



**Olmsted County Public Health Services
Healthy Children and Families
Five Year Report
2013-2017
Annual Update**

“Ensuring that children and families are healthy, safe, and nurtured.”



This page intentionally left blank



**Olmsted County Public Health Services
Healthy Children and Families
Five Year Report
Update
2013 - 2017**

Updated April 15, 2018

**Olmsted County Public Health Services
2100 Campus Drive SE
Rochester, MN 55904**

**Questions regarding this report can be directed to:
Margene Gunderson, Associate Director
Gunderson.margene@co.olmsted.mn.us
(507) 328-7525**

Table of Contents

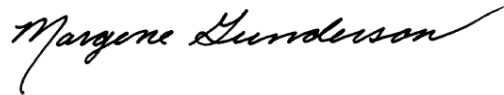
Letter from Director of HCF Program -----	5
Introduction -----	6
Executive Summary -----	7
HCF Staff -----	9
HCF Programs -----	11
HCF Clients and Visits -----	12
Pregnancy and Birth -----	14
Parenting -----	21
Child Growth and Development -----	25
Follow Along Program -----	30
Customer Satisfaction Survey -----	31
Conclusions and Next Steps -----	32

Letter from the Director of the Healthy Children and Families Program

Family home visiting services provide important supports for families in Olmsted County. The goal of these services is to promote healthy pregnancy outcomes, promote school readiness, prevent child abuse and neglect, promote a positive parent-child relationship and economic self-sufficiency for children and families.

Trained public health nurses provide evidenced-based education, support services and coaching to pregnant women, infants and children and their families. Each family participates in an intake visit to identify family strengths and challenges of pregnancy and parenting. Screening and information about adverse childhood experiences (ACES) have been integrated into the program since 2016. Families are receptive to learning how experiences from the past help to shape their parenting skills now and into the future.

It is with great pleasure that Olmsted County Public Health Services publishes this Olmsted County Healthy Children and Families Annual Report. Olmsted County has a long history of providing family home visiting services by trained public health nurses. This report highlights the importance of reducing child adversity and building and maintaining healthy parent-child relationships as a way to promote good population health.



Margene Gunderson, Associate Director
Olmsted County Public Health Services



Introduction

The purpose of this report is to show the parent and child health indicators for families served by the Healthy Children and Families (HCF) Program within Olmsted County Public Health Services (OCPHS). The foundation of the services provided by HCF is based on brain development research and Attachment Theory. The first three to five years of a child's life are critical in establishing a foundation for future health and learning. Healthy brains begin with a healthy pregnancy and continue to develop in the context of nurturing relationships with healthy caregivers.

The HCF Program serves the population of families in Olmsted County who are pregnant or parenting a child birth to five years through programs provided by bachelor's prepared 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 mission, vision and core values of the HCF Program are as follows:

Mission

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

Vision

All children and families reach their full potential

Core Values

Compassion, Excellence, Integrity, Respect, Social Justice



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 2011-2015, published March 2017.

Executive Summary

Reasons for Visits:

34% Child G&D
32% Parenting
14% Pregnancy
10% Newborn
10% Postpartum



6,629 visits
per year

1,340 clients
seen annually



Client Race/Ethnicity

68% White
16% Black
7% Asian
13% Hispanic

Parenting

520 clients
2,785 visits
per year



Olmsted County
Public Health Services

Healthy Children &
Families Division

2013-2017
Averages

Most Frequent Actual Omaha System Problems:

Income
Mental Health
Growth & Development



Pregnancy

247 clients
888 visits
per year



Child Growth & Development

608 clients
2,954 visits
per year



Executive Summary

Olmsted County Public Health Services Healthy Children & Families Division

Maternal & Child Health

Quick Facts

2017



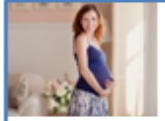
MATERNAL EDUCATION

37% no HS diploma or GED
28% HS diploma or GED
37% some post-secondary or degree



MATERNAL RACE/ETHNICITY

58% White 32% Black
5% Asian 21% Hispanic



PRENATAL CARE

67% of women who were referred to HCF in 1st trimester received prenatal care in the 1st trimester



OUT-OF-WEDLOCK BIRTHS

59% of births were to unmarried women



SMOKING

16% of pregnant women smoked during pregnancy



POSTPARTUM DEPRESSION SCREENING

82% screened for postpartum depression



SUBSEQUENT PREGNANCY

50% no subsequent pregnancy at 24 months postpartum



FIRST TIME MOMS

48% first time moms



BIRTHS

69 births
4% teen births



PREMATURITY

7% of infants were born at least 3 weeks too early



LOW BIRTH WEIGHT

7% of infants were born weighing less than 5.5 pounds



HOME SAFETY CHECK LIST

92% completed



ER/URGENT CARE VISITS

6% had 1 or more visits due to injury



DEVELOPMENTAL MILESTONES

79% met developmental milestones



SOCIAL-EMOTIONAL MILESTONES

95% met social-emotional milestones



CHILD MALTREATMENT

3% of children experienced substantiated maltreatment

HCF Staff



Marilyn Deling, PHN Manager



Sadie Swenson, PHN Manager



Carrie Boyum, PHN



Teresa Buck, PHN



Mary Jo Coleman, PHN



Kristina Collins, PHN



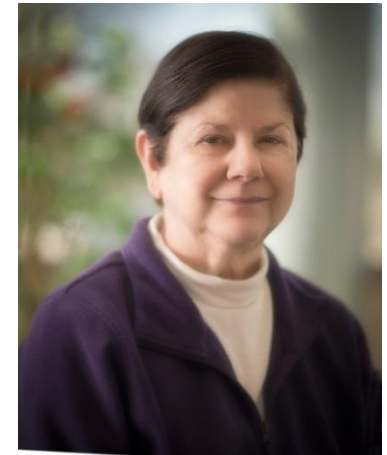
Betsy Eckdahl, PHN



Julie Handley, PHN



Vicki Hattemer, PHN



Becky Hoot, PHN

HCF Staff



Karen Moyer, PHN



Tha Ying Lee, PHN



Christy Niemann, PHN



Rachel Nysetvold, PHN



Paula Ramp, PHN



Lori Root, PHN



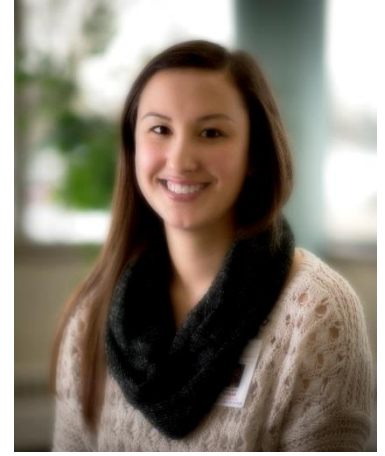
Denise Simons, PHN



Sarah Stevens, PHN



Chris Surprenant, PHN



Tiffany Vang, PHN

HCF Programs

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 public health nurse (PHN) and/or county social worker until the parent is at least 19 years of age.

Babysteps is a program for first time parents with risk factors. Families are enrolled either during pregnancy or within three months 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 three months 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.

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.

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.

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.

Early Childhood Screening Follow-Up Services

OCPHS partners with the Independent School Districts of Bryon, Chatfield, Dover-Eyota, Rochester and Stewartville Early Childhood Screening programs. If an area of need or concern is identified during screening, a PHN is available to assist schools and/or families with information, community resource referrals, and support. These coordinated services help assure kindergarten readiness.

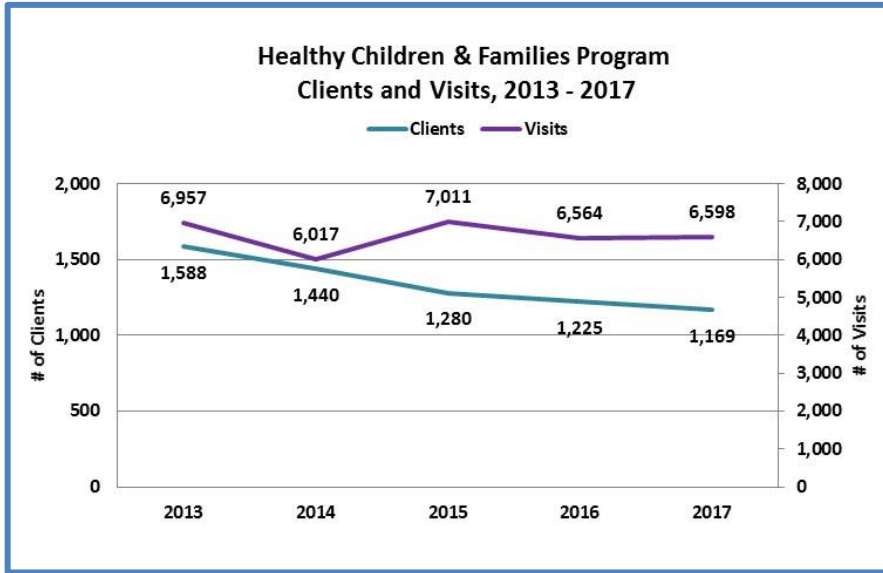
Elevated Blood Lead Case Management

Olmsted County residents under 72 months of age who are tested at a clinic and determined to have an elevated blood lead level are referred to OCPHS. The PHN provides education, support and advocacy to assure follow up lead testing is completed in a timely manner.

HCF Clients and Visits

HCF Clients and Visits

Between 2013 and 2017, the HCF Program PHNs made an average of 6,629 visits to 1,340 clients annually. Since 2013, the number of clients decreased by 26% (1,588 vs. 1,169) and visits decreased by 5% (6,957 vs. 6,598).



HCF Clients – Health Insurance Coverage

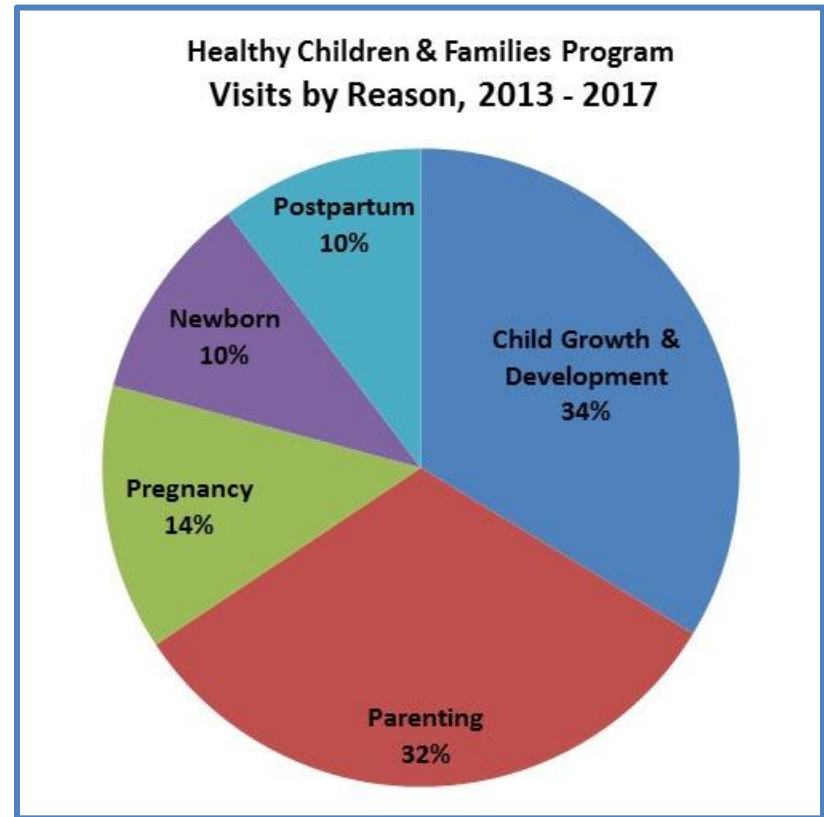


In 2017, 94% of HCF clients had health insurance coverage.

Visits by Reason

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.

From 2013 to 2017, the most frequent reason for HCF visits were related to child growth and development (34%), followed by parenting (32%).



HCF Clients

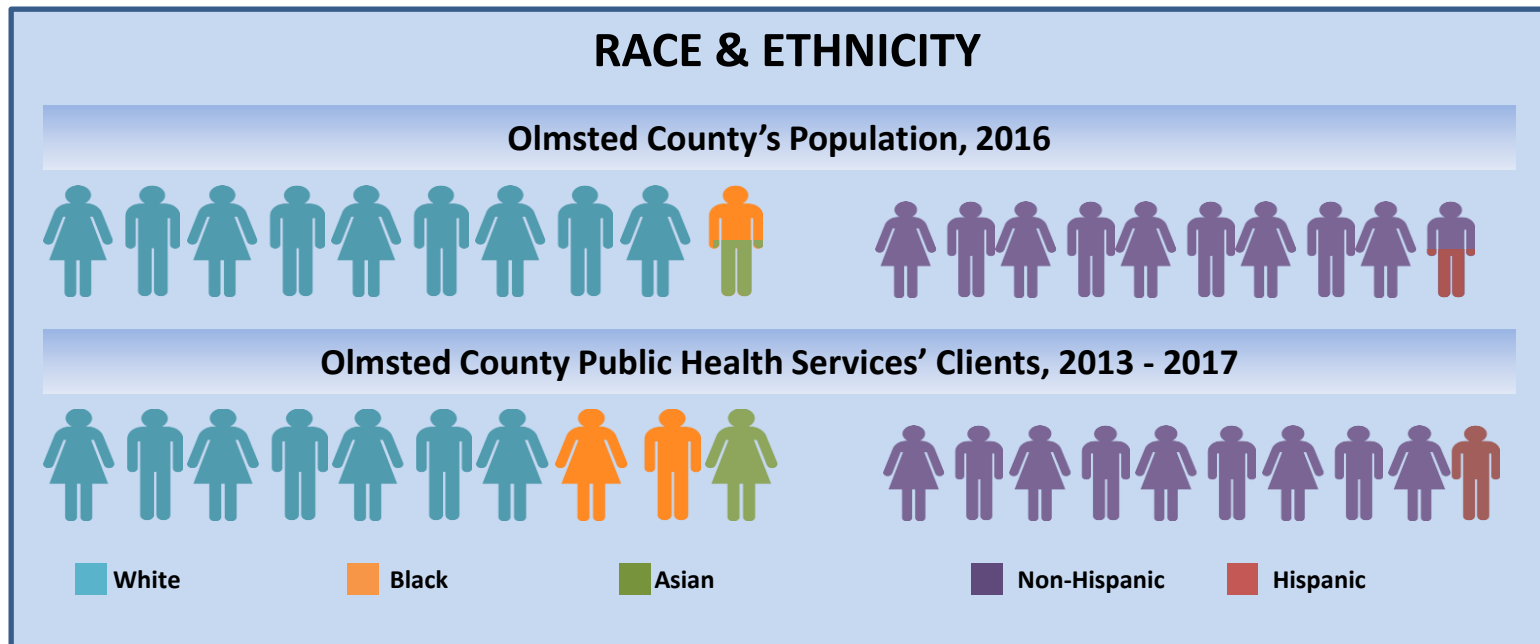
Client Demographics

The HCF client population is more diverse than Olmsted County's general population. The Hispanic population is higher in the HCF Program (13%) compared to Olmsted County (5%)*. This is also true for the black and Asian populations. The racial makeup of HCF clients is 68% white, 16% black, and 7% Asian; Olmsted County's total population is 87% white, 6% black and 7% Asian*.

Females represent 75% of HCF clients.

The largest percentage of HCF clients served are children under five years of age (42%) followed by those between 20 to 29 years of age (27%).

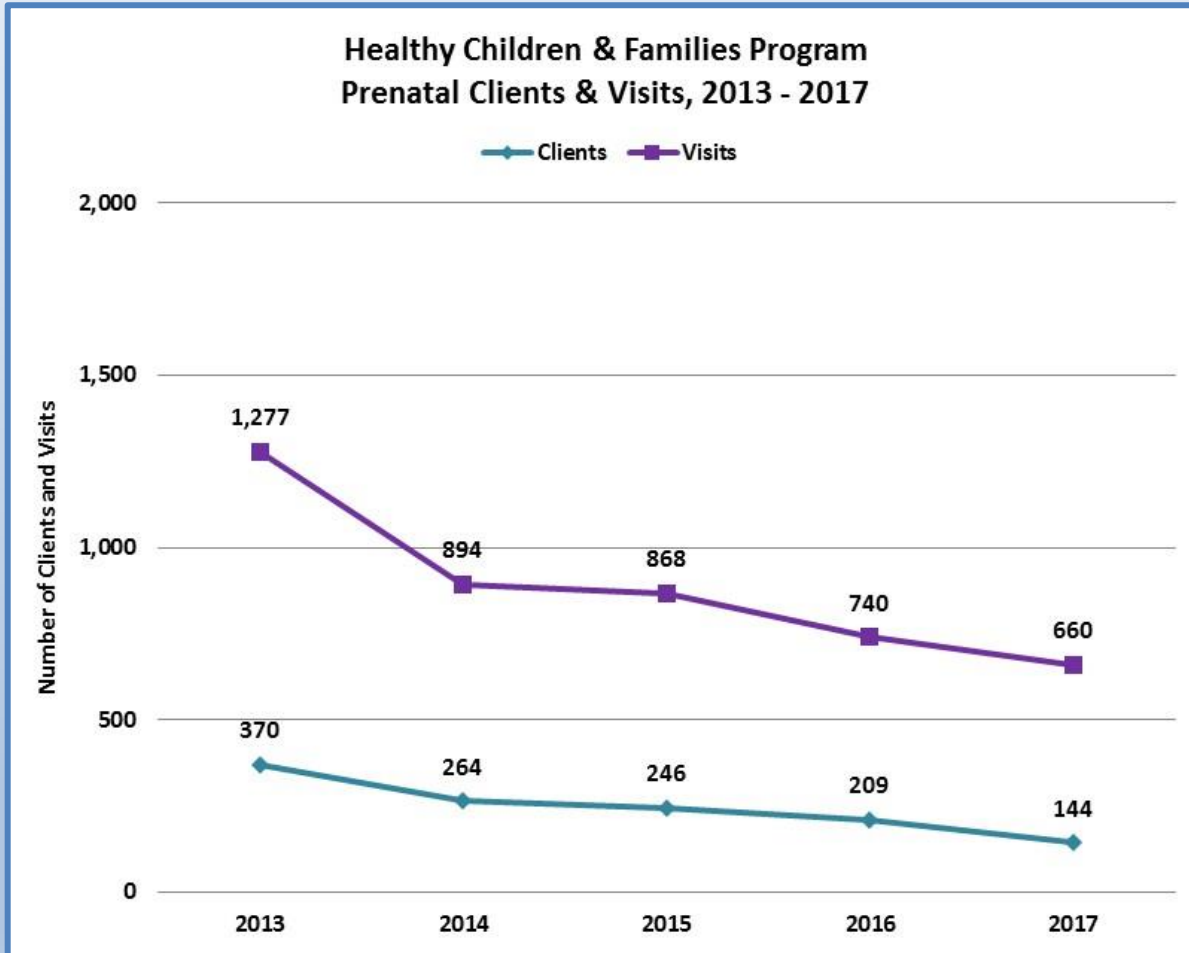
*Olmsted County – 2016 American Community Survey (latest data available)



Pregnancy and Birth

Clients and Visits

From 2013 to 2017, HCF PHNs made an average of 888 visits to 247 prenatal clients annually. There was a 61% decrease in prenatal clients from 2013 to 2017 (370 vs. 144). During this same time period, the number of prenatal visits decreased by 48% (1,277 vs. 660). One potential reason for the decrease is implementation of the Healthy Families America model where more visits are made to fewer families for a longer period of time.

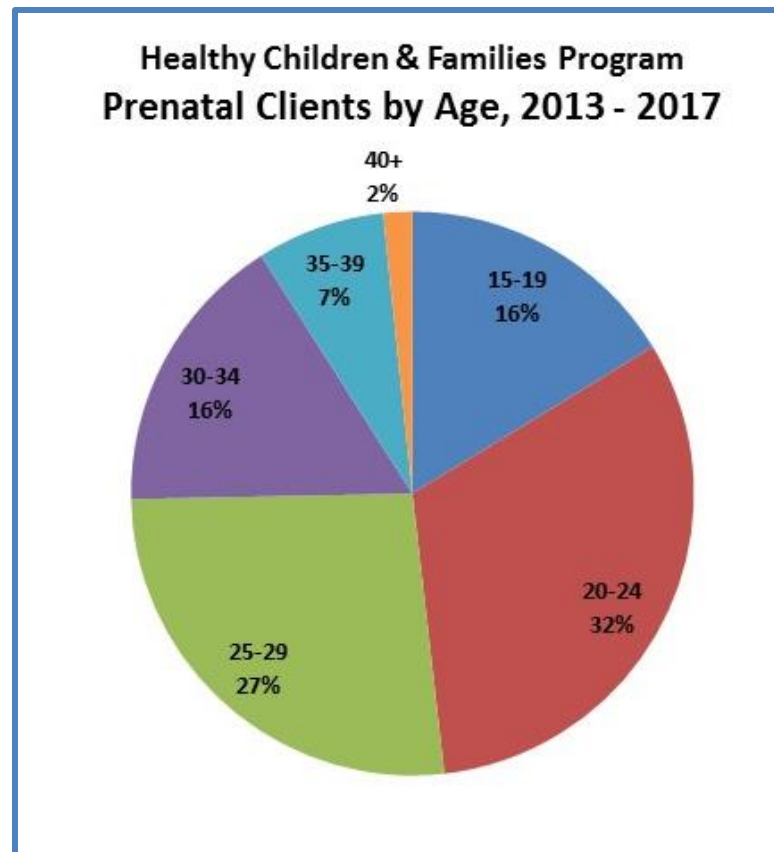
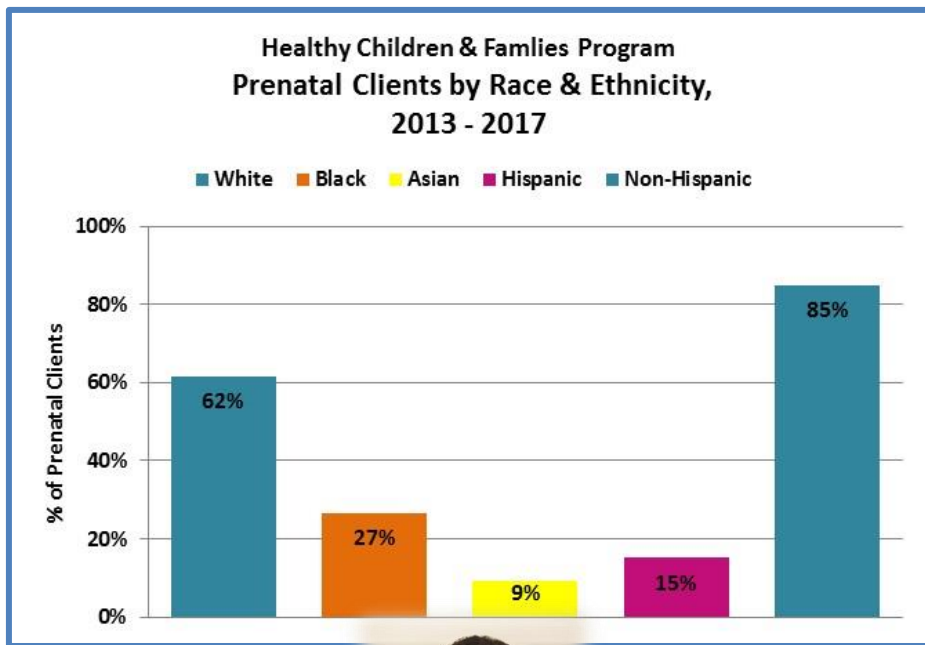


Pregnancy and Birth

Client Demographics

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 62% white, 27% black, 9% Asian and 15% Hispanic. Olmsted County's maternal population is 79% white, 11% black, 8% Asian, and 6% Hispanic*.

From 2013 to 2017, the majority (59%) of HCF clients giving birth were in the 20 to 29 age range. There was a greater percentage of births to those ages 15 to 19 among HCF clients (16%) as compared to Olmsted County (3%*).



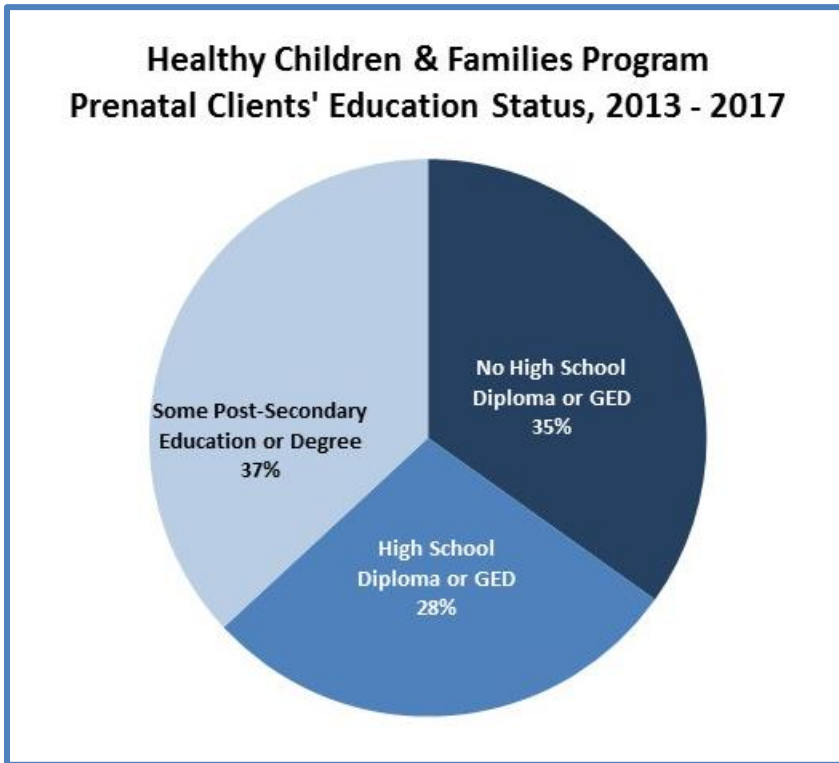
* Olmsted County 2012-2016 – most current data available

Pregnancy and Birth

Maternal Education

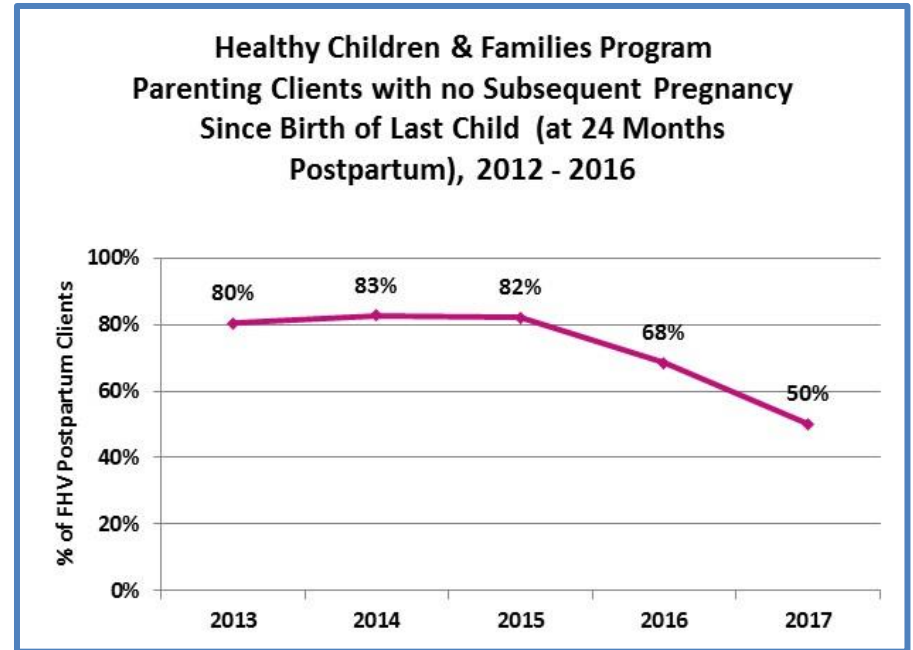
The level of mother's education is defined as the highest level of education achieved within the following categories: high school diploma or GED, no high school diploma or GED, or some post-secondary education or degree.

From 2013 to 2017, 35% of HCF prenatal clients did not have a high school diploma or GED. This is not comparable to Olmsted County since 16% of HCF prenatal clients are teens.



Subsequent Pregnancy

From 2013 to 2017, the percentage of clients reporting they had no subsequent pregnancy at 24 months postpartum decreased 38% (80% vs. 50%).



Pregnancy and Birth

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.

Most Frequent Omaha Problems Prenatal Clients 2013 - 2017		% of Clients
Actual		
1	Income	54.9%
2	Pregnancy	42.3%
3	Mental Health	39.8%
4	Communication with Community Resources	28.0%
5	Caretaking/Parenting	26.2%
Potential		
1	Mental Health	31.0%
2	Income	28.3%
3	Caretaking/Parenting	28.3%
4	Family Planning	16.6%
5	Residence	15.0%
Health Promotion		
1	Caretaking/Parenting	79.3%
2	Health Care Supervision	64.5%
3	Postpartum	64.0%
4	Pregnancy	42.2%
5	Family Planning	38.9%

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 five-point likert scale.

Pregnancy

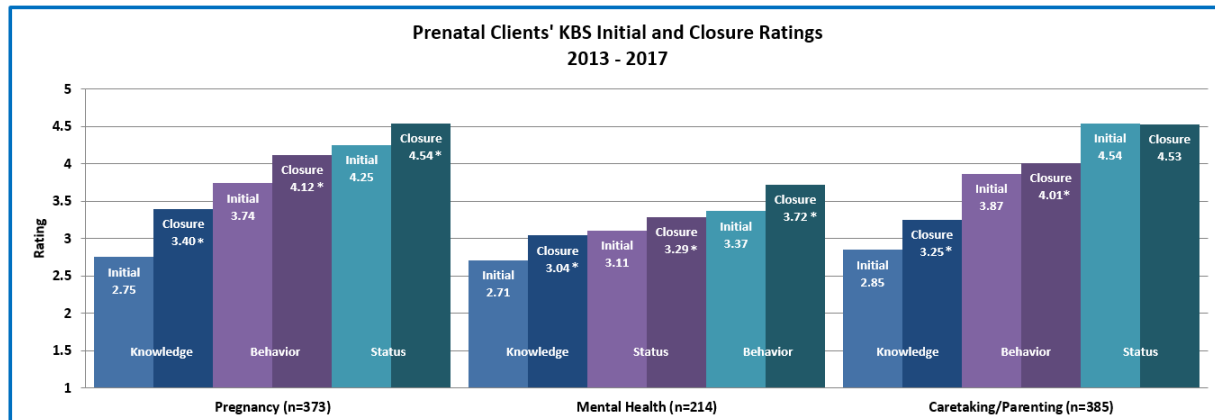
From 2013 to 2017, ratings in all pregnancy KBS areas increased significantly. Client knowledge ratings increased the most from 2.75 to 3.40, while client status ratings increased the least from 4.25 to 4.54. However, the average beginning (4.25) and ending ratings (4.54) were the highest for status. This indicates significant improvement in knowledge, behavior and status related to pregnancy among prenatal clients served.

Mental Health

From 2013 to 2017, ratings in all mental health KBS areas increased significantly. Client status ratings increased the most from 3.37 to 3.72. These ratings indicate significant improvement in knowledge, behavior and status related to mental health among prenatal clients served.

Caretaking/Parenting

From 2013 to 2017, ratings in caretaking/parenting knowledge and behavior increased significantly. Client knowledge ratings increased the most from 2.85 to 3.25. Client status had a slight decrease (4.54 vs. 4.53).



*Significant change

Pregnancy and Birth

Teen Birth Rates

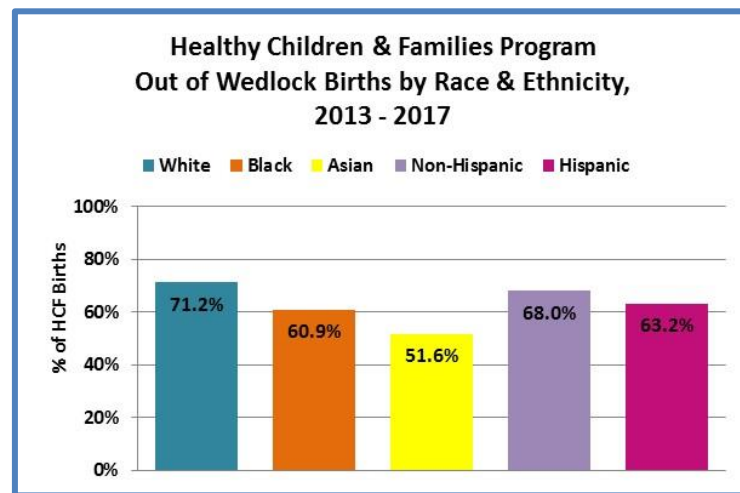
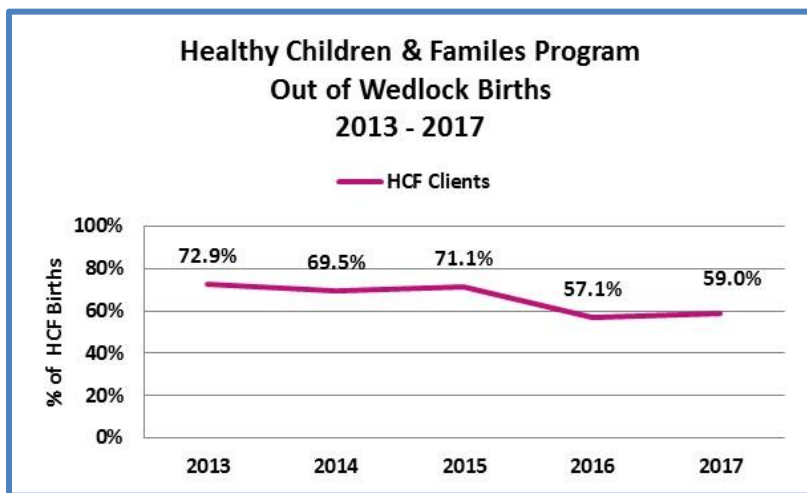
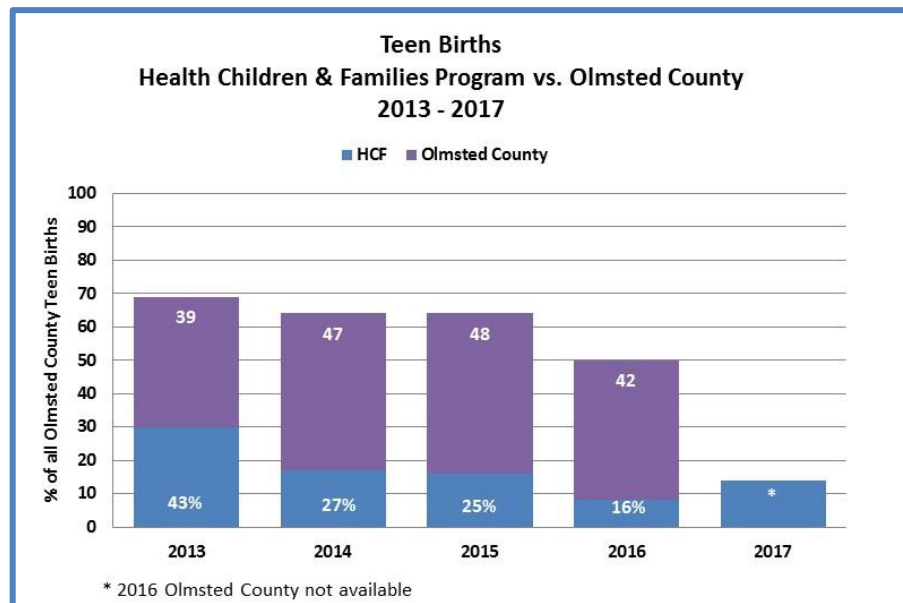
From 2013 to 2017, HCF saw a 53% decrease in Olmsted County teens they served (30 vs. 14).

The maternal race and ethnicity of HCF teen clients was 56% white, 28% black, 8% Asian and 21% Hispanic. Olmsted County's teens giving birth were 72% white, 17% black, 7% Asian and 15% Hispanic*.

Out-of-Wedlock Births

Out-of-wedlock refers to women who are not married to the 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 2013 to 2017, there was a 19% decrease in births to unmarried women (72.9% vs. 59.0%). Births to unmarried white women were 14% higher than black women (71.2% vs. 60.9%) and 38% higher than Asian women (51.6%). Births to unmarried non-Hispanic women were 8% higher than Hispanic women (68.0% vs. 63.2%)



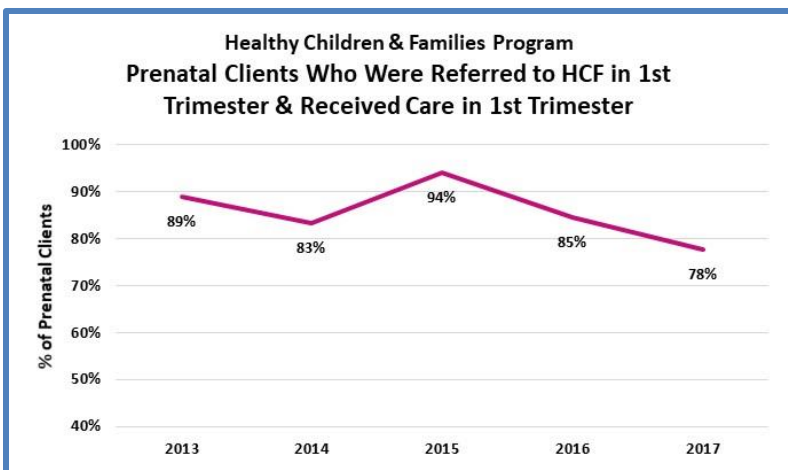
* 2012 – 2016 Olmsted County – most current data available

Pregnancy and Birth

Initiation of Prenatal Care

From 2013 to 2017, an average of 86% of HCF clients who were referred to HCF in their first trimester received prenatal care in their first trimester.

More white clients (97%) who were referred to HCF in their first trimester, received care in their first trimester, compared to black (86%) and Asian (90%) clients. All Hispanic clients who were referred to HCF in their first trimester received prenatal care in the first trimester, compared to 90% of non-Hispanic clients.

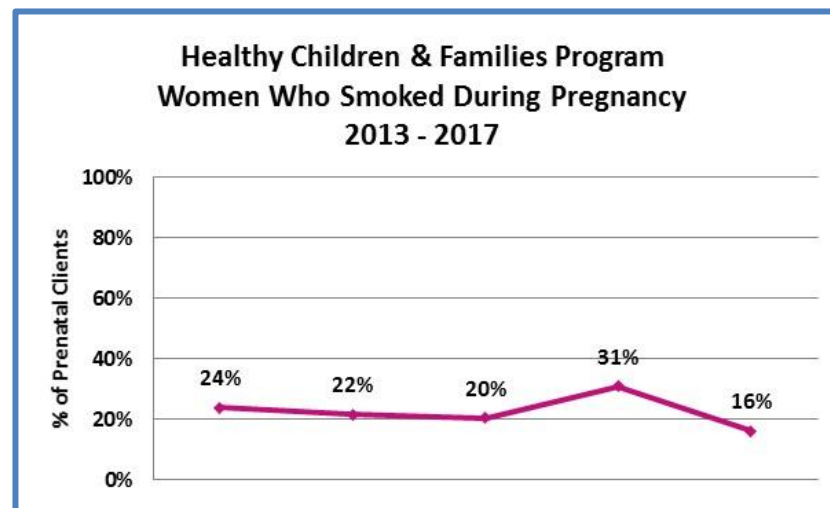


Prematurity

Premature infants are those born before 37 weeks gestation. From 2013 to 2017, 7% of infants born to HCF clients were, the same as Olmsted County*.

Smoking During Pregnancy

In 2017, 16% of prenatal clients reported that they smoked during pregnancy. This is a 33% decrease since 2013 (24%).



* 2012 – 2016 Olmsted County – most current data available

Pregnancy and Birth

Low Birth Weight

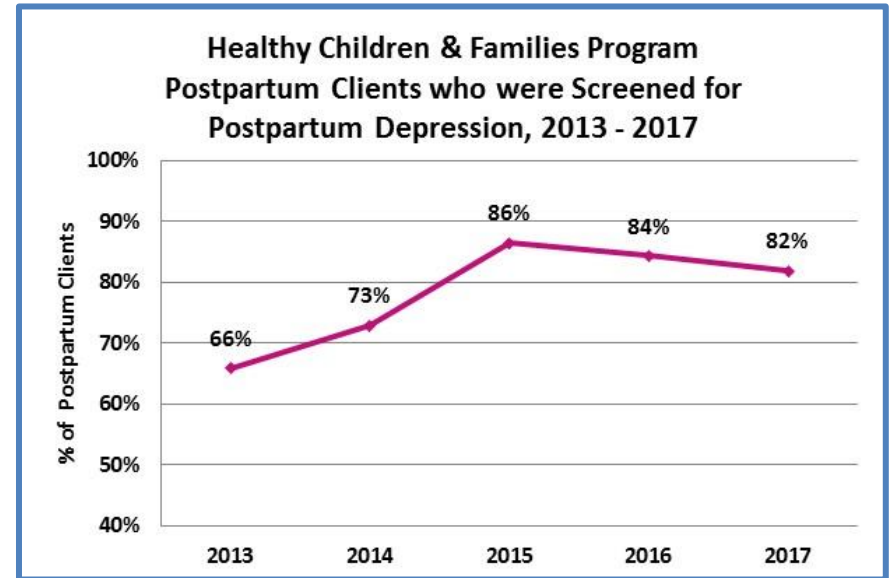
Low birth weight infants are those born weighing less than 2,500 grams, or about 5.5 pounds.

From 2013 to 2017, there were an average of 5 low birth weight babies a year among HCF clients or 6% of all HCF births; the same as Olmsted County.



Postpartum Depression Screening

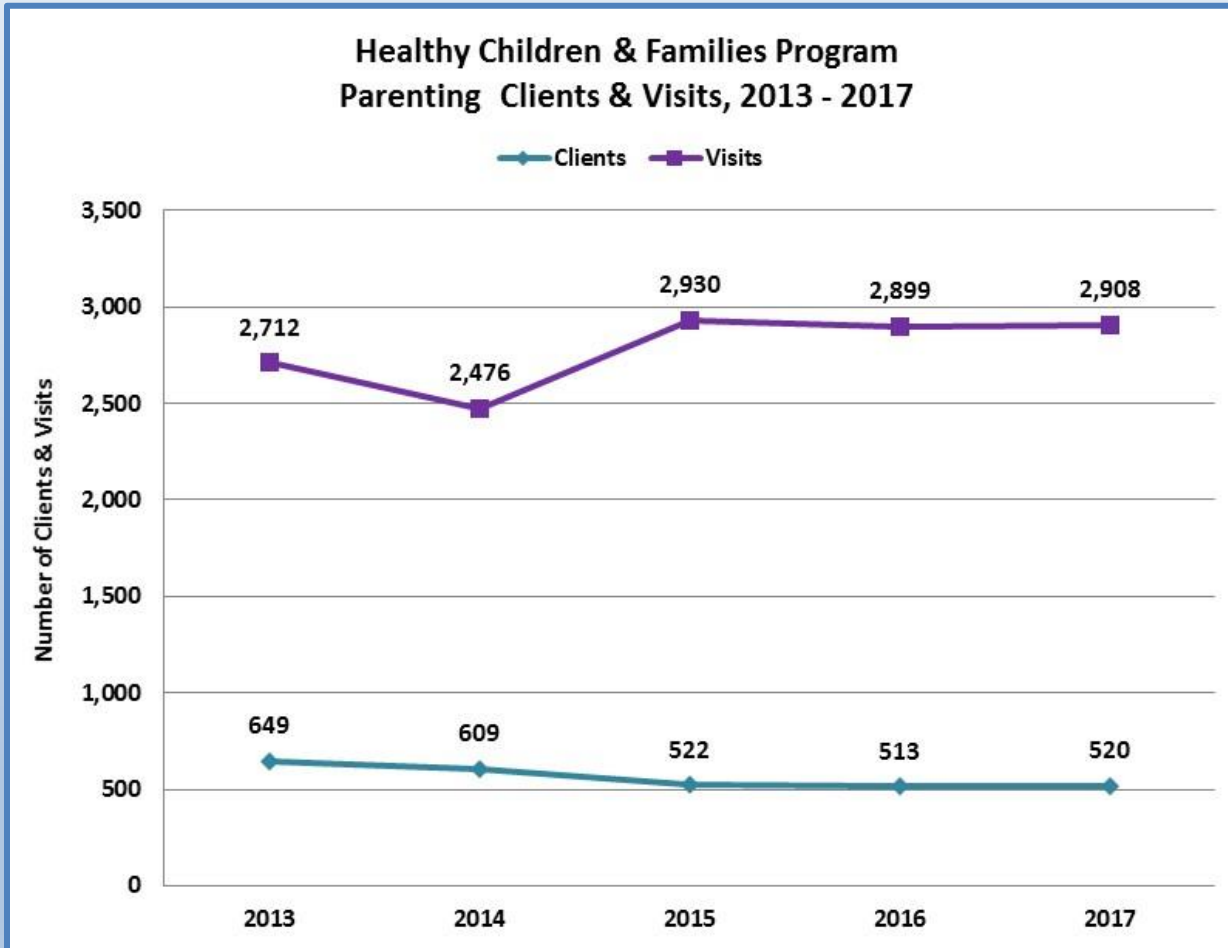
The number of postpartum clients that were screened for postpartum depression increased 30% from 2013 to 2015 (66% vs. 86%), but had a slight decrease from 2015 to 2017 (86% vs. 82%).



Parenting

Clients and Visits

From 2013 to 2017, HCF PHNs made an average of 2,785 visits to 520 parenting clients annually. During this same time period, there was a 20% decrease in parenting clients (649 vs. 520), but a 7% increase in visits (2,712 vs. 2,908) to these clients. One potential reason for the change is implementation of the Healthy Families America model where more visits are made to fewer families for a longer period of time.



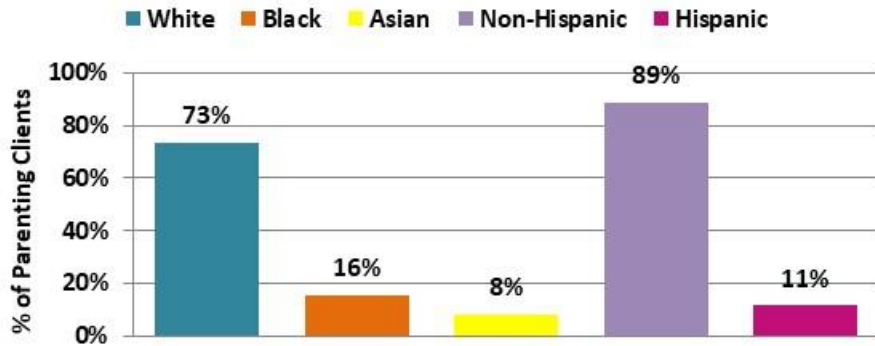
Parenting

Client Demographics

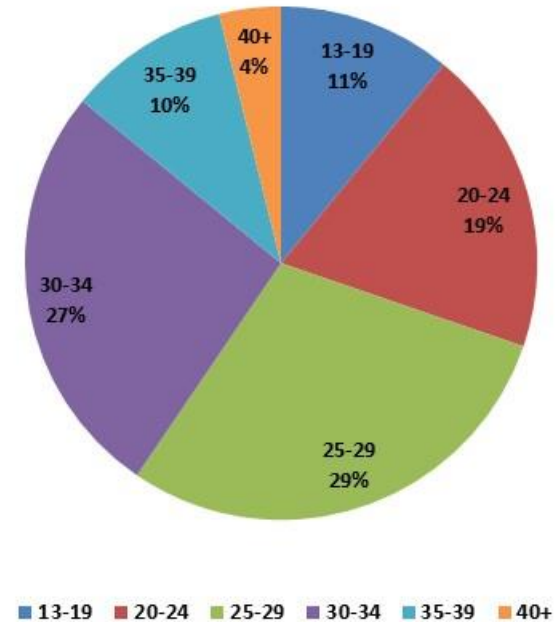
The racial makeup of HCF parenting clients is 73% white, 16% black and 8% Asian; 11% are Hispanic.

The majority of parenting clients are 20 to 34-years-old (75%), followed by 13 to 19-year-olds (11%), and 35 to 39-year-olds (10%). Females represent 95% of all parenting clients.

Healthy Children & Families Program
Parenting Clients by Race & Ethnicity,
2013 - 2017



Healthy Children & Families Program
Parenting Clients by Age, 2013 - 2017



Parenting

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 parenting client problems in each category are listed below.

Rank	Most Frequent Omaha Problems Parenting Clients 2013 - 2017	% of Clients
Actual		
1	Income	51.2%
3	Mental Health	30.2%
2	Caretaking/Parenting	28.4%
4	Residence	19.8%
5	Communication with Community Resources	17.9%
Potential		
1	Income	31.3%
2	Mental Health	21.8%
3	Caretaking/Parenting	20.4%
4	Role Change	18.4%
5	Residence	15.6%
Health Promotion		
1	Caretaking/Parenting	71.6%
2	Postpartum	40.5%
3	Family Planning	24.8%
4	Communication with Community Resources	23.4%
5	Pregnancy	19.8%

KBS

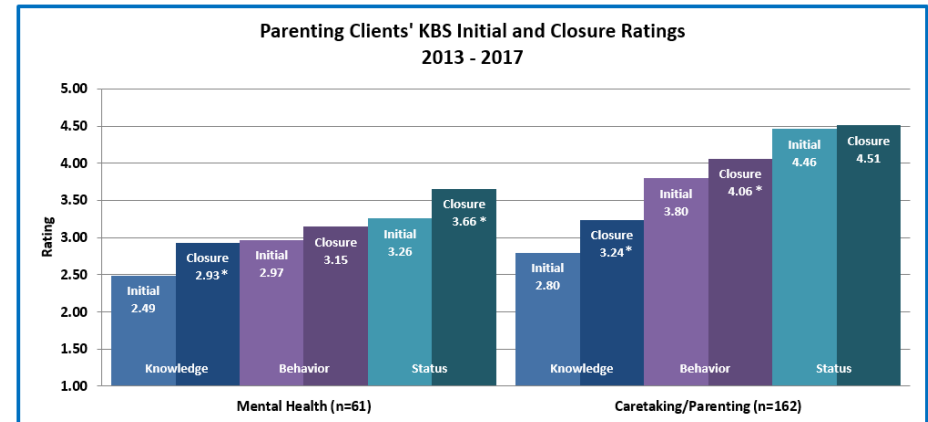
Knowledge, behavior and status (KBS) ratings are used to evaluate a client's progress in relation to one of the 42 health-related problems within the Omaha System, using a five-point likert scale.

Mental Health

From 2013 to 2017, ratings in mental health knowledge and status increased significantly. Client knowledge ratings increased the most from 2.49 to 2.93. Client behavior had a small increase from 2.97 to 3.15. These ratings indicate improvement in knowledge, behavior and status related to mental health among families served.

Caretaking/Parenting

From 2013 to 2017, ratings in caretaking/parenting knowledge and behavior increased significantly. Client knowledge ratings increased the most from 2.80 to 3.24. Client status ratings had a small increase, from 4.46 to 4.51. These ratings indicate improvement in knowledge, behavior and status related to caretaking/parenting among families served.

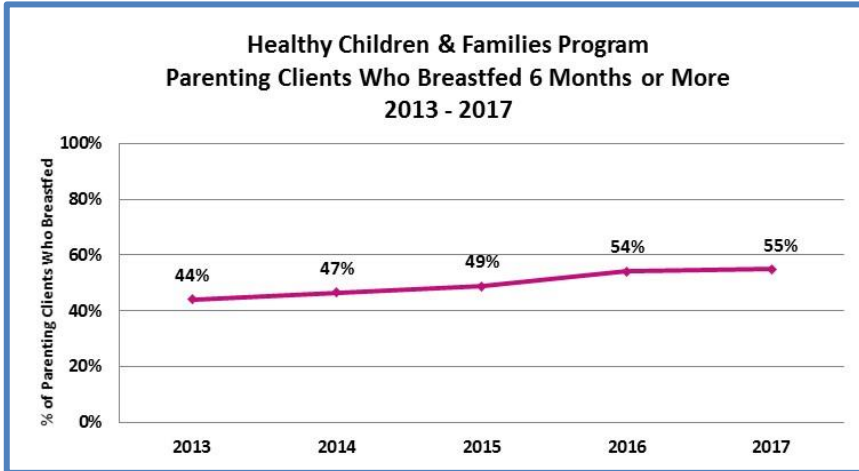


*Significant change

Parenting

Breastfeeding

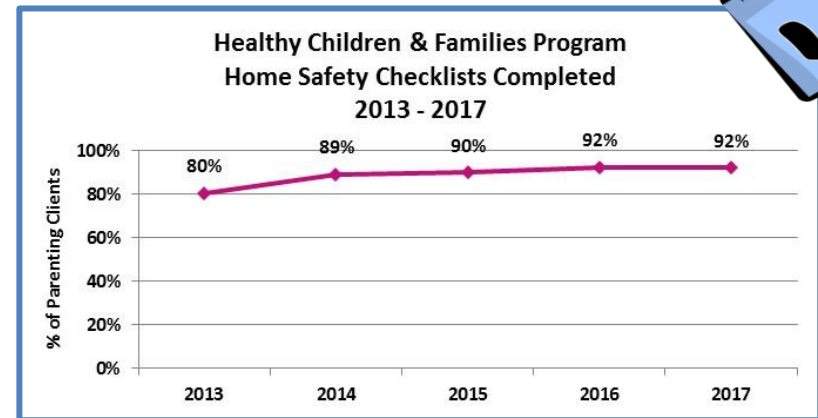
From 2013 to 2017, the number of clients that breastfed six months or more increased by 25% (44% vs. 55%).



Home Safety Checklist

The Home Safety Checklist (HSC) is an educational tool developed by the Minnesota Department of Health that is used to help identify potential hazards in the home of a family or individual. It also suggests ways to prevent injuries and lists home safety supplies.

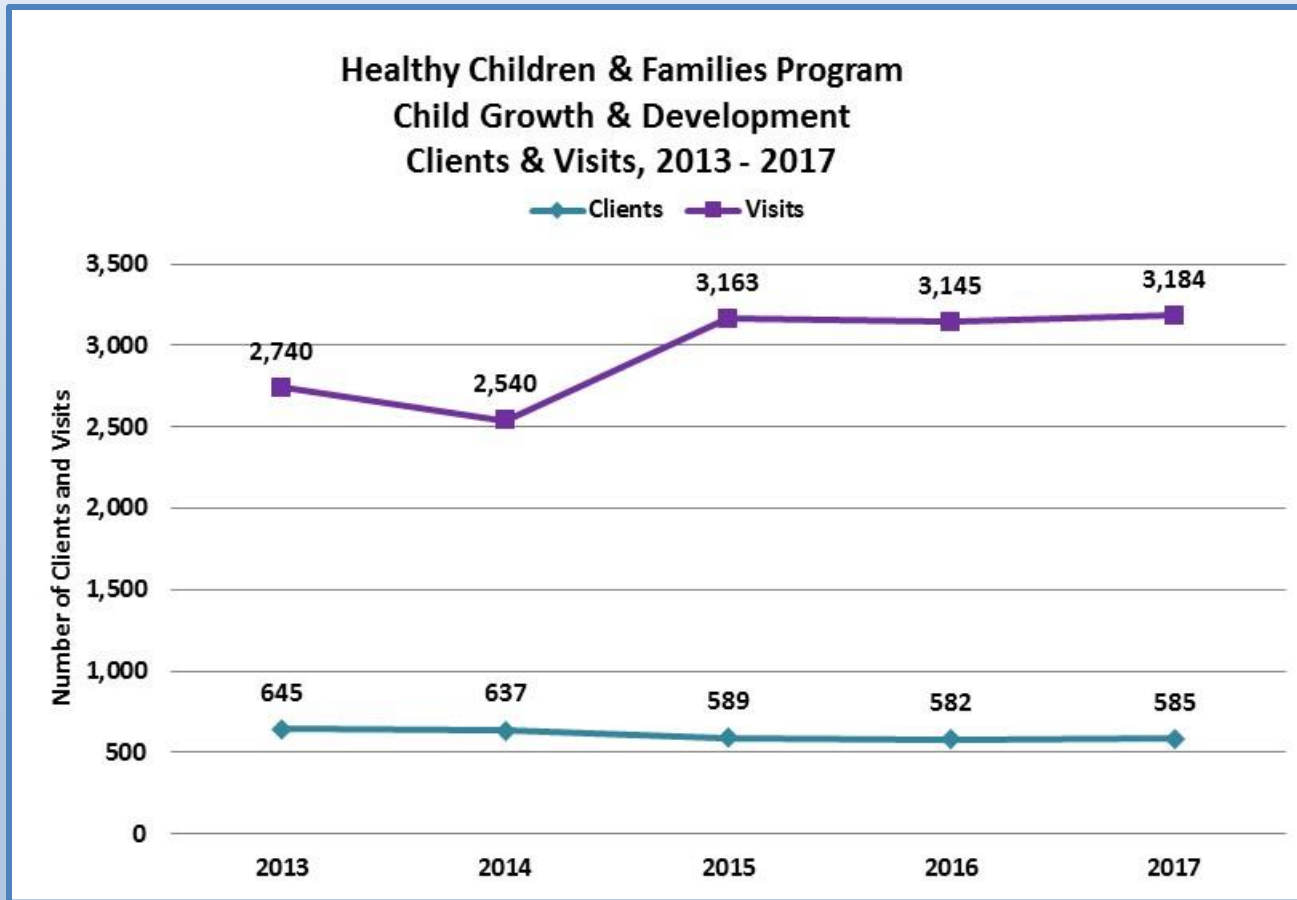
From 2013 to 2017, the percentage of home safety checklists completed increased by 15% (80% vs. 92%).



Child Growth & Development

Clients and Visits

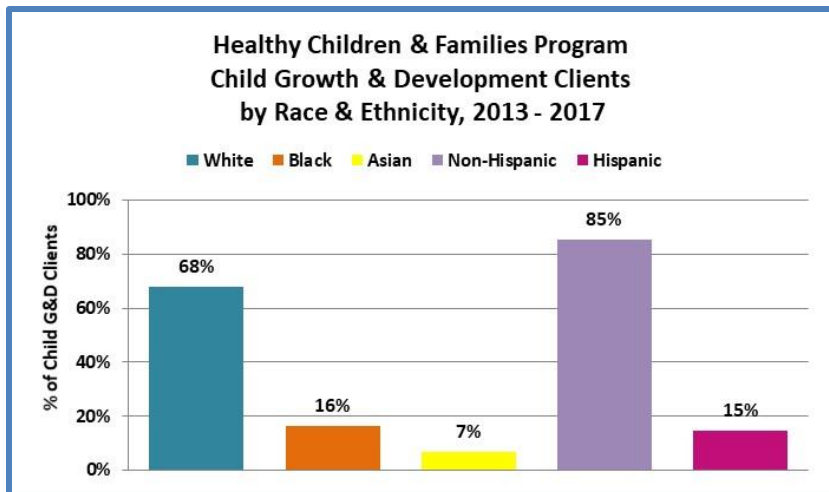
From 2013 to 2017, HCF PHNs make an average of 2,954 visits to 608 child growth and development clients annually. During this same time period, there was a 16% increase in visits (2,740 vs. 3,184). The number of clients decreased by 9% (645 vs 585). One potential reason for the change is implementation of the Healthy Families America model where more visits are made to fewer families for a longer period of time.



Child Growth & Development

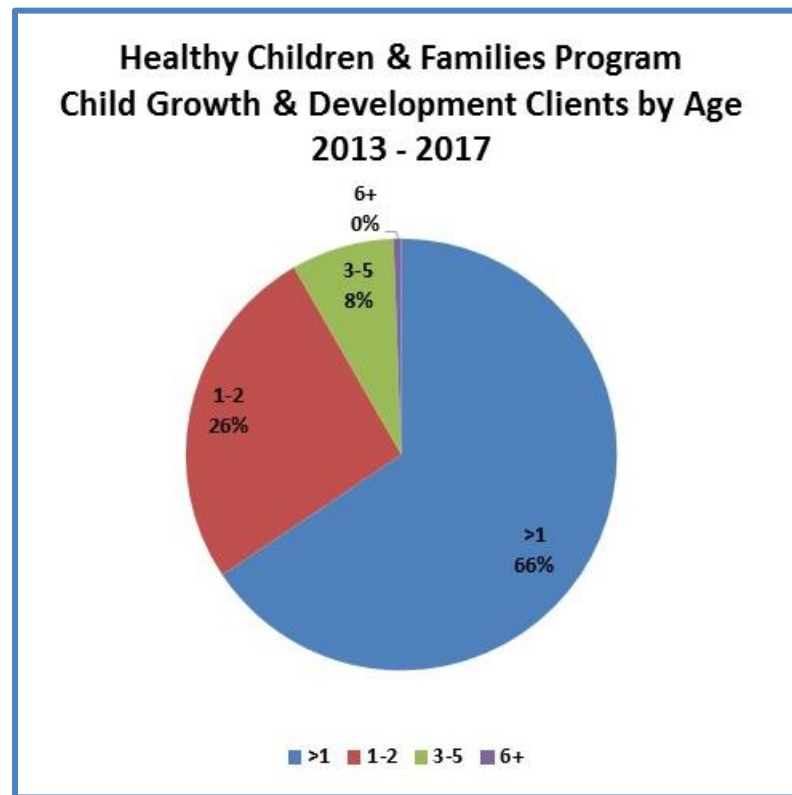
Client Demographics

HCF child growth and development clients' race and ethnicity makeup was 68% white, 16% black and 7% Asian; 15% are Hispanic.



From 2013 to 2017, the majority (66%) of child growth and development clients were under one-year of age, followed by one to two-year olds (26%).

The child growth and development population was 49% male and 51% female.



Child Growth & Development

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 child growth and development client problems in each category are listed below.

Rank	Most Frequent Omaha Problems Child Growth & Development Clients 2013-2017	% of Clients
Actual		
1	Growth & Development	65.8%
2	Health Care Supervision	20.4%
3	Income	9.9%
4	Neglect	5.8%
5	Mental Health	3.8%
Potential		
1	Growth & Development	53.6%
2	Neglect	27.0%
3	Abuse	20.2%
4	Health Care Supervision	21.0%
5	Mental Health	4.0%
Health Promotion		
1	Growth & Development	80.1%
2	Health Care Supervision	80.6%
3	Abuse	6.9%
4	Neglect	6.6%
5	Caretaking/Parenting	3.2%

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 five-point likert scale.

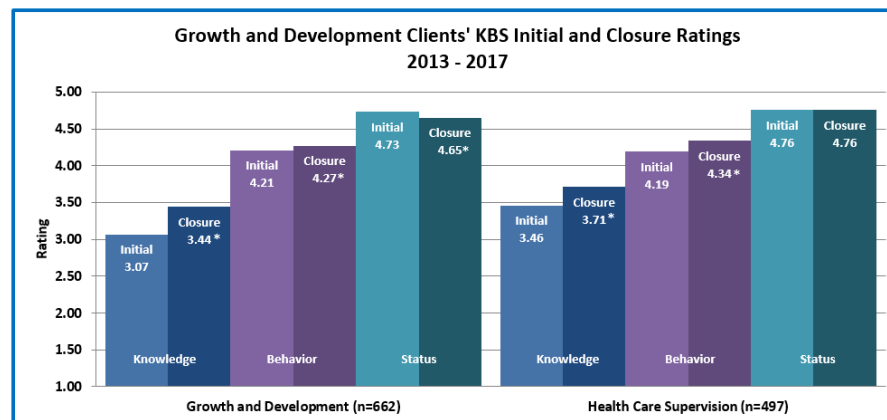
Child Growth and Development

From 2013 to 2017, child growth and development ratings in knowledge and behavior increased significantly. Client knowledge ratings increased the most from 3.07 to 3.44. Ratings in status had a significant decrease, from 4.73 to 4.65. These ratings indicate significant improvement in knowledge and behavior, but a decrease in status, related to child growth and development among families served.

Note: Behavior and status are based on the child, while knowledge is based on the caregiver.

Child Health Care Supervision

From 2013 to 2017, child health care supervision ratings in knowledge and behavior increased significantly. Client knowledge ratings increased the most from 3.46 to 3.71. Client status ratings had no change (4.76). These ratings indicate significant improvement in knowledge and behavior, but no change in status, related to health care supervision among families served.



*Significant change

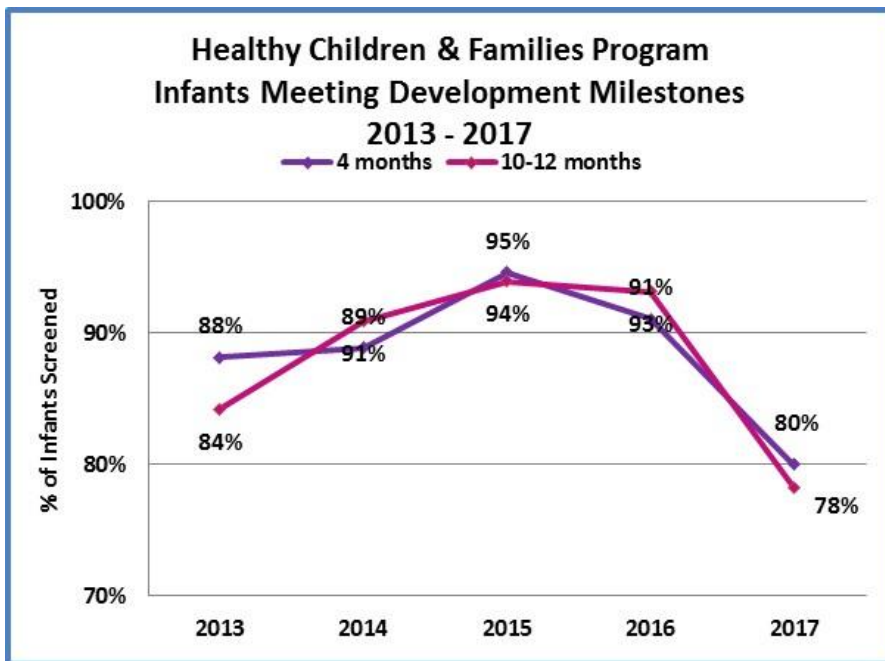
Child Growth & Development

Developmental Milestones

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

In 2017, 80% of 4-month-old infants and 78% of 10 to 12-month old infants met developmental milestones.

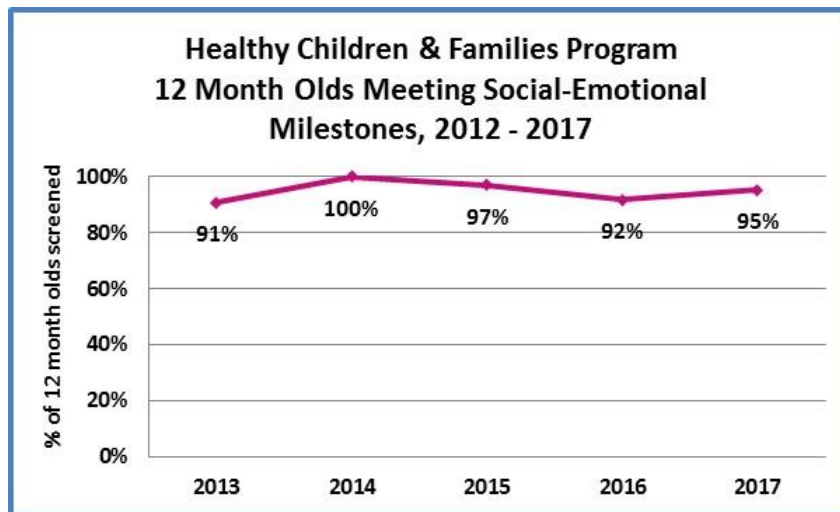
From 2013 to 2017, the majority of infants were meeting developmental milestones. From 2015 to 2017 there was a 16% decrease in 4-month old infants (95% vs. 80%) and a 17% decrease in 10 to 12-month old infants meeting developmental milestones (93.9% vs. 78.3%).



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 2017, 95% of 12-month-olds met social-emotional milestones. From 2013 to 2017, the number fluctuated within 9% but this percentage represents one to eleven children.

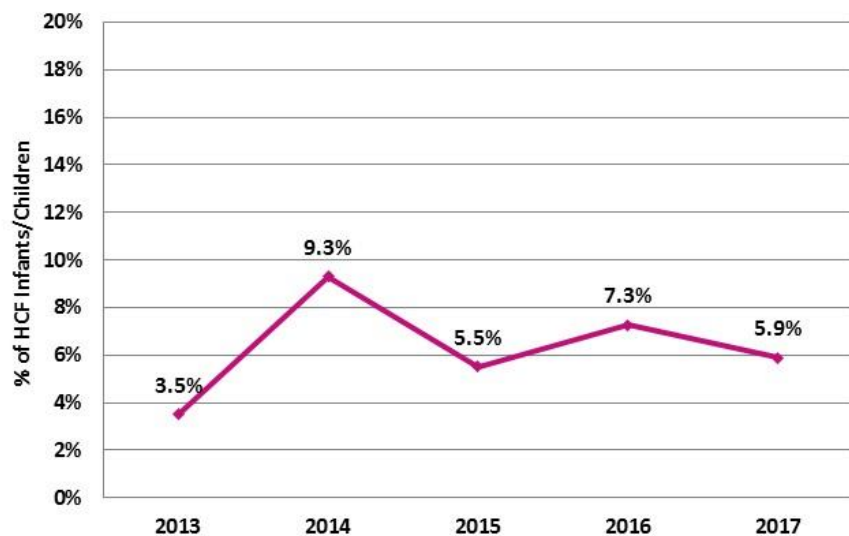


Child Growth & Development

ER/Urgent Care Visits for Injury

From 2013 to 2017, 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 five children to ten children.

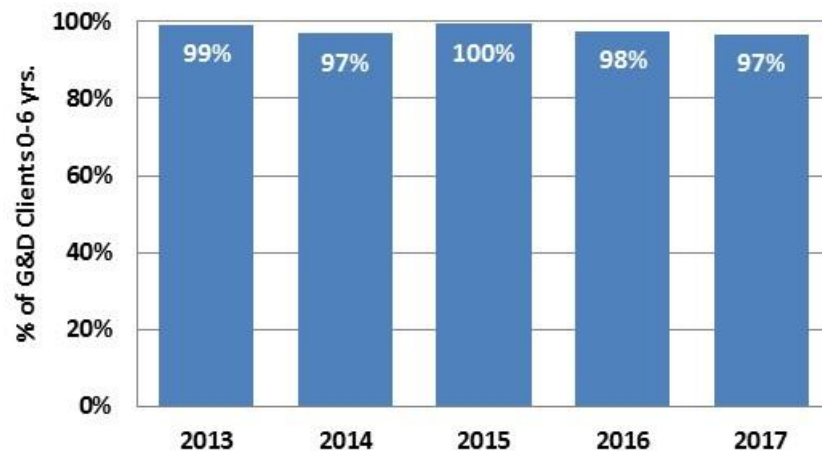
Healthy Children & Families Program
Infants/Children with One or More
ER/Urgent Care Visit For Injury, 2013 - 2017



Substantiated Maltreatment

From 2013 to 2017, 98% of children served by HCF did not experience substantiated maltreatment.

Healthy Children & Families Program
Infants/Children Who Have Not
Experienced Substantiated Maltreatment
2013 - 2017



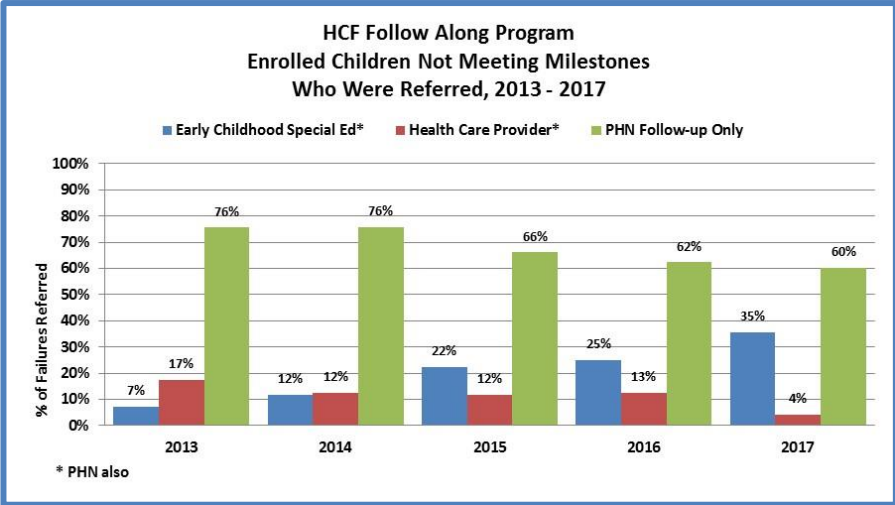
Follow Along Program

Follow Along Enrollment

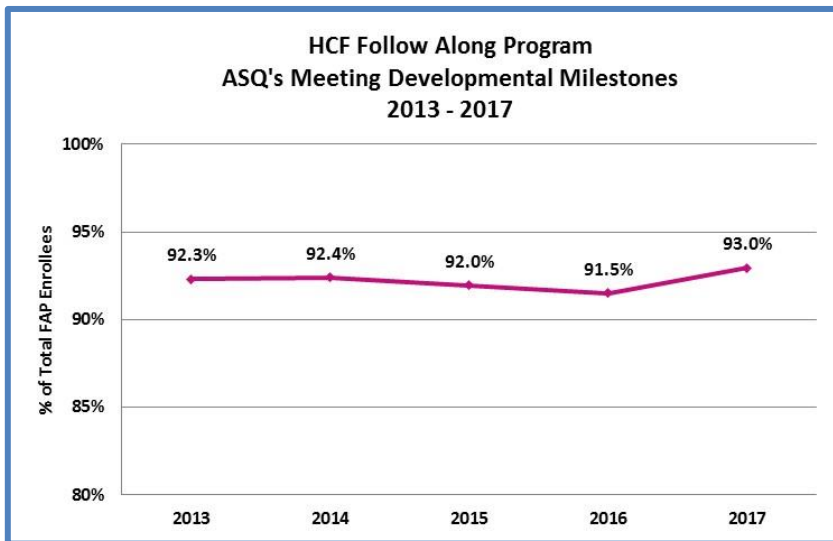
The HCF PHNs and other community partners refer infants to the Follow Along Program (FAP), which offers a periodic assessment of a child's development and ideas for encouraging their development through a computer assisted tracking program. This program is for children birth to 36 months.

From 2012 to 2016, 10% of all first-borns in Olmsted County were enrolled in FAP. *

From 2013 to 2017, over half (54%) of all new enrollees in FAP were first-borns. During this time period, 92% of children met developmental milestones. Of those not meeting developmental milestones, 100% received follow-up from a public health nurse, 21% were referred to Early Childhood Special Education (ECSE) and 11% were referred to a health care provider. Of those referred to ECSE, 60% qualified for services from ECSE.



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.



* Olmsted County 2012-2016 – most current data available

Customer Service

Overview

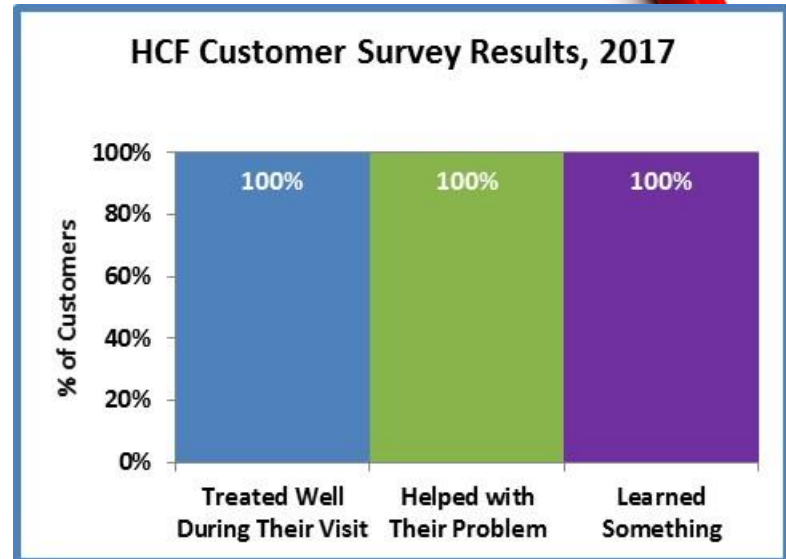
In 2017, HCF Public Health Nurses had clients complete a customer service survey. Clients were randomly selected and surveys were collected three times during the year for a month. The purpose of the survey was to gauge customer satisfaction with the services they were provided. Clients completed questions on how well they were treated, if HCF staff helped them with their problems and if they learned anything from HCF staff. In total, 88 clients completed the survey. The majority of clients had visits that focused on growth and development.

In 2017, **100%** of HCF clients indicated they were:

- **Treated well,**
- **Helped with their problems, and**
- **Learned something**

One client mentioned, *“HCF helps me understand anything I have a question with”*.

Satisfaction Survey	
<input checked="" type="checkbox"/>	Excellent
<input type="checkbox"/>	Good
<input type="checkbox"/>	Acceptable
<input type="checkbox"/>	Fair



Conclusions and Next Steps

Conclusions

The HCF Program 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 (2013-2017), measured improvements have been made among those served in the HCF Program, including:

- 53% reduction in teen births
- 33% decreased in women who smoked during pregnancy

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

All HCF clients indicated they were treated well, were helped with their problems and learned something from their PHN visit.

Next Steps

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

- Continuing to use the Health Families America model 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.

