



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

**State Narrative for
Minnesota**

**Application for 2009
Annual Report for 2007**



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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.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The signed Assurances and Certifications are available upon request from:

Janet Olstad
Assistant Director
Division of Community and Family Health
Minnesota Department of Health
PO Box 64882
St. Paul, MN 55164-0882

Phone number (651) 201-3584

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; expires May 31, 2009.

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. State law (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.

//2009/ MCH Block Grant funds are allocated to CHBs under the Local Public Health Act of 2003. This legislation (Minnesota Statutes 145A.10, Subd. 5a) requires CHBs to establish local public health priorities based on an assessment of community health needs and assets and every five years report to the Commissioner of Health the local priorities the CHB will address. The prioritization and planning processes require CHBs to "seek public input" into the process. The 2005-2009 planning cycle is a transition period for local public health departments. The assessment and action plans will be completed by December 31, 2009 and the priorities and community engagement summary are due by February 1, 2010. Until this more formal process is implemented we ask CHBs to report annually on how community input was obtained and used in the process of identifying the use of federal Title V block grant funds in their communities. //2009//

CHBs reported in 2005, that they primarily used community surveys, focus groups, key informant interviews and community forums to garner public input. /2008/ CHBs reported in 2006, that community surveys, focus groups, key informant interviews and established local Advisory Groups were used to garner public input. One of the most common issues identified by CHBs

was the lack of access in their communities to dental services. With over 76 percent of the agencies indicating 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. //2008//

Other opportunities for community input occur at public hearings when annual budgets for public health activities are reviewed and approved and through dialogue at either Maternal and Child Health or Public Health community advisory groups.

The Maternal and Child Health Advisory Task Force (MCHATF) provides a particularly significant source of input. This statutorily required advisory group, 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 2005 MCH Needs Assessment. ***//2009/ The MCHATF continues to play a significant role in providing input into state MCH block grant activities and in the development of strategies and priorities based on the work of the Needs Assessment. //2009//***

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

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

An attachment is included in this section.

C. Needs Assessment Summary

The following is one example of taking the needs assessment to the next step. The following specifically targets state priority 9 - Eliminate racial and ethnic health disparities impacting mothers and children.

The Maternal and Child Health Advisory Task Force (MCHATF), a statutory directed advisory group, has been in existence since 1982 providing recommendations to the Commissioner of Health on the needs of Minnesota's maternal and child health population. The duties of the 15 member commissioner appointed task force are set out in Minnesota Statute section 145.881, and include advising the Commissioner of Health on 1) the health care needs of mothers and children 2) the type, frequency, and impact of maternal and child health services in the state; and 3) priorities for funding maternal and child health services.

The MCHATF played a key role in guiding the 2005 needs assessment process and in the identification of Minnesota's ten new state priorities. Using data from the needs assessment they went on to identify specific strategies to be used to address the ten state identified priority areas. Called "Monitoring Trends in Maternal and Child Health: Report and Recommendations of the Maternal and Child Health Task Force", the document was completed and sent to the Commissioner of Health in December 2006.

In responding to the report the Commissioner specifically highlights one of the priorities identified in the report "reducing infant mortality. While progress has been made in the last several years, African American and American Indian infant mortality rates continue to be more than double that for whites. The Department of Health through the Office of Minority and Multicultural Health has been directed by the state legislature to work specifically on the issue of reducing disparities in infant mortality rates between white and racial and ethnic communities. The goal outlined in legislation is "...by 2010, to decrease by 50 percent the disparities in infant mortality rates... for American Indians, and populations of color, as compared with rates for whites." While progress has been made, there continues to be significant disparities between African Americans and American Indian infant mortality rates compared to whites. Because of the importance of this issue, the Commissioner of Health requested that the MCHATF work with the Office of Minority and Multicultural Health and their Advisory Group to recommend strategies and next steps that would allow Minnesota to fully meet the goal of reducing the gap in infant mortality rates by 50 percent by the year 2010.

At the same time the Bureau of Community and Family Health Promotion which is comprised of the Divisions of Community and Family Health; Health Promotion and Chronic Disease; and the Office of Minority and Multicultural Health identified infant mortality as a joint work plan area for the coming year. Significant resources from these three Divisions will come to bear on this issue and ultimately allow Minnesota to meet its goal.

/2009/ The MCH Advisory Task Force convened an Infant Mortality Work Group in early 2008. The purpose of the work group was to review the recommendations on reducing infant mortality originally outlined in the "Monitoring Trends in Maternal and Child Health Report (December 2006)". Members of the work group represented individuals and organizations with a range of expertise and interest in reducing infant mortality, including

staff from the Office of Minority and Multicultural Health. The work group indentified action steps, based on the recommendations in the original report, that should be taken by MDH and other partners to reduce infant mortality. The Infant Mortality Work Group will continue to meet periodically to review new information and data regarding infant mortality. The group will monitor the status of the proposed action steps and make the full MCH Advisory Task Force membership aware of information and studies of interest.//2009//

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, 90.4% report that it is excellent or very good (compared to 84.1% nationally). Seventy-eight percent of Minnesota's children have mothers in the work force compared to 69 percent nationally--which may be related to the fact Minnesota has the highest percent (25.6%) of children ages 6 to 11 who stayed home alone. Minnesotans are engaged in their communities; the voter turnout in Minnesota for the 2004 elections was the highest in the nation.

Minnesota is however experiencing the same pressing economic challenges being felt across the country. The 2003 legislative session opened facing a \$4.5 billion shortfall, which was resolved primarily with program cuts -- many of which settled heavily on maternal and child populations. Minnesota's publicly funded health insurance programs such as Medical Assistance and MinnesotaCare, its TANF program, local public health funding, and state's social services programs either had reductions in budget or changes in eligibility criteria - most set to begin July 1, 2003. The most recent 2005 legislative session opened facing an additional \$466 million budget deficit. The legislature is in an extended session working to make painful choices and decisions. /2007/ The 2006 Legislative session however, saw a slight improvement in the economic picture with an available small surplus. It is expected that Minnesota will also enter the 2007 Legislative session with a small surplus. //2007// /2008/ Minnesota entered the 2007 legislative session with a billion dollar surplus as well as an equal amount available in one time funding for the biennium. //2008// **/2009/ Minnesota again experienced the same economic pressures experienced throughout the country. The 2008 legislative session needed to respond to a \$935 million shortfall for state fiscal year 2009 and it is anticipated that for biennial budget years 2010 and 2011 the state will need to react during the 2009 legislative session to a significantly higher anticipated shortfall. //2009//**

Demographics Minnesota is a medium-sized state, encompassing slightly more than 84,000 square miles. Minnesota's per capita income in 2003 was \$34,039, the eighth highest in the country. The 2003 unemployment rate was 5% compared to the national rate of 6%. 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 (2000 Census) count of 4,919,479 people, making Minnesota the 21st most populous state in the nation. Fifty-four percent of the states residents live in the seven-county, Minneapolis-St. Paul metropolitan area. Minnesota has seven metropolitan statistical areas (MSAs) where seventy percent of the population lives. 65 percent of the statewide population increase of 544,380 that occurred between 1990 and 2000 took place in this seven-county Twin Cities area. American Indians comprise a significant proportion of the population and cultural heritage of Minnesota. According to the 2000 US Census, 58,192 American Indian or Alaska Natives lived in the state, of these, 32,029 were children. In 2000, approximately half of the American Indian population lived on seven Chippewa and four Dakota reservations, while the remainder lived in major population centers and communities spread across the state.

/2009/ According to 2006 population estimates, Minnesota residents are becoming increasingly more diverse statewide. However, there are distinct differences in the location of racial and ethnic subpopulations throughout the state. The metropolitan area, a seven-county region containing Minneapolis and St. Paul, shows the most diversity and the lowest percentage of White residents (85.1%), with 8.1% Black, 5.8% Asian, and 1.0% American Indian. In addition, more than two-thirds (68.5%) of the Hispanic population in MN (N=196,135) resides in the metro area.

The northwest (NW) section of the state has the second lowest proportion of White residents (90.7%), largely because it has the highest percentage of American Indians in MN (7.9%). Primary base of this sizeable Indian population (n=15,720) is three large Ojibway reservations located in the remote northern area. However, NW has little overall racial diversification, with less than one percent each of Blacks (0.6%) and Asians (0.7%) and only 2.0% of the state's Hispanic population. All other regions of the state show a White population of 95% or greater. The central region from east to west has the highest combined proportion of White residents (97.6%, west; 96.4%, east), with all other races either at or just below 1%. East central differs from west central only in its Hispanic population, which comprises 5.8% (n=11,289) of Hispanics in MN, the third largest concentration of this ethnic group outside the metro area.

Northeast (NE), southeast (SE) and southwest (SW) Minnesota reflect minimal racial diversification (95.1 -- 97.1 % White). American Indians (2.9%) own and operate three small reservations in the NE forest areas; however, very few Asians (< 1%), Blacks (1%) or Hispanics (1.4%) live in the northern tier of the state. In contrast, SE and SW have seen a modest expansion in their non-White population and a large increase in their Hispanic population. SW is home to the second largest group of Hispanics (11.5%) living in Minnesota, while SE has an additional 9.0%. Primary reason for these substantial numbers of Hispanics, as well as some African-born Blacks (e.g., Somalis) and Asians (6.8%, combined) is the location of large canneries and meat-packing plants in the southern one-third of the state. Jobs are plentiful and do not require fluent English. Also, many Hispanics were originally seasonal workers on local SW farms and became permanent residents when year-round factory jobs became available.//2009//

Minnesota's population is aging. Overall, Minnesota's age distribution is similar to the national average, but there were some marked differences in age group trends between Minnesota and the U.S. between 1990 and 2000. The median age of Minnesota is 35.4 and the United States median age is 35.3. Minnesota's median age is expected to rise to 41.3 by 2025. The elderly population grew much slower in Minnesota than nationally. The under 10 population also grew less in Minnesota than in the nation. The under-5 population showed a 7 percent gain in the U.S., while falling 2 percent in Minnesota. The 5-to-9 group went up 14 percent nationally but only rose 3 percent in Minnesota. In contrast, Minnesota had stronger than average growth in almost every age group from 15 to 64. The biggest difference was among 15 to 19 year-olds. This population went up 26 percent in Minnesota, much higher than the 14 percent gain nationally .

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 small, the rate of change is not. In 2000, Populations of Color represented 10.6 percent of the total population in Minnesota as compared to 5.6 percent in 1990. By 2025 it is estimated that non-White population will represent 17 percent of the State's population . Between 2005 and 2015, the nonwhite population is projected to grow 35 percent, compared to 7 percent for the white population. The Hispanic Origin population is expected to increase 47 percent.

Minnesota's immigrant populations continue to increase. 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. 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.

In the most recent data (federal fiscal year 2002) from the Office of Immigration Statistics, 13,522 immigrants came to Minnesota from 160 different countries and every continent except Antarctica. Minnesota's major immigrant populations include: Latinos, Hmong, Somalis, Vietnamese, Russians, Laotians, Cambodians and Ethiopians. Many immigrants come here from other states. The effects on Minnesota have been far reaching with visible changes in small towns and cities, schools and businesses. These eight national origin, ethnic or language groups noted above each represent more than 1,000 children in Minnesota's schools in the 2003-2004 school year. As an example, in the town of Pelican Rapids, with a population of 1,900, there are now 24 languages spoken .

These significant demographic changes such as the aging of its population, concentration of various populations in its metropolitan areas, and rising dependency ratios (elderly and children as a ratio to the working-age population) 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 In Minnesota there are 718,474 families with related children under 18 years, with 1,186,982 children. Eight percent of children live in poor families, compared to the national percent of 17%. Twenty-four percent of children live in low-income families, compared to 38 % nationally. Fifty-six percent of these children have at least one parent who is employed full-time annually. Only 9% of children in low-income families do not have an employed parent. The number of children eligible for the free/reduced price school lunch has been increasing, from 24.7% in 1992-1993, to 26.4% in 1996-1997, to 28.5 % in 2001-2002. WIC enrollment has been increasing steadily over the past several years. April enrollments for the past 3 years have grown from 111,717 in 2003, to 116,308 in 2004, to 123,643 in 2005. /2008/ WIC participation in May of 2007 was at an all time high of 135,246 women and children. //2008// **/2009/ Continuing to act as a indicator of the state's economic pressures, WIC participation has hit an all time high of 141,864 participants in May 2008. //2009//**

Health Disparities While Minnesota enjoys a high level of health status indicators overall, there are significant and highly concerning disparities in health status measures for populations of color and American Indians -- particularly in outcomes related to women and infants. Because the health status of mothers and infants is highly affected by the social conditions in which they live, it is also important to make note, at least generally, of some of these key indicators, which all show disparities to the disadvantage of populations of color and American Indians. Table 1 provides an overview of some of these social condition indicators. (See attached Table 1).

In 2003 the self-identified racial composition of women who gave birth was mostly white (84%). The remaining 16% of the women who gave birth self-identified as African American (7.6%), Asian (5.5%), and American Indian (2.0%). /2008/ In 2005, the self-identified racial composition of women who gave birth continued to be mostly white (82%). The remaining 18% of women self-identified as African American (8.9%), Asian (6.6%), and American Indian (2%). //2008// The birth rate per 1000 teens 15-19 years old for 2001 -- 2003 varied by race as follows: African-American 122.1; American Indian 112.4; Asian 67.9; Hispanic 129.8; and White 29.4 . /2008/ While progress has been made in the rates of teen births, significant disparities still persist (2004 data: African American (71.1); American Indian (93.6); Asian (47.8) and White (17.3). //2008// According to 1997-2001 Minnesota birth certificate data, rates of inadequate/no prenatal care are three to four times higher among populations of color in Minnesota (African Americans (12.4%), American Indian (17.4%), Asian (9.8%), and Hispanic (11.2%) compared to such rates for white pregnant women (3.2%). **/2009/ Compared to 1997-2001, data from 2001-2005 indicate rates of women receiving inadequate or no prenatal care have decreased for all populations in Minnesota, African Americans (9.0 percent), American Indian (15.9 percent), Asian (6.1 percent), Hispanic (8.4 percent), and white (2.6 percent). However, significant disparities continue to exist with American Indian women six times more likely to receive inadequate care or no care during their pregnancies than white women. //2009//**

Between the time periods 1989-1993 and 1997-2001, the percent of premature births decreased in all racial/ethnic groups except for White, which increased slightly. However disparities still exist so that approximately 1 of 10 African American, American Indian and Asian babies are born premature compared to 1 in 14 White and Hispanic babies. The change in low birth weight (under 2500 grams) from 1989-1993 to 1997-2001 have been less than one percent for all racial and ethnic groups except African Americans, where the LBW decreased from 11.5 to 9.1 percent. This is still the highest disparity in comparison to low birth weights for American Indians at 5.8 percent, Asians at 6.4 percent, Hispanics at 4.8 percent, and Whites at 4.0 percent. ***//2009/ Between the time periods 2001-2005 African Americans were the only group to experience a noticeable decline in low birth weight, but at 8.2 percent still remain two times greater than for whites. //2009//***

Mortality rates for infants and mothers differ greatly by race and ethnicity. Based on 1996-2000 data neonatal mortality rates (deaths that occur before the 28th day of life) are particularly disparate between African Americans (8.5/1,000), American Indians (6.2/1,000) and whites (3.4/1,000). In other words, African American neonates are 2.5 times more likely and American Indian neonates are 1.8 times more likely to die than their white counterparts. In Minnesota, American Indian (5.7/1,000) and African American infants (4.2/1,000) suffer much higher rates of postneonatal mortality (deaths that occur from 28 to 365 days of life) compared to White infants (1.7/1,000). ***//2009/ Based on 2000-2004 data, infant mortality rates for African Americans (9.5/1,000) and American Indians (10.2/1,000) have decreased over time but continue at more than two times that for whites (4.5/1,000). //2009//***

Maternal mortality rates are based on women who die while pregnant or within one year of termination of pregnancy, irrespective of cause. Based on 1990-1999 data, African American women died of pregnancy-associated issues at a rate 2.4 times higher than the white rate. The American Indian women's pregnancy-associated death rate was 2.8 times the white rate. *//2008/ Data from 2000-2004 indicate these disparities continue to persist. //2008//*

Insurance - Access Minnesota continues to maintain one of the lowest rates of uninsured populations in the nation. Some recent information however is showing some potentially negative changes in those rates. Based on the 2004 Minnesota Health Access Survey, there is a general increase in uninsured Minnesotans (from 5.4% in 2001 to 6.7% in 2004). This increase was driven by a decrease in employer-based health insurance coverage, a shift in Minnesota's income distribution, and a change in Minnesota's Hispanic/Latino population. In 2004, Minnesotans were more likely to be uninsured or covered by public health insurance programs and less likely to be covered by group or employer-based health insurance coverage than they were in 2001. Rates of uninsured continue to show disparities based on race, with the change being most pronounced for Hispanic/Latino Minnesotans. ***//2009/ After rising between 2001 and 2004, the percentage of Minnesotans without health insurance was stable between 2004 and 2007 (2007 Minnesota Health Access Survey). An estimated 7.2 percent of Minnesotans, or about 374,000 people, were uninsured in 2007. The rate of uninsurance in 2007 was statistically unchanged from 2004 when it was 7.7 percent. An estimated 4.8 million Minnesotans have health insurance through an employer, public program or individual purchased coverage. National surveys, although not directly comparable to this study, show that Minnesota has the lowest uninsurance rate in the nation. //2009//***

Results from the Minnesota Health Access Survey of 2004 show some significant changes between 2001 and 2004 of insured rates for women and children. Between 2001 and 2004 uninsured rates increased for all children (birth-17) from 6.4% to 7.7%. In the Black population (birth-17) uninsured rates decreased from 16.9% to 12.4 %, but this is still double the White rate of 6.4%. The overall non-White uninsured rate for 2004 is 16.0% with Hispanic being highest at 31.6 % (up from 19.7% in 2001).

Within the birth to 5 year old group, the uninsured rate rose from 5.7% in 2001 to 9.2% in 2004. The non-White rate remained relatively stable, while the White rate increased from 4.2% to 8.0%.

This Birth to 5 year old uninsured rate is higher than the overall uninsured rates for the 6-12 age group (7.0%) and the 13-17 age group (7.1%). It is too early to tell whether these rates may have been influenced by policy changes from the 2003 legislative session, which went into effect on 7/1/2003. The Children's Defense Fund of Minnesota estimated these policy changes would negatively impact the insurance status for 20,000 children.

This study also indicated that rates of uninsurance for women in the childbearing years (15-44) increased from 11.5% to 12.8% overall. Table 2 describes these changes for women. (See attached Table 2).

State funded health programs in Minnesota provided health insurance coverage for roughly 654,000 state residents at some point during state fiscal year 2004 through its three publicly funded basic health care programs -- Medical Assistance (Minnesota's Medicaid program), General Assistance Medical Care (GAMC), and MinnesotaCare. //2008/ Approximately 662,000 Minnesotans received health care through the state's three publicly funded health care programs during state fiscal year 2006. //2008// The Minnesota Department of Human Services (DHS) administers MinnesotaCare and oversees MA and GAMC, administered by counties. About 70 percent of DHS's budget is devoted to these three programs. About half of enrollees in all programs combined are children under 21. //2007/ During the 2006 Legislative session, a pay-for-performance system for publicly funded health care programs was approved. Minnesota will be the first state in the nation to participate in a pay-for-performance protocol known as Bridges to Excellence for diabetes management in state health plans. //2007// //2008/ Minnesota's pay for performance system, called QCare, that rewarded providers for optimum client care for diabetes was expanded during the 2007 legislative session to include cardiac disease. //2008//

Medical Assistance (MA) Medical Assistance 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. Families, children and pregnant women account for 69 percent of Minnesota's MA enrollees, but account for only 22 percent of its expenditures. The majority of expenditures, more than 78 percent, are for people who are elderly or have a disability. //2008/ Children, parents and pregnant women make up the largest Medicaid group (70 percent), but account for only 25 percent of expenditures. The remaining 75 percent of expenditures are for people who are elderly or have a disability. //2008// Program expenditures for state fiscal year 2004 totaled \$4.99 billion, of which the federal share was \$2.63 billion. MA provided coverage for a monthly average of \$464,000 in FY 2004. The average monthly enrollment of children was 321,291. //2009/ ***Efforts the past two legislative sessions have been directed on assuring all children eligible for public programs are enrolled. One of these initiatives is called Community Application Agent Program. This program 1) provides a bonus of \$20 to an organization who successfully enrolls a child on Medicaid, 2) requires the state to provide a toll free number to provide information on public and private health coverage options and sources of free and low cost health care, 3) requires a number of public programs to have applications available for Minnesota's health care programs and to provide direct assistance in completing the application form or provide information on where an applicant can receive application assistance, and 4) requires school districts to provide information to each student on the availability of health care coverage and to provide children determined eligible for free or reduced priced lunch with application assistance.*** //2009//

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 waivers. The Section 1115 waiver is the state's MinnesotaCare Health Care Reform Waiver. The TEFRA waiver allows some children with disabilities who live with their families to be eligible for Medical Assistance without counting parent's income. Also the Home and Community Based Waiver programs allow some children with disabilities who live with their families to be eligible for Medical Assistance without counting the parent's income. Medical Assistance for Employed Persons with Disabilities allows working children with disabilities who

are at least 16 to qualify for Medical Assistance under a higher income limit.

The central Medicaid 1115 waiver is the state's PMAP waiver. The Prepaid Medical Assistance Program (PMAP) began in 1982 when Minnesota was selected by the federal Health Care Financing Administration (HCFA) as one of five original states to implement managed care for non long-term care services for designated Medicaid populations on a prepaid, capitated basis. Populations covered by the now statewide PMAP program include families with children, elderly, children in foster care placement, and on a voluntary basis, children eligible for MA through subsidized adoptions, and children who are seriously emotionally disturbed and who are eligible for MA-covered targeted case management. There is federal financial participation for coverage of pregnant women and children in the MinnesotaCare program (described later in this section). As of December 2004, 83 of Minnesota's 87 counties were participating in the PMAP+ program. A 1997 state law authorized all counties to choose the type of Medicaid managed care model to be implemented in their county: either PMAP or County-Based Purchasing. County-based purchasing would allow counties (instead of the state) to purchase and/or provide comprehensive Medicaid services on a risk basis contingent upon federal 1115 waiver approval.

Minnesota has received approval for an 1115 waiver demonstration project for family planning that is being planned for implementation on July 1, 2006. //2007/ Waiver implementation was delayed one year due to systems issues. When fully implemented the waiver is expected to serve 50,000 individuals between the ages of 15 and 50. //2007// This will provide eligibility for family planning services, including treatment for STIs identified in a family planning visit, to women and men at or below 200% FPG and provide automatic extension of family planning coverage for one year to anyone who loses MA or MinnesotaCare coverage. **//2009/ In state fiscal year 2007, the program served about 26,000 people with total expenditures of approximately \$4.3 million. //2009//**

MinnesotaCare is a state subsidized managed care program funded by a tax on hospitals and health care providers, federal Medicaid matching funds, and enrollee premiums and co-payments. Medical payments for MinnesotaCare totaled \$487 million in FY 2004, with average medical payments per enrollee of \$273 a month. The average monthly MinnesotaCare enrollment in 2004 was 148,000. Families with children are eligible for the program on a sliding-fee scale if their family is income and asset eligible. There is no asset limit for pregnant women or children. Federal financial participation is claimed for pregnant women and for children and benefits for these two populations are the same as those provided for under the Medical Assistance (Medicaid) program. Federal financial participation is also claimed for parents and relative caretakers enrolled in MinnesotaCare. **//2009/ MinnesotaCare enrollment in state fiscal year 2007 was 117,893 with approximately \$434 million expended for care during that year. During the 2008 legislative session eligibility and outreach were expanded and sliding-fee premiums for MinnesotaCare were reduced. Other provisions made the renewal process for staying on MinnesotaCare easier for enrollees. //2009//**

Erosion or crowd-out barriers consist 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. In response to the state's budget deficit, a more limited benefit set was established for adults without children. As a budget reduction strategy, effective 10/1/03 benefits limitations were added to hospitalization, physicians, drugs, outpatient services and lab/diagnostic services. A \$10,000 limit on hospital care with a 10 percent co-pay requirement was added. In addition, premiums were increased for all populations using the program.

General Assistance Medical Care (GAMC) GAMC is a state funded program that covers acute care services for residents not categorically eligible for MA but who meet income and asset standards comparable to the medically needy standards of the MA program. The program provides coverage for most, but not all, of the same health services offered by the MA program. Individuals who may be eligible include adults with no dependent children, adults residing in group resident housing, adults awaiting a determination of disability, and adults participating in the state's General Assistance program. In 2004, GAMC provided medical care for a monthly average of 34,900 low-income Minnesotans - primarily low-income adults, ages 21-64, who have no dependent children. Expenditures in FY 2004 were \$245.6 million, with average medical payment for a GAMC enrollee of \$587 a month. As part of the state's response to the budget deficits of the last few years, effective 10/1/03 eligibility for GAMC was lowered from 175 % of federal poverty level (FPL) to 75 % of FPL. A new "catastrophic" health program for individuals between 75 % of FPL and 175 % of FPL was established but, to cover hospitalization costs only and includes a \$1,000 deductible.

In response to the severe budget shortfalls, changes were made in the 2003 and 2004 Legislative sessions to these public health care programs that have had a significant impact on mothers, children and children with special health care needs. Beginning July 1, 2003, parental fees for children on the TEFRA waiver program were increased -- in some cases by more than 1,000%; waiver slots for MR/RC, TBI, CADI were reduced or capped; and services to adults were modified, requiring co-pays for drugs, doctor visits and non-emergency emergency room visits while dental care was limited to \$500 per year. Beginning July 1, 2004, Medical Assistance income eligibility for pregnant women went from 275 % of FPL to 200 % of FPL, and MA income eligibility for children ages 2 through 18 was lowered from 170 % FPL to 150 % FPL. /2007/ Income eligibility (FPL) changes for Medicaid eligibility were never fully implemented //2007// Infants born to mothers on MA now qualify for one year of automatic eligibility rather than two years. In October 2004, it became necessary for children enrolled in MinnesotaCare and Minnesota's Section 1115 waiver programs to reapply for coverage every six months, rather than the previous 12 months. The Department of Human Services estimates that in FY 2007 this change will reduce the average monthly enrollment in MinnesotaCare by 6,000 children.

As families come off of MA, the data does not indicate that they are enrolling in MinnesotaCare as an alternative. Overall, MinnesotaCare is seeing a steady decline in enrollment numbers since July 2003, when most legislative cuts were implemented. There was a 6% decrease in enrollment numbers for children under 21 from August 2003 (70,447) to August 2004 (66,019).

Effective 7/1/2003 changes were made to General Assistance Medical Care (GAMC) and Emergency GAMC was eliminated, leaving 2,200 of Minnesota's poorest young adults with no health insurance or source of regular care. In the second half of 2003, coinciding with these cuts to GAMC, Hennepin County (largest populated county) experienced a 39% increase in uninsured patients requiring inpatient services and an 8% increase in those requiring outpatient services. After July 1, 2003, Hennepin County's Assured Access Program (not insurance, but enables enrollees who are uninsured and ineligible for public programs to receive discounted services from participating community clinics) saw an increase in enrollment for children of 55%.

Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) are areas that are federally designated as lacking adequate health care services. Populations in 54 out of 87 counties are in federally designated Health Professional Shortage Areas (HPSAs) for primary care. 73 counties include either a HPSA or an MUA designation or both. 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 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. See the HPSAs maps on the following websites. The first one is rural at <http://www.health.state.mn.us/divs/chs/DDHPSADec04.jpg> and the urban map

is at <http://www.health.state.mn.us/divs/chs/MetroDentDec04.jpg>. Also the Medically Underserved Areas can be seen at <http://www.health.state.mn.us/divs/chs/MUASept04.jpg> for rural areas and <http://www.health.state.mn.us/divs/chs/MetroMUAFeb05.jpg> for urban area.

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.

STATE LEVEL INITIATIVES

Minnesota Mental Health Action Group (MMHAG) MMHAG is a public-private effort to improve mental health services in Minnesota. Launched by the Minnesota Department of Human Services, all of Minnesota's major health plans and facilitated by the Citizen's League -- MMHAG has begun developing strategies to implement the changes required to bring about a more coordinated system that meets the needs both of adults and those of children. MMHAG created a blueprint for addressing these issues that called for 1) early identification of mental health problems and early, effective intervention; 2) increasing access to services and inpatient psychiatric hospital beds; and development of quality standards monitoring processes, and introduction of evidence based practices into children's mental health care. Based on recommendations from MMHAG, the 2006 Legislature adopted some key components of the Governor's Mental Health Initiative. These included more than \$10 million in new funding to address the shortage of psychiatrists, improve front-line services for children and adults; track service availability; and to begin to evaluate outcomes. These changes help set the stage for other elements of the initiative to be proposed in the next legislative session.

//2008/ A key accomplishment of the 2007 legislative session is the net investment of approximately \$34 million for the Governor's Mental Health Initiative. The initiative is aimed at improving the accessibility, quality and accountability of publicly funded mental health services. It is based on the recommendations of the Minnesota Mental Health Action Group and builds on mental health improvements approved in 2006. Under this legislation, all publicly funded health care programs will have a comprehensive mental health benefit set. Significant new funding is targeted at shoring up school-based mental health services for uninsured and under-insured children and providing respite care services for families of children with severe emotional disturbance and with expanding mental health crisis intervention as a first-line safety net for children and adults.//2008//

//2009/ In 2008, Governor Pawlenty signed significant health care reform legislation into law. These reforms create a comprehensive health care package making significant advances for Minnesotans. During fiscal years 2010 and 2011, \$47 million will be provided to local public health agencies and tribal governments to reduce the percentage of Minnesotans who are overweight and reduce the use of tobacco. The law also: 1) expands MinnesotaCare eligibility for adults without children to 250 percent of FPG, streamlines access to applications for state public health care programs, 2) includes broad reforms to increase access to private coverage through limited tax credits for the uninsured and Section 125 plans for employees to purchase insurance with pre-tax dollars, 3) creates a work group to make recommendations on an essential set of benefits, 4) requires the Departments of Health and Human Services to develop and implement standards of certification for health care homes by July 1, 2009, 5) promotes the use of health care homes to coordinate care for individuals with complex or chronic conditions, 6) implements a payment system for care coordination, 7) requires providers use nationally-certified electronic health record systems, 8) advances the use of health information technology by requiring all pharmacy prescriptions be ordered electronically by 2011 and 9) includes changes that will provide Minnesotans with more tools to compare cost and quality and that set the stage for payment reform. //2009//

BUILD Initiative in Minnesota Minnesota's BUILD Initiative has developed a statewide five-year plan, Minnesota's Road Map for School Readiness, to help ensure that the programs needed by children and families are available, affordable, and of high quality. Infrastructure, as well as programs, is vital. Elements of the BUILD early childhood infrastructure are early learning standards, assessment, professional development, a quality rating system, governance, adequate resources and financing, and evaluation. Priorities for 2006 include 1) mobilize support for school readiness; 2) enhance quality choices for parents; 3) secure funding; and 4) strengthen accountability. //2007// /2008/ Interest for the 2007 legislative session was directed at expanding home visiting funding and services to support school readiness.//2008//

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 programs 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 areas of MCH and CYSHCN administer, coordinate and support many activities addressing maternal and child health, including the Title V Block Grant. The maternal and child health responsibilities of the Division 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 interagency agreements with the Department of Human Services related to Title V/Title XIX activities, and also partners with local Community Health Boards (local public health entities), the Minnesota Department's of Education, 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 years of this decade, 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 prevention as a priority, with a specific emphasis on obesity. The MDH administration, through it's Health Steering Team (HST), made up of the Executive Office staff and Division Directors, has undertaken strategic planning activities which led to the development of work groups to review these priorities: 1. Vision for MDH; 2. Organizational Structure; 3. Regulatory Roles, Responsibilities and Process; 4. Defining a Coordinated Process for Pursuing Funding for MDH Priorities; 5. Interagency Initiatives; 6. Providing Optimal Support to Local Agencies Responsible for Public Health; and 7. Data Collection.

/2007/ Through the strategic planning process, the Department of Health identified four priority focus areas: Emergency Preparedness; Health Disparities; Preparing for an Aging Population and Health Care System Reform. Committees have been charged with 1) taking a department-wide perspective on the priority; 2) identifying key measures and outcomes the department should accomplish or work toward; 3) identifying how each division contributes to the outcomes and 4) coordinating and monitoring the department's effectiveness in each priority area. The work on these new priorities has just started but they will help frame the work of the Department over the next several years. //2007// /2008/ The Bureau of Community and Family Health Promotion which includes the Division of Community and Family Health as well as the Office of

Minority and Multicultural Health and the Health Promotion and Chronic Disease Division has begun a strategic planning process to identify how the Divisions within the Bureau can work together on major public health efforts. Obesity and infant mortality have been identified as two areas for joint efforts. //2008// ***/2009/ With the Health Care Reform legislation there will be a need for close partnerships within the Bureau, between Bureaus and between state agencies and other key stakeholders. The Bureau of Community and Family Health houses two primary areas in the Health Care Reform legislation, the Statewide Health Improvement Project (SHIP) which is housed in the Health Promotion and Chronic Disease Division and Health Care Home activities which is housed in the Division of Community and Family Health. Additional information on this legislation can be found under STATE LEVEL INITIATIVES found earlier in this section. //2009//***

Throughout 1998 the Department undertook a comprehensive effort to revise the state's public health goals and objectives and published Strategies for Public Health. This document is a compendium of ideas, experience and research offered to help local public health and other community agencies achieve the objectives of Healthy Minnesotans, 2004. Work is now underway to update this document for a Healthy Minnesotan's 2010. Title V staff will be responsible for the update the the Goals and Strategies impacting maternal and child health populations.

Initially established in the Community Health Services (CHS) Act of 1976, Minnesota has a strong public health infrastructure system of locally operated public health agencies and a good relationship between the state and local entities. As part of this original CHS Act, the Minnesota Legislature created the State CHS Advisory Committee (SCHSAC) that provides recommendations to the Commissioner of Health. This statute was revised in 1987 to create the Local Public Health Act, and again in 2003 when significant administrative changes were made.

These revisions included changes in funding for local public health wherein eight funding sources were combined in order to achieve administrative efficiencies, better target local priorities, and move towards results-based accountability. These grants are: the Community Health Services Subsidy, Maternal and Child Health (state funding), WIC (state funding), the Infant Mortality Grant, the Family Home Visiting Grant, the Youth Risk Behavior Grant, the MN ENABL grant, and the Eliminating Health Disparities Grant to Tribal governments. The combined funds are distributed through two formulas -- one to city and county-based community health boards and one to Tribal governments.

Additionally, these administrative changes necessitated planning to create accountability measures -- through development of statewide outcomes associated with a list of essential activities, as well as a revised reporting system. Title V staff have been very actively involved in the planning and development of these changes. Through this work six broad areas of public health responsibility were defined: assure an adequate local public health infrastructure; promote healthy communities and healthy behaviors; prevent the spread of infectious disease; protect against environmental health hazards; prepare for and respond to disasters and assist communities in recovery; and assure access and quality in health services. Title V related work is found in all six responsibilities. /2007/ Statewide outcomes identified for each of the six essential public health responsibilities support the work of the Title V programs and strengthen the partnership around maternal and child health issues with local public health agencies. There are 35 statewide outcomes and except for the outcome to "reduce the rate of hospital admissions for falls in persons aged 65 and older" all outcomes would improve overall maternal and child health within the state. //2007//

More information on this significant planning and infrastructure building activity can be found at <http://www.health.state.mn.us/phsystem.html#essential> A schematic representation on Minnesota's local public health improvement process is available <http://www.health.state.mn.us/cfh/na>

Decision-making Processes

There are a number of institutionalized forums that allow the Commissioner of Health, and the Community and Family Health Division Director 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 the Title V Directors a number of different vehicles for defining problems and policy and for feedback on recently enacted policy.

1. The Health Steering Team (HST) HST consists of the health department's Executive Office staff and the Division Directors. It meets monthly to provide input into departmental policies, determine priorities, and to identify and resolve issues. ***//2009/ HST now meets twice a month. //2009//***
2. 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. In 2005 the MCHATF created two priority work groups to focus on: 1) monitoring the impact of the 2003-2004 Legislative Session policy and budget changes, and 2) maintaining and improving early childhood programming. *//2007/ Significant time this past year has been spent on developing recommendations for the Commissioner of Health in the areas of child and adolescent health, perinatal health, and children with special health care needs. This work builds on the MCH needs assessment completed in 2005. Each recommendation defines specific strategies or action steps that could be taken to address one or more of the state priorities identified in the needs assessment process. As of June 30, 2006 recommendations have been approved for child and adolescent health and prenatal health. Recommendations for children with special health care needs will be developed during the summer of 2006 and the full report and recommendations will be forwarded to the Commissioner of Health in the fall of 2006. This work will be used in refining the work of the Title V programs over the next year. //2007// /2008/ The Commissioner of Health, after reviewing the report, charged the MCHATF to work in partnership with the Office of Minority and Multicultural Health and their Advisory Committee to develop strategies and next steps to reduce the disparities in infant mortality by 50 percent by the year 2010. During this past legislative session, the sunset date of the MCHATF was extended until June 30, 2011. //2008//*
3. 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.
4. The Rural Health Advisory Committee consists 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 too carries out its responsibilities through work groups. Their current focus is on mental health issues in rural communities. *//2007/ Focus areas currently are the aging population, E-Health and telemedicine. //2007// /2009/ ***Earlier this year, the Rural Health Advisory Committee completed a report on Health Care Reform: Addressing the Needs of Rural Minnesotans, and currently is working to develop a new model of rural health care delivery to respond to changing demographics, technology and workforce trends. This project will be addressing the continuum of care and opportunities for integration across the range from prevention and primary care to mental health and aging services. //2009//****

5. Title V/Title XIX: The senior program managers for the Title V and the Title XIX programs meet quarterly 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.

6. The Management team of the Division of Community and Family Health meets on a monthly basis to resolve immediate operational issues and to discuss and define long-range issues. /2008/ The Management Team of the Division of Community and Family Health is comprised of Division management, (Division Director and Assistant Director), the four Section Managers (MCH, MCSHN, WIC and Office of Public Health Practice), and their respective supervisory staff. The Management Team meets weekly to discuss issues and share information. //2008//

B. Agency Capacity

The mission of the Community and Family Health (CFH) Division is to provide 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, underserved and rural 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 language within Minnesota Statutes Chapter 145 lays out the state requirements for the distribution of the Maternal and Child Health block grant, with two thirds to go out to local Community Health Boards through a formula; establishes the MCH Advisory Task Force; and articulates program requirements for use of state funds for WIC, family planning, abstinence education, fetal alcohol syndrome, and home visiting. /2007/ and the Woman's Right to Know and Positive Alternatives Programs. //2007// The Minnesota statute articulates 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)." The Boards themselves are 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 CHBs in the state including 27 single-county boards, 59 counties cooperating in 21 multi-

county boards, four cities, and one city-county board. 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 funding is provided through the Local Public Health Act (\$31 million including \$6.1 million of Title V funds). Total CHB expenditures for 2005 was \$282 million of which a third was from local taxes. ***//2009/ Total CHB expenditures for local public health activities for calender year 2007 was \$302 million, of which a third continued to be from local taxes. //2009//***

CROSS-CUTTING TITLE V PROGRAM CAPACITY

The MCH Advisory Task Force: 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. Current work groups include monitoring the impact of the 2003-2004 legislative session policy and budget changes on mothers and children, and improving early childhood programming. *//2007/* The new work plan for the next year revolves around developing strategies or action steps to address the state priorities identified in the needs assessment process. *//2007// //2008/* The Commissioner of Health charged the MCH Advisory Task Force to work with the Office of Minority and Multicultural Health and their advisory task force to recommend strategies and next steps that would allow Minnesota to fully meet the goal of reducing the gap in infant mortality rates by 50 percent by the year 2010. The 2007 Legislature also extended the sunset date of the MCH Advisory Task Force until June 30, 2011. *//2008//*

MCH Epidemiology: A newly formed data/epi team was created in response to recommendations made during the 2003 CAST 5 data capacity process. The purpose of the team is to provide a broad base of technical expertise and support for data-related activities (e.g., needs assessment, research, and program evaluation) to CFH staff with emphasis on building the capacity of staff to work with data through one-on-one coaching, consultation, and division-wide trainings. The team consists of 3 PhD level staff: the SSDI research scientist, another research scientist, and an epidemiologist. This team brings increased methodological and analytic capacity and will leverage efforts to advance SSDI project objectives. The Data/Epi team has been actively partnering with programs on data activities, working on committees, organizing training opportunities, and developing structures for increased collaboration and data sharing within and across programs. Among the new structures formed is a Data Users Group, which is intended to foster communication and collaboration among researchers, analysts, policy planners, and others responsible for data utilization in and outside of the MDH. *//2007/* In 2005, Title V and Title XIX entered into an Interagency Agreement whereby Title V agreed to cover the salaries of 1.5 FTE epidemiologists at the Department of Human Services to be able to use Medicaid data to work on jointly identified issues. The first project identified was determining cost effectiveness of a medical home model for children and youth with special health care needs covered by Medicaid/MinnesotaCare. *//2007// //2008/* PRAMS was moved organizationally into the Division of Community and Family Health and expands the work of the Data/Epi Unit. The 2007 legislative session also provided additional funding for up to 2.5 FTEs to provide research support to the development of a new data system for Newborn Hearing Screening and Follow-up and to develop a statewide evaluation of the Family Home Visiting Program. *//2008// //2009/ The Title V-CYSHCN program is the recipient of a MCH Bureau EHD Loss to Follow-Up grant. The grant included a 0.5 FTE epidemiologist in the first year. //2009//*

MCH Special Projects Grant: The Maternal and Child Health Special Projects (MCHSP) grant program was created in 1985 to distribute two-thirds of Minnesota's share of the federal MCH Title V Block Grant and an appropriation of state general funding to Minnesota's Community

Health Boards. MCHSP funds provide core funding for support of local public health infrastructure focused on the improved health of mothers, children, and their families. The program also targets funds to serve high-risk and low-income individuals in statewide priority service areas: improved pregnancy outcomes, family planning, children with handicapping conditions/chronic illness, and child and adolescent health. The 2003 Legislature consolidated MCH dollars, along with seven other categorical programs, into the resulting Local Public Health Grant (LPHG) that provides funding for Community Health Boards and Tribal Governments. Accountability for MCH block grant dollars remains separate within this LPHG structure. At the same time the Community Health Board match for the federal MCH Block Grant funds was raised from 25 percent to 50 percent.

Tribal Governments: While the Department of Health and the Community and Family Health Division have been working with tribal governments for some time, the process became more formalized in 2003 with the establishment and the hiring of a Tribal Liaison. Located within the Office of Minority and Multi-Cultural Health (OMMH), the position is uniquely situated to establish stronger ties with Tribal Governments and Tribal Health Directors. 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 the new money in this grant for maternal and child issues. Staff work closely with the Tribal Health Liaison to provide technical assistance and support to the Tribal health staff and programs for all three MCH population groups. /2008/ Currently infant mortality staff are working closely with Tribal Governments on infant death reviews to determine what strategies might be effective in reducing the number of American Indian infant deaths. //2008//
/2009/ Staff completed the Native American Infant Morbidity Review report. Report findings will be used to guide next steps in efforts to reduce the continued disparities seen in Native American infant deaths compared to white infant deaths. //2009//

Dental Health Program: ***/2009/ Minnesota has been able to achieve water fluoridation for 98.8% of our population significantly impacting the overall oral health of our residents.//2009//*** The dental health program provides oral health promotion training, technical consultation and assistance to professionals, and educational materials to CHBs, schools and the general public. Program staff partners with the Department of Human Services in areas of dental policy and access issues. With funding from HRSA, Minnesota Children's Oral Healthcare Access Project grant promoted the oral health of pregnant women and young children, to improve the early oral health status of infants and children served by Minnesota WIC program, and improve the awareness and anticipatory guidance skills of WIC parents related to the oral health needs of their children. /2008/ In partnership with the Minnesota Department of Human Services and the Minnesota Dental Association, the Department of Health will be inviting interested stakeholders to participate in an advisory committee to develop a Public Health/Oral Health Stateplan. The first meeting of this group is targeted for October. The Association of State and Territory Dental Directors will be providing technical assistance to this effort and the Division of Community and Family Health will be responsible for overseeing the process. //2008// ***/2009/ The Oral Health State Summit is scheduled to be held on November 7, 2008. This event will be used to begin the development of a Minnesota specific oral health state plan. In an effort to establish adequate funding for statewide oral health improvement efforts staff have submitted a CDC Oral Health Infrastructure Grant and a grant to HRSA to establish an oral health surveillance system. //2009//***

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, Birth Defects Information System, immunizations, STI and HIV programs, breast and cervical cancer control, asthma, several health promotion program areas, the methamphetamine program, and children's environmental health.

POPULATION CAPACITY: PREGNANT WOMEN, MOTHERS AND INFANTS

Perinatal - The perinatal focus of work involves program staff with health providers to develop quality preconception, family planning, prenatal, perinatal, and genetics services that increase the potential for healthy pregnancies and newborns. Staff assess needs, develop standards, and provide technical support services, training, and public education. This component assures counseling and education for patients and family members with known or suspected genetic diseases; assures genetic consultation, education and diagnostic support to physicians and other health professionals; and partners with the Public Health Laboratories program for detection of metabolic diseases through newborn screening. The infant mortality staff provides education, information and assistance to community and Tribal public health, works closely with Twin Cities Healthy Start, and with the OMMH in their Eliminating Health Disparities Initiative (EHDI) in the area of infant mortality reduction. Infant mortality staff are active with the Prematurity Campaign of the March of Dimes and with the Minnesota Perinatal Organization and work with the Minnesota SIDS Center. In response to the increase of infant deaths due to bedsharing, Infant Sleep Safety Education folders and a brochure entitled "Safety Tips for Bedsharing with Your Baby" were made available. This brochure is distributed to birthing hospitals throughout the state. Another compiled education folder brings together all the infant sleep safety messages including information on bedsharing, and are being distributed to local public health, tribal health, and community-based organization. /2007/ The 2005 Legislative session passed language that required the Department of Health to develop and distribute information on postpartum depression and Shaken Baby Syndrome prevention. Working with community partners, MDH identified materials that are to be used by hospitals and healthcare providers to educate women and their families regarding postpartum depression. Guidance was developed for health care providers regarding educating parents during well-child checks for children birth to 3 years of age regarding Shaken Baby Syndrome prevention. //2007// /2008/ A preconception conference titled "A Lifespan Approach to Reproductive Health: Getting it Right" is being co-sponsored this fall with the March of Dimes and the University of Minnesota. //2008// **/2009/ The conference brought together approximately 150 people. Plans are currently underway for a second conference this fall./2009//**

Substance Abuse - These activities focus on the childbearing and prenatal population and include dissemination of a Women and Substance Use in the Childbearing Years Prevention Primer, a compendium of resources and a guide for client and community prevention educators and planners. Work is underway on the CDC FAS Prevention grant with the purpose to increase Minnesota's capacity to integrate targeted and population based alcohol and contraception screening and behavior change interventions for women of childbearing age in select community settings; to reduce binge and prenatal drinking in women 18-44; to increase contraception use in women 18-44; to increase collection and use of data on women's drinking and contraceptive use; and to prevent and reduce FAS in targeted prenatal and preconceptional populations at risk for binge and prenatal drinking. MDH oversees a state funded FAS prevention grant to a local advocacy organization for work on public education, screening and evaluation activities, and intervention programs. /2008/ The 2007 Legislature authorized an additional \$500,000 a year in state general funds, bringing the total available a year to \$1,690,000 for FAS prevention and intervention. //2008// Prenatal smoking prevention and cessation activities include work with the Indigenous People's Task Force, and work with a new state partnership sponsored and facilitated through the AMCHP, ACOG, PPA, and CDC technical assistance project.

Reproductive Health - The Family Planning Special Projects grants provide funding and technical assistance and support to the 41 community-based clinics and organizations that provide assessment, education and contraceptive methods services, and supports a family planning and STI hotline. Staff work with policy issues at the legislature and with implementation activities of the new state 1115 family planning waiver demonstration project. Abstinence grant activities include: community organization activities, use of a curriculum consistent with established principles for education, a media campaign, and state directed training and technical assistance for community-based projects. /2008/ The state's 1115 family planning waiver began to provide services as of July 1, 2006. The 2007 Legislative session restored the 2003 family planning reductions of \$1,156,000 a year but at the same time reduced funding for Minnesota's abstinence

program by \$220,000 a year. //2008// **/2009/ Funding for the abstinence grant program (MN ENABL) was eliminated during the 2008 legislative session. //2009//**

Home visiting - Staff provide support to local public and Tribal health staff for home visiting activities they undertake through the Local Public Health Grant. The state supports NCAST training for home visiting nurses and has increased a focus on maternal and infant mental health training and assessment. Staff provide training to utilize the home safety checklist for injury prevention. /2008/ This program received significant support during the 2007 Legislative session, with an additional \$4,000,000 a year added to the existing program's \$3,557,000 budget. Legislative language focus home visiting services prenatally whenever possible. Both the Department of Health's role in training and technical assistance as well as its evaluative role were strengthened and funding was directed specifically to these areas. //2008// **/2009/ A steering committee and two workgroups - one on training and technical assistance and one on evaluation - were convened this year. Local health departments have completed and submitted detailed home visiting plans to MDH. //2009//**

Women's Health - Women's Health Grant activities were focused on increasing the number of low-income women of color receiving primary and preventive health care services by identifying service gaps and eliminating barriers to care. Although this federal grant has now ended, the relationships developed through this grant continue to provide opportunities for collaboration. The Women's Health Team, convened by Title V staff, provides opportunity for women's health programs from across the Department to work together so that systems of care serving women are improved. Working closely with the Community Center of Excellence at Northpoint Clinic, and with the U of M Academic Center of Excellence in women's health, a joint women's health website has been developed at www.healthymnwomen.org. **/2009/ MDH has created a Woman's Health Consultant position in the Maternal and Child Health Section. However, due to state budget shortfalls, this position is currently on hold. //2009//**

2007/ The Positive Alternatives Grant Program: This program funds private, non-profit organizations to support, encourage, and assist women in carrying their pregnancies to term and carrying for their babies after birth. This legislation makes available \$2.5 million annually for alternatives-to-abortion programs. Currently 37 organizations have been awarded funding to provide a variety of services to pregnant women including dula and case management services; client advocate services; parenting programs; transitional housing; medical and educational support and necessary items such as cribs, car seats and formula. //2007// **/2009/ The Positive Alternatives grant program distributed second round of grants. Thirty-one organizations were awarded funding for the next four year grant cycle. //2009//**

Infant Health - Staff partner with the MDH Newborn Screening Advisory Committee and with the MDH laboratory on systems development, data and tracking linkages, and providing education, outreach, technical assistance, and materials development. Newborn screening follow-up staff facilitate enhanced care coordination and services for infants found by newborn bloodspot screening. The MDH supports hospitals to provide newborn hearing screening and tracks results through integration with the state's Newborn Bloodspot Screening database, and is developing integration with vital statistics via a web-based system. Staff provide: technical assistance to hospitals; early intervention and follow-up; provider training; public information; and enhancement of a statewide family-to-family support network. Program activities are coordinated with Part C along with other MDH staff, faculty for the University of Minnesota Department of Otolaryngology, and members of the Universal Newborn Hearing Screening Advisory Committee. Staff work with the Departments of Human Services and Education to provide state leadership in early hearing detection and intervention, including tracking and reporting of outcomes. Sixteen regional teams continue to build capacity in their regions to better serve deaf-hard of hearing children and their families. /2008/ The 2007 legislative session mandated newborn hearing screening and requires the Department of Health to establish a Newborn Hearing Screening Advisory Committee to assist in developing the mandated program. The Division of Community and Family Health and the Laboratory Division will be partnering in implementing this new program. //2008//

POPULATION CAPACITY: CHILDREN AND ADOLESCENTS

Child and Adolescent Health Screening - This area of work supports accessible quality health and developmental screening and health promotion for all children. Goals of the program are adoption of healthy behaviors and assurance of early identification, treatment and remediation for those with health problems. Services include development of child health screening and health promotion guidelines, provision of training and technical consultation, and public education efforts. Specific programs supported include Child and Teen Checkups (Minnesota's EPSDT program) consultation, Nursing Child Assessment Satellite Training (NCAST) program, the scoliosis screening program, and maternal/infant mental health. ***/2009/Both Title V programs have joined with the state Title XIX program and the state chapter of the American Academy of Pediatrics to form the Minnesota Child Health Improvement Project (MN-CHIP). Modeled after the successful Vermont "V-CHIP" program, the mission of this public/private partnership is to assure optimal child healthcare by creating and supporting continuous quality improvement in clinical practices.//2009//***

School Health / Child Care - Specific attention is given to promotion of the health and safety of children in child care settings, school health (including hearing and vision screening), adolescent health, and children's mental health issues. Staff work closely with the Title V-CYSHCN as well as staff from related state agencies such as Departments of Education and Human Services. A report has been produced on a comprehensive system for the safe administration of medications in Minnesota schools, anchored by the development of statewide standards and guidelines and local district policies and procedures. This is available at <http://www.health.state.mn.us/divs/fh/mch/schoolhealth.medadmin/>. */2007/ These guidelines are being implemented in schools throughout the state through trainings and technical assistance. //2007//*

Adolescent Health - Adolescent preventive health services are addressed through outreach and implementation of "Being, Belonging, Becoming: MN Adolescent Health Action Plan", which includes a focus on strengthening adolescent health care services and systems. Outreach includes technical assistance on use of a youth development framework for addressing adolescent health issues, information about best practices and health care guidelines, implementation of recommendations for action, and use of available resources to support effective strategies. Staff provides technical assistance to EHDl grantees, local public health and other community-based entities, and works closely with the Department of Education, other adolescent program areas within MDH, and the University of Minnesota Konopka Institute for Best Practice in Adolescent Health, Division of General Pediatrics and Adolescent Health, building skill and capacity of adolescent-focused work and programs across the state. */2008/ The adolescent health coordinator is currently in the process of implementing the Adolescent Health System Capacity Tool developed by Association of Maternal and Child Health Programs and the State Adolescent Health Coordinators Network (SAHCN). The goals of the project are: 1.) document existing capacity of MDH to support adolescent health; 2.) establish if, and how, MDH is meeting the needs of our local public health agencies related to adolescent health; 3.) further define the roles of the Department of Health in addressing adolescent health; and 4.) improve the quality, and coordination, of MDH activities related to adolescent health. //2008// ***/2009/ Work on the Adolescent Health System Capacity tool will continue this fall. The Title V-CYSHCN program co-sponsored "Building an Interdisciplinary Research Agenda to Enhance Quality of Life and Transition to Adulthood for Youth with Chronic Conditions" with the Center for Children with Special Health Care Needs at the University of Minnesota's School of Nursing in the spring of 2008. In addition, the Title V program partnered with the adult mental health services division of the state's department of human services to fund suicide prevention grants using state general funds and SAMHSA block grant funds. Target populations included adolescents, especially those with special health need; adults 18-35 and adults 55 and over. //2009//****

Early Childhood - The MCH Bureau's State Early Childhood Comprehensive Systems Planning

Grant is underway to develop a state plan for an integrated comprehensive early childhood screening system. The interagency partnerships between Title V, the Departments of Human Services and Education, and Minnesota Head Start have increased efforts to decrease duplication of preventive care and foster coordination between childhood programs that require preventive visits. Work through these relationships has provided joint regional screening workshops and the development of the Minnesota Child Health and Development Screening Quality Indicators: A Comprehensive Framework to Build and Evaluate Community Based Screening Systems.

POPULATION CAPACITY: CHILDREN WITH SPECIAL HEALTH NEEDS

Diagnostic Clinics are a component of the MCSHN program and provide quality medical and rehabilitation assessments for children with suspected or diagnosed special health needs, are staffed by a multi-disciplinary team or specialist with pediatric expertise, complement local health care, and are located in communities where such services are not available. Several of these clinics are contracted with institutional providers, including the International Diabetes Center and Gillette Specialty Health Care. /2007/ One clinic is the Development and Behavior Clinic (DBC). The Children's Mental Health Services Division of the Department of Human Services has agreed to assist the Title V - CYSHCN program in analyzing the role of the DBCs as part of the overall children's mental health system. //2007//

Community Systems and Development Team - This team has staff located in District Offices of the state, provides a wide variety of activities at the local, regional, and state levels with public and private agencies and families, including information and referral, child find and outreach, education and training, advocacy, technical consultation, newborn metabolic screening follow-up, and program/policy development. /2007/ The capacity of the team was significantly increased by the addition of another district staff consultant. //2007//

Interagency Systems Development - In addition to the Part C interagency activities, staff participates in the state mandated Minnesota System of Interagency Coordination to support the development and implementation of a coordinated, multidisciplinary, interagency intervention services system for children ages birth through 21 with disabilities. This model, based on Part C, requires the development of an Individual Interagency Intervention Plan for all qualifying children, youth and young adults. Significant interagency planning and negotiating has been required between the Departments of Health, Human Services, Education, and Economic Security to support this multi-agency activity. /2007/ The concepts inherent in collaborative learning sessions that were learned from the medical home collaborative experience will be applied in order to remove barriers to implementation. //2007//

Follow-Along Program - Staff provide technical assistance and training to local public health agencies to support the Follow-Along Program in order to provide periodic monitoring and assessment of infants and toddlers at risk for health and developmental problems and to ensure early identification, assistance and services. The software program for this activity, which uses the Ages and Stages Questionnaire as the screening tool, includes a social emotional component - the ASQ-SE. Special trainings have been targeted on this tool to the Somali population and to the Department of Human Services and local social services agencies on the use of the ASQ-SE to meet the requirements for mental health screening of children in the child welfare system. /2007/ The ASQ and ASQ-SE continues to be adopted by local agencies. It is the screening tool of choice for the Children's Mental Health Services' ABCD-II grant initiative and has been added to the Child and Teen Checkup (EPSDT) program's trainings. //2007//

Research and Policy Analysis - The Research/Analysis and Policy work supports the development and enhancement of capacity to collect and analyze data for research and policy issues around children with special health needs and their families. It has engaged in a number of interagency collaborative activities to assess, direct and influence policy decisions that positively impact children with special health needs. /2007/ Factsheets on each of the 44 conditions followed by the birth defects information system were developed. Leadership will also

be provided at the Part C ICC level for what will be a significant expansion of Part C enrollment.
//2007//

Medical Home - Minnesota has adopted the medical home learning model promoted by the National Initiative for Children's Health Care Quality in its national medical home collaborative to advance the medical home concept -- particularly for children with special health needs. Eleven teams are in place throughout the state, each consisting of a pediatrician, a care coordinator, and two parents. Staff working closely with the state chapter of the AAP, has generated responsiveness to some some productive media education and outreach, and will continue this work through the newly awarded New Freedom initiative grant. /2007/ Minnesota participated in the second National Medical Home Learning Collaborative conducted by NICHQ. It was also one of the original 12 grantees under the President's New Freedom Initiative and will continue medical home activities as part of that initiative. //2007// /2008/ The 2007 Legislature allocated \$1,000,000 in one time funding to expand the work currently being done on the Medical Home project. The CYSHCN program is currently working with the Department of Human Services and the Minnesota AAP chapter to determine next steps. //2008// /2009/ ***The 2008 Legislature enacted significant health care reform legislation including legislation establishing the certification of health care homes. Initially, the target population for health care homes is the fee-for-service Medicaid enrollee. However, the legislation envisions all payers and all populations will participate in health care homes. The Title V-CYSHCN program will be responsible for the certification of practices/practitioners as health care homes by July of 2009. //2009//***

Outreach / education / follow-up - Staff work with Birth Defects Information System (BDIS) staff to provide follow-up to families of all children confirmed as having neural tube defects, cleft-lip/palate or chromosomal anomalies. Staff provide health information related to the infant's condition, and refer the family to additional programs and services and is gearing up to provide these same services for the 44 conditions that BDIS will be tracking.

Staff provides frequent trainings to families and providers about various public program services and how to access them through their "Taking the Maze Out of Funding" sessions. These trainings provide updated information to numerous sectors and providers throughout the state regarding program and policy changes. The Information and Assistance line provides information about and assistance in finding and accessing services and supports for children with special health needs and their families. Additionally, the web-based Central Directory of Early Childhood Services provides information about services and programs in both the web and hard copy format.

Broad dissemination occur of condition-specific Guidelines of Care for Children with Special Health Care Needs which include Asthma, Cerebral Palsy, Cleft Lip and Palate, Feeding Young Children with Cleft Lip and Palate, Congenital Heart Disease, Cystic Fibrosis, Diabetes, Down Syndrome, Deaf and Hard of Hearing, Fetal Alcohol Syndrome and Fetal Alcohol Effect, Hemophilia, Juvenile Rheumatoid Arthritis, Muscular Dystrophy, Neurofibromatosis, PKU, Seizure Disorder, Sickle Cell Disease, and Spina Bifida.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM (SNP) /WOMEN, INFANT AND CHILDREN (WIC)

Also within the CFH Division, Title V staff work with SNP and WIC staff on many shared goals for healthy pregnant women and improved pregnancy outcomes, and healthy infants and young children. Clearly aligned with Title V program activities, Special Supplemental Nutrition Programs has a total of 30.8 FTEs funded by the U.S. Department of Agriculture. This section is comprised of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CFSP). These two programs are 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; and to local food banks to administer the CFSP program. Participation rates have been rising steadily and currently, over 123,000 persons per month are served. /2007/ Over 129,600 persons were served in May of 2006. //2007// /2008 Over 135,000 women and children were served in May 2007 in WIC. //2008// **/2009/ Currently serving 141,864 participants in May of 2009. //2009//**

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 three Bureaus: Policy Quality and Compliance Bureau, Health Protection Bureau, and Community and Family Health Promotion Bureau. Within the Bureau of Community and Family Health Promotion is the Division of Community and Family Health, (CFH), which is responsible for the administration of programs carried out by allotments under Title V.

The CFH Division is organized into the Director's Office and six sections: Office of Public Health Practice (OPHP), Office of Rural Health and Primary Care, Supplemental Nutrition Program (WIC), Maternal and Child Health Section (MCH), Minnesota Children with Special Health Needs Section (MCSHN), and Integrated Support for Cross Divisional Activities Section. The last three 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. This new Division structure was created in August of 2004, when the Division of Family Health was combined with the Community Health Division. The former Director of the Division of Family Health at that time took on a new role of the Title V Coordinator, under which she reports directly to the Director of the Community and Family Health Division. /2008/ CFH was reorganized into four sections, with the Office of Rural Health and Primary Care moving to the Division of Health Policy and the Integrated Support for Cross Divisional Activities Section eliminated and staff reassigned to other areas within the Division. //2008//

The CFH Director's Office houses 17 staff, 8 of which are at least partially funded by the federal Title V funds: 4 grant and administrative staff, an IT staff, and 3 Data/Epi staff. **/2009/ The Director's Office provides overall management of the sections and houses staff who provide shared services to the Division. This includes the Epi and Data Unit, the Communications Unit and grant and financial staff. //2009//**

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 3 work units: Newborn and Child Health Unit, Family and Women's Health Unit, and the Support Unit. This Section has 7.4 FTEs funded by federal Title V funds; 10.8 FTEs funded by targeted state funds; approximately 14.05 FTEs funded by various federal grant programs; and other positions funded through a mix of sources for a current total of 32.3 FTEs. /2008/Changes during this past year include the addition within the section of the Adolescent and School Health Coordinators (both funded by federal Title V funds), the state funded Positive Alternatives Program, and the transfer of 5 state funded FTE's working on Newborn Screening and Follow-up to the MCSHN Section. //2008//

The Minnesota Children with Special Health Needs (MCSHN) 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, and the Community and Systems Development Unit, which has 6 staff housed in District Offices across Minnesota. MCSHN has 18.35 FTEs funded by the federal Title V funds, 3.55 FTEs funded through interagency agreements with the Department of Education, 1 FTEs funded by federal grants, and approximately 1.5 state funded FTEs for a total of 24.05 FTEs. /2008/ Five additional state funded positions supporting the Newborn Screening and Follow-up Unit were transferred to MCSHN from MCH. Additional funding received in the 2007 Legislative session with increase that number by 3 FTEs. The Suicide Prevention Program (state funded) was also transferred into the MCSHN program this year to support children's mental health efforts. //2008// **/2009/ Significant expansion will be seen in 2008 as up to 12.5 FTEs are expected to be added to implement the health care home activities passed in the 2008 legislative session. //2009//**

The Integrated Support for Cross Divisional Activities Section is responsible for supporting and strengthening cross-divisional activities which include: broad internal and external communication; how the Division uses data to monitor and evaluate programs and the health status of mothers and children, including children with special health care needs; and work on emerging issues that require Division --wide input and monitoring as well as a special focus on adolescent and school health. This Section has 6.80 FTEs funded by federal Title V funds; 0.4 funded by Preventive Block Grant; 1.5 FTE funded by SSDI; 0.5 FTE funded by CDC funds; and other partial FTEs funded by a mix of state and federal funds, for a total of 9.8 FTEs. /2008/ The Integrated Support for Cross Divisional Activities Section was eliminated and staff reassigned to others areas within the Division. //2008//

As required, organizational charts are available on file in the Director's Office in the Community and Family Health Division.

Local Public Health More detail regarding the structure, function, and Title V relationships with local public health are described in Section B, Agency Capacity. In 2004, the State Community Health Services Advisory Committee appointed a work group to identify essential local public health activities that should be available in all parts of the state. This Essential Local Public Health Activities Framework is intended to: define a set of local public health activities that Minnesotans can count on no matter where in the state they live; recommend a statewide plan for implementation; provide a consistent framework for describing local public health to state and local policy makers and the public; and provide a basis for ongoing measurement, accountability and quality improvement related to the implementation or assurance of essential local activities. The website address <http://www.health.state.mn.us/cfh/na> provides a schematic of Minnesota's Local Public Health Improvement Process. Title V staff have been and remain actively involved in the ongoing planning for these significant revisions to Minnesota's public health system involving the creation of a set of Essential Local Public Health Activities, Statewide Outcomes, and an Outcome Reporting System. This has provided a good opportunity to insure that MCH related program areas were incorporated into this framework of essential services, statewide outcomes, and development of the reporting system. Title V staff continue a high level of involvement in the ongoing planning, and the training and guidance to local public health as these significant system changes are implemented. More information on this activity is available at <http://www.health.state.mn.us/phsystem.html#essential>. /2008/ Title V programs continue to participate on this project.//2008//

An attachment is included in this section.

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, has served in that capacity since August of 2004. Prior to that time she was the Director of the Community Health Division for 4 years, and has held a number of positions throughout the Health Department including Tobacco Endowment Director, Manager of Environmental Health Services and Manager of Acute Disease Prevention Services. She has worked at the Department for over 20 years, prior to which she worked in local public health agencies in two different Minnesota counties. She has a Masters in Public Health Nursing from the University of Minnesota, and served a term as president of the Minnesota Public Health Association.

/2007/ The Director of the Community and Family Health Division resigned in June 2006 to take another job. The current interim Division Director has worked for the Department of Health for the last 33 years. For the past ten years, she has served as Assistant Division Director first with the Division of Family Health and then with the Division of Community and Family Health. Her educational background is in nursing and she spent her first 20 years with the department in the area of children with special health care needs. The Department intends to do a national search for candidates for this position. It is expected that the position will be filled prior to the end of 2006. //2007//

/2008/ The new Director of the Division of Community and Family Health (Title V Program Director) began her job in February 2007 and 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 has been serving 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. //2008//

The state CYSHCN Director is the MCSHN Section Manager and has a Master's degree in hospital and health care administration and has 21 years of experience in health planning, five in hospital corporation activities, 9 in maternal and child health and 7 in CSHCN.

The state MCH Director is the MCH Section Manager and has worked in public health for 25 years in MCH. Much of her experience has focused on providing services to high risk parents including pregnant and parenting teens. After 20 years of providing MCH services at the local level she accepted a position at the Minnesota Department of Health working in the Reproductive Health Unit. Work in this unit included provision of technical assistance for a MCH programs including MN ENABL (Education Now and Babies Later), TANF home visiting, family planning, infant mortality reduction and women's health. In February 2004 she accepted the position of Maternal Child Health Section Manager at the Minnesota Department of Health. /2008/ The current MCH Section Manager will be leaving in August 2007 to take a new job. Active recruitment for a new Section Manager is all ready underway. //2008// **/2009/ Laurel Briske assumed the responsibilities as the manager of this section in August of 2007. Laurel has been at the Minnesota Department of Health nearly 19 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 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. //2009//

The Title V Coordinator was previously the state MCH Director for 5 years, and has over 20 years of MCH experience -- both at the state and local level. She is an occupational therapist by training and has a MPH in the MCH area from the University of Minnesota. /2008/ This position now is focused on taking the lead role for Child Health Information System development and has assumed a supervisory role for the Data/Epi Unit. //2008//

Parent roles The CYSHCN program has, since FY 2000, had a Family Consultant Advisory Group. Consisting of up to eight parents, this group has brought to policy discussions the voice of parents and their children. Parents demonstrated significant leadership and advocacy skills in service system or policy development at the state or local level prior to his/her selection, and most had been through previous advocacy and or leadership programs. Many parents were either graduates of Parents in Policymaking (a program of the Governor's Council on Developmental Disabilities) or the Minnesota Early Learning Design {MELD} Special Parent trainings. The Family Voices representative in Minnesota has provided administrative oversight to the Advisory Group.

The Advisory Group has been meeting to review the six core outcomes of the Bureau's ten-year action plan and is framing specific actions for the state's work plan, and has also focused on health disparities documented through analysis of the Minnesota Student Survey. Discussions have also been underway regarding important transition issues of responsibilities of local public health agencies brought about by the 2003 legislative changes in the funding of local public health due to significant budget deficits.

/2008/ A parent summit was held this past year. The targeted audience were parents who sat on work groups, advisory committees, and task forces of the Minnesota Departments of Education, Human Services, and Health. The primary purpose of the summit was to foster leadership skills. The keynote speaker was Eileen Forlenza, Family Consultant with the Colorado Title V program. Plans are currently underway to form a youth council and also hold a youth "summit" to assist with transition issues. //2008//

Several 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 MOUs and MOAs in place, and many are less formal.

INTRA-AGENCY COORDINATION

Office of Rural Health and Primary Care Minnesota's Title V and Primary Care Office (PCO) programs support each other's mission and the goals and objectives of 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. The MCH Mental Health Coordinator is working closely with the Rural Health Advisory Committee on their priority for the year -- mental health issues in rural Minnesota. Focus areas include resources and provider capacity, and system issues rural Minnesota in the area of mental health. /2007/ Current focus areas include the ageing population, E-health and telemedicine. The Office of Rural Health and Primary Care was also assigned the responsibility for the Dental Access Grants. These funds support innovative clinical training for dental professionals and programs, which increase access to dental care for underserved populations. Approximately \$1.5 million is available each year to support partnerships between dental training programs and safety net providers, including local public health agencies. //2007// **/2009/ The Office of Rural Health and Primary Care has worked closely with the Division of Community Health and Family Health over the last year on a number of oral health initiatives including: applying for a HRSA oral health workforce grant, supporting a Minnesota Oral Health Summit conference, and working on a state oral health plan. //2009//**

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. Title V continues its leadership and commitment to support work with American Indians in Minnesota. The Title V Coordinator and other key Title V staff work closely with the MDH Tribal Health Liaison on planning for and attending quarterly Tribal Health Directors meetings, supporting internal department-wide meetings on American Indian health; traveling together on site visits to reservations; and providing information, resources and support for the American Indian Health Grants made directly to Tribes in Minnesota. /2008/ The OMMH has recently been moved into the same Bureau as the Division of Community and Family Health facilitating additional opportunities for intra-agency coordination. //2008// **/2009/ 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. //2009//**

Tobacco Prevention and Control Program (TP&C) and Title V MCH Section staff continue to work together to address tobacco prevention 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.

Center for Health Statistics (CHS) staff work on numerous projects with Title V staff, including data analysis, data and systems planning, training and presentations, and consultation. While the Title V Coordinator is the Principal Investigator for PRAMS in Minnesota, the day-to-day administration takes place in CHS, and the PRAMS steering committee includes staff from both Divisions. Joint activities are underway include matching birth certificate information, newborn screening information, and the upcoming Birth Defects Information System (BDIS). /2008/ Responsibility for PRAMS was moved to the Division of Community and Family Health. //2008// **/2009/ CHS continues to play a key role in providing birth and death data for the block grant. They are currently partnering with the Home Visiting program to provide evaluation services and because of their expertise with large data bases are coordinating the matching of WIC and birth certificate data. //2009//**

The Division of Environmental Health houses several program areas on which Title V has been and continues to be priority partners, including the BDIS, lead programs, and work on children's environmental health. 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. Routine newborn screening meetings are held with management staff from both Divisions. ***/2009/ Responding to consumer concerns, the MCH Section and the Division of Environmental Health worked closely to get accurate information out to the public about BPA in baby bottles this year. //2009//***

Ongoing relationships exist between Title V staff and several other program areas in MDH that generally 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), sexual violence prevention, STI / HIV prevention, and as described elsewhere, and the women's health team, /2007/ as well as the mental health team and adolescent health team //2007// convened and supported by Title V but drawing it's 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. See Title V-Title XIX Interagency Memorandum of Understanding . Current collaborative efforts include the Family Service Collaboratives and the Children's Mental Health Collaboratives. 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, home visiting and services to deaf, hard of hearing, and deaf-blind individuals. Management and Executive Office staff of MDH and DHS meet on a quarterly basis to discuss issues of mutual interest and concern. Minnesota has several early childhood programs administered by DHS and representatives of these programs were involved in the MECCS grant (Minnesota's State Early Childhood Comprehensive Statewide Systems grant). Title V staff are important partners with DHS involved in the ABCD II grant, aimed at strengthening services and systems that support the healthy mental development of young children. /2008/ Through a formal Interagency Agreement, Title V funds are used to support 1.5 epi staff at the DHS. Based on jointly identified priorities, these staff have access to the DHS data warehouse for research activities. Current focus is determining if cost savings can be attributed to care coordination within a medical home setting. //2008//

Department of Education The Title V program and the Department of Education (DOE) collaborate on many projects and programs: Family Service and Children's Mental Health Collaboratives, Part C, Early Childhood Screening, pregnancy prevention and abstinence education programs, Fitness Fever, Minnesota Healthy Beginnings, service coordination (for ages 3-21), third party billing, 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 DOE and MDH on the Minnesota Student Survey, including Title V staff. In State Fiscal Year 2004, the CYSHCN program expanded its Interagency Agreement with MDE to include Part B as well as Part C (of IDEA) responsibilities.

The DOE 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, 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 team has primary 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.

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 children's mental health issues provide avenues and linkages 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. Recognizing that no single funding source alone is responsible for changing outcomes, a set of statewide core outcomes was distilled from the collaboratives' efforts. Promoted across systems in 1998, 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. CYSHCN 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.

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. MCH 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 CYSHCN program serves as mentors for each of the students in the University of Minnesota School of Nursing program emphasizing CYSHCN. In addition, CYSHCN program, the School of Public Health and the Center for Urban and Regional Advancement (CURA) of the Humphrey Institute (University) worked together to evaluate MCSHN Developmental Behavior Clinics. 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. MCH epidemiology staff from the University were helpful in planning, recruiting, and hiring for a new MCH Epidemiologist position at MDH.

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	28.4	33.6	25.9	27.5	
Numerator	973	1073	846	885	
Denominator	342137	319809	326227	322047	
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	

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 data are not yet available.

Narrative:

The annual rates for asthma hospitalizations among children less than five years of age increased monotonically from 2001-2004, reaching a peak of 33.6 per 1,000 in 2004, followed by a decline to 25.9 per 1,000 in 2005. Without additional data, we are unable to conclusively explain the patterns observed in the data. Within a given year, asthma hospitalization rates typically show seasonal variations, with a relatively large peak in the fall, followed by a decline and leveling out until the spring, when they show a second smaller peak. Anecdotally, respiratory viruses (i.e., RSV and influenza) and pollens are thought to trigger the fall and spring peak rates of asthma hospitalizations, respectively. Dramatic temporal variations, such as the peak rate of 33.6 per 1,000 during 2004, might be the result of a virulent strain of respiratory virus and/or exceptionally high levels of pollens or other environmental contaminants (e.g., air pollution). Alternatively, large changes in rates might just be a statistical anomaly. Indeed other MDH staff report that Asthma Program data (not shown) suggest that hospitalization rates for children in Minneapolis and St. Paul have decreased over this time period.

The MDH is continuing to identify areas of need, including 'pockets' of higher rates based on geographic location, insurance status, ethnicity, or socio-economic measures. Most recently, in 2007, the MDH in collaboration with stakeholders updated a "Strategic Plan for Addressing Asthma in Minnesota." Supported by a grant from the Centers for Disease Control and Prevention (CDC) and in collaboration with a wide range of partners, the MDH has been implementing a comprehensive set of strategies identified in the original strategic plan. Strategies include expanding and evaluating data collection to better estimate the prevalence and morbidity of asthma in MN; creating better awareness of asthma; providing asthma education to health professionals; and developing public policies to reduce exposure to environmental triggers of asthma. The goal of the plan is to reduce hospitalizations and emergency room visits due to asthma and to improve the lives of those who live with asthma. Although the work of the Asthma Program is not specific to children, it has a significant impact on children with asthma. The Title V programs will continue to work closely in collaboration with the MDH Asthma Program.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	85.7	87.3	87.0	85.1	87.0
Numerator	47494	46819	48467	26114	27667
Denominator	55420	53617	55707	30669	31790
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

Notes - 2006

The 2006 data are not yet available.

Narrative:

Title V staff from both MCH and CYSHCN programs work closely with staff from the Medicaid program (administered by the Department of Human Services) to support continual improvements in this measure. The MCH program is under contract with the Department of Human Services to provide training of providers who implement Minnesota's EPSDT program, which is called Child

and Teen Check-up (C&TC). Trainings specific to administering C&TC are provided to health care providers, and include onsite follow-up consultations and clinic flow assessment. Information is sent to local public health staff regarding C&TC rates in their communities so they can adjust their outreach strategies.

Trainings are also provided to local public health nurses, school nurses, county workers and others about the Medicaid application process and strategies to enhance outreach activities to ensure utilization of preventive services for Medicaid enrolled infants and children. As an example, the Family Home Visiting program administered by MCH, has as one of its outcome measures, that children receive appropriate, timely and ongoing screening. From a broader perspective, there are two existing collaborative activities currently underway focusing on early childhood screening: the Minnesota Early Childhood Comprehensive Screening (MECCS) grant and BUILD a multi-sector planning and advocacy group. Both are assessing needs and capacities, discussing and making recommendations for policy and systems changes to improve child find, screening, assessment and intervention. Additionally, as part of accountability and reporting of local public health agencies two outcome measures are relevant to this HSCI: 1). Increase the percentage of children ages 0-3 who are screened for developmental and social-emotional issues every 4-6 months; and 2). Increase the participation rate of Medicaid and MinnesotaCare enrolled children aged 0 to 21 who receive Child and Teen Check-ups.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
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

Notes - 2007

Historically there are less than 100 children enrolled on SCHIP. Eligibility criteria is children under two whose family income is between 275 FPG and 280 FPG.

Notes - 2006

No changes in MN SCHIP anticipated for 2006.

Notes - 2005

No changes in MN SCHIP anticipated for 2005.

Narrative:

SCHIP eligibility in Minnesota only covers infants 0 to 2 years, whose family income is between 275% and 280% of federal poverty. For this reason, there are very few children enrolled, making this measure non-applicable. MinnesotaCare, Minnesota's state subsidized insurance program was in place prior to federal enactment of SCHIP and MinnesotaCare eligibility at that time went to 275% of federal poverty limiting Minnesota's ability to take full advantage of the SCHIP legislation for coverage of infants and children.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	77.5	77.9	77.6	77.9	
Numerator	54180	54844	54922	57101	
Denominator	69880	70426	70750	73300	
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	

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 data are not yet available.

Narrative:

While the number of women giving birth has increased over the past several years, the Kotelchuck Index has kept pace and even improved slightly. When one digs deeper into the numbers, however, there continue to be disparities in prenatal care for women who are non-White. Low health insurance rates for Hispanic women of child-bearing age, along with a growing number of undocumented immigrants, present challenges for assuring adequate prenatal care. Title V staff collaborate internally with the Office of Minority and Multicultural Health and externally with local public health agencies, Twin Cities Healthy Start, and community clinics to increase these rates. In addition, the MN PRAMS project is now shifting focus to actively promote data analysis and the translation of "data into action." Upcoming analyses of the PRAMS dataset may shed light on the barriers to access to adequate prenatal care experienced by non-White women in MN, and help guide future policy and programming aimed at eliminating these disparities.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	88.1	87.6	79.3	79.2	
Numerator	355484	397000	361695	364416	
Denominator	403484	453000	456000	460000	
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	
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Notes - 2007

2007 data is not yet available

Notes - 2005

Programs included under Medicaid are Medicaid, Emergency Medicaid, and Medicaid subsidized MNCare enrollees covered under the MA/Minnesota Care waiver.

Denominator: 422,000 ever enrolled during the State FY 2005 + 34,000 uninsured all year and potentially eligible for MA or MinnesotaCare (based on the 2004 survey) = 456,000.

Beginning in 2005, capitation payments are no longer included in the numerator count. This largely explains the decrease in the annual indicator.

Narrative:

Continued state efforts described under HSCI #02 will continue to encourage Medicaid enrollment and appropriate health care utilization. The 2007 Legislative Session also enhanced outreach efforts that will impact this indicator. Beginning July 1, 2007 new efforts will include toll-free telephone number for application assistance; application assistance requirements directed at county agencies, hospitals, community health care clinics, libraries, child care centers, school districts and others; and an application assistance bonus (\$25 per application) for organizations.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	45.9	46.7	48.5	48.2	48.8
Numerator	32063	33479	35728	36160	36814
Denominator	69788	71681	73680	75058	75490
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

Notes - 2006

Based on State FY rather than on the CY.

Narrative:

While this indicator has shown improvement over the last five years, it continues to be worrisome that a significant number of Medicaid enrolled children are not receiving appropriate dental services. Minnesota's Medicaid program provides a comprehensive dental benefit set for children. However, challenges continue in locating a provider, especially in rural Minnesota, that will either accept or take new Medicaid patients. Significant legislative attention has created a number of initiatives over the years designed to improve access to services. These include increasing reimbursement fees, collaborative agreements allowing dental hygienists to assume additional responsibilities, dental loan forgiveness programs for working in dental shortage areas, and grants that allow innovative approaches to providing services to underserved populations. During the 2007 Legislative Session add-on payments for critical access dental providers serving

Medicaid clients was continued and one time funding of \$500,000 was targeted to dental services in Minneapolis, Beltrami and St. Louis Counties.

Minnesota was awarded in 2008 both a CDC Oral Health Infrastructure Grant and a HRSA Oral Health Workforce Grant. Activities and funding available under these two grants will assist in building the necessary infrastructure in Minnesota to improve the oral health of our most vulnerable populations, including our Medicaid enrolled children.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0.0	0.0	0.0	0.0	
Numerator	0	0	0	0	
Denominator	9593	8471	9046	10264	
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	

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 data are not yet available.

Narrative:

Almost all children and youth on SSI in Minnesota are eligible for Medicaid. In Minnesota, Medicaid provides a comprehensive package of services including rehabilitative services, thereby negating the role of the Minnesota's CYSHCN program in providing these services. While not providing direct rehabilitative services, the CYSHCN program in Minnesota does contact families who apply for SSI to assure families know about Medicaid eligibility and other options that may be available to them. This is also an opportunity to answer general questions and assist families as needed.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	matching data files	7.7	6	7.1

Narrative:

Low birth weight rates has been increasing for both Medicaid and non-Medicaid births. As occurs with many of Minnesota's data, there are disparities in these populations based on race/ethnicity - - and also for younger mothers. Because there are higher rates of women of color and teen moms enrolled on Medicaid, this higher rate for low birth weight would be expected. It is anticipated that Minnesota's efforts in reducing infant mortality will also impact low birth weight rates.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2005	matching data files	6.2	4.7	5.2

Notes - 2009

2006 birth cohort infant deaths not yet available

Narrative:

Rates of infant death have decreased for both the Medicaid population and for the non-Medicaid population with the Medicaid decrease being the larger of the two. Care must be used however, in interpreting these changes as the number of infant deaths is small.

Title V staff continue to work with the Office of Minority and Multicultural Health on reducing the disparities in infant mortality between Whites, American Indian, and populations of color. The target of reducing by 50% the gap in infant mortality rates between ethnic and racial groups and whites established by the 2001 Legislature has been met for Latinos and Asians. Yet, while infant mortality rates have declined noticeably for African Americans and American Indians disparities between these two groups and Whites continue to exist. Reducing disparities in infant mortality continues to be a priority for the Department of Health.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	76.4	92.1	86.5

Narrative:

Women on Medicaid continue to start prenatal care later than non-Medicaid women. The MN PRAMS project is now shifting focus to actively promote data analysis and the translation of "data into action." Upcoming analyses of the PRAMS dataset may shed light on the barriers to access to adequate prenatal care experienced by non-White women in MN, and help guide future policy and programming aimed at eliminating these disparities.

The Maternal and Child Health section in partnership with the University of Minnesota and the March of Dimes is holding a preconception conference in the fall of 2007, called "A Lifespan Approach to Reproductive Health: Getting it Right". Topics of the conference include: successful models of preconception care, systems challenges and opportunities, genetics and teen health. This effort will be a first step in working to assure efforts in Minnesota are focused on assuring women are healthy prior to pregnancy.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	71.7	81.5	77.9

Narrative:

Kotelchuck Index rates continue to be a concern particularly for our Medicaid population. Significant attention is being placed on improving pregnancy outcomes, especially for Minnesota's racial and ethnic populations, during the upcoming year. In addition, we are trying various strategies to be more successful in over sampling racial and ethnic communities in our PRAMS survey to provide additional insight as to the issues facing these communities.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 <i>The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.</i>	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	275
INDICATOR #06 <i>The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.</i>	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	280

Narrative:

Minnesota's Medicaid program goes to 275% of poverty level for infants 0 to 1 years of age. Minnesota's SCHIP program eligibility is between 275% and 280% resulting in very few infants on SCHIP.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 2) (Age range 2 to 18) (Age range 19 to 20)	2007	275 150 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 2) (Age range to) (Age range to)	2007	280

Narrative:

There are three populations that are eligible for SCHIP in Minnesota. They are 1) infants under 2 who are at or below 275 -- 280% of poverty; 2) Non-citizen, pregnant women, not eligible for Medicaid due to immigration status, who are at or below 275% of poverty; and 3) MinnesotaCare (Minnesota's state sponsored health insurance program) parents who are at or below 100-200% of poverty.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2007	275
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	275

Narrative:

Approximately 34% of all births in Minnesota are to women who are enrolled on Medicaid. SCHIP eligibility only includes: non-citizen, pregnant women, not eligible for Medicaid due to immigration status whose income is at or below 275% of federal poverty level.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for	Does your MCH program have Direct access to the
-----------------------------	--	--

	program planning or policy purposes in a timely manner? (Select 1 - 3)	electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	2	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:

With the establishment of a focused Title V Data/Epi Unit, which now includes 7 FTEs, our capacity in this area continues to improve. Through the SSDI grant activities, relationships with WIC are more productive and linkages with WIC data with Birth and Medicaid files will occur this year. The Data Integration Workgroup continues to work on data compatibility between newborn bloodspot and hearing screening, vital records, and is working with immunizations, birth defects registry and lead screening. The Data/EPI Unit are actively involved in projects with birth defects registry, FAS surveillance, the Follow Along Program, PRAMS, Newborn Hearing Screening and the Family Home Visiting Program. Discussions are underway around enhanced interoperability of child health information systems -- both within MDH and with external partners, including local public health. Shared data positions between Title V programs and Medicaid has significantly improved Title V access to Medicaid data, and further enhanced partnership between the two agencies around Title V issues and program areas.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)

Youth Risk Behavior Survey (YRBS)	1	No
MN Student Survey (similar to YRBS)	3	Yes

Notes - 2009

Narrative:

Minnesota does not participate in the Youth Risk Behavior Survey. Minnesota data on youth is obtained through the Minnesota Student Survey which is administered every three years to 6th, 9th and 12th graders. In response to the question regarding cigarette smoking in the 2007 survey, data indicates a continued downward trend across all three age groups. After increasing in the early 1990's, the smoking rates among 12th graders dropped from 42.1% in 1998 to 23% in 2007. The 6th and 9th grade reported smoking rates have declined slightly between 1995 and 1998, and then the rates started declining precipitously; they were cut more than three quarters among 6th graders (from 7.0% in 1998 to 1.5% in 2007) and by about two thirds among 9th graders (from 29.9% in 1998 to 10.4% in 2007). Although more than one in five 12th graders still reported smoking cigarettes in the past month, these are the lowest rates reported in the history of the Minnesota Student Survey.

IV. Priorities, Performance and Program Activities

A. Background and Overview

//2007/ The 2005 needs assessment identified ten new state priorities. The MCH Advisory Task Force over the last year has worked to identify specific strategies to effectively move Minnesota forward in attaining our annual performance objectives. These recommendations covering all three of the MCH populations will be submitted to the Commissioner of Health this fall for consideration. Both Title V programs have begun the important work of incorporating the priorities into their daily work as noted in the discussion of National and State Performance Measures, their Activity Tables and in other areas of this application.

Minnesota's priorities are broad-based and encompass significant maternal and child health, including children with special health care needs, issues. The ability to impact these priorities will require close partnerships be maintained with local public health, other state agencies, such as the Department of Human Services (the designated Medicaid and Mental Health Authority) and the Department of Education (lead agency for Part C), with advocacy organizations such as PACER and the Minnesota Organization for Adolescent Pregnancy Prevention and Parenting, with professional organizations such as the Minnesota Dental Association, AAP Minnesota Chapter, and ACOG, as well as other areas in the Department of Health such as the Office of Minority and Multicultural Health. As detailed in other areas of the application these relationships have been established and there is a long history of working together for common goals.

The following measures either met or exceeded the target, based on the most recent data available:

- * NPM 1 -- newborn blood spot screening
- * NPM 17 -- VLBW births at high-risk facilities
- * OM 3 -- neonatal mortality rate

Improvement was made on the following performance measures, although the target was not met:

- * NPM 7 -- immunization rates
- * NPM 9 -- third graders with a dental sealant on at least one molar
- * NPM 10 -- motor vehicle accidents of children 14 years or younger
- * NPM 12 -- newborn hearing screening
- * OM 4 -- post-neonatal mortality rates

Measures were maintained, but the target was not met on these following measures:

- * NPM 16 -- youth suicide
- * NPM 18 -- infants born to mothers receiving care in first trimester
- * OM 1 -- infant mortality rate
- * OM 6 -- child death rates

Measures that worsened and will require further focused effort or data analysis:

- * NPM 8 -- teen pregnancy prevention
- * NPM 13 -- children without health insurance
- * OM 2 -- black to whit ratio of infant mortality
- * OM 5 -- perinatal mortality rates

The remaining measures are either based on SLAITS for children with special health needs or are new measures and as such have no new comparison data. //2007//

//2008/ Based on the most recent data available, Minnesota met, exceeded or made progress in meeting the target for the following measures:

- NPM 01 Percent of screen positive newborns who received timely follow-up
- NPM 08 The rate of birth for teenagers

NPM 09 The percent of third grade children who received protective sealants
NPM 10 Rate of deaths to children caused by motor vehicle crashes
NPM 11 Percent of mothers who breastfeed their infants at 6 months
NPM 14 Percentage of children on WIC with BMI at or above 85%
NPM 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
SPM 01 Proportion of counties that universally offer Follow-Along Program
SPM 02 Percent of children who receive EPSDT
SPM 10 Degree to which mental health screening, evaluation, and treatment is provided to CYSHCN.

Based on the most recent data available, Minnesota did not make progress in meeting target for the following measures:

NPM 07 Percent of infants who have received all age appropriate immunizations
NPM 12 Percent of newborns screened for hearing
NPM 16 Rate of suicide deaths among youths
NPM 18 Percent of infants born to pregnant women receiving prenatal care in first trimester
SPM 04 Incidence of determined cases of child maltreatment
SPM 08 Ratio of lbw rate for American Indian women and women of color to the low birth rate for white women.

The remaining measures are based either on SLAITS data or have no new comparison data available. //2008//

2009/ Based on the most recent data available, Minnesota met, exceeded or made progress in meeting the target for the following measures:

NPM 01 Percent of screen positive newborns who received timely follow-up.
NPM 02 Percent of CSHCN whose families partner in decision making.
NPM 03 Percent of CSHCN who receive care within a medical home.
NPM 05 Percent of CSHCN whose families report community-based services.
NPM 06 Percent of CSHCN who received services necessary to make transitions.
NPM 10 Rate of deaths to children caused by motor vehicle crashes.
NPM 11 Percent of mothers who breastfeed their infants at 6 months of age.
NPM 13 Percent of children without health insurance.
NPM 14 Percentage of children on WIC with BMI at or above 85%.
NPM 15 Percentage of women who smoke in the last three months of pregnancy.
NPM 16 Rate of suicide deaths among youths.
NPM 18 Percent of infants born to pregnant women receiving prenatal care in first trimester.
SPM 02 Percent of children who receive EPSDT.
SPM 03 Percent of sexually active ninth grade students who used a condom at last intercourse.
SPM 04 Incidence of determined cases of child maltreatment.
SPM 06 Percent of pregnant women screened for depression during routine prenatal care.
SPM 07 The degree Title V programs enhance statewide capacity for a public health approach to mental health for children and adolescents
SPM 08 Ratio of low birth weight rate for American Indian women and women of color to the low birth rate for white women.
SPM 09 Percent of CSHCN with one or more unmet needs for specific health care services.
SPM 10 Degree to which mental health screening, evaluation, and treatment is provided to CYSHCN.
NOM 02 The ratio of the black infant mortality rate to the white infant mortality rate.
NOM 05 The perinatal mortality rate per 1,000 live births plus fetal deaths.
NOM 06 The child death rate per 100,000 children aged 1 through 14.

Based on the most recent data available, Minnesota did not make progress in meeting targets for the following measures:

NPM 04 Percent of CSHCN whose families have adequate insurance.

NPM 07 Percent of infants who have received all age appropriate immunizations.
NPM 08 The rate of birth for teenagers.
NPM 09 Percent of third grade children who have received protective sealants on one permanent molar.
NPM 12 Percent of newborns screened for hearing.
NPM 17 Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
SPM 01 Proportion of counties that offer a tracking program for birth to age to three.
SPM 05 Percent of pregnancies that are intended.
NOM 01 Infant mortality rate per 1,000 live births.
NOM 03 The neonatal mortality rate per 1,000 live births.
NOM 04 The post neonatal mortality rate per 1,000 live births. //2009//

B. State Priorities

This section describes the relationships between the new state priorities from the recently completed 2005 needs assessment and several measures: the national performance and outcome measures, Health System Capacity Indicators, Health Status Indicators, Minnesota's state priorities from the previous 5 year cycle, and some of the statewide outcomes for Minnesota's developing Local Public Health Grant (LPHG) activities. These LPHG statewide outcome measures are newly developed and work is currently underway to establish the reporting system through which these measures will be reported by local public health agencies to MDH. These priorities are in no particular order. ***//2009/ These state priorities identified in Minnesota's 2005 Needs Assessment process continue to be the focus of Title V activities. //2009//***

Priority 1 -- Improve early identification of and intervention for CYSHCN -- birth to three years. Early identification, screening and referral systems identify children's strengths as well as their needs. These systems can maximize healthy child development and minimize adverse health, social and emotional incidents. Universal screening of all children, birth to age three--regardless of perceived risk factors--promotes thorough identification of those with special health care needs and subsequent provision of intervention services to children who are eligible under Part C of Individuals with Disabilities Education Act (IDEA). This priority is related to NPM 1 - newborn screening, NPM3 - medical home, NPM5 -- services being organized for easy use, NPM12 -- newborn hearing screening, HSCI #2 & 3 children on Medicaid and MinnesotaCare who received at least one initial or periodic screening, and the new statewide outcome for essential local public health activity #19 -- Increase the percentage of children ages birth-3 who are screened for developmental and social emotional issues every 4-6 months. This state priority is essentially the same as the priority from the last 5 year cycle to assure early identification and intervention for young children.

Priority 2 -- Assure that children and adolescents receive comprehensive health care, including well child care, immunizations, and dental health care. Well-child care reduces long-term costs by encompassing a variety of health promoting/disease preventing services and by providing opportunities to detect and treat health conditions early. Within the Medicaid population, as in the

entire population of children and adolescents in Minnesota, incidence of chronic disease is growing - particularly childhood obesity, diabetes, asthma, mental health disorders, and injuries. Prevention and health education services, and early detection and treatment may assist in reversing this trend. This state priority is related to NPM 1 -- newborn screening, NPM 4 -- adequate insurance, NPM 7 -- immunizations, NPM 9 -- 3rd graders with protective sealant on molar, NPM 12 -- newborn hearing screening, NPM 13 -- children without insurance, NPM 14 -- BMI index at or above 85th percentile, HSCI#1 -- asthma hospitalizations, HSCI#2 -- MA enrollees receiving at least one initial or periodic screen, HSCI#6 -- FPL eligibility for MA, HSCI #7B -- EPSDT children receiving dental service, and the new statewide outcome for essential local public health activity #24 increase the percentage of 2 year olds that have been age appropriately immunized.

Priority 3 -- Prevent teen pregnancy and sexually transmitted infections. Teen pregnancy has been steadily decreasing in recent years but has reached a plateau in Minnesota, while STIs have continued to increase among females and among adolescents and young adults, with significant disparities among some racial/ethnic groups. If undetected and untreated, these STIs can lead to other severe health issues and possibly infertility. This priority is related to NPM8 -- teen birth rate, HSI#05a Chlamydia rate for females 15 to 19, and the new statewide outcome for essential local public health activity #13 decrease the rate of births/pregnancies to adolescents ages 15-17.

Priority 4 -- Prevent child abuse and neglect. Child maltreatment is among the most prevalent and far-reaching forms of violence in Minnesota. All four maltreatment types (neglect, physical abuse, sexual abuse, mental/emotional injury) are represented here. Further, child and adolescent maltreatment often precedes adult violence and substance misuse/addiction as the abused child grows older. This is a repeated state priority from the last 5 year cycle and is related to the new statewide outcome for essential local public health activity #21 - reduce the rate of maltreatment and sexual abuse of children ages birth to 17 years olds.

Priority 5 -- Promote planned pregnancies and child spacing. Pregnancies which are intended and/or planned will likely result in improved health outcomes, lower occurrence of perinatal/postpartum depression, fewer abortions, decreased child maltreatment and other negative outcomes for pregnant women, infants and children. Access to family planning is critical to achieve this goal. This priority is a repeat from the last 5 year cycle and is related to NPM8 - teen birth rates, NPM 18 - early prenatal care, HSI#1 -- low birth weight births, and is related to the new statewide outcome for essential local public health activity #13 decrease the rate of births/pregnancies to adolescents ages 15-17.

Priority 6 -- Assure early and adequate prenatal care. Minnesota records approximately 70,000 births annually with an estimated 1.1 million women of childbearing age. The percent of women who met the Kotelchuck Index has been increasing slowly and for 2003 is at 77.5 percent. Women with late or no prenatal care are unlikely to receive the services that promote early identification of problems and the healthiest birth outcome possible. There are continuing racial/cultural and economic disparities in rates of adequate prenatal care. This priority is related to several other measures of prenatal care -- NPM18, HSCI#4, HSCI#5; to 5 of the 6 outcome measures related to infant mortality, as well as HSCI#05b re: infant mortality for MA and non-MA; to birth weights -- NPM 15, HSCI#5, HSI#1, HSI#2; and is related to the new statewide outcome for essential local public health activity #32 early and adequate prenatal care.

Priority 7 -- Promote mental health for children and adolescents, including suicide prevention. Mental disorders were the sixth leading cause of emergency room visits among 5-19 year olds in Minnesota and the leading cause of hospitalization for 5-14 year olds in 2001. From 1998-2002 suicide was the third and second leading cause of death for 10-14 year olds and 15-19 year olds, respectively. Disparities exist within some racial and cultural populations. This priority is related to NPM 16 -- suicide deaths among youth ages 15-19, and to several of the new statewide outcome for essential local public health activities: #14 -- reduce the rates of suicide; #15 --

reduce the rate of hospital-treated self-inflicted injuries; #16 -- increase the screening for mental health needs for children, adolescents, and children with special health needs; #18 -- increase the percentage of children birth to 3 who are screened for mental health and social emotional issues every 4 to 6 months.

Priority 8 -- Eliminate racial and ethnic health disparities impacting mothers and infants. There are substantial health disparities for pregnant women, mothers and infants in Minnesota. Many of these disparities are masked by the excellent health outcomes and very high proportion of our white population. Health disparities exist in birth weight outcomes, infant mortality, neonatal and perinatal mortality, maternal mortality, insurance status, adequacy of prenatal care, and numerous social and economic conditions that affect health. This priority is related to OM #2 -- ratio of black to white infant mortality, HSI#08 -- deaths of infants and children by racial subgroup, and to the new statewide outcome for essential local public health activity #1 increase the number of community health boards that assess disparities and social conditions that underlie health and address them in their action plans.

Priority 9 -- Improve access to care of children and youth with special health needs (including medical home, specialty care and services, oral health and that services are organized for easy use). CYSHCN often have multiple disabilities and service needs cutting across several areas. Thus it is critical to have access to a variety of specialized services, as well as oral health care. Of those children in Minnesota who needed specialty services in 2001, nearly 23,000 (14%) had one or more unmet needs, placing MN last in the Upper Midwest in meeting specialized service needs for CYSHCN. This priority is related to NPM 3 -- medical home, NPM 4 -- adequate insurance, NPM 5 -- families reporting community-based service systems are organized so they can use them easily, NPM 6 -- services to support transition, NPM 9 -- 3rd graders with sealant on molar, NPM 13 -- children without health insurance, HSI#9 -- state health program enrollment, HSCI#1 -- asthma hospitalizations, HSCI#2 -- MA enrollees receiving at least one initial or periodic screen, HSCI#6 -- FPL eligibility for MA, HSCI#7 -- EPSDT children receiving dental service, and new statewide outcomes for essential local public health activities #33 -- families partnering in decision-making, #34 - families reporting organized services systems, and #35 -- increase clients enrolled in health insurance programs.

Priority 10 -- Improve access to comprehensive mental health screening, evaluation, and treatment of CYSHCN. Anxiety, depression (including suicidal thoughts) and other mental disorders often occur among CYSHCN. In addition, CYSHCN are highly vulnerable to maltreatment, including neglect and physical, sexual, and mental abuse. Early identification of and intervention for mental health issues are critical in this population. Having health insurance can influence access to mental health services thereby creating a relationship between this priority and all the insurance measures: NPM 4 -- CYSHCN with adequate insurance, NPM 13 -- children without insurance, HSCI#6 -- FPL eligibility for MA, and HSI#9 -- state program enrollment. This priority also relates to NPM 16 -- youth suicide deaths, HSI#3 -- deaths due to injury, HSI#4 -- nonfatal injury, and to the new statewide outcomes for essential local public health activities #14 suicide rates, #15 hospital treated self-inflicted injuries, #16 increase the screening for mental health needs for adolescents, children with special health needs and pregnant and postpartum women, and #35 -- increase the number of clients who are enrolled in health insurance programs.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	
Numerator	81	74	141	141	
Denominator	81	74	141	141	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

Notes - 2007

2007 data not yet available

Notes - 2006

2006 data not yet available.

a. Last Year's Accomplishments

The percentage of newborns screened remains 99.5% or more as determined by the newborn screening and birth records matching process in place in 2007. The newborn screening fee was increased in July, 2007 to \$101.00 per infant pursuant to the revised newborn screening statute, 144.125. The Minnesota Department of Health Newborn Screening Advisory Committee continued to meet to provide recommendations to the Newborn Hearing Screening Program. In Minnesota, all newborns must be screened for phenylketonuria (PKU), congenital hypothyroidism, congenital adrenal hyperplasia, galactosemia, hemoglobinopathies, biotinidase, amino acid and organic acid disorders and fatty acid oxidation disorders and cystic fibrosis. The Newborn Blood Spot Screening Program tests samples taken from newborns, notifies primary physician of positive test results, tracks the results of confirmatory testing and diagnosis and links families with appropriate resources. This program is operated as a partnership of Community and Family Health Division and the Public Health Laboratory Division.

Major activities completed in 2007 include 1) Integrating short and longer term follow-up activities for newborn blood spot and newborn hearing screening, children with special health care needs and birth defects with goal to work toward a system of integrated data management and improved services to families (HRSA MCHB activity). Resources available for families included primary care, pediatric specialists, genetic counseling, high risk public health follow-up programs, early education, WIC, and financial programs such as Medical Assistance, MinnesotaCare and others. 2) Collaborating with the University of Minnesota to successfully maintain a multidisciplinary clinic for individuals with congenital adrenal hyperplasia and associated conditions. 3) Successfully providing an updated web-based table that lists recommended medically prescribed formula and pharmacotherapy agents for inborn errors of metabolism. 4) Participating in a Region 4 work group that developed a newborn screening online education module for prenatal educators and care providers that made available for CEU credits. 5) Accomplishing educational outreach about newborn screening to key parent, consumer and provider groups, public health partners via displays, presentations. 6) Region 4 Genetics Collaborative with leadership of Minnesota staff developed an information system (registry). In collaboration with seven states in the Region (IL, KY, MI, MN, IN, OH, WI) we identified data elements needed to monitor long term outcomes for individuals with medium chain acyl-CoA dehydrogenase deficiency (MCADD) as the "template" disorder. 6) Minnesota infant and young children with metabolic disorders and congenital adrenal hyperplasia were enrolled in an online emergency care medical services information system (MCHB funded MEMSCIS). Approximately 70 families are participating in this ongoing

activity.

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			
2. Expand follow-up activities to identified infants & their families for all NBS tests.	X	X	X	X
3. Refine lab procedures for reducing false positive/negative test results.	X	X	X	
4. Expand educational materials & activities to include all disorders identified by NBS bloodspot and early hearing detection and intervention	X	X		
5. Refine integrating data collection, infant follow-up & tracking, and program outreach with hearing screening program	X	X	X	X
6. Link identified infants & their families to community resources & a medical home	X	X		X
7. Support primary care providers, comprehensive centers and systems that care for infants and children with rare disorders.	X			X
8. Continue active participation on the Newborn Screening Advisory Committee.				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 Newborn Bloodspot and Newborn Hearing Screening Programs are collaborating to build a system for early identification, diagnosis, treatment and long term follow up. With leadership of Minnesota staff, Region 4 grant to expand an information system for all metabolic conditions found by newborn screening was written and subsequently awarded. Ongoing planning, implementation and evaluation related to this grant activity to determine long term outcomes is extensive and ongoing. To date, data elements for nineteen conditions are developed including a disorder from each of the three major categories: amino academia, organic acidemias and fatty acid oxidation disorders. Conditions over time are being added. A new initiative to establish a means of obtaining information about long term follow-up for congenital adrenal hyperplasia via an information system using information learned from previous experience is now starting. States and endocrinologists from region meet for the first meeting in May, 2008. In April 2008 most aspects of short term tracking with the exception of connecting families to resources were transferred to the Public Health Lab. Staff began assessing means to track infants over an extended period of time as well as improving data linkages. Staff is also providing leadership starting two parent groups related to specific conditions.

c. Plan for the Coming Year

1) Focus on long term follow-up needs of families and learning more about long term outcomes. Staff will collaborate with many partners and systems to better meet the needs of systems serving this population as well as providing information to families about a variety of services for individuals with a confirmed NBS, including those that provide care coordination and referral, medical financial support, parent support, education programs. Methods to integrate activities into the newborn screening system more fully and to evaluate the impact of these activities are being developed. 2) Extensive ongoing work with Region 4 grants will extend and enhance ability to put

in place a registry to record and monitor long term outcomes of individuals with metabolic conditions found by NBS as well as those with congenital adrenal hyperpasia. 3) Collaboration, technical assistance and evaluation of needs of children with cystic fibrosis is a new focus now that Minnesota recently began screening for this disorder. Minnesota has two nationally accredited centers and one seeking accreditation. 4) Maintaining support assistance to parent organizations, especially two new family groups (FAOD and CAH) is anticipated. 4) Plans are in process to support primary care providers to provide high quality care that is family-centered and coordinated for NBS confirmed population via the Minnesota Medical Home Initiative 5) Region 4 activities will support many aspects of collaboration with medical home providers. Minnesota will remain an active participant in the seven work groups and the two competitive grants beginning in 2007 and continuing thru a 5 year period of time.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	59.1	59.1	63	63	63
Annual Indicator	59.1	59.1	59.1	60.3	
Numerator	97156	90893	90109	103284	
Denominator	164329	153795	152468	171251	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	63	63	63	65	65

Notes - 2007

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.

2007 data not yet available.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2005.

a. Last Year's Accomplishments

The MDH/MCSHN funded Parent Leadership Summit was held in the spring of 2007 with 60 parents of children with special health needs attending. In 2007 the focus of the Leadership Summit included information on the success of parent leadership in Minnesota, training on the Model for Improvement as a tool for making changes in policy and committees and building

strength in parent leadership through connecting parents on a regional basis. The journey of a recently elected state legislator who has two children with special needs was highlighted and a parent leader from Colorado gave the keynote address.

In the work of the Minnesota Medical Home Learning Collaborative the role of parent partners continued to grow. When the Medical Home Collaborative began 4 years ago the role of parents participating on quality improvement teams was a relatively new concept for many providers and parents. Now parent partners have become parent leaders and are now taking on a significant role as faculty for the Minnesota Medical Home Collaborative. Medical Home parent partners consistently present during new team orientation on the role of family-centered care in Medical Home and the role of parent partners on the teams. In addition parents are presenters at most breakout session at each Medical Home Learning Session.

Over the past two years the Minnesota Children with Special Health Needs Section at the Minnesota Department of Health has taken an active role in supporting Family Voices of Minnesota, which is part of the Family Voices National network. Family Voices of Minnesota includes an informational web-site and e-mail network of families to provide information and connections to system resources, news, policy updates and connections to opportunities for parents to serve on local, regional and state committees.

District staff held 47 Taking the Maze Out of Funding Workshops with a total of 619 attendees including parents of children with special health care needs, local public health, education and human service providers and numerous private health and related services providers. The tools developed to discern which financial resources a child may be eligible for are particularly useful according to participant evaluations. Decision trees are also quite helpful, particularly when looking for resources which may be based upon immigration status.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Update MAZE training materials to reflect legislative, policy and procedural changes to programs. Update MAZE training materials to reflect legislative, policy and procedural changes to programs.				X
2. Continue to target parents as a MAZE audience.	X		X	X
3. Support medical home teams and their parent-members		X		
4. Provide financial recognition of parent time on medical home and other activities		X		
5. Support outreach activities of the MnSIC process to parents on Interagency Coordinating Committee.				X
6. Support establishment of a strong Family Voices network in the state.				X
7. Establish and support regional networks of parent leaders.				X
8. Support the development of condition specific parent to parent groups through the newborn screening programs				X
9.				
10.				

b. Current Activities

Three basic concepts define the approach that the CYSHCN program takes in its overall strategic and operational program decisions. In April 2008 the focus of the Leadership Summit was on Cultural and Linguistic Competency and included a presenter from the National Center for Cultural Competency discussing the role of cultural competency in the parent leadership

movement. Minnesota Title V-CYSHCN staff were instrumental in planning the Summit as well as providing funding for the Summit. Despite a snow storm on the day of the Summit, 50 families attended.

Over the past year through collaboration with the Healthy and Ready to Work National Center, a youth network has been developed in coordination with Medical Home Improvement teams. This youth network developed a tip sheet for physicians and families in the Medical Home Learning Collaborative that was distributed at the April 2008 Medical Home Learning Session. In addition, the members of this youth network presented a breakout session at the April Medical Home Learning Session.

At the April 2008 Medical Home Learning Session representatives of Partners in Policy Making, a program of the state Developmental Disabilities Council presented a breakout session that included information about the history of disabilities in state and county and how family and consumer leadership in policy has improved the lives of individuals in our state.

Staff continue MAZE trainings and work on expanding parent partners on policy making boards

c. Plan for the Coming Year

The CYSHCN Title V program in Minnesota will continue and increase its role as a leader in the state of Minnesota in promoting parent/family/youth partnership and leadership in program and policy planning, implementation and evaluation. In addition, the CYSHCN program intends to take a leadership role in promoting and enhancing family-centered care throughout Minnesota through partnership with providers, hospital systems, policy makers and other state programs.

Minnesota's CYSHCN program intends to be a leader in supporting the agreement between AMCHP and Family Voices National and therefore will enhance its role in supporting Family Voices of Minnesota.

At the policy level, the CYSHCN program will continue to advocate for the active participation parents in leadership bodies within Title V and related activities such as the Newborn Screening Committee, the Minnesota State Interagency Committee (MNSIC), and the Maternal and Child Health Advisory Task Force.

At the practice level, parents as quality improvement partners is viewed as essential in the Medical Home Collaborative. No clinic is able to participate in the collaborative without first identifying who their parent partners are. The CYSHCN program will continue to promote and facilitate the role of parents as leaders in the Minnesota Medical Home Collaborative. Parents will continue to serve as planners and presenters in the Collaborative Learning Sessions in the next year.

At the individual level, the monograph "Working With Doctors" will continue to be available to families who are looking to become partners with their child's physician. The toll free information and assistance lines will continue to serve as a resource for parents, who sometimes struggle with the physician/parent relationship, by providing resources and ideas for varying approaches to enhance communication.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	48.7	48.7	53.6	53.6	53.6
Annual Indicator	48.7	48.7	48.7	51.8	51.8
Numerator	80059	74898	74252	88280	
Denominator	164392	153795	152468	170372	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	54	54	54	54	54

Notes - 2007

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 - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Denominator is based on prevalence estimate of 12.4% of child population in MN having a special health care need. Child population based on US Census estimate for 2005.

a. Last Year's Accomplishments

Minnesota has had a Medical Home Learning Collaborative since 2004. The collaborative remained at 21 teams last year.

The January learning session focused on transition issues. The May session focused on coordination with specialty care as its focus with guest speaker Rich Antonelli. The September 2007 Medical Home Learning Session highlighted the release of Bright Futures, meeting mental health needs in the primary care setting and on enhancing community organizations partnerships with local public health staff from the Follow Along Program, school based or private speech and language clinicians.

The New Freedom Initiative coordinator continued to participate in the Parents as Teachers Program which is part of the pediatric residency program at the University of MN. Through this program pediatric residents receive an introduction to family-centered care, parent/professional collaboration and Medical Home through discussion and written material as part of the Behavioral Pediatric rotation, which is a mandatory first year rotation for all pediatric residents. This year the Adolescent Health rotation for 2nd year residents began planning for a Parents / Adolescents as Teachers program. Discussions on formally incorporating Medical Home concepts in the the Med/Peds rotation began.

The 2007 Legislature provided funding for four pilot projects for children and adults with complex health care needs who are enrolled in fee-for-service medical assistance, to the extent permitted

by federal requirements. At least two of the grantees must focus on children with autism or children with complex/multi-diagnoses physical conditions. The purpose of the projects is to pilot primary care clinic models of care delivery focused on care coordination and family involvement. It also provided funding for a provider-directed care coordination program for medical assistance recipients who are not enrolled in the prepaid medical assistance program and who are receiving services on a fee-for-service basis. This program provides payment to primary care clinics for care coordination for people who have complex and chronic medical conditions. Clinics must meet certain criteria such as the capacity to develop care plans; have a dedicated care coordinator; and have an adequate number of fee-for-service clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement. Lastly, it appropriated \$500,000 a year for two years to expand the medical home learning collaborative initiative in collaboration with the commissioner of human services. Services provided under this funding must support a medical home model for children with special health care needs.

The Medicaid utilization data project encountered some difficulty in that matching internal and external controls to our medical home participants using administrative data resulting in disparate groups. As predicted, the rate of inpatient admissions decreased as did ER visits to a certain extent among the children seen by medical home team providers. Well-child and dental visits increased among those children. In the absence of adequate control groups, it is difficult to say if those improvements are directly affected by having a medical home or are the result of some other factor.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Direct and Coordinate Medical Home Learning collaborative		X		
2. Continue to partner with the state chapter of the AAP				X
3. Continue efforts to assuring identified reimbursement strategies for medical home come to fruition.				X
4. Continue efforts at integration of mental health services with medical home activities.	X		X	X
5. Promote concept of medical home through education of local public health personnel.				X
6. Pursue curricula development about medical home with appropriate university programs.				X
7. Work with state medical association, as it promotes medical home.				X
8. Plan implementation of 2008 "Health Care Home" legislation with a continued focus on need of cshcn and their parents.			X	
9.				
10.				

b. Current Activities

An emphasis has been placed on recruiting new teams for the Medical Home Learning Collaborative now that funding has been secured for two more years. Five teams started in January; three will start in April. The teams include a hospital based primary care clinic specializing in CYSHCN and a team led by a family physician serving adults with chronic care needs. A team from Eastern North Dakota (where a number of CYSHCN from Minnesota receive their care), will also attend at least one learning session. January's learning session focused on the relationship between primary care and the IEP / IFSP process, parent partnerships from focus groups to parent networks and making the case for care coordination. In April, planned care visits and coding will be emphasized.

The Governor signed health care reform legislation in June. Article 2 in that bill established "health care homes" in Minnesota with the intent that Medicaid enrollees will participate first but that health care homes will be available on a voluntary basis for all regardless of payer. The Title V-CSHCN program will establish and utilize the IHI Collaborative learning model to train and certify primary care practitioners who decide to become a health care home. The Medicaid agency will develop a commensurate level of reimbursement for health care homes.

c. Plan for the Coming Year

The MCSHN program will continue medical home learning collaboratives through funding appropriated during this past legislature session. This will include learning sessions, continued support of the state AAP chapter with specific outreach to the Minnesota Academy of Family Physicians (which has now endorsed the medical home model), nurse practitioners, physician assistants and others who may provide primary care to individuals with complex or chronic conditions. Such significant expansion of Medical Homes may dictate a regional approach.

The current medical home collaborative will be integrating the EHDI regional teams and their quality improvement initiative beginning in September. In addition, a medical home mental health index tool will be created to encourage medical home teams to work toward best practices in mental health screening, evaluation and treatment. This year's collaborative curriculum will highlight care coordination and cultural competence. Collaborative faculty will include staff from the Center for Medical Home Improvement and from the National Center for Cultural Competence.

The methods used in the Medicaid cost study will be revised to more closely align the control groups to the current medical home patients if at all possible.

Continued participation in the care coordination workgroup spearheaded by the Department of Human Services is anticipated as is work with the University of Minnesota Medical School.

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	2003	2004	2005	2006	2007
Annual Performance Objective	68.8	68.8	70	70	70
Annual Indicator	68.8	68.8	68.8	66.3	66.3
Numerator	113101	105795	104898	116294	
Denominator	164392	153795	152468	175428	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	66	66	66	70	70

Notes - 2007

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 - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Denominator is based on prevalence estimate of 12.4% of child population in MN having a special health care need. Child population based on US Census estimate for 2005.

a. Last Year's Accomplishments

Although not one of the final 10 priorities ultimately adopted in the Title V Needs Assessment process, insurance coverage was one of the top 15 priorities in each of the three population groups (CYSHCN, Women and Infants, and Children and Adolescents) participating in that process. 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. Latest available data (2007) indicate 94 percent of children and youth 17 and under have insurance. However, 19 percent of youth between 18 and 24 were uninsured. The overall uninsured rate for the state is 7.2 percent.

Uninsured rates for the state have been derived from periodic health care access surveys. Historically, these studies have always been funded from non-state sources. The 2007 Legislature appropriated funds to conduct these studies every two years. The Title V-CSHCN program was instrumental in including a question on disabilities on the 2007 survey. Results have yet to be analyzed.

The issue of the adequacy of insurance for children in general, and CYSHCN in particular, has never been as rigorously addressed as the question of whether children have any type of health insurance. The only studies analyzing adequacy of insurance are the National Survey of Children with Special Health Care Needs conducted in 2001 and 2005. The 2001 study indicated that 68.8 percent of Minnesota's children with special health care needs had adequate insurance at the time of the survey and the 2005 study indicated 70 percent had adequate insurance.

One area of continuing activity by the CYSHCN program is that staff is instrumental in educating families and community professionals about eligibility and coverage criteria of publicly funded, health insurance programs. This activity, called MAZE trainings ("Who Pays? Taking the Maze out of Funding"), provided 42 different training sessions during the report year.

Minnesota expanded enrollment criteria in its Part C program this past year. Title V-CSHCN staff were instrumental in developing protocols for eligibility determination for participating in Part C.

Staff also work closely with the Children's Mental Health Services Division of the Minnesota Department of Human Services by supporting training sessions on the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood™ (DC:0-3™). This is a classification system developed by the Zero to Three organization and is based on the recognition that young children can experience social-emotional and developmental disorders and that a system for diagnostic classification sensitive to the developmental issues of young children was needed. It can also be used as a basis for third-party reimbursement since DC: 0-3™ codes can be converted to DSM-IV codes. Approximately 990 professionals received this

training through December of 2006.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyze 2008 legislative changes in publicly-funded, state health insurance and waiver programs.				X
2. Update MAZE materials to reflect legislative policy or procedural changes to programs				X
3. Promote and conduct MAZE trainings statewide.		X		X
4. Integrate MAZE trainings as a resource into medical home activities.		X		X
5. Continue support of Children's Mental Health Services initiatives and DC:0-3 Trainings.	X		X	
6. Maintain and enhance staff knowledge base about insurance, issues and implications.				X
7. Promote inclusion of CYSHCN-related insurance questions on appropriate surveys conducted by MDH (or other) programs.				X
8. Address the impact of availability of health insurance for small business employees and its impact on families of CYSHCN.				X
9. Continue to work with DHS on reimbursement for care coordination.				X
10.				

b. Current Activities

Five activities have been directed to the issue of adequacy of insurance during the current federal fiscal year. Approximately 900 parents and professionals received MAZE trainings between October of 2007 and April of 2008. Secondly, the collaboration with Children's Mental Health Services of the Minnesota Department of Human Services (DHS) to sponsor DC: 0-3™ trainings throughout the state will continued through calendar years 2007 and 2008.

The CYSHCN program continues to partner with the hospice and palliative care program of a local children's hospital to support its efforts to restructure Medicaid reimbursement for children's hospice/palliative care. Title V funds continue to be used to support positions at the state Medicaid agency to utilize the Medicaid claims database in order to research claims and analyze the efficacy of medical home practice. Lastly, MCSHN staff worked closely with department of human services colleagues in the development of a universal assessment protocol to ensure greater consistency across the state for determining eligibility for publicly-funded programs for all populations with disabilities under the age of 65.

c. Plan for the Coming Year

MAZE and DC: 0-3™ trainings will continue as will the partnership with DHS to research Medicaid claims and encounter data on MCH populations. MCSHN will continue to support the effort to restructure hospice and palliative care reimbursement for children. Given the on-going and multi-faceted efforts to segment health insurance coverage, it is incumbent upon MCSHN to develop an expertise on insurance products such as Health Savings Accounts, Health Reimbursement Accounts and other forms of consumer directed health care products in order to provide timely and accurate information to families of CYSHCN on these issues. Finally, Minnesota is embarking on significant efforts at health care reform and MCSHN needs to ensure that linkages between those efforts and the Title V-CSHCN program exist to ensure interests of CSHCN and their families are represented.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	73.5	73.5	78.5	78.5	78.5
Annual Indicator	73.5	73.5	73.5	90.7	90.7
Numerator	120828	113039	112064	160677	
Denominator	164392	153795	152468	177112	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	91	91	91	94	95

Notes - 2007

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 - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Denominator is based on prevalence estimate of 12.4% of child population in MN having a special health care need. Child population based on US Census estimate for 2005.

a. Last Year's Accomplishments

In 1998 Minnesota enacted legislation known as the Interagency Services for Children with Disabilities Act. This system, now formally referred to as the Minnesota System of Interagency Coordination (MnSIC) by its state and local partners, has as its purpose the "...development and implementation of a coordinated, multidisciplinary, interagency intervention service system for children ages birth through 21 with disabilities."

This legislation affects all agencies and educational organizations working with these individuals and their families. It includes the state Departments of Health, Human Services, Education, Corrections, Commerce, Employment and Economic Development, and Human Rights. A state appointed committee -- the State Interagency Committee (SIC) -- has been appointed to oversee and make key policy decisions about the development and implementation of this initiative at the state level. The CYSHCN director is a member of this policy-making body.

The legislation also affects local community interagency committees serving children and youth

with disabilities and their families. The governing boards of the 95 plus local Interagency Early Intervention Committees (IEICs) are designated with the responsibility of designing and implementing their birth through 21 interagency system. The governing boards are members of local school boards and county boards. However, other local interagency groups such as the Family Services Collaboratives, Children's Mental Health Collaboratives, and Community Transition Interagency Committees have responsibility to work in cooperation and coordination with this process. The goal of this endeavor is to increase the level of coordination of services for the individual child and his or her family. Success has been modest. This coordinated birth through 21 interagency system is modeled after the Part C program.

The Minnesota Department of Education is the lead state agency for the implementation of the Part C program of IDEA. The CYSHCN program has an interagency agreement with the department of education that delegates the child find responsibility pursuant to IDEA to the Title V-CYSHCN program. The Infant Follow Along Program is the means by which this responsibility is implemented. The Follow Along Program is implemented at the local level primarily by local public health agencies. There were more than 40,000 children birth to five enrolled in the program. The program uses the ASQ and ASQ-SE screening tools.

Use of these screening tools has, in part, increased the collaboration with the Children's Mental Health Services (CMHS) Division of the Minnesota Department of Human Services (DHS). It is the recipient of a Commonwealth Fund grant (ABCD-II), the goal of which is to integrate mental health services into the primary care practitioner setting. Part of the objectives designed to meet this goal have included provider training in the ASQ and ASQ-SE screening tools, as well as trainings in the Diagnostic Classification 0-3 (DC:0-3™) system. The purpose of these trainings is to facilitate young children with diagnosable conditions accessing mental health services under the state's Medicaid system.

MCSHN staff conduct trainings called "Who Pays? Taking the Maze out of Funding" targeted to parents, professionals and advocates. Over 800 individuals attended these trainings during the report year. The content of the trainings provides up-to-date information about eligibility and coverage on the state's Medicaid program, the MinnesotaCare program and the state's home- and community-based waiver programs.

The Environmental Health Surveillance and Assessment Section of the Environmental Health Division of the Minnesota Department of Health is a CDC grant recipient to develop and implement a birth defects surveillance system. MCSHN has assisted this unit through serving as a resource for the families of infants identified with a birth defect, development of fact sheets for each of 44 different birth defects and working with local public health agencies for those agencies electing to be the first public health point of contact for families.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to partner with other state agencies to fully implement the interagency coordination process				X
2. Maintain the web-based central directory of services for children with special health care needs		X		X
3. Continue state support and technical assistance for the Follow-Along Program			X	X
4. Continue participation and leadership in statewide ICC, IEIC and Part C activities				X
5. Continue support of the birth defects surveillance system at the state level and support of local public health at the community level	X		X	X

6. Provide support and technical assistance to local public health agencies in their systems development work relevant to CYSHCN				X
7. Partner with department of education in implementing revised state rule for Part C eligibility				
8.				
9.				
10.				

b. Current Activities

The MnSIC activity is an on-going activity. The implementation of the concept of interagency coordination of services for disabled children has met with modest success. Local concerns, especially local education, center on unfunded mandates and payer of last resort for mental health services. Consequently, much of the current year has been spent on revising training materials used by state level personnel for trainings at the local level. The overall goal of MnSIC is to increase the number of children and families participating in the process.

The MCSHN program is the original point of contact for families identified through the birth defects surveillance system for the purpose of linking families with resources. During the current year discussions have taken place with local public health agencies of some of the more populous counties for those agencies to assume that function; some have chosen to do so and some not.

The proposed revision of the Part C Rule was completed in July of 2007. Implementation of the revised rule consumed the time and resources of education, health and human services throughout state fiscal year 2008 because these are the state agencies with Part C responsibilities.

c. Plan for the Coming Year

The Title V-CYSHCN program continues its support of the MnSIC concept and activity because Title V believes there are many parallels between medical home and the MnSIC goal of interagency coordination including coordination of services, family-centered care and an increased role for parents in the decision-making process. The primary strategy for communication over the next few years to ensure community-based service systems are organized for ease of use by families rests with utilizing the infrastructure of the 96 local Interagency Early Intervention Committees (IEICs).

The CYSHCN program will continue to collaborate with Children's Mental Health Services through co-sponsorship of the DC:0-3™ training sessions and will continue implementation of medical home activities. "Who Pays?" training materials will be updated and trainings will be provided free of charge to multi-disciplinary audiences. Significant and numerous trainings will be required for local level providers at the community level (IEICs, education, social services, public health) as a result of the expanded Part C Program.

MCSHN will support the birth defects surveillance activity in three different ways. First, it will review and update as necessary the fact sheets on each of the 44 different birth defect conditions. Secondly, the Information and Assistance function will be used to link families with resources. Lastly, MCSHN will serve as a back-up for those local agencies that elect to be the first point of contact to link families with resources. The family follow-up from newborn hearing screening and newborn metabolic/endocrinology screening was relocated to the MCSHN program in SFY 2008. This presents several managerial challenges through the coming federal fiscal year, but also presents several opportunities for more complete integration of these screening programs with the on-going medical home activity.

Lastly, MCSHN is engaged in a multi-division activity on the topic of integrated child health information systems, the purpose of which is to establish a department-wide, coordinated approach to the analysis, planning and business case development of activities that will enable thoughtful and efficient progress towards creating greater interoperability across child health information systems within MDH.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	5.8	5.8	6.4	6.4	6.4
Annual Indicator	5.8	5.8	5.8	5.8	52.9
Numerator	9535	8920	8843		
Denominator	164392	153795	152468		
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
	2008	2009	2010	2011	2012
Annual Performance Objective	55	55	57	57	59

Notes - 2007

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 - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Denominator is based on prevalence estimate of 12.4% of child population in MN having a special health care need. Child population based on US Census estimate for 2005.

a. Last Year's Accomplishments

Participation on State Transition Interagency Committee (STIC) continued. District staff is active in Community Transition Interagency Committees (CTIC) and work with local public health agencies. District staff shared information at local Maternal Child Health meetings to help local public health nurses better understand the impact of health on transition. District staff presented information to school nurses on the impact that health, education and human services can have on transition outcomes. Transition information was distributed at Developmental Behavior Clinics.

Adolescents are taught how to advocate for themselves. Self care, social skills, transition to adult health among other interventions was discussed.

The January 2007 medical home collaborative learning session focused on transition issues. A real highlight was a youth, parent, physician panel addressing building independence over a lifetime. Dr. Nimi Singh from the Department of Pediatrics at the University of Minnesota presented physicians with real world tools and strategies to use in interviewing adolescents. Ceci Shaplund of the National Healthy and Ready To Work Center provided parents with a checklist for building independence. A youth panel unveiled a website they have developed for teens with special health needs called Project C3.

MCSHN developed information on transition issues for it's website. The Minnesota Student Survey will be in the field in the spring of 2007. A great deal of effort and discussion regarding the question identifying students with special health care needs resulted in dividing the original question "Do you have a physical or mental health condition that has lasted more than a year?" into two questions to allow analysis by physical condition or mental health condition. Previous surveys have demonstrated substantial disparities between youth with special health care needs and their peers, particularly in the areas of victimization (both at home and at school) and symptoms of depression.

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 medical home learning sessions				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 further analysis of the MN Student Survey relevant to youth with special health care needs				X
6. Continue involvement with the CTIC			X	X
7. Provide transition services for adolescents seen in the DBCs.	X			
8. Provide information and assistance to individual callers seeking advice on transition planning	X			
9. Promote transition as a topic to be addressed by state professional medical organizations			X	X
10.				

b. Current Activities

The Taking the Maze out of Funding transition packet is annually update and distributed throughout the state as part of Maze presentations. District staff offers technical assistance to local service providers, parents and youth on transition issues.

MCSHN co-sponsored a conference with the CSHCN at the University of Minnesota School of Nursing called "Building an Interdisciplinary Research Agenda to Enhance Quality of Life and Transition to Adulthood for Youth with Chronic Health Conditions" on Jan. 18. The working conference brought together health professionals, educators, policymakers, human service providers and young adults to focus on transition issues facing adolescents with chronic conditions. The attendees recommended that measurable outcomes be developed through interdisciplinary research.

The co-director of the Healthy and Ready To Work National Center serves on the Medical Home

Collaborative Leadership Advisory Committee. In April Healthy and Ready to Work provided a breakout session at the Medical Home Collaborative on transition in order to engage individual health care practitioners in improving transition services for CYSHCN. A number of Medical Home teams are engaged in improving transitions. Youth focus groups, having youth members of the quality improvement team and developing materials are among the activities.

A MNSic priority this year has been the transition from special education to community-based services for young adults

c. Plan for the Coming Year

The Minnesota Department of Education will be distributing a Transition Toolkit during the next year. The kick off workshop will be in October. MCSHN will be providing the information on health and transition and also be a part of the planning and distribution. Medical Home teams will be utilized where ever possible to educate the medical community about the culturally appropriate needs of children in transition so that youth are able to transition to adult health care, work and independence.

District staff will increase their involvement in CTICs, Medical Home Teams, School Nurse and MCH meetings to address the implications of chronic disease and disability on youth with special health needs. MCSHN staff will serve on the state level transition advisory group.

Analysis and dissemination of the Minnesota Student Survey relative to students with special health care needs will be priority area for MCSHN.

The coordinator of the Healthy and Ready to Work National Center will continue on the Medical Home Leadership Committee and facilitate youth leadership 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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	90	90	90	90	90
Annual Indicator	83.9	85.2	82.5	82.6	
Numerator	55373	56015	55417	58242	
Denominator	65999	65745	67173	70511	
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
	2008	2009	2010	2011	2012
Annual Performance Objective	85	85	86	87	87

Notes - 2007

2007 data not yet available

Notes - 2006

2006 data are not yet available.

Notes - 2005

The percentage of children age 19 to 35 months old who have completed recommended immunizations is estimated from the National Immunization Survey. The denominator is estimated from the birth records, resident 2 year olds. The numerator is calculated as the percentage of children, age 19 to 35 months old, who have completed immunizations, multiplied by the denominator.

Data is estimated from the National Immunization Survey and not true population values and have a built-in error margin which fluctuates between 1-5%. When comparing estimates between years, the difference, especially if small could easily be due to chance. Thus, this decrease is believed to be due to natural fluctuations rather than an indication of negative trends. Next years data will be monitored closely to assure this assumption is correct.

a. Last Year's Accomplishments

Although Minnesota's statewide immunization rate is consistently above the national average, there are pockets of under-immunized children in some high risk populations. In Minnesota, Title V is not the lead entity on immunization activities; rather the immunization program is housed in 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 training sessions to providers through Child and Teen Check-Ups (C&TC) trainings. C&TC is EPSDT in Minnesota.

Minnesota continued its work around 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. Immunization registry staff supported some "pilot" attempts for ICHIS, using their system to test possibilities of data matching across child health program areas. 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, local health departments, 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. This information system provides clinics, schools, and parents with secure, accurate, and up-to-date immunization data. MIIC users can generate reminder cards for upcoming or past due immunizations and can use the system to greatly simplify the work of schools in enforcing the school immunization law. In Minnesota, all parents of newborns are notified of their enrollment in the registry through Minnesota's birth record process and an immunization information packet given to them in the hospital. They are given an 800 number to call if they have questions or do not want to participate. Only a few individuals decline each month, most because they object to immunizations in general. Many who consider opting out stay in MIIC once they understand the benefits to themselves and their child.

Regional immunization registries are supported by the MDH through technical, policy, and financial assistance, as well as hosting the web-based information system and managing its security. The MIIC is increasing its saturation level and currently has a saturation level of 80% or more for 80 out of 87 counties for children 19 to 35 months of age for one shot entered into MIIC. For children of the same age with 2+ immunizations entered into MIIC, 79 out of 87 counties have a saturation level of 80% or above.

The Eliminating Health Disparities Initiative (EHDI), established in the 2001 legislative session to close the gap in the health status of Africans/African Americans, American Indians, Asians, and

Hispanic/Latinos in Minnesota compared with Whites, supports grants to communities. One of the priority areas is increasing immunization rates. Activities this past year included conducting immunization clinics, awareness campaigns and education workshops, and assisting individuals with accessing health care and referral services. Anecdotal information indicates increased immunizations by school entry and increased knowledge of the importance of immunizations among people of color and American Indians.

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. Assure immunization review part of WIC clinic services			X	X
4. Support local community immunization registries			X	X
5. Support MIIC (immunization registry) 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 continues to provide information and training about immunizations, immunization requirements, access, availability, and other immunization related information to child care, home visiting and C&TC nurses, and other local public health MCH staff. Information is also downloadable from the MDH web site. Recently, the immunization unit, WIC, and C&TC providers have been collaborating to link immunization information in the various systems to improve vaccination coverage.

The IPI (Immunization Practices Improvement) Program uses MIIC data in working with medical and other immunization providers. The focus of IPI is on provider quality assurance. An IPI assessment is now required of all providers. IPI hosts monthly conference calls with local health departments.

MIIC saturation levels will continue to be tracked and increased participation in MIIC encouraged.

c. Plan for the Coming Year

Continue activities stated above with a focus on those activities that support the development of ICHIS with MIIC as a key partner. This work with ICHIS will continue over the next several years as Minnesota works to meet its statewide e-Health goals. Collaboration with MCH and partners will continue to address and work to eliminate health disparities related to immunizations.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	13.5	13.5	13	13	12
Annual Indicator	13.4	13.6	12.5	13.8	
Numerator	1467	1478	1365	1533	
Denominator	109237	108688	109134	110819	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	13	12.5	12	11.5	11

Notes - 2007

2007 data not yet available

Notes - 2006

2006 data are not yet available.

Notes - 2005

The 2005 data is not yet available.

a. Last Year's Accomplishments

Minnesota used approximately \$5.5 million in state and federal funds to support the Family Planning Special Projects (FPSP) grant program. 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). Approximately one-third of the funds support family planning services for teens. In 2006, over 25,000 women received contraceptive methods from the 39 FPSP grantees. Thirty-three percent of females served were from populations of color and American Indians.

MDH provided technical assistance to LHD to address teen pregnancy in their communities. The MDH Adolescent Health Coordinator worked with the Kandiyohi County Teen Pregnancy Prevention Coalition on a five month strategic planning process to address teen pregnancy and birth disparities. This was done in partnership with the Minnesota Organization on Adolescent Pregnancy Prevention and Parenting (MOAPPP).

The Adolescent Health Coordinator partnered with the Minnesota Department of Human Services (DHS) to provide information to foster parents of teenagers on how to prevent teen pregnancies. The project was supported by the National Governor's Association.

State funds support a Family Planning and STI hotline staffed by individuals trained in information, referral, family planning and STI counseling. Over 4,700 calls were handled by the hotline in 2006. Information on the hotline is mailed annually to Medicaid and MinnesotaCare recipients.

Grant activities continued through June of 2007 under the MN Education Now and Babies Later (MN ENABL) program. Activities include: 1) community organization activities implemented collaboratively by community groups and interested persons to reinforce the MN ENABL message; 2) use of a curriculum consistent with established principles; 3) a media campaign promoting the abstinence message; 4) state directed training and technical assistance for

community-based projects. MN ENABL was funded by state general fund dollars and 510 federal abstinence dollars.

The Medicaid 1115 Waiver program, Minnesota Family Planning Program (MFPP), began July 1, 2006 and completed its first year of enrolling participants on June 30, 2007. Under MFPP, adolescents (15 years of age and above) are eligible for family planning services. MFPP served a total of 25,814 individuals in its first year of operation.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support PRAMS data collection and analysis				X
2. Provide access to Family Planning Special Projects services	X	X	X	
3. Partner with DHS to successfully implement 1115 Waiver for family planning services			X	X
4. Increase public understanding of social, economic, and public health burdens of unintended pregnancy, especially to teens			X	X
5. Develop public understanding and support for policies and programs that reduce unintended pregnancies			X	X
6. Continue abstinence programs that support adolescents in their decision to postpone sexual involvement	X	X	X	X
7. Promote youth activities that support resiliency and healthy behaviors	X		X	X
8. Support hotline for family planning and STI services	X			X
9. Support school-based clinics and comprehensive reproductive education	X		X	X
10. Update and implement with other stakeholders the state Teen Pregnancy Prevention Plan			X	X

b. Current Activities

Forty grantees received a total of \$10.8 M dollars awarded for 2 years beginning July 1, 2007. This was a 25% increase in funding. Staff will conduct one site visit to all grantees during the 2-year grant period. Grantees receive a monthly newsletter of trainings and the latest research. MDH continues to link the provider community and DHS to promote the 1115 Medicaid Waiver and assist FPSP grantees in implementation in their clinics.

The Adolescent Health Coordinator provides technical assistance to MOAPPP on their annual conference. Staff distribute teen pregnancy prevention best practices and funding opportunities to LHDs, community based organizations through the monthly Adolescent Health E-Newsletter. Staff recently received funding for Adolescent Pregnancy Prevention through AMCHP and NAACHO. This funding will establish a partnership between the MDH, a LHD and a community based organization to address the high rates of teen pregnancy and STIs in Richfield, MN. Staff continues to provide presentations and one-on-one technical assistance to LHDs doing family home visiting to increase the capacity to address adolescent pregnancy prevention/youth development related activities.

c. Plan for the Coming Year

Continued coordination, collaboration and advocacy will be necessary to preserve and continue work on prevention of unintended pregnancy. Minnesota has a strong history of building on existing partnerships and shared resources to reduce teen pregnancy.

MDH staff will continue to facilitate communication and collaboration with community partners on teen pregnancy prevention through a variety of vehicles. The Adolescent Health E-Newsletter provides research, resources, funding opportunities and conferences on many topics related to adolescent health, including teen pregnancy prevention. The FPSP Coordinator will continue to provide a monthly newsletter to grantees and will conduct site visits with current and future grantees. Technical assistance will be provided to counties on an as needed basis.

It is anticipated that a new FPSP Request for Proposal will be posted in early 2009 for the next grant cycle. Grants will be awarded beginning July 1, 2009. Staff will continue to help promote the 1115 Medicaid waiver and support family planning service providers use of 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 2008 Minnesota legislature eliminated funding for the MN ENABL grant program.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	16	17	18	14	14.5
Annual Indicator	10.4	12.0	13.4	12.8	
Numerator	12861	14794	16420	16069	
Denominator	124201	122956	122626	125178	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	14	14	15	15	16

Notes - 2007

2007 data not yet available

Notes - 2006

2006 data are not yet available.

Notes - 2005

As reported, this indicator represents the percent of Medicaid-eligible children (ages 6-12) who received protective sealants. Data among third grad children in the general population are not available.

a. Last Year's Accomplishments

Minnesota does not have data on all third grade children who have received protective sealants on at least one permanent molar tooth. The MDH continues to use the number of children ages 8-12 enrolled in Minnesota's Medicaid or MinnesotaCare programs who had sealants placed on one or more molar teeth during the past year as a proxy.

Minnesota continues to have significant access issues for children who are uninsured or rely on Medicaid/MinnesotaCare coverage. Efforts have been directed at 1) increasing reimbursement

fees, 2) dental loan forgiveness programs and collaborative dental agreements to expand the number of available providers, and 3) grant programs to support innovative ways to assure dental access for low-income individuals.

Title V staff provided education and training resources for Child and Teen Checkup (C&TC -- Minnesota's EPSDT) providers on dental screenings, the importance of oral health promotion through age appropriate anticipatory guidance and prevention strategies such as dental sealants and fluoride varnish application and resources. Community collaboratives have been created between dentists, oral hygienists, and local health departments. Community-based services are becoming available through dental schools and oral hygienist programs. Over one-third of the local health departments in Minnesota have received instruction and training in fluoride varnish application.

Title V staff, under contract with the Department of Human Services (DHS) to provide training for Minnesota's C&TC providers, have designed an online training module on oral health screening. The module was made available July 2007 and was developed in collaboration with the University of Minnesota.

A major effort last year was the completion of the Oral Health Data Book. This provides advocates, policy makers and state agencies with information on the oral health needs of Minnesotans and will provide baseline information as new preventive or access strategies are implemented.

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. Integrate oral health anticipatory guidance into WIC clinics.	X		X	
7. Staff Oral Health State Plan Advisory Group.			X	X
8. Integrate oral health into Medical Home efforts			X	X
9. Work with local public health and other stakeholders on improving children's oral health.			X	X
10. Continue to seek federal or other resources to support oral health promotion activities			X	X

b. Current Activities

Staff are working with the Minnesota Dental Association and the Department of Human Services on a state Oral Health Summit scheduled for later this fall. The summit will be used to begin the discussions on developing a state oral health plan.

Applications were submitted to HRSA for an Oral Health Workforce grant and CDC for an Oral Health Infrastructure grant. These grants would provide the necessary resources to have a comprehensive Oral Health Program in Minnesota.

Local public health agencies have identified oral health needs as one of their priority issues.

They are involved in activities to promote oral health, such as a complete oral exam (including 'lift-the-lip' procedure), fluoride varnish application, and oral health promotion with anticipatory guidance for parents and children.

Title V staff participate in several local and state oral/dental health meetings to ensure coordination of activities and more efficient use of MDH resources. The 2007 Oral/Dental Health online modules continue to be used by public and private providers. Evaluation and feedback continues to be positive.

c. Plan for the Coming Year

Primary activity will be providing staff support and resources for the Oral Health Summit. This resulting state plan will assist the Title V program and the MDH in prioritizing oral health efforts.

The Title V staff involved in C&TC education training will continue to support and advance Oral Health promotion and screening as a priority in the Medical Assistance population. This will be accomplished through workshops, online resources, and state and local meetings.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	2.5	2.5	2.4	3.2	2.3
Annual Indicator	3.5	3.4	2.4	2.2	
Numerator	36	35	24	23	
Denominator	1024333	1030130	1005572	1030354	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	2	2	2	1.5	1.5

Notes - 2007

2007 data not yet available

Notes - 2006

2006 data are not yet available.

a. Last Year's Accomplishments

The motor vehicle crash child death rate (birth to age 14) per 100,000 in 2006 was 2.2 compared to 2.4 in 2005 and 3.4 in 2004. This progress offers encouragement for Minnesota to continue educational and enforcement initiatives, combined with providing car seats and booster seats when and where possible. The activities that contributed to reducing risk of injury in a motor vehicle-related crash included: 1) statewide distribution of car seats and booster seats to those in need; and 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. These activities were accomplished in partnership and collaboration with Minnesota Safe Kids, the Department of Public Safety, local health

departments and, increasingly, trauma centers across Minnesota.

More than 1,000 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 (http://www.dps.state.mn.us/ots/CPS_Program/childhome.asp).

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. Support, through data analysis, the shift in Minnesota to standard enforcement of seat belts (Every body, 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 use for children.		X	X	
8. Promote safe routes 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, such as Positive Alternatives, continued to distribute car/booster seats and to train providers and parents in the correct installation and use. Health care providers at the clinic, hospital and local health department levels continue to encourage appropriate restraint usage in motor vehicles by all population sub-groups.

The Child and Teen Checkup program provides training sessions that includes anticipatory guidance on safety issues including car seats and seat belt use.

The best practice literature suggests that if health professionals champion motor vehicle safety as an aspect of their daily responsibilities, crash death rates will be reduced. Correct restraint needs to be modeled by parents and care givers, taught by health professionals, and car/booster seats need to be provided to those who otherwise would not be able to afford them.

The Minnesota Legislature again considered a strengthened graduated driver's license law that would restrict the number of teen passengers for teen drivers aged 16 and 17, and reduce night-time driving. This law did not pass during the legislative session. Excess speed, lack of seat belt use, distracted and drowsy driving remain significant concerns across all ages, but have particular impact on persons aged birth through 14 years of age. Action in any of these categories will improve the health outcomes of Minnesota's children. Continued improvements in Minnesota's EMS and trauma care systems will reduce the risk of death.

c. Plan for the Coming Year

Activities described in Current Activities will continue, with ongoing emphasis on recent immigrants from West Africa, Somalia, Sudan and Southeast Asia (Myanmar, Laos and Vietnam). 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 great 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.

Car seat inspection clinics will continue. These can be a one-day event or an on-going service that an agency provides (a fitting station). At these clinics, trained technicians will inspect car seats as they are currently installed within a vehicle. Trained staff members mostly come from fields within public health, law enforcement, healthcare, and EMS/Fire. Overall, however, very few communities around the state of Minnesota offer this valuable service. Many agencies will continue to try to incorporate car seat checks as part of other programs. These agencies use a variety of blended funding sources to support this critical community-level intervention.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				45	48
Annual Indicator		44.3	46.5	46.5	
Numerator					
Denominator					
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	48	48	49	50	50

Notes - 2007

2007 data not yet available

Notes - 2006

2006 data are not yet available. The amended, final percentage for 2005, based on CDC's 2005 Breastfeeding National Immunizations Survey, is 46.5% of mothers. Sample represents 340 women.

Notes - 2005

Data from CDC's 2004 Breastfeeding National Immunizations Survey, which is based on a sample of 340 women. 2004 data applied to 2005 because 2005 data are not yet available.

a. Last Year's Accomplishments

While Minnesota met the Healthy People (HP) 2010 goal for breastfeeding initiation, MDH continued to work promote and support breastfeeding for all Minnesota mothers and infants. The percentage of women who breastfed their infants at hospital discharge was reported as 80.1 +/- 5.9 in 2005, essentially unchanged (2004: 79.4 +/- 5.3, 2003: 79.5 +/- 5.1). Rates are from the CDC National Immunization Survey. Breastfeeding initiation rates for some special population groups, including refugee and low-income populations, are lower. The Hmong and Somali populations have lost breastfeeding traditions upon immigration to the United States, the Hmong often ceasing to breastfeed and the Somali often breastfeeding with supplementation and shorter duration than before immigration. Native Americans also breastfeed at lower rates than the general population. Rates vary considerably between Minnesota communities. We have made progress, but numerous barriers to breastfeeding remain.

Research demonstrates a dose-response to breastmilk, with greater benefits for exclusive breastfeeding and longer durations of breastfeeding. Increasing the duration of breastfeeding continues to be a challenge for all population groups; however Minnesota has made progress. In 2005 breastfeeding duration to 6 months for the general population was reported as 46.5 +/- 6.5 (2004: 44.3 +/- 6.4, 2003: 44.7% +/- 6.1. CDC immunization survey). The HP2010 goal is 50 percent.

Breastfeeding is encouraged and supported through the MDH Family Home Visiting (FHV) program, and other local health department activities, including breastfeeding support groups and educational offerings. Breastfeeding materials, such as best practices and resources, were distributed through FHV e-mail lists and posted on the FHV website. The Minnesota WIC program implemented multiple activities to promote and support breastfeeding.

Breastfeeding information for parents and professionals is available on the Minnesota WIC website. WIC updated their breastfeeding promotion and support guidance document, incorporating strategies and messages to increase breastfeeding exclusivity. The new document will be available on the WIC website in the summer 2008. In 2007, WIC sponsored breastfeeding workshops in northeast, southeast and southwestern Minnesota. WIC, local health department, hospitals, clinics and voluntary organization staff attended the workshops. Several counties have reported changes in practice, including changes in hospital practice, following the workshops. WIC supplemental funding projects have led to development of several local breastfeeding coalitions. Minnesota now has 23 local breastfeeding coalitions and a fledgling statewide Minnesota Breastfeeding Coalition (MBC).

WIC peer breastfeeding support is now available in 10 Minnesota counties. Breastfeeding information were made available in English, Spanish, Somali, and other languages.

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 & support through WIC, ie 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 TA to grantees	X			X

6. Convene cross-program meetings to identify ways to integrate breastfeeding promotion & support into a wide array of MCH programs.				X
7. Propose policies that support breastfeeding.			X	X
8.				
9.				
10.				

b. Current Activities

Informal sharing of information and opportunities to promote and support breastfeeding is shared between the Title V and WIC programs. Local health department staff, supported by the federal Title V Block Grant, advocate breastfeeding and include breastfeeding promotion strategies in contacts with families.

WIC provides leadership for multiple activities to promote and support breastfeeding. WIC continues to offer workshops on breastfeeding counseling, in locations throughout the state. Breastfeeding information for parents and professionals is available on the Minnesota WIC website. WIC is updating their breastfeeding promotion and support guidance document, incorporating strategies and messages to increase breastfeeding exclusivity. The new document will be available on the WIC website in summer 2008.

Breastfeeding continues to be encouraged and supported through the MDH Family Home Visiting (FHV) program, and other local health department activities, including breastfeeding support groups and educational offerings. Breastfeeding materials, such as best practices and resources, are distributed through FHV e-mail lists and posted on the FHV website.

c. Plan for the Coming Year

Continue to develop linkages to promote and support breastfeeding, including meeting with MCH and WIC staff to discuss breastfeeding promotion and support, and practices within communities that can hinder breastfeeding. Continue to place special interest in our newest cultural/ethnic populations. Investigate partnering for breastfeeding training. Explore opportunities to incorporate information regarding breastfeeding and cultural practices related to breastfeeding in the foundations training being developed for family home visitors. Continue to provide current and relevant breastfeeding information to local public health staff, and work on the consistency of breastfeeding messages between programs and between staff within programs and communities.

The Minnesota Breastfeeding Coalition is holding a statewide meeting in November 2008 for an expanded membership and to form work groups. MCH plans to send a representative to this meeting and will participate in the ongoing activities of the MBC.

MDH will provide information and resources to Positive Alternatives grantees. The Positive Alternatives Program is a grant program designed to support women in maintaining their pregnancies and supporting their infants after birth. This program will also be in a position to encourage and support women who choose to breastfeed.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	95	98	98	98	90
Annual Indicator	77.0	96.5	85.2	80.2	

Numerator	53904	68123	59657	60683	
Denominator	70006	70579	70030	75656	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	85	85	87	87	90

Notes - 2007

2007 data not yet available

Notes - 2006

2006 data are not yet available.

Notes - 2005

Rate is based only on the 111 hospitals in MN that report directly on the occurrence of a newborn hearing screening. The remaining 15% of hospitals conduct the hearing screening but do not report. For the first time, the performance indicator is based on matched records of birth certificates and newborn hearing screening results.

a. Last Year's Accomplishments

By the end of the Year 2006, all of the 108 birthing hospitals and 22 NICU/Special Care Nurseries reported implementation of universal newborn hearing screening (UNHS). For newborns born in 2006 (75,656), 80.21% (60,683) were reported screened for hearing. Results are reported voluntarily on the dried blood spot form and then matched with birth certificates. About 4.45% (2,699/60,683) of newborns screened failed. Nineteen Percent (14,973/75,656) were not screened, including newborns who died and parents declining services, plus 96% unknown (14,464/14,973).

The Centers for Disease Control and Prevention (CDC) Early Hearing Detection and Intervention (EHDI) 3-year Cooperative Agreement (7/1/05-6/30/08) supported building the EHDI tracking and surveillance system. The HRSA MCHB Universal Newborn Hearing Screening (UNHS) 3-year grant (4/1/05 -- 3/31/08) funded activities to decrease lost-to-follow-up and enhance access to early intervention.

New mandate and new role update:

Early Hearing Detection and Intervention (EHDI) Legislation passed in 5/2007 mandating newborn hearing screening and added hearing loss to the panel of more than 50 disorders for which every Minnesota newborn is screened. This legislation (Minnesota Statutes SS 144.125 and SS 144.966) changes newborn hearing screening from a voluntary program to a mandatory program in Minnesota. It requires hospitals, audiologists, and other providers to screen every infant born in Minnesota for hearing loss, diagnose if necessary and report the results to the Minnesota Department of Health unless parents request otherwise. This legislation also defines "child" as a person 18 years of age or younger for the purpose of hearing detection and intervention.

Newborn hearing screening is the first part of a comprehensive EHDI program at the Minnesota Department of Health. Minnesota's Newborn Screening Program will coordinate screening for all 54 disorders, including hearing loss. The Minnesota Children with Special Health Needs (MCSHN) program is responsible for long-term follow-up services to families once a diagnosis is confirmed. MCSHN will ensure appropriate and timely intervention and connections for families

with statewide services and resources until the child transitions into adulthood

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	X
2. Provide education and training of providers, including Audiologists		X	X	X
3. Provide information to parents of the importance of screening & if identified with a hearing loss, additional follow-up		X	X	X
4. Refine & expand the data tracking & follow-up system			X	X
5. Integrate data collection, follow-up and tracking with newborn blood spot screening			X	X
6. Work with a variety of stakeholders on assuring follow-up, referral and intervention for infants		X	X	X
7. Continue federally funded grant activities in this area		X	X	X
8. Support hospital quality assurance activities		X	X	X
9.				
10.				

b. Current Activities

The state EHDI group [MDH, Departments of Human Services (DHS) and Education (MDE)] provides leadership in training/assistance for 17 regional teams, making site visits for discussions of regional needs. These teams build regional capacity to better serve deaf children/families.

Staff continue to collaborate with local Part C Coordinators and contracts with Hands & Voices MN Chapter to assure statewide intervention services including family-to-family support are provided to infants who are deaf or heard of hearing.

Information continues to be provided via exhibits and presentations at national, state and local conferences for providers/parents.

c. Plan for the Coming Year

As the new 2007 MN EHDI legislation is implemented, the focus will be on long-term follow-up assuring children with a hearing loss and their families are connected to needed resources especially early intervention and parent support. In addition, further enhancement of the data integration with other child health data systems, such as vital records, immunization, birth defects and WIC to assure that children are not lost to follow-up in the EHDI process. Activities will include developing a long-term follow-up and early intervention protocols and revising existing protocols on screening, diagnosis and amplification under the advice of the legislative Newborn Hearing Screening Advisory Committee, and according to the 2007 Joint Committee of Infant Hearing (JCIH) recommendations.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	2.6	2.4	2.2	7.5	7

Annual Indicator	6.5	7.9	7.9	6.0	
Numerator	81170	98354	97554	75476	
Denominator	1248770	1240280	1229578	1254930	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	5.5	5.5	5	5	5

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 data are not yet available.

Notes - 2005

Source of 2005 data is the 2004 MN Health Access Survey. Percent of children without health insurance in the sample was applied to 2005 census data to calculate the numerator. .

a. Last Year's Accomplishments

At the end of each legislative session, Title V CSHCN staff update MAZE training materials. MAZE stands for Taking the MAZE out of Funding. These materials reflect eligibility criteria and benefits coverage for Minnesota's publicly-funded health insurance programs, which include Medical Assistance (Medicaid), MinnesotaCare, home and community-based waivers. Title V CSHCN staff then conduct trainings throughout the state for providers, social service staff and families. In 2006-07 staff trained 805 people in 43 trainings. Over the past 4 years (2003-2007) nearly 4,000 people have been trained in 168 trainings.

Staff in the Family Home Visiting, Positive Alternatives Program, Family Planning Special Projects and WIC programs continued to emphasize to grantees the importance of assessing insurance status and the referral of clients to appropriate resources.

Minnesota's local health departments (LHDs) are required to report on their progress toward the achievement of a number of outcome measures. One of these measures is to increase the number of clients enrolled in health insurance programs. To measure progress toward this outcome, LHDs are asked to annually indicate: 1) those programs in which they routinely assess the health insurance status of clients; and 2) those programs in which they refer clients without insurance to appropriate insurance resources. LHDs are asked these questions about a wide range of public health programs. Following is a summary of their performance (for the 2007 calendar year) in the programs that are most likely to reflect on the insurance status of children. Early intervention service coordination for CSHN: 89% assessed insurance status, 90% referred to resources. WIC clinics: 94% assessed insurance status, 95% referred to resources. Family home visiting: 96% assessed insurance status, 96% referred to resources. CTC Outreach: 76% assessed insurance status, 82% referred to resources. Follow-along program: 67% assessed insurance status, 71% referred to resources.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service
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	DHC	ES	PBS	IB
1. Provide MAZE trainings for parents and professionals		X		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. Continue to participate on the Build Initiative		X		X
5. Update and distribute the Part C Central Directory			X	X
6. Maintain insurance coverage component of the Family Home Visiting program			X	X
7. Develop communication plan for using information related to health insurance to educate and inform providers, families, planners and policymakers				X
8. Participate on Department priority area of Health Care reform activities				X
9. Continue to monitor insurance referral reporting in local public health programs				X
10.				

b. Current Activities

The 2008 Legislature, responding to a \$1 billion deficit, considered a number of proposals affecting eligibility for Medicaid and MinnesotaCare. Changes passed by the Legislature and adopted by the Governor will be analyzed and will be incorporated into the MAZE training.

The MDH in partnership with the University of Minnesota has periodically conducted the Minnesota Health Care Access Survey over the last 12 years. These surveys are the source of data for state policy makers to define and respond to insurance issues of Minnesotans. The most recent survey, conducted in 2007, reports that Minnesota's rate of uninsurance remained stable since 2004, the last time the survey was conducted. About 7.2 percent of Minnesotans were without insurance in 2007.

Residents covered by publicly-funded state programs like Medical Assistance or MinnesotaCare remained relatively stable at 25.2 percent. There was a decrease in the number of uninsured children between the ages of birth to 5 (from 7.4 percent in 2004 to 5.5 percent in 2007). However, in children between the ages of 6 and 17 the number increased from 10.3 percent in 2004 to 15.2 percent in 2007.

c. Plan for the Coming Year

MAZE training material will be updated throughout the summer based on legislative changes during the 2008 session. Beginning in late 2008, Title V staff will conduct trainings throughout the state on eligibility criteria and benefit coverage of the state's publicly-funded programs. Title V staff continue to work closely with their Title XIX colleagues on a myriad of topics and program implementation challenges and will continue to do so.

The MDH will respond to any changes that may place during the 2009 legislative session that may have an impact on the insurance of 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.

Minnesota participates in the Early Childhood Comprehensive System (ECCS) initiative funded by the federal Maternal and Child Health Bureau. A key component of that system is to address

the need for access to comprehensive health services and medical homes, including assuring access to insurance resources.

Minnesota is one of 5 states participating in the Build Initiative -- a national multi-state partnership that supports efforts to make sure that children from birth through age five are safe, healthy, and ready to learn. The Build Initiative's lead organization in Minnesota is Ready 4 K, a Minnesota non-profit advocacy group. The state health department, through its ECCS initiative, works in partnership with Ready 4 K and multiple other partners to assure a coordinated system of care for children, including have access to health insurance resources

The department will apply for continuation funding from the MCHB for Minnesota's ECCS initiative. The department, through its ECCS initiative, will continue to partner with Ready 4 K and the Build Initiative.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				29	28.5
Annual Indicator		30.7	29.7	30.4	29.9
Numerator		14701	16723	17502	18272
Denominator		47885	56307	57609	61109
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
	2008	2009	2010	2011	2012
Annual Performance Objective	28	28	27	26.5	25

Notes - 2006

Final data for 2005 are as follows:

Indicator = 29.7%

Numerator = 16,723

Denominator = 56,307

Data reported in the 2005 column are based on the 2004 PedNSS.

The 2006 data are not yet available.

Notes - 2005

Performance indicator for 2004 was applied to 2005 because data for the 2005 are not yet available. Source of data is PedNSS.

a. Last Year's Accomplishments

During 2006, the Pediatric Nutrition Surveillance System for Minnesota WIC reported that 29.6% of children enrolled had BMI/age at or above the 85th percentile. This was the second year to show a very slight decline from the previous year. In 2004, it was 30.7% in 2005 it was 29.7%.

The Minnesota WIC program has recognized this growing health issue and the disparities across this measure. The Minnesota WIC Nutrition Education Plan is focused on childhood obesity

prevention, with the following objectives: 1) staff training; 2) participant education; 3) staff modeling of healthy behaviors; and 4) collaborating with community partners who share the goal. The WIC food list was revised to highlight and encourage breastfeeding and use of lower fat foods.

State WIC staff work to support the implementation of the state's WIC Nutrition Education Plan by local WIC staff. In compliance with this plan and WIC requirements, local WIC staff weigh and plot BMI to identify children who are overweight or at risk for becoming overweight and provide counseling and referrals for the parents and/or caregivers. Title V responsibilities include: referral of young children in need of nutritional services identified through Title V programs to WIC; coordinating services to jointly served families; and in collaboration with WIC, identifying public health strategies to address obesity. Both WIC and Title V staff were asked to join other MDH programs in the development of the "Minnesota's Plan to Reduce Obesity and Obesity Related Chronic Diseases."

A component of a Child and Teen Check-up (C&TC -- Minnesota's EPSDT) visit is measuring height and weight and tabulating BMI. The C&TC Refresher workshop provided the Healthy Eating and Activities Together (HEAT) Toolkit for addressing obesity in young children and their families. Two C&TC Refreshers were offered (June '07 and August '07) to 20 public health nurses (PHN) that provide C&TC visits. The HEAT Toolkit incorporates motivational interviewing techniques to assist families in examining their eating and activity habits. This toolkit will be evaluated by the PHN participants over a 12 month period to identify strengths and weaknesses and indications for future implementation to C&TC providers.

In January 2007, the Minnesota Task Force on Obesity Prevention published state guidelines: "Recommendations to Prevent and Reduce Childhood Obesity in Minnesota." These guidelines begin the dialogue between stakeholders and professionals knowledgeable in children's health. The guidelines provide direction for the development of the "Minnesota Plan to Reduce Obesity and Obesity Related Chronic Diseases" (the State Plan). This plan is endorsed by Governor Pawlenty and will address obesity across all ages. Application for a CDC grant has been completed that would provide funding for the infrastructure to carry out the State Plan.

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 on development of Obesity State Plan and the implementation of the 2008 Legislative Initiative on reducing obesity.			X	X
9. Incorporate appropriate referral mechanisms to WIC from other child programs such as home visiting, Follow-Along			X	X

Program, Positive Alternatives grantees, etc.				
10.				

b. Current Activities

The state WIC program will continue clinical activities, data management and reporting; and build on activities described in FY 06-07 WIC Nutrition Education Plan and reflected in the FY 07 WIC State Plan.

The WIC goals for 2007 and 2008 are: 1) Childhood obesity prevention for children one year and older. Educate parents on healthy eating for their children and families by influencing their health-related knowledge, attitudes, and behaviors; and 2) Increase the duration of breastfeeding among Minnesota WIC participants by addressing factors that lead to early breastfeeding cessation.

State WIC staff provided training for local WIC staff on assessing nutrition status. Value Enhanced Nutrition Assessment (VENA) was developed by USDA for all WIC programs. Through better assessment and relationship building, VENA is intended to improve overall services provided to WIC.

As The State Plan is implemented through the Chronic Disease Reduction Unit, LHDs will be able to utilize the recommendations listed in The State Plan, identify their community partners, and establish priorities based on their community needs and resources. There is an evaluation and surveillance section that can offer local health departments options for how to measure and evaluate their initiatives.

The Title V staff will continue to evaluate the HEAT Toolkit as utilized in the C&TC Refresher workshop summer of 2007 in order to provide best practice strategies to address obesity in children during a C&TC visit.

c. Plan for the Coming Year

The WIC Nutrition Education Plan for the next year will reflect the goals previously mentioned with emphasis on VENA. There are some changes in the WIC food package: fruits and vegetables and whole grains will be promoted and available, the message to 'limit' fat intake will be demonstrated in meal planning as well as to drink less sweetened beverages and limit juice consumption. Breastfeeding moms will have increased food choices and breastfed babies will be given baby meat after 6 months old.

One of the priorities of the MDH is to reduce childhood obesity 50% by 2012. Strategic planning including development of an action plan is underway.

In addressing the obesity concerns in Minnesota, STEPS to a Healthier US continues in four communities. This is a 5-year cooperative agreement with the CDC (beginning in 2004) that funds state, cities, and tribal entities to implement chronic disease prevention efforts to reduce the burden of diabetes, obesity, and asthma and addressing three related risk factors: physical inactivity, poor nutrition, and tobacco use.

The Title V staff will continue to research programs and provide best practices to prevent obesity in children and young adults through education and training of private and public C&TC providers, including ongoing use and evaluation of the HEAT Toolkit.

The Title V staff will also continue to identify collaborative opportunities with the CDC funded grant for Coordinated School Health programs.

The 2008 Legislature as part of Health Care Reform Legislation established a statewide health

improvement program to reduce the percentage of Minnesotans who are obese or overweight and to reduce tobacco use. Beginning in state fiscal year 2010, 20 million dollars will be provided to local public health departments and tribal governments to support these objectives. In state fiscal year 2011, funding available is \$27 million a year. This year, will be devoted to planning for the implementation of this initiative. Title V programs will participate in the planning and implementation of this initiative.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				13	13
Annual Indicator		15.9	14.9	13.6	
Numerator		10533		9427	
Denominator		66095		69367	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	13	12	12	12	12

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 PRAMS data are not yet available. The most recent PRAMS data available are for 2004 and are as follows:

Indicator = 15.9%

Numerator = 10,533

Denominator = 66,095

Notes - 2005

The performance indicator for 2003 was applied to 2005 because data for 2005 are not yet available. Source of data is the PRAMS survey.

a. Last Year's Accomplishments

The State Team on Tobacco Prevention for Women of Childbearing Age including Pregnant Women (State Team) continued to meet and implement activities. This team is comprised of Title V staff, staff representing MDH's Tobacco Prevention and Control Section, Planned Parenthood of MN/SD, Minnesota American College of Obstetricians and Gynecologists (MN ACOG), the Minnesota March of Dimes, and local health department (LHD) staff.

State Team members displayed resources at the January 2007 Birth to Three Conference to help families reduce secondhand smoke around infants, children, and pregnant women. At this conference, over 300 early childhood workers, public health nurses and social service providers received family-friendly patient education information based on the U.S. Surgeon General's Report on Secondhand Smoke, June 2006.

The State Team also displayed resources on smoking cessation during pregnancy at the annual State WIC Conference in March 2007, reaching hundreds of WIC workers. State Team members continued to participate in quarterly training for new WIC staff and provide information on "2As and an R" (Ask, Advise and Refer) and other resources they can incorporate into WIC counseling. WIC staff are encouraged to refer participants to Minnesota's Quit Line program and to provide information on protecting infants, children, and pregnant women from secondhand smoke.

In May 2007, through a partnership with the Metropolitan Health Plan (MHP), the State Team presented a one-day conference on using the "5 As" (Ask, Advise, Assess, Assist, Arrange) and motivational interviewing to reduce smoking in pregnancy. Conference participants were primarily clinic staff from the Minneapolis and St. Paul metropolitan area.

LHD staff in West Central Minnesota received training on smoking cessation during pregnancy using the 5 As and the Dartmouth virtual clinic training module.

Using an Association of Maternal and Child Health Programs (AMCHP) mini-grant, the State Team developed a brochure aimed at reducing postpartum relapse among women who quit or reduced their smoking during pregnancy. The grant also supported the development of window clings promoting smoke-free homes and cars (for use with the general population) and window clings that were culturally-specific for American Indians. In Minnesota, the American Indian population has the highest rates of smoking during and after pregnancy. These materials were available to LHD and community-based organizations in late August 2007. The materials were given to the Tobacco Prevention and Control Program's "Save a Bundle" grantees, along with information on the 5 As. They also received information on how to refer to Minnesota's Quit Line Program. These 60 grantees received a \$1,000.00 incentive grant to promote and distribute the materials.

Information on pregnancy and postpartum smoking cessation and information on the elimination of secondhand smoke around infants was included in the Safe Infant Sleep workshop conducted for Twin Cities Healthy Start staff in August 2007.

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. Implement with partners the Smoking Cessation for Women State Plan.		X		X
3. Repeat and extend motivational interviewing (MI) training for smoking cessation			X	X
4. Consult with metro Neighborhood Health Care Network community health centers to develop staff skills, then offer cessation services onsite			X	X
5. Work with others within the Department (OMMH) and external partners, (ACOG and midwives) to identify strategies on effectively reaching high-risk populations.				X
6. Intergrate the "stop smoking" message with other health promotion messages targeted to young wome.			X	
7.				
8.				

9.				
10.				

b. Current Activities

Each quarter, Title V staff train all new WIC staff on "2 As and an R." Staff receive resource packets to assist families in reducing secondhand smoke exposure.

Safe Infant Sleep presentations were made to the Maternity Case Management Excellence group and the MCH Coordinators regional meeting. All Safe Infant Sleep presentations included the importance of smoking cessation and the need for secondhand smoke reduction to decrease the risk of sudden infant death.

State Team members presented a breakout session at the Birth to Three Conference and had a display table with "Save a Bundle," Minnesota's Quitplan, "5 A's" materials. Over 250 participants from early childhood education, childcare, public health, and social service organizations attended the conference.

A training conference is planned for June 2008 to address the impact of substance use (including tobacco) during pregnancy. Training partners include the State Team, Twin Cities Healthy Start and MHP. Motivational interviewing training will be offered as a strategy to address all substance use during pregnancy.

Title V staff will attend health fairs on the Leech Lake and Red Lake Tribal Reservations to promote smoking cessation during pregnancy, prevention of relapse, and reduction of secondhand smoke exposure. The information will be presented as part of the Safe Infant Sleep campaign. These materials were also shared with the Little Earth Housing staff at the American Indian Health Fair in Minneapolis.

c. Plan for the Coming Year

The State Team will continue to implement the Smoking Cessation for Women State Plan. This includes participation in health fairs, conferences and community events. Plans are underway to repeat the motivational interview training for smoking cessation and to extend this program to reach more providers. MDH staff will consult with the Neighborhood Health Care Network community health centers to develop staff skills and expand the availability of cessation services. Title V staff will continue to work with other MDH staff (specifically in the Office of Minority and Multicultural Health and Tobacco Prevention) and other partners to reach high-risk populations.

Efforts will be made to fully utilize Minnesota vital records, PRAMS and WIC databases to estimate baseline incidence of smoking in pregnancy. The State Team will continue planning activities and coordinating with direct service providers across the state.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	8.4	8.2	8	9.8	11
Annual Indicator	10.1	10.0	11.7	8.9	
Numerator	38	38	44	33	
Denominator	376843	378976	375522	372719	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	8.5	8.5	8	8	7.5

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 data are not yet available.

Notes - 2005

The 2005 data are not yet available.

a. Last Year's Accomplishments

Staff, in collaboration with two community organizations held regional focus groups in six locations throughout Minnesota. Approximately 70 people attended, including survivors, family members, school personnel, mental health professionals, crisis workers, and community organizations. Additional input on the state suicide prevention plan was gathered and updated evidence-based information on suicide prevention resources provided. MDH continued revisions to its state suicide prevention plan as well as a widely distributed suicide prevention fact sheet. Staff also collaborated with community organizations to identify resources to move two initiatives forward: a suicide attempters follow-up project and a youth summit. The 2007 Legislature appropriated approximately \$300,000 for suicide prevention grants to local communities.

Staff provided technical assistance to communities regarding their suicide prevention initiatives, including identifying strategies, resources and partners. Additionally, staff reviewed recommendations for suicide prevention in the elementary school setting to promote earlier identification and intervention. The Governor's Mental Health Initiative was partially funded allowing forward movement in revamping Minnesota's current mental health service system. This initiative came out of a private/public effort to improve mental health services in Minnesota called MMHAG. This initiative provided increased funding for children's mental health crisis services.

MDH provided training for staff on relational aggression and its connection with violence against self. MDH promotes resources in self-inflicted injury and advocates for the addition of a question related to self-inflicted injury on the Minnesota Student Survey. MDH is collaborating with the MDE, Public Safety, the University of Minnesota, the Search Institute and Youth Community Connections on a conference on protective factors for youth

Title V staff convened a mental health workgroup to provide coordination and communication about mental health activities across the department. Title V is represented on both the Children's Mental Health Subcommittee of the State Advisory Council on Mental Health. The focus of involvement is the Early Intervention and Prevention Workgroup, which has worked primarily on promoting a socio-emotional component to early childhood screening, in particular, educating parents from diverse backgrounds about the importance of and process for screening. Staff also coordinated resources for a mental health workshop at the Community Health Conference.

Staff participates on the Mental Health in Special Education Leadership Committee, which has developed three modules of training for teachers around early intervention and classroom strategies. Staff also collaborated with the Departments of Education, Public Safety and Human Services to plan a cross-disciplinary conference on children's mental health. Over 125 professionals from the fields of education, public health, juvenile justice and out-of-school time

programs attended.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Update and implementation of 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. Continue to support youth activities that support resiliency and healthy behaviors			X	X
5. Continue to analyze student survey data to identify populations at higher risk				X
6. Collaborate with external partners such as Suicide Awareness Voices of Education				X
7. Continue to staff American Indian Suicide Prevention Workgroup				X
8. Continue to evaluate hospital discharge and ER care			X	
9. Implement new suicide prevention grants	X	X	X	X
10. Continue to work with the Department of Human Services Mental Health and Children's Mental Health Divisions to coordinate activities.			X	X

b. Current Activities

The Title V program was approached in the fall of 2007 by the Department of Human Services (the state's mental health authority) to determine interest in combining funds for suicide prevention. The adult mental health services division offered to combine SAMHSA Community Mental Health Block Grant funds for suicide prevention with the 2007 state appropriation for suicide prevention. In addition, the CYSHCN program added state funds from its clinic program providing a combined total of approximately \$800,000 for a two year period. The Title V program published an RFP in the spring of 2008; twenty-two applications were received and five were funded. Target populations included adolescents, especially adolescents with special health needs; adults 18-35 and adults 55 and over. Four of the five grantees included adolescents as part of their target population.

Staff continues to provide technical assistance to local public health and community organizations on suicide prevention, including surveillance data, information about evidence-based strategies, and resource information. The 2007 student survey data will be used in policy decisions affecting suicide prevention programs when completely analyzed. The Title V program in collaboration with the Injury and Violence Prevention Unit of the MDH submitted a youth suicide prevention grant (Garret Lee Smith) to SAMHSA.

c. Plan for the Coming Year

Staff in both the CYSHCN and MCH programs will continue to offer technical assistance to local public health and community organizations on health promotion and prevention strategies, surveillance, intervention and postvention services. Staff will continue to research best practices on emerging issues related to suicide prevention such as peer leadership strategies, promotion of protective factors and parent involvement in suicide prevention programs. MDH will also continue to present the latest suicide prevention information and resources at conferences, including submitting proposals for the Minnesota Association for Children's Mental Health Conference, the

Community Health Conference, the Safe and Healthy Learners Conference and the Transcultural Mental Health Conference. MDH will continue to work with partner organizations to identify strategies to support youth suicide attempters and their families and it will continue to partner with the Department of Education on school safety initiatives and with community organizations on military mental health issues.

MDH will continue work on mental health initiatives regarding screening for socioemotional and /or mental health concerns, crisis intervention services for youth, relational aggression and innovative approaches to increasing access to mental health services. It will promote the updated state plan through its website, meetings and with its partners.

Staff will partner with the Departments of Corrections, Human Services, Education, Public Safety and other organizations on juvenile justice and mental health and focus on improving outcomes for youth involved in corrections and diverting youth from corrections.

MDH will work with community partners to offer train-the-trainer opportunities in suicide prevention, which will educate school personnel, mental health professionals, community organizations and family members on gatekeeper training and referral processes. It will provide grant management oversight on the five grantees awarded funds in the early summer of 2008.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	79	80	82	86	87
Annual Indicator	76.8	84.6	84.1	83.2	
Numerator	584	654	702	674	
Denominator	760	773	835	810	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	84	84	85	85	87

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 data are not yet available.

a. Last Year's Accomplishments

In 2006, 83.2 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 deliveries. This represents a decrease from 84.1 percent in 2005. Minnesota has not progressed on this indicator since a precipitous drop in 2002 when one of Minnesota's Level III hospitals, located in St. Paul, downgraded their nursery to Level II.

Both the Minnesota Perinatal Organization (MPO) and the Minnesota March of Dimes are examples of organizations focusing on healthy pregnancy outcomes. Title V staff worked with

both organizations on program planning for health professionals. The MPO targets all health professions involved in perinatal care. This organization provides educational conferences to improve the health care of pregnant women and newborn infants. The March of Dimes focuses on both consumer and professional education. Title V and other MDH staff work closely with the March of Dimes to address professional and consumer education on folic acid, preconception care, disparities in infant mortality and birth defects. Title V staff collaborate with the March of Dimes on their prematurity education and research campaigns. Title V staff and the March of Dimes, with others, collaborated on Minnesota's first preconception care conference (October 2007).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor the status of perinatal centers in Minnesota				X
2. Collaborate with external partners such as the March of Dimes and the MN Perinatal Organization				X
3. Promote guidelines for Perinatal Care			X	X
4. Monitor the number and place of birth for high-risk deliveries				X
5. Actively participate in maternal case management collaborative meetings to improve maternity and infant care for diverse and low-income families.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Title V staff continue collaborative community work, including planning for the second Minnesota preconception care conference -- Reaching Underserved Populations. Title V staff continue to monitor births of very low birth weight infants according to "Guidelines for Perinatal Care" 6th edition, 2007, published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG).

In addition to the loss of the Level III facility in 2002 (mentioned above) Minnesota does not have Level III obstetrical and neonatal intensive care available throughout the state. This circumstance is not likely to improve. Title V staff, in partnership with the March of Dimes, continue to approach this issue educating providers and patients about risk factors for preterm low birth weight births and encouraging more timely referrals to Level III facilities when risk factors indicate that a very low birth weight delivery is possible.

c. Plan for the Coming Year

Title V staff, others at MDH and community partners will continue the activities stated above and explore opportunities to educate providers about the importance of high-risk deliveries occurring at appropriate level facility. This will include providing information at Minnesota's second preconception care conference and other opportunities that may arise throughout the year. In addition, MDH in collaboration with partners, will continue to monitor the status of perinatal centers in Minnesota and the number and place of high-risk births. MDH staff and partners will also continue to promote the AAP/ACOG guidelines among providers.

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)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	88.8	89.7	90.5	88	88
Annual Indicator	86.5	86.4	86.2	86.5	
Numerator	57935	58410	58125	59928	
Denominator	66963	67633	67410	69281	
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	
	2008	2009	2010	2011	2012
Annual Performance Objective	87	87	88	88	89

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 data are not yet available.

Notes - 2005

The 2005 data are not yet available.

a. Last Year's Accomplishments

In 2006, 86.5 percent of infants were born to women receiving care beginning in the first trimester, representing a minimal increase from 86.2 percent in 2005. Minnesota has not achieved the Healthy People 2010 goal that 90 percent of births will occur to women who began prenatal care during the first trimester. Minnesota's average rates for women of color are far beneath the Healthy People 2010 goal. For the years 2001-2005, African American women had a rate of 61.6 percent, American Indian women had a rate of 50.6 percent and Asian women had a rate of 67 percent. The rate for White women those years was 81.6 percent. (Populations of Color in MN, Spring 2007.)

Work continued with local health departments (LHD), representatives of health plans, and local providers to create a comprehensive, population-based model of prenatal care. Within this model, early identification of pregnancy, pregnancy intent, and early initiation of prenatal care is emphasized. Examples of initiatives to improve the number of women who initiate early prenatal care include the Twin Cities Healthy Start (TCHS) Program, the Nurse-Family Partnership initiatives in several Minnesota counties, and the Maternity Case Management Excellence (MCME) project in Minneapolis and St. Paul.

MCME met semi-annually for education, resource sharing, and networking among providers, health plans and Title V staff. Activities included identifying gaps in services, implementing improvements and evaluating their effectiveness. MCME has created partnerships for service delivery as exemplified by the Perinatal Services Grid. This grid was created by the health plans to simplify service delivery for provider agencies.

Health plans provided financial incentives to low income women on Medicaid prepaid health plans

to access prenatal care in the first trimester and keep all scheduled appointments.

TCHS provided early identification of pregnancy, risk assessment, wrap around support and education to high risk African American and American Indian women. They serve families until the infant is two years old, thereby providing interconceptional care and education about early prenatal care for the next pregnancy.

LHDs, with Title V support, promoted the initiation of prenatal care in the first trimester. Some LHDs provided free pregnancy testing with referrals for appropriate services.

The Positive Alternatives Grant Program continued funding for grantee organizations that encourage and support women in carrying their pregnancies to term by providing a variety of designated services. Among these services is the requirement that all grantees provide information on, referral to, and assistance with accessing medical care. This includes encouraging and facilitating early access to prenatal care through early pregnancy testing, assistance in enrolling in state-funded medical programs, and prompt access to medical care.

Minnesota PRAMS data (2002-2003) has identified women's barriers to obtaining early prenatal care. For mothers who did not get care as early as they wanted, the following barriers were identified: 29 percent of mothers stated they didn't know they were pregnant; 25 percent said they could not get an appointment earlier; 24 percent said their doctor or health plan would not start care earlier; 21 percent did not have money or insurance to pay for visits; and 10 percent did not have their Medicaid or MinnesotaCare card.

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	X	X	
2. Continue involvement on the Healthy Start grant		X	X	X
3. Partner with racial and ethnic communities to identify & implement strategies for improving early prenatal care		X	X	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 mortality				X
7. Sponsor Preconception Conference		X		X
8.				
9.				
10.				

b. Current Activities

Outreach activities are fundamental to increase the number of women who begin early prenatal care. In Minnesota, local health departments initiate and maintain collaborative relationships with community organizations frequented by women of childbearing age. They promote messages through collaborations with area health clinics, hospitals, extension services, social services, schools, Head Start programs, and early child and family education programs.

Title V staff will continue to partner with state colleges and universities on their education program for community health workers (CHW). It is anticipated that CHWs will extend the reach of the health system, to serve more people, particularly populations of color, immigrants, and American

Indians, those at most risk for a late start to prenatal care. The 2007 Legislature approved Medicaid reimbursement for CHWs and the 2008 Legislature expanded reimbursement to oral health.

Title V staff consult quarterly with Twin Cities Healthy Start. At their Maternal Child Health Bureau evaluation meeting they were advised to focus on improving rates of early and adequate prenatal care within their high risk population. Title V staff continues to work with them on this issue.

c. Plan for the Coming Year

Work will continue to address overarching issues leading to delays in prenatal care including pregnancy intendedness, family planning, preconception care, primary health care and establishing a medical home. We will work collaboratively with communities to promote culturally appropriate education and awareness regarding the importance of early prenatal care and to address disparities in accessing early prenatal services.

A second preconception care conference is planned for late in 2008. The conference will focus on reaching underserved populations and will bring attention to the need for providers to address women's health issues throughout the childbearing years. The conference will also address the need for systemic change in Minnesota to assure continuous health care access for women and assure adequate reimbursement for providers. The current system of health insurance coverage leaves many low-income women without insurance preconceptionally and interconceptionally as they may become eligible for Medicaid only when they become pregnant. Women with intermittent insurance coverage tend to start prenatal care later and rarely have the benefit of preconception care.

D. State Performance Measures

State Performance Measure 1: *Proportion of counties that universally offer the Follow-Along Program, or an equivalent approved tracking program, to all children birth to age three.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				53	65
Annual Indicator		0.3	0.5	0.6	0.6
Numerator		28	46	55	52
Denominator		87	87	87	87
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	0.7	0.8	0.8	0.8	0.8

Notes - 2006

In addition to the 55 counties, 1 tribal jurisdiction reported universally offering the Follow Along Program to its children.

a. Last Year's Accomplishments

The CYSHCN program has an interagency agreement with the Minnesota Department of Education for the child find or outreach activities pursuant to relevant provisions in Part C of the Individuals with Disabilities in Education Act (IDEA). Some of these responsibilities are carried out through the Follow Along Program (FAP). The FAP provides periodic screening and monitoring of those infants and toddlers at risk for health and developmental problems. It improves chances of

identifying developmental problems at an early age, facilitates early intervention services for the child and links families and children to needed services. The FAP is supported programmatically and is funded through Title V and Part C of IDEA at the state level and a combination of Part C, Title V and local funds at the local level. The Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire (ASQ-SE) is the screening tool utilized by the FAP. The Ages and Stages Questionnaire (ASQ-SE) has been added to screening activities at local agency discretion over the last four years. Ongoing training is provided to local agencies (primarily local public health agencies) on administration of and implementation of the FAP.

In 2005 the MDH Environmental Health Division ended a two-year, CDC-funded birth defects pilot study that focused on newborn infants with confirmed neural tube defects, cleft-lip/palate or chromosomal anomalies and began implementation of a more comprehensive birth defects information system that includes 44 identified conditions. In the pilot study, the CYSHCN program contacted identified families to provide health information and referrals to programs and services. This has subsequently expanded and continues that referral responsibility in the more comprehensive system. Infants born in the seven-county, Minneapolis-St. Paul Metropolitan Area with one of any of the 44 conditions are referred for follow-up. Families are then contacted to ensure appropriate referrals to services are made and families are also referred to either the Follow Along Program or Part C Early Intervention Services. Fact sheets for use by families and providers on each of the 44 conditions were completed in the summer of 2005 and continue to be updated.

Local agencies continued to expand the FAP by increasing the number of children screened for social-emotional or behavioral issues. Most of the children identified through the social emotional screening stay within public health usually in the home visiting component as these families need parental support rather than direct "mental health" services. Most are very young and have not yet started to display the severe behavioral symptoms of the older children

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. Convene advisory group to guide implementation of program enhancements			X	X
3. Continue hosting regional FAP Coordinators Meetings				X
4. Analyze program data & disseminate written report			X	X
5. Provide statewide training on reimbursement & funding sources & effective screening, assessment & intervention			X	X
6. Train professionals including FAP coordinators and Human Services professionals on ASQ-SE				X
7. Collaborate and coordinate FAP activities with other state agency initiatives involving social-emotional screening of young children				X
8. Continue developmental and social-emotional screening of children 0-3 as an outcome measure for the Local Public Health Grant Activity.			X	X
9. Support Community Health Board use of federal Title V funds for this activity	X			X
10.				

b. Current Activities

The CYSHCN program continues to provide technical assistance to local public health agencies through training sessions and software enhancements for the Follow Along Program. Children enrolled in the FAP as of December 31, 2007 totaled 23,640 children (Birth to 3) and 6862 (3 to 5) The numbers have decreased due to a cut in funds to local public health agencies from local Part C funds and increased postage costs. More agencies are using their data for reports to community services on their activities in the FAP. One finding this year was discovered by accident. In an effort to reduce postage costs, agencies were inactivating families who had not returned developmental questionnaires. When informed of being dropped from the program, many families contacted the agencies with the request to stay on FAP. The families indicated that they were using the questionnaires with their child, but were not returning them because they did not have any concerns. Other agencies report that some families do not return the forms for several times but then they all come back when concerns are indicated. Many agencies continue to send the forms as anticipatory guidance for families and to stay connected with families in the event that the family does need to contact someone with a concern. Seventy percent (70%) of the local agencies offer the FAP to families regardless of risk factors. In addition, local public health departments provide direct services to over 4,600 very young CSHCN.

c. Plan for the Coming Year

A new and related priority - improve early identification and intervention for children birth to three - was identified in the most recent Title V needs assessment. Three specific areas of activity will contribute to early identification: The Follow-Along Program, the Birth Defects Information System and child find capacity building at the local level for early intervention services through Part C of IDEA. Current activities will continue and expand. The BDIS will expand from surveilling births in the seven-county, Minneapolis-St. Paul Metropolitan area to all births in the state. The change to Minnesota Rules for Part C eligibility criteria were re-written and brought to public hearings in May 2007. Technical assistance and training will be provided to Follow-Along Programs. The FAP software will be upgraded to include the capacity to email families with internet access to reduce some of the postage costs. Work continues on encouraging 2 of the non participating counties to reinstitute the FAP. It is anticipated that child find materials will be modified to the extent that the results of the evaluation indicates with increased efforts to provide culturally and linguistically appropriate materials.

Work with interagency partners to increase the percentage of young children who receive early intervention services will continue. A particular focus has been participating in evaluating various screening tools for use by local agencies that can be used to identify children who may have a developmental delay. Trainings have been provided to local agencies (public health, education, social services, Headstart, child care on the correct use and interpretation of the ASQ and the ASQ-SE. Improving early identification and intervention for children birth to three is the priority this performance measure addresses. However, this single performance measure provides a limited picture of the multiple efforts directed toward this priority.

State Performance Measure 2: *Percent of children enrolled in Medicaid who receive Early Periodic Screening, Diagnosis, and Treatment (EPSDT), also known as Child & Teen Checkup (CTC) in MN.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				64	65
Annual Indicator		62.3	63.8	63.8	65.5
Numerator		156113	161179	161179	165652
Denominator		250456	252584	252584	253051
Is the Data Provisional or Final?				Final	Final

	2008	2009	2010	2011	2012
Annual Performance Objective	66	67	68	68	68

Notes - 2007

2007 data is not yet available

Notes - 2006

Data is being corrected from data entry error in previous years. Data presented for 2005 should be for 2006.

a. Last Year's Accomplishments

In Minnesota the Title XIX EPSDT program is called Child and Teen Check-Ups (C&TC). The percent of C&TC eligible children and adolescents who received at least one preventive health visit was 65.5% in 2007 compared with 63.8% in 2006. This represents a small increase in the past year.

Under contract with the Department of Human Services (DHS), Title V staff offered an extensive schedule of C&TC training sessions to health care providers. Participants included public health nurses, school nurses, private providers, C&TC outreach coordinators, and other child health screeners. On-site follow-up consultations were provided by a certified pediatric nurse practitioner for newly trained public health nurses and refresher training was offered to more experienced nurses.

The C&TC documentation templates were updated in 2007 to: 1) reflect legislative changes in EPSDT components; 2) update the recommended screening tools; and 3) enhance anticipatory guidance congruent with evidence-based practice. These templates serve as a guide for providers to address each of the components in a C&TC visit. A web-based list of recommended developmental and social emotional screening instruments was developed for private and public providers. A new edition of the vision screening manual was completed and posted to the website. An oral health online module for providers was posted June 2007.

A series of workshops were developed for providers of C&TC through the efforts of the Metro Action Group (MAG) whose membership consists of representatives from Title V, DHS, local and state public health departments including C&TC coordinators, and the seven county Minneapolis and St. Paul metropolitan area health plans. These highly successful workshops were presented to over 200 private providers in October 2007 at various metro area sites. The workshops provided a general overview of C&TC including: 1) best practice standards for hearing and vision screening; 2) practical methods to incorporate developmental and social-emotional screening into a busy practice; and 3) detailed billing information to ensure appropriate and complete reimbursement for C&TC.

Title V staff collaborated with DHS and Women, Infants and Children (WIC) to develop C&TC/WIC family recipe book, projected for completion in the summer of 2008. The recipe book which will be used as an outreach tool for families contains nutritional recipes as well as information about both programs. Title V and Emergency and Community Health Outreach provided technical support and resources for the development and distribution DVDs for a variety of child health cable TV programs produced in several languages (<http://www.echominnesota.org>).

The interagency partnership between the Title V programs, DHS, the Department of Education, the University of Minnesota Irving B Harris Center for Infant and Toddler Development, and the Minnesota Head Start provided updates to the statewide recommended pediatric developmental and social-emotional screening instruments list (www.health.state.mn.us/divs/fh/mch/devscrn).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue as a joint activity with the DHS as it relates to the Medicaid enrolled children				X
2. Provide technical assistance and training to a variety of key providers			X	X
3. Maintain and enhance partnerships with other organizations that are working to assure child care.			X	X
4. Continue Medicaid participation on MECCS Interagency Leadership Team			X	X
5. Support local public health outreach activities to Medicaid eligible children	X		X	X
6. Continue collaboration with state agencies to review and recommend developmental and social-emotional screening instruments		X	X	X
7.				
8.				
9.				
10.				

b. Current Activities

Title V staff continues to collaborate with DHS on the C&TC program. Staff provide technical support to C&TC providers and outreach coordinators to increase participation. Staff also provide statewide training for Medicaid providers on quality pediatric comprehensive preventive health services.

In early 2008, the New Mexico Department of Health requested the use the MDH materials on vision and hearing screening as a base for recommendations and training to early childhood programs, public schools and Medicaid providers. After reviewing materials from several states, the New Mexico Vision and Hearing Task Force determined that MDH materials best reflected current evidenced-based practice and are user-friendly.

Title V staff partnered with the Minnesota Chapter of the American Academy of Pediatrics, and DHS to obtain technical assistance from the Vermont Child Health Improvement Partnership to improve child health care in clinical practice. The first project, "Healthy Development through Primary Care," is a quality improvement learning collaborative of 11 private pediatric clinics that are introducing pediatric developmental and social-emotional and maternal depression screening into their clinical practice. Title V staff provide consultation and site visits to support these clinics.

The C&TC provider fact sheets were updated to: reflect changes in MN EPSDT Rule; describe each component; clarify documentation requirements; and provide guidelines for evidenced-based practices.

c. Plan for the Coming Year

The Title V staff will continue to review and evaluate current literature as well as information in respected publications such as Bright Futures to develop recommendations for health supervision of infants, children, and adolescents that reflect current evidenced-based practice.

The "Developmental Screening" online modules will be posted June 2008 on the MDH/C&TC web site.

The Interagency Developmental Screening Task Force has sponsored trainings for several recommended screening instruments such as, the Brigance, IDI/CDR-PQ, and the ASQ/SE which

will be captured on videotape and posted to the MDH/C&TC website in late 2008.

Under current review are several developmental and social/emotional screening tools. Additionally, the MDH Lead Project was initiated in early 2008 in eight pilot Minnesota counties. The Lead Project will continue for 12-18 months and will test the effectiveness of outreach methods for increasing the rate of completed lead level screenings for children at their 12 and 24 month C&TC visits.

Updates to the C&TC Newborn Training and Anticipatory Guidance are ongoing. Changes in curriculum include: 1) competencies and vulnerabilities with the addition of infant mental health and maternal depression screening tools; and 2) low birth weight and prematurity.

Title V staff serve on the Minnesota Child Health Improvement Project advisory group and will continue to provide technical assistance and consultation as needed to future learning collaboratives. Staff is working with the health plans and C&TC county coordinators in greater Minnesota to replicate the successful workshops that were sponsored and presented last fall by the MAG for providers of C&TC.

State Performance Measure 3: *Percent of sexually active ninth grade students who used a condom at last intercourse.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				70	71
Annual Indicator		69	69	69	70.8
Numerator					5642
Denominator					7971
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	71	71	74	74	74

Notes - 2006

Data from the 2004 MN Student Survey were applied again to this year.

Notes - 2005

Data from the 2004 MN Student Survey were applied to this year, as no new data are available. Next MN Student Survey will be administered in 2007.

a. Last Year's Accomplishments

Minnesota uses state funding (\$4.3 million) to support Family Planning Special Projects grants (FPSP). This includes financial support for all method services (including condoms), as well as outreach and education to community groups and juvenile detention sites. Local health departments continue to use federal Title V funds to provide family planning method services, reproductive counseling services, and health education in schools.

A total of \$10.86 million dollars in new Family Planning Special Projects (FPSP) grants were awarded for two years beginning July 1, 2007 to 39 programs representing all regions of the state, as well as a family planning and sexually transmitted infection (STI) hotline (Hotline). This represents a 25 percent increase in awarded funds from the last grant cycle. \$1.2 million per year of this total is received from Temporary Assistance for Needy Families (TANF) funds. The Hotline is staffed by individuals trained in information and referral as well as family planning and STI counseling. Over 4,700 calls were handled by the Hotline in 2006. Thirty-two percent (9,978) of the clients receiving counseling services through FPSP and thirty-four percent (8,396) of the

clients receiving family planning methods were 14-19 years of age. There were 1,639 male clients receiving family planning methods through FPSP.

The Medicaid 1115 Waiver program, Minnesota Family Planning Program (MFPP), began July 1, 2006 and completed its first year of enrolling participants on June 30, 2007. Under MFPP, adolescents (15 years of age and above) are eligible for family planning services. MFPP served a total of 25,814 individuals in its first year of operation.

Minnesota continues to support an abstinence education program that supports adolescents in their decision to postpone sexual involvement. Funding for Minnesota Education Now and Babies Later (MN ENABL) in FY 2006 was \$1.04 million (\$489,000 Federal 510 Abstinence Grant, \$480,000 General Fund, and \$71,000 State Government Special Revenue Fund). Twenty-two community grantees representing a diverse group of organizations and racial and ethnic populations provide curriculum, community events, and public awareness activities that support positive youth-based abstinence messages. Community events and public awareness activities strengthen the abstinence message in MN ENABL communities. MN ENABL grantees include non profit organizations, local public health agencies, and school districts.

The STD and HIV Section of MDH conducted the highly successful and well-received Condom Distribution Project. This project made available bulk quantities of condoms and lubricant free of charge to all current HIV grantees and STD screening grantees. The condoms were also offered to all local health departments throughout the state. Forty-two agencies participated. Each agency received 2-4 boxes of free condoms (1,000 condoms/box). The STD and HIV Section of MDH also implemented two STD prevention campaigns in 2007 designed to reach sexually active teens and young adults, 15-24 years of age, experiencing the highest STD rates in Minnesota, African Americans and Latinos. The goals of the campaigns were to raise awareness on how to prevent the spread of STDs through increased condom use, routine testing and informing sexual partners if infected.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support Minnesota Student Survey data collection and analysis				X
2. Support access to family planning services for sexually active Youth	X	X	X	
3. Increase public understanding of social, economic and public health burdens of unintended pregnancy			X	X
4. Continue abstinence programs that support adolescent in their decision to postpone sexual involvement	X		X	X
5. Support school based clinics and comprehensive reproductive education	X		X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FPSP and the Title V continue to support reproductive health services including method services and outreach.

Minnesota did not apply for federal 510 funds this year. A state reduction in funding during the

2007 Minnesota legislative session resulted in an assessment of the MN ENABL program and how the remaining funds could be used in the state.

MDH hopes to enhance and expand the implementation of the Teen Outreach Program in Minnesota by financially supporting and delivering in-depth training about the importance of service-learning and how to structure service-learning opportunities for existing programs.

The MDH adolescent health coordinator is working with the Minnesota Department of Education to increase collaboration and joint efforts directed at STI/HIV prevention. The two departments are currently in the planning stages of developing an intervention to address the STI epidemic. The intervention would take place during summer session and target for high risk students from alternative learning centers in Minneapolis and St. Paul.

c. Plan for the Coming Year

Staff will continue to provide technical assistance to FPSP grantees. The current grant cycle will end June 30, 2009. Staff will complete site visits of all 40 grantees by March 2009. It is anticipated that a new Request for Proposal will be posted in the early months of 2009 for the next grant cycle of FPSP and that grants will be awarded beginning July 1, 2009. Staff will continue to help promote MFPP and support family planning service providers use of the waiver.

The 2008 Minnesota legislature eliminated funding for the MN ENABL program.

State Performance Measure 4: *Incidence of determined cases of child maltreatment by persons responsible for a child's care.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				6.1	6
Annual Indicator		6.0	6.2	5.4	
Numerator		7784	7983	6998	
Denominator		1286894	1286894	1286594	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	5	4.5	4.5	4	4

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 data are not yet available.

a. Last Year's Accomplishments

Determined child maltreatment by a person responsible for a child's care decreased from 6.2 incidents per 1,000 children 17 years and younger in 2005, to 5.4 incidents per 1,000 children 17 years and younger in 2006. Counties may use the Family Assessment, a strengths-based and family focused alternative to working with families in the child protection system when no determination of maltreatment is made.

In February 2007, four trainings were provided for local health department (LHD) and tribal agency staff on a curriculum developed by NCAST-AVENUW titled "Promoting Maternal Mental Health During Pregnancy." The trainings addressed the impact that maternal mental health has

on the health and well being of children, including intervention strategies to promote positive parenting and prevention of child maltreatment. Over 100 public health nurses and home visitors attended the 2007 trainings. In April 2007, staff partnered with Prevent Child Abuse Minnesota (PCAMN) to plan and co-sponsor PCAMN annual state conference and interactive videoconference trainings for LHDs and community partners to promote April as Child Abuse Prevention Month.

The 2007 Legislature amended the Family Home Visiting (FHV) statute and increased Temporary Assistance for Needy Families (TANF) funding to LHDs and tribal governments to support home visiting services for families with identified risk factors including risk for child maltreatment.

Staff participate on the Department of Human Services' (DHS) Child Mortality Review Panel. The state panel reviews clusters of similar deaths of children and makes recommendations for systems changes to protect children.

Staff coordinated NCAST-AVENUW Parent Child Interaction (PCI) trainings and supported use of the PCI tools by trained local and tribal public health nurses.

Minnesota launched the "Safe and Asleep in a Crib of their Own" campaign (July 2007), in partnership with the Minnesota SID Center of Children's Hospitals and Clinics, the Minnesota Association of Coroners and Medical Examiners, and the DHS Child Mortality Review Panel. MDH had a news release and several media contacts were made. Posters, flyers and brochures consistent with the American Academy of Pediatrics infant sleep guidelines (November 2005) are available and have been disseminated across the state to local health departments, tribal health, community organizations, child care providers, hospitals, and clinics. The brochure is available in English, Spanish, Hmong, and Somali.

MDH staff have presented Safe and Asleep information at conferences through presentations and exhibits. Family home visiting staff distribute information and materials in their trainings and meetings.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify and participate in opportunities to collect surveillance, best practices and policy development to reduce maltreatment.				X
2. Continue involvement on infant/Child Death and Child Maltreatment Review Panels				X
3. Develop/update and distribute infant death investigation Guidelines			X	X
4. Provide information to local health and other partners regarding available crisis services		X		X
5. Disseminate strategies for prevention of child maltreatment i.e., home visiting			X	X
6. Continue to provide NCAST training				X
7.				
8.				
9.				
10.				

b. Current Activities

MDH convened FHV Steering, Training, and Evaluation Work Groups to advise on the implementation of the 2007 FHV statute. LHDs and tribal governments submit a plan describing

their approach to providing home visiting services to families. Of 91 plans submitted, over 90% of LHDs indicated targeting populations with a history of child abuse/neglect, reduced cognitive functioning and lack of knowledge of child growth and development. The Training Work Group is developing a plan to assure quality FHV services. The Evaluation Work Group is developing a plan for identification of measurable outcomes for the program. Examples of outcome measures recommended in the 2007 statute include: rates of substantiated child abuse and neglect and rates of unintentional child injuries.

In April 2008, staff collaborated with the SID Center to sponsor a training for LHD and newborn nursery staff. The goals were to discuss data on sudden unexpected infant deaths and current recommendations for safe infant sleep practices and assure parents receive consistent evidenced based messages regarding safe infant sleep environments.

In May and June 2008, staff sponsored two trainings for PHNs and family home visitors on a curriculum developed by NCAST-AVENUW titled "Promoting First Relationships" (PFR). PFR is a guide for PHNs and home visitors to assist parents and other caregivers to meet the social and emotional needs of young children. Over 50 PHNs and home visitors attended the PFR trainings.

c. Plan for the Coming Year

MDH will maintain an ongoing partnership with the SID Center as a key component of Minnesota's efforts to reduce infant mortality. The Center serves the state by providing grief support to families and child care providers. The Center also provides education on risk reduction interventions. The Center maintains communication with coroners and medical examiners and encourages use of Minnesota's Infant Death Investigation Guidelines to improve diagnosis of sudden unexpected infant deaths.

Increasing numbers of infant deaths have occurred as unintentional injuries related to unsafe infant sleep conditions. Title V staff will continue to collaborate with the SID Center to distribute infant sleep safety education folders covering topics related to infant sleep including bedding, cribs, the Safe Sleep Top Ten, tummy time, and information for grandparents. MDH plans to distribute 10,000 to 20,000 folders in the coming year for use in prenatal and parenting classes, on home visits, and for community baby showers.

FHV will continue to coordinate NCAST-AVENUW PCI trainings and support the use of the PCI scales by trained county and tribal public health nurses.

FHV and infant mortality staff participate on the DHS Child Mortality Review Panel and will continue to participate in the coming year. The panel reviews clusters of similar deaths of children and makes recommendations for systems changes to protect children.

FHV staff plan to implement the FHV training and evaluation plans and will provide consultation and support to family health supervisors, MCH and home visiting program staff in local health departments and Tribal Governments in areas related to MCH, home visiting, reflective supervision and relationship based practice. Activities related to these priorities continue to evolve. The FHV website (<http://www.health.state.mn.us/divs/fh/mch/fhv/>) will be maintained and updated with training resources, home visiting strategies and best practices, home safety resources, shaken baby syndrome prevention materials, infant sleep safety, postpartum depression educational materials and home visiting guidelines.

State Performance Measure 5: *Percent of pregnancies that are intended.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				70	71
Annual Indicator	66.0	64.4	66.3	64.0	
Numerator	43136	42153	44408	43882	
Denominator	65329	65501	67017	68538	
Is the Data Provisional or Final?				Provisional	
	2008	2009	2010	2011	2012
Annual Performance Objective	65	66	66	67	67

Notes - 2007

2007 data not yet available

Notes - 2006

PRAMS data for 2006 are not yet available.

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure. PRAMS data for 2005 are not yet available.

a. Last Year's Accomplishments

Minnesota uses state funding to support Family Planning Special Projects grants (FPSP). FPSP funds are used by local communities to provide method services, as well as outreach and education to those at risk for unintended pregnancy. Local health departments use federal Title V funds to provide family planning method services, reproductive counseling services, and health education in schools. A total of \$10.86 million dollars in new FPSP grants were awarded for two years beginning July 1, 2007 to 39 programs representing all regions of the state, as well as a Family Planning and STI Hotline. This represents a 25 percent increase in awarded funds from the last grant cycle. \$1.15 million per year of this total is received from Temporary Assistance for Needy Families (TANF) funds. The Medicaid 1115 Waiver program, Minnesota Family Planning Program (MFPP), began July 1, 2006 and completed its first year of enrolling participants June 30, 2007. MFPP served a total of 25,814 individuals in its first year of operation.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyze PRAMS data				X
2. Ensure efficient and effective use of state funds for family planning services.	X	X	X	
3. Partner with Department of Human Services to successfully implement 1115 Family Planning Waiver			X	X
4. Increase public understanding and support for policies and programs that reduce unintended pregnancies			X	X
5. Promote statewide implementation of abstinence based education for 12 to 14 year olds			X	X
6. Consider policy and program recommendations for prenatal, interconception care and child spacing.			X	X
7. Implement youth activities that increase resiliency and support healthy behaviors			X	X
8. Continue to direct resources to a hotline for family planning and STI services	X	X	X	X
9. Support school-based clinics and comprehensive reproductive health education	X	X	X	X
10.				

b. Current Activities

MDH staff conducts site visits with current FPSP grantees to monitor their progress and provide technical assistance. Staff sends a monthly newsletter with news of trainings and the latest research on family planning to all grantees. MDH continues to provide key linkages between the provider community and DHS to help promote MFPP and assist FPSP grantees to implement it within their clinics.

The first annual Preconception Care Conference was held on October 5, 2007, with approximately 150 participants. One of the primary goals of the conference was to facilitate the inclusion of preconception care into current standard delivery systems. Based upon pre and post test data, the percent of conference participants indicating the goal was attainable increased from 74 percent to 80 percent while those who were "unsure" decreased from 25 percent to 14 percent.

PRAMS, BRFSS, Minnesota Student Survey and Abortion Report data will continue to be analyzed to provide information on possible strategies for improving pregnancy intendedness.

c. Plan for the Coming Year

Staff will continue to provide technical assistance to FPSP grantees in the current grant cycle which will end June 30, 2009. Staff will complete site visits of all 40 grantees by March 2009. It is anticipated that a new Request for Proposal will be posted in the early months of 2009 for the next grant cycle of FPSP and that grants will be awarded beginning July 1, 2009. Staff will continue to help promote the MFPP.

MDH staff are working with a variety of partners to plan the second annual Preconception Care Conference scheduled for November 7, 2008. This conference will focus on challenges and solutions to reach underserved populations. The conference will bring attention to health disparities and the need to increase awareness of and accessibility to preconception care among populations of color. The conference will also address women's health issues throughout the childbearing years and focus on community based strategies that will assure continuous health care access for women including reproductive health services to reach underserved populations in Minnesota.

State Performance Measure 6: *Percent of pregnant women screened for depression during routine prenatal care.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				83	84
Annual Indicator	82.5	82.1	85.4	85.6	
Numerator	54491	54466	56690	59389	
Denominator	66046	66369	66396	69413	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	86	86	87	88	88

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 data are not yet available.

Notes - 2005

The data for 2005 are pre-populated with data from 2004 for this performance measure. 2005 data are not yet available.

a. Last Year's Accomplishments

Postpartum depression education legislation was passed in 2005 that requires hospitals to provide new parents and other family members written information about postpartum depression (M.S.145.906). A work group, the Postpartum Depression Education Work Group, representing a broad range of health care providers, consumers, mental health advocates and families was brought together to develop educational materials and to recommend policies and procedures for the implementation of the legislation. The brochure and fact sheet are now available in five languages: English, Hmong, Russian, Somali, and Spanish. These materials are available on the MDH website at: <http://www.health.state.mn.us/divs/fh/mch/fhv/strategies/ppd/index.html>.

The Postpartum Depression Education Work Group continued to meet in 2007 in order to share knowledge of resources related to perinatal depression, discuss systems issues related to screening and treatment, and develop and refine a PowerPoint presentation on perinatal depression which can be adapted for various audiences. Multiple presentations and exhibits were provided on maternal mental health and postpartum depression in a variety of venues. Examples include statewide conferences, workshops and community events, such as the 2007 Minnesota Children's Mental Health Conference, the 2007 Minnesota Association of Community Mental Health Programs Conference, and the Twin Cities Healthy Start Family Fair. In May 2007 a half-day National Alliance for the Mentally Ill-Minnesota (NAMI-Minnesota) conference was dedicated to postpartum depression.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote maternal depression screening by providers during routine prenatal and postpartum visits as well as during pediatric and well child visits			X	
2. Update/translate (as needed) and disseminate maternal depression education materials to prenatal, hospital, postpartum, and pediatric/well child practitioners		X		
3. Provide technical assistance and educational opportunities for county and tribal health staff on maternal mental health promotion, risk/protective factors, screening and referral, and issues related to working with women with mental illness				X
4. Provide education through appropriate media to health consumers and the public on maternal mental health and the importance to the health and well being of the mother and her family.		X		
5. Provide leadership and collaborate with other state agencies and providers, health plans, and others regarding the need to address appropriate mental health services for prenatal and postpartum depression.				X
6. Promote and monitor reimbursement for prenatal and postpartum depression screening by the Department of Human Services and Minnesota Health plans.				X
7.				
8.				
9.				
10.				

b. Current Activities

Pregnancy Risk Assessment Monitoring System (PRAMS) data on if women are receiving information about "baby blues" or postpartum depression is being analyzed by program staff. Between 2002 and 2006, the percentage of women reporting that a doctor, nurse, or other health care worker talked with them about "baby blues" or postpartum depression during their pregnancy or after delivery has increased in a significant linear trend (2002: 76.87%; 2003: 82.50%; 2004: 82.06%; 2005: 85.38%; 2006: 85.56%).

Planning for a 2008 National Alliance on Mental Illness (NAMI)-Minnesota conference on postpartum depression is underway. Presentations and exhibits continue to be made at various venues, such as the Community Health Worker Conference and the Healthy Development through Primary Care Learning Collaborative.

The Great Start Minnesota project continues to promote screening for maternal depression in pediatric clinic settings.

The Postpartum Depression Education Work Group meets periodically and an informal speakers' bureau is being developed to utilize the PowerPoint presentation that was developed and piloted in 2007. Work Group members continue to share information about resources and assist in the development of a statewide resource list with a community partner, Postpartum Support International of Minnesota.

MDH staff monitor funding opportunities to support education regarding postpartum depression and advance perinatal depression screening and services.

c. Plan for the Coming Year

Analysis of Minnesota's PRAMS data on postpartum depression will continue. Data continue to be analyzed and shared to raise awareness of the need to screen for perinatal depression. The MDH plans to assess whether this data item should be revised or additional questions developed and added when CDC next allows revisions in 2009. Staff will confer with other agencies, institutions and health plans about the possibility of collaborating with them in the collection and analysis of perinatal depression screening data from other sources. If no other sources can be identified, discussions will be held about the possibility of adding this data item to other collection systems for future data collection and analysis. Development of a PRAMS publication on depression and related issues has been discussed.

MDH will continue to provide leadership, technical assistance, and training opportunities with community partners, local health department and tribal health staff, and others regarding the importance of perinatal depression screening and the need to address system issues that limit access to timely and appropriate mental health services for perinatal depression.

State Performance Measure 7: *The degree to which Title V programs enhance statewide capacity for a public health approach to mental health promotion and suicide prevention for children and adolescents.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				2	2
Annual Indicator		0	1	1	2
Numerator		0	1	1	2

Denominator	4	4	4	4	4
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	2	3	3	4	4

Notes - 2005

Stage 1 is nearly completed with the remaining activity being to c) draft a mission statement which outlines our vision of and commitment to mental health promotion and suicide prevention in the state.

a. Last Year's Accomplishments

Staff convened regular meetings of a departmental Mental Health Work Group, open to anyone from MDH with interest in or relationship to mental health in their work. The group consists of approximately 40 staff across the department. The primary objectives of the group are to provide a focus and forum for sharing mental health activities, looking for possibilities for coordination and collaboration, providing information and training around mental health promotion, and providing a focal point for broader planning and resource development. This work group provided the "material" for the development of an informal inventory of current mental health related activities across the department.

Over this past year, several trainings were held across the state around maternal mental health promotion for visiting nurses, with one specifically offered for Tribal workers. Several trainings have also been held around infant mental health, with both general education and skill development and training specific to the DC: 0-3 classification of infant diagnostic coding that supports treatment and reimbursement. The State legislation required that information be provided for physicians to give to mothers about post partum depression.

The Governor's Mental Health Initiative was partially funded allowing forward movement in revamping Minnesota's current mental health service system. This initiative came out of a private-public effort to improve mental health services in Minnesota called MMHAG. This initiative provided increased funding for children's and adults' mental health crisis services.

Staff represents the Department of Health on both the Children's Mental Health Subcommittee and the State Advisory Council on Mental Health. The focus of involvement is the Early Intervention and Prevention workgroup, which has worked primarily on promoting a socioemotional component to early childhood screening, in particular, educating parents from diverse backgrounds about the importance of and process for screening. Staff collaborated with the Departments of Education, Public Safety and Human Services to plan a cross-disciplinary conference on children's mental health. Planning is underway for a second conference which will focus on youth development and mental health protective factors.

In collaboration with two community organizations staff is holding regional focus groups in six locations throughout Minnesota. Survivors, family members, school personnel, mental health professionals, crisis workers, local public health and community organizations are invited to gather input on updating the state suicide prevention plan.

Staff in this area provides technical assistance to local public health and community organizations on mental health and suicide prevention, including surveillance data, information about evidence-based strategies, and resource information. MDH provide training at several conferences. New trainings on screening for socioemotional health and perinatal depression are in development.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Update with key stakeholders the State Suicide Prevention Plan				X
2. Continue to provide trainings around suicide prevention and children's mental health issues				X
3. Continue to partner with DHS (mental health authority) related to mental health screening, intervention and treatment				X
4. Design and implement a suicide prevention program in reponse to 2008 legislation			X	X
5. Represent MDH on State Advisory Council on Mental Health and children's mental health subcommittees and related mental health workgroups				X
6. Partner with the Departments of Education and Human Services on annual statewide mental health conference				X
7. Administer suicide prevention grants	X			X
8. Continue to partner with the Department of Education related to suicide prevention strategies and suicide response.			X	X
9.				
10.				

b. Current Activities

MDH continues activities noted above with the mental health work group, supporting or providing trainings as resources are available. Complete phase one of the action plan for this measure to draft a mission statement that outlines our vision of and commitment to mental health promotion and suicide prevention throughout the state, including the role of public health in attaining that vision. MDH begins to move into phase 2 during which time we will work with local public health agencies to: (1) determine the additional capacity and training needs of LPH nurses, health educators and other local staff regarding mental health promotion and suicide prevention; and (2) support development of needed resources and capacity for our LPH constituents statewide.

Title V staff wrote and published an RFP for suicide prevention grants and awarded five grants. The funds for these grants combined state general fund dollars, SAMHSA block grant dollars and state funds from the CSHCN program. The Title V program and DHS entered into an Interagency Agreement to combine the dollars from the federal State Mental Health and Substance Abuse block grant with state dollars appropriated for suicide prevention.

c. Plan for the Coming Year

MDH will continue to provide technical assistance to local public health and community organizations on mental health and suicide prevention, including surveillance data, information about evidence-based strategies, and resource information. MDH staff will continue to provide training at conferences. Trainings on screening for socioemotional health and perinatal depression will be offered.

Staff continues activities noted above with the mental health work group, supporting or providing trainings as resources are available. MDH will work with local public health agencies to: (1) determine the additional capacity and training needs of LPH nurses, health educators and other local staff regarding mental health promotion and suicide prevention; and (2) support development of needed resources and capacity for our LPH constituents statewide.

Title V staff will continue management of the grants awarded for suicide prevention.

State Performance Measure 8: *The ratio of the low birth weight (<2500 grams) rate for American Indian women and women of color to the low birth rate for white women.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				1.2	1.2
Annual Indicator		1.3	1.4	1.3	
Numerator		80.9	86	82	
Denominator		60.6	60.1	61	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	1.1	1	1	1	1

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 data are not yet available.

Notes - 2005

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a. Last Year's Accomplishments

Title V staff provide consultation and resources to community-based programs that address racial/ethnic disparities in birth outcomes, including infant mortality and low birth weight. The federally funded Twin Cities Healthy Start (TCHS) program provides outreach, case management and health education to African American and American Indian pregnant and parenting families in Minneapolis and St. Paul. The TCHS programs focus on reducing disparities in infant mortality and reducing LBW, especially among African American infants. Low birth weight rates among African American infants are more than twice the rate of White infants (8.5% vs. 4.2% for the years 2001-2005). TCHS staff attended the smoking cessation in pregnancy and motivational interviewing workshop presented by Title V staff in May 2007. TCHS programs use the cessation resources available from MDH. Smoking cessation in pregnancy is a strategy to reduce low birth weight.

Title V staff participated on the Community Health Worker (CHW) project through the CHW Policy Council and Curriculum Development Committee. Recognizing that disparities in low birth weight are related to the availability of culturally competent health care services, collaboration occurred with the Minnesota State Colleges and Universities to assure implementation of the CHW education program at community colleges in Minnesota. Legislation in 2007 allowed for Medicaid reimbursement for CHW services when provided under the supervision of a Medicaid-enrolled provider. CHWs are recognized as valuable community providers who can bridge a gap between health care providers and populations of color. Connecting women to health care and other resources in pregnancy can help reduce LBW.

Title V staff provided consultation and resources to programs funded by the Department of Health's Office of Minority and Multicultural Health's Eliminate Health Disparities Initiative. This funding includes support for reducing infant mortality and LBW disparities between Whites and populations of color. The funded programs provide a variety of services including doulas, health education, smoking cessation, child spacing and support for breastfeeding. All services address reducing the disparity in infant mortality and reducing low birth weight.

Title V staff participated in the Latino Healthy Mothers and Babies work group initiated by Catholic priests in the Minneapolis and St. Paul metropolitan area. This group of Catholic priests reported an increasing number of fetal and infant deaths among families they serve. The work group identified the Latino community's barriers to accessing existing health and support services, especially when pregnant. A Latino Healthy Mothers and Babies community workshop occurred

in April 2007 to address these barriers and to promote healthy birth outcomes and healthy birth weights.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing collaboration with Twin Cities Healthy Start		X	X	X
2. Ongoing partnership with MN State Colleges on Community Health Worker education project		X	X	X
3. Ongoing technical assistance to the Eliminate Health Disparities Initiative, infant mortality grantees			X	X
4. Ongoing collaboration with the Latino Healthy Mothers and Babies group		X	X	
5. Continue to dialogue with Tribal Health Leaders around issues related to poor pregnancy outcomes.			X	X
6. Continue to provide TA to Tribal Governments on Family Home Visiting			X	X
7. Continue efforts to inform the public of the need to stop smoking and engaging in other high risk activities during pregnancy.			X	
8.				
9.				
10.				

b. Current Activities

Title V staff completed the American Indian Infant Mortality Review project. The project was done in collaboration with many partners from the American Indian community. Partners are meeting to discuss dissemination and implementation of the strategies and recommendations that were developed through this project. The overall goal is to reduce the disparity in American Indian infant deaths and decrease low birth weight.

Title V staff provides quarterly education and resources to WIC staff on interventions to promote smoking cessation during pregnancy and postpartum reduction of secondhand smoke exposure. Both of these are strategies to reduce low birth weight, SID, and other smoking-related complications.

The leading cause of death for American Indian infants and the second leading cause for African American infants is a combination of SID and sleep-related injury. These deaths contribute to the disparity in infant mortality experienced by these two populations. To address the increase in the number of deaths classified as sleep-related, MDH (in partnership with the Minnesota SID Center) has implemented the "Safe and Asleep in a Crib of Their Own" campaign.

A statewide video conference on the topic was held in April 2008 to raise awareness among hospital nursery and public health staff on the importance of modeling and conveying a consistent message to new parents.

c. Plan for the Coming Year

Plans are to continue all activities described above. Title V staff will continue to expand and integrate Title V activities with the Office of Minority and Multicultural Health activities, especially efforts to eliminate the disparity in infant mortality among populations of color and American Indians.

The TCHS director is a member of the planning team for Minnesota's Second Annual Preconception Care Conference: Reaching Underserved Populations to be held in November 2008. This conference will address the social conditions that contribute to poor birth outcomes among populations of color. The conference will also address the chronic, untreated health conditions that underserved minority women often bring to a pregnancy. The conference will also present strategies for better outreach before pregnancy to reduce low birth weight and other poor pregnancy outcomes and improve women's health.

State Performance Measure 9: *Percent of Children and Youth with Special Health Care Needs (CYSHCN) with one or more unmet needs for specific health care services.*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				14.1	10
Annual Indicator		14.1	14.1	12.9	
Numerator		21685	21498	22967	
Denominator		153795	152468	177669	
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	12	12	11	11	10

Notes - 2007

2007 data not yet available

Notes - 2006

The 2006 data are not yet available.

Notes - 2005

The data reported in 2005 are pre-populated with 2000-02 SLAITS data. Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2005.

a. Last Year's Accomplishments

This measure specifically addresses access to a medical home, oral health, specialty care and the organization of services.

There is professional consensus that children with a medical home are more likely to have their need for services met across all systems than are children without a medical home. Establishing, spreading and sustaining the concept of medical home in Minnesota is the primary activity used to address this performance measure. Medical Home Learning Collaborative teams were first established in Minnesota in 2004 through a MCH Bureau Medical Home grant (2002-2005). A subsequent MCH-B grant, the New Freedom Initiative (NFI) grant (2005-2008), integrates the six core outcomes within the context of the Medical Home. That grant funded collaborative learning sessions held in January, May and September of 2007. Curricula included the concept of medical home, issues of spread, parent role, cultural and linguistic competence, community outreach, the Medical Home Index tool, the Chronic Care Model, the Model for Improvement, care coordination, data collection, specialist-primary care practitioner interaction and transition.

The CYSHCN program continued to support medical home learning collaboratives and to provide technical assistance and consultation to medical home teams in conjunction with the New Freedom Initiative grant. Learning collaborative objectives included exploration of methods to increase access to mental health care that involve establishing relationships between medical

home clinics and mental health providers, using consultation with mental health professionals to assist primary care physicians in management of mental health diagnosis, and coordination of telemedicine to make specialty care (including mental health) more accessible.

The CYSHCN program continues to partner with the Children's Mental Health Services Division at the Minnesota Department of Human Services (DHS) to provide statewide trainings on the DC: 0-3™ diagnostic criteria as a method to increase local capacity. This is a taxonomy that allows a more child friendly diagnostic classification system that can be converted to the DSM-IV classification system for purposes of reimbursement thereby decreasing financial barriers to mental health services. To date, 990 professional have been trained in the diagnostic criteria specifically and infant mental health generally.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue support of Medical Home Teams		X		X
2. Continue support of mental health activities and initiatives underway		X		X
3. Continue support of interagency planning at the individual level				X
4. Continue operation of MCSHN clinics located in underserved areas of the state	X			
5. Sponsor specialty healthcare regional conferences				X
6. Continue leadership role in health conditions and early intervention eligibility		X		X
7. Provide outreach to increase awareness of community-based resources among the health provider community		X		X
8. Continue the Take the Maze out of Funding workshops to inform families, community agencies and health care providers of resources available.		X		
9. Assist in the implementation of Health Care Home legislation.	X	X	X	X
10. Work with Children's Hospital to analyze reimbursement for hospice and palliative care				X

b. Current Activities

The CYSHCN program intends to decrease this number of children with unmet needs through efforts to enhance and spread the medical home concept with primary care providers throughout the state. The NFI grant ended in April of 2008, but the state legislature enacted significant health care reform legislation expanding the concept of a medical home to patients of all ages and insurers. There will be major activity during the next year in implementing this legislation.

As part of the NFI grant a statewide family summit was held in April of 2007. All parents serving in an advisory capacity to state- and community-level education, health and human services programs, work groups and task forces were invited.

The CYSHCN program continues to maintain and staff a toll-free phone line giving families and providers access to information regarding services and resources in their communities. The program will continue to promote and support DC:0-3™ trainings and the state Medicaid program in its efforts to increase developmental surveillance as part of the EPSDT well child screenings.

A Title V MCH Bureau SPRANS grant (EHDl: Reducing Loss to Follow-UP) was awarded in March of 2008. Its goal is to ensure all infants who have a confirmed diagnosis of hearing loss are enrolled in Early Intervention (Part C) services. Staff began to implement the grant's work plan in April.

c. Plan for the Coming Year

Regional Parent Leadership Teams are in the early stages of development and will be a focus of the New Freedom Initiative / MCSHN partnership. They have the potential to serve as a conduit to state policy makers to help identify unmet needs in their communities and propose potential solutions to community problems.

Medical Home Teams, now numbering 26 throughout the state, will continue to receive support for participation in the Learning Collaborative where they share successful strategies for assuring each child has a comprehensive, coordinated plan of care. The Title V program will concentrate on implementing the 2008 legislation establishing health care homes. This legislation directed the commissioner of health to begin certifying practices/practitioners as of July 2009.

The MCSHN Information and Assistance (I and A) program will continue to work closely with the Birth Defects Information System providing follow-up services to families of children with birth defects assuring access to information regarding health care services and financing. It will also continue to field calls from families and professionals seeking health care resources for CYSHCN. Further analysis and dissemination of I and A program data will be a priority. In addition to the toll-free number, efforts focusing on the availability of web-based information will continue. Through the MCSHN web-pages, families currently have access to information on financial and other resources, health conditions, early intervention, transition issues, emergency planning, medical home and data and reports.

The Follow-along Program for infants and young children which is administered through MCSHN will track and analyze services needed and received by its approximately 33,000+ participants.

Part C of IDEA (Early Intervention for Infants and Toddlers with Disabilities) underwent an eligibility rule revision. MCSHN is taking the lead in coordinating the identification of conditions with a high probability of resulting in a developmental delay by school age. This is the first eligibility rule revision since the inception of the Part C program in Minnesota. Until this point, Minnesota has served a smaller percentage of infants and toddlers than would be anticipated. This is a rare opportunity for Birth Defects, Newborn Screening, MCSHN and Part C staff to utilize one another's areas of expertise for a common goal that will result in improved access to services.

State Performance Measure 10: *Degree to which comprehensive mental health screening, evaluation, and treatment is provided to Children and Youth with Special Health Care Needs (CYSHCN).*

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				7	8
Annual Indicator		5	6	7	9
Numerator		5	6	7	9
Denominator	20	20	20	20	20
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	9	10	11	11	11

Notes - 2006

Actual scale score is 6.5

a. Last Year's Accomplishments

This state performance measure examines the state's progress in relation to a mental health system (screening, evaluation and treatment) for CYSHCN.

The state Title V program (especially its CYSHCN program) has worked closely with Children's Mental Health Services (CMHS) of the Minnesota Department of Human Services over the last few years. CMHS is one of five grantees in the Assuring Better Child Development -II (ABCD-II) grant activity, funded by the Commonwealth Fund and administered by the National Association of State Health Policy (NASHP). Minnesota's objectives include supporting primary care provider efforts to meet the needs of children at risk for delay in social or emotional development that do not meet the criteria for receiving services from the existing children's mental health system. The CYSHCN program collaborated with the CMHS program through financial and staff support of its DC:0-3 trainings. It contracted with the Zero-to-Three organization to conduct these training sessions throughout the state, purchased required training materials and, through its district consultants, served as site facilitators for the trainings.

MCSHN district staff and CMHS regional staff have met periodically to discuss issues surrounding service availability and planning within respective regions. Regional quarterly meetings which include Medicaid Home and Community Based Waivered Services, CMHS and MCHSN identify resource issues, gaps in services and develop plans that can be implemented regionally addressing the availability of appropriately trained and supervised behavioral aides for children and their families.

MCSHN focused its efforts on DC 0-3 trainings, integrating mental health curricula into medical home learning sessions and the provision of Development and Behavior Clinics. These clinics provide a one-day, multidisciplinary team diagnostic assessment of children up to the age of 21. The children who were referred have multiple behavioral, developmental, educational and physical issues. Most referrals originate from schools districts of less than 2000 children and were already receiving special school services. Most children are five to nine years of age and most have private insurance. The median number of days from referral to diagnosis has decreased to 85 -- down from 100 days as measured at the time of the last needs assessment. Changes in clinic system infrastructure are thought to have been a major contributor to movement in this positive direction.

The Minnesota Department of Education (MDE) is the lead state agency for implementation of Part C in Minnesota. Through an interagency agreement, the CYSHCN program is responsible for the child find outreach activities pursuant to Part C requirements. One of the ways this has been fulfilled is through the Follow Along Program (FAP). The Ages and Stages Questionnaire (ASQ) is the screening tool used by the FAP. Staff provided training and consultation to local agencies on the FAP and administration of the ASQ-SE. Over 600 professionals and paraprofessionals were trained in the administration and scoring of the ASQ and ASQ-SE in this last year. 60 FAPs have now integrated the Social/Emotional component of the ASQ into their programs - which is up from 47 last year. A total of 379 early childhood professionals were trained in ASQ/ASQ-SE administration in addition to Follow-Along Program staff.

The Medical Home Collaborative learning sessions included enhancing collaboration between primary care and specialty providers with the identification of specific strategies which can be employed by primary care practitioners. In addition to an in-depth discussion of the new Bright Futures, one learning session was dedicated to mental health topics in primary care. Plenary and breakout sessions included incorporating developmental and mental health screening into the primary care visit, caring for every child's mental health in primary care, an introduction to the ASQ-SE and the Follow-Along Program and how that program relates to primary care and the medical home.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue collaboration with Children’s Mental Health Services (CMHS) of the Minnesota Department of Human Services.				X
2. Continue financial and logistical support for DC:0-3™ trainings throughout the state.				X
3. Continue supporting CMHS in its implementation of the Commonwealth Fund’s ABCD-II grant.				X
4. Support regional trainings and workshops.				X
5. Continue to promote universal implementation of the ASQ and ASQ-SE.	X		X	
6. Continue to promote adoption of the III-P product and process.				X
7. Continue to conduct MCSHN Development and Behavior Clinics.	X			
8.				
9.				
10.				

b. Current Activities

Administrative and training activities continue through the Follow-Along Program, use of the ASQ screening tool and its social-emotional component, the ASQ-SE. The state Medicaid program contracts with the Title V program for CTC (EPSDT) trainings for local public health agencies and these trainings include training on the ASQ and ASQ-SE screening tools as well. Staff facilitated capacity building around infant and early childhood social-emotional issues.

Six (6) Minnesota Initiative Foundations launched a statewide effort to help communities support the healthy social and emotional well-being of young children. Known as the Minnesota Thrive Initiative, CYSHCN regional staff members participated in the planning for pilot sites and provided technical assistance and consultation to the area action teams. MCSHN is on the steering committee for Minnesota Association for Infant and Early Childhood Mental Health (MAIECMH), a consortium groups to develop standardization and / or credentialing for infant mental health providers.

The Development and Behavior clinics continue. The number of days from referral to date seen went up to 94 days, likely the result of the winter storm related cancellation and rescheduling of several clinics from late February/early March.

Collaboration with CMHS and DC 0-3 statewide trainings continue, reaching a total of 2008 mental health and early childhood professionals during this year.

ASQ/ASQ-SE training continues this year. Training now on video.

c. Plan for the Coming Year

Collaboration with the Department of Human Services at the state and regional level through the support to CMHS in its ABCD-II activities and financial and administrative support of DC:0-3 trainings will continue. Trainings are expected to include a repeat of the previous offerings as well as advanced curricula for individuals who desire a more indepth knowledge and understanding of interventions to promote the social-emotional health of young children.

Local capacity building initiatives such as regional mental health needs assessment and planning, consultation and technical assistance in the area of mental health continue. Support planning and

implementation of efforts addressing the availability of appropriately trained and supervised behavioral aides for children and their families.

MCSHN district staff will work in collaboration with CMHS regionally assigned staff to promote the development and implementation of models of co-location of health and mental health staff, quality improvement models that include telemedicine or other methods of psychiatric consultation to pediatric and family practice physicians in the far reaches of Greater Minnesota and models of service delivery for young children and their families that promote cross agency collaboration in rural areas where both population and services are sparse.

State staff will continue to offer ASQ/ASQ-SE training for early childhood personnel.

E. Health Status Indicators

HSI 01A-B, 02A-B: Low and very low birth-weight births

While the percentage of very low birth weight births has remained fairly constant since 2001, there was a small increase in the percentage of LBW births in recent years. Specifically, between 2003 and 2004, live births weighing less than 2,500 grams increased from 6.3 to 6.6 percent and live singleton births weighing less than 2,500 grams increased from 4.7 to 4.9 percent.

Improvements in the medical management of high-risk pregnancies, with induction and early delivery or rapid cesarean delivery, as well as improvements in neonatal care are most likely contributing to these trends. With eight level-3, perinatal centers and a thriving Assisted Reproductive Technology (ART) industry, Minnesota is well positioned to respond effectively to the changing health care needs of pregnant women and neonates.

Another contributing factor to the rise of live LBW births is an increase in multiple births in Minnesota, which reflects trends nationwide. Since the introduction of ART, the ratio of multiple births to singleton births in Minnesota has increased from 1 in 55 births in 1980 to 1 in 29 births in 2003. The CDC estimates that 9 percent of ART singleton infants are born at LBW and 94 percent of ART triplet or higher order multiples are LBW. ART infants account for 18 percent of multiple births nationwide.

//2009/ Minnesota has met its overall infant birth weight benchmarks quite consistently over the past decade. For example, the proportion of all live low birth weight (LBW) infants weighing <2500 grams born in Minnesota during 2006 is 6.6%, exactly the same as the previous two years and up very slightly from earlier years (2001 -- 2003) at 6.3%. The proportion of live LBW singleton births is also identical to 2005 at 4.9%, up .3% from 2001 at 4.6%. The proportion of all 2006 live births in Minnesota classified as very low birth weight (VLBW), or <1500 grams, is 1.2%, compared with 1.3% the previous year. This figure has also remained quite consistent throughout the past six years. The proportion of VLBW live singleton births is even lower, at 0.9%, identical to 2005. In the past, VLBW singleton births have remained constant within .1% each year since 2001. These discrepancies are extremely small and can be attributed to typical annual variations. However, a factor of greater concern is the disproportionate number of White births in Minnesota, which tends to conceal the inherent disparities seen in the much smaller number of births to racial and ethnic populations, which often do not show the same level of positive outcomes. //2009//

HSI 03A-C, 04A-C: Fatal and non-fatal injuries

No clear patterns emerge from data reported on fatal and non-fatal injuries among children 14 years and younger or youth aged 15 through 24 years. There was a slight increase in the death

rate due to unintentional injuries among children aged 14 years and younger between 2003 and 2004; however, this increase (from 7.6 per 100,000 in 2003 to 9.2 per 100,000 in 2004) cannot be explained by a corresponding increase in deaths due to motor vehicle crashes and may simply indicate random variation. A slight, downward trend is evident in the rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years. Similarly, the death rate from unintentional injuries due to motor vehicle crashes decreased substantially in this age group between 2003 and 2004, dropping from 25 per 100,000 in 2003 to 20 per 100,000 in 2004. A downward trend is also evident in the rate of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger. Factors that might help to explain these reductions include increased seat belt usage among children and adolescents, and some strengthening of policies related to graduated drivers' licenses in Minnesota.

Over the past two years, MDH has worked to improve its procedures for entering and managing hospital discharge data, which is helping to reduce duplicates and errors in diagnostic and e-codes. With these new procedures in place, the validity of data reported on injuries in the Title V Block Grant is expected to be of increasingly high standard.

//2009/ Rates in both fatal and non-fatal injuries among children and youth have been trending downward in the past two years (2005-2006), after sharp spikes in both 2002 and 2004. The 2006 child death rate due to all unintentional injuries is 6.9 per 100,000 children age 14 and under, compared with 7.4 in 2005 and 9.2 in 2004. The highest peak for the past six years was 10.0 in 2002. Similarly, the 2006 unintentional injury death rate due to motor vehicle crashes is 2.2 per 100,000 children in that same age group. In 2005 this rate was 2.4, down from a high of 4.2 in 2002.

As might be expected, fatalities due to motor vehicles crashes escalate steeply as the age of young children climbs through the teen years. Youth ages 15 through 24 had a death rate of 20.5 per 100,000 due to motor vehicle crashes in 2006, nearly ten times the rate for children 14 and under. The 2006 youth rate is up from 18.8 in 2005 but down from a six-year high of 25.0 in 2003.

In terms of all nonfatal injuries, the 2006 rate for children ages 14 and younger is 188.3 per 100,000 children in that age range, a welcome reduction after a six-year high of 213.7 in 2005. The previous low was 196.4 in 2001. The total number of nonfatal injuries requiring inpatient care and receiving a hospital discharge in 2006 was 1,940 down from 2,149 in 2005.

The rate of nonfatal injuries specifically due to motor vehicle crashes per 100,000 children in that same age group was 14.2 in 2006. Again, these numbers refer to inpatients only. Thousands of additional children had nonfatal motor vehicle injuries and were seen in hospital emergency departments but were not admitted to the hospital. The 2006 indicator is the lowest rate for this measure in the past six years, down from 18.3 in 2005 and a high of 23.5 in 2002. The actual number of motor vehicle injuries requiring hospitalization in 2006 for children ages 14 and younger was 146, compared with 184 in 2005.

Similar results were obtained in the older age range. The rate of nonfatal injuries due to motor vehicle crashes for youth ages 15 through 24 years was 80.9 in 2006, descending from 92.6 in 2005 and a six-year high of 111.0 in 2003. The actual number of nonfatal motor vehicle injuries in 2006 for this age group is 604 (inpatient only), down from 701 in 2005 and 827 in 2003. //2009//

HSI 05A-B: Chlamydia

Between 2003 and 2004 in Minnesota, the rate of Chlamydia for adolescent women aged 15 through 19 years decreased 9.5%, from 16.3 to 15.5 per 1,000 women. During the same period for women aged 20 through 44 years, the rate of Chlamydia increased 15%, from 5.2 to 6.1 per

1,000 women. While a decreased infection rate among adolescent females is somewhat encouraging, Chlamydia rates for both 15 through 19 year olds and 20 through 44 year olds remain high compared to previous years. In fact, the overall rate of Chlamydia in Minnesota has doubled since 1996. Doubling of the rate has occurred among both men and women and has nearly tripled among 25-29 year olds and 30-39 year olds. Among 15-19 year olds, rates have increased 1.5 times.

In addition to age groups, increases in Chlamydia have been observed across racial groups and geographical areas. Since 1996, rates have doubled among Hispanics, Whites and Asian/Pacific Islanders. Rates for Blacks and American Indians have increased by 32% and 60%, respectively. Chlamydia rates have also increased by geography with the most marked increases happening in Greater Minnesota and the suburban 7-county metro area.

The observed increase since 1996 is most likely due to a combination of four factors: 1) improved testing technology with increased sensitivity; 2) improved screening practices by clinicians, 3) the addition of an active surveillance component, and 4) an increase of the disease in the population. The effect of the first three factors are likely to have leveled off over time, so recent increases are most likely being driven by an actual increase of the disease in the population.

//2009/ Overall, reported cases of sexually transmitted diseases (STDs) for Minnesota women ages 15 through 44 years escalated to a record high again this year. Reported chlamydia cases rose from a previous record of 9,063 cases in 2006 to a new high of 9,465 cases in 2007. Minnesota teens, ages 15 through 19 years, account for the bulk of this increase with a chlamydia rate nearly three times as high as older females: 18.3 cases per 100,000 teens compared with 6.8 cases per 100,000 adult women ages 20 through 44 years.

From an all-time low in 1996 of 115 cases per 100,000 (including both genders, all ages, racial/ethnic groups, and geographic regions), the chlamydia rate increased by nearly 2.5 times to 273 cases per 100,000 in 2007. Rates doubled among the White, Hispanic and Asian populations and increased among Blacks and American Indians by 69% and 65%, respectively. Racial disparities in chlamydia continue to persist in Minnesota with the incidence among Blacks being 15 times that of the White population. Other racial/ethnic groups are also disproportionately and negatively affected by chlamydia. Incidence among Asian/Pacific Islanders, American Indians, and Hispanics were 2.5, 4, and 5 times higher than incidence among Whites, respectively.

An increase in the overall population of the state, as well as within several non-White groups--including large numbers of Somali, Hmong and Hispanic immigrants--is partially responsible for the rise in chlamydia cases. Other contributing factors include improved diagnostic tools for STDs, improved screening procedures by clinicians, increased reporting by providers, and the addition of an active STD surveillance component to the standard MDH surveillance system. //2009//

HSI 06A-B: Population demographics enumerated by age group and race/ethnicity

Population estimates for 2004, enumerated by sub-populations of age group and race/ethnicity, were provided by the U.S. Bureau of Census. According to these projections, the population of infants and children aged 0 to 24 years accounts for 35% of the total population in Minnesota. With respect to race, estimates suggest that 86% of Minnesota's infants and children are White, 7% are Black or African-American, 5% are Asian, and 2% are American Indian or Native Alaskan. An estimated 5% of Minnesota infants and children are Hispanic. Given that these population data are projections only, little can be said about actual trends in state demographics over the past four years. However, it is clear that there is increasing diversity in Minnesota and, with this diversity, increasing challenges for Title V programs to introduce culturally appropriate strategies

that target the diverse set of needs of this growing segment of the population.

//2009/ In 2006 the overall population of Minnesota children and youth ages 0-24 remained quite consistent at 1,777,008, increasing only 0.8% over the previous year. Within this larger age group, ages 1-4 and 5-9 years showed the greatest increases (3.5% and 3.3%, respectively). The two oldest age groups both showed small general declines: age 15-19 declined by 0.7 % and age 20-24 fell by 2.1%.

The overall population of White children rose only 0.5% in 2006. Black children increased by 6.4% during this time, whereas the proportion of Asian children decreased 2.8%. The percentage of American Indian children remained nearly identical to 2005.

Within specific age groups, Black children increased in every age category with the exception of a very small decrease (0.2%) in the oldest group, age 20-24. Black infants (< 1 year old) increased by 16.4% in 2006, while Black children ages 1-4 increased by 15.3%. Age distribution of American Indian children remained basically the same as 2005, with only slightly more children (2.5%) in the 1-4 year age group. While overall numbers of Asian children decreased, nevertheless it was the oldest age groups (15-24 years) that were responsible for this reduction, particularly 20-24 year olds who declined by a sizeable 21.8%. The proportion of all other Asian children (0-14 years) actually expanded, with the youngest age groups showing the largest rise: infants (< 1 year) increased by 7.8%, and the 1-4 age group grew by 7.9%.

In terms of ethnicity, the overall number of children and youth in Minnesota who identify as Hispanic grew only slightly (4.3%) in 2006. However, a more interesting pattern is seen in the age groupings, which are quite similar to Asians--and to a lesser extent, Black children. The oldest Hispanic age group (20-24 years) declined by 4.3%, while children 1-4 and 5-9 have both increased by 8.1%. In addition, the population of children ages 10-14 has grown by 7.4%. Thus, it appears that the proportion of younger age (0-14 years) Black, Asian, and Hispanic children is increasing in Minnesota, while older age children (20-24 years), who might be viewed as young adults, are decreasing. //2009//

HSI 07A-B: Live births

Live births to Minnesota residents increased only 0.8% between 2003 and 2004, from 70,053 to 70,709 infants. The crude birth rate decreased from 13.9 to 13.8 per 1,000 persons, a decrease of 0.7%. The fertility rate (births per 1,000 female population age 15-44) increased 0.6% from 64.1 in 2003 to 64.5 in 2004.

Births to mothers under the age of 20 and to those age 35 and over have been of special interest to public health professionals because these births tend to have more complications during pregnancy and childbirth, more infants of low birth weight and with congenital anomalies, and more infant deaths. There were 4,123 births to mothers under 20 years of age in 2004, a drop of 16.8% from the births to this age group in 2003. The number of live births to mothers age 35 and over continues to rise, increasing 1.4% from 2003 to 2004. In 2004, an average of thirty births were to women age 35 and older each day.

Compared with data reported in 2003, the number of births appeared to increase in 2004 for Black, Asian and Pacific Islander, and Hispanic mothers, but decreased for White and American Indian women. These changes, particularly for White mothers, are due in part to a change in the way race information is collected and coded. Beginning with 2004 data, an individual may report more than one race, as well as Hispanic origin, which is still collected as a separate item. It appears that most of the decrease for White mothers is an artifact of the method used to assign a race code to those who reported their race as 'Other'.

//2009/Live births in the state of Minnesota increased from 70,920 births in 2005 to 73,515

infants born in 2006, an overall growth of 3.5%. This increase is considerably higher than the .4% difference which occurred between 2004-2005. An expanded population likely resulted in a higher crude birth rate, which rose from 13.8 live births per 1,000 population in both 2004 and 2005 to 14.2 in 2006. The fertility rate also increased from 64.9 live births per 1,000 female population (ages 15-44) in 2005 to 68.6 in 2006, an increase of 5.7% over the previous year. Both the crude birth rate and the fertility rate in Minnesota are now almost identical to rates for the entire U.S., which are 14.3 and 68.7 respectively. Not only is Minnesota's population growing, but it is simultaneously becoming more heterogeneous from a racial and ethnic perspective; thus, it now corresponds more closely to U.S. population statistics.

When broken down into racial/ethnic categories and age groups, we see the largest numbers of Minnesota births occurring in the 20-34 age range, across all racial and ethnic categories. Approximately three-quarters of all births (72-77%, depending on race and ethnicity) occur to women in that age range. However, there is a much larger variation between racial/ethnic groups in the proportion of births to young women ages 15-19, with Whites and Asians on the low end (5% and 9%, respectively) and Blacks, Hispanics and American Indians on the high end (12%, 14% and 21%, respectively). Young women in their teens give birth to low birthweight (LBW) and very low birthweight (VLBW) babies with greater frequency than slightly older women; thus, the high proportion of such births within Black, Hispanic, and American Indian populations is of considerable concern.
//2009//

HSI 08A-B: Deaths of infants and children

There were a total of 912 deaths to Minnesotan infants and children in 2004, which represents a slight increase (2.9%) from the 883 deaths reported in 2003. Minnesota's infant mortality rate of 4.7 per 1,000 live births did not change during this timeframe. The number of infant deaths, 332 in 2004 compared to 327 in 2003, is an increase of 1.5 percent. Care must be exercised in interpreting these changes as the number of infant deaths is very small. Thus a change in number or rate, though appearing to be rather large, may not be statistically significant.

Beginning with 2004 data, more than one race may be reported for an individual as well as Hispanic origin, which is still collected as a separate item. No significant changes were noted in the distribution of deaths by race as a result of this change. Improving the collection and standardizing the use of demographic data will help to identify high-risk populations and monitor the effectiveness of health promotion and disease prevention interventions targeting these groups.

/2009/ There was a total of 986 deaths to children ages 0-24 in 2006, compared with 938 deaths in 2005, a 5% increase over the previous year. The greatest proportion of those deaths (38.6%) occurred to infants less than one year of age, almost identical to 2005 infant deaths in this age group (38.7%). Minnesota's infant mortality rate remained quite consistent at 5.2 per 1,000 live births in 2006, compared with 5.1 in 2005.

Infant death is tragic and preventable in many instances, we recently completed an American Indian Infant Mortality Review of the Minnesota Native American population, including both those living on reservations and those living in urban settings. We learned that a substantial number of early infant deaths (< 1 year) in both settings were attributable to asphyxia and related conditions resulting from co-sleeping or bed sharing. We will be embarking on a project in the upcoming year to address these issues.

The second largest proportion of child deaths (26.2%) occurred in the young adult range between 20-24 years, which when combined with teens ages 15-19 accounts for nearly half (46%) of all 2006 deaths for ages 0-24. While that age range is wide (15-24 years), this category of individuals is particularly important due to the many preventable injuries,

motor vehicle crashes, suicides, and drug/alcohol related deaths frequently occurring in this age range. //2009//

HSI 09A-B: Miscellaneous demographic data

Racial/ethnic estimates in 2006, indicate that Minnesota is predominately white with 89.3% of the population White; 4.5% of the population Black; 1.2% American Indian and 3.5% Asian, with 3.7% of the population Hispanic or Latino. //2008// According to the U.S. Bureau of Census there were an estimated 1,394,018 infants and children aged 0 through 19 years in Minnesota in 2004. Approximately, 21% of children were reported to live in households headed by single parents in 2000, with the percentage varying considerably by race. Whereas an estimated 16% of Asian children and 17% of white children lived in single parent homes in 2000, 62% of African-American children and 73% of multi-racial children lived in such households.

While the Minnesota Department of Human Services (DHS) does not provide data on the number of children living in foster homes, specifically, they do report on the number of children living in "out of home placements" and estimate that roughly 57% of these placements are in foster home care. The number of children in out of home placements decreased by 6% between 2003 and 2004, with just 1% of children aged 0 through 19 years reported to be in placements in 2004. American Indians had the highest percentage (7%) of children in out of home placements compared to any other racial or ethnic population in that year. Given that adverse health outcomes disproportionately affect infants and children in foster care and/or single parent homes, increased attention must be directed to these high-risk groups.

According to the National Center for Education Statistics (NCES), the high school dropout rate for Minnesotan youth, grades 9-12 years old, has been declining steadily since 1996, when a 5.5% dropout rate was reported. More recent estimates indicate a 4% dropout rate for the 2000-01 school year. Despite this relatively low rate for Minnesotan youth overall, racial and ethnic disparities are evident and reflect national trends of disproportionately high dropout rates in Hispanic and African-American youth and low rates among White, non-Hispanic, and Asian/Pacific Islander students. Leaving high school before graduation is known to lead to continued poverty and a higher incidence of juvenile arrests. It is therefore not surprising that racial disparities are evident in the rates of juvenile crimes in Minnesota in 2004, with a four times higher arrest rate for African-American youth and a two times higher arrest rate for American Indian youth compared to the rate for youth overall. In 2004, juvenile arrests accounted for 25% of total arrests, with the total number of arrests increasing by approximately 2% from the previous year.

Data on enrollment in various State programs for 2004 and 2005 indicate a 17% decrease in the percentage of children in TANF families and a 28% decrease in enrollment of children in the Food Stamp Program (which includes children in the Minnesota Family Investment Program [MFIP] who receive a food assistance benefit). This compares to a 25% increase in enrollment in the WIC program and relatively stable enrollment in the Medicaid program. Decreases in TANF can be explained by the introduction of a back to work program that occurred in Minnesota during the last four months of the 2005 fiscal year. The program resulted in a higher employment rate at the end of the fiscal year and a six-month delay in TANF enrollment. Given this delay, it is likely that participation in TANF program will increase again in the coming years.

//2009/ According to the U.S. Census Bureau, an estimated 1,403,073 infants and children ages 0 through 19 years lived in Minnesota during 2006. Of these numbers, 409,082 (29.2%) were enrolled in Medicaid, and 5.6 % lived in households receiving a TANF grant. There were noticeable differences in racial and ethnic groups, with more than three-quarters (76.6%) of Black children and nearly three-quarters (71.4%) of American Indian children receiving Medicaid, compared with 40.8% Asian and 18.5% White children. Likewise, more than twice as many Black and American Indian children lived in TANF households (26.9% and 27.3%, respectively) than Asian (10.4%) or White (2.2%)

households. Regarding Hispanic children, nearly two-thirds (61.1%) received Medicaid, while 10.9 % lived in households receiving TANF grants. In general, enrollment data in various State programs for 2005 and 2006 indicate an approximate 6% decrease in the percentage of children in TANF households for 2006 and a relatively stable enrollment in the Medicaid program.

Overall 2007 enrollment in Minnesota's WIC program for infants and children ages 0 to 5 years was 165,724, with noticeable racial and ethnic differences. White infants and children comprised more than half (58%) of WIC recipients, and Black infants/children accounted for an additional 20%, along with Asians (9%), American Indians (4%) and children of mixed racial heritage (8%). Non-White infants and children represent a greater proportion of WIC recipients than their percentage in the general population would suggest. Participation in the WIC program has been increasing in Minnesota in recent years, particularly in non-White categories. In addition to infants and children, the Minnesota WIC program also served 70,075 pregnant women and breastfeeding mothers (with infants under age one) in 2007. Our caseload of pregnant women and mothers has also continued to rise steadily each year.

In terms of foster home placement, overall numbers received from the Minnesota Department of Human Services remained quite consistent over the past year with 2006 data showing less than 1% overall increase in out-of-home placements. This increase is distributed relatively equally across all racial categories. American Indian children continue to have the highest percentage of out-of-home placements, followed by Black children. Asians have the lowest number of children placed out of their own homes. Placement of Hispanic children increased by 4.5% this year, but raw numbers are still relatively low for this group.

The education system in Minnesota is generally regarded as one of the best in the nation. However, it appears that the White population, and secondarily the Asian population, is taking the greatest advantage of this benefit. The high school dropout rate for Minnesota youth in grades 9-12 has been declining steadily since 1996 when a 5.5% rate was reported. More recent data indicate a 3.1% overall dropout rate for the school year ending in May 2006. The White dropout rate for the same year is even lower at 1.9%. On the other hand, important educational differences are seen in the American Indian population and the Black population, with high school dropout rates of 11.8% and 8.6% respectively. These differences do not forecast positive outcomes in terms of future employment or financial independence for these youth, and they are also reflected in high crime rates.

Arrests for juvenile crime in Minnesota during 2006 have increased overall, with Black arrests more than double the White rate. American Indian arrests are 3.5 times greater than White youth arrests. Racial and ethnic discrepancies in educational outcomes need to be addressed if we are to achieve our goal of reducing disparities in major areas of concern such as healthy pregnancies, normal birthweight babies, fewer infant deaths, lower STD rates, fewer TANF and Medicaid households, fewer out-of-home placements, and lower juvenile crime rates. //2009//

HSI 10-12: State Demographic Data

According to the U.S. Census Bureau, Minnesota's population increased 6% between 1990 and 2000, from 4,626,514 persons to 4,919,479 persons. In 2000, it was estimated that 10% of the statewide population was of color, American Indian and/or Hispanic. Dramatic increases occurred in some populations during the recent decade, including a 165% increase in the Hispanic population, a 90% increase in the Asian population, and a 100% increase in the African-American population. Home to the largest Somali population and the second largest Hmong population in the United States, Minnesota is experiencing increasing diversity.

Approximately 70% of Minnesota's population lives in urban areas, primarily in the Twin Cities area of St. Paul and Minneapolis, and 29% live in rural areas (collectively referred to as "Greater Minnesota"). A significant number of American Indians and people of color live in the areas of Greater Minnesota as well as in the Twin Cities metropolitan area. On average, these populations are considerably younger than the Caucasian population with one-third of non-white and American Indian populations under the age of 18 years compared to one-quarter of the white population within this age group.

The demand on health care services in the metropolitan and urban areas where Minnesota's population is concentrated is considerable. The high concentration of poor families living in these areas without a regular source of coordinated health services also translates into over utilization of emergency services and frequent walk-ins to community and public health clinics. Reflecting national trends, there are a greater percentage of children at all levels of poverty (50%, 100% and 200%) than the State's total population, underscoring the tremendous importance -- and considerable challenge -- of the work that is done by Title V programs to protect the health and wellbeing of Minnesota's infants, children and families.

F. Other Program Activities

Toll-free Telephone Numbers - For parents and others, the Minnesota Title V programs assure toll-free telephone access to information about health care providers and practitioners who provide health care services under Titles V and XIX SSA and about other relevant health and health-related providers and practitioners. MDH has worked to accomplish the intent of this requirement by improving the effectiveness of previously established special purpose toll-free arrangements.

1. The Title V CYSHN Program has operated a toll-free Information and Assistance telephone line since March of 1990. The toll-free number is 800 728-5420. 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 informational publications developed and distributed and is included in all media announcements.
2. Minnesota does not have a dedicated 800 number for questions related to prenatal care or pregnancy. The Department of Human Services (DHS) consumer services call center 800 number handles questions related to obtaining prenatal care services from Medical Assistance or MinnesotaCare. Calls related to prenatal health programs and other maternal and child health matters are referred to Title V. Information regarding obtaining prenatal services and related questions can also be accessed via the MDH or DHS internet web sites.
3. The MinnesotaCare program provides an automated state toll-free line that operates 24 hours a day, seven days a week. The automated message is available in seven languages including Spanish, Hmong, Somali, Vietnamese, Laotian, Bosnian, and Russian. The number is (651) 297-3862 (metro) and 1-800-657-3672 (greater Minnesota). The toll-free number will provide the caller with general information about the plan, qualifications for acceptance, and application information. All outreach materials distributed by the Department of Human Services include this state toll-free number for clients to call with questions. The line handle about 200,000 calls per year.
4. The Minnesota Family Planning and STD hotline is staffed by individuals trained in information and referral as well as family planning and STD counseling. The number is 800-78-FACTS. Approximately 5,000 calls are handled by the hotline annually. All family planning and STD related educational materials distributed by the Minnesota Department of Health include the

hotline number. Annually, a pamphlet about family planning, which includes the hotline number, is mailed to all Medicaid recipients.

5. The WIC Program (Women, Infants and Children) 800 number is funded through Minnesota's federal WIC grant and provides 24 hour - 365 days a year phone coverage. Callers to the WIC 800 number are provided with the business telephone number of the local WIC project in their geographic area. The toll-free number is 800-WIC-4030. The service responds to approximately 3,300 calls per year. All WIC outreach materials distributed by the state WIC office and the local projects include the 800 number. There is also a WIC supported specialized line related to breastfeeding (877-214-BABY).

6. The Minnesota Immunization Hotline was established in 1994 and operates between the hours of 8:00 a.m. - 4:30 p.m. Monday through Friday. The toll-free number is 800 657-3970. The Hotline is staffed by a team of nurses and other professionals highly-trained in immunizations. Its primary purpose is to provide a timely source of information and consultation for providers and consumers faced with the increasing complexities of immunizations. /2007/ The Minnesota Immunization Hotline ended July 2, 2006. This decision was made in order to best use limited resources. Providers and patients with general immunization questions are referred to CDC INFO Contact Center. //2007//

/2009/ No changes made to above information.//2009//

G. Technical Assistance

Form 15 outlines the technical assistance needs identified by the Title V programs for the upcoming year. Additional discussions will be occurring internally to determine priorities, timing and suggested TA providers.

V. Budget Narrative

A. Expenditures

Please see Forms 3-5 and appropriate related notes.

B. Budget

V. Budget Narrative

A. Expenditures

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. The language in Minnesota Statutes Chapter 145.88 distributes two-thirds of Minnesota's federal MCH Block Grant funding (approximately \$6.1 million) by formula to 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. 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 and some state grant dollars to meet their required match.

The legislation directs funding to be used 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 has responsibility to provide fiscal oversight and technical assistance to Community Health Boards in the use of these federal dollars.

CHBs are required to report annually on their expenditures of the federal MCH Block Grant. The approximately \$6.1 million provided to the 53 CHBs 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 and their total budgets. The range of MCH Block Grant funding to their total funding is 2 percent to 16 percent, with the average being 5 percent. One issue with the distribution of a significant portion of the MCH Block Grant in this manner is that the 53 CHBs redirect these funds to where they are most needed to maintain core maternal and child health services. This causes a constant fluctuation in populations served, total numbers of individuals served, and type of services provided resulting in frequent 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 CHBs, 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. Indirect charges for the total MCH Block grant are included in this portion of the funding.

Currently, the MCH Block Grant supports a total of almost 30 FTEs within the Division of

Community and Family Health, fifteen of which are located in the children and youth with special health needs program. The maternal and child health and children and youth with special health needs sections efforts are augmented with additional funding received from other federal grants (HRSA -- SSDI, Loss to Follow-up and SECS grants, CDC -- FAS, PRAMS and Preventive Block Grant funds directed at Suicide Prevention activities) and from various state (state general funds, newborn screening fees, marriage license fees, and Health Care Access Funds) and federal funds (Medicaid match and TANF funding as well as Department of Education Part C and Part B funding).

Other federal sources of funds that are administered by the Division of Community and family Health include Preventive Block Grant funds (\$600,000) directed at providing public health technical assistance to CHBs and Department of Agriculture funds (\$124,576,000 - which includes formula rebate funds) supports the WIC program, Commodity Food Supplemental Program and a small Breastfeeding Peer Support grant.

State appropriations used to support programs within the Division of Community and Family Health comes to over \$32 million with the primary portion (\$21 million) going to CHBs through the Local Public Health Grant. State funds support Division administration including the CYSHCN and MCH managers, family planning services, technical assistance to local CHBs, CYSHCN diagnostic clinics, FAS prevention, newborn screening follow-up and intervention, Women's Right to Know, Family Home Visiting program, Positive Alternatives Program, Suicide Prevention, infant mortality and technical assistance to local public health agencies.

The source of matching funds for the Title V Block Grant comes from both state and local sources. As mention earlier, CHBs are required to provide a 50% match for the federal Title V funding they receive. Additional federal match requirements are met by state funds administered by the Division of Community and Family Health that support MCH and CYSHCN program efforts. The largest of these efforts is the state funded Family Planning Special Projects Grants.

Minnesota's maintenance of effort from 1989 is \$6,184,197. The budget documents that Minnesota continues to exceed this level of effort.

Additional program areas impacting the health of mothers and children, including children and youth with special health care needs located in other areas of the Minnesota Department of Health include: newborn screening program (Laboratory Division), reducing disparities in infant mortality (Office of Minority and Multicultural Health), lead screening and Birth Defects Registry (Environmental Health), Tobacco and childhood injury prevention (Health Promotion and Chronic Disease) and immunizations (Infectious Disease, Epidemiology, Prevention and Control Division). Funds supporting these programs are in addition to those outlined in this application. While Title V staff collaborates and work closely with these programs, no federal Title V funds are used directly to support these activities nor are any of these activities currently used to meet Minnesota's match or maintenance of effort.

Minnesota legislative activity impacting the Division include:

Significant changes in the budget occurred with the loss of Suicide Prevention Grant funding (\$918,487) and the Dental Health Program (\$100,000) in the 2005 Legislative session. However, during that same session the Department of Health was appropriated \$50,000 in SFY 2006 and \$2.5 million in SFY 2007 and thereafter for the Positive Alternatives Program. The primary goal of the program is to support, encourage, and assist a woman in carrying her pregnancy to term and caring for her baby after birth.

Budgetary changes made from the 2007 Legislative session impacting the Division of Community and Family Health included an additional \$4 million allocation a year of TANF funds for the Family Home Visiting Program; an additional \$1,156,000 dollars a year in TANF funding to replace reduced funding experienced in 2002 in the Family Planning Program; an additional \$500,000 a

year in state funds for FAS prevention and intervention activities; \$335,000 in the first year and \$145,000 thereafter in state funds to reinstate some Suicide Prevention activities that were lost in the 2003 session; \$1,000,000 in Health Care Access Funds for the next two years to expand the Medical Home Project currently underway in the CYSHCN program; and over \$800,000 in fees and general fund appropriations to support Early Hearing Detection and Intervention Programs, including a Hearing Aid Loaner Bank and Family Support activities. The Division did see a reduction of \$220,000 in state funds for the MN ENABL (abstinence education) Program.

//2009/ Budgetary changes made during the 2008 legislative session impacting the Division of Community and Family Health was the loss of the state funded abstinence education program and an across the board 1.8 percent reduction in funds available for the following grant programs: Local Public Health Act, Suicide Prevention, Positive Alternatives, Fetal Alcohol Syndrome Program, Hearing Aid Loaner Program and the Family Planning program. This equated to an overall budget reduction in the Division's grant programs of \$754,000 beginning in state fiscal year 2009. The 2008 legislative session also provided approximately \$1.1 million in additional funding for the next three years to the current budget of \$500,000 to support Health Care Home (Medical Home) implementation. //2009//

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.