



**Maternal and Child Health Services  
Title V Block Grant**

**State Narrative for  
Minnesota**

**Application for 2013  
Annual Report for 2011**



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## **I. General Requirements**

### **A. Letter of Transmittal**

The Letter of Transmittal is to be provided as an attachment to this section.

***An attachment is included in this section. IA - Letter of Transmittal***

### **B. Face Sheet**

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

### **C. Assurances and Certifications**

The signed Assurances and Certifications are available upon request from:

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### **D. Table of Contents**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2012; expires January 31, 2015.

### **E. Public Input**

In Minnesota, the opportunity for public input into the MCH planning process is ongoing, utilizing a variety of methods at both the state and local levels. Minnesota Statutes 145.882 subd. 3, distributes two-thirds of the federal MCH Block Grant by formula to local public health agencies (called Community Health Boards (CHBs)) and specifically limits the use of these funds to programs that address MCH and CYSHCN issues. CHBs report annually to the department on how community input was obtained and used in the process of identifying how federal Title V Block Grant funds will be used in their communities. Other opportunities for local community input occur at public hearings when annual budgets for public health activities are reviewed and approved, and through dialogue at either community Maternal and Child Health or Public Health Advisory Groups.

Local public health agencies report that they primarily use community surveys, focus groups, key informant interviews, local MCH advisory groups and community forums and their every five year community assessment and planning process to garner public input (attachment). In 2010, one of the most common issues identified by CHBs was the lack of access in their communities to dental services. Local public health agencies reported that they responded by working on addressing this issue during the reporting period. Examples of activities include providing fluoride varnish application at EPSDT and WIC clinics, convening community stakeholder groups to address the issue of dental access, and participating with local dentists in Give Kids a Smile Day.

The Maternal and Child Health Advisory Task Force provides a particularly significant source of

input. This statutorily required advisory group (Minnesota Statutes 145.881), comprised of 15 members equally representing professionals, representatives from local public health, and consumer representatives, is charged with reviewing and reporting on the health care needs of Minnesota's mothers and children and recommending priorities for funding and activities. The Task Force played a key role in the 2010 MCH Needs Assessment and they are encouraged to review and comment on the annual application and report.

In addition, the Commissioner of Health, in consultation with the State Community Health Services Advisory Committee and the Maternal and Child Health Advisory Task Force, develops a set of statewide public health measures for the local public health system every five years. The State Community Health Services Advisory Committee is a statutorily (Minnesota Statutes 145A.12, subdivision 7(e)) required advisory group that is charged with providing the Commissioner of Health with recommendation on the development, maintenance, funding, and evaluation of community health services. These statewide local public health objectives are to be based on state and local assessment data regarding the health of Minnesota residents, the essential local public health activities, and Minnesota public health goals.

***//2013/ The State Community Health Services Advisory Committee currently has a Performance Improvement Steering Committee. One of the tasks of this committee is to identify performance measures for local public health -- including MCH measures. Title V staff have been working with this group to solicit significant input on those measures from local public health staff on the committee and local public health representatives on the MCH Advisory Task Force. The goal is to identify measures that most accurately reflect MCH activities at the local level and that support the Title V national and state performance measures. This group has met monthly for over a year and will continue to meet throughout 2013. //2013//***

A number of initiatives that have taken place since 2004 will inform the current effort. These include: the modifications of a the local public health measurement reporting system for Minnesota; the development of national voluntary accreditation standards; the release of County Health Rankings from the University of Wisconsin Population Health Institute measurement project; and the priority needs and measures identified for the Title V Needs Assessment for 2010-2014. Additionally, the MDH is undertaking a strategic planning process to identify goals and key indicators for the Department. The statewide local public health objectives need to fit with and complement these other important projects.

The MCH block grant application and annual plan is available on the Minnesota Department of Health website for review and comment by the general public.

## **II. Needs Assessment**

In application year 2013, Section IIC will be used to provide updates to the Needs Assessment if any updates occurred.

### **C. Needs Assessment Summary**

Minnesota recently revised the local public health assessment and planning process to more closely align with national standards established by the Public Health Accreditation Board. This includes requiring local public health departments to submit to the MDH "Ten Areas of Greatest Community Health Need." The submission of these needs is timed to assure that the compilation of local public health MCH needs can be reflected in the 2015-2020 Title V needs assessment.

The MCH Advisory Task Force receives annual updates on activities related to the overall implementation of the Title V Block Grant at the state and local level. The group also receives an update on the results of Minnesota's Title V review. Following the review discussion, Task Force members brainstorm ideas for the next year's Task Force work plan. While the priority needs identified through the needs assessment serve as the framework for this discussion, emerging issues and state and local MCH issues are also considered.

The MCH Advisory Task Force is implementing a Children and Youth with Special Health Needs Work Group. The charge of this group is to "inform the statewide children and youth with special health care needs program to improve the quality, efficiency and effectiveness of the public health role in meeting the needs of children with special health care needs and their families. The group will also provide direction and advice on establishing priorities and developing plans for CYSHN activities." While Minnesota's Title V needs assessment and plan outline a number of activities related to CYSHN, the MDH is convening this work group to explore the next steps to more specifically outline a plan to meet the priority needs specific to CYSHN.

The State Community Health Services Advisory Committee currently has a Performance Improvement Steering Committee. One of the tasks of this committee is to identify performance measures for local public health -- including MCH measures. Title V staff have been working with this group to solicit significant input on those measures from local public health staff on the committee and local public health representatives on the MCH Advisory Task Force. The goal is to identify measures that most accurately reflect MCH activities at the local level and that support the Title V national and state performance measures. This group has met monthly for over a year and will continue to meet throughout 2013.

### III. State Overview

#### A. Overview

Minnesota is seen as a state where the people enjoy a high quality of life and experience generally better measures of health compared to most other states. Minnesota consistently ranks as one of the most desirable and healthy states in which to live and work. When parents are asked about the overall health status of their child, 91.4 percent report that it is excellent or very good (compared to 84.4 percent nationally). In 2008, nearly 79 percent of Minnesota adults (16-64) were employed, compared to 71 percent in the nation overall. Minnesotans are engaged in their communities; the voter turnout in Minnesota for the 2008 elections was the highest in the nation at 74 percent of the voting-age population casting a ballot and approximately 37 percent of Minnesotans volunteer, which is 10 percentage points higher than the rest of the nation.

Minnesota is however experiencing the same pressing economic challenges being felt across the country. In May 2010, the Minnesota legislature and the Governor agreed on a budget that closed the state's \$3 billion shortfall for SFY 2010. While programs for children did receive cuts, the cuts were less than the Governor originally recommended. However, a projected state budget deficit of almost \$6 billion for 2012-2013 biennium will again put significant pressures on state funded programs supporting mothers and children. //2012// As of this writing, the state of Minnesota is facing an unresolved 5 billion dollar deficit for the next biennium. By state constitution the legislature ended May 23, 2011 with many of the state's major agencies without budgets for 2012-2013 biennium. While a special session may be called before June 30, 2011 to finalize agency budgets, the state is in the midst of planning for a possible shutdown of most of state government on July 1, 2011. Only the Department of Agriculture and a few minor agencies have approved budgets for the SFY 2012-2013 biennial budget period and would remain open.//2012/ ***2013/ Despite intense negotiations over a \$1.4 billion short fall, a budget stalemate occurred between the Governor and legislature resulting in a historic state shutdown for twenty-one days. Only services deemed "critical" continued during the shutdown. These critical services included basic custodial care for residents of state correctional facilities, regional treatment centers, nursing homes, veteran's homes and residential academies; maintenance of public safety and immediate public health concerns; provision of benefit payments and medical services to individuals; preservation of the essential elements of the financial system of government; necessary administration and supportive services, including but not limited to computer system maintenance, Internet security, issuance of payments and the judicial system. All state Title V staff were placed on layoff status. Despite the significant financial issues experience in the 2011 legislative session, the 2012 session was relatively quiet with a small budget surplus. Each of Minnesota's 201 legislators will face election this fall due to a 10 year redistricting plan and speculation is already occurring about whether the GOP will be able to maintain their past majority in the house and/or senate. //2013//***

**Demographics** Minnesota is a medium-sized state, encompassing slightly more than 84,000 square miles. Minnesota's per capita income in 2008 was \$42,772, which ranked thirteen in the country, with the national per capita income of \$39,138. The 2009 Minnesota unemployment rate of 8.0 percent was a significant increase from our 2008 rate of 5.4 percent although it compares favorably with the national unemployment rate in 2009 of 9.3 percent. //2012// The annual average Minnesota unemployment rate in 2010 was 7.3 percent, compared with the national rate of 9.6 percent. As of April 2011 the seasonally-adjusted unemployment rate was 6.5 percent, continuing a decline from a high of 8.5 percent in mid-2009. //2012// While it remains a major agricultural producer, Minnesota's economy is also driven by service sector industries such as healthcare, manufacturing, financing, insurance, real estate, and wholesale and retail trade. The workforce sustaining this economy comes from a population of 5,220,393 (2008 estimate) people, making Minnesota the 21st most populous state in the nation. More than half of Minnesota's residents live in the 7-county Minneapolis-St. Paul metropolitan area. The Minneapolis-St. Paul area is one of the fastest growing regions in the Midwest and is predicted to continue rapid

growth, expecting to reach three million in 2010. //2012//Population counts from the 2010 US Census show over 5.3 million people in Minnesota, with over half (2.85 million) in the 7 county Minneapolis-St. Paul metropolitan area.//2012//

In 2008, there was an estimated 1,406,875 rural Minnesota residents (27 percent of the total Minnesota population). American Indians comprise a significant proportion of the population and cultural heritage of Minnesota. //2010//In 2008, the American Community Survey estimated 18,775 American Indian children lived in Minnesota, which was about one percent of the total child population. The majority of these children lived across northern Minnesota. According to the Minnesota State Demographic Center, the American Indian population is projected to grow more slowly than other communities of color in Minnesota. Approximately half of the American Indian population live on seven Chippewa Ojibwe (all seven reservations in Minnesota were originally established by treaty and are considered separate and distinct nations by the United States Government) and four Dakota reservations (which represent small segments of the original reservation that were restored to the Dakota by Acts of Congress or Proclamations of the Secretary of Interior), while the remainder lived in major population centers and communities spread across the state.//2012//

Minnesota's population is aging. Overall, Minnesota's age distribution is similar to the national average. The three year estimates from the American Community Survey 2006-2008 indicates that sex and age distribution of Minnesota is close to that of the United States. The Minnesota population is estimated at 49.8 percent males and 50.2 percent females which are close to the United States estimates of 49.3 and 50.7 percent respectively. Children under the age of five represent 6.8 percent of Minnesota's population (6.9 percent U.S.) with eighteen years and older comprising 75.8 percent of the Minnesota population (75.5 percent U.S.) and individuals over 65 comprising 12.3 percent (12.6 percent U.S.). The median age of Minnesota is 37.1 and the United States median age is 36.7. By 2030, the number of Minnesotans over age 65 is expected to more than double and older adults will comprise about one-fifth of Minnesota's total population.

***//2013/ Birth rates in Minnesota have dropped to their lowest levels in 20 years. In 2010, there were 68,407 births in Minnesota and 2011 numbers are expected to be lower. At the same time the number of women getting abortions has declined to the lowest level since the department began data collection in 1975. Last year, 11,071 abortions were performed in Minnesota and for the first time the abortion rate dropped below 1 percent among Minnesota women of child bearing age, to 0.97 percent.//2013//***

Demographically, Minnesota had a relatively homogenous racial and ethnic population for most of the twentieth century. This is changing, and although the absolute numbers of populations of color are not large, the rate of change is. Between 2000 and 2008 the state's population of color grew by 32 percent, compared to only 2 percent among whites. About 15 percent of our state's residents are now persons of color, compared to only about 1 percent in 1960. The 2008 population estimates indicates that 89 percent of Minnesotans are White, 4.6 percent are Black; 1.2 percent American Indian; 3.5 percent Asian; 1.5 percent are of two or more races and 4.1 percent are Hispanic/Latino. Population estimates for children by race in 2007 highlight the changing face of Minnesota in that 78 percent of children were white; 6 percent black; 1 percent American Indian; 5 percent Asian; 3 percent two or more races and 6 percent Hispanic or Latino. //2012// The 2010 US Census show that almost 27 percent of Minnesota children under age 18 are persons of color, compared with 14 percent of Minnesotans aged 18 or older (7.9 percent of children in Minnesota are Hispanic or Latino (of any race), 7.4 percent Black or African American, 5.2 percent Asian, 1.4 percent American Indian, 73.4 percent White, and 4.5 percent are of two or more races.//2012// ***//2013/While still less diverse than the U.S. as a whole, minorities currently make up 17 percent of the total Minnesota population compared to 36 percent of the national population. However, minorities now make up 30 percent of the state's population under age 5. In some parts of the state, the percentage of preschool-age children who are minorities is approaching 50 percent or more. Minorities have become the majority among the preschool population in Mahnommen County (71%); Nobles County***

**(60%); Ramsey County (54%) and Hennepin County (48%). St. Paul has the largest percentage of Hmong and Karen students of any district in the country.//2013//**

Beginning in the late 1970's Minnesota began to see a new wave of international immigration. Following the end of the war in Vietnam, large numbers of refugees from Southeast Asia began to arrive in Minnesota. After the fall of the Soviet Union in 1991, an increased number of refugees came from Eastern Europe. The hostilities in Bosnia-Herzegovina brought more refugees from what was Yugoslavia. Famine and civil war bring large numbers of refugees from Africa, particularly from Somali. Minnesota's non-profit organizations are welcoming and provide needed services and support to these newcomers, and Minnesota has become a prime destination for refugees. During this same period of time, immigrants came to Minnesota to work in high tech industries. Large numbers of people came from India, China, and Pakistan. These well-educated and well-trained immigrants were hired in the 1990's by the booming technological companies throughout the state. Populations moving to Minnesota from other countries have reached historically high numbers in recent years. In 2008, about 7 percent of Minnesota residents were born outside the U.S.

In the most recent data (federal fiscal year 2004) from the Department of Homeland Security and Immigration and Naturalization Service Statistics, 11,708 immigrants came to Minnesota from over 110 different countries. Minnesota's major immigrant populations include: Latinos, Hmong, Somalis, Vietnamese, Russians, Laotians, Cambodians and Ethiopians. Many immigrants also re-home here from other states. The Minnesota State Demographers Office estimates that in 2008, Minnesota saw 15,832 new immigrants, including refugees. The effects on Minnesota have been far reaching with visible changes in our towns and cities, schools and businesses. St. Paul has the largest urban Hmong concentration in the world. Minnesota has the largest Somali population in the United States, most of them living in Minneapolis. More than 80 languages are spoken in the Twin Cities. In 2007, it was estimated that nearly 38 percent of foreign-born Minnesotans were Asian, 25 percent were Latino, 14 percent were European, and 19 percent were African. Approximately 14 percent of Minnesota's total child population (177,000 children), is estimated to live in immigrant families. Among people at least five years old living in Minnesota in 2006-2008, 10 percent spoke a language other than English at home. Of those speaking a language other than English at home 37 percent spoke Spanish. **/2013/These immigrants, who came to the state in their late teens or early 20s, are now having children, and are influencing the racial and ethnic changes Minnesota is seeing in it's youngest residents.//2013//**

These significant demographic changes such as the aging of its population, **/2013/ decreasing birth numbers//2013//** and ethnic concentration of the population in its metropolitan areas, and rising dependency ratios (elderly and children as a ratio to the working-age population) **/2013/ rapid growth in minority and ethnic populations//2013//** will impact not only the need for and the type of healthcare, but will also affect housing, education, business, commerce, employers and social services.

Economics - Poverty Overall, one in 10 Minnesotans lived in poverty in 2008 and an estimated 140,000 children (11 percent of children) lived in families whose incomes fell below the federal poverty guidelines. Between 2000 and 2008, the percentage of children living in poverty has grown almost a third. In addition, there are significant racial disparities that exist for children living in poverty. In 2007, Minnesota had the highest poverty rate in the nation for Asian children with 24 percent of Asian children living at or below the poverty line. Children living in single parent families are over nine times more likely to live in poverty than children living in families with married parents. The percent of children born to single mothers in Minnesota has increased from 26 percent in 2001 to 33 percent in 2007. The number of children eligible for free/reduced price school lunch has been increasing steadily over the past two decades and currently thirty-three percent of K-12 children are approved to receive free and reduced price lunches. WIC participation has also increased from 111,717 participants in 2003 to 137,712 in May 2010. **/2013/ As of March 2012, WIC monthly participation was 127,985. this decline has been attributed**

**to not only the decrease in births in Minnesota but as a result of more Minnesota families living in poverty, meeting TANF eligibility criteria with subsequent access to SNAP (Supplemental Nutrition Assistance Program) benefits//2013//** //2012// Estimates from the 2009 American Community Survey indicates that 13.9 percent of Minnesota children under age 18 lived below the federal poverty threshold; for children under age 5 the poverty figure is 15.7 percent. These numbers are sharp increases from recent years - the child poverty rate in Minnesota has more than doubled since 2000-2002, when 9 percent of children lived in poverty. The number of children receiving free or reduced school lunches has increased to over 300,000 in 2010-2011, or 37 percent of K-12 students.//2012//

Disparities In the 2009 edition of America's Health Rankings Minnesota was identified as the sixth healthiest state in the nation. Since the annual state health rankings began in 1990, Minnesota has ranked first in health 11 times. While overall, Minnesota enjoys a high level of health, there are significant and highly concerning disparities in health status measures for Minnesota racial and ethnic populations.

- Low birth weight births among African Americans in Minnesota remains two time greater than Whites and low birth weight is higher for American Indians, Asians, and Hispanic/Latinos as compared to Whites.

- Despite a decline in infant mortality rates among American Indian and African Americans in Minnesota, infant mortality rates for these groups are still more than two times higher than the White rate. The five-year average mortality rate for White infants in Minnesota during 2001-2005 was 4.4 per 1,000 infants, the rate for African American infants was 9.2 and for American Indians it was 10.3 per 1,000 infants.

- Women of Color were two to three times more likely and American Indian women seven times more likely to receive inadequate care or no care during their pregnancies than White women in Minnesota.

- Based on 3-year averages, 41% of African American children, 39% of American Indian children, 23% of Asian children, 27% of Hispanic children and 8% of White children under the age of 18 live in poverty in Minnesota.

- In Minnesota, overall 13 percent of WIC participants age 2-4 are overweight. Rates for racial/ethnic populations are: 25 percent American Indian children, 18 percent of Hispanic or Latino children, 16 percent of Asian children, 13 percent African American children and 10 percent White children are overweight.

- In 2009, African Americans were three times more likely to be unemployed than Whites. **//2013/This figure remains unchanged in 2011 and makes the Twin Cities the worst metropolitan area for disparity between black and white unemployment.//2013//**

- Compared to White children African American children are 5 times more likely and American Indians are 12 times more likely to experience out-of-home care.

- African American population in Minnesota has the highest proportion of CYSHCN at 19.5 percent while Asian and Spanish-speaking Hispanic communities have the lowest percentage at 11.9 percent and 2.6 percent respectively. The White population is in the mid-range at 14.4 percent.

- The teen birth rate for Whites in Minnesota is lower than the U.S. rate. However, for other racial and ethnic groups in Minnesota the teen birth rates are higher than their corresponding U.S. rate. The teen birth rate for Whites is 17.9 per 1,000 and for African Americans 68.4, for American Indian 97.1, for Asian 51.7, and for Hispanic 114.6 per 1,000. **//2013/ While overall rates of teen pregnancy have went down, disparities persist. In 2010, the teen birth rate for Whites was 14.9 per 1,000 and for African Americans 48.5, for American Indians 67.1, for Asians 31.4, and for Hispanics 63.2 per 1,000.//2013//**

- The rate of uninsured for the African American population (16 percent); American Indian (18.8 percent); and Hispanic/Latino (29.6 percent) are 2 to 3.7 times higher than the 7.8 percent rate for the white population.

- In 2008, only about seven of 10 Minnesota students graduated on time from high school; less than half of students of color did.

- American Indian death rates are two and a half to three and a half times higher than death

rates for Whites for most age groups. Death rates for African Americans are more than one and a half times higher than Whites in most age groups.

- The age-adjusted mortality rate for African Americans due to homicide is 13.5 times higher than the rate for Whites and the rate for AIDS/HIV is 15.7 times the rate for Whites.

- The age-adjusted mortality rate for American Indians due to homicide is 13.3 times the rate for Whites.

Insurance - Access Minnesota ranked third best among all states in the percentage of residents under 65 who had health care coverage in 2008. Results of the 2009 Minnesota Health Access Survey indicate a continued erosion of insurance coverage in Minnesota. Based on the 2001 survey, 5.4 percent of Minnesotans were uninsured. In 2004 this increased to 6.7 percent, in 2007 to 7.2 percent and in 2009 approximately 9.1 percent of Minnesotans, or about 480,000 people did not have health insurance coverage. **//2013// According to the 2011 Minnesota Health Access Survey, 9.1 percent of the population continues to lack health insurance. Although not statistically different from the 2009 estimate, the number of uninsured Minnesotans represents an increase of nearly 10,000 individuals compared to 2009. Children ages 17 years or younger made up a smaller share of the uninsured in 2011 (17.8%) than in 2009 (24.6%) although this difference is not statistically significant. Approximately 70,000 children, or 5.4 percent, were without health insurance coverage in 2011.****//2013//** Of the 480,000 Minnesotans who were uninsured, approximately 85,000 were children under the age of 18. Nearly all of the increase in the number of uninsured that occurred between 2007 and 2009 were among adults. The number of individuals who had been uninsured for a year or longer increased from 4.6 percent in 2007 to 6.2 percent in 2009. Between 2007 and 2009, there was a significant decline in employer insurance coverage of 62.5 percent to 57.2 percent. This decline in employer-based coverage was identified as the main reason for the increase seen in the uninsured rate. Despite the potential for access to public program coverage, uninsured rates for the lowest income groups are all significantly higher than the rate for the state overall. Large health coverage disparities by race and ethnicity in Minnesota continue to exist with uninsured rates for African American, American Indian and Hispanic/Latino two to 3.7 times higher than for the White population. Not surprising, immigrants in Minnesota were twice as likely as the overall population to be uninsured, Minnesotans living outside the Twin Cities metropolitan area had a higher rate of not having insurance 10.3 compared to 9.1 for metropolitan residents, and individuals who were not married were almost twice as likely as the state population overall to be uninsured. Of particular note is that the rate of uninsured among college graduates in Minnesota nearly doubled between 2007 and 2009 (from 2.4 percent to 4.5 percent), although this should reverse in response to recent health care reform legislation.

**//2012//** The number of Minnesotans who get health insurance through employers had dropped 10 percentage points in the past decade, outpacing the decline nationwide. A decade ago, about 8 in 10 workers and their families received health benefits from a company-offered plan. By 2009, the most recent year available, 71 percent of Minnesotans were covered through the workplace. The shift parallels a trend in which growing numbers of Minnesotans earn lower wages and the ranks of those living in poverty swells. **//2013// Employer coverage in 2011 has not continued to erode but it also has not recovered from the significant decline seen in 2009. In 2011, 56.4 percent of the state's population held group coverage, compared with 57.4 percent in 2009. In 2011, almost one-third of Minnesotans held public coverage either through Medicaid, MinnesotaCare or Medicare.****//2013//**

Minnesota continues to spend less on health care per person than the country as a whole. In 2009, per person spending in Minnesota was \$6,913, compared to \$7,590 nationally. Health care spending in Minnesota also accounts for a smaller share of the economy than nationally (14.1 percent compared to 16.5 percent). Because the economy shrank in 2009 at the same time that health care spending continued to grow, the share of the economy spent on health care experienced the single largest annual increase in both Minnesota and the U.S. The severe economic downturn and slow recovery affected 2009 health care spending in Minnesota with private spending accounting for a smaller share of total spending as individuals used less health

care. Factors contributing to decreases in private spending include: loss of private health insurance coverage, the expectation to pay more in premiums or out-of-pocket costs and declines in income in 2009. At the same time, public spending rose in part because the recession caused more people to enroll in public health insurance programs.//2012//

State funded health programs in Minnesota provide health insurance coverage for more than 805,000 Minnesotans through three publicly funded health care programs -- Medical Assistance, General Assistance Medical Care (GAMC) and MinnesotaCare. Medical Assistance (MA) is the state's Medicaid program and provides acute, chronic and long-term care services to low-income seniors, children and families, and people with disabilities. In May 2010, 630,780 individuals were enrolled on MA up from 2009 figures of 574,942 a reflection of the economic struggles many families are currently experiencing. Of the individuals on MA, 55 percent are children under age 21. Approximately 6 percent of children receiving MA are eligible because of a disability. In Minnesota, local county agencies determine eligibility for MA within federal and state guidelines. Income eligibility criteria is as follows: pregnant women with incomes at or below 275% of the federal poverty guidelines (FPG); infants under age two with incomes at or below 280% of the FPG; children ages two through 18 at 150% of the FPG; and parents, relative caretakers, and children ages 19 and 20 at or below 100% of the FPG. Most services for this population are through capitated rate contracts with health plans versus a fee for service arrangement. The state currently operates its Medicaid program with one Section 1915(a) waiver, one Section 1915(b) freedom of choice waiver, six Section 1915 (c) home and community-based waivers and Section 1115 waiver. The TEFRA and Home and Community Based Waiver programs allow some children with disabilities to be eligible for MA regardless of parental income. In 2006, the Minnesota Department of Human Services began implementing an 1115 waiver for family planning services. Called the Minnesota Family Planning Program (MFPP), the program provides contraception management services, including STI screening and treatment for individuals age 15 years of age or older and under age 50, who are not eligible for other public programs and who have an income at or below 200 percent of the FPG. Participation in the program does not require the consent of anyone other than the applicant and they may apply at a provider's office for presumptive eligibility. During the presumptive eligibility period the applicant must apply for ongoing eligibility for MFPP or if eligible for MA. The unduplicated count of individuals enrolled in the MFPP in SFY 2009 was 39,271.

General Assistance Medical Care pays for health care services for low-income Minnesotans who are ineligible for MA or other state or federal health care programs. In May 2010 there were 33,534 adults enrolled on GAMC which serves primarily single individuals between the ages 21 and 64 who do not have dependent children and whose income does not exceed 75 percent of FPG. Many of the individuals on GAMC have chronic mental health or chemical dependency problems. The number of current enrollees is significantly less than the number of 36,520 who were enrolled in October 2009, a possible reflection of the confusion recipients experienced as the legislature debated the continuation of the program these past two legislative sessions. As part of the 2010 budget balancing, GAMC was eliminated as of March 2010 and it was proposed that as many individuals as possible be moved to MinnesotaCare.

The 2010 legislature reinstated GAMC before the elimination went into effect, but it underwent massive changes. As of June 1, 2010, GAMC changed from a fee for service program to a coordinated care delivery system (CCDS). A CCDS is run by a hospital and is responsible for providing and coordinating hospital and non-hospital health care services. Covered services include: inpatient hospital, outpatient hospital, outpatient clinic preventive and some specialty, mental health, medical transportation and medications. The state pays the CCDS an annual fixed dollar amount for the care of the individual. At this time four twin cities metro-area hospitals have established themselves as CCDS and are available to provide service for individuals on GAMC. However, this leaves a number of outstate Minnesotans having to travel hundreds of miles to the Twin Cities to get preventive and acute care.//2012// See section below for information regarding the end of GAMC and expansion of Medical Assistance starting March 1, 2011.//2012//

MinnesotaCare is Minnesota's publicly subsidized program for Minnesotans who do not have access to affordable health care coverage and are not eligible for enrollment in Medical Assistance. In May 2010, there were 141,070 individuals enrolled in the program with 30 percent being children under age 21. MinnesotaCare is funded by a state tax on Minnesota hospitals and health care providers, federal Medicaid matching funds and enrollee premiums. All health services are provided through health plans. There is a monthly premium required for most families - determined by a sliding-fee scale based on family size and income.

MinnesotaCare legislation included erosion or crowd-out barriers consisting of essentially three eligibility provisions. First, children, families and pregnant women must be permanent residents; families without children must not only be permanent residents, but also must have resided in the state for six months prior to enrollment. Second, individuals cannot have had other health coverage for four months prior to enrollment except for children in families with income at or less than 150 percent of FPG or for individuals making a transition to MinnesotaCare from MA or GAMC. The third eligibility provision denies, with certain exceptions, eligibility for individuals who have had access to employer subsidized insurance (50 percent or more of premium cost) through a current employer in the 18 month period prior to enrollment in the MinnesotaCare program.

//2012//On March 1, 2011, Minnesota began implementation of the expanded Medical Assistance (MA) program. The federal Affordable Care Act permits states to provide Medicaid coverage to certain adults before the January 1, 2014 deadline, and the 2010 Minnesota Legislature authorized the early MA expansion. The governor issued an executive order on January 5, 2011 to implement the MA expansion no later than March 1, 2011. Adults eligible for the MA expansion program are between ages 21-65, have income below 75 percent of FPG, are not eligible for Medicare, and do not have another basis for MA eligibility (such as disability, pregnancy, or minor children). All individuals enrolled in GAMC, and some adults enrolled in MinnesotaCare, were converted to the MA expansion program; the MA expansion eliminates the GAMC CCDS program that existed prior to implementation. As of April 1, 2011, 51,853 individuals were enrolled in the MA expansion program. Average monthly enrollment in the MA expansion for fiscal 2012 is projected to be 98,000. Preliminary figures for MA enrollment for April 2011 show 711,454 eligible, including MA expansion enrollees. Data for MinnesotaCare enrollment for the same month shows 148,610 enrolled. //2012//

Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) are areas that are federally designated as lacking adequate health care services. Populations in 45 counties out of the total 87 Minnesota counties are in federally designated Health Professional Shortage Areas (HPSAs) for primary care. Additionally, populations in 41 counties are in dental HPSAs and populations in 70 counties are in mental health HPSAs. While some of these designations are in urban areas such as St. Paul and Minneapolis with high percentages of poverty and minority populations, the majority are located in frontier and rural counties in the state. These areas tend to lack employment opportunities and experience a higher rate of uninsurance than other areas in the state.

HPSAs and MUAs help meet the health care needs of medically underserved rural and urban populations of Minnesota by supporting the health care safety net services. Clinics located in these areas and providing health care services to underserved population can meet eligibility criteria for a number of federal and state assistance programs, including grants and reimbursement incentive programs. Community Health Centers in Minnesota collectively serve 180,000 patients per year--38 percent of them uninsured, 43 percent in public insurance programs and 6 percent on Medicare. The current economy is expected to provide additional stress on this system as more unemployed individuals seek low cost medical services.

## STATE LEVEL INITIATIVES

Early Childhood Governor Pawlenty under Executive Order 08-14 created the State Advisory Council on Early Childhood Education and Care in September of 2008. This was in response to

federal provisions in the Improving Head Start for School Readiness Act of 2007. In addition to federal responsibilities outlined in Public Law 110-134 the Early Childhood Advisory Council was charged with making recommendations on the most efficient and effective way to leverage state and federal funding streams for early childhood and child care programs; how to coordinate or collocate early childhood and child care programs in one state Office of Early Learning; to review program evaluations regarding high-quality childhood programs; and to propose legislation on how to most effectively create a high quality early childhood system in Minnesota in order to improve the educational outcomes of children so that all children are school-ready by 2020. While the Department of Health did not have a membership on the Council, Title V staff along with staff from our federally funded Early Childhood Systems grant participated on a number of work groups. During the 2010 legislative session a number of small but meaningful changes was made to Minnesota's early care and education system. Legislation required that a representative from the Minnesota Department of Health be added to the Council. The Governor's Early Childhood Advisory Council was also directed to 1) create and implement a statewide school readiness report card and to examine current practices and make recommendations for expanding assessments and screenings to more children at younger ages 2) explore how Minnesota can improve screening and assessment of young children and 3) establish a task force of the Council to explore coordinating or co-locating early childhood programs in a state Office of Early Learning. The School Readiness Funders Coalition, which supported these legislative provisions, has agreed to provide \$158,000 in private funds to assist the Council in this work.

***//2013/ In late 2011, Minnesota was notified that it was awarded four year \$45 million federal Race to the Top Early Learning Challenge grant to improve results for young children and build capacity and accountability into our early learning system. The Departments of Education, Health and Human Services are partners in the grant application and it's activities. The Early Learning Challenge grant targets direct services to children with high needs (those living below 200% of FPG) and quality improvement supports to programs serving those children in four communities- White Earth Reservation, Itasca County, St. Paul's Promise Neighborhood and Minneapolis' Northside Achievement Zone. The state's efforts will be focused in three key areas 1) accountability and decision-making through an improved governance structure, expanded child and provider assessment and a data system; 2) a great early childhood workforce by supporting professional/career development of early childhood professionals; 3) access to high-quality, accountable programs by using the Parent Aware Quality Rating and Improvement System to improve quality and to give parents good information, scholarships to increase access to quality programs for high need children and supporting district use of Title 1 for pre-Kindergarten programs.//2013//***

Health Care Reform In May 2008, Governor Pawlenty signed significant health care reform legislation into law. This comprehensive health reform package laid the groundwork toward achieving quality, affordable and accessible health care for all Minnesotans and set into place reforms in four broad areas: 1) population health with the goal of investing in public health to help Minnesotans live longer better, healthier lives by reducing the burden of chronic disease. Approximately \$47 million dollars in the fall of 2009 were awarded to 39 communities to address obesity and tobacco use in Minnesota residents. These awards covered 86 counties (out of 87) and eight (out of 11) tribal governments. Efforts will utilize policy, systems and environmental changes in four settings: schools, work sites, health care and community to tackle the top three causes of preventable illness and death: tobacco use, physical inactivity and poor nutrition //2012//Continuation of this component of health care reform is in jeopardy. Neither the Republican lead House or Senate included this Governor's recommendation for continued funding in their budget proposals for Health and Human Services. //2012//; 2) market transparency and enhanced information with the goal of providing public reporting of health care costs and quality information that will allow providers, purchasers, policy makers and consumers to make better decisions about health and health care delivery; 3) payment reform with the goal to promote quality outcomes; and 4) the development of health care homes in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life

for individuals with chronic health conditions and disabilities. The legislation includes payment to primary care providers for partnering with patients and families to provide coordination of care. Minnesota Statutes SS256B.0751, subd.2, directed the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) to develop and implement standards of certification for health care homes for state health care programs. The MDH and DHS published the adopted rule related to health care homes on January 11, 2010. This adopted rule carries out these directions by developing and implementing the standards. It also spells out the procedures for certification and re-certification of health care homes. The rule became effective when it was published and the Department of Health is in the process of certifying health care homes. //2012// As of May of this year, 134 clinics have been certified as health care homes, covering 1,651 primary providers and reaching 1,797,230 patients or 34% of Minnesotans. Based on this work, Minnesota was selected as one of the eight states to participate in the Centers for Medicare & Medicaid Services Multi-Payer Advanced Primary Care Practice demonstration and will require participating Medicare clinics to become certified health care homes. //2012// **/2013/ As of May 2012, the Health Care Home Section had certified 170 health care homes and 1,764 clinicians. These providers care for over 2 million Minnesotans.//2013//**

#### TITLE V PROGRAM ROLE

The role of the Title V program in the state's health care delivery environment is to assess the health needs of mothers, children, and their families and to use that information to effectively advocate on their behalf in the development of policies concerning organizational and operational issues of health systems, and to advocate for services and funding streams which have the potential to improve their health. The state's Title V program does have a significant assurance role. The Title V program area of MCH/CYSHCN administer, coordinate and support many activities addressing maternal and child health, including the Title V Block Grant activities. The maternal and child health responsibilities include statewide planning and coordination of services through the acquisition and analysis of population-based data, the provision of technical support and training; coordination of various public and private efforts; and support for targeted preventive health services in communities with significant populations of high risk and low income families.

Program goals described in a later section are accomplished through partnerships with both state and local level agencies. The Department has inter-agency agreements with the Department of Human Services and the Department of Education related to Title V/Title XIX activities, and Part C/Part B of IDEA, and also partners with local Community Health Boards (local public health entities), the Minnesota Department's of Economic Security, Corrections, and Public Safety. Along with many other institutions of higher education, Minnesota is fortunate to have an excellent School of Public Health at the University Of Minnesota's Twin Cities campus. The close working relationship with this school, particularly with the MCH and nursing programs provides resources for both members of this partnership and future MCH practitioners.

#### CURRENT DEPARTMENTAL PRIORITIES/INITIATIVES

As the Minnesota Department of Health positions itself for the next two to five years, legislative and gubernatorial direction as well as community- and population-based health issues will shape its priorities. The current governor, Tim Pawlenty, has identified health reform as one of the state's priorities and charged MDH with significant responsibilities in its implementation plan. //2012// In January 2011, a new Democratic Governor and his appointed cabinet was installed into office. Resolving the over \$5 billion in Minnesota's budget deficit has been the primary priority for the Governor and his cabinet. Dr. Ed Ehlinger was named Commissioner of Health in January. Prior to his appointment Dr. Ehlinger served as director and chief health officer for Boynton Health Services at the University of Minnesota from 1995-2011. Dr. Ehlinger comes to his position with a strong interest and passion for children's issues after serving 15 years as the director of Personal Health Services for the Minneapolis Health Department. In 1996, Dr. Ehlinger was the recipient of the first Ed Ehlinger Award from CityMatCH (urban maternal and child health directors). Once a new budget is in place it is anticipated that a strategic review of current department priorities will occur. //2012//

The MDH administration, through the Health Steering Team (HST), made up of the Executive Office staff and Division Directors, strategic planning activities in 2007 identified four priority focus areas: Emergency Preparedness; Health Disparities; Preparing for an Aging Population and Health Care System Reform. In 2010, the department once again entered into a strategic planning process. A result was that while Emergency Preparedness continues to be a critical issue, significant progress had been made and that it could now be retired as a priority focus area. Two other new strategic priorities were identified, reducing obesity and tobacco use and "Investing in Our Children".

***//2013/ As a way to ensure quality and performance of public health, the Minnesota Department of Health is actively moving forward in seeking voluntary national public health accreditation of the state health department and is actively engaging local and tribal public health agencies in their efforts at accreditation. A CDC infrastructure grant supports accreditation and has increased organizational capacity and commitment for quality improvement projects. The department plans to submit its Letter of Intent to the Public Health Accreditation Board (PHAB) this fall, the application the winter of 2012 with an anticipated site visit and accreditation by PHAB in 2013. Staff from MCH and CYSHN is represented on the 12 interdisciplinary Domain Teams who are charged with collecting evidence of the department's activities that meet the accreditation standards. Accreditation for local public health agencies is targeted for 2015. //2013//***

The goal of "Investing in Our Children" is to direct the department's child health resources toward promoting the optimal health and well-being of Minnesota's children and to ensure that these resources are well targeted, well coordinated, and achieving the desired outcomes. The focus on the first phase of the initiative was on current MDH policy and programs whose services address the needs of infants and children, prenatally through age 24. Key staff from all Divisions who administer child health programs came together for a two day "event" to 1) recommend key childhood objectives for the department; 2) to recommend how the department could strengthen child health efforts; and 3) to recommend how the department could sustain a coordinated approach to children's health issues. Recommendations from Phase 1 were forwarded to the commissioner of health at the end of June. In July, approval to implement Phase 2 was obtained. Phase 2 activities will begin in early August and include: 1) convene an internal Children's Health Council to guide the work of the Initiative, 2) recommend key indicators of child health to monitor MDH progress in improving the health status of children, 3) develop an MDH Child Health Strategic Action Plan that will recommend processes and approaches by which MDH will: enhance program and partner collaborations; coordinate partnerships with their state agencies who contribute to children's health; identify priority strategies for addressing health disparities in children; identify opportunities to integrate services; eliminate overlaps and gaps in activities; 4) develop SMART child health objectives for the department, 4) conduct a "Kaizen" event to focus communications strategically including key child health messages to be used by child health programs to support each other, 5) select one to two child health objectives for further development; establish cross-divisional teams to develop department wide work plans identifying specific activities that will assist MDH in reaching these objectives, and 6) propose a variety of methods for engaging a wide range of partners in discussions about child health issues including, brown bag lunches, webinars, conferences and or a Child Health Summit. Title V staff play a key role in this initiative and the 2010 MCH Needs Assessment will help shape the work of this cross-department activity. //2012// The Initiative is currently working on institutionalizing department-wide strategies to address eliminating child health disparities. Considerations for moving efforts externally to other state agencies and community partners is under discussion.//2012//

**Decision-making Process** There are a number of institutionalized forums that allow the Commissioner of Health, the Community and Family Health Division Director and the Title V Directors to remain up-to-date on the social, political and economic dynamics affecting health care issues. All of the groups described below provide for a statewide perspective of various stakeholders on different policy issues, which affords a number of different vehicles for defining problems and policy and for providing feedback on recently enacted policy.

1. The Health Steering Team (HST) HST consists of the health department's Executive Office staff and the department's highest managers, the Division Directors. It meets bi-monthly to provide input into departmental policies, determine priorities, and to identify and resolve issues.

2. Bureau Leadership Meeting are monthly meetings of the Assistant Commissioner of the Community and Family Health Promotion Bureau and the Directors of the four areas she oversees: Community and Family Health Division; Health Promotion and Chronic Disease Division; the Office of Minority and Multicultural Health and the Office of Statewide Health Improvement Initiatives. These meetings discuss cross division issues and help assure that coordinated and effective strategies are implemented.

3. The Maternal and Child Health Advisory Task Force (MCHATF) is a statutorily created standing advisory committee that assists the Commissioner of Health on selected policy issues. It is a 15-member group equally represented by consumers, maternal and child health professionals, and community health agency members with ex-officio representation from the Minnesota Department of Human Services; the Minnesota Department of Education; and the University of Minnesota MCH Program. Its purpose is to advise the Commissioner, the Division Director and the Title V program on the health status and health care needs of mothers and children. Work groups are established to work on key issues of maternal and child health importance. //2013// ***The 2012 MCH Advisory Task Force Work Plan includes 1) a work group to provide direction and guidance to MDH on issues related to the Family Home Visiting Program's expansion and integration of evidence-based home visiting programs in Minnesota's health and early childhood systems and 2) a work group to provide direction and advice to MDH on defining statewide activities to support children and youth with special health needs.***//2013//

***/2013/ As a result of the state government shutdown, the MCH Advisory Task Force sunseted June 30, 2011. The Task Force continued to meet at the request of the Commissioner of Health. The Task Force was reestablished during the 2012 legislative session. The purpose, structure and membership requirements remain the same. Applications are being accepted for the reestablished Task Force. New membership will be appointed later in 2012.***//2013//

4. The State Community Health Services Advisory Committee (SCHSAC) is a standing advisory committee comprised of county commissioners and local community health administrators. It meets at least four times a year and its purpose is to advise the Commissioner of Health on all matters relating to the development, maintenance, funding and evaluation of the local public health system. Each year the SCHSAC forms 3-5 work groups comprised of local public health experts to address topics of pressing interest to local public health agencies. It also sponsors an annual statewide conference for state and local public health professionals. The Commissioner of Health, in consultation with SCHSAC and the MCH Advisory Task Force, is directed by MN Statutes 145A.12, subdivision 7(e), to develop a set of statewide public health measures for the local public health system every five years. These statewide local public health objectives are to be based on state and local assessment data regarding the health of Minnesota residents, the essential local public health activities and Minnesota public health goals. The last set of such measures was developed in 2004. A Statewide Local Public Health Objectives Work Group is being convened and the charge of the work group will be to identify and recommend a new set of statewide local public health objectives to meet the state requirements of the Local Public Health Act funding. /2013/ ***SCHSAC work groups of special interest to Title V include 1) Building Health Information Exchange Capacity (HIE), 2) Mental Health and 3) Performance Improvement Steering Committee. The Mental Health work group is charged with examining how MDH and local public health can play a leadership role in raising public awareness about mental health disparities and developing a policy agenda with respect to mental health. The HIE work group, which is comprised of public and private health***

**sectors is charged with making recommendations for complying with the state's 2015 electronic health record mandate and facilitating work necessary for bi directional exchange of public health data for population based information and outcomes. The Performance Improvement Steering Committee is developing a performance management, reporting and quality improvement system for local public health agencies. This includes MCH-related activities and performance measures.//2013//**

5. The Rural Health Advisory Committee was created during the 1992 Legislative session and serves as a statewide forum for rural health concerns and features a diverse membership consisting of legislators, rural providers, and consumers. Its purpose is to advise the Commissioner and other state agencies on rural health issues and rural health planning. It also carries out its responsibilities through work groups.

6. Title V/Title XIX: The senior program managers for the Title V and the Title XIX programs meet to discuss maternal and child health issues and proposed changes in their respective programs and concerns due to changes in federal and/or state policy. The Title XIX agency is also the designated Title XXI agency. Coordination efforts are laid out in a signed Interagency Agreement.

7. The Management team of the Division of Community and Family Health meets weekly to resolve immediate operational issues and to discuss and define long-range issues. The Management Team of the Division of Community and Family Health is comprised of Division management, (Division Director and Assistant Director), the three Section Managers (MCH/CYSHCN, WIC, and Health Care Home), and their respective supervisory staff. **//2013/ The Managers from the Maternal and Child Health Section, the Children and Youth with Special Health Needs Section, WIC and Health Care Homes Section and their respective supervisory staff are members of the Management Team.//2013//**

## **B. Agency Capacity**

Protecting, maintaining and improving the health of all Minnesotans is the mission of the Minnesota Department of Health (MDH). The Community and Family Health (CFH) Division works to support this mission by providing collaborative public health leadership that supports and strengthens systems to ensure that families and communities are healthy. This is done by partnering to: ensure a coordinated state and local public health infrastructure; improve the health of mothers, children and families; promote access to quality health care for vulnerable and underserved populations; and provide financial support, technical assistance, accurate information and coordination to strengthen community-based systems.

The vision for the public health system in Minnesota is of a strong and dynamic partnership of governments, fully equipped to address the changing needs of the public's health. Minnesota Statutes Section 144.05 gives authority to the Commissioner of Health to develop and maintain an organized statewide system of programs and services to protect, maintain and improve the health of Minnesotans. This includes authority to collect data, prevent disease and disability, establish and enforce health standards, train health professionals, coordinate local, state and federal programs, assess and evaluate the effectiveness and efficiency of health service systems and public health programs in the state, and advise the governor and legislature on matters relating to the public's health. The department carries out its mission in close partnership with local public health departments, tribal governments, the federal government, foreign countries, and many health-related organizations. The MDH workforce of approximately 1,300 //2012// 1,403 //2012// includes many MD's, PhD's, nurses, health educators, biologists, chemists, epidemiologists and engineers. MDH budget is approximately \$1.081 billion a year and approximately 85 percent of its funding is from non-general fund resources -- primarily federal funds, dedicated fees, and the healthcare access fund. Approximately 62 //2012// 58% //2012//percent of the budget is "passed through" to local governments, nonprofit organizations,

community hospitals, and teaching institutions in the form of grants.

The language within Minnesota Statutes Chapter 145 lays out the state requirements for the distribution of the federal Maternal and Child Health block grant, with two thirds to go out to local Community Health Boards (local public health agencies) through a formula; establishes the MCH Advisory Task Force; and articulates program requirements for use of state funds for family planning, abstinence education, fetal alcohol syndrome, Women's Right to Know, Positive Alternatives Program, Maternal Death Studies and home visiting. Minnesota statutes articulate that a third of the block grant money retained by the Commissioner of Health may be used to: 1) meet federal maternal and child block grant requirements of a statewide needs assessment every five years and prepare the annual federal block grant application and report; 2) collect and disseminate statewide data on the health status of mothers and children within one year of the end of the year ; (3) provide technical assistance to community health boards in meeting statewide outcomes; (4) evaluate the impact of maternal and child health activities on the health status of mothers and children; (5) provide services to children under age 16 receiving benefits under Title XVI of the Social Security Act; and (6) perform other maternal and child health activities as listed in federal code for the MCH block grant and as deemed necessary by the commissioner.

The delivery of primary and preventive public health services by local government in Minnesota occurs within a framework governed by "Community Health Boards (CHB)." Comprised of elected officials, either county commissioners or city council members, the Boards provide policy formulation and oversight of the local public health administrative agencies which are responsible for conducting public health core functions. There are 53 //2012// 52 //2012// CHBs in the state including 27 single-county boards, 59 //2012// 58 //2012// counties cooperating in 21 multi-county boards or city-county and four metropolitan cities have their own CHB. This infrastructure provides for a community-based decision-making process based on a needs assessment with state leadership and support. The process recognizes differences among communities and provides a flexible range of responses. Core public health funding is provided through the Local Public Health Act (a total of \$21 million). Total CHB expenditures for public health activities in 2009, was \$298 million, of which 64 percent came from locally generated funds.

#### CROSS-CUTTING TITLE V PROGRAM CAPACITY

The Maternal and Child Health (MCH) Advisory Task Force was created by the Minnesota Legislature in 1982 to advise the Commissioner of Health on the health status and health care services needs of Minnesota's mothers and children, and the distribution and use of federal and state funds for MCH services. Fifteen members are appointed by the Commissioner with five each representing MCH professionals, MCH consumers, and Community Health Boards. Terms are four years, half coterminous with the governor's term and half one year later. Work groups of the Task Force are often convened with a specific charge to bring back to the full Task Force recommendations made following more in-depth research and discussion. The Task Force meets quarterly and has an executive committee and work groups. The Task Force is supported by staff in the MCH/CYSHCN Section. ***//2013/The MCH Advisory Task Force legislation was renewed during the 2012 legislative session. Membership and structure remain the same. The Task Force has established two groups for 2012-2013. The Children and Youth with Special Health Needs Work inform the statewide children and youth with special health care needs program to improve the quality, efficiency and effectiveness of the public health role in meeting the needs of children with special health care needs and their families. The Family Home Visiting Committee will provide direction and guidance to the Commissioner of Health and MDH staff on issues related to the expansion and integration of evidence-based public health home visiting programs in Minnesota's health and early childhood systems. //2013//***

The Interoperable Child Health Information System project a cross departmental project working to enhance capacity for interoperability between child health data systems at MDH. Since 2005, Title V and Title XIX have had in place an Interagency Agreement whereby Title V agreed to

cover the salaries of one FTE epidemiologists at the Department of Human Services to be able to access Medicaid data for MCH issues. ***/2013/ Beginning in 2012, another Title V funded staff was placed within the Department of Human Services to identify and analysis information on children and youth with special health needs and their families. Her work will provide policy makers, families and state agencies with current information related to how this population is faring in Minnesota.//2013//***

The Department's Investing in Our Children's Initiative relies heavily on the expertise of Title V staff. The goal of the initiative is to direct the department's child health resources toward promoting the optimal health and wellbeing of Minnesota's children and to ensure that these resources are well targeted, well coordinated, and achieving the desired outcomes.

Tribal Governments: There are 11 federally recognized tribal governments within Minnesota. The Community and Family Health Division coordinates it's key work with the tribes through the Office of Minority and Multi-Cultural Health (OMMH) another Division within the Community and Family Health Promotion Bureau. ***/2013/ In 2012, the MDH named the department's first Indian Health director. The director will work closely with the commissioner and executive leadership of MDH and with tribal governments in strategic planning to maximize use of resources and expertise and to support collaboration around American Indian health initiatives within the department. //2013//*** Legislative action in 2003 acknowledged the role Tribal Governments play in the health status of their communities by including them in the Local Public Health Grant. In response to the significant disparities in infant mortality, childhood obesity, teen suicides and teen pregnancies, tribes were directed to use half of the state general revenue money in this grant for maternal and child issues. *//2012//* An additional \$848,000 a year is available to the tribes to support home visiting and/or teen pregnancy prevention efforts. *//2012//* Community and Family Health staff work closely with the Tribal Health Liaison in OMMH to provide technical assistance and support to the Tribal health staff and programs for all three MCH population groups. ***/2013/ In 2012, the MDH named the department's first Indian Health director. The director will work closely with the commissioner and executive leadership of MDH and with tribal governments in strategic planning to maximize use of resources and expertise and to support collaboration around American Indian health initiatives within the department. //2013//***

In addition to specific program areas listed below, Title V staff and programs work to leverage capacity by partnering with related programs situated in other Divisions within MDH. These include lead screening and abatement, laboratory newborn screening, immunizations, STI and HIV programs, oral health, alcohol and tobacco prevention, breast and cervical cancer control, asthma, injury and sexual violence and children's environmental health.

The programs within the MCH/CYSHN Section strive to improve the health status of infants, children and youth, children and youth with special health needs, women and families. The section provides a focal point for influencing the efforts of a broad range of agencies and programs committed to this goal. The role of the section is to: assess the health needs of mothers, children, and their families; use that information to advocate effectively on their behalf in the development of policies concerning organizational and operational issues of health systems; and advocate for programs and funding streams which have the potential to improve their health. The Section provides administrative and technical assistance to community health boards, tribal governments, schools, voluntary organizations, and private health care providers. Activities at a section level include: Children and Youth with Special Health Needs: The section provides state-level leadership in partnership with families and other stakeholders to achieve a vision on ongoing improvement of community-based systems serving CYSHN and their families. This is done through emphasis on six national priorities for children and youth with special health care needs. Maternal and Child Health Advisory Task Force: See description above. MCH/CYSHN Data and Epidemiology: The MCH State Epidemiologist provides overall leadership on MCH/CYSHN data and epidemiology. This includes technical assistance and consultation on the development and implementation of surveys, study design, program evaluation, data collection and analysis, and

the review and coordination of state and local data. This staff also mentors and assists new epidemiologists on applying knowledge and skills to public health problems. Autism-Related Activities: The MDH provides consultation, data analysis and dissemination and policy development around autism and autism spectrum disorders. This includes the development of community collaborative teams to improve screening and evaluation systems. This work is done in partnership with the Departments of Education and Human Services, the University of Minnesota, the Minnesota Chapter of the American Academy of Pediatrics Autism Society Minnesota, parents of children with autism and other stakeholders.

***/2013/Rapidly expanding programs under the Maternal and Child Health/Children and Youth with Special Health Needs Section lead the Division to re-evaluate the size and breadth of programs administered under this Section. In early 2012, it was determined that the establishment of a separate section would allow for an appropriate span of responsibility, strengthen programmatic oversight and provide focused leadership on maternal and child health and children and youth with special needs populations.//2013//***

#### POPULATION CAPACITY: PREGNANT WOMEN, MOTHERS AND INFANTS PROGRAMS

Family Home Visiting: The Family Home Visiting Unit promotes healthy pregnancies and happy, healthy babies, toddlers and preschoolers. Family home visiting has been shown to be an effective service strategy for very young children and their families, improving outcomes in health, safety, school readiness, and economic self-sufficiency. These voluntary, home-based services, ideally delivered prenatally through the early years, connect parents with trained professionals who provide health and caregiving information and support. Goals of the Family Home Visiting Unit include planning and statewide capacity-building to ensure family home visiting services are an integral component of a comprehensive early childhood system as well as a vital link with state and tribal health care systems, ensuring a continuum of health care and support services to families. The MDH Family Home Visiting Unit provides administrative oversight for grant funds to Community Health Boards and Tribal Governments to support family home visiting services. Staff also provide training, consultation, data collection and analysis, and technical assistance statewide to family home visiting programs administered at the local level, assuring the application of current science and research to a range of home visiting models and practices.

***/2013/ Almost \$7 million in federal TANF and \$10 million in federal Maternal Infant Early Childhood Home Visiting (MIECHV) funds annually are administered by the Family Home Visiting Program.//2013//***

Family Planning: The Family Planning Special Projects Grant Program provides over \$5 million annually to 32 eligible nonprofit agencies, local health departments, and other governmental agencies to provide family planning services to women and men who have barriers to accessing these services such as poverty, lack of insurance, race, age or culture. MDH staff provides consultation, technical assistance and support for implementation of best practices. This work is done in close collaboration with the MDH HIV/STD staff, the family planning grantees, the MDH Office of Minority and Multicultural Health and the Department of Human Services. State funds also support a family planning and sexually transmitted infection (STI) hotline staffed by individuals trained in information, referral, family planning, and STI counseling. Information on the hotline is mailed annually to Medicaid and Minnesota Care recipients.

Infant Mortality Reduction: The infant mortality reduction initiative provides resources, education, and technical assistance to local health departments, tribal governments, and community agencies to improve birth outcomes and reduce infant mortality with a particular focus on reducing racial and ethnic disparities in infant mortality and other poor birth outcomes. MDH also supports work to improve the health disparities around infant mortality that exists in the tribal communities in Minnesota. Partners in the program include the Office of Minority and Multicultural Health, the American Indian Community Action Team, the March of Dimes, the Department of Human Services, Twin Cities Healthy Start, Minnesota SID Center, Tribal nursing directors, urban American Indian programs, local health departments, and ACOG Minnesota.

Positive Alternatives Program: The Positive Alternatives Program provides funds of approximately \$2.4 million annually to support services to pregnant women and women parenting infants that promote healthy pregnancies and assist them in developing and maintaining family stability and self-sufficiency. Currently, 31 grantees offer women information on medical care, nutritional services, housing assistance, adoption services, education and employment assistance, including services that support the continuation and completion of high school, child care assistance, and parenting education and support services. Grantees may directly provide these or other needed services, working in collaboration with community resources.

Women's Health: MDH recently conducted an evaluation of women's health issues and need. A women's health consultant position has been created within the section and was recently filled. This new position will provide consultation, technical assistance and support to partners working to address multiple women's health issues. The position will collaborate on the student parent grant initiative and staff working with the Birth Defects Information System.

#### POPULATION CAPACITY: CHILDREN AND ADOLESCENTS

Adolescent Health: The adolescent health coordinator provides leadership and support to promote healthy youth development and help meet the health needs of adolescents statewide. This work is done in partnership with the Departments of Education, Human Services and Public Safety and the MOAPPP. Primary activities include consultation, data analysis, capacity-building and support for best practices in adolescent health at the state and local levels.

Student Parents Support: MDH recently received federal funding to support a Student Parents Initiative. The goals of the initiative are to assure that pregnant and parenting teens and young women and men accomplish their higher education/post secondary education goals and; and that pregnant and parenting young students maintain positive health and well-being for themselves and their children. These goals will be achieved by expanding current services to young parenting students on campus; starting new student parent help centers at higher education institutions, and reaching out to young student parents through technology and media.

Abstinence Education: The section recently received federal funding for Minnesota's Abstinence Education Program. With this grant, Minnesota will implement a statewide primary prevention and positive youth development program targeting communities at highest risk for teen pregnancies and births. Minnesota's program will be a coordinated statewide approach focusing on adolescents 14 and under, reaching them before they start engaging in sexual activity. Minnesota will convene a task force of experts in the field of teen pregnancy prevention, health disparities, social services and education to help create the strategic goals of this initiative.

Child Health Consultation/Child & Teen Checkup Program: This program provides statewide technical assistance and consultation in the areas of adolescent and newborn/child health, especially developmental and socio-emotional screening instruments. The Child and Teen Checkups (C&TC) Program is a Department of Human Services preventative health care program for children under 21 years of age who are enrolled in the Minnesota Medical Assistance program. Staff conduct numerous trainings and workshops statewide for C&TC providers (public and private). Participants are taught skills in well child screenings, such as hearing, vision, developmental and mental health. A contractual arrangement with the Minnesota Department of Human Services matches dollar for dollar of MDH state funds with federal Medicaid funds. MDH staff also provide technical assistance to those who perform early childhood screenings (ECS). ECS is the mandated preschool screening program administered by the Department of Education. MDH staff train on several of the required and optional components of ECS.

Minnesota Early Childhood Comprehensive Systems (MECCS): The purpose of MECCS (a federal grant) is to build and implement statewide early childhood comprehensive systems that support families and communities in their development of children that are healthy and ready to learn at school entry. These systems are multi-agency and include the key public and private

agencies that provide services and resources to support families and communities in providing for the healthy physical, social, and emotional development of all young children. The overall goal of the MECCS program is to coordinate early childhood systems for children from birth to 5 years of age. Grant activities do not involve direct service provision or referrals for services.

School Health: The school health nurse consultant provides education, consultation, and technical assistance throughout the state to school nurses, school administrators, school boards, teachers, parents, early childhood and child care. In addition to working with numerous MDH staff, the school health nurse consultant partners with the Departments of Education and Human Services and the Minnesota Board of Nursing to share program information and assure quality school health activities.

***/2013/ Child Care: MDH received funding in 2012 as part of Minnesota's Early Learning Challenge Grant. MDH will use this funding to support a Child Care Health Consultant position at the state. In addition, MDH will contract for child care health consultation services in the four Early Learning Challenge Grant transformation zones. These contractors will assist child care facilities/families to improve the quality of their facilities. These consultants will also assist the MDH in expanding the state's child care health consultation network. /2013/***

***Mental Health Promotion/Suicide Prevention: MDH provides information to the public and grants to local communities for the implementation of proven effective prevention strategies to reduce suicide. In addition to monitoring grants, the program coordinator monitors suicide trends throughout the state, provides expertise about best practices in suicide prevention, and offers technical assistance with local program development and suicide prevention policy. MDH also works closely with other state and local agencies and represents public health on statewide committees, such as the State Advisory Council on Mental Health. This program is also responsible for the development of initiatives to support a public health role in mental health promotion. The MDH works closely with state and local agencies and committed citizens to foster environments where all Minnesotans have an opportunity to live, learn, work, and fully participate in caring communities that promote mental health and overall wellbeing. /2013/ Suicide Prevention staff and grant program was moved to the Injury and Violence Prevention Unit in the Health Promotion and Chronic Disease Division. The Community and Family Health Division will continue to take the lead on children's mental health.//2013//***

#### POPULATION CAPACITY: CHILDREN WITH SPECIAL HEALTH NEEDS

Part C of the Individuals with Disabilities Education Act (IDEA) -- Help Me Grow: Part C Early Intervention staff provide training, technical assistance and educational materials to health care and early intervention providers relevant to eligibility guidelines for Minnesota's Early Intervention Program, "Help Me Grow" and health conditions/disorders with a high probability of resulting in developmental delays at school age. Part C refers to services under the Individuals with Disabilities Education Act (IDEA) for infants and toddlers ages birth to three through Part C of the Act, and for ages three to five years through Part B619 of the Act. Part C staff provide leadership, oversight and staff support to this program, partially funded by Part C of IDEA through a MN Department of Education interagency agreement.

Part B of the Individuals with Disabilities Education Act (IDEA) - Minnesota System of Interagency Coordination (MnSIC): In accordance with Part B of the IDEA, Minnesota law requires a statewide, interagency, coordinated service system for students with disabilities ages 3--21 who need services from the school and at least one other public agency. The MnSIC initiative brings together the Minnesota Departments of Education, Employment and Economic Development, Commerce, Corrections, Health, Human Rights, and Human Services and charges them with developing and implementing the system, including identifying and removing barriers to local coordination of services, identifying funding sources and developing a standardized written plan

for service provision. Staff (funded by an interagency agreement with the Minnesota Department of Education) provides leadership for the state interagency committee as well as staff to achieve these goals. At the community level, school boards and county boards develop local interagency agreements for service provision and payment arrangements. Each eligible child has an individual interagency intervention plan (IIIP) setting out the child's programs, services and funding sources. The contents of other service plans, such as IEPs, home care plans and Medicaid plans are to be incorporated into the IIIP.

**Follow-Along Program:** MDH provides technical assistance and training to local public health agencies to support the Follow-Along Program. This program provides periodic monitoring and assessment of infants and toddlers at risk for health and developmental problems and to ensure early identification, assistance and services. This program uses the Ages and Stages Questionnaire (ASQ-3) as the developmental screening tool and its social/emotional component - the ASQ-SE.

**Newborn Screening Long-Term Follow Up:** Staff from the section work in partnership at MDH with the Public Health Laboratories (PHL) on systems development, data and tracking linkages, and providing education, outreach, and technical assistance. Staff also collaborate with primary care providers, specialists, local public health nurses, special education providers and other key stakeholders to assure infants find early treatment/intervention and immediate support services after initial diagnosis of the condition. This collaboration also ensures that ongoing medical/habilitative management, including specialty care, are provided within the context of the health care home. In addition, MDH provides grants to local health departments to facilitate connections to local resources and reduce loss to follow-up of infants who fail their newborn hearing screening. These grants also support connections to local and state resources for those diagnosed with a permanent hearing loss.

#### **Newborn Screening Advisory Committee**

The Minnesota statute that mandates newborn screening also created the MDH Newborn Screening Advisory Committee. This committee, which meets on a semi-annual basis, has members that include parents of affected infants and children, advocacy groups, health care providers, hospital representatives, and other medical and educational experts. One of the main purposes of the advisory committee is to discuss issues related to newborn screening, including making informed recommendations on adding new disorders to the newborn screening panel. This committee is supported by staff from the MCH/CYSHN section and the Public Health Lab (PHL).

#### **Newborn Hearing Screening Advisory Committee**

The Minnesota statute (144.966) that mandates newborn hearing screening also created a MDH Newborn Hearing Screening Advisory Committee. This committee meets four times per year to discuss issues surrounding newborn hearing screening and follow-up for infant and children with a confirmed hearing loss. Members include parents of children with a hearing loss, advocates with expertise in issues affecting people who are deaf and hard of hearing, health care providers, hospital representatives, and other medical and education experts. One of the main purposes of the advisory committee is to make informed recommendations for newborn hearing screening and hearing loss management. The committee is staffed by staff from the MCH/CYSHN section and PHL.

**CYSHN Information and Assistance Line:** The CYSHN information and assistance line is a toll free line that serves as a resource for families, health care providers, public health nurses, teachers, social workers and anyone who needs help identifying and locating resources for children with special health needs. The information and assistance line provides resources and ideas for varying approaches to Minnesota to enhance communication and partnership between families and providers. Both national and state information is available. Staff partner with parent-to-parent support agencies such as Family Voices and Parent-to-Parent Health Information Center - Pacer to assure up-to-date information is available to parents and providers about

various public programs and how to access them. The Information and Assistance line continues to provide information about and assistance in finding and accessing services and supports for children with special health needs and their families.

The Birth Defect Monitoring and Analysis Program gathers information on 44 nationally reported birth defects as well as one additional heart defect. Original funding came from CDC to initiate a birth defects surveillance system in Hennepin and Ramsey Counties. In 2010, the Minnesota legislature provided funding for the program to expand state-wide. Efforts include development of a surveillance system, preventive activities such as use of folic acid, reduction in alcohol and tobacco use during pregnancy, and improved diabetes control, there is also follow-up with families whose infants have been determined to have a reportable birth defect to assure that appropriate linkages with specialists and community resources have occurred.

Health Care Home -- A "health care home", also called a "medical home", is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for children and adults with chronic health conditions and disabilities. Minnesota legislation enacted in SFY 2009 provides payment to primary care providers who are certified as a health care home and who partner with patients and families to provide coordination of care. Title V staff play an important role in the support and technical assistance provided to the pediatric health care home teams in their geographic areas. This technical assistance/consultation has included activities such as quality improvement techniques, in particular guiding teams through the use of Plan Do Study Act cycles; facilitating team meetings, focus groups, community meetings, assisting with the development, collection and analysis of community/consumer survey data; recruiting and facilitating child/family participation in decision making; providing informational resources to increase provider understanding of care plans, care coordination, funding options, community resource and training opportunities; and connecting health care home teams to learning opportunities, ideas for quality improvement processes and joint planning across clinics and service providers.

***//2013/ The CYSHN Section is involved in several activities related to autism. The 2011 Minnesota Legislature created an Autism Spectrum Disorder Task Force composed of 19 members. The CYSHN Director is a member of the Task Force representing the Health Department. The duties of the Task Force include: developing a statewide strategic plan focused on improving awareness, early diagnosis, and intervention and on ensuring delivery of treatment and services for individuals with autism, including the coordination and accessibility of cost-effective treatments and services throughout the individual's lifetime. The strategic plan is to be submitted to the legislature by January 15, 2013. The 2012 Minnesota Legislature appropriated \$200,000 for MDH to conduct a qualitative study focused on cultural and resource-based aspects of autism spectrum disorders that are unique to the Somali community and to report back to the legislature on by February 15, 2014. This report must also include recommendations for the establishment of a population-based public health surveillance system for ASD. Title V staff is also working with the University of Minnesota on the University's CDC supported grant looking at prevalence of autism in the Somali community.//2013//***

## **C. Organizational Structure**

The Minnesota Department of Health (MDH) is one of the major administrative agencies of state government. The Commissioner of Health is appointed by the governor with confirmation by the state senate, and serves at the pleasure of the governor. State law imposes upon the Commissioner the broad responsibility for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens of Minnesota.

The Executive Office is organized into four Bureaus: Policy Quality and Compliance Bureau, Health Protection Bureau, Community and Family Health Promotion Bureau and Administrative Services. Within the Community and Family Health Promotion Bureau are four Divisions, Health Promotion and Chronic Disease; the Office of Minority and Multicultural Health; Office of Statewide Health Improvement Initiatives and Community and Family Health. The Community and Family Health Division (CFH) is responsible for the administration of programs carried out by allotments under Title V.

***//2013//Rapidly expanding programs under the Maternal and Child Health/Children and Youth with Special Health Needs Section lead the Division to re-evaluate the size and breadth of programs administered under this Section. Earlier this year it was determined that the establishment of a separate section would allow for an appropriate span of responsibility, strengthen programmatic oversight and provide focused leadership on maternal and child health and children and youth with special health needs populations. As of February 2012, the Division of Community and Family Health established a new Section called Children and Youth with Special Health Needs. The Title V programs are now administered by:***

- The Maternal and Child Health (MCH) Section assesses the health needs of mothers, children, and their families; uses that information to advocate effectively on their behalf in the development of policies and advocates for programs and funding streams which have the potential to improve their health. The Section provides administrative and technical assistance to local public health agencies, tribal governments, schools, non-profit organizations and private health care providers.***
- The Children and Youth with Special Health Needs (CYSHN) Section provides leadership through partnerships with families and key stakeholders to improve the access and quality of all systems impacting children and youth with special health care needs and their families. CYSHN connects children and families to services and resources; provides health information about many chronic illnesses and disabilities; follows families whose infants have been diagnosed with metabolic or endocrine disorders, confirmed hearing loss or identified with a birth defect; provides leadership and expertise related to state policy development.***

***The other two Sections under the Community and Family Health Division are Health Care Home and WIC which are described below.//2013//***

*//2012//*A management restructuring occurred in 2010 that was precipitated by: a number of retirements, the need to leverage and maximize available resources and the need to refocus priorities. Restructuring on a Department level moved the Office of Public Health Practice from the Community and Family Health Division into the Executive Office. Now called the Office of Performance Improvement, their efforts were refocused to integrating Department-wide continuous improvement processes and supporting both state and local public health accreditation efforts. Within the Division, restructuring resulted in the re-aligning of staff to

support key priorities including expansion of health care homes, early childhood systems coordination, and mental health promotion. The MCH Section Manager took over administrative responsibilities for children with special health care needs federal requirements and supervises the Title V Children with Special Health Care Needs Director. In an effort to foster and strengthen integration of children with special health needs and their families into Health Care Home, seven Title V funded staff have been assigned to work under the Health Care Homes Section, bringing to bear their expertise related to children with special health care needs, their families and the systems necessary to support them to this effort.

The CFH Division is organized into the Director's Office and three sections: Supplemental Nutrition Program (WIC), Health Care Homes, and the Maternal and Child Health Section/Children and Youth with Special Health Care Needs Section (MCH/CYSHCN). The last two sections house the staff and resources where the primary Title V activities take place, although Title V staff work across the whole CFH Division -- as well as across the department. ***/2013/ The CFH Division is organized into the Director's Office and four sections: Supplemental Nutrition Program (WIC), Health Care Homes, Maternal and Child Health and Children and Youth with Special Health Needs.//2013//***

The CFH Director's office provides overall management of the sections and houses staff who provide shared services to the Division. This includes the Epidemiology and Data Unit, the Communications Unit, and grant and financial management staff. The Director's Office houses 21 staff, seven of which are at least partially funded by federal Title V funds. ***/2013/ The Director's Office houses 10 staff (the Birth Defects Monitoring & Analysis Unit was moved this past year under the CYSHN Section) three are at least partially funded by federal Title V funds.//2013//***

The programs within the MCH/CYSHN Section strive to improve the health status of infants, children and youth, children and youth with special health needs, women and families. The section provides a focal point for influencing the efforts of a broad range of agencies and programs committed to this goal. The role of the section is to: assess the health needs of mothers, children, and their families; use that information to advocate effectively on their behalf in the development of policies concerning organizational and operational issues of health systems; and advocate for programs and funding streams which have the potential to improve their health. The Section provides administrative and technical assistance to community health boards, tribal governments, schools, non-profit organizations, and private health care providers. Activities at a section level include: Children and Youth with Special Health Needs: The section provides state-level leadership in partnership with families and other stakeholders to achieve a vision on ongoing improvement of community-based systems serving CYSHN and their families. This is done through emphasis on six national priorities for children and youth with special health care needs. The Maternal and Child Health Advisory Task Force: provides recommendations to the Commissioner of Health on MCH and CYSHCN issues. MCH/CYSHCN Data and Epidemiology: The MCH State Epidemiologist provides overall leadership on MCH/CYSHCN data and epidemiology. This includes technical assistance and consultation on the development and implementation of surveys, study design, program evaluation, data collection and analysis, and the review and coordination of state and local data. This staff also mentors and assists new epidemiologists on applying knowledge and skills to public health problems. Autism-Related Activities: The MDH provides consultation, data analysis and dissemination and policy development around autism and autism spectrum disorders. This includes the development of community collaborative teams to improve screening and evaluation systems. This work is done in partnership with the Departments of Education and Human Services, the University of Minnesota, the Minnesota Chapter of the American Academy of Pediatrics Autism Society Minnesota and other stakeholders. The MCH/CYSHN Section structure to support this work consists of four work units: Child & Adolescent Health; Family Home Visiting; Women and Infant Health and Newborn & Child Follow-up. The section has a total of 44 staff of which 7 are funded by Title V. The remaining staff are funded by a combination of state general fund, fees and other federal funding sources. ***/2013/ MCH Section has a total of 34 staff, of which 7FTEs are***

***funded by Title V. The CYSHN Section has a total of 22 staff of which 1.5 FTE are Title V funded.//2013//***

Health Care Homes This section is responsible for implementing the health care home component of the ground-breaking health reform legislation passed in May 2008. This legislation included payment to primary care providers for partnering with patients and families to provide coordination of care. Building on the earlier work initiated by the Minnesota Children and Youth with Special Health Needs (Title V program) on medical homes for children and youth with special health care needs, this effort also includes adults with chronic health conditions or disabilities. This section partners closely with the Minnesota Department of Human Services in developing standards for health care homes, the certification process and payment methodology for primary care providers. Ultimately the goal is to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities. This section has a total of 13 staff of which 7 are funded by Title V. The remaining staff are funded by the Health Care Access fund.

Also housed within the Community and Family Health Division is the WIC section. Clearly aligned with Title V program activities, WIC provides over 138,000 women, infants and young children with nutritional foods each month. This program, with a budget of \$131,000,000, was designed to improve the health and nutritional status of the eligible populations through the provision of healthy foods, nutrition education and health care referrals. This section distributes federal funds from the United States Department of Agriculture to local Community Health Boards, Community Action Programs, and Tribal governments to administer the WIC program. This section also oversees the Commodity Supplemental Food Program that provides approximately 16,000 individuals, mostly seniors, with monthly commodity foods.

As required, organizational charts are available on file in the Director's Office in the Community and Family Health Division and attached to this application.//2012//

The CFH Division is organized into the Director's Office and five sections: Office of Public Health Practice (OPHP), Supplemental Nutrition Program (WIC), Health Care Homes, Maternal and Child Health Section (MCH), and Minnesota Children and Youth with Special Health Needs Section (MCYSHN). The last two sections house the staff and resources where the primary Title V activities take place, although Title V staff work across the whole CFH Division -- as well as across the department.

The CFH Director's office provides overall management of the sections and houses staff who provide shared services to the Division. This includes the Epidemiology and Data Unit, the Communications Unit, and grant and financial management staff. The Director's Office houses 21 staff, seven of which are at least partially funded by federal Title V funds.

The mission of the MCH Section is to provide statewide leadership and public health information essential for promoting, improving or maintaining the health and well-being of women, children and families throughout Minnesota. The structure to support this work consists of three work units: Child and Adolescent Health Unit, Family Home Visiting Unit and the Women's Health Unit. This Section has a total of 24 staff of which six FTEs are funded by federal Title V funds; eight FTEs funded by targeted state funds; approximately ten FTEs funded by various federal grant programs; and other positions funded through a mix of sources for a current total of 32.3 FTEs.

The Minnesota Children and Youth with Special Health Needs (MCYSHN) Section is the Title V CYSHCN program. As such, it seeks to improve the quality of life for children with special health needs and their families through the promotion of the optimal health, well being, respect and dignity of children and youth with special health needs and their families. MCSHN provides statewide support to achieve early identification, diagnosis and treatment, family centered services and systems of care, access to health care and related services, community outreach and networking, and collection and dissemination of information and data. MCSHN is structured into the Research and Policy Unit, the Newborn Follow-up Unit and the Community and Systems

Development Unit, which has five staff housed in District Offices across Minnesota. MCSHN has thirteen FTEs funded by the federal Title V funds, two FTEs funded through interagency agreements with the Department of Education, one and a half FTEs funded by federal grants, and approximately eight and a half state funded FTEs for a total of 25 FTEs.

Also within the Community and Family Health Division are the WIC, Health Care Home and Office of Public Health Practice sections. Title V staff work with all of these sections on many shared goals for improved pregnancy outcomes and healthy infants, children and families.

**Special Supplemental Nutrition Program for Women, Infants and Children (WIC)**  
Clearly aligned with Title V program activities, WIC provides over 138,000 women, infants and young children with nutritional foods each month. This program, with a budget of \$131,000,000, was designed to improve the health and nutritional status of the eligible populations through the provision of healthy foods, nutrition education and health care referrals. This section distributes federal funds from the United States Department of Agriculture to local Community Health Boards, Community Action Programs, and Tribal governments to administer the WIC program.  
**Health Care Homes** This section is responsible for implementing the health care home component of the ground-breaking health reform legislation passed in May 2008. This legislation included payment to primary care providers for partnering with patients and families to provide coordination of care. Building on the earlier work initiated by the Minnesota Children and Youth with Special Health Needs (Title V program) on medical homes for children and youth with special health care needs, this effort also includes adults with chronic health conditions or disabilities. This section partners closely with the Minnesota Department of Human Services in developing standards for health care homes, the certification process and payment methodology for primary care providers. Ultimately the goal is to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.

**Office of Public Health Practice** The Office of Public Health Practice provides coordination and support to the local public health system which works in tandem with MDH to fulfill public health responsibilities. This interlocking system of state and local effort is critical to mounting an effective response to public health threats. Minnesota has delineated a set of essential local public health activities that characterize local roles for carrying out disease prevention, public health emergency preparedness, environmental health, health promotion, maternal and child health, and connecting people to needed health services. They do this work by partnering with local elected officials, Community Health Boards and local public health administrators and directors to ensure a strong state and local governmental public health system in Minnesota.

***An attachment is included in this section. IIC - Organizational Structure***

#### **D. Other MCH Capacity**

See previous Section C Organizational Structure for the location and numbers of Title V staff.

#### **SENIOR MANAGEMENT BIOGRAPHICAL SKETCHES**

The Director of the Community and Family Health Division, Maggie Diebel, has served in that capacity since February 2007. She has extensive experience working in public health, both in service provision and in managing public health programs. She is a registered nurse and has a BA in Human Services Administration from Metropolitan State University in St. Paul, and an MPH from Johns Hopkins University Bloomberg School of Public Health in Baltimore, Maryland. She has clinical nursing experience both at the University of Minnesota and Johns Hopkins hospitals, and served as a nursing advisor in the Cambodian refugee camps along the Thai-Cambodian border. As a Senior Public Health nurse in Arlington County, Virginia, she managed public health support to the county's homeless population, and in 1998, she became the Director of the Office

of Population, Health, and Nutrition (PHN) for the United States Agency for International Development in Nairobi, Kenya, having previously managed a regional project operating in east, central, and southern Africa. More recently, she served as Vice President, Program Support Department of Family Health International in Arlington, Virginia where she had oversight of international HIV/AIDS prevention, treatment, care and support programs in over 50 countries.

***//2013/ In February 2012, Barb Dalbec assumed responsibility for the Children and Youth with Special Health Needs Section and was named the state's CYSHCN Director. Ms. Dalbec has a Bachelor of Science in Nursing from the University of Minnesota and is pursuing her Master's in Public Health. She comes to the position with a strong background in quality improvement and work with children and youth with special health needs. Prior to becoming the state's Title V-CYSHCN Director, Ms. Dalbec was the Supervisor of the Newborn Child Follow-up Unit linking infants identified in newborn screening with appropriate supports and resources. She was also the Department of Health's Part C Coordinator working closely with the Departments of Education and Human Services to assure a coordinated, comprehensive system of early intervention services for infants and toddlers with disabilities and their families.//2013//***

John Hurley is the state CYSHCN Director and the MCYSHN Section Manager. He has held this position since the fall of 2000. He has a Master's degree in Hospital and Health Care Administration from the University of Minnesota, is a Bush Fellow and pursued further graduate education at the Kennedy School of Government, Harvard University through that fellowship. Prior to becoming the state's Title V-CYSHCN Director, he spent nine years with the Maternal and Child Health section of the state's Title V program specializing in child health issues. Previous to his experience with the state's Title V program, he worked for 18 years in regional health systems planning and hospital corporate activities. He is a member of AMCHP's Legislative and Health Care Finance Committee, a Board member of Minnesota's System of Interagency Coordination, a member of the advisory board for the University of Minnesota School of Nursing's Center for CSHCN and an ex-officio board member for the State Council on Disability. //2012// Mr. Hurley retired and Sara Thorson assumed responsibility as the states' CYSHCN Director. She has held the position since November of 2010. Sarah has been with the Minnesota Department of Health for 18 years where she served most recently as the Research and Policy Supervisor for CYSHCN. There she designed and implemented Minnesota's early Medical Home initiatives, a rigorous data analysis and information dissemination program, program evaluation and community-based quality improvement initiative for children with autism and other developmental disabilities and recommendations for a standard benefits set for CYSHCN. Sarah has a bachelor's degree in social work from St. Catherine University in St. Paul, MN with over 30 years experience. Prior to coming to MDH, Sarah worked in early intervention in the Minneapolis Birth to Three Program, as a social worker in a local health and human services agency, and as a social worker in a variety of health care settings. Sarah has used her personal experience as the parent of young adults with special health care needs to improve systems of care for CYSHCN throughout Minnesota.//2012//

The state MCH Director is the MCH/CYSCHN Section Manager. Laurel Briske is the current Director and assumed the responsibilities in August of 2007. Laurel has been at the Minnesota Department of Health nearly 21 years where she served most recently as the public health nursing director in the Office of Public Health Practice. There she managed a technical support and training program for public health nurses and local public health departments. She has also worked in the area of injury and violence prevention, children with special health needs, and child health screening. Laurel has a master's degree in nursing and is a pediatric nurse practitioner with 30 plus years of experience in public health programs. Prior to coming to the state health department, Laurel worked as a Head Start health consultant for the U.S. Public Health Service, in a primary care clinic for homeless women and children, as a public health nurse in county public health departments and as a school nurse. //2012// Ms Briske assumed supervisory responsibilities for the CYSHCN Director in 2010.//2012// ***//2013/ In early 2012, responsibilities for Children and Youth with Special Health Care Needs programs was transferred to Barb***

***Dalbec. Ms. Briske retains the MCH Title V Director position.//2013//***

**PARENT ROLES.**

One of the operational tenets of CYSHCN's medical home activity historically was the presence of at least two parents on each medical home team, as well as the use of parents and parent resources as faculty for the learning sessions in the medical home collaborative. Between 2005 and 2010, MCYSHN conducted three separate quality improvement initiatives using the IHI Breakthrough Model and the structure of collaborative learning sessions. These initiatives were focused on medical home, early hearing detection and intervention loss to follow-up and autism/developmental disabilities community partnerships. Teams were formed in each of these initiatives and a condition for team participation was parent representation/membership on each team. In addition, colleagues at the Minnesota Department of Human Services (the state's Medicaid Agency), because of their participation in medical home activities have adopted the structure of this quality improvement approach, including the presence of parents on teams. Both the EPSDT program and the Children's Mental Health Services (CMHS) program have used it. Examples being the DHS participation in the ABCD-II grant program sponsored by The Commonwealth Fund and its current participation in the ABCD-III grant program. Finally, Minnesota is one of the states participating in state improvement partnerships modeled after the Vermont Children's Health Improvement Partnership. The Title V program was instrumental in the formation of the Minnesota effort and the inclusion and recruitment of parents on the advisory board of the Minnesota Child Health Improvement Partnership (MN-CHIP).

*//2012//* Building on the experiences of the medical home activities consumer/parent involvement has been integrated into Minnesota's Health Care Home (HCH) program values which facilitates active involvement of consumers in both an advisory capacity and in evaluation of applicant clinics to become certified health care homes. Consumer representatives are solicited for membership and receive fiscal compensation to participate on several HCH committees: HCH Consumer and Family Council, HCH Certification Committee, HCH Performance Measurement Work Group, and Payment Methodology Work Group. Additionally, there are several consumers under contract with HCHs to perform site visit evaluations as part of the determination of whether or not a clinic meets the requirements to become a certified Health Care Home.*//2012//*

The MCH Advisory Task Force is a legislatively mandated committee that provides the Commissioner of Health recommendations on the health and well-being of Minnesota's women and children. It is a fifteen member committee made up of five each of MCH professionals, local public health representatives and consumers. The five current consumers are:

Carol Grady: Carol was appointed to the task force in 2005. She was a journalist who pursued a career in nursing following the birth of her special needs son (who passed away in 2007). Carol has become an advocate for parents and works to bridge the gap of understanding between MCH professionals and parents. In 2009, Carol served as Minnesota's AMCHP family delegate and AMCHP family scholar. In 2010, Carol served again as one of Minnesota's AMCHP family delegates. Carol currently works as a school nurse and in the NICU of a children's hospital.

John Hoffman: John was appointed to the task force in 2007. John also serves on the executive committee of the task force. John's daughter was diagnosed with spina bifida at 24 weeks gestation. John's experience with the medical system and his daughter's eventual connection to a medical home led him to advocacy work for children with special needs. In 2009 John was an AMCHP family delegate and was also selected as an AMCHP family mentor. John works as Marketing and Public Relations Director for an organization that finds employment opportunities for adults with disabilities.

Allison Senogles: Allison was appointed to the task force in 2007. Allison is Native American and has been a foster mother to special needs children; many of whom she has adopted. During her tenure with the task force, Allison has pursued a career in nursing. She recently moved her family to northern Minnesota to be closer to her family and her work at the Red Lake Indian Reservation

hospital.

Wenqing Han: Wenqing was appointed to the task force in 2008. She is a Chinese native (U.S. Permanent Resident) living in the U.S. for 12 years. She has been a volunteer for the Chinese Clinic in St. Paul for four years. She is a nurse by training and worked as a general surgery nurse in China.

Coral Garner: Coral was appointed to the task force in 2004. Coral also serves on the executive committee for the task force. Coral, an African American, is the director of Community and Public Health Initiatives for the City of Minneapolis Department of Health and Family Support. Ms. Garner was also the director of Twin Cities Healthy Start, which provides maternal and child health outreach, case management, and education to American Indian and African American women in the metro area. ***//2013/Coral Gardner left the Task Force in early 2012. At this time, this position has not been refilled. Applications are currently being accepted for membership to the MCH Advisory Task Force. The consumer representative positions will be filled in September 2012.//2013//***

//2012// Two MCH Advisory Task Force consumer representatives either left the Task Force or their term expired. Allison Senogles and Wenqing Han are no longer members. These consumer representative positions are now held by:

Nancy Jost: Nancy was appointed to the task force in 2011. She has served as the Early Childhood Coordinator to the West Central Initiative in Fergus Falls since 2003. This includes coordination of the Early Childhood Initiative, THRIVE Initiative, Early Childhood Mental Health Initiative, the Early Childhood Dental Network and a school readiness project. She has a long career in early childhood and child care programs that support families.

Stephanie Graves: Stephanie was appointed to the task force in 2011. She is the MCH Coordinator for the City of Minneapolis Department of Health and Family Support. She has extensive experience in MCH issues. The Executive Committee is recommending Stephanie as a consumer representative because she has been a foster care provider for children with special health care needs over the last 20 years and brings a valuable dual perspective of both provider and consumer of MCH services. //2012//

Several Title V staff are also parents with one or more children who have a special health care need. The roles these parents perform and the positions they occupy in the program include supervisory, policy and program planning, and technical consultation for statewide programs.

## **E. State Agency Coordination**

Collaboration and coordination is a fundamental value and strategy for the work of Title V. It is essential to the accomplishment of our goals. Many of the earlier sections of this report as well as the Performance Measure narratives describe multiple partnerships between Title V, other MDH program areas, other state agencies, community-based entities, and local public health. These relationships are both long-standing, and also include some exciting new opportunities. Some of these are formal with Interagency Agreements and MOUs in place, and many are less formal.

### **INTRA-AGENCY COORDINATION**

The Office of Rural Health and Primary Care through their Primary Care Office (PCO) and Minnesota's Title V programs support each other's mission and the goals and objectives through their respective SSDI and Cooperative Agreement (CA) grants. The mission of the PCO is to improve access to preventive and primary care services for underserved Minnesotans. The Title V program works, in part, to further efforts of organizations that deliver health services to mothers

and children and to provide leadership for statewide maternal and child health issues. Both programs promote the development of community-based, family-centered, comprehensive, coordinated, and culturally competent systems of services as a priority. Annually, the Office of Rural Health and Primary Care, the Minnesota Rural Health Association and the Rural Health Resource Center host a Rural Health Conference that brings hospital and clinic administrators, EMS, rural public health agencies as well as others together to discuss pressing issues. It is an opportunity for Title V programs to present new information and hear from our partners the issues facing mothers and children in outstate Minnesota.

The Office of Minority and Multi-Cultural Health (OMMH) relies on Title V staff for specific program area expertise for the Eliminating Health Disparities grantees, and Title V staff likewise rely on OMMH staff for access, guidance and assistance in their work with ethnic/cultural activities and groups. These partnerships have produced several joint trainings, conferences and other projects. Recent joint efforts have focused on an American Indian Infant Mortality Review project. This activity examined American Indian infant deaths (within the first year of life) that occurred in 2005 and 2006. Information for case summaries was obtained from birth and death records, health records, autopsy reports as well as interviews with mothers. Qualitative and quantitative data were combined to create a comprehensive picture of each infant death which was then reviewed by an expert panel, representing a cross section of professionals and key community representatives. Recommendations from that report have guided community action teams in the American Indian communities to address this issue. Another joint effort is around Family Home Visiting. A staff member from the OMMH responsible for tribal Family Home Visiting programs was transferred to Title V program to assure a coordinated state approach to implementing and evaluating the program between local public health and tribal governments.

Tobacco Prevention and Control Program (TP&C) and Title V staff continue to work together to address tobacco prevention and reduction of exposure to second hand smoke among children and families in Minnesota, with a growing focus on smoking cessation for pregnant women. Staff from both sections partner in the Robert Wood Johnson/ ACOG/Planned Parenthood project.

***//2013/ The Department of Health submitted and was awarded an Association of State and Territorial Health Officials and Robert Wood Johnson grant to improve the health departments efforts in impacting tobacco use and exposure by leveraging and coordinating cross divisional activities. This quality improvement effort, which is focused on improved communications across divisions, includes: Environmental Health Division which has responsibility for the enforcement of the Minnesota Clean Indoor Air Act and Healthy Home Initiative; the Division of Community and Family Health which is responsible for MCH efforts on Infant Mortality reduction, pre-conception and prenatal health, child and adolescent tobacco use and exposure to secondhand smoke as well as administrative oversight of PRAMS and WIC data; the Health Promotion and Chronic Disease Division which is responsible for asthma prevention and the Office of Statewide Health Improvement Initiative which is responsible for Minnesota's tobacco prevention program.//2013//***

Center for Health Statistics (CHS) The Center for Health Statistics staff work on numerous activities with Title V staff including data analysis, data and systems planning, training and presentations, and consultation. Joint activities underway include matching birth certificate information with newborn screening information, and with the Birth Defects Information System (BDIS). The CHS unit continues to play a key role in providing birth and death data for the block grant. They are currently partnering with the teen pregnancy prevention coordinator analysis birth record data and because of their expertise with large data bases have agreed to coordinate the matching of WIC and birth certificate data.

The Division of Environmental Health houses several program areas with which Title V is a priority partner including the lead program and other environmental programs that affect the health of children.

The State Public Health Laboratory and Title V staff work in tandem on the newborn bloodspot and hearing screening programs in planning, administration, education and training, monitoring, evaluation and follow-up.

Ongoing relationships exist between Title V staff and several other program areas in MDH that enhance the work of both partners and frequently produce special short-term projects or activities. These areas include the immunization program, injury prevention, nutrition (outside of WIC), obesity, sexual violence prevention, STI / HIV prevention and Refugee Health. The autism team is convened and supported by Title V but draws its members from across the department.

#### INTER-AGENCY COORDINATION

Department of Human Services (DHS): The Title V programs and the Department of Human Services (the state's designated Title XIX and Title XXI agency) have a long history of collaboration framed by a formal interagency agreement. DHS is represented on the MCH Advisory Task Force in an Ex-Officio status and Title V participates on the Medicaid Advisory Task Force. Numerous other activities are noted throughout this application. Formal contracts exist which provide DHS funding for staff in Title V programs relative to EPSDT, and Title V funds an Epidemiologist at DHS to provide assistance with Medicaid data requests. Management and Executive Office staff of MDH and DHS meet to discuss issues of mutual interest and concern. Minnesota has several early childhood programs administered by DHS (i.e. Child Care) and representatives of these programs were involved in the MECCS grant (Minnesota Early Childhood Comprehensive Statewide Systems) grant. Title V staff are important partners with DHS involved in the ABCD grants, aimed at strengthening services and systems that support the healthy mental development of young children as well as working in collaboration with the Alcohol and Drug Abuse division on substance abuse and treatment for women, especially pregnant women. ***/2013/ Beginning in 2012, a Title V funded staff was placed at the DHS to work with the Title V funded Epidemiologist to identify, analyze and report on state information related to children and youth with special health needs. Over the course of the next couple of years, this effort will provide additional information related to how this population is faring in Minnesota./2013//***

Department of Education: The Title V program and the Department of Education (MDE) collaborate on many projects and programs: Children's Mental Health, Part C, Early Childhood Screening, teen pregnancy prevention, home visiting, service coordination (for ages 3-21), a children's advocate group, and a grant advisory board regarding children with special health care needs and child care. There is active collaboration between MDE and MDH on the Minnesota Student Survey. The MDE is the lead agency in Minnesota for the Early Childhood Intervention Program (Part C), a joint initiative of three state agencies: (Health, Human Services, and Education) and local IEICs (Interagency Early Intervention Committees). Through an interagency agreement, the Department of Health receives funding for specific activities and staff within the CYSHCN program. As part of the Part C activities, Title V staff actively participate on the mandated State Agency Committee (SAC) and the governor appointed Interagency Coordinating Council (ICC). The Department of Health's Part C team provides outreach, information, training, and technical assistance on health related early childhood topics and issues to families; state, regional, and local health, education, and human service agencies; public and private providers and IEICs (Interagency Early Intervention Committees). The MDH team takes the lead for public awareness/child find; ongoing technical support of the Follow Along Program (tracking system for identifying children at-risk); a statewide information and assistance line (central directory requirement); establishing and maintaining an interagency data system; and providing training and technical assistance on managed care issues, health benefits coordination, and outreach to health care providers on Minnesota's early childhood intervention system. ***/2013/Minnesota was awarded a \$44.8 million dollar federal Race to The Top Early Learning Challenge grant. Participating state agencies in the application were the Departments of Education, Health and Human Services. Funding will support the state's plan for early learning reform, including increasing early childhood program quality and accountability, building a skilled early childhood workforce, increasing access to quality early childhood programs***

***for children with high needs, and measuring outcomes and progress. The grant 1) targets direct services to children with high needs-those living below 200% of FPG, 2) provides quality improvement supports to programs serving those children and 3) develops a longitudinal state early childhood data system that will evaluate programs and measure child outcomes. Implementation of the plan will focus on four high-need communities -- White Earth Reservation, Itasca County, St. Paul's Promise Neighborhood and Minneapolis' Northside Achievement Zone -- providing best practices that can be implemented in communities throughout the state.//2013//***

Department of Corrections: The Department of Corrections participates with MDH, DHS, and Minnesota Department of Education on children's mental health issues in the state. This relationship has been long standing and provides avenues to address children's mental health issues in juvenile correction centers. Title V staff also collaborate with the Minnesota Department of Corrections on adolescent health issues through the Interagency Adolescent Female Subcommittee (IAFS). This is a subcommittee of the Department of Correction's Advisory Task Force for Female Offenders in Corrections. The MCH Adolescent Health Coordinator is a member of the IAFS and provides the adolescent health perspective to its work, assuring gender-specific programming for girls in corrections.

Children's Mental Health Collaboratives: The primary focus for children's mental health in Minnesota is the development of a community-based, unified system of services for the child and family. The Comprehensive Children's Mental Health (CCMH) Act requires that counties provide a specified array of mental health services to children. The CCMH Act establishes guidelines for development of Children's Mental Health Collaboratives including integration of funds in order to use existing resources more efficiently, minimize cost shifting and provide incentives for early identification and intervention. This focus on early identification and intervention gives increased importance to public health agency efforts and expands opportunities for coordination with other services. Local partnerships with social services, corrections, and education agencies create integrated systems that improve services to children with mental health problems and provide services for their families.

Family Service Collaboratives: Family services collaboratives were initiated in 1993 by the Minnesota legislature which mandated public health's involvement, recognizing the vital role public health plays in assessing and addressing the health of all mothers and children in communities and the state. Included in this initiative were collaboration grants to foster cooperation and help communities come together to improve results for Minnesota's children and families. By providing incentives for better coordination of services, Minnesota hoped to increase the number and percentage of babies and children who are healthy, children who come to school ready to learn, families able to provide a healthy and stable environment for their children and children who excel in basic academic skills. Through these collaboratives a set of statewide core outcomes was identified. Promoted across state systems that serve children and families this list has been included in the work of the Family Support Minnesota, formerly the STATES Initiative, the KIDS Data Project, and Minnesota Healthy Beginnings, among others. Many of these outcomes and their indicators align with the federal/state MCH performance measures and many others offer future directions for development of measurement tools, in particular, those with the promotional perspectives of family support.

Coordinated System for Children with Disabilities Aged Three to 21 -- involving multiple state agencies: State law mandates a coordinated interagency system for children from three to 21 with disabilities, as defined by IDEA. Title V staff have been actively involved with an 18 member State Interagency Committee made up of seven state agencies and other participants for oversight of this planning, as well as numerous workgroups creating the guidance for this system at both the state and community level.

Community Health Boards The Community Health Services (CHS) Act of 1976, and its revisions through the 1987 Local Public Health Act, established a comprehensive local public health

system and laid the foundation for the effective state-local public health partnership Minnesota enjoys today. The 1976 CHS Act allowed county and city boards of health to organize as community health boards, provided they met certain population and boundary requirements. By meeting these requirements, counties and cities became eligible to receive a state subsidy. Local boards of health are consolidated into 53 community health boards. Twenty-eight counties function as single-county CHBs, 59 counties cooperate in 21 multi-county or city-county CHBs, and four are city CHBs. Title V programs collaborate closely with all community health boards as they implement MCH programs at the local level. Title V programs provide grant administrative oversight of the Title V funds awarded to CHBs, provide MCH and CYSHCN technical assistance, consultation and share best practices on such topics as evidenced based home visiting, infant mortality, teen pregnancy prevention, and transition, and work to build capacity to meet the needs of mothers and children.

University of Minnesota: Collaboration between the Title V programs and the University of Minnesota School of Public Health continues on various research, evaluation and training projects. The MCH program within the School of Public Health holds an Ex-Officio position on the Maternal and Child Health Advisory Task Force. The Department's Title V program collaborates with the school's MCH program community education activities including presenting at its annual summer Institute. A number of MPH students have their internships in the Division of Community and Family Health, and several Title V program staff are graduates of the program. Faculty from the University have provided training and technical assistance to Title V staff through informal communications as well as some sessions--particularly as part of the building capacity activities underway over the past two years. The MCH Adolescent Health Program collaborates extensively with the University of Minnesota Konopka Institute for Best Practices in Adolescent Health, Division of General Pediatrics and Adolescent Health. This partnership focuses on building the capacity and skill of adolescent-focused programs across the state. Reproductive Health staff collaborate with the National Teen Pregnancy Prevention staff at the University of Minnesota on numerous projects including the implementation of the state teen pregnancy prevention and parenting plan. The MCH/CYSHCN program serves as mentors for each of the students in the University of Minnesota School of Nursing program emphasizing CYSHCN. The University of Minnesota receiving status as an Academic Center of Excellence in Women's Health has brought opportunities for enhanced relationship and shared activities. This dual partnership has also extended to include the Community Center of Excellence at an urban Minneapolis clinic. The University receives a LEND grant from the MCHB. Title V staff assisted in the preparation of the application, participate on its advisory board and collaborate in other ways on topical issues such as autism.

## **F. Health Systems Capacity Indicators**

Health systems capacity Indicators provide valuable measure of important MCH issues. The annual reporting process helps us monitor progress and utilize this information to inform public health practice and policy. In addition, periodic data collection and review of these indicators creates opportunity for collaborative work with partner programs at MDH such as asthma, dental, and injury programs as well as the Center for Health Statistics.

The Title V programs have strong working relationships with our state Medicaid program which is administer by our sister agency the Department of Human Services. Title V funds two positions at DHS which facilitates access to the Medicaid data and supports identification of potential projects of shared interest. Various other state agencies play a lesser but valuable role in our work, including the Minnesota Department of Education.

While Minnesota is a state with relatively generous health care programs and typically does very well on many of these indicators, the overall numbers mask significant disparities based on race, ethnicity, poverty and other factors. As we drill down further into these indicators and view them

based on race, ethnicity, geographic location and income levels, we find additional issues needing targeted focus and creative strategies.

The following is a discussion of three Health Systems Capacity Indicators that are particularly relevant to Minnesota's current and future program planning efforts: (1) asthma hospitalization rates; (2) screening programs for children; (3) Medicaid and children.

Prevalence of asthma is lower in this state than it is nationwide. Currently, 7.0% or approximately 90,000 children in Minnesota, ages 0 to 17 years, have asthma. In any given year, hospitalization for asthma usually shows seasonal fluctuations, peaking in the fall, then declining gradually until spring when a second, slightly smaller peak occurs. Two major risk factors are predictive of asthma hospitalization: (1) exposure to triggers, or substances such as secondhand smoke, which activate asthma symptoms; and (2) lack of quick access to prevention, such as medication and/or primary care.

The annual rate of asthma hospitalization in Minnesota peaked in 2007 at 31.2 hospitalized asthmatic children per 10,000 children under five years of age. This rate has decreased markedly each year, falling to a rate of 17.0 hospitalized asthmatic children in 2010. Preliminary data show evidence of additional decline in 2011. However, there are noticeable racial and ethnic disparities in asthma prevalence and hospitalization, as in other health issues.

Although our asthma program is doing very well in meeting the needs of our White population, we also need to expand existing strategies and involve our populations of color in actively controlling their asthma. While smoking has decreased significantly in Minnesota in recent years, a higher percentage of persons of color and American Indians still smoke and/or live in households where others smoke. Educational programs about the effects of smoking and secondhand smoke on asthmatic children could be useful. Other creative programs may also serve to reduce the disparities in hospitalization between children living in white households and children from other racial and ethnic groups.

The MDH Asthma Program sponsors and conducts an asthma surveillance system, which monitors several different dimensions of this illness. A major goal of surveillance is planning and developing appropriate strategies and health policies with an eye towards better control of asthma in the future. It is quite possible that we may be able to monitor the outcomes of our populations of color and learn more about their health needs from this surveillance effort.

Another Health Systems Capacity measure which has significance for us is health screening for young children, particularly those who do not have a regular source of ongoing medical care. Early and periodic health screening, especially among Minnesota's population of Medicaid children, has been rising consistently over the past several years and now stands at 92.2% of eligible children less than one year old. This percentage represents more than 24,000 Minnesota children, all of whom have been continuously enrolled in Medicaid for at least 90 days.

It is essential to have children receiving Medicaid screened early and often, at regular predetermined intervals so that preventive measures (including immunizations, well-child care, and early childhood education) may be initiated as soon as they are indicated. Also, children with disabilities--physical, emotional and/or mental--need to be identified and linked to appropriate resources to improve outcomes.

One example of the importance of regular screening for children receiving Medicaid can be found in relevant data comparisons. Health Systems Capacity Indicators show that infant death outcomes for the 2009 birth cohort were substantially different between Medicaid, non-Medicaid, and all live births. Medicaid recipients had the highest rate of infant deaths (5.9 per 1000 live births). Non-Medicaid rates were lowest at 3.4 per 1000 live births, and all deaths combined were 4.5 per 1000 live births.

Two of our new State Performance Measures also address the issue of screening and Medicaid. We have now implemented two closely-related measures: (1) the percentage of children enrolled in Medicaid who receive at least one recommended Child and Teen Checkup (C&TC). (Minnesota's version of EPSDT is known as C&TC); and (2) the percentage of Minnesota children, birth to five years, enrolled in Medicaid who receive a mental health screening using a standardized instrument as part of their Child and Teen Checkup. Data from these screenings and assessments will shed further light on children receiving Medicaid and will help quantify outcomes.

In conclusion, one of our most important goals in the upcoming year is to develop additional strategies for reducing health disparities between the White population, people of color, and American Indians. The magnitude of people of color in Minnesota has grown substantially and has also diversified over the years, with substantial numbers of new immigrants arriving from Africa and Eastern countries. Many cite our education system as the principal reason that they remain in Minnesota. In addition to education, we also need to make our health system more accessible and user-friendly for those who cannot easily navigate the system and/or do not have the financial means to do so.

In past years, we have partnered with our Office of Minority and Multicultural Health (OMMH) on a variety of health-related projects in the community. Currently, we are working closely with OMMH on American Indian and African-American infant mortality reviews, reducing disparities in teen pregnancy, and tribal maternal and child health. These projects, as well as upcoming events, will strengthen our relationships with people of color and American Indians, as well as reduce health disparities between racial and ethnic communities in Minnesota.

Along the same screening pathway, we are also committed to looking at the health outcomes of young children enrolled in Medicaid. The HSC measure which addresses this issue reads: "Percent of Medicaid enrollees less than one year old who received at least one initial periodic screen." This measure has been consistent over the past several years, ranging from a low of 85.1% in 2006 to a high of 92.2% in 2010. However, due to a change in methodology, current calculations include only children who have been enrolled in Medicaid for at least 90 continuous days. Therefore, the 2010 percentage cannot be compared directly with previous data. Using the former methodology, the FFY percentage would be 88.2%, which is still higher than preceding years.

Data Note: There was significant challenges to this year's data collection and thus data analysis.

- WIC introduced their new data system (went from a dedicated server environment to web-based and to a new software design) in several large sites in 2010 as pilots and then expanded to all other sites in 2011. Challenges related to unduplicated counts between the old and new system have prevented us from updating information related to WIC participants, particularly racial and ethnic compositions. For accuracy we will need to wait for the end of 2012 to update some of the block grant data.
- Due to a HIPAA required upgrade in the format that Managed Care Organizations use to transmit data, no medical services data was transmitted to the Department of Human Services for Medicaid eligible enrollees from December 2010 up until the end of June 2011. Significant portions of data collected for the block grant hinge on this data. DHS was not able to get it fully aggregated, cleaned and ready for analysis prior to the Block Grant submission. We anticipate that this data will be available prior to September and we will be able to update the block grant when it is reopened at that time.
- The Minnesota Department of Health went live with a new Vital Record system in early 2011. The resulting change in the environment (now web-based), in the software being used, and in the data being collected on the birth certificate resulted in significant issues with submission, cleaning and analyzing data. It is anticipated that issues will not be fully resolved until the end of 2012. It will not be until the submission of the 2014 application and the 2011 report that we will be able to reflect even provisional data.



## **IV. Priorities, Performance and Program Activities**

### **A. Background and Overview**

This section provides an overview of Minnesota's success and activities in addressing the priorities established through the Title V block grant and as determined by Minnesota's needs assessment process. The state performance measures reported in this section are in the last year of a five year reporting cycle. New state priorities and performance measures have been developed through the 2010 needs assessment process. These new state priorities and measures will be discussed in Section B. The measurement of the new state priorities will begin next year.

At the end of the previous five-year cycle, Minnesota data show that the majority of 2005 State Performance Measures have improved. These include:

- SPM 1: Counties offering the Follow-Along Program.
- SPM 2: Children receiving C&TC.
- SPM 3: Sexually active ninth graders using condoms.
- SPM 4: Child maltreatment.
- SPM 5: Pregnancies that are intended.
- SPM 6: Maternal depression screening during prenatal care.
- SPM 7: Enhanced mental health promotion and suicide prevention.
- SPM 9: CYSHCN with unmet needs for specific health care services.
- SPM 10: CYSHCN receiving mental health screening, evaluation, and treatment.

One state performance measures remained the same:

- SPM 8: LBW infants to American Indian women and women of color compared to white women.

As for the National Performance Measures, Minnesota has show improvement (based on the most recent data available) on the following measures:

- NPM 1: Newborn bloodspot screening follow-up.
- NPM 2: Families partnering in decision making for CYSHCN.
- NPM 7: Children receiving age appropriate immunizations
- NPM 9: Children receive protective sealants on one molar.
- NPM 11: Mothers who breastfeed their infant at 6 months of age.
- NPM 12: Newborns screened for hearing before hospital discharge.
- NPM 13: Children without health insurance.
- NPM 15: Women who smoke during pregnancy.
- NPM 16: Suicide deaths among youth.
- NPM 17: VLBW births high-risk facilities.

One measure stayed the same; however was slight improvement from year to year.

- NPM 10: Motor vehicle deaths of children.

Minnesota did not show improvement on the following NPMs. Again, some of these measures showed either very slight change or sometimes improvement from year to year over the five years.

- NPM 4: Adequate public and/or private insurance for CYSHCN.
- NPM 8: Births to teenagers.
- NPM 14: Children with a BMI at or above the 85th percentile.
- NPM 18: Infants born mothers receiving prenatal care beginning in the first trimester.

Three measures for CYSHCN are not comparable between the baseline year ensuing years.

However, it is known that in comparison to other states, Minnesota ranks 44th in the percentage of CYSHCN with a medical home and that a statically significantly larger percentage of YSHCN received adequate transition services.

NPM 3: CYSHCN receiving care in a medical home.

NPM 5: A service system for CYSHCN that is organized and easy to use.

NPM 6: Youth with special health care needs receiving services necessary for transition adulthood.

//2012// Minnesota has made progress on a number of National Performance Measures since last year's report. This includes the following:

NPM 8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

NPM 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

NPM 11: The percent of mothers who breastfeed their infants at 6 months of age.

NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.

NPM 14: Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

NPM 15: Percentage of women who smoke in the last three months of pregnancy.

NPM 16: The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

No change occurred in the following measure. Minnesota has already achieved 100% on this measure.

NPM 1: The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs. ().

The following five measures are based on the National Survey CSHCN. 2010 data is not available as the National Survey CSHCN is not done every year.

NPM 2: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.

NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

NPM 5: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.

NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

There was no change from the previous year for the following measures.

NPM 7: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

NPM 13: Percent of children without health insurance. (2010 data is not available as the survey is not done every year.) //2012//

***/2013/Minnesota made progress on the following National Performance Measures since last year's report:***

***NPM #2 The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.***

***NPM#8 The rate of birth (per 1,000) for teenagers aged 15 through 17 years.***

***NPM# 13 Percent of children without health insurance.***

***Minnesota slipped in progress on the following National Performance Measures sine last year's report:***

***NPM#3 The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.***

***NPM#4 The percent of children with special health care needs age 0 to 18 who have adequate private and/or pubic insurance to pay for the services they need.***

***NPM#5 Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.***

***Minnesota had little or no change in the remaining national performance measures.//2013//***

## **B. State Priorities**

The 2010 needs assessment document (II. Needs Assessment) more fully describes the relationship between the new Minnesota priority needs, the national and state performance measures and the capacity of the state Title V program. Minnesota identified two overarching goals seven priority needs that reflect the comprehensive nature of the Title V block grant and the complexity and inter-relatedness of the target populations. The two overarching goals and seven broad priority needs for Minnesota include:

Overarching Goal 1: Increase health equity and reduce health disparities for pregnant women, mothers and infants, children and adolescents, and children and youth with special health care needs.

Overarching Goal 2: Focus efforts on activities that result in positive outcomes across the lifespan.

Priority Need 1: Improve Birth Outcomes

Priority Need 2: Improve the Health of Children and Adolescents

Priority Need 3: Promote Optimal Mental Health

Priority Need 4: Reduce Child Injury and Death

Priority Need 5: Assure Quality Screening, Identification and Intervention

Priority Need 6: Improve Access to Quality Health Care and Needed Services

Priority Need 7: Assure Healthy Youth Development

A number of items were included in the development of the priorities for the state, including priority issues for the state identified in a stakeholder survey; the national performance measures; the national health outcome measures; the national health status indicators; and the national health system capacity indicators.

Following is a listing of state and national measures and their relationship to Minnesota's goals and priority needs.

Overarching Goals 1 and 2:

HSI 06A&B: MCH populations by race/ethnicity  
HSI 07A&B: Live births by maternal age, race and ethnicity  
HSI 10: Geographic living area for children  
HSI 11: State population at federal poverty level  
HSI 12: State MCH populations at federal poverty level

#### Priority Need 1: Improve Birth Outcomes

NEW SPM 1: Women who did not consume alcohol during pregnancy  
NPM 8: Births to teenagers  
NPM 15: Women who smoke during pregnancy  
NPM 17: VLBW births high-risk facilities  
NPM 18: Infants born to mothers receiving prenatal care beginning in the first trimester  
HSCI 04: Women with a live birth receiving expected prenatal visits  
HSI 01A: Live births less than 2,500 grams  
HSI 01B: Live singleton births less than 2,500 grams  
HSI 02A: Live births less than 1,500 grams  
HSI 02B: Live singleton births less than 1,500 grams  
HOM 1: Infant mortality  
HOM 2: Black infant mortality compared to the white infant mortality  
HOM 3: Neonatal mortality  
HOM 4: Post-neonatal mortality  
HOM 5: Perinatal mortality plus fetal deaths

#### Priority Need 2: Improve the Health of Children and Adolescents

REVISED SPM 2: Children receiving recommended C&TC visits  
NPM 7: Children receiving age appropriate immunizations  
NPM 9: Children receive protective sealants on one molar  
NPM 11: Mothers who breastfeed their infant at 6 months of age  
NPM 14: Children with a BMI at or above the 85th percentile  
HSCI 09B: States ability to monitor tobacco use by children and youth  
HSCI 07B: EPSDT eligible children who receive any dental services  
HSCI 01: Children hospitalized for asthma  
HSI 05A: Women aged 15 through 19 with chlamydia  
HSI 05B: Women aged 20 through 44 with chlamydia

#### Priority Need 3: Promote Optimal Mental Health

NEW SPM 3: Children who receive a mental health screening  
NPM 16: Suicide deaths among youth

#### Priority Need 4: Reduce Child Injury and Death

REVISED SPM 4: Cases of child maltreatment  
NPM 10: Motor vehicle deaths of children.  
HSI 03B: Death from motor vehicle crashes in children 14 and younger.  
HSI 03C: Death from motor vehicle crashes in youth 15 through 24  
HSI 04B: Non-fatal injuries from motor vehicle crashes in children 14 and younger  
HSI 04C: Non-fatal injuries from motor vehicle crashes in youth 15 through 24  
HSI 03A: Death due to unintentional injuries in children 14 and younger  
HSI 04A: All non-fatal injuries in children 14 and younger  
HSI 08A&B: Deaths to infants and children by age, race and ethnicity.  
HOM 6: Child death rate.

Priority Need 5: Assure Quality Screening, Identification and Intervention

- NEW SPM 5: Children enrolled in the Follow-Along Program.
- NEW SPM 6: Children under the age of one year participating in early intervention
- NPM 1: Newborn bloodspot screening follow-up.
- NPM 12: Newborns screened for hearing before hospital discharge.
- HSCI 02: Medicaid enrollees less than one year old receiving at least one initial or periodic screening
- HSCI 03: SCHIP enrollees less than one year receiving at least one periodic screen

Priority Need 6: Improve Access to Quality Health Care and Needed Services

- NEW SPM 7: Percentage of participants in Minnesota's family home visiting program referred to community resources that received a family home visitor follow-up on that referral.
- NEW SPM 8: Percentage of children and youth with special health care needs that have received all needed health care services. (National Survey of CSHCN)
- NEW SPM 9: Percentage of families of children age 0-17 that report costs not covered by insurance are usually or always reasonable.
- NPM 2: Families partnering in decision making for CYSHCN.
- NPM 3: CYSHCN receiving care in a medical home.
- NPM 4: Adequate public and/or private insurance for CYSHCN.
- NPM 5: A service system for CYSHCN that is organized and easy to use.
- NPM 13: Children without health insurance.
- HSCI 08: SSI beneficiaries receiving rehabilitation services
- HSCI 05: Comparison of health system capacity indicators for Medicaid, Non-Medicaid, and all MCH populations
- HSCI 06: Poverty level eligibility in the State's Medicaid and SCHIP programs
- HSCI 07A: Potentially Medicaid-eligible children receiving services paid by Medicaid
- HSI 09A&B: Infants and children enrolled in State programs by race and ethnicity

Priority Need 7: Assure Healthy Youth Development

- NEW SPM 10: Identify a SPM and benchmark to monitor positive youth development
- NPM 6: Youth with special health care needs receiving services necessary for transition adulthood

**C. National Performance Measures**

**Performance Measure 01:** *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	142	149	149	162	173
Denominator	142	149	149	162	173
Data Source		MDH Newborn Screening Program	MDH Newborn Screening Program	MDH Newborn Screening	Newborn Screening Program
Check this box if you					

cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	100	100	100	100	100

**Notes - 2010**

We have provided estimates for 2010 because the data are not yet available.

**Notes - 2009**

We obtain our data from the newborn screening program, and their data has not been updated to 2009 yet.

**a. Last Year's Accomplishments**

The Newborn Blood Spot Screening Program tests samples taken from newborns, notifies the primary physician of positive test results, tracks the results of confirmatory testing and diagnosis and links families with appropriate resources. This MDH program is operated as a partnership between the Public Health Laboratory Division and the Title V-CYSHN program.

Short term tracking (prior to point of confirmatory diagnosis) is the responsibility of the Public Health Lab providing education and information to the provider community. Roles and responsibilities are defined for short and long term follow-up activities for newborn blood spot and newborn hearing screening. The goal is to work toward a system of integrated data management and improved services to families.

Collaboration and technical assistance for follow up continues with the University of Minnesota and Mayo genetics and metabolism team clinics for individuals with newborn screened metabolic conditions.

Other activities occurring in this time frame include the provision of an updated website including the Star-G fact sheets with Minnesota specific resources; development of a parent organizer given out to families at the time of diagnosis as a place to give and keep important information in one spot, leadership, support, and technical assistance for two parent/family networking and support groups: one for fatty acid oxidation (FAOD) disorders and the other for congenital adrenal hyperplasia (CAH) and associated disorders. A staff supported Parent to Parent Contact program continued to offer families with a new baby found to have CAH or a FAOD an opportunity to connect with a trained parent volunteer who also has an infant/child with a similar disorder.

While family networking and support groups for CAH and FAOD continued under the leadership of staff and parents, a new family networking group for Organic Acidemias was still needed. To address this gap, key stakeholders have started an Organic Acidemia Family Networking and Support Group.

Title V-CSHN staff collaborated with six other states in the Region 4 Newborn Screening and Genetics Collaborative (IL, KY, MI, IN, OH, WI) to continue to build a data collection framework (registry called Inborn Errors of Metabolism Information System supported by a HRSA funded

grant) to support collection of data elements needed to monitor long-term outcomes for individuals with rare metabolic disorders (~25 conditions to date). A similar data framework is being developed regionally for individuals with congenital adrenal hyperplasia. Minnesota infants and young children with CAH and metabolic conditions were enrolled in an online emergency care medical services information system (MCHB funded MEMSCIS). More than 280 families are participating in this ongoing activity.

In the Region 4 Genetics Collaborative, Minnesota participants in a workgroup of other state stakeholders, parents, PCP's, and others to develop and publish "Partnering with your Doctor: The Medical Home Approach -- A guide for families with children who have genetic conditions." This publication is available for Minnesota families.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide newborn testing as recommended by the State Newborn Screening Advisory Committee			X	X
2. Expand long-term follow-up activities to infants and their families for all NBS conditions		X	X	X
3. Refine lab procedures for reducing false positive/negative test results		X	X	
4. Expand educational materials and activities to include all disorders identified by NBS bloodspot and early hearing detection and intervention		X		
5. Refine integrating data collection, infant follow-up and tracking, and program outreach with hearing screening program			X	X
6. Link identified infants and their families to community resources and a medical home		X		X
7. Support primary care providers, comprehensive centers and systems that care for infants and children with rare disorders.				X
8. Continue active participation on the Newborn Screening Advisory and Newborn Hearing Screening Advisory Committees				X
9. Implement linking blood spot and hearing data with birth/death certificates			X	X
10. Develop and implement an evaluation plan for program initiatives				X

**b. Current Activities**

The Region 4 Newborn Screening and Genetics Collaborative received a NIH grant in April 2011 to expand the IBEM-IS registry to increase the registries metabolic conditions and add metabolic centers outside the region track patient and family outcomes for metabolic disorders. The Region 4 states will focus on emerging national recommendations that address state data needs for surveillance, quality improvement, and resources to support evidenced based long term follow-up for people with metabolic and endocrine disorders found by newborn screening.

Collaborations with partners and systems are integral to this activity. Statewide partners include primary care providers (Health Care Home), population-based programs such as the Universal Hearing Screening Program, high-risk follow-up programs, local public health, early education and families.

The major MDH policy issue during the current year is the legislative and legal issues raised about storing blood spots. A lawsuit was filed against the MDH for storing blood spot card of infants born in the past two years. The court dismissed the lawsuit with prejudice and appeal court supported the previous decision. Oral arguments were heard in the MN Supreme Court in

early 2011 and a decision was made on November 17, 2011 that limits the number of days the MDH can store and use the blood spots. Legislative changes now clarify the blood spot storage and use. This also includes the data collected as part of the newborn screening program.

**c. Plan for the Coming Year**

Staff will continue collaboration with partners to more effectively improve the systems serving this population as well as provide information to families about a variety of services for infants diagnosed with a condition found through newborn screening. Collaboration, technical assistance and evaluation of the needs of children will continue related to projects and activities.

Acknowledging regional and national concerns about the increase in incidence and prevalence of Congenital Hypothyroidism (CH) and the divergent practices surrounding diagnosis and treatment of CH, Minnesota is responding by convening a Congenital Hypothyroidism Consensus Workgroup to define the issues, review literature, review current newborn screening methods, discuss definition for diagnosis of CH and to work toward more consistent follow up guidelines of CH.

Continuing active participation in Region 4 Genetics Collaborative NIH grant and IBEM-IS grant will support learning more about outcomes in order to develop guidelines for best practice for metabolic conditions and CAH. Exploring methods for Minnesota to obtain long term follow up data for surveillance through web inter-connectivity and to obtain key reports is in early stages and will continue in the future. Integration with other data systems and child health records may be possible in the future.

The Title V program will continue to support parent organizations, especially the two family groups for FAOD and CAH and the new family group for Organic Acidemia. The Region 4 Genetics Collaborative activities will support many aspects of collaboration with health care home providers. The state will remain an active participant in the seven workgroups of Region 4 and its two competitive HRSA grants. The Public Health Lab is redesigning its management information systems. The program has created an internal data system to track those children with a diagnosis for long term follow-up; this will be in use until another data system is in place. The labs continue to add tests for additional conditions and follow up actions will have to accompany those additional tests.

**Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated**

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

<b>Total Births by Occurrence:</b>	<b>68277</b>					
<b>Reporting Year:</b>	<b>2010</b>					
<b>Type of Screening Tests:</b>	<b>(A) Receiving at least one Screen (1)</b>		<b>(B) No. of Presumptive Positive Screens</b>	<b>(C) No. Confirmed Cases (2)</b>	<b>(D) Needing Treatment that Received Treatment (3)</b>	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	67788	99.3	16	10	10	100.0

Congenital Hypothyroidism (Classical)	67788	99.3	236	62	62	100.0
Galactosemia (Classical)	67788	99.3	45	11	11	100.0
Sickle Cell Disease	67788	99.3	27	24	24	100.0
Biotinidase Deficiency	67788	99.3	70	9	9	100.0
Congenital Adrenal Hyperplasia	67788	99.3	119	6	6	100.0
Cystic Fibrosis	67788	99.3	247	8	8	100.0
Hemoglobinopathies	67788	99.3	39	25	25	100.0
Organic Acidemias	67788	99.3	33	16	16	100.0
Fatty Acid Oxidation Disorders	67788	99.3	42	12	12	100.0
Amino Acidemias	67788	99.3	27	13	13	100.0

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

#### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	63	63	63	63	65
Annual Indicator	60.3	60.3	60.3	60.3	76.3
Numerator	103284	103284	103284	103284	135144
Denominator	171251	171251	171251	171251	177106
Data Source		National Survey of CSHCN 05/06	National Survey of CSHCN 05/06	National Survey of CSHCN 05/06	National Survey of CSHCN 09/10
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	76	79	79	82	82

#### Notes - 2011

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate this indicator for both the 2001 and the 2005-06 CSHCN survey. However, in 2009-2010 there were wording changes and

additions to the questions used to generate this indicator. The data for 2009-2010 are NOT comparable to earlier versions of the survey.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2009**

Data source is the National Survey of CSHCN 2005/ 06

**a. Last Year's Accomplishments**

The Title V program in Minnesota continued to promote parent/family/youth partnership and leadership. CYSHN took a leadership role in promoting and enhancing family-centered care across Minnesota through partnership with families, providers, hospital systems, policy makers and other state programs.

The MCH Advisory Task Force included a number of parents of CYSHN as consumer representatives. Consumer members share their experiences at each task force meeting in an effort to educate the Task Force on the issues relevant to CYSHN and their families. The Task Force identified a family scholar and mentor to participate in the annual AMCHP conference.

CYSHN continued to staff a toll free information and assistance line that serves as a resource for parents and providers to understand and access services and resources in their local communities. A significant amount of work was done to seek parent input into information on the department website and written materials for families whose children were identified with a birth defect or newborn screening condition.

CYSHN district staff held "Taking the Maze Out of Funding" workshops during this period. Attendees included parents of children with special health care needs, local public health, education and human service providers and numerous private health and related services providers. Materials were available on the department website.

The health department maintains a Consumer-Family Council that advises the department on all areas of health care home implementation. The Council met regularly during this time frame and participated in all work groups involved in health care home implementation.

MDH supported the development of a Parent-to-Parent Support program through a contract with Family Voices of Minnesota to train Support Parents. Family Voices of Minnesota has identified a geographically diverse group of parent leaders to support regional systems improvement activities.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide financial support for parent involvement in CYSHN activities		X		
2. Revise (as necessary) fact sheets for parents on genetic conditions of infants identified through the state's birth defects information system and newborn screening			X	X
3. Continue leadership in the Part C program and support of		X		X

parents on the ICC, Newborn Screening Advisory Committee, Newborn Hearing Screening Advisory Committee and the IEICs				
4. Support establishment of a strong parent to parent support networks across the state				X
5. Promote and support connection of parents to other parents through Minnesota's Family to Family Health Information Center –Pacer and Minnesota Family Voices.		X	X	
6. Support Minnesota Hands & Voices to offer parent-to-parent support at time of hearing loss diagnosis			X	X
7. Continue supporting the Consumer Representatives on the MCHATF and Family Consumer Council				X
8.				
9.				
10.				

**b. Current Activities**

The CYSHN Section continues its strong collaboration with parents through many of the advisory committees and partners. Examples include: Family Voices of Minnesota, the Family-to-Family Health Information Center at PACER, the Governor's Interagency Coordinating Council for Young Children with Disabilities, Legislative Autism Task Force, MnSIC, Minnesota Hands and Voices, the MCHATF and other state and local organizations.

A work group of the MCHATF has been established to focus on CYSHN and provide guidance on gaps, strengths related to our public health (Title V) role and determining statewide priorities.

Families whose children are identified as having a birth defect, health condition identified through blood spot screening or hearing loss receive needed information and support through direct contact from a parent-to-parent support agency, MDH, and/or Local Public Health.

**c. Plan for the Coming Year**

CYSHN will continue its commitment to parent partnerships at the individual and systems levels; along with its commitment to system-wide quality improvement to enhance the satisfaction of families with health care services.

The CYSHN Section will continue to collaborate with parents through many of the advisory committees and partners. Examples include: Family Voices of Minnesota, the Family-to-Family Health Information Center at PACER, the Governor's Interagency Coordinating Council for Young Children with Disabilities, Legislative Autism Task Force, MnSIC, Minnesota Hands and Voices, the MCHATF and other state and local organizations.

The work group mentioned above will continue with its charge is to inform the statewide children and youth with special health care needs program to improve the quality, efficiency and effectiveness of the public health role in meeting the needs of children with special health care needs and their families. The group will also provide direction and advice on establishing priorities and developing plans for CYSHN activities. Over half of the work group members are parents of a child with a special health need. The other half includes pediatricians, local public health nurses, and other key stakeholders involved with serving CYSHN and their families.

Assuring that families have the information they need to effectively partner in making decisions on behalf of their children continues to be a priority. The CYSHN Information and Assistance program will be incorporated into existing information and assistance programs such as the state Disability Linkage Line, the Family to Family Health Information Center, Family Voices and First Call for Help. This will help maximize the expertise of current systems and decrease duplication.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	53.6	54	54	54	54
Annual Indicator	51.8	51.8	51.8	51.8	48.0
Numerator	88280	88280	88280	88280	82855
Denominator	170372	170372	170372	170372	172638
Data Source		National Survey of CSHCN 05/06	National Survey of CSHCN 05/06	National Survey of CSHCN 05/06	National Survey of CSHCN 09/10
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	48	50	50	52	52

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. The data for the 2001 and 2005-2006 surveys are not comparable for NPM 3. However, the same questions were used to generate the NPM 3 indicator for both the 2005-2006 and 2009-2010, therefore these two surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

**Notes - 2009**

data source: National Survey of CSHCN 2005/06

**a. Last Year's Accomplishments**

The Title V-CYSHN district staff, now called Regional HCH Nurse Consultants are formally integrated into the Health Care Home Unit at MDH. This unit's function is to certify primary care practices as health care homes (aka medical homes). Health Care Homes (HCH) are intended for patients of all ages with a particular focus on those with complex and chronic conditions, including CYSHN. State law directs all those insured, including Medicaid and Medicare (except for ERISA) to be eligible to participate in a health care home on a voluntary basis. Minnesota is one of eight states to participate in the Centers for Medicare and Medicaid Services Multi- Payer Advanced Primary Care Practice demonstration and requires participating clinics receiving Medicare reimbursement to become certified health care homes.

In the past the HCH CYSHN district staff played an important role in the support and technical assistance to the pediatric medical home teams in their assigned area. This technical assistance/consultation included: quality improvement techniques such as the use of Plan-Do-Study-Act (PDSA) cycles; facilitating team meetings, focus groups, community meetings, etc.; assisting with the development, collection and analysis of community/consumer survey data; recruiting and facilitating child/family participation in decision making, providing informational resources to increase provider/team understanding of care plans, care coordination, funding options, community resources and training opportunities; and connecting teams within regions to provide learning opportunities, ideas for quality improvement processes and joint planning across clinics and service providers.

The CYSHN/HCH nurse consultants were active in their first full year supporting capacity building in clinics. They worked with 87 clinics or clinics systems across the state of which 20% became certified Health Care Homes and another 16% are in process of becoming certified. The nurse consultants focus their capacity building efforts by providing the above mentioned support to small and medium sized rural and urban community and independent clinics. The nurse consultants find that many clinics in greater MN are slower to adopt Health Care Home certification as they seek to implement electronic medical records or lack project assistance to develop new care models. They have also worked with larger primary care systems that increasingly dominate greater Minnesota health care delivery. They have hosted regional forums for education and discussion of Health Care Home standards and work with clinics that are recipients of unique Health Care Home grants directed towards safety net clinics and the development of community care teams, which seek to integrate certified primary care clinics with community-based services.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Use learning collaborative approach to expand the number of children receiving coordinated care		X		
2. Continue to partner with the state chapter of the AAP				X
3. Continue efforts to assure identified reimbursement strategies for medical home/health care home				X
4. Continue efforts at integration of mental health services with medical home/health care home activities	X		X	X
5. Promote concept of medical home/health care home through education of local public health personnel				X
6. Pursue curricula development about medical home/health care home with appropriate university programs				X
7. Work with state medical association, as it promotes medical home/health care home				X
8. Seek funds to continue leadership in quality improvement activities that involve primary care providers				X
9.				

10.				
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**b. Current Activities**

The CYSHN/HCH nurse consultants will continue their outreach and support of primary care clinics. The HCH nurse consultants' community outreach activities included educating community partners about health care homes, quality improvement initiatives and patient and family centered care models to Local Public Health Directors, Regional School Health Coordinators, SHIP community leaders, MCH Coordinators, Schools of Nursing, Area Health Education Centers, the MN Rural Health Association, Child and Teen Checkup Coordinators, and Parish RNs throughout the state. They continued their participation in activities with community partners focused on children with special health needs in an effort to continue our goals in fostering growth of HCH for these children. That work included participation in the Interagency Early Childhood Intervention Committee (IEIC) regional transition planning, Assuring Better Child Health and Development ADCD III grant, Great Start, children's mental health initiatives as well the transition of the Maze training program. They also participated in outreach activities at a number of conference including the Rural Health Conference and conferences sponsored by primary care association provider groups.

**c. Plan for the Coming Year**

HCH Nurse Consultants will continue to support and facilitate the connection of local primary care providers and clinics in understanding the HCH certification process and provide leadership in addressing the unique issues of children and youth with special health care needs in primary care.

HCH CYSHN district staff will also provide guidance to HCH capacity building projects such as the development of community care teams and the provision of regional trainings. Other capacity building activities include meeting with community partners, local public health and other community resources to address issues such as screening, access and quality improvement.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective	70	66	66.3	66.3	70
Annual Indicator	66.3	66.3	66.3	66.3	62.5
Numerator	116294	116294	116294	116294	109987
Denominator	175428	175428	175428	175428	176054
Data Source		National Survey of CSHCN 05/06	National Survey of CSHCN 05/06	National Survey of CSHCN 05/06	National Survey of CSHCN 09/10
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	63	65	65	70	70

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. This survey was first conducted in 2001. The same questions were used to generate the NPM 4 indicator for the 2001, 2005-06, and 2009-2010 CSHCN surveys.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

**Notes - 2009**

Data source: National Survey of CSHCN 2005 / 06

**a. Last Year's Accomplishments**

Minnesota has always been a leader in insurance coverage of its children. State specific studies over the last ten years indicate 93-95 percent of children in this state have had health insurance during that time and that the majority of those without coverage are eligible for either Medicaid or MinnesotaCare. Data from 2006 indicated 67.3 percent of the state's population are privately insured (both fully-and self-insured) and 25.1 percent are insured through programs such as Medicare, Medicaid and MinnesotaCare compared to 62.2 percent privately insured and 28.7 percent publicly insured in 2009. Latest available data (2011 Minnesota Health Access Survey) indicate 94.9 percent of children 0 to 5 and 94.5 percent of youth 6 to17 have insurance. However, 16.7 percent of youth between 18 and 25 were uninsured, implying potential transition issues for CYSHN. The overall uninsured rate for the state in 2011 was 9.1 percent compared to 7.2 percent in 2007.

In 2007, privately insured children were much less likely to report adequate insurance than those participating in public programs. Minnesota did not compare favorably to other states in relation to insurance adequacy ranking 51st on this measure for the child population generally.

Staff throughout the state in Minnesota's Family Home Visiting, Positive Alternatives, Family Planning Special Projects, Early Hearing Detection and Intervention program, and WIC programs continued to work with clients on finding adequate insurance resources including public programs and supporting families to reduce out-of-pocket costs.

MDH staff in the Newborn Screening Follow-up program provide follow-up and consultation with families of children diagnosed with a medical condition during the newborn screening process. A component of the consultation is helping families find insurance and other resources that will reduce unreasonable costs to families.

Through the MDH Information and Assistance and MCH lines, staff continued to provide information to consumers on addressing out-of-pocket costs. This includes information on access to supplemental insurance programs (such as TEFRA and other waiver programs) that reduce

costs and help connect families with public health insurance programs. This material is available through referral to the Minnesota Department of Human Services.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 1. Provide assistance to Family Voices and Pacer's Parent to Parent Information Line to provide parents with health insurance information. (Previous MAZE Activities)				X
2. Continue to support and monitor local public health activities to assure access to insurance resources	X			X
3. Partner with DHS to assure that all children have access to information on supplemental insurance program information			X	X
4. Work within existing systems to assist families in identifying insurance payment options			X	X
5. Continue EHD and newborn follow-up activities to assure families have access to appropriate information	X	X		
6. Work with health care home staff to continue to implement activities that support the MCH and CYSHN populations.				X
7. Continue to monitor state and federal health reform legislation				X
8. Provide assistance to Family Voices and Pacer's Family to Family Health Information Center to provide parents with health insurance information. (Previous MAZE Activities)				X
9.				
10.				

**b. Current Activities**

Through the MDH Information and Assistance and MCH lines staff will continue to provide information to families on addressing health insurance coverage. Adequate health insurance is a concern for CYSHN and their families. MDH provides web-based information on financial and other as well as support for Minnesota Parent-to-Parent Support Agencies. MDH works to assure the needs are continually monitored so that families have accurate information.

Staff in the Newborn Screening Follow-up and Early Hearing Detection and Intervention programs assure that children identified with blood spot disorder or hearing loss receive information on insurance and supplemental payment resources.

Local public health departments continue to support client access to insurance resources through multiple programs, including early identification and intervention activities, infant and child screening, Child and Teen Check-up (Minnesota's EPSDT), family home visiting, WIC, etc. In these programs, LPH departments work to increase the number of clients enrolled in insurance and link them to resources to reduce out-of-pocket costs.

Staff are evaluating alternative models of information dissemination. The Information and Assistance line data and regular meetings with other information and assistance programs continues to provide information that can resolve system issues around insurance and coverage.

The Legislative Task Force on Autism will discuss benefit coverage issues unique to this sub-population.

**c. Plan for the Coming Year**

The implementation of both state and federal health reform will require the Title V program assure linkages between health reform efforts and the Title V-CYSHN programs. These linkages will

ensure that the interests of CSHN and their families are represented. As direct calls to the Information and Assistance line continue to diminish, we are partnering with other agencies to develop an outreach plan so families and providers can get the answers they need with one call. Through our partnership with the Departments of Human Services and Education, we will be enhancing an existing statewide website to include information about public and private resources and training additional Greater Minnesota partners to provide "in-person" support to online resources.

Staff in the Newborn Screening Follow-up and Early Hearing Detection and Intervention programs will continue to assure that identified children receive information on insurance and supplemental payment resources.

MDH and local public health department staff will continue to assure information is available to families participating in their programs on access to health insurance including public programs.

Minnesota will continue health care home activities currently underway (see NPM #3). As certified health care homes become more robust in their activities, it is anticipated that their coordination of patient care for children with special health care needs will increase efficiency, reduce redundancy, and ultimately reduce the number of children who are under insured. Title V staff will continue to work closely with health care home staff to assure linkages between the needs of CYSHN families and health care home activities.

The MDH, in partnership with the University of Minnesota, periodically conducts the Minnesota Health Access Survey. These surveys are the source of data for state policy makers to define and respond to health insurance issues of Minnesotans and are stratified random digit dial telephone surveys that include both cell and landline telephones. Title V staff will be working with staff in the MDH Health Policy Division to determine if a measure can be added to more clearly measure out-of-pocket costs for Minnesota families especially those with children who have a special health need.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	78.5	91	91	91	94
Annual Indicator	90.7	90.7	90.7	90.7	69.5
Numerator	160677	160677	160677	160677	123013
Denominator	177112	177112	177112	177112	176941
Data Source		National Survey of CSHCN 05/06	National Survey of CSHCN 05/06	National Survey of CSHCN 05/06	National Survey of CSHCN 09/10
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	70	72	72	75	75

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were revisions to the wording, order, and number of questions used to generate this indicator for the 2005-06 CSHCN survey. The questions were also revised extensively for the 2009-2010 CSHCN survey. Therefore, none of the three rounds of the surveys are comparable.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

**Notes - 2009**

Data Source: National Survey of CSHCN 2005 / 06

**a. Last Year's Accomplishments**

Enhancing and transforming primary care is central to Minnesota's health care reform efforts and is vital to assuring services are organized so CYSHN and their families can use them easily. To qualify, a clinic must provide 24-hour access, maintain a method of tracking patient health histories, monitor and report the clinic's quality performance, and provide care planning and coordination to patients including children with special health needs. MDH has certified 170 health care homes and 1,764 clinicians. In this practice, model health care is integrated at the primary care site for all medical care. Even beyond these health care services, health care homes are the right partners to integrate medical and community services to provide care for the CYSHN and their families. Title V HCH Consultants have direct relationships with local clinics and health care providers and assist in developing best practice policies on serving CYSHN and their families.

The purpose of the Minnesota System of Interagency Coordination Committee (MnSIC) is to develop and implement a coordinated, multidisciplinary, interagency intervention service system for children with disabilities ages three through 21. All organizations working with these individuals and their families participate in MnSIC. The CYSHN director is a member of the policy-making body overseeing this effort.

Minnesota's Part C system was restructured from 95 local Interagency Early Intervention Committees (IEIC) to 12 regional IEICs during this period. One of the goals of restructuring was to assure consistency and standardization of child find and public awareness strategies at a regional level. Interagency relationships between state and local education, public health and human services partners have been strained and fragmented as new roles and responsibilities are defined. Local public health partners are mandated representatives on the regional IEICs and have continued to represent the interagency commitment of supporting infants and toddlers and their families through local public health programs, such as FAP, C&TC, WIC, and Family Home

Visiting. CYSHN staff served on the state team assigned to all regional IEICs during the restructuring and assisted each IEIC in developing the process to scan and evaluate current child find and public awareness strategies.

The Follow-Along Program is responsible for assuring coordinating needed services to make services and systems easier to use. The Follow-Along Program is implemented at the local level primarily by public health agencies. The program uses the ASQ and ASQ-SE screening tools. Families are referred to needed services based on the screening results and the result of on-going assessment of family needs and resources.

Title V-CYSHN staff supported the state's Birth Defects Surveillance program by linking families with resources and served as a backup for those local agencies that elected to be the first point of contact to link families with resources. The Birth Defects Program joined the newly formed CYSHN section along with the Newborn Screening Long Term Follow-up Unit.

MDH continues to partner with the LEND program, Departments of Education, Human Services and Employment Services to address ongoing issue of ASD and DD.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Use learning collaborative approach to expand the number of children receiving coordinated care				X
2. Partner with organization to assure resources for CYSHN and their families are up-to-date in the multiple information and assistance lines in the state.		X		
3. Continue state support and technical assistance for the Follow Along Program			X	X
4. Continue active participation and leadership in statewide ICC, MnSIC, IEIC and Part C activities				X
5. Support collaborative activities to address autism			X	X
6. Continue support for EHDI long-term follow-up activities			X	X
7. Continue support of the birth defects surveillance system at the state level and support of local public health at the community level			X	X
8. Support the work of the MCHATF CYSHN workgroup				X
9.				
10.				

**b. Current Activities**

A work group of the MCHATF is meeting to focus on CYSHN to inform the statewide CYSHN program to improve the quality, efficiency and effectiveness of the public health role in CYSHN. The group will also provide direction on establishing priorities and developing plans for CYSHN activities.

The MnSIC activity described above is ongoing. Activities also continue within the EHDI program focusing on system-wide quality improvement through partnerships with local public health. The Birth Defects program is working with non-metro hospital to expand the program statewide. They continue to contract with LPH agencies to connect families with needed resources and services.

Minnesota's Part C system is currently evaluating the impact of the statewide reorganization. CYSHN staff are responsible for communicating with health care providers and to local health partners to obtain input and monitor the impact of the changes to the children and families.

In the EHDI staff continued to identify points in the screening-diagnosis-intervention continuum that need improvement at the state level to assure the earliest possible intervention and reduce loss to follow-up.

The CYSHN/HCH nurse consultants will continue their outreach and support of primary care clinics. They continued their participation in activities with community partners focused on children with special health needs in an effort to continue our goals in fostering growth of HCH for these children.

**c. Plan for the Coming Year**

The Title V-CYSHN program continues its support of the MnSIC concept and activity due to the opportunities for collaboration between health care homes and the achievement of MnSIC goal of interagency coordination including coordination of services, family-centered care and an increased role for parents in the decision-making process. MCH/CYSHN will continue to support the positive momentum in Minnesota's health care home (medical home) program development and implementation and ensure that critical connections are made between families, communities, and care providers.

CYSHN will monitor the impact of implementation of the regional IEICs on the coordination of services for young children with special needs. The CYSHN Director will continue to be an active member of the Governor's Interagency Coordinating Council for Young Children with Disabilities.

CYSHN staff will continue to support the Follow Along Program and pursue the use of online screening tools (ASQ and ASQ-SE) to promote ease of use by families; provide targeted technical assistance and training to the health care and medical community around implementation of Help Me Grow; promote early hearing screening and referral; and provide technical assistance and family support for the birth defects surveillance system.

Minnesota will continue health care home activities currently underway (see NPM #3). As certified health care homes become more robust in their activities, it is anticipated that their coordination of patient care for children with special health care needs will increase efficiency, reduce redundancy, and ultimately reduce the number of children who are under insured. Title V staff will continue to work closely with health care home staff to assure linkages between the needs of CYSHN families and health care home activities.

The 2012 Minnesota Legislature appropriated \$200,000 for MDH to conduct a qualitative study focused on cultural and resource-based aspects of autism spectrum disorders that are unique to the Somali community and to report back to the legislature on by February 15, 2014. This report must also include recommendations for the establishment of a population-based public health surveillance system for ASD. Title V staff is also working with the University of Minnesota on the University's CDC supported grant looking at prevalence of autism in the Somali community.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	6.4	55	55	57	57
Annual Indicator	52.9	52.9	52.9	52.9	47.1
Numerator	39459	39459	39459	39459	35719
Denominator	74600	74600	74600	74600	75796

Data Source		National Survey of CSHCN 05/06	National Survey of CSHCN 05/06	National Survey of CSHCN 05/06	National Survey of CSHCN 09/10
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	47	50	50	55	55

**Notes - 2011**

For 2011-2014, indicator data come from the National Survey of Children with Special Health Care Needs (CSHCN), conducted by the U.S. Health Resources and Services Administration and the U.S. Centers for Disease Control and Prevention in 2009-2010. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate this indicator for the 2005-06 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the 2 surveys are not comparable for NPM 6, and findings from the 2005-06 survey may be considered baseline data. However, the same questions were used to generate the NPM 6 indicator for the 2009-2010 survey. Therefore, the 2005-2006 and 2009-2010 surveys can be compared.

All estimates from the National Survey of CSHCN are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes.

**Notes - 2010**

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

**Notes - 2009**

Data Source: National Survey of CSHCN 2005 / 06

**a. Last Year's Accomplishments**

Title V CYSHN staff worked with local public health agencies to keep them informed of events around transition through regional maternal child health meetings to help local public health nurses better understand the impact of health on transition. Health Care Home (HCH) Nurse Consultants also presented information to school nurses on the impact that health, education and human services have on transition outcomes.

The "Taking the Maze out of Funding" transition packet was updated with the recent legislative changes included and was distributed to our local parent to parent support agency partners including the Parent to Parent Health Information Line and Family Voices as a means to provide parents and providers across the state with the most up-to-date information. HCH District Consultants continue to offer technical assistance to local service providers, health care

providers, parents and youth on transition issues.

MnSIC is described in detail in NPM 5. A MnSIC priority this year was the transition from special education to community-based services for young adults. MnSIC focused on health care and employment services over the last year.

A local CTIC convened a workshop for HCH staff. The HCH parent partner now sits on the CTIC. Improvements in transitions for persons with autism were seen over the last year because of previous work with community partners on the autism/DD collaborative.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue involvement with MnSIC and interagency coordination activities				X
2. Continue to incorporate transition into health care home activities				X
3. Include transition expertise on medical home/health care home leadership group				X
4. Continue involvement with the State Council on Disability				X
5. Provide analysis of the MN Student Survey relevant to youth with special health care needs				X
6. Partner with parent to parent support agencies (Pacer, Family Voices, Hand & Voices) to provide information and assistance to families throughout the state seeking advice on transition planning	X			
7. Promote transition as a topic to be addressed by state professional medical organizations			X	X
8.				
9.				
10.				

**b. Current Activities**

A "HCH Transition in Health Initiative" pilot project involves a collaboration between the Health Care Home Initiative in the Minnesota Department of Health (MDH), the National HealthCare Transition Center (NHCTC), Family Voices of Minnesota and three selected pediatric clinics certified as a Health Care Home (or in process to become certified). This project will develop a model of successful health care transition to adult care for youth with special health care needs and their families by testing strategies, tools and materials supplied by the NHCTC. Family Voices will provide technical support, and funding will be made available through MDH. This pilot project requires engagement of youth with special health care needs and their families along with the experience of pediatric providers to test and implement health care transition tools, strategies, and a transition model that can be disseminated statewide and nationally.

**c. Plan for the Coming Year**

HCH District staff will continue their involvement in HCH/medical home teams and develop local capacity to address transition from pediatric to adult care. As the number of certified clinics increase the reach of best practice around transition from pediatric to adult care will continue to grow. CYSHN staff will serve on the Minnesota State Council on Disability level transition advisory group. Work on the development and implementation of the State Autism Plan will continue and will address transition to adult services.

A work group of the MCHATF is meeting to focus on CYSHN to inform the statewide children and

youth with special health care needs program to improve the quality, efficiency and effectiveness of the public health role in meeting the needs of children with special health care needs and their families. The group will also provide direction and advice on establishing priorities and developing plans for CYSHN activities.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	90	85	85	92	95
Annual Indicator	93.1	91.1	94.7	95.0	95.0
Numerator	65174	65124	68012	68700	68700
Denominator	70004	71486	71790	72316	72316
Data Source		National Immunization Survey	National Immunization Survey	National Immunization Survey	Estimates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	96	96	97	97	97

**Notes - 2009**

2009 data will not be available from MN Vital Statistics until 2011. These data are estimates.

**a. Last Year's Accomplishments**

In Minnesota, the Title V program is not the lead entity for immunization activities. The immunization program is managed by the Infectious Disease Epidemiology, Prevention and Control Division. Title V staff collaborate with the immunization program by supporting and providing outreach and information, and providing immunization information to providers through Child and Teen Checkups (C&TC) trainings. C&TC is EPSDT in Minnesota.

Minnesota continues work on Integrating Child Health Information Systems (ICHIS) involving immunization registry, vital records, newborn dried blood spot screening, newborn hearing screening, Birth Defects Information System, WIC, CYSHCN, blood lead program, and legal and system technology staff. This work will continue over the next several years as Minnesota works to meet its statewide e-Health goals.

Minnesota's immunization registry, the Minnesota Immunization Information Connection (MIIC), is a statewide network of seven regional immunization registries and services involving health care providers, public health agencies, health plans and schools working together to prevent disease and improve immunization levels. These regional services use a confidential, computerized information system that contains shared immunization records. MIIC provides clinics, schools, and parents with secure, accurate, and up-to-date immunization data. MIIC users can generate reminder cards about which immunizations are due to be given and when they are past due. The system greatly simplifies the work of schools in enforcing the school immunization law.

In Minnesota, all parents of newborns are notified of their enrollment in MIIC through Minnesota's birth record process. An immunization information packet is given to all new parents in the hospital. They are given a toll- free number to call with questions or if they do not want to participate in MIIC. Very few individuals decline each month. Most declinations are due to a general objection to immunizations.

MDH provides support for increasing immunization rates in a variety of ways. MDH provides educational materials in English and other languages and provides educational opportunities for immunization providers around the state. MDH facilitates the use of informed members within specific communities to educate and promote the complete immunization of infants and young children. The Immunization Practices Improvement (IPI) program uses MIIC data in working with medical and other immunization providers. The focus of the IPI program is provider quality assurance.

The percent of 19 to 35 month old children receiving a full schedule of age appropriate immunizations has steadily increased in recent years and Minnesota has consistently exceeded the annual objectives. In 2011, 95% of the 19 to 35 month old children received a full schedule of immunizations including Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilis Influenza, and Hepatitis B.

In 2011 Minnesota had 23 confirmed cases of measles, ranging in age from 4 months to 51 years. Of the cases, sixteen were not vaccinated, two were vaccinated and five had unknown vaccination status. Information about vaccination safety is available on MDH website.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Target information on immunizations to high-risk populations			X	X
2. Provide immunization training sessions to public and private providers through C&TC/EPSTDT training			X	X
3. Immunization review as part of WIC clinic services			X	X
4. Support local community immunization registries			X	X
5. Support MIIC strategic plan with emphasis on recommendations for integrating information with other child health data systems				X
6. Support local immunization clinics	X			
7. Support interoperability of data across various data sets (Medicaid, WIC, Birth Certificates, Immunization Registry, BDIS, etc.)			X	X
8. Continue to work with the Office of Minority and Multicultural Health on improving immunization rates for racial and ethnic populations			X	X
9.				
10.				

**b. Current Activities**

Title V staff provide consultation and training on immunizations to professionals who provide care to children, including schools, child care facilities, clinics, local public health. This is done through conferences, materials, direct contact, and the MDH website. MDH supports regional MIIC registries, and hosts the web-based application.

The Minnesota Strategic Plan for Health Information Exchange includes the Interoperable Child Health Information Systems (ICHIS) project. ICHIS was established by MDH and involves several MDH programs to create greater interoperability across child health information systems. The Local Public Health Work Group associated with this project has been extended into 2013 as they have been instrumental in identifying issues and making recommendations for complying with the 2015 electronic health record mandate.

Although Minnesota's statewide immunization rate is consistent with the national average, there are pockets of under-immunized children in some high risk populations. The Title V program will continue to work with Eliminating Health Disparities Initiative (EHDl) grantees to address health disparities related to immunizations. Five recipients of EHDl grants in SFY 2011 are promoting immunizations for adults and children. Additionally, the MDH immunization program is continually developing strategies to address misinformation regarding vaccines and to eliminate barriers to the complete immunization of children.

**c. Plan for the Coming Year**

Title V activities will continue as in the current year. In addition, immunization activities are supported and promoted through state and local family home visiting programs, C&TC and early intervention programs. MIIC regional immunization registry staff will continue to encourage an increase in the number of providers using MIIC. This level of provider "saturation" will continue to be tracked.

MDH will work with populations experiencing disparities in immunization rates through various programs and through medical providers/clinics as well as use of community members in underserved populations to increase immunization rates. MDH also continues to work with community partners to provide accurate information about vaccine schedules and safety.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	12	13	12.5	12	10
Annual Indicator	13.9	12.9	11.5	10.0	9.6
Numerator	1519	1377	1205	1072	1035
Denominator	109548	106591	104596	107400	108200
Data Source		MN Vital Statistics	MN Vital Statistics	MN Vital Statistics	Estimates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2012	2013	2014	2015	2016
Annual Performance Objective	9	9	8.5	8.5	8

**Notes - 2010**

2010 data will not be available until later in 2011. We have provided a provisional estimate based on recent trends.

**Notes - 2009**

2009 data will not be available from MN Vital Statistics until 2011. These data are estimates.

**a. Last Year's Accomplishments**

The teen birth rate has decreased from 10.9 in 2010 to 9.98 in 2011. Even more significantly the rate has dropped from 13.9 in 2007. However, there are still striking differences in teen birth rates by racial and ethnic population: Asian, African-American, Hispanic and American Indian teen birth rates range from three to six times higher than that of white teens. Reducing teen pregnancy continues to be a priority in Minnesota.

Minnesota is using a total of \$10.7 million in state and federal funds to support the Family Planning Special Projects (FPSP) grant program over four years beginning July 1, 2009. These funds are distributed through grants to local health departments (LHDs), tribal governments and non-profit organizations to support family planning services (outreach, public information, counseling, and method services).

Thirteen percent of the funds support family planning services for teens. From July 2010 through June 2011, over 19,500 men and women received contraceptive methods from the 25 FPSP grantees. Thirty-three percent of females served were from populations of color and American Indians. MDH provided technical assistance to LHDs to address teen pregnancy in their communities.

State funds support a family planning and sexually transmitted infection (STI) hotline staffed by individuals trained in information, referral, family planning and STI counseling. In addition to the toll-free phone line, individuals throughout the state can now access information by web chat and text messaging at [www.sexualhealthmn.org](http://www.sexualhealthmn.org). From July 2010 through June 2011, the Hotline responded to over 2,500 inquiries.

The Title V Adolescent Health Coordinator provided technical assistance to Teenwise Minnesota for their annual conference. The coordinator distributed information on teen pregnancy prevention best practices and funding opportunities through the monthly Adolescent Health E-Newsletter. Additional funding for teen pregnancy prevention, and supporting adolescents and young adult parents was sought. The Adolescent Health Coordinator wrote applications for formula-based federal funding opportunities for both the Abstinence Education grant and for the Personal Responsibility Education Program (PREP). The Adolescent Health Coordinator continues to provide support for the Teen Outreach Program (TOP) in collaboration with Teenwise Minnesota.

Staff drafted a comprehensive adolescent sexual health data report, which includes data on STIs and teen pregnancy/birth, as well as analysis of data. For example, staff worked with the Department of Human Services to find ways to approximate the rate of teen births among foster care youth. It also includes a comprehensive picture of adolescent sexual health behaviors, including both risk and protective factors.

Staff provided one-on-one technical assistance to LHDs doing family home visiting, and other community based organizations implementing the Eliminating Health Disparities Initiative, to increase their capacity to address adolescent pregnancy prevention/youth development related activities.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide access to Family Planning Special Projects services	X	X	X	
2. Partner with DHS to successfully implement 1115 Waiver for family planning services			X	X
3. Increase public understanding of social, economic, and public health burdens of unintended pregnancy, especially to teens			X	X
4. Develop public understanding and support for policies and programs that reduce unintended pregnancies			X	X
5. Promote youth activities that support resiliency and healthy behaviors	X		X	X
6. Support hotline for family planning and STI services	X			X
7. Support school-based clinics and advocate for comprehensive sexuality education	X			X
8. Support LPH in implementation of abstinence education activities			X	X
9. Support PREP grantees in implementation of activities			X	X
10. Provide support to EHDI grantees on teen pregnancy prevention activities in targeted populations			X	X

**b. Current Activities**

A monthly FPSP newsletter is sent to all grantees. MDH promotes the 1115 Medicaid Waiver and assists FPSP grantees in implementation of the waiver.

Staff provides technical assistance to Teenwise Minnesota on their annual conference. Staff are finalizing the adolescent sexual health data report.

Staff continues to provide technical assistance to LHDs doing family home visiting to increase their capacity to address adolescent pregnancy prevention/youth development related activities.

MDH has provided funding to St. Paul-Ramsey County Public Health to implement activities under the federal Abstinence Education funding. St. Paul-Ramsey is working with the TOP program to provide TOP training in the community. Additional abstinence education activities are ramping up for the coming year.

Staff was hired to begin work on the Personal Responsibility in Education Program (PREP) grant. It is anticipated that this grant will have a focus on communities at greatest risk for teen pregnancy and STIs. At risk youth will be targeted are those residing in the 25 counties experiencing the highest rates of teen pregnancy in the state and youth in foster care or juvenile justice system. An RFP is being drafted and will be posted for eligible applicants. It is anticipated that grantees will begin work in the fall of 2012.

**c. Plan for the Coming Year**

Minnesota has a strong history of building on partnerships to reduce teen pregnancy. MDH staff will continue to facilitate collaboration with partners on teen pregnancy prevention. Partnering with Teenwise and Wyman Center on TOP replication issues, training, and service learning will also be a part of this coming year's activities. Rates of teen pregnancy and teen births will continue to be monitored and information disseminated on the most up to date information to LHDs and professionals statewide. Staff will be on the planning committee for the Teenwise yearly conference on teen pregnancy prevention. The Adolescent Sexual Health Data Report will be printed and disseminated and will serve as a springboard for statewide planning related to sexual health.

As noted previously, the PREP RFP will be disseminated in June with the anticipation that grantees will be starting programs in the fall. The grant application will target those communities with the highest rates of teen pregnancy and populations at highest risk for teen pregnancy. Grantees will be required to choose evidence based curriculum for their program. Programs will also include adult preparation topics.

Work will continue on the Abstinence Education (Healthy Youth Development) activities. In addition to TOP funding in the community, St. Paul-Ramsey will release an RFP seeking proposals from qualified organizations to recruit, train and supervise a network of parent educators to implement the "It's That Easy" healthy sexuality and relationship curriculum. A diverse cadre of at least 25 Parent Educators will be trained in "It's That Easy", with each Parent Educator supported in reaching roughly 40 parents and other adult caregivers during the course of the contract.

A new RFP for the Family Planning Special Projects (FPSP) grant will be posted for eligible applicants in 2013. The Family Planning Coordinator will continue to provide technical assistance to FPSP grantees through a monthly newsletter and annual site visits. Staff will continue to help promote the 1115 Medicaid waiver and support family planning service providers in using the waiver. FPSP grantees, in partnership with MDH, will provide critical direct services to Minnesota adolescents in an effort to reduce teen pregnancy and teen birth rates.

The MDH Eliminating Health Disparities initiative will release the list of new grantees in the July 2012. Title V staff will continue to support those new grantees to implemented teen pregnancy prevention activities.

The MDH Office of Minority and Multicultural Health is issuing a RFP for the prevention of teen pregnancy grants in July 2012. Local public health, tribal governments and nonprofit organizations will be eligible to apply. Grants will focus on the expansion or enhancement of current evidence-based programs, use of community navigators for the systems teens use, use of the curriculum "Proud Choices" in foster care, or training in evidence-based curriculums.

**Performance Measure 09:** *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	14.5	14	14.5	15	64
Annual Indicator	14.2	14.2	15.0	64.1	64.1
Numerator	17235	18388	26018	1132	1132
Denominator	120950	129526	173442	1766	1766
Data Source		MN Dept. of Human Services	MN Dept of Human Services	Basic Screening Survey (BSS)	Basic Screening Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years					

is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	64	64	64	70	70

**Notes - 2010**

We have changed our data source as of 2010 because we now have access to the Basic Screening Survey (BSS) which is more comparable to dental data from other states. We will no longer be using Medicaid data from the MN Dept. of Human Services as it deals with a very small subset of third graders, whereas BSS data is more representative of the entire population. Our 2010 data should not, and cannot, be compared with 2009 or previous years' data.

**Notes - 2009**

2009 DHS data will not be available until next calendar year (2011).

**a. Last Year's Accomplishments**

The Oral Health Program in the MDH Health Promotion and Chronic Disease Division conducted a needs assessment to determine schools with school-based dental sealant programs and to document existing infrastructure and management of school-based dental sealant programs in the state. A survey questionnaire for school principals was developed and sent out February 2011. Prior to the request for proposal for school-based dental sealant programs published in 2011, several organizations were providing school-based programs in the state. These include: Children's Dental Health Services, Children's Dental Services, and Just Kids Dental, Inc. During the 2009-2010 school-year, these programs provided dental sealants to 19,328 children who were predominantly children eligible for free/reduced price lunch.

A 2010-2012 HRSA Supplemental Workforce Innovation grant enabled the Oral Health Program to fund five school based dental sealant grants in March of 2011. Thirteen applications were received requesting a total of \$236,129.26. Requests ranged in value from \$13,500 to \$20,000.00. The grants support school-based dental sealant program infrastructure by creating new, sustainable, school-based dental sealant programs and/or expands upon existing programs with a focus on 2nd grade children who are at highest risk for dental disease. For children ages 6-9 yrs., this means there will be an increase in the number of Minnesota 2nd graders with at least one dental sealant on their first permanent molars. MDH supplemented the three existing programs and funded three new school-based programs to make a total of six school-based dental sealant programs. New programs include: Apple Tree Dental, Community Dental Care, and Northern Dental Access.

The Oral Disease Prevention Unit also received a supplemental grant to the three-year Workforce Innovation Grant it received through the Health Resources and Services Administration (HRSA). The Public Health Nurses Primary Caries Prevention Project is centered on public health nurses and primary dental caries prevention. Its objective is "to improve oral health medical and community-based prevention services by strengthening the infrastructure of and expanding the capacity of the collaboration between dental hygienists, dentists, and medical clinics delivery programs."

This created the opportunity to provide primary caries prevention (PCP) by increasing utilization of fluoride varnish treatments during early wellness visits in public health nurse agencies and increases the collaboration between dental hygienists and public health nurses whether provided in a medical clinic or public health nurse (PHN) agency (as occurs with great frequency in Greater Minnesota).

The funding also provided support for municipalities facing challenges with aging fluoridation equipment which also has an impact on preventing and mitigating the effects of dental caries in the entire population.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote the use of dental sealants and other preventive measures to parents, health professionals and the general public.			X	X
2. Develop strategies that make it easier for children to receive sealants.			X	X
3. Promote and encourage school-based/school-linked sealant programs and appropriate follow-up.			X	X
4. Partner with the DHS to increase utilization of dental services for public program participants.			X	X
5. Incorporate preventive dental practices in the C&TC trainings.			X	X
6. Staff Oral Health State Plan Advisory Group.			X	X
7. Integrate oral health into health care home efforts.			X	X
8. Work with local public health and other stakeholders on improving children's oral health.			X	X
9. Continue to seek federal or other resources to support oral health promotion activities.			X	X
10.				

**b. Current Activities**

Evaluation of intermediate and process outcomes for school-based dental sealant initiative indicates a positive impact on the number of high-risk children that are receiving preventive services through MDH programs. In 2009-10 25% of high-risk schools had sealant programs. Now, 29% of high-risk schools in MN have school-based dental sealant programs.

Supplemental funding is being sought to allow the Oral Health Program to continue and expand on the Public Health Nurses Primary Caries Prevention Project. New community based programs will increase the capacity of the MN oral health workforce and the public health, to meet the growing needs of the uninsured and underserved. Providing support for municipalities facing challenges with aging fluoridation equipment, increasing utilization of fluoride varnish treatments during wellness visits, increasing collaboration between dental hygienists and public health nurses, will positively impact prevention efforts.

Title V staff participate in the MN Oral Health Coalition. Meetings were held February 17 and April 20, 2012.

MCH staff participates in the School-based Dental Sealant Advisory Group for the School-based Dental Sealant Program. The MDH Oral Disease Prevention Unit obtains input and advice from individuals and organizations on ways to provide a coordinated, comprehensive approach to improve oral health and reduce the burden of oral disease. The focus of the work is to assist in the development of a comprehensive plan.

**c. Plan for the Coming Year**

Continued program collaboration between MCH and the Oral Disease Prevention Unit will include regularly scheduled meetings: To collaborate with the Minnesota Department of Human Services to increase the number of children with MinnesotaCare (Medicaid) benefits who have at least one

dental sealant; Review and update the Minnesota State Oral Health Plan; Review fluoride recommendations and communications for program recipients (public) and program staff; Review and update program materials and trainings for Child & Teen Check-ups; Oral health resources will made available to school nurses, early childhood programs and initiated into the new early childhood Race to the Top pilots; and Other initiatives that arise.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	2.3	2	1.9	2.3	2
Annual Indicator	1.9	2.4	1.8	1.9	2.0
Numerator	20	25	19	20	21
Denominator	1035183	1035562	1045645	1063382	1065000
Data Source		MDH Injury Unit	MDH Injury Unit	MDH Injury Unit	Estimates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	1.9	1.9	1.8	1.8	1.7

**Notes - 2010**

2010 injury data are not yet available; therefore, these data are estimates.

**Notes - 2009**

The MDH Injury Unit will not have precise 2009 data until 2011. These data are general estimates.

**a. Last Year's Accomplishments**

The motor vehicle traffic crash child death rate (birth to age 14) of 1.88 per 100,000 in 2010 increased statistically (but practically remained the same) from the rate (1.82) and number of deaths in 2009. Our prevention partnerships continued their educational and enforcement initiatives, combined with providing car seats and booster seats to those who need them. Joint public safety and public health initiatives to reduce risk of injury in a motor vehicle-related crash include: 1) statewide distribution of car seats and booster seats to those in need; 2) intensive training of public health staff and local volunteers in proper car seat and booster seat installation, combined with educational techniques and approaches for families to whom car / booster seats are given; and 3) improving Minnesota's emergency medical and trauma responses. Active partners include Minnesota Safe Kids, the Department of Public Safety, local health departments and trauma centers across Minnesota.

Many car seat safety specialists have passed child passenger safety training and are available to assist and to serve in communities across Minnesota. These specialists are listed by county on the searchable web site maintained by our partners at the Department of Public Safety, Office of

Traffic Safety (<https://dps.mn.gov/divisions/ots/child-passenger-safety/Pages/car-seat-checks.aspx>).

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute car seats and booster seats to families; teach proper installation and use	X	X		
2. Train car seat and booster seat checkers			X	X
3. Support the GDL and "Click it or ticket" campaigns of OTS, Department of Public Safety				X
4. Evaluate, through data analysis, the impact in MN of standard (primary) enforcement of seat belts (Everybody, every seat, every time)				X
5. Continue emphasis in Positive Alternatives, Family Home Visiting and C&TC on using the home safety checklist with families being served			X	X
6. Support enforcement of speed limits, prevention of distracted and drowsy driving, and reduction of impaired driving, which place children at risk			X	X
7. Promote seat belt (and safety seat) use for children		X	X	
8. Promote safe routes to schools and walkable communities for children		X	X	
9. Promote safe bicycling routes and practices for children		X	X	
10. Promote crosswalk and pedestrian safety for children		X	X	

**b. Current Activities**

Programs continue to distribute car/booster seats and train providers and parents on correct installation and use. Providers at clinics, hospitals and local health departments continue to encourage appropriate restraint usage in motor vehicles by all population sub-groups.

The C&TC program provides training sessions that includes guidance on safety issues including car seats and seat belt use. The best practice literature suggests that as health professionals champion motor vehicle safety as part of their work, crash death rates will be reduced. Correct restraint needs to be modeled by parents and caregivers, taught by health professionals, and car/booster seats need to be provided to those who cannot afford them. Excess speed, lack of seat belt use, distracted and drowsy driving remain concerns across all ages, but have particular impact on persons aged birth through 14 years of age.

Minnesota has completed three years of enforcing our primary seat belt law and strengthened booster seat law; preliminary impact analyses suggest 50 lives saved and several hundred serious injuries prevented thus far. As of June 13, 2012, 124 of Minnesota's 130 acute care hospitals have been designated -- or are in the process of being designated -- as a Level I, II, III or IV trauma center. These improvements in Minnesota's EMS and trauma care systems will reduce the risk of motor vehicle crash-related death.

**c. Plan for the Coming Year**

Activities described in Current Activities will continue, along with prevention activities in and among Minnesota's minority populations through our state-funded Eliminating Health Disparities Initiative.

New funding for child car restraints and appropriate parental safety training has enabled local non-profit organizations to identify and support low-income families in the use of appropriate child

restraints. However, the need far surpasses available funds and gaps persist.

For families who do not qualify for an assistance program, new car seats can be found across Minnesota at various stores. If a used car seat is obtained, parents are encouraged to ensure that the seat is safe by assuring that the seat is less than six-years old and has never been involved in a vehicle crash. Parents are discouraged from using car seats missing the label with the manufacturing date, model number and original instructions, or one that has missing or broken parts. Parents are advised to not purchase used car seats through garage sales or second-hand stores.

**Performance Measure 11:** *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	48	48	48	52	53
Annual Indicator		51.6	51.6	51.6	50.9
Numerator					113
Denominator					222
Data Source		National Immunization Survey data	NIS data	NIS	NIS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	53	53	54	54	54

**Notes - 2010**

A numerator and denominator for 2010 are not available at this time.

**Notes - 2009**

The most recent birth cohort available on the NIS website is 2006.

**a. Last Year's Accomplishments**

Minnesota continues to strongly promote breastfeeding of all infants and address challenges to initiation and continued breastfeeding. Minnesota has met and exceeded the Healthy People 2010 goal of 50 percent of mothers who are breastfeeding their infants at six months of age. In other breastfeeding success measures, Minnesota has met the Healthy People 2010 goal for breastfeeding initiation and the MDH continued to work to promote and support breastfeeding for all Minnesota mothers and infants. Breastfeeding initiation rates for some population groups, including refugee and low-income populations, remain low. The Hmong and Somali populations have lost breastfeeding traditions upon immigration to the United States, Hmong women often cease to breastfeed and the Somali usually initiate breastfeeding at birth but often supplement and have shorter duration than before immigration. Native Americans in most locations in Minnesota also breastfeed at lower rates than the general population. Rates vary considerably between Minnesota communities. We have made progress, but barriers to breastfeeding remain.

Title V and WIC program staff collaborate to promote and support breastfeeding. Local health departments advocate breastfeeding and implement breastfeeding promotion strategies with families as well as support mothers with breastfeeding concerns and questions. Breastfeeding materials are distributed through Family Home Visiting (FHV) e-mail lists and posted on the FHV website and on the WIC website. WIC provides leadership for activities to promote and support breastfeeding. WIC continues to offer workshops on breastfeeding management, promotion, and counseling. FHV staff as well as WIC staff (sometimes one nurse is both) at local public health departments attend workshops/trainings on breastfeeding support offered through WIC, through local public health, through State Health Improvement Plan (SHIP) projects and hospitals or other health care settings.

SHIP is a state funded health improvement initiative through which local health departments received grants from MDH to target interventions aimed at improving health and containing health care costs by reducing the percentage of Minnesotans who use or are exposed to tobacco and by reducing the percentage of Minnesotans who are obese or overweight through better nutrition and increased physical activity. Project sites selected to implement policy, systems and environmental change strategies in their schools, communities, worksites and health care settings. Eight of the forty grantee sites selected breastfeeding support either with health care settings or worksites as one of their interventions for reduction of obesity or overweight in the population.

The Minnesota Breastfeeding Coalition (MBC) held its fourth statewide meeting in Duluth, October 2011. The MBC works to build coalitions between public agencies, non-profits, hospitals and other organizations that promote breastfeeding. The 4th annual meeting included resources for hospitals, work sites, public health agencies and others, and included a presentation from the first hospital in Minnesota to reach "Baby Friendly" (BFHI) designation.

MDH staff provide breastfeeding information to local public health staff and communities. The FHV Unit provides professional training on NCAST Parent-Child Interactions to assess feeding interactions. WIC staff have provided breastfeeding training and information to Positive Alternatives grantees. The MDH FHV Unit collects data annually on breastfeeding initiation and duration rates. Breastfeeding is promoted and supported through evidence-based home visiting models implemented in Minnesota (Nurse-Family Partnership and Healthy Families America).

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure that MCH Public Health Strategies on breastfeeding promotion continue to be available			X	X
2. Support breastfeeding promotion and support as a component of the Family Home Visiting services	X			X
3. Continue to provide breastfeeding education and support through WIC, i.e. training and technical assistance to local WIC programs, and local programs provide breastfeeding support services to WIC participants	X		X	X
4. Provide technical assistance and training to local programs to help them identify opportunities and implement strategies to promote and support breastfeeding			X	X
5. Continue WIC Peer Breastfeeding Support Grants and technical assistance to grantees	X			X
6. Convene cross-program meetings to identify ways to integrate breastfeeding promotion and support into a wide array of MCH programs				X

7. Propose policies that support breastfeeding			X	X
8. Support BFHI summit for health care administrators			X	X
9.				
10.				

**b. Current Activities**

MDH staff in the FHV Unit and WIC continued to provide training and technical assistance to promote and support breastfeeding.

Minnesota has met the HP 2020 goal for breastfeeding initiation and is working toward the HP2020 goal of 60.6% breastfeeding at 6 months. As of 2008 the Minnesota rate is 50.9%, as reported in the 2011 CDC Breastfeeding Report Card: Outcome Indicators.

MDH employs 2 FTE WIC staff dedicated to support breastfeeding. Many MDH staff in WIC, Women's Health, FHV, Child and Adolescent Health and others support breastfeeding as part of their programs and work to enhance program linkages.

MBC partnered with MDH obesity prevention staff to develop Supporting Breastfeeding in Your Child Care Program. MBC partnered with the Public Health Law Center and SHIP on a fact sheet on laws in Minnesota that support breastfeeding mothers. A website has been set up by MBC.

The MN WIC Peer Breastfeeding Support Program includes 11 programs in 17 counties and 2 American Indian Tribes. The goal is to institutionalize peer counseling in WIC as a core service focused on increasing breastfeeding rates. Austin Medical Center is the first MN Hospital to be designated a Baby-Friendly Hospital by WHO and UNICEF. Fairview Children's Amplatz Hospital is the second MN hospital to achieve this designation.

**c. Plan for the Coming Year**

MCH and other MDH programs plan to support a summit related to the Baby Friendly Hospital Initiative (BFHI) that is being planned for hospital administrators for spring/early summer 2013. A mother-baby collaborative for hospitals is also being discussed.

The Minnesota Breastfeeding Coalition obtained non-profit status and is now working on building membership. The fifth Annual MBC Statewide Meeting is planned for October 2012. MBC will also continue to partner with WIC staff and staff from the chronic disease unit as an intervention for preventing obesity.

MDH is an outreach partner for text4baby, an initiative of the National Healthy Mothers, Healthy Babies Coalition, which sends text messages to pregnant and parenting women participants including messages supporting breastfeeding and is currently meeting with Minnesota Department of Education and other partners to plan outreach strategies for enrollment. Many of the other MDH initiatives for breastfeeding are ongoing. The MDH infant mortality consultant will be promoting breastfeeding as a protective factor in reducing infant deaths from SIDS.

WIC will continue to add more Peer Breastfeeding Support Programs as funding becomes available. A requirement of the program is to have at least one International Board Certified Lactation Consultant working with each peer program. WIC has offered 5 day lactation specialist trainings and other trainings for local WIC staff to increase each agency's capacity for breastfeeding support.

WIC launched a new educational initiative for WIC staff at local sites. The breastfeeding curriculum is called Grow and Glow and is a USDA endorsed program which was piloted in 2011 and in April and June 2012 eight additional trainings are offered at locations throughout the state. Where space permits, MN WIC has encouraged local WIC to invite some of their partners to the trainings to promote consistency of message.

**Performance Measure 12:** *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	90	85	90	97	98
Annual Indicator	88.9	96.7	97.2	97.8	98.3
Numerator	65434	69790	68466	66798	67165
Denominator	73608	72169	70432	68277	68300
Data Source		MDH newborn screening program	MDH Newborn Screening Program	MDH Newborn Screening	Estimates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	98.5	98.5	98.5	99	99

**Notes - 2010**

2010 hearing screening data are not available at this time; therefore, we have provided estimates. Our newborn screening procedures have improved over the past few years, resulting in de-duplication of cases and a smaller numerator. This is a positive step and should not be regarded as an actual decrease in the number of newborns screened in MN.

**Notes - 2009**

For various reasons, we are unable to accurately separate infants screened before discharge from those screened after discharge. Therefore, these numbers represent the total number and percent of infants who have received screening in 2009, regardless of when the screening occurred.

**a. Last Year's Accomplishments**

The Minnesota Department of Health (MDH) made progress toward reduction in loss to follow-up and documentation at all stages of the Early Hearing Detection and Intervention (EHDI) system. In particular, MDH made significant improvements in reducing loss to follow-up/documentation and documented enrollment rates in early intervention for children identified with hearing loss.

Of all 2010 births, 98.4 percent (66,590 of 68,113) of newborns were screened for hearing loss. Results are reported on the dried blood spot form and then matched with birth certificates. There were 570 infants who did not pass hearing screening and continued to have an unknown

diagnostic status (lost to follow-up/documentation). During this time period 229 infants were reported to have a hearing loss (permanent or conductive). For those infants, the average time from birth to diagnosis was 4.2 months.

MDH continued to build upon a strategy implemented in early 2010 to utilize a strong and already established state system of local public health to significantly enhance its efforts in reducing loss to follow-up/documentation. Contracts with 85 (of 87) counties require local public health nurses to facilitate and document rescreening, diagnosis, and connection with early intervention programs for families whose infants are lost to follow-up or had an identified hearing loss. Contracted local public health agencies designated a staff member as the EHDI Key Contact to receive MDH notifications of children requiring EHDI follow-up. The identified contact is trained and expected to provide guidance as the content expert for the agency.

Between June -- Dec. 2011, MDH requested EHDI LPH follow-up for 325 children considered "lost" despite considerable efforts from MDH public health lab staff to locate these children. Reports were returned for 134 cases (41%). Of those, approximately 30% of the most difficult cases were resolved, 34% were considered lost and 19% were in process.

In addition, during that same period, 145 notifications for children with confirmed hearing loss were sent to LPH. Of those sent, 42% were returned confirming that 100% of those children have been referred to Early Intervention and 79% were enrolled. EHDI staff actively track reports returned by LPH. The vast majority of outstanding reports were considered "in progress" and have a LPH nurse actively involved in the case. Local public health nurses who have provided the follow-up have reported improved communication and coordination between community partners such as public health, primary care, and Part C/Early Intervention.

The department also contracted with MN Hands & Voices to provide parent-to-parent support for families of children newly identified with permanent hearing loss. Guides are trained parents who have a child that has already been identified as having a hearing loss.

Educational efforts to decrease loss to follow-up and documentation were also focused on primary care providers. Lunch and Learn Sessions and display/exhibits at state-wide conferences focused on the primary care provider's role in assuring families receive the additional screening or testing that is needed.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance on implementing newborn hearing screening to hospitals, and communities			X	X
2. Provide education and training of providers, including audiologists, primary care providers, public health nurses, etc.		X	X	X
3. Provide information to parents of the importance of screening and if identified with a hearing loss, additional follow-up		X	X	X
4. Refine and expand the data tracking & follow-up system			X	X
5. Integrate data collection, follow-up and tracking with other child health data systems			X	X
6. Work with a variety of stakeholders on assuring follow-up, referral and intervention for infants and children with hearing loss			X	X
7. Continue federally funded grant activities in this area		X	X	X
8. Continue partnership with MN Hands & Voices		X	X	X
9. Support Local Public Health to facilitate screening, rescreening and entry into EI for those with a hearing loss for those who are lost to follow-up		X	X	X

10.				
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**b. Current Activities**

EHDI follow-up staff continue to work with their counterparts in the public health lab (PHL) to improve hearing screening protocols and outcomes. MDH continues to contract with Minnesota counties to support local public health (LPH) nurses to facilitate and document rescreening, diagnosis, and connection with early intervention programs for families whose infants are lost to follow-up or who have been identified with hearing loss.

Several activities are currently underway to improve the ease and accuracy of data reported to MDH by LPH. Data reports were created to evaluate the number of cases sent to LPH and the number of cases that remain outstanding. These reports are sent to LPH on a monthly basis to track progress. An additional annual report is currently being developed that will allow counties and MDH to assess the quality of their follow up. Data quality will also be improved through electronic referrals to local public health contacts and direct reporting on clients assigned to their care through the Minnesota Electronic Disease Surveillance System (MEDSS). PHL staff continue working on a major revision for the newborn screening information system for short term long- term follow-up.

**c. Plan for the Coming Year**

The Minnesota Electronic Disease Surveillance System (MEDSS) has assisted in developing an integrated state-local disease surveillance system to allow electronic data exchange with partners including hospital systems, local public health, public and private laboratory systems, and individual health care settings. This secure, web-based system will allow for rapid disease reporting, surveillance, and follow-up, thus allowing for care management for several reportable conditions in a person-centric system. EHDI staff will begin work to enhance MEDSS to allow audiologists to directly report confirmation of hearing loss.

MCH/MCYSHN staff will continue working with representatives from the other state agencies, Minnesota Hands and Voices, and the Commission of Deaf, DeafBlind and Hard of Hearing Minnesotans to recommend policy and system changes that improve the outcomes for newborn screening including those who have a permanent hearing loss. This includes implementation of the Minnesota Collaborative Outcomes Plan for Children Who Are Deaf, DeafBlind, and Hard of Hearing. The first goal of this plan focuses on EHDI objectives regarding the child and family (i.e. parents have the resources they need to effectively advocate for their child and themselves, are confident their child is getting the services and supports s/he needs, and are confident that their child is making progress and reaching his/her fullest potential). Measures will be based on one annual survey developed and agreed upon by collaborative partners. The Minnesota Commission Serving Deaf, DeafBlind, and Hard of Hearing Minnesotans has agreed to spearhead this project. An interagency agreement with the Commission will provide support for coordination of partners, facilitation of meetings (including accessibility), as well as survey development, distribution and analysis of results. Baseline measures described in the Collaborative Plan will be determined by early 2013.

MDH will continue to support LPH facilitation of connection to supports and services for children identified with hearing loss and those lost to follow-up. By March 2013, LPH will report at least 75% of children identified with hearing loss are documented as enrolled in EI.

Additionally, the MDH will continue to contract with the parent-to-parent support organization, Minnesota Hands & Voices. The parent guides are able to provide direct parent-to-parent support linking families with resources in their area. Minnesota Hands and Voices has parent guides in all regions in the state.

**Performance Measure 13:** *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	7	5.5	5.5	6	6
Annual Indicator	6.0	6.0	6.7	6.7	5.4
Numerator	75600	75450	85000	85000	70000
Denominator	1257000	1257900	1259500	1259500	1300000
Data Source		2006 MN Health Access Survey	2009 MN Health Access Survey	2009 MN Health Access Survey	2011 MN Health Access Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	5	5	5	4	4

**Notes - 2010**

There is no new MN Health Access Survey this year; therefore, we are repeating 2009 data.

**a. Last Year's Accomplishments**

The Minnesota Department of Health (MDH), in partnership with the University of Minnesota, has periodically conducted the Minnesota Health Access Survey over the last 13 years. These surveys are the source of data for state policy makers to define and respond to health insurance issues of Minnesotans and are stratified random digit dial telephone surveys that include both cell and landline telephones.

The most recent survey was conducted in the fall of 2011. In 2011, 9.1 percent of Minnesotans were uninsured compared to 7.2 percent in 2007. The uninsurance rate for children (birth to 17) in Minnesota is 5.4 percent (estimated). This is a decrease from 2009 when then percentage of uninsured children was 6.7 percent.

Staff throughout the state in Minnesota's Family Home Visiting, Positive Alternatives, Family Planning Special Projects, and WIC programs continued to work with clients on assessing insurance status and the referring clients to appropriate insurance resources. MDH Title V staff also provide technical assistance and support to local health departments (LHDs) and program grantees on insurance billing and eligible services.

Staff in the MDH Minnesota Early Hearing Detection and Intervention program provide grant funds to LHDs to provide follow-up and support of families of children identified at birth with hearing loss. During these follow-up visits, LHD staff discuss and refer families to appropriate insurance resources. MDH staff in the Newborn Screening Follow-up program provide follow-up

and consultation with families of children diagnosed with a medical condition during the newborn screening process. A component of the consultation is referral to appropriate insurance resources.

Minnesota's local health departments are required to report on their progress toward increasing the number of clients enrolled in health insurance programs. To measure their progress LHDs report annually on those programs in which they routinely assess the health insurance status of clients and the programs in which they refer clients to insurance resources.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor both federal and state health reform activities to assure integration of MCH and CYSHN issues				X
2. Partner with DHS to assure that all children eligible for public programs are enrolled		X	X	X
3. Work within existing systems to assist families in identifying insurance options				X
4. Maintain insurance coverage component of the Family Home Visiting program			X	X
5. Continue to monitor state and federal health reform legislation and the impact on health insurance coverage of children in Minnesota				X
6. Assure insurance issues in the MCH and children and youth with special health needs populations are considered in statewide health reform activities.				X
7. Continue to support and monitor local public health activities to assure access to insurance resources		X		X
8. Continue EHDl and newborn follow-up activities to assure families have access to appropriate information		X	X	
9.				
10.				

**b. Current Activities**

A number of health reform activities are underway in Minnesota. Comprehensive health reform legislation was passed in 2008. Since that time the state has continued to receive input through a variety of groups and committees. Governor Dayton has convened a Health Reform Task that is charged with developing strategies that: 1) Improve access to health care for all Minnesotans; 2) Lower health care costs by reforming how Minnesota pays for health care and changing the incentives, to encourage preventative care and reward healthy outcomes, not sickness, and 3) Improve the health of all Minnesotans and address the health disparities that plague the state. The work is being carried out through three work groups: Access, Care Integration and Payment Reform, Prevention and Public Health, and Workforce.

Title V staff continue to monitor changes brought about by the federal 2010 health reform legislation as well as state health reform legislation. Staff are monitoring the impact on Title V programs and preparing to address requirements from the legislation that will impact the insurance needs of mothers and children in Minnesota.

Minnesota's LHD continue to assess the insurance status of clients in multiple public health programs, including home visiting, hearing detection follow-up, WIC, early intervention services, C&TC, and the Follow-Along Program. MDH will support LHD in this effort. LHD will also continue to assist clients in obtaining adequate insurance.

**c. Plan for the Coming Year**

MDH Title V staff will continue most activities currently underway. MDH Title V staff will continue to monitor federal and state health reform efforts. MDH staff will also continue to work with Minnesota Department of Human Services staff to assure MDH staff are up to date on any changes in insurance programs.

Title V staff have been fully integrated into the Health Care Home program. These staff previously provided regional consultation on children and youth with special health care needs. In their new role, they will be working to expand the number of certified pediatric health care homes. Expansion of health care homes for pediatric clients increases the state's capacity to assure adequate insurance coverage for children.

The MDH will continue to work with LHD to monitor rates of insurance referral reporting of clients in public health programs as a way to monitor progress toward the statewide goal to increase the number of clients who are enrolled in health insurance programs.

Staff in the Newborn Screening Follow-up and Early Hearing Detection and Intervention programs will continue to assure that identified children receive information on insurance.

The MDH is examining options for refining the information and assistance services to families. This includes expanding the informational resources available regarding public and private insurance options.

**Performance Measure 14:** *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	28.5	28	28	27	26.5
Annual Indicator	29.9	30.4	29.9	29.1	29.1
Numerator	18272	19944	20630	19960	20541
Denominator	61109	65607	68997	68594	70589
Data Source		PedNSS	PedNSS	PedNSS	PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	27	27	25	25	24

**a. Last Year's Accomplishments**

The percentage of children with a BMI at or above the 85th percentile has remained the same. However, there has been a slight decrease over the past five years.

The Minnesota WIC program requires local WIC staff to assess the weight status of all children participating in WIC, and provide individualized services to address the particular needs of that child and family. Services include: 1) counseling caregivers on how to help children eat a healthy diet and be physically active; 2) referrals to community nutrition and physical activity resources, as well as to their primary care provider; and 3) a customized food package (which includes low

fat milk, whole grains, and fruits and vegetables).

The MN WIC program continued to build local agency capacity to more effectively address with parents their child's weight status, and to achieve healthy weight. WIC continued working with local agencies to increase breastfeeding initiation and duration among WIC participants. The Minnesota WIC program provided local agencies dedicated training funds to use for staff development in maternal and infant nutrition, breastfeeding and counseling. For the fourth year, the WIC program sponsored a 5-day certified lactation specialist course, free of charge for local WIC staff. WIC breastfeeding peer support programs expanded to other regions of the state.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Weigh and measure (twice/year) children ages 2-5 participating in WIC, plot data on growth grids and calculate BMI	X			
2. Identify children at-risk-of-overweight or overweight, using BMI	X			
3. Provide referrals to primary health care provider and other health and social services as needed	X			
4. Counsel caregivers and provide nutrition education (e.g. related to feeding practices, diet and physical activity)	X	X		
5. Tailor the WIC Food package to best meet child's dietary needs	X	X		
6. Transmit anthropometric data to CDC for PedNSS reports				X
7. Share anthropometric data summaries with local and state stakeholders to guide policy decisions				X
8. Participate in development of Obesity State Plan			X	X
9. Incorporate appropriate referral mechanisms to WIC from other child programs such as home visiting, Follow-Along Program, Positive Alternatives grantees, etc.			X	X
10. Provide obesity prevention and screening education and training to pediatric C&TC providers		X	X	

**b. Current Activities**

MN WIC continues to track the incidence and rates of overweight and obesity in children participating in WIC. The fact sheet Obesity and Overweight in Minnesota WIC Children summarizes the WIC data and includes a map of overweight/obesity rates by county. This fact sheet is available to all MN WIC local agencies and community partners.

MN WIC is beginning to integrating the Participant Centered Service model into WIC services. The model builds staff skills and competencies, as well as environmental and organizational supports, for more effectively engaging participants and meeting their nutrition and health needs. Local WIC leadership and staff recognize the need for better counseling skills, particularly in working with parents around sensitive issues such as childhood overweight.

MN WIC continues efforts to increase local staff capacity to encourage and support breastfeeding. WIC is providing breastfeeding support training for all WIC staff through the Grow & Glow training, developed by USDA for WIC staff to institutionalize breastfeeding in the WIC environment and recognize roles for every staff in promoting and supporting breastfeeding. WIC expects to train approximately 500 staff. For the third year, MN WIC is sponsoring Building Bridges for Breastfeeding Duration, a joint training for WIC, hospital, and clinic staff, intended to promote collaboration and consistent breastfeeding messages.

MN expanded peer breastfeeding support services to three additional WIC programs.

**c. Plan for the Coming Year**

The MN WIC program will implement new growth standards for assessing weight status of children birth to 24 months. The new standards, based on international data collected by WHO, are recommended by CDC, NIH, and AAP, and required for use in WIC by USDA. These new standards will result in fewer infants being identified as underweight, and more infants being identified above the 95th percentile for weight for length. (Weight status of children 2 to 5 years will continue to be assessed using the CDC BMI reference data.) Additionally, WIC will implement revised anthropometric risk criteria, including a new risk criteria, High Weight for Length, for children birth to 24 months.

The MN WIC Program will pilot the PCS model in 5-8 WIC local agencies in the coming year with training, on-going mentoring and continuous feedback, it is expected that WIC staff will be better skilled in constructively addressing childhood overweight and more effective in assisting WIC families in meeting their nutrition, breastfeeding and health behavior goals.

**Performance Measure 15:** *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	13	13	13	11	10
Annual Indicator	15.0	11.6	14.4	13.7	13.1
Numerator	10303	7865	9534	8858	8513
Denominator	68911	67563	66319	64733	65000
Data Source		MN PRAMS	MN PRAMS	MN PRAMS	Estimates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	12	11	11	9	9

**Notes - 2010**

2010 PRAMS data are not available from CDC at the present time. CDC is currently processing our 2009 data, which is also unavailable; thus, we are providing estimates for 2010.

**Notes - 2009**

Most recent PRAMS data available from CDC is 2008. CDC is currently cleaning the Minnesota data; it will not be weighted and ready to use for several weeks. Thus, we are providing estimates for 2009.

**a. Last Year's Accomplishments**

Staff provided support to local health departments on the "5 A's" for smoking cessation. Toolkits and resources for implementation are provided.

Staff worked to promote the safe sleep campaign and SIDS risk reduction with the MN SID

Center. Smoking cessation is integrated into messages. Twin Cities Healthy Start focuses on smoking reduction in pregnancy and secondhand smoke reduction to reduce infant mortality, low birth weight, SIDS and other sleep-related infant deaths. Staff conducted a workshop on smoking cessation at the Strong Foundations (Birth to Three) Conference. The conference promotes the importance of building strong families to support children in their earliest years.

Staff provided an education session on the impact of smoking on pregnancy and infant health to an American Indian women's group. Staff support culturally specific messages for the American Indian population to reduce exposure to secondhand smoke and continues to distribute Healthy Native Babies window clings with the smoke free home and car messages.

Grantees funded by the MDH Office of Minority and Multicultural Health to eliminate health disparities, including disparities in infant mortality, provide opportunities for technical assistance which is provided as needed.

WIC staff were encouraged to refer participants to Minnesota's QUITPLAN program and to provide information on protecting infants, children and pregnant women from secondhand smoke. WIC staff provided toolkits with resources on smoking cessation in pregnancy and postpartum, referrals to QUITPLAN and reducing secondhand smoke.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Access MN vital record, PRAMS and WIC databases for baseline incidence of smoking in pregnancy and ethnic/racial disparities			X	
2. Repeat and extend training for smoking cessation			X	X
3. Reach out to diverse community partners for training opportunities			X	X
4. Work with others within the OMMH and external partners, (ACOG and midwives) to identify strategies on effectively reaching high-risk populations				X
5. Integrate the "stop smoking" message with other health promotion messages targeted to young women			X	
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

MDH was awarded an 18 month Robert Wood Johnson/ASTHO grant to implement cross-divisional tobacco messages. This project utilizes QI tools and techniques to improve coordination by 50% to maximize departmental tobacco outreach activities in order to reduce the percentage of the public reporting secondhand smoke exposure by 25% in 3 years.

Staff work to promote the safe sleep campaign and SIDS risk reduction with the MN SID Center. Smoking cessation is integrated into messages. Twin Cities Healthy Start focuses on smoking reduction in pregnancy and secondhand smoke reduction to reduce infant mortality.

Staff presented MN PRAMS data about preconception tobacco use. This presentation led to a larger preconception health effort. Preconception health grants were made to local public health, clinics, and community non-profits which aim to improve preconception health in Minnesota. One area that grantees could address is decreasing tobacco use.

Staff in LHD continued to promote smoking cessation through family home visiting and other programs. Positive Alternatives grantees address smoking cessation as part of the pregnancy education that they provide to women. Staff provide technical assistance around the issue of preconception tobacco use to grantees. Tobacco use assessment will be incorporated into routine preconception health risk assessment that grantees will implement.

**c. Plan for the Coming Year**

Title V staff will continue to work with multiple partners to address smoking during pregnancy and postpartum and reducing pregnant women's, infants' and children's exposure to secondhand smoke.

MDH will continue implementation of the 18-month grant through Robert Wood Johnson Foundation and the Association of State and Territorial Health Officials (ASTHO). This grant provides an incredible opportunity to implement consistent cross-divisional tobacco messages. This project utilizes QI tools and techniques to improve cross-divisional coordination by 50 percent to maximize departmental tobacco outreach activities in order to reduce the percentage of the public reporting secondhand smoke exposure by 25 percent in three years. Many of the lessons that have been learned in this 18-month process will be implemented across divisions at MDH to continue to address tobacco messaging.

Staff will provide technical assistance around the issue of preconception tobacco use to grantees. Tobacco use assessment will be incorporated into routine preconception health risk assessment that grantees will implement.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	11	8.5	7.2	7.1	8
Annual Indicator	9.7	7.4	8.7	10.6	10.1
Numerator	36	27	32	39	37
Denominator	371683	366844	368101	367829	367830
Data Source		MN Vital Statistics	MN Vital Statistics	MN Vital Statistics	Estimates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	9	9	8	8	7.5

**Notes - 2011**

2011 data for this measure should be available by the end of June 2012, and will be submitted along with all other measures.

**Notes - 2010**

2010 Vital Statistics data will not be available until later in 2011. We are providing estimates.

**Notes - 2009**

Most recent Vital Statistics data available is 2008.

**a. Last Year's Accomplishments**

MDH administered suicide prevention grants out of state general fund dollars. MDH issued a Request for Proposals in February, 2010 to distribute the current allocation for suicide prevention grants. A total of \$196,000 was granted to three organizations to implement evidence-based suicide prevention programs, including statewide public awareness; a project to reduce access to lethal means for suicide; and a school-based program to reduce youth suicide. These projects began in June, 2010. Between June, 2010-December, 2011, nearly 1,500 people were trained in an evidence-based suicide prevention curriculum, including over 700 youth in Beltrami County who received gatekeeper training. Each 9th grade student in Beltrami County received gatekeeper training through a grant to that area, in addition to training for teachers and school staff. MDH provided ongoing technical assistance and oversight of the grant projects.

MDH provided technical assistance to individuals and organizations and held workshops at relevant meetings and conferences. For example, MDH staff provided assistance to a local school district that experienced a suicide cluster and helped a local task force in that area develop a series of informational community conversations about suicide and mental health. Information about suicide and suicide prevention was presented to Maternal and Child Health coordinators and public health nurses across the state and to professionals at a conference on teen parenting and pregnancy prevention. Staff was also responsive to local public health requests for information about suicide following a high profile death in Kandiyohi County and supported Carlton County's application for the SAMHSA Garrett Lee Smith Grant for Youth Suicide Prevention. MDH staff participates on the advisory committee for this SAMHSA grant.

Staff works with public and private partners in suicide prevention to improve outcomes for youth and young adults involved in various systems, including human services, corrections, child welfare and education. For example, the Suicide Prevention Coordinator presented information on trauma, mental health, suicide, and developing trauma-informed systems to a local, interdisciplinary child welfare collaborative in Washington County. Staff also participated in the child mortality review in which suicide deaths of children and youth involved with state mental health and child welfare service systems are discussed for the purpose of developing policy recommendations for prevention. Staff has also educated Minnesota National Guard chaplains about effective suicide prevention practices and promoted local collaboration between community-based mental health crisis teams (funded by the Department of Human Services) and local public health and other youth- serving agencies. These teams are a particularly valuable resource in rural areas, which often lack adequate mental health services.

The Suicide Prevention Coordinator served on the State Advisory Committee on Mental Health and the Children's Mental Health Subcommittee and collaborated with key partners at the Department of Human Services (DHS). MDH staff worked closely with the Department of Education (MDE) on bullying and suicide prevention, and participated on an advisory committee to provide advice and guidance as they prepared for the loss of a funding source for programs that promote safe and healthy schools. MDH also disseminated statistics to local media and other interested parties and provided educational materials to media outlets regarding how to report on suicide safely and appropriately.

In addition to our state level activities, some local public health agencies were also engaged in suicide prevention including Carlton County, Anoka County, Washington County, and Dakota County. County health departments participated on local mental health advisory committees (LACs) and mental health collaboratives to help create a coordinated system of care. In addition, county health departments play a critical role in the early identification of mental health problems

through a variety of programs, including Child and Teen Checkups, Family Home Visiting, WIC clinics, and others. Some departments also provide medication management services for clients with mental illness. In May, 2011, MDH attended a Policy Summit offered by SAMHSA on using health care reform to address disparities in behavioral health, and we expect to continue this work.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor and implement state suicide prevention plan			X	X
2. Technical assistance to public health and other community agencies				X
3. Participate actively on the Children's Subcommittee of the State Advisory Council on Mental Health				X
4. Support youth activities that support resiliency and healthy behaviors			X	X
5. Analyze student survey data to identify populations at high risk				X
6. Collaborate with public and private partners in suicide prevention			X	X
7. Implement and monitor suicide prevention grants		X	X	X
8. Implement statewide public education campaign for suicide prevention			X	
9. Educate and inform the public and key constituencies about suicide and suicide prevention			X	X
10. Local public health activities (screening, assessment, education)	X	X	X	X

**b. Current Activities**

The grants awarded in the previous year were continued for an additional 18 month cycle and will end on June 30, 2012. The same activities continue: public education messages will be disseminated to targeted communities, training will be provided on lethal means education, and gatekeeper training will be provided to youth and youth gatekeepers. A Youth Summit for Suicide Prevention will be held September 30 and October 1, 2012, sponsored by MDH through a grant to a local suicide prevention organization.

Staff promotes the use of evidence-based practices in suicide prevention and collaboration between public health and mental health systems. The Suicide Prevention Coordinator offers education and technical assistance and works closely with partners at DHS, the Department of Education, and other state agencies. For example, MDH, through state suicide prevention dollars, helped to finance the training of all mental health crisis teams in Minnesota in "Recognizing and Responding to Suicide Risk," a nationally recognized training program in clinical suicide risk assessment.

MDH is participating in the Community of Practice in Youth Suicide Prevention sponsored by the Child Safety Network. Program staff build capacity at the local level by disseminating information and resources and providing technical assistance. In April, 2012, MDH staff presented information to a local coalition on using social media for suicide prevention safely and effectively.

**c. Plan for the Coming Year**

MDH has been closely monitoring the development of an updated National Strategy for Suicide Prevention, and expects to begin planning for an updated state plan in the coming year based on the new national strategy.

In addition, the Youth Summit for Suicide Prevention will take place 9/30/12-10/1/12, and grant activities will continue through 6/30/13. There will be a targeted public awareness campaign in collaboration with the Mille Lacs Band of Ojibwe, ongoing gatekeeper training in Beltrami County, and ongoing training in lethal means education for health providers and mental health professionals. If state funding is continued beyond 6/30/13, a new RFP will be released or grants will be extended another term.

MDH is also engaged in a strategic planning effort with county public health leaders to articulate the local public health role in mental health, which includes promoting public health approaches to suicide prevention. MDH will continue to support the Carlton County Garret Lee Smith Youth Suicide project and serve on its advisory committee, and will continue to respond to requests for information and technical assistance from county public health agencies. Program staff will provide guidance and support to the various local coalitions and task forces that have emerged throughout the state in the last few years.

The Suicide Prevention Coordinator will also continue to provide suicide prevention education to a variety of audiences, including local coalitions, general audiences, nursing assistants, child psychiatrists, and others. Technical assistance will be provided, including intensive support and assistance following high profile suicide deaths. Efforts to educate the media around safe reporting for suicide will also continue.

The Suicide Prevention Coordinator will continue to work closely with colleagues in other state agencies, including MDE, DHS and the Minnesota National Guard. Staff will provide information and support to the Governor's Bullying Task Force, which has been requested based on the increased attention to the role of bullying in suicide among young people. Program staff will also continue to serve on the State Advisory Council on Mental Health and the Children's Mental Health Subcommittee, which anticipates developing recommendations around suicide prevention for schools during its next two year work plan (2012-2014).

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	87	84	87	87	88
Annual Indicator	85.6	85.5	85.6	83.0	83.5
Numerator	718	693	664	586	601
Denominator	839	811	776	706	720
Data Source		MN Vital Statistics	MN Vital Statistics	MN Vital Statistics	Estimates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	88	89	89	89	89

**Notes - 2009**

2008 is the most recent data available from MN Vital Statistics.

**a. Last Year's Accomplishments**

In 2010, the last final data available, 83 percent of very low birth weight infants (infants weighing 1,500 grams or less) were born in facilities appropriate for high-risk, very low birth weight (VLBW) deliveries. This represents a decrease from 2007-2009.

Title V staff continued to collaborate with four local organizations that focus on healthy pregnancy outcomes; The Minnesota Perinatal Organization, Twin Cities Healthy Start, the Minnesota March of Dimes, and the Minnesota Premature Infant Health Network. Activities included professional conference planning, technical assistance and training to service providers, policy development and implementation, and assistance with role and resource definitions.

Title V staff provided ongoing consultation and technical assistance to Twin Cities Healthy Start, an agency whose mission is to work with underserved populations at risk for very low birth weight (VLBW) infants. An on-line assessment tool (The Pregnancy Risk Overview) was utilized to assess risk factors among pregnant women and to refer them to an appropriate prenatal care facility dependent upon their level of risk for VLBW deliveries. Care management to promote improved birth outcomes incorporated referral to Level Three facilities for perinatal care and delivery.

Title V staff participated in the biannual Maternity Case Management Excellence regional meetings which included numerous paraprofessional and professional community partners.

Surveillance of very low birth weight infants as defined by the American Academy of Pediatricians (AAP) and the American College of Gynecologists (ACOG) born within the previous year continued.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide surveillance on identification of, appropriate referral, and birth outcomes at all Level III perinatal centers			X	X
2. Collaborate with MDH and external partners to address multiple barriers to timely referral and use of Level III perinatal centers			X	X
3. Support external community organizations' prevention and early identification efforts to improve birth outcomes through consultation and technical assistance			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Title V staff continue to explore opportunities for provider education focusing on early identification of high risk pregnancies and timely referral to the most appropriate perinatal facility. Additionally, MDH staff and community partners continue ongoing efforts to promote the use of current AAP and ACOG guidelines among care providers.

Staff worked with the Minnesota Department of Human Services to develop an evidence-based

policy related to elective inductions. Subsequently, Minnesota law was developed that Minnesota hospitals are asked to implement policies and procedures designed to minimize non-medically necessary inductions prior to 39 completed weeks gestation and to report induction of labor data for all births covered by Minnesota HealthCare programs.

The 2011 legislature formed a Prematurity Task Force that includes MDH staff and a wide range of stakeholders. The Prematurity Task Force provided a report regarding the current state of prematurity in Minnesota.

The African American community and the American Indian community both experience high infant mortality rates. A primary cause of death for African American infants is prematurity. African American and American infant mortality reviews have begun with the goal of identifying community and systems level changes needed to reduce infant mortality in both communities.

Staff provided content expertise related to infant mortality to applicants of the Eliminating Health Disparities Initiative grants in Minnesota.

**c. Plan for the Coming Year**

Title V staff will continue several of the activities undertaken in the previous year. Additionally, staff will work on the following projects.

Collaborate with MDH partners including the Office of Multicultural and Minority Health, the Office of Rural Health and Primary Care, local public health, and tribal entities to address geographic, cultural, language, health literacy, and social barriers to timely referral and use of Level III perinatal centers.

Collaborate with external community partners such as the March of Dimes, Twin Cities Healthy Start and the Minnesota Prematurity Task Force to support their prevention and early identification efforts targeting high risk pregnancies.

Participate in the final report to the Minnesota legislature from the Prematurity Task Force on recommendations for systems and community level changes that will effectively decrease prematurity in Minnesota.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures  
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective	88	87	87	88	88
Annual Indicator	85.8	85.6	85.9	86.3	86.3
Numerator	60085	60180	59342	59678	57975
Denominator	70020	70268	69085	69172	67206
Data Source		MN Vital Statistics	MN Vital Statistics	MN Vital Statistics	Estimates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	89	89	90	90	90

**Notes - 2010**

2010 MN Vital Statistics data will not be available until Fall, 2011; therefore, we have provided estimates for 2010.

**Notes - 2009**

2008 is most recent specific data available from MN Vital Statistics. Data listed for 2009 are general estimates based on overall MN trends.

**a. Last Year's Accomplishments**

Of all infants born in 2010, the most recent year final data available, 86.3 percent had mothers who received prenatal care in the first trimester. There has been relatively little variation in the percent receiving prenatal care in since 2005.

Title V staff work to create and promote models of care which focus on pregnancy intent, early identification of pregnancy, and initiation of comprehensive prenatal care. This was continued throughout last year with Title V staff providing outreach to external community partners, health plan representatives, local public health departments, and health care providers. Examples include Twin Cities Healthy Start and the Nurse-Family Partnership, two population-based models that provide intensive case management services for select populations described within the parameters of their respective programs. A continued focus on first trimester prenatal care, client/family education, and wraparound support for clients describe salient program components.

Title V staff continued to represent MDH on the executive committee of Twin Cities Healthy Start. Improving the rates of early and adequate prenatal care among African American and American Indian women continued as the committee's focus.

The Positive Alternatives Program continued to receive state grant funding and received technical assistance/consultation from Title V staff on infant sleep safety and smoking cessation during pregnancy. The Positive Alternatives Program staff encourages and facilitates early access to care including early pregnancy testing, access to state-funded insurance programs and prompt access to medical and prenatal health care.

The 2011 legislature formed a Prematurity Task Force that staff is participating in. The Prematurity Task Force will make recommendations to the legislature to mitigate factors that result in premature infants.

**Table 4a, National Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support activities that focus on primary health care, family planning, and medical homes for women				X
2. Continue involvement on the Healthy Start grant		X	X	
3. Partner with racial and ethnic communities to identify and implement strategies for improving early prenatal care		X		
4. Continue partnerships related to community health worker Program		X		X
5. Improve statewide universal and system capacity to provide perinatal mental health care				X
6. Continue TA to OMMH and their grantees on reducing infant		X		X

mortality				
7. Sponsor Preconception Conference				X
8.				
9.				
10.				

**b. Current Activities**

Title V staff worked with local communities to promote the importance of culturally appropriate, early prenatal care. The work has included addressing disparities at the local level as identified by community members.

The Prematurity Task Force provided a report regarding the current state of prematurity in Minnesota. This report was the first step to making recommendations to the legislature to mitigate factors that result in premature infants.

Use of the 2010 "Populations of Color Health Status Report" continues to guide Title V staff work throughout the year in addressing the issues of pregnancy intent, family planning, preconception care, primary health care and establishing a health care home; all issues that can impact timeliness of establishing prenatal care. Staff continues ongoing surveillance of PRAMS data as it helps guide strategic direction.

Title V staff are collaborating with MDH Office of Minority and Multicultural Health on an Eliminating Health Disparities Initiative (EHDI) grant that addresses infant mortality as the health priority focus. Community level dialogue guides the process; the Title V staff provides technical assistance and consultation on best practices and programs to improve birth outcomes, available data, and the life course perspective as related to infant mortality. Staff also provides content expertise regarding the EHDI grant RFP.

**c. Plan for the Coming Year**

Title V staff will continue several of the activities undertaken in the previous year. Additionally, staff will work on the following projects.

Explore potential barriers to first trimester prenatal care including mental health diagnosis and intimate partner violence for the purpose of improving women's preconception use of primary health care, family planning, and health care homes.

Together with partners on the Prematurity Task Force, recommendations will be made to the legislature regarding decreasing premature births. These recommendations will focus on community and systems level changes.

Support Twin Cities Healthy Start in their efforts to identify and refer women to first trimester prenatal care for the purpose of improved perinatal and post-neonatal outcomes among African American and American Indian women.

Collaborate with MDH partners and community agencies to engage community health workers across the state in promoting the message on the importance of early identification of pregnancy and first trimester prenatal care within their communities.

**D. State Performance Measures**

**State Performance Measure 1:** *Percentage of women who did not consume alcohol during the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					92
Annual Indicator			92.1	94.2	92.0
Numerator			61149	60940	59268
Denominator			66429	64719	64450
Data Source			MN PRAMS Survey	MN PRAMS Survey	Estimates
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	93	94	95	96	96

**a. Last Year's Accomplishments**

The MDH provides a grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). Through efforts supported by MDH, MOFAS has implemented a large public education campaign, "049", Zero Alcohol for Nine Months. This campaign provides a consistent and simple message about abstaining from alcohol during pregnancy.

WIC staff are trained to screen for alcohol use in pregnant women. Women identified as using alcohol during their pregnancy are advised to quit and educated about the potential risks of drinking during a pregnancy. Identified women are referred to community resources for additional treatment and assistance.

Title V staff provide training and technical assistance to local health departments (LHDs) and family home visiting staff around the issue of alcohol use during pregnancy.

Title V staff have been using PRAMS data to conduct surveillance for alcohol use during pregnancy. PRAMS data demonstrates that reported alcohol use during the last trimester of pregnancy has increased among White women as compared to populations of color. Older mothers (over 35 years of age) and women not on WIC or public assistance also report a slightly higher use of alcohol during their last trimester of pregnancy. PRAMS data about preconception alcohol use was presented at the University of Minnesota Powell Center for Women's Health conference

The Fetal Alcohol Spectrum Disorders -- Regional Network (FASD-RN) is a group of local children's mental health collaboratives and chemical health action groups that are working to eliminate fetal alcohol spectrum disorders. MCH staff from local health departments serve as members of this group.

The Minnesota Network for Families and Recovery through Education, Support and Healing brings together providers of chemical health services with the goal of improving substance abuse services for women and children through collaboration and sharing best practices.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Minnesota Organization on Fetal Alcohol Syndrome to promote the message of alcohol abstinence during pregnancy			X	
2. Identify systems of care in Minnesota as it relates to maternal alcohol use				X
3. Utilize PRAMS data to continue to assess alcohol use during				X

pregnancy				
4. Explore evidence-based programs that target alcohol use during pregnancy			X	X
5. Partner with staff from the Birth Defects Surveillance Unit at MDH to assess best practice related to alcohol use during pregnancy and collaborate on outreach and prevention			X	X
6. Support preconception health efforts planned within the Department of Health and with other community partners			X	
7. Provide technical assistance to Preconception Health in Minnesota and Positive Alternatives grantees around the issue of preconception alcohol use and alcohol use during pregnancy			X	
8.				
9.				
10.				

**b. Current Activities**

MDH continues to partner with MOFAS to promote the "049" message to women and health care providers. MOFAS expects to deliver 575,009 "impressions" to health care providers during this campaign. The same "049" message will be delivered to women ages 18-30. The campaign uses social media, outdoor boards, posters, and give-aways.

Title V staff work with the Birth Defects Surveillance Unit; which has been doing work around the issue of birth defects prevention. Nationally, one infant in 100 is born with a disability from prenatal alcohol exposure making it more prevalent than autism or Down Syndrome. In collaboration with the Birth Defects Surveillance Unit, preconception health grants will be provided to local agencies serving women of reproductive age. As part of the grants, women will be assessed for their alcohol use and be connected to resources if a problem is identified.

MDH received a federal grant to support college-level student parents. One of the activities of the grantees is to provide screening for pregnant and parenting students. MDH staff will provide support and technical assistance to grantees on this activity.

**c. Plan for the Coming Year**

For the upcoming year, Title V staff will continue to work collaboratively MOFAS. MDH will support MOFAS' message of "049" campaign by providing MOFAS material to local grantees and other community organizations requesting this information.

Title V staff will continue to support preconception health efforts supported by the MDH and other community partners. Title V staff will continue to provide technical assistance around preconception alcohol use to grantees of the Preconception Health in Minnesota grants. Title V staff will also provide technical assistance to Positive Alternatives grantees and local family home visiting staff around FASD and alcohol use during pregnancy.

The Young Student Parent Support Center Initiative grantees will conduct screening on college campuses at parent support centers. These screenings will primarily target students who are pregnant or are parenting young children.

**State Performance Measure 2:** *Percentage of children enrolled in Medicaid who receive at least one recommended Child and Teen Checkup (C&TC) visit (EPSDT is known as C&TC in Minnesota).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2007	2008	2009	2010	2011
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<b>Data</b>					
Annual Performance Objective					72
Annual Indicator				72.2	68.5
Numerator				198808	200035
Denominator				275509	292068
Data Source				DHS Medicaid data	2010 DHS data
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	72	74	74	75	75

**Notes - 2011**

Data presented is 2010 data. There was a delay in MN Dept. of Human Services receipt of claims data from managed care organizations due to a HIPPA required upgrade in the format of data being transferred from MCOs to DHS.

**Notes - 2010**

Methodology for this measure has changed. Calculations only include children who have been enrolled in Medicaid for at least 90 continuous days. Therefore, the 2010 annual indicator is not directly comparable to percentages reported in previous years. Using the old methodology, the percentage for FFY 2010 would be 70.0% 205,176/293,777

**a. Last Year's Accomplishments**

The Title XIX EPSDT program in Minnesota is called Child and Teen Checkups (C&TC). The percent of C&TC eligible infants, children and adolescents who received at least one preventive health visit was 72 percent in 2010 compared with 70 percent in 2009. It is estimated this number will remain the same for 2011.

Under contract with the Department of Human Services (DHS), MDH staff offered an extensive schedule of C&TC trainings on best practices in well child health screening exams to public and private providers of childhood screening and health care. Participants included public health nurses, school nurses, private health care providers, C&TC outreach coordinators, managed care health plan representatives, and other child health screeners. On-site follow-up consultations by MDH staff (pediatric nurse practitioners) were conducted for public health nurses newly trained to provide comprehensive C&TC screening services. MDH staff continue to revise and update several resources available online for providers, including e-learning trainings and fact sheets, that provide further information about each required component of the C&TC screening exam. MDH staff also provides C&TC education to graduate and undergraduate students (nursing, medicine).

Staff promote frequent and comprehensive C&TC visits through trainings, regional meetings and data monitoring. Staff collaborates with MDH Family Home Visiting and the MDH Part C Coordinator to provide joint training for local public health, education, social services, and other providers on social-emotional development, with information on developmental and mental health screening recommendations and referral resources.

The Interagency Developmental Screening Task Force, which is a partnership between the Title V program, DHS, the Department of Education (MDE), University of Minnesota, and the Minnesota Head Start, continues to provide updates to the statewide recommended pediatric developmental and social-emotional screening instruments for Minnesota public programs, such as C&TC and Head Start. ([www.health.state.mn.us/divs/fh/mch/devscrn](http://www.health.state.mn.us/divs/fh/mch/devscrn)).

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>
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	DHC	ES	PBS	IB
1. Continue to provide education, training, and technical assistance on the multiple components of C&TC as a joint activity with DHS				X
2. Develop, implement and promote quality improvement initiatives for child health in partnership with public and private organizations focused on pediatric health care			X	X
3. Maintain and enhance partnerships with other organizations that are working to assure optimal child and adolescent health care		X	X	X
4. Assess the needs of public and private providers of C&TC screening services and provide training, education, and technical assistance around identified needs		X	X	X
5. Promote evidence-based best practices in child and adolescent health care		X	X	X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

MCH staff continues to collaborate with DHS to provide training and technical assistance to C&TC providers to increase client participation and assure quality preventive health services. Staff continues to partner with the MN Chapter of the American Academy of Pediatrics, DHS, and MDE to provide technical assistance to the MN Child Health Improvement Partnership's (MnCHIP) second quality improvement project, Minnesota's ABCD III Project: Communities Coordinating for Healthy Development. The purpose of this project is to improve linkages between primary care providers, medical specialists, and other child and family service providers to support the healthy development of Minnesota's children ages birth through 3 years.

MCH staff are members of the Minnesota Community Measures (MNCM) Pediatric Preventive Care Measure Workgroup, which was convened in September 2011 to review, select and/or develop pediatric preventive quality care measure(s) for clinics and health care providers across the state. Workgroup members represent medical providers, clinic administration, quality improvement professionals, interested consumers and public health agencies. Several measures are under consideration, such as adolescent depression screening, immunizations, BMI, etc.

**c. Plan for the Coming Year**

Staff will continue to review and evaluate current literature as well as key resources such as Bright Futures to develop recommendations for C&TC health supervision of infants, children, and adolescents that reflect evidenced-based practice.

Staff plans to convene a best practices workgroup to review recommendations for hearing screening for children birth to 21 years of age.

Title V staff serve on the MnCHIP advisory group and will continue to provide technical assistance and consultation to C&TC providers as needed on the MN ABCD III: Communities Coordinating for Healthy Development quality improvement project.

Staff continues to revise the online C&TC e-learning trainings for the following topics: hearing screening, vision screening, developmental and social-emotional screening, oral-dental health screening, lead screening, and introduction to EPSDT. Other web resources will be updated as needed, including recommendations from Minnesota's Interagency Developmental Screening

Task Force.

Staff will continue to assess the education/training needs of C&TC providers to assure high quality and culturally appropriate services.

**State Performance Measure 3:** *Percentage of MN children birth to 5 enrolled in Medicaid who received a mental health screening using a standardized instrument as part of their C&TC visit (EPSDT is known as C&TC in Minnesota).*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					3
Annual Indicator				2.7	1.6
Numerator				3733	2193
Denominator				137487	133029
Data Source				DHS Medicaid data	DHS Medicaid data
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	3.3	3.5	3.8	4	4

**Notes - 2010**

2010 data will remain provisional until January 2012.

Source is MN Health Care Programs paid claims and encounter data from the DHS Data Warehouse.

Note: it is possible that the mental health screening took place outside of the C&TC visit for a given child.

**a. Last Year's Accomplishments**

The Title XIX EPSDT program in Minnesota is called Child and Teen Checkups (C&TC). The percentage of MN children birth to 5 enrolled in Medicaid who received a mental health screening using a standardized instrument as part of their C&TC visit was 2.7%.

Title V staff worked closely the past year with Children's Mental Health Services (CMHS) and Child and Teen Checkups at the Minnesota Department of Human Services (DHS) to promote mental health screening.

DHS was one of five grantees in the Assuring Better Child Development III (ABCDIII) grant activity funded by the Commonwealth Fund and administered by the National Association of State Health Policy (NASHP). This project builds upon previous developmental and mental health initiatives (ABCDII and ABCD Screening Academy) and focuses on supporting quality improvement in developmental and mental health screening at three different levels: primary care, community child and family service providers, and across statewide systems. The purpose of the ABCDIII is to improve linkages between primary care providers, medical specialists, and other child and family service providers to support the healthy development of Minnesota's children ages birth through 3 years. The project has already increased awareness of Minnesota's statewide Help Me Grow (early intervention) online and phone referral system and the Minnesota Parents Know website. Title V staff have participated in training and learning collaborative activities with participating pilot sites, provided technical assistance, and participate in ABCDIII project subcommittee meetings.

Title V staff conducted numerous trainings throughout the state for primary care providers on the recommendations for developmental and mental health screening for children. These trainings include regularly occurring full-day trainings in collaboration with Family Home Visiting and MDH's Party C/Early Intervention Coordinator, in which recommendations and resources for developmental and mental health screening are provided across the state to public health, education, social service, and other providers of services to children. Additionally, staff has provided technical assistance to clinics wanting to implement developmental and mental health screening.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide education, training, and technical assistance on mental health screening for providers seeing children and adolescents enrolled in C&TC				X
2. Develop, implement, and promote quality improvement initiatives (e.g. ABCDIII) in mental health screening for children and adolescents in partnership with public and private organizations focused on pediatric health care			X	X
3. Maintain and enhance partnerships with other agencies and organizations that working to assure optimal children and adolescent mental health		X	X	X
4. Promote evidence-based best screening practices in child and adolescent mental health		X	X	X
5. Participate in workgroups to determine C&TC recommendations for mental health surveillance and screening		X	X	X
6. Continue to collaborate with Children's Mental Health Services with the Minnesota Department of Human Services				X
7.				
8.				
9.				
10.				

**b. Current Activities**

As part of an interagency agreement with DHS, Title V staff continue to provide training and technical assistance to C&TC providers (physicians, nurse practitioners, public health nurses, etc.) on developmental and mental health screening recommendations and referral resources. These trainings include grand rounds presentations, clinic-based "lunch and learns", as well as customized trainings based on the needs of the requesting providers.

As members of Minnesota's Interagency Developmental Screening Task Force, staff continues to conduct epidemiologic reviews of mental health and developmental screening instruments for children birth to 5 years; present findings to the Task Force; maintain the website with recommendations; and develop related e-learning modules and other trainings.

In their participation on the Minnesota Community Measures (MNCM) Pediatric Preventive Measures Workgroup, Title V staff is raising developmental and mental health screening as an important preventive measure to consider for adoption by MN health care providers.

**c. Plan for the Coming Year**

Title V staff plans to continue to collaborate with DHS and MDE on the ABCDIII project (ending October 2012); provide training, technical assistance, and consultation as needed to the pilot sites; and develop a plan for spread and sustainability. This plan includes a developmental and

mental health screening toolkit, designed to provide logistical help to improve linkages between healthcare providers, educators, and the community for children who are identified with developmental or mental health concerns.

Additionally, Title V staff will continue to promote mental health screening as a component of the C&TC screening exam through in-person and online trainings. As state mental health screening surveillance and screening recommendations are determined by DHS's Children's Mental Health and Child and Teen Checkups staff, Title V staff will provide education, training, and technical assistance to providers.

**State Performance Measure 4:** *Incidence rate of child maltreatment reports per 1,000 children ages birth through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					12
Annual Indicator			12.1	12.1	10.8
Numerator			16905	16905	15102
Denominator			1402406	1402406	1402406
Data Source			DHS Data Warehouse	DHS Data Warehouse	DHS Data Warehouse
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	11.5	11	10.5	10	10

**Notes - 2011**

2011 data is not yet available for this measure. It should be available by the end of June 2012.

**a. Last Year's Accomplishments**

Based on the most current data available from the Minnesota Department of Human Services, the incidence rate of child maltreatment has decreased from 12.1 per 1000 in 2010 to 10.8 per 1000 in 2011.

Minnesota's Family Home Visiting (FHV) statute supported with Temporary Assistance for Needy Families (TANF) and Maternal, Infant and Early Childhood Home Visiting Program (MIECHV) funds provided financial, technical assistance and training support to local health departments (LHD) and Tribal Governments. Funding and related activities support family home visiting services to pregnant and parenting families with identified risk factors including risk for child maltreatment. The FHV Evaluation Plan identified measurable outcomes for the FHV program including an indicator on the incidence of child maltreatment.

The MDH convened a new FHV Committee, a work group of the MDH Maternal and Child Health Advisory Task Force, to provide direction and guidance to the Commissioner of Health and MDH staff on issues related to the expansion and integration of evidence-based public health home visiting programs in Minnesota's health and early childhood systems. Evidence-based home visiting programs (i.e., Healthy Families America and Nurse-Family Partnership) focus on and have demonstrated a reduction in child maltreatment.

Trained MDH staff coordinated and provided ongoing NCAST Parent Child Interaction trainings for nurse home visitors across the state. A new MDH FHV consultant was certified to provide

NCAST training.

This same new consultant was also certified as a Nurse-Family Partnership (NFP) state consultant. One of the goals of the NFP model is to improve child health and development and reduce child maltreatment by helping parents provide responsible and competent care. Two MDH nurse consultants provided consultative and technical support to NFP sites to assure implementation of the model with fidelity.

A third MDH nurse consultant completed certification as a trainer of Integrated Strategies, an approved curriculum for Healthy Families America (HFA). An MDH health educator has completed steps toward becoming certified as a trainer in Growing Great Kids, another approved curriculum for HFA. Both trainings were delivered statewide to home visitors becoming certified as HFA-implementing sites.

FHV staff delivered a number of statewide trainings and provide consultation to groups and conferences to promote early social and emotional development, safe and secure parent-child relationships, and trauma-informed care, all foundational to the prevention of child maltreatment.

The 2009 Administration of Children and Families (ACF) grant to support evidence-based home visiting to prevent child maltreatment was combined with the MIECHV Program. The goal is to enhance, expand and sustain evidence-based home visiting programs by supporting infrastructure development and the implementation of the NFP and HFA models among population groups experiencing health disparities. In addition, mini-grants were disseminated to NFP-implementing sites to support start-up and training costs.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify and participate in opportunities to provide surveillance, identify and disseminate best practices and develop policies to reduce maltreatment				X
2. Continue involvement Child Death Review Panels				X
3. Develop/update and distribute Infant Death Investigation Guidelines			X	X
4. Disseminate strategies for prevention of child maltreatment i.e., home visiting		X		X
5. Continue to provide NCAST training			X	X
6. Continue to educate parents and other caregivers on prevention of abusive head trauma (Shaken Baby Syndrome)				X
7. Continue to promote education of parents and other caregivers on Safe Infant Sleep		X		
8.				
9.				
10.				

**b. Current Activities**

FHV staff implement training and evaluation plans and provided support to supervisors and staff in LHDs and Tribal Governments on reflective supervision, motivational interviewing, relationship based practice, and comprehensive assessment and care planning. The FHV website continues to be updated.

Staff are implementing the final ACF plan (now rolled into the MIECHV Program) to build capacity for evidence-based home visiting programs in Minnesota via infrastructure development and implementation of the NFP and HFA models among a population group(s) experiencing health

disparities not previously included in NFP randomized trials. FHV staff trained in the NFP model provide consultation and support to Minnesota's NFP home visiting projects to maintain model fidelity. Staff continue to provide NCAST PCI trainings and supporting the use of the PCI scales by trained county and tribal public health FHV nurses.

MDH partners with the SID Center to reduce infant mortality. The Center communicates with coroners and medical examiners, encouraging use of MN Infant Death Investigation Guidelines to improve diagnosis of sudden unexpected infant deaths.

Title V staff participates on the DHS Child Mortality Review Panel, making recommendations for systems changes. MCH staff provides technical assistance to the Infant Mortality Community Action Team regarding safe infant sleep in the American Indian population.

The MDH continues to convene the FHV Committee.

**c. Plan for the Coming Year**

MDH will be implementing the work plan for the competitive MIECHV expansion grant and evaluation plan with the University of Minnesota, as well as continue all activities as described above.

**State Performance Measure 5:** *The number of children enrolled in the Follow-Along Program.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					33000
Annual Indicator				32820	30120
Numerator					
Denominator					
Data Source				Follow-Along Program	Follow-Along Program
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	33000	33250	33250	33500	33550

**Notes - 2011**

The number entered is the sole indicator for this measure. There is no numerator or denominator.

**Notes - 2010**

There is no denominator for this performance measure

**a. Last Year's Accomplishments**

The CYSHN program had an interagency agreement with the Minnesota Department of Education (MDE) for the provision of child find and public awareness/outreach activities to assure that children with special needs are identified early and receive appropriate and timely services. These are activities pursuant to relevant provisions in Part C of the federal Individuals with Disabilities in Education Act (IDEA). Many of the child find and public awareness responsibilities in Minnesota's early intervention system, known as "Help Me Grow", are carried out through the Follow Along Program (FAP). The FAP provides periodic screening and monitoring of infants and toddlers at risk for health, social emotional or developmental problems. It improves the identification of developmental and mental health issues at an early age, facilitates early intervention services for the child and links families and children to needed services. The FAP is

funded through Title V and Part C of IDEA at the state level and through a combination of Part C, Title V and local funds at the local level.

FAP is offered to families as a way to track the development of their children and to learn about typical growth and development. The Ages and Stages Questionnaire (ASQ-3) and the Ages and Stages Questionnaire -- Social Emotional (ASQ-SE) are the screening tools utilized by the FAP. Families of children enrolled in the program typically receive the ASQ at the following intervals: 4, 8, 12, 16, 20, 24, 30, and 36 months. Families may also receive the ASQ-SE at: 6, 12, 18, 24, 30 and 36 months. There are 15 programs that extend their FAP to the 42, 48 and 60 month intervals. Several of the FAP agencies have also added the new 2 month ASQ-3 interval. Ongoing training is provided to local public and private agencies (primarily local public health) on administration of and implementation of the FAP. Sixty-eight of Minnesota's 87 counties and one tribal reservation offer the Follow-Along Program universally to all children birth to three years of age that are residing in their jurisdiction (without regard to the presence of risk factors known to adversely affect development). Sixteen counties/tribal reservations currently offer the FAP to high-risk children. Only three counties do not provide FAP services to families of young children.

As of July 1, 2011, Minnesota local Interagency Early Intervention Committees (IEIC) were restructured into 12 regional groups. During this period, many of the local public health departments did not receive specific Part C funding for their FAPs. The majority of FAPs were able to sustain their current level of programming by shifting other funding sources. The local commitment to FAP is impressive and unwavering across the majority of the state.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical support to local public health agencies participating in the program				X
2. Support advisory group to guide implementation of program enhancements				X
3. Integrate social emotional component into all screening programs			X	X
4. Convene regional FAP Coordinators Meetings				X
5. Analyze program data & disseminate written report			X	X
6. Provide statewide training on reimbursement and funding sources, effective screening, assessment and intervention			X	X
7. Train professionals including FAP coordinators and Human Services professionals on ASQ-SE				X
8. Collaborate and coordinate FAP activities with other state agency initiatives involving developmental screening including social-emotional screening of young children				X
9. Continue developmental and social-emotional screening of children 0-3 as an outcome measure for the Local Public Health Grant Activity			X	X
10. Support Community Health Board use of federal Title V funds for this activity	X			

**b. Current Activities**

Children enrolled in the FAP as of December 31, 2011 total 30,120 children (21,926 - Birth to 3 and 8,194- 3 to 5). The CYSHN program continues to provide statewide technical assistance to FAP agencies, as well as printed ASQ-3 and ASQ-SE screening questionnaires. Minnesota's Part C system underwent a significant IEIC restructuring in 2011 which decreased the number of local IEICs from 95 to 12 regional committees. The restructuring efforts led to a redistribution of Part C funding, which has caused much concern for the sustainability of the FAP. Four local public

health departments have discontinued their FAP within the past year. There are currently 7 counties not offering FAP, although, one tribal reservation has implemented a new FAP within the past year. Several counties added screening intervals to their FAP specifically for children who were receiving Part C services until 36 months and did not qualify for Part B services.

CYSHN staff are surveying all FAP agencies on current procedures to evaluate the program consistency and to develop state-level program guidelines for all FAP agencies to consider adopting. Strategies for utilizing existing funding sources and the possibility of aligning new funding sources to support the state-level FAP program guidelines will be explored.

### **c. Plan for the Coming Year**

The current two-year Part C interagency agreement with the MN Department of Education and CYSHN will expire on June 30, 2013. Beginning in early 2013, CYSHN will work with MDE to identify our continued coordination of the FAP as a state-level Part C public awareness and child find strategy. The FAP is significantly intertwined with several public health programs in many of the local public health departments, such as family home visiting, Child & Teen Checkups and WIC -- all of which support the Part C system in Minnesota.

There is a great variation in program administration among the 83 FAP agencies across the state. As previously noted, some FAP agencies offer the program universally to children in their jurisdiction and others offer it only to their high-risk populations. Some FAP agencies are currently offering fewer than the supported ASQ screening intervals and none of the ASQ-SEs, or they offer a minimal number of ASQ-SEs. The level of support and offering of a local FAP has historically been an agency-by-agency decision dependent on agency capacity. However, there is a need at the state level to assure a standard level of consistency of FAP implementation across the state so that early childhood partners are able to include the FAP in their planning and referral processes.

CYSHN will continue to provide technical assistance and support to the FAP agencies so they may provide periodic screening and monitoring of infants and toddlers at risk for health, social emotional or developmental problems. As a result of the statewide FAP survey to analyze the current variability of program procedures, CYSHN staff will develop state-level program guidelines to be used as a model for all FAP agencies to adopt. Data definitions and input consistency of specific data fields will also be developed in order to assure there is reliable and valid data collected at a state level. Strategies for utilizing existing funding sources and the possibility of aligning new funding sources to support the state-level FAP program guidelines will be explored.

Minnesota received a federal Early Learning Challenge grant of \$45 million for 2012-2015 to support a plan to improve results for children and build capacity and accountability into our early learning system. One of the grant activities is to increase access and improve delivery of developmental screening for children birth -- 36 months. Over the next four years, the MN Department of Education will develop an on-line ASQ-3 and ASQ-SE screening and referral system that will be available to all parents in Minnesota. This system will be developed with input from the MN Interagency Developmental Screening Task Force (which includes staff from MCH/CYSHN). It is the goal of CYSHN staff to assure that the FAP is recognized as an early step in the screening process if parents have concerns about their child's development or there is a failing score on an ASQ-3 and/or ASQ-SE.

**State Performance Measure 6:** *Percentage of children under the age of one year participating in early intervention through Part C of the Individuals with Disabilities Education Act.*

### Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					0.9
Annual Indicator			0.7	0.9	0.9
Numerator			543	629	597
Denominator			73019	68407	68407
Data Source			IDEA data	IDEA data	IDEA data
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	1	1.1	1.2	1.2	1.2

**a. Last Year's Accomplishments**

The MN Department of Education (MDE) is the lead agency for the state's Part C of IDEA program. CYSHN has an interagency agreement with MDE to provide state-level, interagency coordination of Part C activities and to assure technical assistance and support are provided to local providers working with infants and toddlers and their families. Minnesota's Part C program served 629 out of 69,009 (or .91%) infants under the age of one year in 2010; the last year final data is available.

Specific priority areas for CYSHN's interagency collaboration included the identification of strategies to provide early intervention services to premature infants and infants diagnosed with a condition or disorder that has a high probability of resulting in a developmental delay. Through this priority area, staff provided educational opportunities for health care providers, including NICU staff, as well as medical and nursing students, on the Part C referral, eligibility and services available to children with high probability conditions. This strategy helped to assure that infants are referred to Part C as soon as a potential developmental concern is identified.

Staff provided technical assistance and support to the local public health agencies that provide the Follow Along Program (FAP), which is a means of tracking at-risk children and referring them to Part C or other community services as appropriate. In 2010, there were 8,172 children between 0-12 months of age enrolled in the FAP, which provided an efficient means of referring a child to Part C as soon as a developmental concern is identified.

Minnesota's Part C system was restructured from 95 local Interagency Early Intervention Committees (IEIC) to 12 regional IEICs during this period. One of the goals of restructuring was to assure consistency and standardization of child find and public awareness strategies at a regional level. Local public health partners are mandated representatives on the regional IEICs and have continued to represent the interagency commitment of supporting infants and toddlers and their families through local public health programs, such as FAP, C&TC, WIC, and Family Home Visiting. CYSHN staff served on the state team assigned to all regional IEICs during the restructuring and assisted each IEIC in developing the process to scan and evaluate current child find and public awareness strategies.

Prior to the restructuring, Minnesota established a statewide identity and referral system for its Part C and Part B program called Help Me Grow. A component of this system was the development of an on-line referral portal and a toll-free phone number to make it easier for primary referral sources, especially physicians, to make referrals to Help Me Grow. The numbers of monthly statewide referrals doubled during this period, from 110 referrals in September 2010 to 235 referrals in September 2011 (80 percent of these referrals were from health care providers).

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Participate in state-level collaborative activities designed to enhance the Part C statewide system of services for all young				X

children and families				
2. Provide outreach and education to health care providers on Help Me Grow referral, eligibility and services		X	X	X
3. Provide technical assistance and support to the FAP agencies to maintain one of the leading child find strategies in the state		X	X	X
4. Serve as a technical resource for NICUs and special care nursery staff to assure there is a standardized process for referrals to the Part C system				X
5. Provide ongoing training and updated information to local public health departments regarding the IEIC restructuring process and Help Me Grow central points of intake for Part C referrals			X	X
6. Assure that state and local public health activities that enhance Part C child find strategies are included in the development of regional IEIC work plans				X
7. Partner with state agencies to develop/make available appropriate early childhood typical developmental and mental health information for primary referral sources and families			X	
8.				
9.				
10.				

**b. Current Activities**

Minnesota's Part C program estimates it served 597 infants under the age of one year in 2011, which is a decrease from 2010. Two significant changes have occurred that has placed additional emphasis on the state's Part C program and its consistency across the state; restructuring of the IEICs and the federal 2011 Part C regulations.

The restructuring of the state's IEICs went into effect on July 1, 2011, which identified 12 regional interagency entities to continue the Part C policy and procedure development. Many of the previous 95 IEICs have disbanded since the restructuring, which has led to a decrease in networking and coordination at a local level. New communications strategies are being developed to assure that public health partners are provided information on regional events and activities.

CYSHN staff continues to support the efforts of the statewide FAP which is a leading Part C child find strategy in many counties. CYSHN staff are surveying all FAP agencies on current program procedures to evaluate the consistency of the programs' ability to identify infants and toddlers that should be referred to the Help Me Grow system.

The 2011 Part C regulations will go into effect on July 1, 2012. Two areas that may impact the number of infants birth -- 12 months that are eligible for early intervention services are: 1) the addition of a screening process to the referral process and 2) the use of informed clinical opinion as an independent basis for determining eligibility.

**c. Plan for the Coming Year**

The current two-year Part C interagency agreement with the MN Department of Education and CYSHN will expire on June 30, 2013. Beginning in early 2013, CYSHN will work with MDE to identify our continued state-level Part C coordination efforts and contributions to the identification of and implementation of effective child-find strategies and activities. These efforts will include continued outreach to the health care providers (including local public health departments) to assure a uniform referral process with the medical and health community across the state to the Help Me Grow system will also continue.

CYSHN will continue to provide information and educational/training opportunities for health care

professionals and other primary referral sources about Help Me Grow referral processes, eligibility and services. Staff will work closely with statewide NICUs, family practice physicians and pediatricians to assure that the Help Me Grow referral system meets the needs of medical providers thereby increasing the likelihood of future referrals.

CYSHN will continue to provide technical assistance and support to the FAP agencies so they may provide periodic screening and monitoring of infants and toddlers at risk for health, social emotional or developmental problems. As a result of the statewide FAP survey to analyze the current variability of program procedures, CYSHN staff will develop state-level program guidelines to be used as best practice for all FAP agencies to adopt. Data definitions and input consistency of specific data fields will also be developed in order to assure there is reliable and valid data collected at a state level. Strategies for utilizing existing funding sources and the possibility of aligning new funding sources to support the state-level FAP program guidelines will be explored.

There are several other contributions to effective child find strategies coordinated by state and local public health agencies, such as WIC, family home visiting and Child and Teen Checkups (EPSDT). CYSHN will work to assure all public health programs are aware of the Help Me Grow referral process, eligibility and services to assure that families with infants are referred to Help Me Grow as soon as a developmental concern is identified.

CYSHN staff will continue to serve on the Minnesota Task Force on Prematurity, which will be evaluating the new guidelines for discharging late preterm infants (34 to 36 weeks completed gestational age). A component of the discharge checklist is to assure that appropriate referrals are made to family home visiting, WIC and early intervention services.

**State Performance Measure 7:** *Percentage of participants in Minnesota's family home visiting program referred to community resources that received a family home visitor follow-up on that referral.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					79
Annual Indicator			83.0	77.0	81.6
Numerator			16104	9763	10498
Denominator			19396	12674	12870
Data Source			MDH Home Visiting Program	MDH Home Visiting Program	MDH Home Visiting Program
Is the Data Provisional or Final?				Final	Provisional
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	80	82	84	85	85

**a. Last Year's Accomplishments**

Minnesota' family home visiting (FHV) program promoted referrals to community resources as well as family home visitor follow-up contacts on those referrals. In 2010 77 percent of FHV participants referred to a community resource received a follow-up on that referral. That number increased to almost 82 percent in 2011. Effective interventions included early identification and referral to community resources for problems related to meeting basic family needs of food, shelter, clothing, health care and safety. FHV program staff also collaborated and participated in

cross-departmental and interagency systems planning (i.e., public health, housing, human services) to facilitate effective referrals.

Evidence-based home visiting (EBHV) models such as Nurse-Family Partnership (NFP) and Healthy Families America (HFA) promoted referrals to community resources and required the collection of related data constructs to ensure model fidelity. For example, agencies implementing NFP collected data on maternal referrals at every visit. Also, the number of completed referrals was documented in each client's chart.

MDH FHV staff provided statewide capacity-building support to local public health agencies for EBHV models and best practices that include referrals and follow-up. Activities included consultation, NFP mini-grants to agencies for start-up and training costs, training, reflective supervision and technical assistance on data collection and analysis.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide support to local health departments implementing family home visiting programs Participate in interagency planning to assure awareness of services for families	X			X
2. Support implementation of evidence-based FHV models and best practices through training				X
3. Provide consultation on implementation of evidence based models				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Minnesota' family home visiting (FHV) program will continue to promote referrals to community resources as well as family home visitor follow-up contacts on those referrals and will collaborate and participate in cross-departmental and interagency systems planning (i.e., public health, housing, human services) to facilitate effective referrals.

Training and consultation provided to FHV programs will continue to promote evidence-based home visiting (EBHV) models such as Nurse-Family Partnership (NFP) and Healthy Families America (HFA) that promote referrals to community resources and require the collection of related data constructs to ensure model fidelity.

MDH FHV staff provide statewide capacity-building support to local public health agencies for EBHV models and best practices that include referrals and follow-up. Activities include consultation, NFP mini-grants to agencies for start-up and training costs, training, and technical assistance on data collection and analysis.

**c. Plan for the Coming Year**

MDH will continue to promote referrals and follow-up at the local level by maximizing FHV funding opportunities including TANF (Temporary Assistance to Needy Families) and the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program. As funding allows, MDH staff will continue to provide consultation, NFP mini-grants to agencies for start-up and training costs,

MIECHV program grants for HFA and NFP, training, and technical assistance on data collection and analysis.

**State Performance Measure 8:** *Percentage of children and youth with special health care needs who have received all needed health care services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					89
Annual Indicator				87.1	79.7
Numerator				154701	138259
Denominator				177668	173551
Data Source				2005-06 CSHCN Survey	2009-10 CSHCN survey
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	79	82	82	85	85

**a. Last Year's Accomplishments**

The CYSHCN Survey indicates in 2005 that 12.9% of the CYSHCN in Minnesota have at least one unmet need for health care or related services versus 20.3% in the 2009/10 survey. Children and youth with a medical home are significantly less likely to have any unmet health and related service needs. So we continue to support the work of the Health Care Home Section to certify clinics as health care homes and increase their capacity to serve CYSHN and their families. To qualify, a clinic must provide 24-hour access, maintain a method of tracking patient health histories, monitor and report the clinic's quality performance, and provide care planning and coordination to patients including children with special health needs.

MDH has certified over 170 health care homes and 1,764 clinicians. These providers care for over 2 million Minnesotans. In addition, the department is committed to supporting health care homes as the crucial delivery model of a new health system. In this practice, model health care is integrated at the primary care site for all medical care. Even beyond these health care services, health care homes are the right partners to integrate medical and community services to provide care for the people and families we serve. There is promising evidence that the health care home approach is making better health easier for all Minnesotans to achieve by improving the quality of primary care clinics and reducing costs. Title V HCH District Consultants and other Title V staff continue to provide technical consultation and assistance to those practices seeking certification as health care homes

Learning collaboratives continue to provide a means for primary care clinics to learn best practices and share with other providers what works so they can quickly implement them into their practice. As a result of the EHDI and Autism and Other Developmental Disabilities Learning Collaborative, many of the partnerships continue to work on spreading best practices across the state.

The CYSHN Information and Assistance (I and A) program continued to respond to calls from families and professionals seeking health care resources for CYSHN.

CYSHN was part of a multi-agency public/private partnership that participated in the Region V "Learn the Signs, Act Early" Summit. The group has broadened as is now working on an Act Early Summit for regional teams across Minnesota to learn about best practices and take them back to their local areas. Many of the group members have been appointed to the State Legislative Task Force on Autism.

Title V continues to work closely with the state's Medicaid program. The Medicaid program has been awarded the ABCD-III grant from the Commonwealth Fund to create more efficient linkages to support healthy child development. Title V will work closely with Title XIX to implement the grant's objectives.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide TA to Medical Home/Health Care Home Teams		X		X
2. Partner with the University of Minnesota School of Nursing CYSHCN program to prepare future care coordinators and disseminate best-practices		X		X
3. Continue support of interagency planning				X
4. Continue interagency development and implementation of a state autism plan				X
5. Strengthen the partnerships with the F2F HIC and Family Voices of Minnesota as a mechanism to reach families in need of services and supports				X
6. Continue leadership role in Help Me Grow and Part C early intervention		X		X
7. Provide outreach to increase awareness of community-based resources among the health provider community		X		X
8. Assist in the implementation of Health Care Home	X	X	X	X
9. Support habilitation technology mobile clinics to provide access to sub-specialty orthopedic care in Greater Minnesota	X			
10.				

**b. Current Activities**

The Information and Assistance toll free number continues, with staff available for consultation with the Birth Defects Monitoring Program and Newborn Screening Long-term Follow-up.

CYSHN continues to sponsor Parent-to-Parent Support Training provided through Family Voices of Minnesota utilizing the Parent-to-Parent USA evidenced-based curriculum. Parents from geographically diverse communities throughout the state are fully trained, with ongoing learning opportunities and consultation available through CYSHN. The Family to Family Health Information Center at PACER continues and utilizes the information created as part of the previous "MAZE" training to educate parents and provides in the state.

A work group of the MCHATF is meeting to focus on CYSHN to inform the statewide children and youth with special health care needs program to improve the quality, efficiency and effectiveness of the public health role in meeting the needs of children with special health care needs and their families. The group will also provide direction and advice on establishing priorities and developing plans for CYSHN activities.

**c. Plan for the Coming Year**

MAZE as well as Information and Assistance Activities are being evaluated and redesigned to maximize all State activities as well as parent partnerships with the potential to improve access to needed services. Until any changes are implemented, the above activities will continue. In addition, we will be exploring the potential for disseminating best practices to clinical service providers through webinars and broadcasts.

The successful implementation of the Health Care Homes will be pivotal in assuring access to all needed services and as such will remain a CFH Divisional priority.

The CYSHN work group will continue to meet and report to CYSHN staff and the MCHATF.

**State Performance Measure 9:** *Percentage of families of children age 0-17 that report costs not covered by insurance are usually or always reasonable.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Annual Performance Objective					63
Annual Indicator				62.9	62.9
Numerator				533727	533727
Denominator				848067	848067
Data Source				NSCH 2007-08 survey	NSCH 2007-08
Is the Data Provisional or Final?				Final	Final
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
Annual Performance Objective	65	68	70	72	72

**a. Last Year's Accomplishments**

In 2007 (the most recent data available from the National Survey of Children's Health) of the Minnesota respondents that 1) had insurance and 2) had out-of-pocket expenses, 62.9 percent those out-of-pocket expenses were usually or always reasonable. Only 8.4 percent indicated that those expenses were never reasonable. Additionally, a different measure on the National Survey of Children's Health indicates that of Minnesota respondents with insurance, 27.9 percent had no out-of-pocket expenses.

Staff throughout the state in Minnesota's Family Home Visiting, Positive Alternatives, Family Planning Special Projects, Early Hearing Detection and Intervention program, and WIC programs continued to work with clients on finding adequate insurance resources and supporting families to reduce out-of-pocket costs.

MDH staff in the Newborn Screening Follow-up program provide follow-up and consultation with families of children diagnosed with a medical condition during the newborn screening process. A component of the consultation is helping families find insurance and other resources that will reduce unreasonable costs to families.

Through the MDH Information and Assistance and MCH lines, staff continued to provide information to consumers on addressing out-of-pocket costs. This includes information on access to supplemental insurance programs (such as TEFRA and other waiver programs) that reduce costs and help with out-of-pocket expenses such as high deductibles. This material is available through referral to the Minnesota Department of Human Services.

**Table 4b, State Performance Measures Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Provide assistance to Family Voices and Pacer's Parent to Parent Information Line to provide parents with health insurance information. (Previous MAZE Activities)				X
2. Continue to support and monitor local public health activities to assure access to insurance resources	X			X

3. Partner with DHS to assure that all children have access to information on supplemental insurance program information			X	X
4. Work within existing systems to assist families in identifying insurance payment options			X	X
5. Continue EHDl and newborn follow-up activities to assure families have access to appropriate information	X	X		
6. Work with health care home staff to continue to implement activities that support the MCH and CYSHN populations.				X
7. Continue to monitor state and federal health reform legislation				X
8. Work with MDH Health Policy Division on development of out-of-pocket cost measure in the Minnesota Health Access survey				X
9.				
10.				

**b. Current Activities**

Through the MDH Information and Assistance and MCH lines, MDH will continue to provide information to families on addressing out-of-pocket costs. Out-of-pocket costs for children and youth with special health needs are of special concern. To address this issue, MDH provides web-based information and linkages on financial and other resources for families of children with special health care needs as well as support our Minnesota Parent to Parent Support Agencies have the most up-to-date information. Staff in the Newborn Screening Follow-up and Early Hearing Detection and Intervention programs assure that children identified with blood spot disorder or hearing loss receive information on insurance and supplemental payment resources.

Local public health departments continue to support client access to insurance resources through multiple programs, including early identification and intervention activities, infant and child screening, Child and Teen Check-up (Minnesota's EPSDT), family home visiting, WIC, etc. In these programs, LPH departments work to increase the number of clients enrolled in insurance and link them to resources to reduce out-of-pocket costs.

**c. Plan for the Coming Year**

MDH Title V staff will continue most activities currently underway as indicated above. Additionally, MDH will continue to monitor state and federal health reform legislation and its impact on out-of-pocket cost for CYSHN families. Information and resources will be made available on the web. MDH staff will also continue to work with Minnesota Department of Human Services staff to assure MDH staff and our partners are up to date on any changes in supplemental insurance programs.

Staff in the Newborn Screening Follow-up and Early Hearing Detection and Intervention programs will continue to assure that identified children receive information on insurance and supplemental payment resources.

MDH and local public health department staff will continue to assure information is available to families participating in their programs on access to services at low or no cost providers (e.g. community health centers).

Minnesota will continue health care home activities currently underway (see NPM #3). As certified health care homes become more robust in their activities, it is anticipated that their coordination of patient care for children with special health care needs will increase efficiency, reduce redundancy, and ultimately reduce out-of-pocket costs for families. Title V staff will continue to work closely with health care home staff to assure linkages between the needs of CYSHN families and health care home activities.

The MDH, in partnership with the University of Minnesota, periodically conducts the Minnesota

Health Access Survey. These surveys are the source of data for state policy makers to define and respond to health insurance issues of Minnesotans and are stratified random digit dial telephone surveys that include both cell and landline telephones. Title V staff will be working with staff in the MDH Health Policy Division to determine if a measure can be added to more clearly measure out-of-pockets costs for Minnesota families especially those with children who have a special health need.

**State Performance Measure 10:** *By 2013, in collaboration with other state agencies, identify a state performance measure and benchmark to monitor positive youth development in Minnesota.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2007	2008	2009	2010	2011
Annual Performance Objective					3
Annual Indicator				1	1
Numerator					
Denominator					
Data Source				Adolescent Health Workgroup	Adolescent Health Workgroup
Is the Data Provisional or Final?				Final	Final
	2012	2013	2014	2015	2016
Annual Performance Objective	5	6	0	0	0

**Notes - 2011**

We do not have an Adolescent Health Coordinator at this time; therefore, the Adolescent Work Group has been unable to achieve its goals as rapidly as had originally been expected.

**Notes - 2010**

There is no denominator for this performance measure

**a. Last Year's Accomplishments**

Staff drafted an adolescent health report, looking specifically at existing adolescent sexual and reproductive health data from multiple sources, allowing for a new analysis of sexual behaviors, attitudes and health outcomes among Minnesota adolescents. The goal of the report is to completely and accurately characterize adolescent sexual and reproductive health. Even though the report frequently describes sexual health using data that better describes illness, it is important to understand adolescent sexual health holistically to balance both risk and protective factors. This type of approach complements other activities related to positive youth development and a positive youth development framework. In Minnesota's report, sexual health was defined as making healthy choices about sexuality that support adolescent physical and emotional well-being.

Staff conducted Teen Outreach Program (TOP) training with Teenwise staff.

**Table 4b, State Performance Measures Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Create a shared definition for positive youth development (PYD) among state agency partners				X

2. Collaborating state agencies will identify ways to measure PYD. This could include identification of new measures, modification of existing measures, or identification of existing measures that can be combined into a composite measure				X
3. Collaborating state agencies will finalize additions or modifications of existing survey instruments, such as the Minnesota Student Survey				X
4. Survey instruments are modified and tested				X
5. Measure/ composite measures are included in survey instrument and administered				X
6. Baseline data from measure/ composite measure are available				X
7.				
8.				
9.				
10.				

**b. Current Activities**

Staff continue to collaborate with Teenwise, in their service learning training, specifically the Teen Outreach Program (TOP). Staff also serves on Teenwise's yearly conference planning committee, which always incorporates elements of positive youth development programming and approaches.

Staff is working with St. Paul-Ramsey County Public Health Department as part of the abstinence education program grant. The focus of the program is healthy youth development utilizing the TOP curriculum. It is anticipated that information gathered from implementation will help inform and define healthy youth development including ways to measure it.

Staff is putting final touches on the Adolescent Sexual Health data report.

**c. Plan for the Coming Year**

Once the cross-agency group charged with measuring positive youth development determines the best way to measure it, the questions will be incorporated into the Minnesota Student Survey or some other survey instrument. This measure will be a way for Minnesota to measure assets as well as deficits over time.

Staff will continue to consult with Teenwise on future conferences and Teen Outreach Program training.

The Adolescent Sexual Health data report will be finalized and disseminated.

Staff are convening a group of epidemiologists and other data professionals in the departments of Health, Education, Public Safety and Human Services to determine how Minnesota should measure positive youth development. This group will include data professionals that are also part of the planning for the Minnesota Student Survey, a statewide survey of Minnesota students about their activities, opinions, behaviors and experiences. It includes questions on an array of issues -- substance abuse (tobacco, alcohol and illegal drugs), school climate, violence and safety concerns, healthy eating, out-of-school activities, connections with school and family, and many other topics. It is assumed that this new question, or the composite questions, will come from the Minnesota Student Survey.

## **E. Health Status Indicators**

Health Status Indicators:

Minnesota consistently ranks as one of the most desirable and healthy states in which to work and live. However, Minnesota data often masks the disparities seen between African Americans/Africans, American Indians, Asian Americans and Latinos as compared with Whites. While still less diverse than the U.S. as a whole, minorities currently make up 17 percent of the total Minnesota population compared to 36 percent of the nation. However, minorities now make up 30 percent of the state's population under the age of 5. In some parts of the state, the percentage of preschool-aged children of color or American Indian children is approaching 50 percent or more. Overall African Americans/Africans, American Indians and Latinos have fared worse on all measures of health, with significant disparities when compared to Whites. The ability to closely monitor, determine trends and to target resources will allow Minnesota to assure we remain a healthy state to work and live for all of our populations.

We will discuss three Health Status Indicators that are of particularly of interest: live births; low birth weight, and child and infant deaths.

**Live births:** It is beneficial, and often critical, to have a clear understanding of population size and composition when planning statewide initiatives and other projects. If MDH is to plan effectively for the future, population parameters are important and in fact necessary, beginning with births and ending with deaths.

The number of births in Minnesota has been steadily declining from 73,675 in 2007 to 68,407 in 2010, and preliminary 2011 data indicate that it may have declined to its lowest point in the past 20 years. However, this decline has not been evenly distributed, with the white population showing a large and more rapid decrease than other racial and ethnic groups. Racial distribution for the 2010 birth cohort, as calculated by the Minnesota Center for Health Statistics, is as follows: White, 75%; African-American, 10%; Asian, 7%; American Indian, 2%; other, 6%.

As might be expected, the largest number of births occurred to women between the ages of 20 through 34 years, both overall and across all racial and ethnic groups. At the same time, age-specific birth rates have been decreasing steadily for young females ages 15-19. This occurrence may be indicative of a statewide trend to delay childbearing beyond teen and early working years, particularly among Minnesota's sizeable White population. It may also be reflective of Title V's efforts targeting teen pregnancy prevention.

**Low birth weight:** In Minnesota, annual indicators have remained consistent in recent years, varying only .1% (VLBW) to .4% (LBW). This same consistency has been observed throughout the past decade. Despite this positive trend, however, these figures mask the discrepancy between White populations, American Indians, and populations of color. Three-quarters (75%) of all births in Minnesota occur within the White population. Because birth outcomes are often less positive for minority populations, the data above do not accurately reflect the need to address birth weight issues for non-white and ethnic populations in Minnesota.

Towards that end, we are continually evaluating how well our strategies are working to low birth rate rates. Premature birth, late and/or inadequate prenatal care, younger or older age, periodontal health, use of chemicals (alcohol, drugs, tobacco, others), and lack of social support are all areas efforts have been directed.

One such initiative involves a recent study of 70,000+ annual births in the state, mapping their location by county and documenting the timing and adequacy of mothers' prenatal care using the Kotelchuck Index, which measures early and continuous prenatal care. We found definite geographic variations across the state. Further steps will include working with local public health agencies to improve the adequacy of prenatal care across all populations in the state.

Current prenatal care standards have emphasized the importance of early (first trimester) and consistent medical care in order to minimize negative outcomes such as low birth weight, preterm birth, and infant death. However, Minnesota outcomes on the Kotelchuck Index have remained

constant at 82% from 2008 through 2010. In an effort to improve these outcomes, the MN Commissioner of Health has identified as a priority reducing preterm births, and efforts across state agencies are beginning to focus on this issue.

Child and infant death: Minnesota's infant mortality rate (0 to age 1) has been edging slightly upward over the past several years, ranging from 4.7 deaths per 1,000 live births in 2003 to 6.0 in 2008, then down again to 4.5 in 2010. Reasons for this increase and subsequent decrease are not completely clear. However, it is noteworthy that White babies have the lowest proportion of deaths in the 0 to 1 age group when compared with other racial/ethnic groups. In addition, infant deaths were higher among Medicaid children (5.9% in 2009) than non-Medicaid children (3.4% in 2009).

The causes of infant mortality are complex and vary across racial and ethnic groups, rendering it difficult to develop a single public health approach which is appropriate and effective for all populations. Racial and ethnic disparities remain a major maternal and child health issue, which often compromise accurate interpretation of overall outcomes.

Note: Vital Statistics records maintained by the MDH Center for Health Statistics are the source for data on live births, low birth weight, and infant and child deaths in the State of Minnesota.

## **F. Other Program Activities**

Toll-free Telephone Numbers -- For parents and others, the Minnesota Title V programs assure access to information about health care providers and practitioners who provide health care services under Titles V and XIX and about other relevant health and health-related providers and practitioners. Title V programs accomplish the intent of this requirement by improving the effectiveness of previously established special purpose toll-free numbers and up-to-date websites.

The Title V CYSHCN has operated a toll-free Information and Assistance telephone line since March of 1990. This line offers a comprehensive listing of services provided by state and county health and human services departments, hospitals, associations, family support groups and allied public and private entities. The toll-free number is included on all educational and information publications developed and is included in all media announcements.

The Department of Human Services consumer services call center 800 number handles questions related to obtaining prenatal care services from Medical Assistance or MinnesotaCare. Calls related to prenatal health and other maternal and child health matters are referred by the Department of Human Services to the Title V program to be addressed. Information regarding obtaining prenatal services and related questions can also be accessed via the MDH or DHS web sites.

The MinnesotaCare program provides an automated state toll-free line that operates 24 hours a day, seven days a week. The toll-free number will provide the caller with general information about the plan, qualifications for acceptance and application information. The automated message is available in seven languages including Spanish, Hmong, Somali, Vietnamese, Laotian, Bosnian, and Russian. All outreach materials distributed by the Department of Human Services include this state toll-free number for individuals to call with questions.

The Minnesota Family Planning and STD hotline is staffed by individuals trained in information and referral as well as family planning and STD counseling. All family planning and STD related educational materials distributed by the Minnesota Department of Health include the hotline number. Annually, information about family planning which includes the hotline number is mailed to all Medicaid/MinnesotaCare recipients.

The WIC Program 800 number is funded through Minnesota's federal WIC grant and provides 24 hour -- 365 days a year phone coverage. Callers are provided with the business telephone number of the local WIC project in their geographic area. All WIC outreach materials distributed include the 800 number. There is also a WIC supported specialized line related to breastfeeding.

***/2013/www.MNParentsKnow.info : A website developed by the state of MN in 2009 to provide "trusted parenting information, resources and activities to help children grow, develop and learn from birth through high school". Information is broken down by the following age groups: newborn, age 1-2, age 3-5, grade K-8 and grad K-12. The website was developed for parents with extensive input of parents and provides up-to-date research-based information on infants and children on strategies to support children's learning, newsletters, expert tips, interactive early childhood and child care search, connections to Minnesota services and resources, video clips, and non-commercial child development and health Websites. Extensively used by the Departments of Education (who host the site), Human Services and Health.***

***www.MinnesotaHelp.info : A state website hosted by the Department of Human Services initially developed to provide community connections and services to seniors. Has since expanded to include a Disability Link; Youth Corner; Health Care Link; Immediate Help; Adults, Families and Children; Services for Homeless People and Refugees. With over 12,000 providers included it offers Minnesotans a one stop site to identify resources within their community.//2013//***

## **G. Technical Assistance**

Form 15 outlines the current technical assistance needs identified by Minnesota's Title V programs for the upcoming year. Additional discussions will be occurring internally over the course of this year to determine the timing and proposed technical assistance providers.

## V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

### Form 3, State MCH Funding Profile

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>1. Federal Allocation</b> <i>(Line1, Form 2)</i>	9072643	9002379	9060776		8939248	
<b>2. Unobligated Balance</b> <i>(Line2, Form 2)</i>	384363	2955	78627		116431	
<b>3. State Funds</b> <i>(Line3, Form 2)</i>	7032333	6754000	6854552		6791759	
<b>4. Local MCH Funds</b> <i>(Line4, Form 2)</i>	3704946	3521734	3498112		3659554	
<b>5. Other Funds</b> <i>(Line5, Form 2)</i>	6587720	8902168	8873529		10329763	
<b>6. Program Income</b> <i>(Line6, Form 2)</i>	78571	97463	97461		97462	
<b>7. Subtotal</b>	26860576	28280699	28463057		29934217	
<b>8. Other Federal Funds</b> <i>(Line10, Form 2)</i>	147421896	143497787	150706894		154518652	
<b>9. Total</b> <i>(Line11, Form 2)</i>	174282472	171778486	179169951		184452869	

### Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Federal-State MCH Block Grant Partnership</b>						
<b>a. Pregnant Women</b>	5696238	5914959	5614440		6350378	
<b>b. Infants &lt; 1 year old</b>	3522025	3929374	3762948		4218627	

<b>c. Children 1 to 22 years old</b>	6971376	7319212	6933931		7827120	
<b>d. Children with Special Healthcare Needs</b>	9023895	9444661	10272221		9704454	
<b>e. Others</b>	847042	1055909	1169517		1133638	
<b>f. Administration</b>	800000	616584	710000		700000	
<b>g. SUBTOTAL</b>	26860576	28280699	28463057		29934217	
<b>II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).</b>						
<b>a. SPRANS</b>	300000		300000		270000	
<b>b. SSDI</b>	100000		97260		65357	
<b>c. CISS</b>	132000		143438		150000	
<b>d. Abstinence Education</b>	0		279550		261650	
<b>e. Healthy Start</b>	0		0		0	
<b>f. EMSC</b>	0		0		0	
<b>g. WIC</b>	136511917		135249825		130266604	
<b>h. AIDS</b>	0		0		0	
<b>i. CDC</b>	147997		345529		352750	
<b>j. Education</b>	0		0		260000	
<b>k. Home Visiting</b>	0		0		10049101	
<b>k. Other</b>						
<b>Medicaid</b>	0		0		235410	
<b>Pregnant Parenting T</b>	0		0		2000000	
<b>PREP</b>	0		0		874780	
<b>TANF</b>	0		0		9733000	
<b>Children and Familie</b>	0		300000		0	
<b>Department of Educat</b>	0		280000		0	
<b>HHS</b>	0		13711292		0	
<b>ED</b>	255000		0		0	
<b>HRSA</b>	9974982		0		0	

**Form 5, State Title V Program Budget and Expenditures by Types of Services (II)**

	FY 2011		FY 2012		FY 2013	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
<b>I. Direct Health Care Services</b>	11351551	11614566	12392722		11495959	
<b>II. Enabling Services</b>	4131189	4928028	4225718		4870650	
<b>III. Population-Based Services</b>	6032603	7038547	6536890		8718543	
<b>IV. Infrastructure Building Services</b>	5345233	4699558	5307727		4849065	
<b>V. Federal-State Title V Block</b>	26860576	28280699	28463057		29934217	

<b>Grant Partnership Total</b>						
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**A. Expenditures**

Minnesota consistently has year to year expenditure variations related to populations served (pregnant women and infants, children and adolescents and children and youth with special health care needs) and types of services provided (direct health care services, enabling services, population based services and infrastructure building services). Minnesota Statute 145.882 subd. 3, distributes two-thirds of the federal MCH Block Grant by formula to fifty-two local public health agencies. The statute outlines the use of these funds to activities that address MCH and CYSHCN issues. Local public health agencies are required to report how funding was expended but, have the flexibility of moving funding between populations or types of services provided to meet community needs or to respond to critical or emergent health issues. This ability to respond to identified community needs or critical local health issues often results in significant variations between years as to populations served or type of service provided using Title V funds. The state retains one-third of the block grant to support federal maternal and child block grant requirements of a statewide needs assessment and to prepare the annual report and application; to collect and disseminate statewide data on the health status of mothers and children, to provide technical assistance to local public health agencies, to evaluate the impact of maternal and child health activities on the health status of mothers and children. The state is much more consistent year to year in the populations served and types of services provided.

As was noted in the notes section of our application, the 21 day state shutdown had an impact to our projected salary and S&E expenditures for federal fiscal year 2011.

The increase in expenditures between federal fiscal year 2010 and federal fiscal year 2011 on Form 3 of "other funds" is primarily attributed to the receipt of additional state resources for statewide expansion of the Birth Defects Information System and efforts directed at Health Care Home certification.

Please refer to Form 3 State MCH Funding Profile; Form 4 Budget Details by Types of Individuals Served and Sources of Other Federal Funds and; Form 5 State Title V Program Budget and Expenditures by Types of Services for more specific information related to Minnesota's expenditures.

**B. Budget**

Please see Forms 3-5 and appropriate related notes.

B. Budget

Oversight of the Title V, MCH Block Grant is the responsibility of the Division of Community and Family Health within the Minnesota Department of Health.

Minnesota Statutes 145.88 distributes two-thirds of Minnesota's federal MCH Block Grant funding by formula to 52 Community Health Boards (CHBs), Minnesota's local public health structure. The boards are comprised of elected officials, either county commissioners or city council members. They are responsible for policy formulation and oversight of the local public health administrative agencies which conduct core public health functions in their localities. State law requires CHBs to provide at least a 50 percent match for federal MCH Block Grant funds received each year. CHBs predominately use local tax dollars augmented with some state grant dollars to meet their required match.

The legislation directs CHBs to use the funding for high risk and low-income individuals who 1)

have a high rate of infant mortality and children with low birth weight, 2) target pregnant women who have an increased likelihood of complications during pregnancy, 3) address the health needs of young children who have or are likely to have a chronic disease or disability or special health need, 4) provide family planning services, 5) address the frequency and severity of childhood and adolescent health issues, 6) address preventing child abuse and neglect, reducing juvenile delinquency, promoting positive parenting and resiliency in children, and promoting family health and economic sufficiency through public health nurse home visiting and 7) address nutritional issues of women, infants and young children through WIC clinic services. The Division of Community and Family Health, which houses the Title V programs, has responsibility to provide fiscal oversight and technical assistance to CHBs in the use of these federal dollars.

Local public health agencies are required to report annually on their proposed budgets and expenditures of the federal MCH Block Grant. The approximately \$5.9 million provided to local public health agencies annually represents approximately 2 percent of their total funding available for public health efforts. However, this percent of total funding is an average and does not reflect the wide variance between CHBs of their total budgets. The range of Title V MCH Block Grant funding to their total available funding is 1 percent to 6 percent, with the average being 2 percent. One issue with the distribution of a significant portion of the MCH Block Grant in this manner is that the 52 local public health agencies can redirect MCH Block Grant funds to where they are most needed to maintain core maternal and child health services. This causes a constant fluctuation in the populations served, total numbers of individuals served, and the types of services provided. This flexibility in funding at the local public health level results in year to year changes in block grant data reporting greater than 10 percent.

State law allows one-third of the federal MCH Block Grant to be retained at the state to: 1) meet federal maternal and child health block grant requirements of a five year needs assessment and to prepare annual federal block grant applications and annual plans, 2) collect and disseminate statewide data on the health status of mothers and children, 3) provide technical assistance to Community Health Boards, 4) evaluate the impact of maternal and child health activities on the health status of mothers and children, 5) provide services to children under age 16 receiving benefits under title XVI of the Social Security Act; and 6) perform other maternal and child health activities. Agency indirect charges for the total MCH Block grant are supported from the state portion of the funding. The MCH Block Grant supports a total of 22.6 FTEs within the state Department of Health.

MCH Block Grant funds used to support Minnesota's maternal and child health including children and youth with special health care needs efforts are augmented with other federal funding (all funds are rounded) including Evidenced Based Home Visiting (MIECHV) \$10 million; Young Student Parents \$2 million; Abstinence Education \$280,000; PRAMS \$150,000; SECCS \$140,000; Universal Newborn Hearing \$300,000; EPSDT Medicaid drawdown \$240,000; Preventive Block Grant to support children's mental health efforts \$55,000; Personal Responsibility Education Program \$900,000 and Interagency Agreements with Department of Education that provides \$280,000 for support for Part C and Part B of IDEA activities and \$500,000 annual from the Early Childhood Challenge grant; Birth Defect Information System \$190,000; SSDI \$100,000 state annual appropriations include family planning \$5.4 million (which includes \$1.16 million in TANF funding); home visiting \$8.8 million of which most is federal TANF funds; Positive Alternatives \$2.4 million; newborn hearing screening \$369,000; cyschn grant activities \$160,000; \$1.8 million for Birth Defects surveillance, prevention and education; \$2 million for Fetal Alcohol Syndrome; \$136,000 for Women's Right to Know; and \$200,000 in one time money for autism efforts. Programs supported by fee generated funds include Newborn follow-up at \$970,000 (portion of the Newborn Bloodspot Card fee) and \$71,000 (\$2 for every marriage license) for abstinence education.

Other maternal and child health related activities administered by the Division of Community and Family Health include WIC \$130 million, Breastfeeding Peer Grant \$600,000, and Health Care

Home \$1.7 million.

## **VI. Reporting Forms-General Information**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. Performance and Outcome Measure Detail Sheets**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. Glossary**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. Technical Note**

Please refer to Section IX of the Guidance.

## **X. Appendices and State Supporting documents**

### **A. Needs Assessment**

Please refer to Section II attachments, if provided.

### **B. All Reporting Forms**

Please refer to Forms 2-21 completed as part of the online application.

### **C. Organizational Charts and All Other State Supporting Documents**

Please refer to Section III, C "Organizational Structure".

### **D. Annual Report Data**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.