provided. This approach fosters growth, resilience, and a deeper reflection on the work we do with families."

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 December of 2025, Strong Foundations grantees shared different ways they gathered information about family voice, as shown in Figure 7. Most grantees collect this information from informal feedback (80%). Grantees that chose the other category described using model specific feedback tools and informal feedback. Gathering information about family voice is a first step in promoting health equity by ensuring that the program work is centered around the interests of families.

Figure 7. How are you gathering information about family voice



Source: Progress Monitoring Report

Applying family voices

Grantees shared how they applied information from family voices and how they reflect this feedback in their family home visiting program. Below is a summary of this information.

Involving all family members

Grantees shared the importance of involving all family members to meet the needs of the whole family.

"Based on CAB feedback, we've reminded staff that transition plans should not focus only on the transition for the parent but also involve the child(ren) involved since their relationship with the family home visitor has spanned the child's entire life."

"Our agency has … included more education and activities for Dads because of family request; we have also used their voice to include most information for families on other services (car seats)."

Centering family needs

Grantees shared how they updated language to center families and their unique needs.

"…having the flexibility to do real time problem-solving as crisis needs arise around their lived experiences."

"Updates to satisfaction surveys to make language clearer/simpler (most recent). Ongoing emphasis on offering interpreters or bilingual staff when families prefer a language other than English."

"Most recently, we have incorporated family voice into how we do annual assessments (DV [domestic violence], Chemical Health, and Mental Health screenings). Many of these questions can make families feel uncomfortable, particularly if they have something to disclose, and many parents worry about being judged, shamed, denied services, or referred to CPS [child protective services].

Based on feedback from families, we have implemented the following practices: 1) We explain to families why we are collecting this data, what we are going to do with it, where and how we will store it, and who will have access to it. Families have shared that they are more willing to engage in these screeners when they view them as goal-planning documents that no-one but their home visitor will ever see the details of, rather than diagnostic assessments that will result in referrals to services families may not trust. 2) Presenting these assessments as something that we do with everyone in order to improve our program also helps. Families have shared that they like knowing they are not being singled out and that they like knowing that their participation is something that could help other families."

Developing goals and improving programs

Grantees described how they use family voice to develop goals and inform program improvements.

"Family feedback is discussed during supervision and team meetings and used to inform ongoing program improvements. Feedback is used to build more resources, adjust approaches to reflect family needs and preferences."

"Family Voice feedback is taken into consideration when we develop program goals. We monitor performance and quality improvement in our home visiting program through a dashboard and complete annual program evaluations that are shared with various community leaders such as commissioners and our advisory committee. Family success stories and survey results are collected and included in these dashboards and agency evaluations."

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 or service and involves regularly collecting and analyzing data, implementing changes, and evaluating their impact, with the goal of enhancing effectiveness and efficiency.

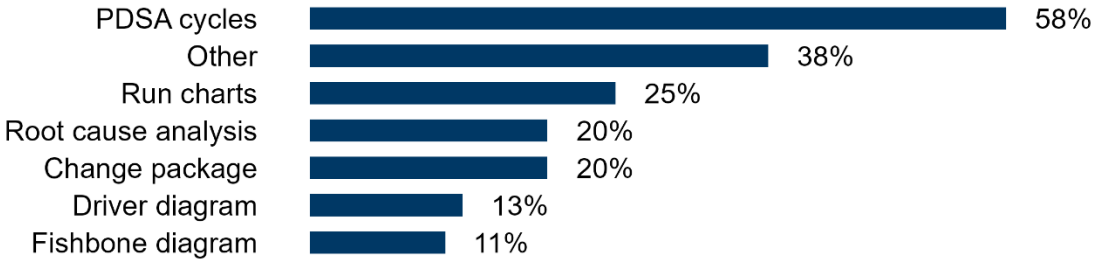
CQI is essential for public health family home visiting because it allows for ongoing assessment and refinement of services to ensure they meet the evolving needs of families, resulting in more effective and impactful interventions. This approach fosters data-driven decision-making, promotes innovation,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

Several agencies participated in CQI efforts to reduce missing data and improve parent-child interaction tool completion. Additionally, in 2025, family home visiting agencies used a CQI lens to try new and innovative things to improve their programs. Agencies wanted to prioritize CQI and therefore implemented having more regular and organized planning meetings, with a focus on keeping CQI practical, family-centered, and culturally responsive. Other ideas tried throughout the year included using electronic health record systems to their full potential to save staff time and supporting families with two home visitors which aided in family retention.

Family home visiting agencies also identified some challenges for engaging in CQI activities. Agencies shared that they often find that they have limited time and staff capacity to prioritize CQI, with it particularly being difficult to involve home visitors. Agencies also identified finding discrepancies in their data and having multiple different data systems being challenges.

In July 2025, Strong Foundations grantees shared the different tools they use for CQI with over half of grantees (57%) using Plan-Do-Study-Act cycles to engage in CQI (see Figure 8).

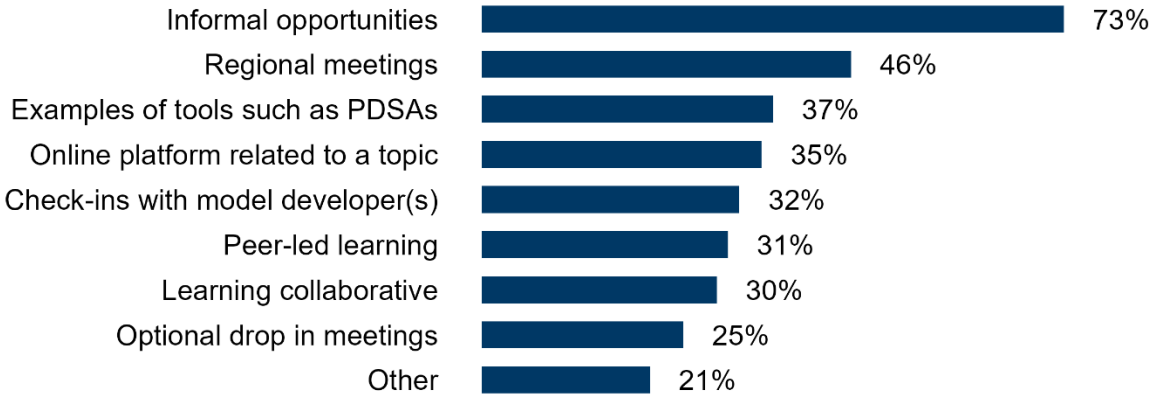
Figure 8. What tools do you regularly use to engage in CQI?



Source: Progress Monitoring Report

Grantees shared different strategies for engaging regularly in CQI and many found informal opportunities and regional meetings useful for their agencies as shown in Figure 9.

Figure 9. What strategies are useful for your agency to engage regularly in CQI?



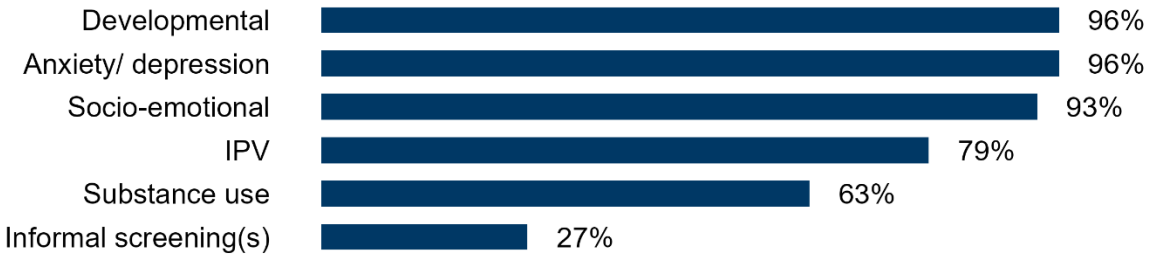
Source: Progress Monitoring Report

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. Most Strong Foundations grantees administer developmental and socio-emotional screenings for children as well as anxiety/ depression and intimate partner violence (IPV) screenings for caregivers as seen in Figure 10.

Figure 10. Percent of programs that administer different types of screenings



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. Below is a summary of reported new or innovative strategies.

Strategies to promote communities of practice

Collaboration

Grantees use COPs to collaborate across Minnesota and with other states.

"We have regular meetings of the local advisory committee, monthly internal case consults with the broader Metro Family Services team, we attend live webinars offered by PAT [Parent as Teachers] and Rapid Response Home Visiting, there are monthly PAT supervisor meetings, and sometimes we make it to the MDH CQI sessions."

"Starting 2026 these meetings will also include PAT representatives from other States."

Shared ownership

COPs contribute to shared ownership and collaboration among grantees.

"We actively solicit feedback from staff to ensure topics are relevant, timely, and aligned with key components of current work. This is accomplished through multiple strategies, including surveys, facilitated feedback activities, and leveraging our [planning workgroup]. These efforts not only inform planning but also foster shared ownership and continuous improvement within the CoP."

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.

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. Table 16 shows that home visitor staffing vacancies ranged from 18-27% across 2025.

Table 16. Percent of Strong Foundations grantees with staff vacancies, 2025

[blank]	Q1	Q2	Q3	Q4
Home Visitors	27%	21%	18%	18%
Supervisors	3%	6%	3%	1%
Other Staff	3%	4%	3%	3%

Source: Quarterly Report

Early childhood system coordination

Services for pregnant and parenting families should integrate healthcare, social services, and community programming to promote a holistic approach of family support. Service coordination promotes overall family wellbeing 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. Below is a summary of reported new or innovative strategies.

Strategies to promote early childhood system coordination

Structural changes

Grantees described structural changes that will lead to innovations in early childhood system coordination.

"The Early Childhood Coordinator is being transferred to Public Health and will be working in the FHV Division and she is working on referral system through Bridge to Benefits [online screening tool]"

Developing accessible resources

Grantees described innovations around developing accessible resources to improve coordination.

"We have enhanced early childhood systems coordination by strengthening partnerships across departments and with external agencies, streamlining referral processes, and using collaborative meetings to ensure families can access needed resources efficiently. These efforts help create a more connected, responsive, and family-centered system of support"

"We have a shared resource list that home visitors create. Staff do rely on each other for the updated information. The resources in our community are constantly changing. We want to encourage more of this shared learning in 2026."

Beyond community and family engagement

Grantees described innovative community activities that improve early childhood systems coordination.

"We have partnered with various 'not for profit' organizations who are willing to take on our participants for events which we only have little or no funds we need to contribute.

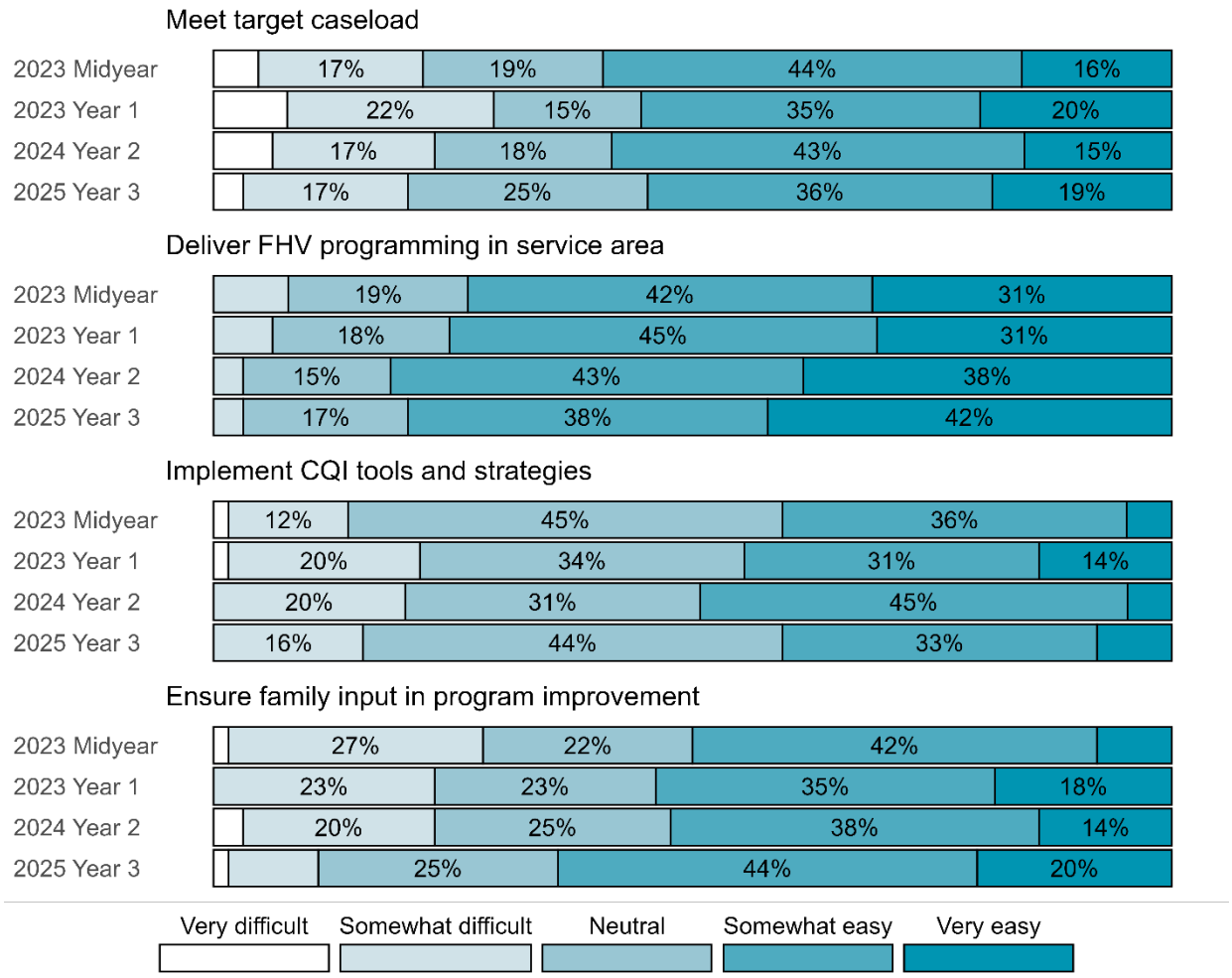
"Families were able to attend a librarian led story time, learn about how to read books with their children, apply for a library card, and bring home free books in their home language(s)."

"We have seen significant success with our partnership, in the currently developing, Family Resource Centers across our counties. These centers serve as hubs for families, offering coordinated and co-located services that streamline access and reduce barriers. We are able to partner to offer Family Home Visiting connections like … group activities, Lactation Connection breastfeeding support with Public Health Nurses, alongside WIC services, and other essential family resources-all under one roof. This collaborative model not only enhances convenience for families but also strengthens relationships among providers."

Grant agreement compliance

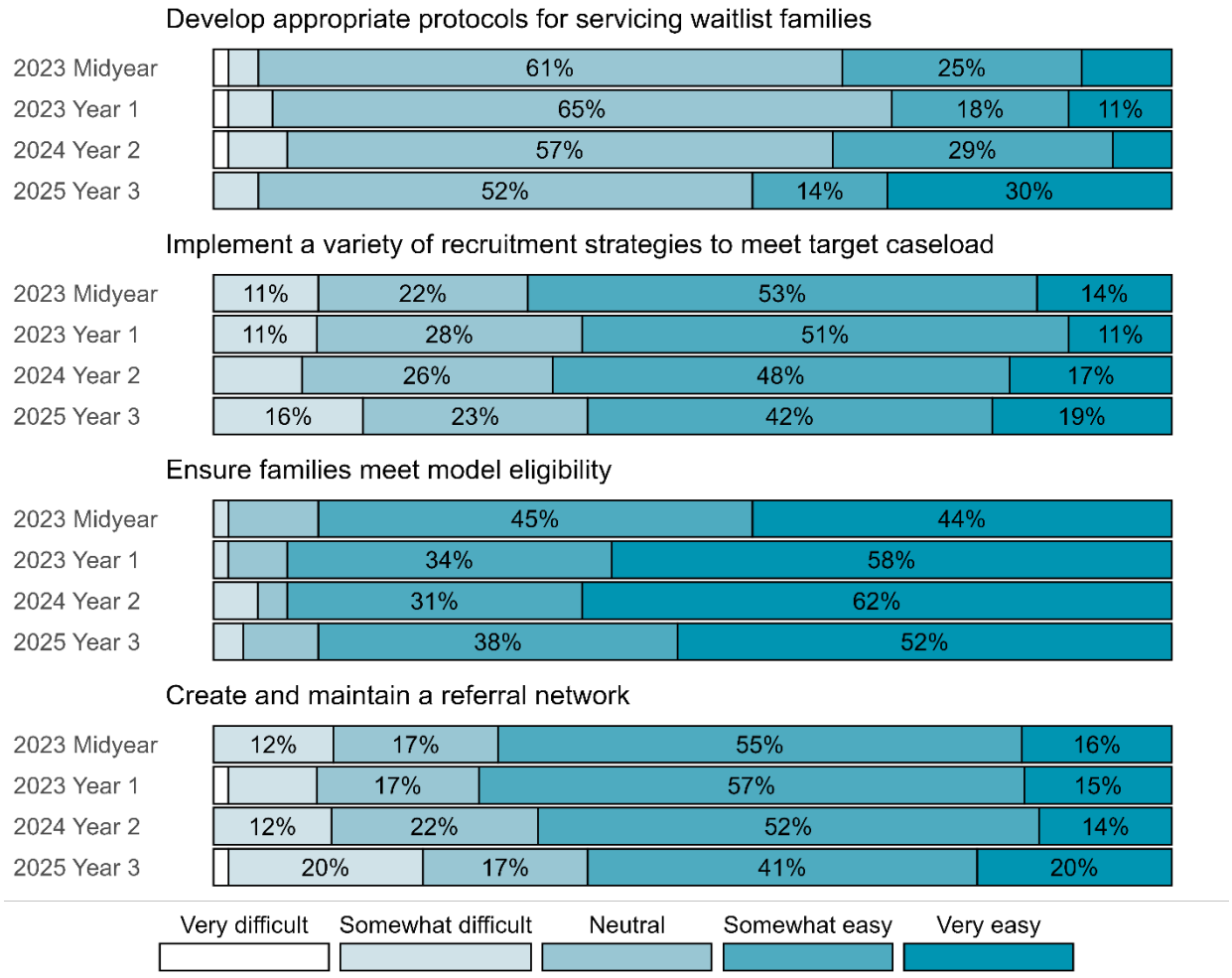
Grant compliance indicates that a grantee can ensure their promised deliverables are achieved. Demonstrating compliance is an important indicator in securing and maintaining grant funding. This includes fiscal responsibilities, work plan deliverables, and progress/data reporting. The figures below display Strong Foundations grantees' self-reported ease or difficulty in meeting key grant activities over four time periods (midyear 2023, year-end 2023, year-end 2024, and year-end 2025). Note that data values are not displayed for percentages smaller than 10%.

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



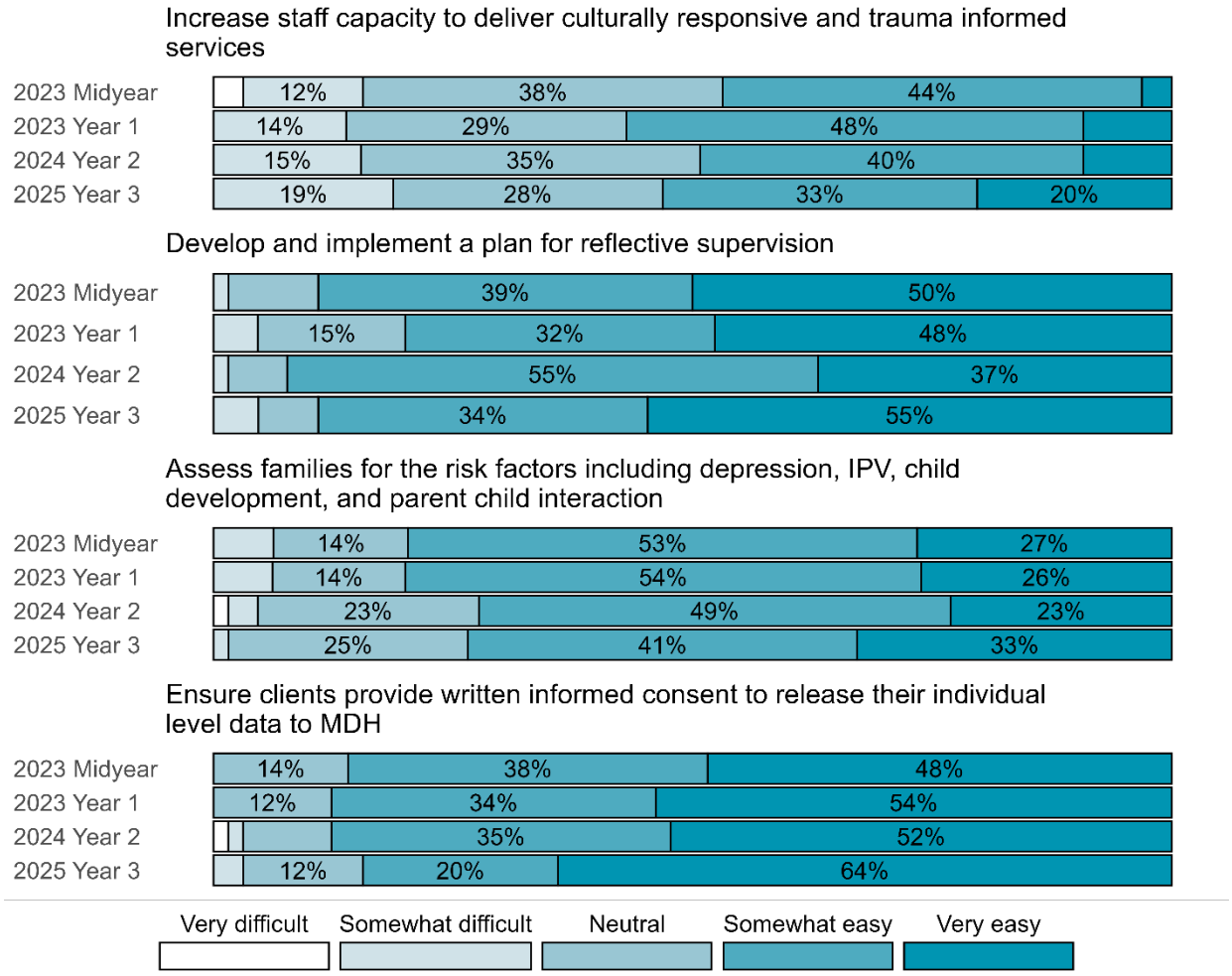
Source: Progress Monitoring Report

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



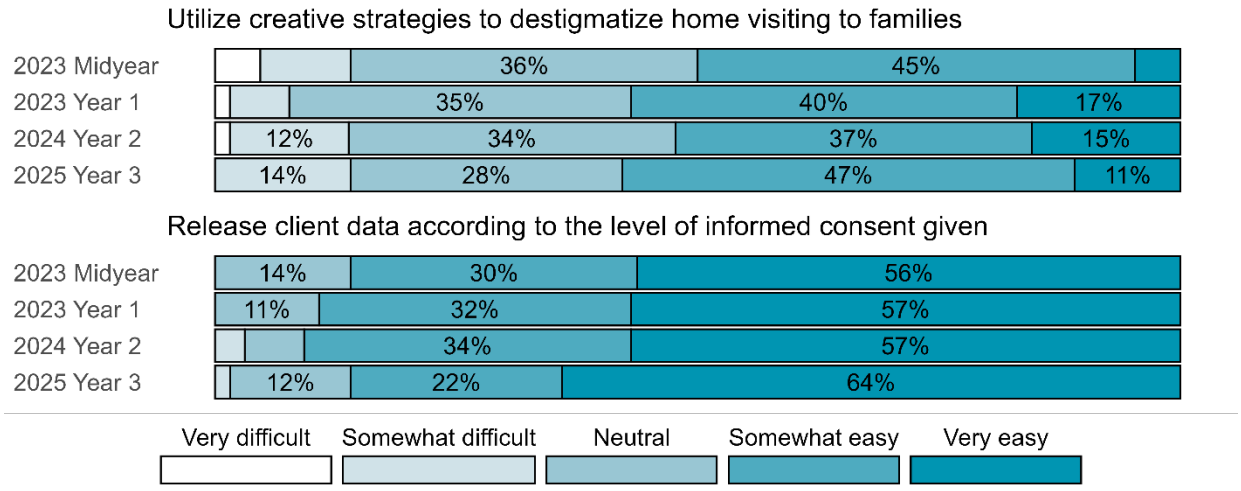
Source: Progress Monitoring Report

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



Source: Progress Monitoring Report

Figure 14. Strong Foundations grantees' ease in implementing grant requirements outlined in workplan: Part IV



Source: Progress Monitoring Report

Appendix

Appendix A. Outcome measure descriptions

Developmental screening and referral

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

- Ages and Stages Questionnaire, Third Edition (ASQ-3)
- Bayley Scales of Infant and Toddler Development
- Brigance Early Childhood Early Childhood Screen
- Devereux Early Childhood Assessment (DECA)
- Desired Results Developmental Profile (DRDP)
- Modified Checklist for Autism in Toddlers (M-CHAT)
- Modified Checklist for Autism in Toddlers , Revised (M-CHAT-R)
- Parents' Evaluation of Developmental Status (PEDS)
- PEDS- Developmental Milestones

In 2025 the developmental and social-emotional screening and referral measures were updated to include the following:

- Removing clients without a data collection opportunity
- Fixing a bug in the calculation around dates when referrals were provided and completed.
- Children who had a concern identified and were already receiving services were included in the screening measure and excluded from the concern and referral measures.

These updates resulted in decreases in referral and referral completion measures ranging from 4-22%. Previous measures were recalculated to include these updates and are in Appendix B.

Table 17. Developmental screening measure descriptions

Measure	Numerator	Denominator
Children screened	Target children in the denominator that received a developmental screen during the reporting year.	Target children who were between 1 month and 66 months during the reporting year and received home visiting. Target children that had a concern identified prior to this reporting year are excluded. Target children that are screened outside of home visiting are excluded
Children with concern identified	Target children in denominator with a concern identified from a developmental screen administered during the reporting year.	Target children who were between 1 month and 66 months during the reporting year, received home visiting, and received a developmental screen during the reporting year. Children with a concern identified who are already receiving services are excluded.
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, Healthcare Specialist Provider, Mental Health Services, or Other Provider or Community Service	Target children who were between 1 month and 66 months during the reporting year and received home visiting, and had 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 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.

Social-emotional screening and referral

The measures for social-emotional screening were calculated using the following definitions for denominator and numerator. The social-emotional developmental screening tools included: Ages and Stages Questionnaires: Social=Emotional, Second Edition; Pediatric Symptom Checklist; and Devereux Early Childhood Assessment (DECA).

Table 18. Social-emotional screening and referral measure descriptions

Measure	Numerator	Denominator
Children screened	Target children in the denominator that received a social-emotional screen during the reporting year.	Target children who were between 1 month and 66 months during the reporting year and received home visiting. Target children that had a concern identified prior to this reporting year are excluded. Target children that are screened outside of home visiting are excluded
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 were between 1 month and 66 months during the reporting year, received home visiting, and received a developmental screen during the reporting year. Children with a concern identified who are already receiving services are excluded.
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, Healthcare Specialist Provider, Mental Health Services, or Other Provider or Community Service	Target children who were between 1 month and 66 months during the reporting year and received home visiting, and had 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 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.

Depression screening and referral

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

- Center for Epidemiological Studies Depression Scale (CES-D)
- Center for Epidemiological Studies Depression Scale Revised (CESD-R)
- Edinburgh Postnatal Depression Scale (EPDS)
- Patient Health Questionnaire-2, -4, & -9 (PHQ)
- Postpartum Depression Screening Scale (PDDS)

In 2025 measure calculations were updated to include the following:

- The PDSS, CES-D, and CESD-R were added to the existing set of depression tools.
- Referral types were expanded.
- Caregivers who had a concern identified and were already receiving services were included in the screening measure and excluded from the concern and referral measures.

The updates increased the referral and service received measures by 8% and 6%, respectively. Previous measures were recalculated to include these updates and are included in Appendix B.

Table 19. Depression screening and referral measure descriptions

Measure	Numerator	Denominator
Caregivers screened	Primary caregivers in the denominator that received a depression screen during the year.	All primary caregivers who received at least one 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 with a concern identified with a PHQ-2 or PHQ-4 are excluded from the concern identified numerator, because positive screens should be followed up with a PHQ-9. Caregivers with a concern identified who are already receiving services are excluded from the numerator.
Caregivers referred	All primary caregivers in the denominator that received a referral during the year. Referrals include referral to mental health services, mental health crisis services, primary care provider, or referral to other provider or community service where "Mothers and Babies", babysteps, or mn health centr st. Cloud, is specified in the referral type.	All primary caregivers who received at least one 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 who received at least one home visit and a depression screen and concern referral and had concern identified during the year.

Perinatal depression screening

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

In 2025 the prenatal depression measure was updated by removing clients who didn't have a data collection opportunity (e.g. didn't receive a visit during the window). These updates, along with the expanded tools, improved depression screening rates after the child was born from 5-6%.

Table 20. Perinatal depression screening measure descriptions

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 who had a visit 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 had a visit 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 had a visit at 12 months after the child's birth.

Intimate partner violence screening and referral

The measures for intimate partner violence (IPV) screening and referral were calculated using the following definitions for denominator and numerator. The following IPV screening tools were included:

- Conflict Tactics Scale (CTS)
- Humiliation, Afraid, Rape, Kick (HARK, HARK-C, HITS, RAT, CTS)
- HARK plus Child (HARK-C)
- Hurt-Insult-Threaten-Scream (HITS)
- Relationship Assessment Tool (RAT)

In 2025 the IPV measures were updated to include:

- Accounting for a data collection opportunity.
- Including write-in responses for referrals.

These updates resulted in a 4% increase in screening rates and a 1% increase in concerns identified. Measures from previous years were recalculated to include these updates and are included in Appendix B.

Table 21. IPV screening and referral measure descriptions

Measure	Numerator	Denominator
Caregivers screened	Primary caregivers in the denominator that received an IPV screen.	Primary caregivers who reached 6 months of enrollment during the reporting year and received home visiting on or after this date.
Caregivers with concern identified	Primary caregivers in the denominator that received a referral the day of screen.	Primary caregivers who reached 6 months of enrollment during the reporting year, received home visiting on or after this date and received an IPV screen. Caregivers with a concern identified who are already receiving services are excluded from the numerator.
Caregivers referred	Primary caregivers in the denominator that received a referral for IPV services during the reporting year.	Primary caregivers who reached 6 months of enrollment during the reporting year, received home visiting on or after this date, received an IPV screen, and had a concern identified with that screen.

Appendix B. Participant demographic characteristics

Table 22. Caregiver age

Caregiver Age	Total	Percent
<= 17	104	2%
18-19	219	4%
20-21	390	8%
22-24	810	16%
25-29	1,341	26%
30-34	1,182	23%
35-44	1,007	20%
45-54	48	1%
55-64	5	0%
>= 65	5	0%

Table 23. Caregiver employment

Caregiver Employment	Total	Percent
Not employed	2,782	54%
Employed Full-Time (30+ hours/week)	1,212	24%
Employed Part-Time (Less than 30 hours/week)	929	18%
Declines to answer	42	1%
Unknown/Did not Report	146	3%

Table 24. Caregiver insurance status

Caregiver Insurance	Total	Percent
Medicaid or CHIP	3,795	74%
Private or Other	535	10%
No Insurance coverage	432	8%
Tricare	16	0%
Unknown/Did not report	333	7%

Table 25. Caregiver education

Caregiver Education	Total	Percent
High School Diploma or GED	1,730	34%
Less than HS Diploma	1,077	21%
Some college or post high school training	733	14%
Bachelor's degree or higher	551	11%
Declines to answer	347	7%
Associate's degree	197	4%
Technical training or certificate	168	3%
Other	44	1%
Unknown/Did not Report	264	5%

Table 26. Household military service

Household Miliary Service	Total	Percent
No	4,396	86%
Yes	124	2%
Unknown/Did not Report	591	12%

Table 27. Languages spoken in child's household

Language	Total	Percent
English	2,942	62%
Spanish	1,321	28%
Somali	91	2%
Hmong	66	1%
Karen	60	1%
Arabic	28	1%
Oromo	21	0%
Amharic	16	0%
Burmese	7	0%
Nepalese	4	0%
Other language	187	4%
Client declines to answer	12	0%

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