Olmsted County Public Health Services
Healthy Children and Families
Five Year Report
2010-2014
Annual Update

“Ensuring that children and families are healthy, safe, and nurtured.”
Olmsted County Public Health Services
Healthy Children and Families
Five Year Report
Update
2010-2014

April 27, 2015

Olmsted County Public Health Services
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Rochester, MN 55904

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Introduction

The purpose of this report is to show the condition of parent and child health indicators for families served by the Healthy Children and Families (HCF) Division within Olmsted County Public Health Services (OCPHS).

Improving the health of mothers, infants, and children is an important public health goal. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the health care system.

The HCF Division serves the population of families in Olmsted County who are pregnant or parenting a child birth to five years through programs provided by public health nurses (PHNs). Some of the services provided are available to all families, such as newborn/postpartum home visits and the Follow Along Program, whereas others are targeted to families with risk factors, such as the targeted family home visiting programs or the Early Hearing Detection and Intervention Program.

The Vision, Mission, and Core Values of the HCF Division are as follows:

**Vision**
All children and families reach their full potential

**Mission**
Ensuring that children and families are healthy, safe, and nurtured

**Core Values**
Compassion, Excellence, Integrity, Respect, Social Justice

The foundation of the services provided by HCF is based on brain development research and Attachment Theory.

Healthy brains begin with a healthy pregnancy and continue to develop in the context of nurturing relationships with healthy caregivers. The first three to five years of a child’s life are critical in establishing a foundation for future health and learning. Parents work voluntarily with HCF PHNs, who serve as a parenting guide or coach, in addition to their nursing role as it relates to the child and family’s health. HCF PHNs focus on strengthening the parent-child relationship while continually assessing and teaching information related to healthy child growth and development.

**Methodology**

The data in this report was collected from PH-Doc, the electronic health record program used by OCPHS. PH-Doc includes the Omaha System, an American Nurses Association recognized standardized nursing terminology. The Omaha System describes the clients as individuals, the care provided, and the outcomes of that care. It has been formulated to promote health care practice and documentation, and to manage information.

The report combines HCF program information, demographic information about the populations served by HCF, risk factors for these populations, and Family Home Visiting outcomes determined by the Minnesota Department of Health (MDH).

The average change in KBS ratings was calculated using a paired t-test. A p-value of 0.05 was used to determine significance. If a p-value was less than 0.05, the change was considered significant. If it was greater than 0.05, the change was considered not significant.

For information related to the condition of maternal and child health for all of Olmsted County, please refer to the Olmsted County, Minnesota Maternal and Child Health Annual Report 2008-2012, published October 2014.
Executive Summary

Olmsted County Public Health Services

Healthy Children & Families Division

2010 - 2014 Averages

1,666 Clients seen annually
6,295 visits per Year

Reasons for Visits:
- 26% Parenting
- 26% Child G&D
- 19% Pregnancy
- 15% Newborn
- 12% Postpartum

Client Race/Ethnicity
- 73% White
- 16% Black
- 8% Asian
- 14% Hispanic

Top Risk Factors:
- Low Income
- Minority Group
- Unmarried
- Family Stress
- Condition
- Financial Difficulty

Most Frequent Actual Omaha System Problems:
- Income
- Growth & Development
- Mental Health

Parenting
- 655 clients
- 2,413 visits per year

Child Growth & Development
- 741 clients
- 2,681 visits per year

Pregnancy
- 364 clients
- 1,266 visits per year
Executive Summary

OCPS HCF Division
Maternal & Child Health
Client Quick Facts
2014

- **BIRTHS**: 65 births, 26% teen births
- **PREMATURITY**: 8% of infants were born at least 3 weeks too early
- **LOW BIRTH WEIGHT**: 9% of infants were born weighing less than 5.5 pounds
- **FIRST TIME MOMS**: 54% first time moms
- **HOME SAFETY CHECKLIST**: 89% completed
- **ER/URGENT CARE VISITS**: 9% had 1 or more visits due to injury
- **DEVELOPMENTAL MILESTONES**: 90% met developmental milestones
- **SOCIAL-EMOTIONAL MILESTONES**: 100% met social-emotional milestones
- **CHILD MALTREATMENT**: 3% of children experienced substantiated maltreatment
- **MATERNAL EDUCATION**: 39% No HS Diploma or GED, 32% HS Diploma or GED, 29% Some Post-Secondary Degree
- **MATERNAL RACE/ETHNICITY**: 68% White, 27% Black, 3% Asian, 4% Hispanic
- **PREGNATAL CARE**: 69% of women received prenatal care in the 1st trimester
- **OUT-OF-WEDLOCK BIRTHS**: 42% of births were to unmarried women
- **SMOKING**: 11% of pregnant women smoked during pregnancy
- **POSTPARTUM DEPRESSION SCREENING**: 73% screened for PPD depression
- **BREASTFEEDING**: 61% of those who breastfed, breastfed 4+ months
- **SUBSEQUENT PREGNANCY**: 93% no subsequent pregnancy at 24 mo. postpartum
All HCF programs provide pregnancy and parenting support, promote an enjoyable parent-child relationship, and encourage the healthy social-emotional and physical development of the child.

**Bright Futures** is a program for pregnant or parenting teens. Visits are provided by a PHN and/or County social worker until the parent is at least 19 years of age and/or for up to three years.

**Babysteps** is a program for first time parents with risk factors. Families are enrolled either during pregnancy or within six weeks of the baby’s birth. Visits are provided by a PHN and County social worker until the child turns two to three years old.

**Steps to Success** is a program for families with risk factors who are expecting their second or third child, when their other children are under the age of five. Families are enrolled either during the pregnancy or within six weeks of that child’s birth. Visits are provided by a PHN and County social worker until the youngest child turns two to three years old.

**Pregnancy and Parenting Connections** is a program for families who are either expecting a baby or who have a child birth to five years of age. Visits are provided by a PHN for a few months or up to three years, depending on risks and needs.

**New Baby Visits** are available to all parents living in Olmsted County. PHNs make home visits within a few days of parents arriving home from the hospital. PHNs provide information about caring for an infant and the new mother, as well as support for new parents, assistance with questions about breast or bottle feeding, baby care, and infant development.

**Children with Special Health Needs** is a program for families who have a child with special needs. PHNs make home visits focusing on early intervention, providing weight checks, assisting in case management, promoting an enjoyable parent-child relationship, and making community resource referrals.

**WIC/MCH Clinic** is offered to pregnant clients with risk factors, as an adjunct to their WIC nutritional intervention program and health education. The clinic visit is provided by a PHN, who obtains vital signs, completes a brief assessment, and provides information about pregnancy related topics and community resources.

**The Minnesota Early Hearing Detection and Intervention (EHDI) Program**
PHNs support and assist families whose infant failed a newborn hearing screen to follow up with screening/testing, assure that families of children with a hearing loss are connected to appropriate resources and caregiver supports, and increase the number of children with hearing loss who attain developmental milestones similar to their hearing peers. This is a collaboration between OCPHS, MDH, the medical community, early intervention providers, and parents of children with hearing loss.

**Early Childhood Screening Follow-Up Services**
OCPHS partners with the Independent School Districts of Byron, Chatfield, Dover-Eyota, Rochester and Stewartville Early Childhood Screening programs. If an area of need or concern is identified during screening, a public health nurse is available to assist schools and/or families with information, community resource referrals, and support. These coordinated services help assure kindergarten readiness.
Follow Along Program offers parents a periodic assessment of their child’s development and ideas for encouraging their development through a computer assisted tracking program. This program is for children birth to 36 months.

Elevated Blood Lead Case Management
Olmsted County residents under 72 months of age who are tested at a clinic and determined to have a blood lead level above 5 ug/dl are reported to MDH. MDH then notifies the blood lead case manager at OCPHS. Case management activities include assessment, education, support, advocacy, and home visiting, as needed by the children and their caregivers. The case manager works closely with the clinic and MDH to assure follow up lead testing is completed in a timely manner. This is a collaborative program with MDH and local clinics.

Healthy Families America
Services are provided to clients through home visiting. The HCF Division of OCPHS integrates the Healthy Families America (HFA) model of home visiting with families who qualify based on a parenting risk assessment. HFA is a nationally recognized, evidence-based home visiting model designed to connect expectant parents, and parents of newborns, with parenting and child development assistance in their homes. In 2013, HCF chose HFA because it aligns well with our past relationship-based home visiting model based on attachment theory. HFA is designed to work with overburdened families who have histories of trauma, intimate partner violence, mental health issues, substance abuse issues, and other risk factors. HFA services begin prenatally or right after the birth of a baby and are offered voluntarily, intensively and for three years after the birth of the baby.
Between 2010 and 2014, the HCF division PHNs made an average of 6,295 visits to 1,666 clients annually. Since 2010, the number of clients decreased 21% and the visits decreased by 17%.

HCF PHNs provide visits for a variety of reasons. Services are primarily provided to enhance parenting skills, maximize the healthy growth and development of infants and children and provide prenatal education for a healthy pregnancy and healthy child.

The most frequent reason for HCF visits are related to parenting and child growth and development (26%), followed pregnancy (19%).

Between 2010 and 2014, an average of 87% of HCF Clients had health insurance coverage.
The HCF client population is more diverse than Olmsted County’s general population. The Hispanic population is higher in the HCF Program (14%) compared to Olmsted County (4.5%)*. This is also true for the black and Asian populations. The racial makeup of HCF clients is 73% white, 16% black, and 8% Asian; Olmsted County’s total population is 85.4% white, 5.4% black and 5.4% Asian*.

Females represent 74% of HCF clients.

The largest percentage of HCF clients served are children under 5 years of age (44%) followed by those between 20 to 29 years of age (30%).

*2009 – 2013 Olmsted County – most current data available
Pregnancy and Birth

Prenatal Clients and Visits

From 2010 to 2014 HCF PHNs made an average of 1,266 visits to 364 prenatal clients annually. There was a 44% decrease in prenatal clients from 2010 to 2014. The number of prenatal visits fluctuated up and down during this period, but there was an overall 35% decrease in visits from 2010 to 2014. This may be due to making more visits to fewer families for a longer period of time, with the implementation of Healthy Families America.

* HFA Model Implemented
Client risk factors impact the complexity of client health issues. These risk factors are addressed by the PHN and client during a visit. During the 2010 to 2014 time period, the top risk factors for prenatal clients were low income (90%), unmarried (60%) and in a minority group (47%).

In 2014, 89% of prenatal clients reported an income at 200% or less of federal poverty level.

### The Omaha System: Assessment

The Omaha System is used by the PHN to assess clients’ problems. **Actual** problems are identified as problems with signs and symptoms. **Potential** problems have no signs or symptoms present, but have associated risk factors. When the client requests information about a problem, but they have no signs or symptoms or risk factors present, this becomes a **Health Promotion** problem. The top five actual, potential, and health promotion problems for prenatal clients are listed below.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Most Frequent Omaha Problems</th>
<th>% of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Prenatal Clients 2010 - 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Actual</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Income</td>
<td>60.6%</td>
</tr>
<tr>
<td>2</td>
<td>Pregnancy</td>
<td>58.0%</td>
</tr>
<tr>
<td>3</td>
<td>Mental Health</td>
<td>31.0%</td>
</tr>
<tr>
<td>4</td>
<td>Communications with Community Resources</td>
<td>26.7%</td>
</tr>
<tr>
<td>5</td>
<td>Nutrition</td>
<td>25.8%</td>
</tr>
<tr>
<td></td>
<td>Potential</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Caretaking/Parenting</td>
<td>29.3%</td>
</tr>
<tr>
<td>2</td>
<td>Income</td>
<td>27.0%</td>
</tr>
<tr>
<td>3</td>
<td>Mental Health</td>
<td>26.3%</td>
</tr>
<tr>
<td>4</td>
<td>Role Change</td>
<td>16.4%</td>
</tr>
<tr>
<td>5</td>
<td>Interpersonal Relationship</td>
<td>15.3%</td>
</tr>
<tr>
<td></td>
<td>Health Promotion</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Caretaking/Parenting</td>
<td>77.3%</td>
</tr>
<tr>
<td>2</td>
<td>Family Planning</td>
<td>43.9%</td>
</tr>
<tr>
<td>3</td>
<td>Postpartum</td>
<td>53.4%</td>
</tr>
<tr>
<td>4</td>
<td>Pregnancy</td>
<td>39.1%</td>
</tr>
<tr>
<td>5</td>
<td>Communication with Community Resources</td>
<td>31.0%</td>
</tr>
</tbody>
</table>
From 2010 to 2014 there was an average of 112 births to HCF clients per year.

Births to HCF clients decreased 48% from 2010 (125) to 2014 (65). Births to all Olmsted County residents decreased by 1%.

From 2010 to 2014, over half (52.4%) of HCF clients giving birth were in the 20 to 29 age range, the same as Olmsted County.

There was a greater percentage of births to those ages 15 to 19 among HCF clients (28%) as compared to Olmsted County (4%).

*2009 – 2013 Olmsted County – most current data available

The HCF maternal population is more diverse than Olmsted County’s maternal population. The Hispanic, black and Asian populations are higher in the HCF Program compared to Olmsted County. The racial and ethnic population of HCF maternal clients is 63% white, 25% black, 9% Asian and 23% Hispanic. Olmsted County’s maternal population is 81% white, 8% black, 8% Asian, and 6% Hispanic.

Level of mother’s education is defined as the highest level of education achieved within the following categories: high school diploma or GED, no high school diploma or GED, or some post-secondary education or degree.

From 2010 to 2014, 44% of HCF prenatal clients did not have a high school diploma or GED. This is not comparable to Olmsted County since 28% of HCF prenatal clients are teens.
Teen Birth Rates

Teen birth rates are defined as the number of live births to 15 to 19 year olds, expressed as a percentage of all live births.

From 2010 to 2014, teen births among HCF client (28%) were higher compared to Olmsted County (4%). Birth rates among HCF teens decreased 21% from 2010 (33.3%) to 2014 (26.2%). Olmsted County saw a 7% decrease*.

The maternal race and ethnicity of HCF teen clients is 65% white, 20% black, 9% Asian and 21% Hispanic. Olmsted County’s black (15%) and Hispanic (8%) populations are much smaller*.

*2009 – 2013 Olmsted County – most current data available

Out-of-Wedlock Births

Out-of-wedlock refers to women who are not married to baby’s father at the time of conception, the time of delivery, or any time between conception and delivery.

The out-of-wedlock rate is the number of live births to unmarried mothers expressed as a percentage of total live births. From 2010 (65.9%) to 2014 (43.1%) there was a 35% decrease in births to unmarried women. Births to unmarried Asian and black women were lower than to white unmarried women (53% and 32% respectively).
Initiation of Prenatal Care

From 2010-2014 an average of 75% HCF clients received prenatal care in the first trimester. White (84%) and Asian females (78%) were more likely to get prenatal care in the first trimester than blacks (71%). There were no differences between Hispanics and non-Hispanics (66%).

Prematurity

Premature infants are those born at less than 37 weeks gestation.

Between 2010 to 2014, the percentage of premature births among HCF clients was 8%. Olmsted County had 9% premature births*. HCF clients had an average of 8.6 premature births per year.

Smoking

The number of HCF prenatal clients who reported smoking during pregnancy fluctuated from 2011 to 2014, with a low of 13% and a high of 19%. This compares to an average of 8% in Olmsted County.*

*2009 – 2013 Olmsted County – most current data available
Pregnancy and Birth

Low-Birth Weight

Low-birth weight infants are those born weighing less than 2,500 grams, or about 5.5 pounds.

From 2010 to 2014, there were an average of 7 low-birth weight babies a year among HCF clients, 7% of total births; slightly higher than Olmsted County (6%)*.

Postpartum Depression Screening

The number of postpartum clients that were screened for postpartum depression increased 52% from 2010 (48.1%) to 2014 (72.9%).

The Omaha System: KBS

Knowledge, Behavior and Status (KBS) ratings are used to evaluate a client’s progress in relation to one of the 42 health-related problems within the Omaha System, using a one to five likert scale.

All Ratings increased significantly from 2010-2014 in all three KBS areas. Client’s knowledge increased the most from 2.80 to 3.66, while client’s status rating increased the least 4.10 to 4.39. However, the average beginning (4.10) and ending ratings (4.39) were the highest for Status. This indicates significant Pregnancy and Parenting improvement in Knowledge, Behavior and Status ratings among prenatal clients served.

*2009 – 2013 Olmsted County – most current data available
From 2010 to 2014, HCF PHNs made an average of 2,413 visits per year to 655 parenting clients. The number of visits increased by 11%, but the number of clients decreased by 7%. This may be due to making more visits to fewer families for a longer period of time, with the implementation of Healthy Families America.
The Omaha System is used by the PHN to assess clients’ problems. **Actual** problems are identified as problems with signs and symptoms. **Potential** problems have no signs or symptoms present, but have associated risk factors. When the client requests information about a problem, but has no signs or symptoms or risk factors present, this becomes a **Health Promotion** problem. The top five parenting client problems in each category are listed below.

### Olmsted County Public Health Services  
**Healthy Children & Families Division**

**Parenting Clients**  
**Top Risk Factors**  
2010 - 2014

<table>
<thead>
<tr>
<th>Rank</th>
<th>Risk Factor</th>
<th>% of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Income</td>
<td>5.3%</td>
</tr>
<tr>
<td>3</td>
<td>Communication with Community Resources</td>
<td>3.7%</td>
</tr>
<tr>
<td>2</td>
<td>Postpartum</td>
<td>3.4%</td>
</tr>
<tr>
<td>4</td>
<td>Caretaking/Parenting</td>
<td>3.1%</td>
</tr>
<tr>
<td>5</td>
<td>Pregnancy</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

**Potential**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Risk Factor</th>
<th>% of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Caretaking/Parenting</td>
<td>2.5%</td>
</tr>
<tr>
<td>2</td>
<td>Mental Health</td>
<td>2.1%</td>
</tr>
<tr>
<td>3</td>
<td>Income</td>
<td>1.4%</td>
</tr>
<tr>
<td>4</td>
<td>Postpartum</td>
<td>1.3%</td>
</tr>
<tr>
<td>5</td>
<td>Residence</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

**Health Promotion**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Risk Factor</th>
<th>% of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Caretaking/Parenting</td>
<td>6.9%</td>
</tr>
<tr>
<td>2</td>
<td>Postpartum</td>
<td>4.2%</td>
</tr>
<tr>
<td>3</td>
<td>Family Planning</td>
<td>2.8%</td>
</tr>
<tr>
<td>4</td>
<td>Pregnancy</td>
<td>2.0%</td>
</tr>
<tr>
<td>5</td>
<td>Communication with Community Resources</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

Client risk factors impact the complexity of client health issues that are addressed by the nurse and client during a visit. The top risk factors for parenting clients are low income (66%) and in a minority group (43%).
The racial makeup of HCF parenting clients is 75% white, 13% black and 9% Asian, with 12% of Hispanic ethnicity.

The majority of parenting clients are 20 to 34 years old (76%), followed by teen parents, 13 to 19 years (11%). Females represent 98% of all parenting clients.
Breastfeeding

The number of clients reporting that they breastfed for 6 months more than doubled from 2010 (25%) to 2014 (61%).

Home Safety Checklist

The percentage of home safety checklists completed from 2010 (83.8%) to 2012 (74.8%) decreased by 11% but increased by 19% from 2012 (74.8%) to 2014 (89.1%).
From 2011 (85%) to 2014 (93%), the percentage of clients reporting they had no subsequent pregnancy at 24 months postpartum increased by 9%.

Knowledge, Behavior and Status (KBS) ratings are used to evaluate a client’s progress in relation to one of the 42 health-related problems within the Omaha System, using a one to five likert scale.

All Ratings increased significantly from 2010-2014 in all three KBS areas. Client’s knowledge increased the most from 3.14 to 3.57 while client’s behavior rating increased the least 3.91 to 3.99. These ratings indicate significant parenting improvement in Knowledge, Behavior and Status rating among families served.
HCF PHNs make an average of 2,681 visits to 741 children annually. There was a 19% increase in child growth and development visits from 2010 (2,480) to 2012 (2,952), but a 13% decrease from 2012 (2,952) to 2014 (2,554). The number of clients has decreased by 20% since 2010. This may be due to making more visits to fewer families for a longer period of time, with the implementation of Healthy Families America.
HCF child growth and development clients’ race and ethnicity makeup is 72% white, 16% black and 8% Asian, and 15% Hispanic ethnicity. Males represent 51% of the child population. The majority (90%) of child growth and development clients are newborn to two years old.

Client risk factors impact the complexity of client health issues that are addressed by the nurse and client during a visit. During the 2010 to 2014 time period, the top risk factors for child growth and development clients were low income (56%) and in a minority group (43%).
The Omaha System: Assessment

The Omaha System is used by the PHN to assess clients’ problems. **Actual** problems are identified as problems with signs and symptoms. **Potential** problems have no signs or symptoms present, but have associated risk factors. When the client requests information about a problem, but has no signs or symptoms or risk factors present, this becomes a **Health Promotion** problem. The top five child growth and development client problems in each category are listed below.

### Most Frequent Omaha Problems

<table>
<thead>
<tr>
<th>Rank</th>
<th>Most Frequent Omaha Problems</th>
<th>% of Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Child Growth &amp; Development</td>
<td></td>
</tr>
<tr>
<td><strong>Actual</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Growth &amp; Development</td>
<td>11.4%</td>
</tr>
<tr>
<td>2</td>
<td>Health Care Supervision</td>
<td>1.3%</td>
</tr>
<tr>
<td>3</td>
<td>Income</td>
<td>1.2%</td>
</tr>
<tr>
<td>4</td>
<td>Digestion-Hydration</td>
<td>1.0%</td>
</tr>
<tr>
<td>5</td>
<td>Neglect</td>
<td>1.0%</td>
</tr>
<tr>
<td>6</td>
<td>Neuro-Musculo-Skeletal Function</td>
<td>1.0%</td>
</tr>
<tr>
<td><strong>Potential</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Growth &amp; Development</td>
<td>11.0%</td>
</tr>
<tr>
<td>2</td>
<td>Abuse</td>
<td>2.2%</td>
</tr>
<tr>
<td>3</td>
<td>Neglect</td>
<td>2.2%</td>
</tr>
<tr>
<td>4</td>
<td>Health Care Supervision</td>
<td>1.3%</td>
</tr>
<tr>
<td>5</td>
<td>Caretaking/Parenting</td>
<td>0.4%</td>
</tr>
<tr>
<td>6</td>
<td>Hearing</td>
<td>0.4%</td>
</tr>
<tr>
<td>7</td>
<td>Nutrition</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Health Promotion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Growth &amp; Development</td>
<td>51.5%</td>
</tr>
<tr>
<td>2</td>
<td>Health Care Supervision</td>
<td>10.6%</td>
</tr>
<tr>
<td>3</td>
<td>Caretaking/Parenting</td>
<td>0.9%</td>
</tr>
<tr>
<td>4</td>
<td>Neglect</td>
<td>0.9%</td>
</tr>
<tr>
<td>5</td>
<td>Abuse</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

ER/Urgent Care Visits

From 2010 to 2014, there was an increase in the reports of infants/children with one or more visits to the emergency room/urgent care center for injury. This increase represents a report of one child in 2010 to 8 children in 2014.

![Infants/Children with One or More ER/Urgent Care Visit For Injury, 2010 - 2014](chart.png)
In 2014, 3% of children served by HCF experienced substantiated maltreatment. This is an increase from 2010, although the numbers still remain low.

The ASQ-3 is a developmental screening tool that helps determine the overall physical development of a child as reported by parents. Areas screened include: gross motor, fine motor, communication, problem solving, and personal/social.

Overall, many infants are meeting developmental milestones. From 2010 to 2014, there was a 6% increase in 4 month olds and a 15% increase in 10 to 12 month olds meeting developmental milestones.
The Omaha System: KBS

Knowledge, Behavior and Status (KBS) ratings are used to evaluate a client’s progress in relation to one of the 42 health-related problems within the Omaha System, using a one to five likert scale.

Client’s knowledge rating was the only rating to increase significantly from initial (3.14) to problem closure (3.62). Client’s status rating decreased significantly from initial (4.64) to problem closure (4.57). Client’s behavior rating did increase (.014) but it was not significant. Behavior and status are based on the child, while knowledge rating is based on the caregiver.

Social-Emotional Milestones

The ASQ-SE is a social-emotional screening tool, reported by the parent, which helps determine the social-emotional development of children.

In 2014, 100% of 12 month olds met social-emotional milestones. This is a 10% increased from 2013.

12 Month Olds Meeting Social-Emotional Milestones, 2010 - 2014

Child Growth & Development Clients’ KBS, 2010 - 2014

* Significant change

Child Growth and Development

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The HCF PHN’s and other community partners refer infants to the Follow Along Program (FAP), which offers a periodic assessment of a child’s development and ideas for encouraging their development through a computer assisted tracking program. This program is for children birth to 36 months.

From 2009 to 2013, 13% (1,365) of all first-borns in Olmsted County were enrolled in FAP. Over half (55%) of all new enrollees into FAP are first-borns.

During this time period, an average of 92% of children met developmental milestones. Of those not meeting developmental milestones, 100% received follow-up from a public health nurse, 13% of them were referred to Early Childhood Special Education and 18% to a health care provider.

*A public health nurse follows up with all children who do not meet milestones and/or whose parents have concerns. Some of these children are also referred to ECSE and/or a health care provider.
Overview
In 2014, HCF Public Health Nurses had clients complete a customer service survey. Clients were randomly selected and surveys were collected three times this year for a month. The purpose of the survey was to gauge customer satisfaction with the services they were provided. Customers completed questions on how well they were treated, if OCPHS staff helped them with their problems and if they learned anything from OCPHS staff. In total 71 customers completed the survey and which resulted in a 19% response rate. The majority of customers that completed the survey had visits that focused on growth and development.

Treated Well
In 2014, all HCF customers indicated they were treated well. Customers shared that the PHN’s were respectful, helpful, comforting, and informative.

Helped with Their Problems
Overall, most of HCF customers reported being helped with their problems (99%). In the first three quarters, 100% of customers felt they were helped with their problems. Customers mentioned having someone explains things, ideas and information on how to help their child, and having someone to talk to are all beneficial parts of the visit.

Learned Something
In 2014, 81% of the customers learned something from their public health nurse visit. Customers learned how to teach their children, how to care for their child, and how to understand their baby.
Conclusions and Next Steps

Conclusions

The HCF Division serves the population of families in Olmsted County who are pregnant or parenting a child birth to five years through programs provided by public health nurses. All HCF programs provide pregnancy and parenting support, promote an enjoyable parent-child relationship and encourage the healthy social—emotional and physical development of the child. These services are valuable to improving the health of mothers, infants and children in Olmsted County.

Overall, the HCF client population is more diverse in regards to race and ethnicity than Olmsted County’s general population. HCF serves a high percentage of Hispanics, blacks and Asians; knowing this, it is not recommended to generalize HCF outcomes to the full Olmsted County population.

Over the past five years (2010-2014), measured improvements have been made among those served in the HCF Division, including:

- 144% increase in breastfeeding duration (≥6 months)
- 52% increase in postpartum depression screenings
- 21% reduction in teen births
- 9% reduction in subsequent pregnancies at 24 months postpartum

Along with the above improvements, many measures continue to remain positive, including:

- Children meeting developmental milestones and receiving PHN follow-up
- Parents gaining knowledge to help their children learn, grow and be healthy
- Children living in safe homes that are free of neglect and maltreatment
- Families remaining covered by at least one form of health insurance

Next Steps

All HCF clients indicated they were treated well.

- 99% reporting being helped with their problems
- 81% learned something from their PHN visit

The mission of the HCF Division is to ensure that children and families are healthy, safe and nurtured. In the next year, HCF will strive to fulfill this mission by:

- Becoming Nationally Accredited in Health Families America model and continue to use this evidence based practice to connect expectant parents, and parents of newborns, with parenting and child development assistance in their homes
- Conducting maternal depression screening as a normal part of PHN practice and making referrals as appropriate
- Developing and monitoring additional performance measures to further enhance describing how services provided by HCF improve maternal and child health outcomes