MINNESOTA
2010 Needs Assessment

Maternal and Child Health Services Title V Block Grant

July 2010

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Introduction

The Maternal and Child Health Services (Title V) Block Grant is the key source of support for promoting the health of all mothers and children. As a requirement of the block grant, Minnesota must conduct a statewide needs assessment every five years. The focus of the needs assessment is on three maternal and child health (MCH)[1] target populations:

- Pregnant Women, Mothers and Infants,
- Children and Adolescents, and
- Children and Youth with Special Health Care Needs (CYSHCN).

This document outlines the process used to conduct the needs assessment for Minnesota and the resulting priorities and state performance measures for 2011-2015. It also provides a comprehensive overview of the health of Minnesota's mothers, infants, children and adolescents, and children and youth with special health care needs.

Minnesota's Priority Needs

Minnesota identified two overarching goals and seven priority needs for the maternal and child health target populations. The priority needs reflect the comprehensive nature of the Title V block grant and the complexity and inter-relatedness of the target populations. The two overarching goals and seven broad priority needs for Minnesota include:

Overarching Goal 1: Increase health equity and reduce health disparities for pregnant women, mothers and infants, children and adolescents, and children and youth with special health care needs.
Overarching Goal 2: Focus efforts on activities that result in positive outcomes across the lifespan.

Priority Need 1: Improve birth outcomes
Priority Need 2: Improve the health of children and adolescents
Priority Need 3: Promote optimal mental health
Priority Need 4: Reduce child injury and death
Priority Need 5: Assure quality screening, identification and intervention
Priority Need 6: Improve access to quality health care and needed services
Priority Need 7: Assure healthy youth development

Minnesota's Successes

The success of Minnesota's needs assessment process was dependent on the involvement multiple stakeholders, including Minnesota Department of Health (MDH) leadership and staff. Involving stakeholders strengthened the process and built on interests of the entire MCH community. Involving MDH staff and leadership will be the longest-lasting benefit of the process. Their involvement has led to a commitment to not only the needs assessment but to working together to address the priority needs.

The hope is that this needs assessment will provide a comprehensive overview of the needs of Minnesota's mothers and children and set a solid direction for activities for the next five years. The process was a valuable and positive experience for all involved.

[1] Unless referring to a specific entity, the use of the general term of maternal and child health (MCH) refers collectively to all three target populations.

SECTION 1: Process for Conducting Needs Assessment

Goals and Vision

The goals for the needs assessment process in Minnesota were established at the initial meeting of Minnesota's needs assessment leadership team (described under Leadership below) in February, 2009. The goals were to:

1. Determine Minnesota's priority needs for the maternal and child health and children and youth with special health care needs populations;
2. Enhance stakeholder and MDH staff commitment to identifying the priority needs; and
3. Increase the state's commitment to addressing the final priorities.

Beyond these specific goals for the process, the leadership team identified principles to help guide the completion of the needs assessment. The leadership team wanted:

- The process to be less burdensome to staff than previous needs assessments, yet assure that staff expertise was fully utilized;
- To obtain as much stakeholder input as possible, recognizing that the involvement of stakeholders would strengthen the process;
- To assure that the outcome of needs assessment process has value outside of the MDH;
- To use technology wisely to increase input and assure efficiency; and
- To have the outcomes of the needs assessment process be inclusive of all target populations by looking holistically at families and children, not segmenting (more than is necessary) into the three target populations.

The process of conducting the needs assessment was important because it allowed for the development of a "snapshot" of the health of pregnant women, infants, children, adolescents, and children and youth with special health care needs; engaged stakeholders and MDH staff in identifying priority needs and what they think can be done to address those issues; and set the stage for a coordinated effort to address the priority needs.

Leadership

The MDH used a number of mechanisms to assure strong leadership for the 2010 Minnesota Title V needs assessment process, including direction by a needs assessment leadership team, guidance from the Maternal and Health Advisory Task Force, engagement of MDH management, and consultation with MDH staff. The role of each is described below.

Title V Needs Assessment Leadership Team

The needs assessment leadership team began meeting in February 2009. Members of the leadership team included:

- Manager of the MDH Maternal and Child Health (MCH) Section;
- Manager of the MDH Minnesota Children and Youth with Special Health Needs (MCYSHN) Section;
- Chair of the MCH Advisory Task Force (representing Minnesota's local public health departments);
- Director of MDH Public Health Nursing;
- Two MCH epidemiologists;
- Supervisor of the MDH Data and Epidemiology Unit;
- Supervisors from the MCHSN Section; and
- Supervisors from the MCH Section.

The team met at least monthly throughout the process. The team was responsible for ongoing, direct oversight, including final decision-making on all aspects of the needs assessment. The team established the framework to

be used for the needs assessment process, developed the goals and objectives, led the development of the list of potential priorities, provided input on the survey process, reviewed outcomes of the stakeholder survey, and decided on the final priorities and performance measures for the state. Additionally, the team maintained ongoing communication about the process with staff, stakeholders and management. The team reported quarterly to the MCH Advisory Task Force and assured ongoing communication with the MDH executive office.

MCH Advisory Task Force

The Maternal and Child Health (MCH) Advisory Task Force was created by the Minnesota Legislature in 1982 (see Minnesota Statute 145.881) to advise the commissioner of health on the health care services/needs of maternal and child health populations in Minnesota, on the use of funds for maternal and child health and children with special health needs administered through MDH, and the priorities and goals for maternal and child health activities.

Fifteen members, five each representing MCH professionals, MCH consumers (including parents of CYSHCN), and local health departments are appointed by the commissioner of health to four year terms. The members are both professionally and culturally diverse. A list of members can be found at: http://www.health.state.mn.us/divs/fh/mchatf/members.html. Due to the expansive scope of maternal and child health services and the need to assure representation from key partners with specific expertise, the Task Force also has a number of ex-officio task force members. Currently, the ex-officio members represent the Minnesota Department of Human Services, the Minnesota Department of Education, the University of Minnesota School of Public Health, the University of Minnesota Department of Pediatrics, Medica Health Plan, the Office of Minority and Multicultural Health Advisory Committee, the State Community Health Services Advisory Committee, and the Minnesota Chapter of the March of Dimes.

The leadership team reported quarterly to the MCH Advisory Task Force on the progress of the needs assessment. The Task Force, in its advisory capacity, made recommendations to the commissioner of health on the process framework and the final seven priority areas identified through the needs assessment. The members also participated in the stakeholder survey, the stakeholder retreat, and provided input to the problem and solution mapping process (explained more fully in the Methodology section).

MDH Management

MDH management was involved throughout the needs assessment process. The MDH assistant commissioner and division director approved the framework for the process. In addition, they received ongoing updates in the process. Division management participated in the capacity assessment process and assured support of the process through communication with the MDH executive office. MDH management also assured that the process and results of the needs assessment were integrated into, or connected with, other MDH activities.

MDH Staff

Staff in the MCH and MCYSHN Sections played valuable roles in the needs assessment process. Throughout the process, staff served as topical experts on potential priorities. Staff also participated in the problem and solution mapping process and the capacity assessment. Staff were involved in the development of numerous fact sheets on each of the potential priority issues. Each of these fact sheets provided an overview of the issues and information on the current resources and capacity (explained more fully in the Methodology section).

Staff were also involved for their understanding of the systems that impact the three target populations. Program staff with expertise in the following areas were involved: child health, adolescent/youth health, school health, early childhood comprehensive systems, family home visiting, infant mortality prevention, family planning, woman's health, children and youth with special health care needs, newborn screening and follow-up, early intervention, and data and epidemiology.

Methodology

The process for conducting the needs assessment was a series of steps designed to assure a thoughtful, comprehensive, inclusive, and thorough process. The steps used in Minnesota were based on guidance provided by the federal Maternal and Child Health Bureau and agreed upon by Minnesota's needs assessment leadership team. The steps, described in greater detail below, included:

Step 1: Engage Stakeholders
Step 2: Assess Needs and Identify Desired Outcomes and Mandates
Step 3: Examine Strengths and Capacity
Step 4: Select Priorities
Step 5: Seek Resources
Step 6: Set Performance Objectives
Step 7: Develop Action Plan
Step 8: Allocate Resources
Step 9: Monitor Progress for Impact on Outcomes
Step 10: Report Back to Stakeholders

This methodology for the needs assessment was shared with MDH leadership and the MCH Advisory Task Force to assure support for the process. Steps 7, 8, 9 and 10 of the process will primarily occur after the completion of the needs assessment. These steps are briefly described below.

Step 1: Engage Stakeholders

Early in the process the leadership team identified potential stakeholders to be involved in each step of the needs assessment. This included stakeholders from the public and private sectors, state and local government, tribal governments, advisory groups, citizens and family members.

The leadership team also identified mechanisms to engage and provide ongoing communication to stakeholders. A website for the 2010 needs assessment process was developed. Existing communication mechanisms were used to provide information about the website. Minnesota has several long-standing methods to communicate with stakeholders that were used to forward information about the website and survey, including:

- CHS Mailbag (a weekly communication to "friends of public health"),
- MCH coordinators listserv,
- Adolescent health and family planning newsletters,
- MCH Advisory Task Force members,
- MCYSHN webpage subscribers,
- Multiple listservs to parents and providers working with CYSHCN,
- Family Voices website,
- Governor's Council on Developmental Disability members,
- State Disability Council members,
- Local interagency early intervention committees.

One of the primary purposes of engaging stakeholders and assuring their awareness of the website was to assure their participation in the needs assessment survey. The process for developing and conducting the survey are is described in Step 2. Additionally, multiple stakeholders were brought together for a stakeholder retreat to undertake a process of problem analysis, prioritization, and capacity assessment. More information on the stakeholder retreat is also included in Step 2.

Step 2: Assess Needs and Identify Desired Outcomes and Mandates

There were several components involved in Step 2 of the process. Initially, the leadership team developed a broad list of "potential" priority issues. Sources for these issues included:

- Issues identified through the 2000 and 2005 needs assessment processes;
- Input from stakeholders;
- Expertise of MCH and MCYSHN staff;
- Healthy People 2010; and
- Other assessment processes taking place.

This initial list of nearly 100 issues was narrowed down by the leadership team to 79 potential priority issues (33 issues for pregnant women, mothers and infants, 23 issues for children and adolescents and 23 issues for children and youth with special health care needs). These issues were included in a web-based survey conducted in June and July of 2009.

Stakeholder Survey

Minnesota created a web-based survey to gather stakeholder opinions on priority needs for the next five years (see Attachment 1 for the complete survey). The purposes of the survey were to: 1) utilize available technology to gather the broadest possible input on priorities; 2) replace in-person target population specific stakeholder retreats used in 2004; and 3) identify the priority needs most frequently chosen to narrow down the list of possible priorities.

The survey was available for approximately one month (from mid-June to mid-July 2009) and included a section on stakeholder demographics. Information on the availability of the survey was broadly distributed. In the survey, respondents were asked to identify their top five priority needs for each of the three target populations. Respondents were not required to complete the survey for all three target populations. The survey was also available in print format for distribution at community and parent meetings.

In total, 867 people completed the survey with most respondents providing input into all three target populations. An analysis of the survey results was then completed by the leadership team. Based on this analysis, the leadership team then narrowed the list of possible priority needs to 21 issues. Details on the analysis of the survey are included in Section 5: Selection of State Priority Needs.

Title V Needs Assessment Fact Sheets

Based on the analysis by the leadership team, the list of potential priority issues was narrowed to 21 (8 for pregnant women, mothers and infants, 10 for children and adolescents, and 7 for children and youth with special health care needs). Several of these issues crossed target populations – hence only 21 issues. Two issues (comprehensive well baby/child care and infant and child developmental, social and emotional screening) were included in two target populations and one issue (health insurance) was included in all three target populations.

A fact sheet was developed for each of these 21 issues. A sample fact sheet can be found in Attachment 2. The entire set of fact sheets can be found at: http://www.health.state.mn.us/divs/cfh/na/2010FactSheets.html. Each fact sheet included information on the seriousness of the issue, the evidence-based strategies available to address the issue, and the current resources and capacity devoted to the issue.

Stakeholder Retreat

The fact sheets served as background information for a day-long stakeholder retreat held in September 2009 (see Attachment 3 for retreat agenda). Stakeholders were invited to participate in the retreat. Using an invitation-only format assured broad but equal representation of multiple stakeholder groups representing the interests of each of the three target population groups. A complete list of participants can be found in Attachment 4.

The MDH contracted with another state agency (Minnesota Management Analysis and Development) to facilitate the retreat and provide consultation on the process. Following an overview of the Title V needs assessment purpose and process; the participants were divided into the three target population groups. For the first half of the day participants discussed the issues presented in the fact sheets. Following that discussion, each participant was asked to complete a prioritization worksheet (see Attachment 5). The prioritization worksheet asked participants to rank (from 1 to 5) each of the issues based on six criteria. Three of these criteria were "fact-based" criteria; focusing on information presented in the fact sheets. Three of the criteria were "opinion-based" criteria; focusing on the stakeholder's opinions and personal knowledge about the criteria and the issues. The criteria included:

- Seriousness of the Issue (fact-based)
- Evidence-Based Strategies (fact-based)
- Current Resources (fact-based)
- Momentum for Change (opinion-based)
- Return on Investment (opinion-based)
- Ease of Measurement (opinion-based)

Each participant was provided a definition of the criteria (see Attachment 6). Additionally, each of the criteria was given an importance weight. This weight was used to clarify for the stakeholders the significance or importance of that criteria to the overall decision.

During the second half of the day, target population groups participated in a comprehensive problem mapping process of two selected issues. These included:

- Pregnant Women, Mothers and Infants
  - Issue 1: Infant and child developmental, social and emotional screening
  - Issue 2: Early and adequate prenatal care
- Children and Adolescents
  - Issue 1: Teen pregnancy and teen birth rate
  - Issue 2: Mental health screening, assessment and treatment
- Children and Youth with Special Health Care Needs
  - Issue 1: Early intervention for young children with special health care needs
  - Issue 2: Health insurance

The decision was made to only do a problem analysis on six issues based on the available time and the interest/expertise of stakeholders. A problem analysis process was done on most of the additional issues at a later date with MDH staff and members of the MCH Advisory Task Force. The results of the stakeholder retreat and its impact on the selection of the state priority needs is explained more fully in Section 5: Selection of State Priority Needs.

Step 3: Examine Strengths and Capacity

Following the stakeholder retreat, the leadership team hosted a series of meetings with MDH staff and leadership to continue the in-depth problem analysis on each of the issues. Staff were also asked to brainstorm possible solutions to the problems identified. Following this series of discussions, staff were asked to complete a capacity assessment tool (see Attachment 7). The tool assessed the state's capacity to address potential priority needs. The capacity assessment examined if:

- The MDH or local public health departments currently conduct activities to address this issue.
- The responsibility for addressing this issue lies primarily within state/local MCH or public health.
- The resources devoted to this issue are sufficient or if it is probable that more resources could be acquired.
- There are measurements available to monitor this issue.
- The current political environment supports this issue.
- The significant potential to improve the role of public health in addressing this issue.

This series of discussions and the involvement of staff provided significant insight into the possible priority needs. It also resulted in staff being more engaged and supportive of the outcome of the process.

Step 4: Select Priorities

At this point in the process, the leadership team, stakeholders and staff had comprehensively examined the 21 potential priority needs. The leadership team then developed an algorithm for selection of priority issues (see Attachment 8). This algorithm outlined a decision-making process and decision points for examining the possible priorities. The leadership team also assessed if each issue was currently being measured by a national performance measure and the adequacy of that measure. This is discussed more fully in Section 5: Selection of State Priority Needs.

Another key component in selecting the state priority needs was the desire to assure that the needs assessment reflects the comprehensive nature of the Title V block grant in its entirety. The leadership team felt that focusing solely on the 10 state performance measures provided a limited picture of the complexity of the issues addressed or measured by the block grant. The leadership team chose to examine the following items:

- The 21 potential priority issues for the state,
- The national performance measures,
- The national health outcome measures,
- The national health status indicators, and
- The national health system capacity indicators.

All of these issues were organized into two overarching goals and seven broad priority needs. The goals and state priority needs were approved by the MCH Advisory Task Force on March 12, 2010. These goals and priority needs will serve as the framework for MCH activities for the next five years. The priority needs are broad and more inclusive of the multiple issues addressed by public health. The priority needs and the measures associated with these priorities are discussed in Step 6: Set Performance Objectives and Section 5: Selection of State Priority Needs.

Step 5: Seek Resources

The leadership team and staff examined the seven state priority needs to determine if there were priorities that would require additional resources or authority to address. The current budget climate in Minnesota was considered as part of the capacity assessment (see Step 3). Those priorities that required new or redirected resources, and the state's ability to acquire those resources in the current political environment, were considered when considering the Minnesota's capacity to address a priority need. With a state budget deficit in the next year, it is difficult to request new state resources.

The new health care reform funding offers Minnesota the opportunity to apply for home visiting funding and teen pregnancy prevention grants to address two significant priority needs. The state will use the needs assessment and priorities to seek additional resources as they become available.

Step 6: Set Performance Objectives

Following the identification of the seven priority needs, the leadership team undertook a process to select the state performance measures. The leadership team, in consultation with staff, discussed each of issue to determine:

- If data are currently available to measure progress on performance (unless there is compelling evidence that new data are needed);
- If the issues is being *adequately* measured by a national performance measures; and
- If the issue is one that the work of the Title V program (MDH and local public health) can significantly impact.

Based on these discussions, ten issues were selected to be measured as state performance measures. These ten issues are not the sole measure for that priority need, but one of many measures (including the multiple national measures) to monitor Minnesota's progress on achieving the priority needs. The chosen state priority measures reflect a current gap in the existing measures for the priority needs. The actual state performance measure for each of these issues can be found in Section 5: Selection of State Priority Needs.

Step 7: Develop an Action Plan

The leadership team and staff are identifying activities that need to take place to address the state priority needs and state performance measures. These actions will be outlined in next years Title V block grant application and report. Activities to address the current national and state performance measures are included in the 2009 report.

Step 8: Allocate Resources

In Minnesota, two-thirds of the Title V funding is provided to local health departments through the Local Public Health Act as described in Section 4: MCH Program Capacity by Pyramid Levels. The provision of MCH services through this partnership has been tremendously successful. Funding to support the infrastructure activities provided by MDH will continue for the MCH and MCYSHN Sections and the division.

Step 9: Monitor Progress

The Minnesota's Title V program will report annually on the status of the state and national measures and the activities being undertaken to address these measures. As appropriate, the state will modify activities to assure ongoing success. The results of the annual report will be made widely available.

Step 10: Report back to Stakeholders

Throughout the course of the needs assessment, progress and outcomes of the process have been shared with stakeholders, including routine meetings with MCH and MCYSHN staff. Reports have been provided quarterly to the MCH Advisory Task Force and MDH management. The needs assessment document will be made available to stakeholders as a stand-alone document.

In late 2010, MDH staff will be meeting with local public health staff to discuss the needs assessment and the Title V priorities for the next five years. MDH staff will be working with local health departments to determine if local health departments and MDH can identify and work collaboratively on a set of activities that will focus on one or two specific priority needs.

Methods for Assessing Three MCH Populations

A number of methods were used to assess the strengths and needs of each of the target populations – pregnant women, mothers, and infants; children and adolescents; and children and youth with special health care needs. This included the stakeholder survey, the development of fact sheets, the stakeholder meeting, and the problem analysis process. Each method has been previously discussed and is briefly described below:

- **Stakeholder survey:** The stakeholder survey was the assessment of stakeholder opinions on priority needs for the three target populations.
- **Fact sheets:** The fact sheets included quantitative data on the target populations specific to the priority issue.
- **Stakeholder meeting:** This meeting brought together over 60 people to provide input into the assessment of the target populations, including a ranking of needs for each population.
- **Problem analysis process:** Stakeholders and MDH staff engaged in a problem analysis process to further define the strengths and needs of each population.

Methods for Assessing State Capacity

Four primary methods were used to assess state capacity to provide services. Each of the fact sheets developed to describe potential priority needs included a section on current capacity and resources. This was a comprehensive examination of activities taking place in Minnesota to address an issue. It also included information on gaps in capacity and resources to address the issue.

Secondly, MDH staff, management and stakeholders completed a capacity assessment tool to examine the state's capacity and political will to address an issue. This tool allowed for a more quantitative analysis of capacity.

Third, MDH staff and member of the MCH Advisory Task Force participated in a problem analysis process. As part of that process, people were asked to identify possible solutions to address the issue. These possible solutions highlighted available capacity and gaps.

Lastly, MDH staff and the leadership team outlined the state's capacity – including information compiled from the methods noted above – in Section 4: MCH Programs by Capacity Level.

Data Sources

There were multiple data sources used in the needs assessment. Each fact sheet contains multiple data sources in addition to multiple references (Factsheets can be found at: http://www.health.state.mn.us/divs/cfh/na/2010FactSheets.html). Data were also used to complete Section 3: Strengths and Needs of the Maternal and Child Health Population Groups and Desired Outcomes. Data sources from Section 3 are included as footnotes to that section. A complete listing of data sources is included in Attachment 9. This includes only those sources for quantitative data; the list does not include a listing of literature and professional references used to complete the fact sheets and MCH population overview. These references can be found on the fact sheets.

There were some limitations to the data. This included, but is not limited to the following examples:

- Systems may not be available to gather information on specific issues to present a comprehensive picture of that issue. For example, there is currently not a system available in Minnesota to track every well child visit completed for every child. Information is however available on the Medicaid population.
- The issue may be emerging and therefore a specific data set has not been identified and vetted that can present that information. For example, the state has not agreed on one measure (or composite measure) to monitor positive youth development.
- Data may not be as current as desired. For example, several data sources (National Survey of Children's Health, National Survey of Children with Special Health Care Needs, Minnesota Insurance Survey) are compiled on a less than annual basis.
- Data is not designed to provide information specific to the MCH population. For example, several of the data sources are designed to gather information for social services or educational purposes. This data may not readily apply to the MCH populations.
- Data may not be available to support a perceived problem. For example, because Minnesota chose to focus the needs assessment equally on perceived need and needs supported by data, data may not be readily available to measure that issue. Substance use during pregnancy is seen as an important issue; however, good data is not available to specifically measure drug use during pregnancy due the extreme complexity of this issue.
- Data for various racial and ethnic populations may not be readily available. For example, Minnesota is a healthy state; yet there are significant disparities in health status among minority populations. Information on racial and ethnic breakdowns in data for specific needs may be more difficult to obtain.

Linkages between Assessment, Capacity and Priorities

As described above, the purpose of entire-ten step needs assessment process was to create linkages between the assessment of strengths and needs, the examination of capacity, and the selection of priorities. The process focused on identifying possible priority needs through data and public input, examining multiple aspects of the state's capacity to address those needs, and ultimately identifying priorities that reflect the comprehensive and complex nature of the needs of the target populations in Minnesota.

Dissemination

Dissemination of information related to the Title V needs assessment occurred throughout the process and will continue following the completion of the needs assessment. As described in Methodology, multiple efforts were made to engage stakeholders in the process. In addition, results of the process have been shared regularly with the MCH Advisory Task Force, MDH management and staff, and other stakeholders and state agency partners.

Plans for dissemination of the final needs assessment report include, but are not limited to, the following:

- The complete needs assessment stand-alone document will be posted on the MDH website. Notification will be sent to all local health departments, state agency partners, MCH Advisory Task Force members and stakeholders.
- A presentation on the needs assessment, and the Title V Block Grant annual report, will be presented to the MCH Advisory Task Force in September 2010. The needs assessment will serve as a focus of the Task Force work plan for the next several years.
- An overview of the needs assessment will be presented to MDH staff.
- MDH leadership and staff are planning statewide regional meetings to meet with local public health staff to discuss the needs assessment priorities and develop a strategy for coordinated work to address the priority needs.
- The State Community Health Services Advisory Committee, a committee advisory to the commissioner of health on state and local public health policy, will be convening the Local Public Health Statewide Objectives Work Group. This work group will make recommendations for a new set of statewide local public health objectives for the Local Public Health Act. Title V funds to local health departments are administered as part of this act. The new objectives will incorporate the priority needs and measures identified by the needs assessment. Title V staff and representatives of the MCH Advisory Task Force will participate in the work group.

The MDH will work to disseminate the information from the needs assessment as broadly as possible. It is anticipated that information from the needs assessment will be made available in condensed formats for ease of use.

Strengths and Weaknesses of Process

Overall, the process of conducting the needs assessment was seen as a very valuable and positive experience for all involved. Following is a summary of the strengths and the weaknesses of the process.

Strengths

- **Leadership Team:** The entire process was guided by a leadership team that represented all three MCH populations and local public health. The leadership team provided valuable direction to the process and assured that the needs of all three target populations were equally addressed. The leadership team was committed to the process and assured the full engagement of staff.
- **Web-based Survey:** One of the greatest strengths of the process was the engagement of stakeholders through the stakeholder survey. Conducting a web-based survey of possible priorities allowed for input from a broader representation of stakeholders than would have ever been possible using an in-person process. This survey allowed for all stakeholders to have their voices heard. It also gave the state a more

comprehensive picture of what Minnesotan's thought of as important issues for all three target populations.

- **Fact Sheets:** An enormous amount of time and effort was dedicated to the research and development of the fact sheets on each of the issues. The fact sheets served as critical tool in the needs and capacity assessment process. They will continue to be an important and useful resource for MDH staff and stakeholders.
- **Stakeholder Retreat:** The stakeholder retreat was a valuable key opportunity to bring together staff and stakeholders to have an in-depth discussion of the needs of the MCH populations. As noted earlier, this retreat followed the analysis of the web-based survey. This allowed stakeholders to serve as representatives of their own interests, but to also build on the interests of the broader MCH community. It was also beneficial to have this meeting facilitated by professional external to the process.
- **Problem/Solution Analysis:** Engaging MDH staff and stakeholders in a problem analysis process provided insight into the issues beyond what could be found through data alone. This process allowed for groups of people to discuss an issue in depth. This process provided information on the "real" problem beyond the numbers. The participants shared experiences of families and professional dealing with these issues on a daily basis. It also allowed the participants to propose solutions to those problems.
- **MCH Advisory Task Force:** The Task Force received regular updates regarding the progress of the needs assessment process. Engaging this group, which represents consumers, professionals, local public health and other stakeholders, was invaluable to the process. The members were involved in the stakeholder retreat, but through discussion at regular meeting, the members also brought a depth of understanding to the issues. Their support in the results of the process will be important as we bring the needs assessment to a broader audience.
- **Engagement of MDH Staff:** Involving MDH staff and leadership in the process will probably be the longest-lasting benefit of the process. Staff contributed their expertise to the development of the fact sheets, participated in the problem/solution analysis process, provided input into the development of performance measures and provided invaluable expertise on how to address the priority needs. Their involvement in the process has lead to an investment in not only the needs assessment but the entire block grant.

Weaknesses

- **Time Commitment:** The needs assessment process was very time intensive. The number of collaborations established, the amount of data incorporated, the 21 fact sheets developed, the stakeholder retreat, and the numerous leadership team meetings demanded great dedication from MDH staff and administration, other state agency staff, and stakeholders. This investment seems to have enhanced and solidified the overall commitment to the process and the final priority needs, but nonetheless the expenditures required were substantial.
- **Inclusiveness:** There is always difficulty in identifying a set of priorities that are inclusive of everyone's interests. The range of issues address by the Title V Block Grant is vast and stakeholders will want their issue to be addressed. The leadership team took every effort to assure that all opinions were heard and the soundest decisions were made for Minnesota.

The MDH and leadership team will review the strengths and weakness of this process and the process used in other states to refine the process for the next needs assessment. In general, the strengths of the needs assessment process greatly outweighed the weaknesses.

SECTION 2: Partnership Building and Collaboration Efforts

Efforts were made throughout the needs assessment process to build partnerships and strengthen collaboration. Minnesota has strong existing relationships with multiple partners. The needs assessment benefited from those partnerships to enhance the process. So many individuals and organizations were involved in the needs assessment process that it is difficult to consolidate. The following is a limited overview of the partners involved in the process and their role.

Minnesota Department of Health

MCH Program: The state MCH program led the overall needs assessment process, including direction, coordination, logistics, and meeting facilitation. Additionally, multiple staff from the state MCH program were involved in the needs assessment process; including staff from adolescent health, family home visiting, child health, family planning, infant mortality, child development, school health, and ECCS. The staff were responsible for development of fact sheets, involved in the problem mapping process and served as technical experts in the selection of performance measures and for the stakeholder retreat. The staff also engaged their partners in the needs assessment process. Information about the process was distributed through existing communication channels.

MCYSHN Program: Several staff from the state MCYSHN program were also greatly involved in the process. Management staff served on the leadership team and provided ongoing input and support to the development of the needs assessment. Staff developed fact sheets on issues specific to children and youth with special health needs and also worked closely with MCH program staff to assure coordination and consistency in the data and information presented. In addition to management, staff involved in the process included staff from Part C, early childhood screening, newborn screening follow-up, newborn hearing screening follow-up, data and information/referral, children's mental health and regional behavioral/developmental staff.

Data and Epidemiology Program: The MCH epidemiologist and the data and epidemiology program manger were involved in the needs assessment process from the beginning. This unit was responsible for developing a data overview of the MCH population in Minnesota. They also assisted MCH and MCYSHN staff in gathering data for the fact sheets. Another key role for this program was the development of the state performance measures. The MCH epidemiologist and PRAMS staff help identify and explore the feasibility of potential measures.

While the MCH, MCYHSN and data and epidemiology programs in Minnesota have a long history of working together, including being located within the same division, the needs assessment process was a very successful collaboration. The leadership team assured equal representation of all target populations while trying to create a more holistic approach to identifying issues that cross all population groups. This collaboration resulted in greater respect and understanding of the issues faced within each of the target populations.

Other MDH Programs: Several other MDH programs were engaged in the needs assessment process. Staff from the Office of Minority and Multicultural Health (OMMH) provided input and expertise on the needs of diverse populations. Staff in OMMH serve as liaisons to multiple racial and ethnic groups, including Minnesota's tribal governments. OMMH also has a statewide advisory committee. A representative of the OMMH Advisory Committee is a member of the MCH Advisory Task Force. This important link has greatly enhanced the needs assessment process. As described more fully under SECTION 4: MCH Program Capacity by Pyramid Levels, the OMMH provides funding through the Eliminating Health Disparities Initiative to agencies working to eliminate health disparities. These grants can address a number of areas related to MCH, including infant mortality and teen pregnancy.

Additional MDH programs engaged in the needs assessment process included:

- Health promotion and chronic disease, providing expertise on oral health, nutrition and physical activity, alcohol and substance use;
- Infectious disease, providing expertise on immunizations, HIV/AIDS, STD/STIs and acute infectious diseases;
- Rural health, proving information on the health care work force and federally (HRSA) funded community clinics;
- Health policy, providing information on insurance coverage and gaps;
- Injury and violence prevention, providing expertise on child maltreatment, childhood injury, and youth and sexual violence;

- A very important MDH partner for successful completion of the needs assessment was the Minnesota Center for Health Statistics. The needs assessment process relied heavily on their ability to assist with data, including the availably, quality and reliability of data.

The participation of all of these MDH programs in the needs assessment promoted their awareness, commitment to the process, and determination to address the final priorities.

Local Government

Local Health Departments: The MDH carries out its mission in close partnership with local health departments, tribal governments, the federal government, and many other health-related organizations. In Minnesota, a state law specifies that public health responsibilities are shared between state and local governments. Local health departments work in partnership with MDH to prevent diseases; protect against environmental hazards; promote healthy behaviors and healthy communities; respond to disasters; ensure access to health services; and assure an adequate local public health infrastructure. This interlocking, statewide system is a critical component of an effective public health system.

Local public health departments have been actively involved in the needs assessment process. Local health departments participated in the stakeholder survey (207 respondents), were represented on the leadership team, have representatives on the MCH Advisory Task Force and participated in the stakeholder retreat. Local health department staff also played an informal role in the needs assessment process. Throughout the process the leadership team turned to key local public health leaders to discuss various decision points and explore the impact of these decisions on local health departments.

Tribal Governments: Minnesota has eleven tribal governments. Nine of these tribal governments receive funding from the MDH to undertake public health activities. This includes activities specific to the MCH populations (e.g. family home visiting, injury prevention, teen pregnancy prevention, infant mortality prevention). MDH works closely with tribal governments to provide support and technical assistance. Due to the unique role that tribal governments play in the health of their population, the leadership team worked to assure their involvement in the needs assessment process. Representatives of tribal governments participated in the stakeholder survey and stakeholder retreat. In addition, MCH leadership, local health department staff, and MDH staff worked closely with the MDH tribal liaison, MDH tribal home visiting training coordinator, and local tribal health staff to assure their participation.

Other Governmental Agencies

One of greatest benefits of the needs assessment process has been the increased collaboration around MCH issues among state governmental agencies. Multiple state agency staff were involved in the stakeholder survey (97 respondents) as well as the stakeholder retreat. Those involved in the process included:

- Minnesota Department of Education: Head Start, Coordinated School Health, Part C – Early Intervention;
- Minnesota Department of Human Services: Children's Mental Health, Child Protection, Medicaid, Commission of Deaf, DeafBlind, and Hard of Hearing, Child Abuse Prevention;
- University of Minnesota: Center for Excellence in Children's Mental Health, School of Public Health – MCH Program, School of Nursing, School of Medicine.

Many of these agencies are represented on the MCH Advisory Task Force and provided valuable, ongoing input into the process. Several are also represented on the Minnesota Early Childhood Comprehensive Systems (MECCS) grant Interagency Leadership Team. The MECCS leadership team is an ongoing collaborative group to enhance state agency system that support young children. These and many other activities and collaborations are discussed more fully under Section 4: MCH Program Capacity by Pyramid Levels.

Another ongoing collaboration involving multiple state agencies is the development of the federal Patient Protection and Affordable Care Act of 2010 Maternal, Infant, and Early Childhood Home Visiting Program needs assessment. A group of state agency representatives, led by MDH, have been meeting to discuss the needs assessment and possible activities related to this new federal legislation.

Families and Parents

An important aspect of the needs assessment was to assure that the voices of parents and families were heard. The MCH Advisory Task Force has five consumer representatives. These consumers are parents, most to children with special health care needs. During the needs assessment process, two of these parents attended the national AMCHP conference as family delegates and mentors.

Parents also participated in the stakeholder survey and stakeholder retreat. Ninety-five of the 867 survey respondents indicated that their primary affiliation to the MCH population was that they were a parent or grandparent; four parents also participated in the stakeholder retreat. All were parents of children with special health care needs.

Other Partners

Three primary mechanisms were used to assure collaboration with other partners. These included the stakeholder survey, the stakeholder retreat, and the MCH Advisory Task Force. Retreat participants exemplified a diverse and critical collaboration in the process. The selection of members for this collaboration was very strategic to insure representation and/or expertise for various demographic factors, including profession, race/ethnicity, gender, and geographic location. The participants were extremely committed to the needs assessment process as demonstrated by the time and effort they shared and their interest in the related data. Table 1 is a general list of other partners and their participation in the process. This does not include those partnerships discussed in the previous sections.

Table 1

Partner	Participation Role
Advocacy Organizations	
Minnesota SIDS Center	survey, retreat
Minnesota Association for Children's Mental Health	survey, retreat
Minnesota Organization for Adolescent Pregnancy, Prevention & Parenting	survey, retreat
Minnesota Hands & Voices	survey, retreat
ARC Greater Twin Cities	survey, retreat
PACER Center	survey, retreat
Clinics and Hospitals	
Park Ave Family Practice (Asian community)	survey, retreat
Native American Community Clinic	survey, retreat, Task Force
CentraCare Health System	survey, retreat, Task Force
Community-Based Organizations	
Centro (Hispanic community)	survey and retreat
Ready4K	survey and retreat
Division of Indian Work	survey, retreat, Task Force
West Central Initiative Foundation	survey and retreat
Twin Cities Healthy Start	survey, retreat, Task Force
Hennepin County Breastfeeding Coalition	survey and retreat
Health Care Providers	survey, retreat, Task Force
Health Plans	survey, retreat, Task Force
Local Social Services	survey
Schools	survey

It is clear that much of the success of the needs assessment process must be credited to the various collaborations and individuals and organizations represented within the various partnerships. The importance of

collaboration was emphasized through each stage of the needs assessment – planning, design, and implementation. Future measures to address the priority needs will also depend on collaborations both within MDH and between MDH and its various partners.

SECTION 3: Strengths and Needs of the Maternal and Child Health Population Groups and Desired Outcomes

This section of the need assessment is a quantitative description of the health status of the three MCH populations:

1. Pregnant women, mothers and infants;
2. Children and adolescents; and
3. Children and youth with special health care needs.

It provides insight into the health needs of the three target populations, the social and economic factors that can impact the health of women and children, and highlights disparities in health status among various populations in Minnesota. Information is presented specific to many of the priority needs identified to Minnesota for 2011-2015.

Overall Demographic Issues in Minnesota

Estimates of Minnesota's state population, obtained from the 2008 US Census Bureau's American Community Survey, indicate a total of 5,220,393 persons, with approximately 65% of these individuals living in the ten-county metro area surrounding and including the cities of St. Paul and Minneapolis. Outstate or "Greater Minnesota," containing many small to medium-sized urban cities and towns, makes up the remaining 30-35% of state residents, while unincorporated rural areas account for less than 5% of the population. [2]

In 2008 there were 1,402,406 infants, children and teens birth to under age 20 years old living in Minnesota.[3] This group of young people represents more than one-quarter (27%) of the total population. However, it is the age range of 20-64 years which contains the bulk of the population (61%), with persons age 65 and over rounding out the remaining 12%. While seniors are the smallest subgroup, they are also the fastest growing age group.

Minnesota is generally regarded as a self-sufficient state, particularly in terms of job security, low unemployment rates, and overall income. Per capita income in 2007 was eleventh highest in the nation, and unemployment has been consistently lower than most other states (7.0%, May 2010)[4]. Further, Minnesota ranks tenth in state rankings of household earnings, with a median household income of $55,802 in 2007. Nevertheless, the US Census Bureau estimates that 9.6% of Minnesota's population (n=490,911) was living below 100% poverty in 2008. [5]

Minnesota is also considered to be a well-educated state, which is reflected in a large number of post-secondary schools, colleges, and universities, as well as a substantial number of college graduates. The American Community Survey (2007) shows that nearly one-third (31%) of Minnesota residents age 25 and over have earned Bachelor's Degrees, placing the state eleventh among all states. Minnesota's high school graduation rate is also above the national average. Still, these measures differ greatly among newer immigrant populations as well as the various races and ethnicities within the state. Likewise, while Minnesota has a high level of health overall, there are significant health-related disparities for our populations of color, American Indians and recent immigrants, particularly with regard to women, infants and children.

[2] 2008 US Census Bureau's American Community Survey.
[3] Minnesota Center for Health Statistics. (2010). 2008 Minnesota Health Statistics (p. 95). St. Paul, MN: MDH.
[4] Minnesota Department of Employment and Economic Development, Local Unemployment Statistics, May 2010.
[5] 2008 US Census Bureau's American Community Survey.

Although Minnesota has had a comparatively homogeneous population for most of the 20th century, the past decade has revealed a noticeable increase in non-White and other ethnic population groups. The 2010 decennial census will shed more light on the magnitude and specificity of these population changes. Meanwhile, it is clear that there continues to be greater diversity in the state than in past decades.

Geographic Distribution of Minnesota's Racial and Ethnic Populations

While 2006 population estimates revealed that Minnesota residents have become more diverse, there are distinct differences in the location of racial and ethnic subpopulations. The metropolitan area, a seven-county region containing Minneapolis and St. Paul, displays the most diversity and the lowest percentage of White residents (85.1%), with an additional 8.1% Black, 5.8% Asian, and 1.0% American Indian population. St. Paul has the largest urban Hmong population in the world[6] (approximately 45,000 persons) while Minneapolis has an ever-increasing population of Somalis, currently estimated at more than 30,000 residents. In addition, more than two-thirds (68.5%) of the total Hispanic population in Minnesota (n=196,135) resides in the metro area. More than 80 languages are spoken in the Twin Cities area (Minneapolis-St. Paul).

The northwest region of the state has the second lowest proportion of White residents (90.7%) largely because it has the highest percentage of American Indians (7.9%). The primary base of this sizeable American Indian population (n=15,720) is three large Ojibwe reservations located in the northern area of the state. Northwest Minnesota has very little overall racial diversification, however, with less than one percent each of African Americans (0.6%) and Asians (0.7%) and only 2.0% of the state's Hispanic population. All other regions of the state contain a White population of 95% or greater.

Southeastern and Southwestern Minnesota have seen a modest expansion in their non-White population and a large increase in their Hispanic population in recent years. The Southwest region is home to the largest group of Hispanics outside of the metro area (11.5%) while another 9.0% live in the Southeast region. The main reason for these substantial numbers of Hispanics, as well as some Asians and African-born Blacks (e.g., Somalis), is the location of large canneries and meat-packing plants in the southern one-third of the state. Jobs in this area do not require fluent English or technical skills and they are relatively abundant. Many Hispanics were originally migrant seasonal workers on local farms but transitioned to permanent residency when year-round factory jobs became available. The impact which this changing demographic scene has had on the three MCH populations will be addressed further in the following sections.

Pregnant Women, Mothers and Infants

In 2008, the most recent year for which population statistics are available, there were an estimated 1,048,477 women of normal childbearing age (15-44 years old).[7] There were also 84,653 reported pregnancies,[8] including 114 pregnant females under the age of 15. The age-specific pregnancy rate for Minnesota women ages 15-44 years in 2008 was 80.7 per 1,000 females in that age range, down from 2006 and 2007 (81.1 and 82.0, respectively) but up from earlier years: 1991-2005 ranged from 72.1 – 79.0, varying according to the specific year.[9] Pregnancy rates also differ by race and ethnicity and generally follow the pattern of birth rates described below.

In 2008, 72,382 live births occurred in Minnesota, expressed as a birth rate of 13.9 per 1,000 population.[10] The largest number of births occurred to women between the ages of 20-34 years, both overall and across all racial and ethnic categories. African-American and American Indian births increased slightly (2.5% and 2.6%,

[6] The Minneapolis Foundation, 2004.
[7] Minnesota Center for Health Statistics. (2010). 2008 Minnesota Health Statistics (p. 95). St. Paul, MN: MDH.
[8] This figure includes induced abortions and fetal deaths of 20 weeks or more gestation as well as all live births.
[9] Minnesota Center for Health Statistics. (2010). 2008 Minnesota Health Statistics (p. 95). St. Paul, MN: MDH.
[10] Minnesota Center for Health Statistics. (2010). 2008 Minnesota Health Statistics (p. 16). St. Paul, MN: MDH.

respectively), while births in the White population declined by the same percentage (2.5%). Nevertheless, White babies still comprise the great majority of births in Minnesota (n=53,970 or 75% of all births). Hispanic births also declined by 3.1%. One-third (33.3%) of all births in Minnesota during 2008 were to unmarried women, although infants born to unmarried mothers did not necessarily live in single-parent households.[11]

The Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS) data indicate that use of alcohol and/or tobacco during pregnancy is a noteworthy issue for Minnesota mothers. Binge drinking during the first trimester of pregnancy was reported by 6.6% of Minnesota women ages 15-44. In addition, 5.6% of pregnant women said they used alcohol during the last trimester of their pregnancy.[12] Actual alcohol use may be somewhat higher as it tends to be underreported. Approximately 16% of all pregnant Minnesota women smoked during their pregnancy. Smoking rates were substantially higher for specific groups: women with less than high school education (30%); women receiving public insurance (30%); 20-24 year olds (33%); unmarried mothers (33%) and American Indian mothers (59%).

During 2008, the great majority of Minnesota women (85.6%) received prenatal care beginning in the first trimester. This percentage has been very consistent over the past ten years, varying by less than 1% from 1999 through 2008. Our overall goal has been to reach the 90% threshold specified in the federal "Healthy People 2010" target objectives. Ten Minnesota counties did achieve this objective during 2008. These counties were scattered across the state and had no apparent common factors.[13]

Maternal mortality, defined by the state of Minnesota as the death of a woman during pregnancy or within one year after termination of pregnancy from any cause,[14] has dropped dramatically since the early part of this century. In Minnesota it began to level off in the 1980s. Between 2000 and 2004, the rate of maternal deaths per 100,000 live births decreased from 51.9 in 2000 to 43.9 in 2004. The maternal mortality rate during this same five-year period was 45.9 per 100,000 live births (n=157). Populations at greatest risk for pregnancy-related death in Minnesota are women over the age of 40 and those who have had little or no prenatal care, as well as women without a high school education. Violence is also a factor in pregnancy-related injury and/or potential death. During 2004-2007, a yearly average of 2.4% of Minnesota women reported physical abuse by husbands or other intimate partners during pregnancy.[15]

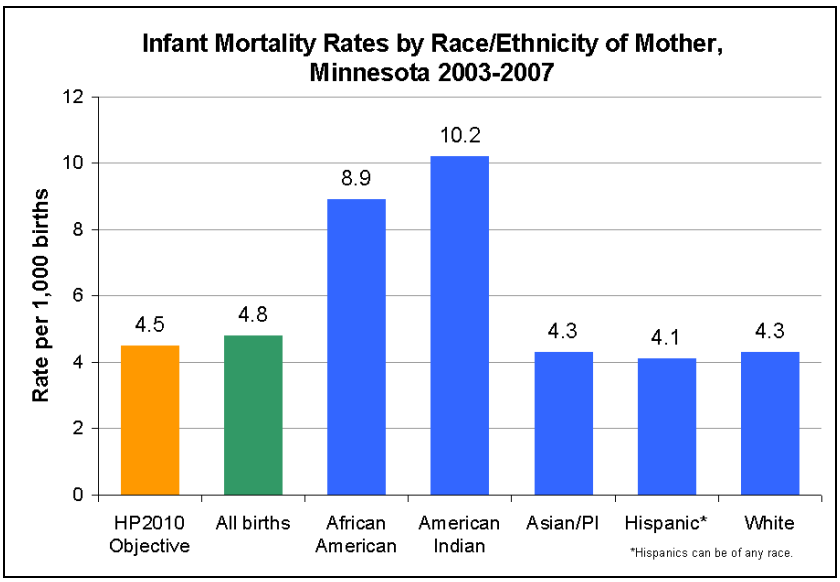
Improving Birth Outcomes

Minnesota's infant mortality rate has remained quite stable over the past few years with 5.1 deaths per 1,000 live births in 2005, 5.2 in 2006, and 5.5 in 2007. Infant deaths increased in 2008 from 407 to 433, producing an infant mortality rate of 6.0 per 1,000 infants, while both fetal (n=375) and neonatal deaths (n=275) decreased very slightly (3.1% & 1.1%, respectively). The majority of infant deaths (n=196) were the result of conditions originating during the perinatal period (e.g., low birth weight, short gestation, maternal complications, respiratory stress). Congenital anomalies (n=107) were responsible for the second highest number of infant deaths.[16]

In Minnesota, infant mortality rates (birth to age one) vary considerably by race and ethnicity. White infants under the age of one year account for more than half of infant deaths (n=266 or 61.4%) while Black infants comprise nearly one-quarter of infant deaths (n=94 or 21.7%) in 2008. It is important to note, however, that the *rate* of infant mortality is nearly four times greater for Black infants (16.2 per 1,000 Black infants under age one) than for White infants (4.3 per 1,000 White infants less than one). The rate of infant death in the American

[11] Minnesota Center for Health Statistics. (2010). 2008 Minnesota Health Statistics (p. 16). St. Paul, MN: MDH.
[12] Minnesota PRAMS Survey, 2007. MDH.
[13] Community and Family Health. (2010). Prenatal Care in Minnesota. Unpublished Fact Sheet scheduled for release, summer 2010. St. Paul, MN: MDH.
[14] Minnesota adopted this definition in 1993.
[15] Community and Family Health. (2010). Intimate Partner Violence. Fact Sheet prepared by Data Epidemiology Unit. St. Paul, MN: MDH.
[16] Minnesota Center for Health Statistics. (2010). 2008 Minnesota Health Statistics. (p. 37). St. Paul, MN: MDH.

Indian community is even higher: 16.8 per 1,000 American Indian infants under one year of age. In terms of ethnicity, the mortality rate for Hispanic infants is substantially lower than Blacks or American Indians but still higher than Whites: 7.2 per 1,000 Hispanic children under age one.[17] Improving infant mortality rates among the non-White population is a priority in Minnesota.



The number of low birth weight (LBW) infants in Minnesota weighing less than 2500 grams has declined from 6.8% in 2007 to 6.4% in 2008. There was a similar reduction in preterm births (< 37 weeks gestation) from 10% in 2007 to 9.6% in 2008. As noted previously, short gestation is a major contributor to early infant death. One of Minnesota's state performance measures for 2005-2010 is the reduction of birth weight disparities between the White population and other subpopulations. While the ratio of the LBW rate for women of color and American Indian women to LBW for White women did decline very slightly in 2006 (from 1.4 to 1.3) it increased again to 1.4 in 2007 and 1.5 in 2008. Thus, the rate of low birth weight is one-and-one-half (1.5) times greater for women of color and American Indian women than White women in Minnesota.[18]

Promoting Optimal Mental Health for Pregnant Women and Mothers

Maternal age and racial/ethnic background have been shown to have a substantial impact on perinatal depression. The Minnesota PRAMS survey indicates that Black women may be the racial/ethnic subpopulation whose mental and emotional health is most affected during the perinatal period. Nearly one-quarter (23.1%) of African-American women reported frequent postpartum depressive symptoms after their child was born, more than double the rate of White women (9.7%), who scored lowest on this measure. White women also had the lowest scores on pregnancy intention: one-third (33.5%) did not plan to become pregnant at the time of their most recent pregnancy. In contrast, nearly half of Black women (47.4%) reported they did not intend to become pregnant, perhaps contributing to depressive symptoms. Hispanic mothers were the second highest racial/ethnic group to report unintentional pregnancy (45.9%). However, only 13.4% of new Hispanic mothers reported frequent postpartum depressive symptoms, an interesting contrast which merits further investigation.[19]

Young women less than 25 years of age are also a concern in terms of perinatal depressive symptoms: 16.4% of new mothers less than 20 years of age reported frequent postpartum depression, as did 13.1% of women

[17] Minnesota Center for Health Statistics. (2010). 2008 Minnesota Health Statistics. (p. 39). St. Paul, MN: MDH.
[18] Unpublished data from the Minnesota Center for Health Statistics.
[19] Minnesota PRAMS Survey, 2007. MDH.

between the ages of 20-24 years. Women older than 35 years were the least likely to be depressed (9.2%) after their babies were born.[20]

Children and Adolescents

More than 70,000 babies are born in Minnesota every year. In 2008 there were 358,471 children less than five years old (6.9% of the state population), up slightly from 353,901 (6.8%) in 2007. Children under the age of five accounted for approximately one-quarter (25.6%) of all children 0-19 years old in 2008 and a similar percentage in 2007 (25.2%). Taking a broader view, children and youth ages 0-19 years represented more than one-quarter (26.9%) of Minnesota's total population in 2008.

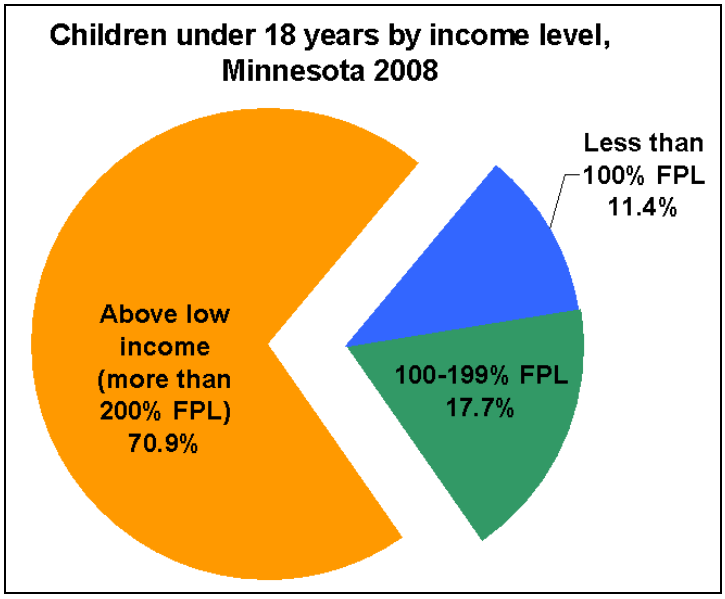
The statewide population of young White children in Minnesota (ages 0-9) has increased every year from 2005 to 2008, while the number of older children (ages 10-19) has decreased during that time. The population of Black children (ages 1 through 19) also increased from 2005 to 2008, as did Asian children under age 15. However, the number of American Indian children/adolescents ages 5 through 19 years has decreased slightly over that period of time. In terms of ethnic populations, *all* age categories of Hispanic children have increased – from infants through age 19. In part, this reflects the influx of new immigrants from the southwestern states, as well as from Mexico. It also reflects the number of migratory farm workers who have chosen to remain in Minnesota full-time.

As indicated in the US Census, 21% of Minnesota children and youth birth to 19 years were living in households headed by single parents in 2007. This percentage varied considerably by race. Nearly two-thirds (62%) of Blacks and three-fourths (73%) of multi-racial children lived in single-parent households, while only 17% White and 16% Asian children lived in this type of family. [21]

According to the Minnesota Department of Human Services 6,430 Minnesota children ages birth to 12 years experienced one or more days in a placement setting outside of their original family home, often referred to as foster care or out-of-home placement. Approximately one-quarter of all placements were one week in duration or less. Most children were placed in a family type setting. American Indian children and Black children had the highest rates of out-of-home placement at 78.8 and 34.6 per 1,000 children, respectively. Although White children had the highest actual numbers in foster care, their placement rate was only 6.6 per 1,000 children. Recent Department of Human Services trends reveal decreasing numbers of children age eight and older placed outside of their original home, while placements of younger children have increased slightly since 2000.

The US Census Bureau estimates that 11.4% or 140,211 Minnesota children under age 18 were living in poverty during 2008; 5.2% of these young persons were living at less than 50% of the federal poverty level (FPL).[22] In addition, a slightly larger group of children (17.7%) were living at 100-199% FPL, which is generally considered to be "low income." The foregoing percentages are conservative estimates of the prevalence of poverty among children and adolescents. Due to outdated statistical methods for calculating FPL, childhood and adolescent poverty data are likely to be underestimated across the nation. New procedures for calculating poverty are currently underway at the federal level.

[20] Minnesota PRAMS Survey, 2007. MDH.
[21] 2008 US Census Bureau's American Community Survey.
[22] 2008 US Census Bureau's American Community Survey.



Poverty is a major factor in food security/insecurity, especially for children. When compared with other states, Minnesota ranks quite low in numbers of children with food insecurity. During the three-year period from 2005 to 2007, the estimated average rate of food insecure children in Minnesota was 13.7% for all children under 18 years of age and 13.0% for children under five. The national average was 17.0%, while the highest states were 22.1% (children under 18 years) and 24.2% (children under 5 years). [23]

In 2008, 239,923 Minnesota children and adolescents, or 171 per 1,000 children/adolescents ages birth through 19 years, participated in the food stamp program. Slightly less than half (47.0%) were White, more than one-quarter (28.7%) were Black, 8.0% were Asian, and 6.2% were American Indian. Ten percent (10.0%) were children reporting more than one race. Blacks comprise a disproportionate share of children receiving food stamps, with a rate of 287 per 1,000 Black children/adolescents. In addition, 11.2% of Hispanic children/adolescents participated in the food stamp program.[24]

In terms of nutrition status, children between the ages of two and five years who are enrolled in the Minnesota WIC program are slightly less obese than the national average; however, this area still needs improvement. Nationally, nearly one-third (31.3%) of all children in this age range were overweight, having a BMI higher than the 85th percentile. There were 16.5% between the 85th and 95th percentile and an additional 14.8% with a BMI in excess of the 95th percentile, which is considered obese (2008). Minnesota's two to five year old WIC children were 16.8% overweight and 13.1% obese for an overall total of 29.9%, or 20,630 children, with a BMI in excess of the 85th percentile.[25]

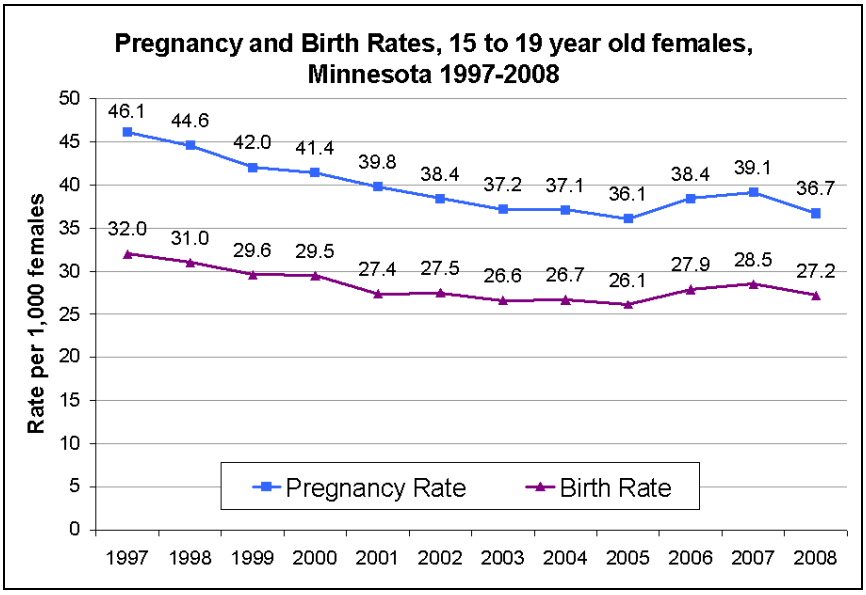
Children in Minnesota are generally appropriately immunized, with 91.1% (n=65,124) of all children under the age of two having completed the full schedule of age-appropriate immunizations (measles, mumps, rubella, polio, diphtheria, tetanus, pertussis, influenza, and hepatitis B). This percentage has increased considerably since 2004, when it was 85.2% (n=56,015 children).

Improving the Health of Children and Adolescents

Reducing teen pregnancy, as well as sexually transmitted infections (STIs), has been an objective for the past several years in Minnesota. Contracting infectious diseases and participating in early parenthood do not promote

[23] 2007 US Census Bureau's American Community Survey.
[24] 2008 US Census Bureau's American Community Survey.
[25] Minnesota WIC Program 2009. MDH.

high quality physical, mental, or emotional health of adolescents, either males or females. During the period from 1997 through 2008, pregnancy and birth rates for 15 to 19 year old females in Minnesota have declined steadily. As seen in the chart below, pregnancy rates fell from 46.1 per 1,000 females in 1997 to 36.7 in 2008, while birth rates decreased from 32.0 to 27.2 per 1,000 females during that same period.



At the same time, sexually transmitted diseases have been increasing among young Minnesotans. Chlamydia rates climbed steadily from 735 cases per 100,000 women ages 15 through 19 years in 2000 to 1,196 cases per 100,000 women in 2009. Results from the Minnesota Student Survey show that 70.8% of sexually active ninth grade students in public high schools throughout the state reported they did use a condom at last intercourse. The state goal for this performance measure, created for the 2005-2010 needs assessment, is 74%.[26]

Use of tobacco, alcohol and drugs among older children and teens has also been a concern in this state. The Minnesota Student Survey (MSS) is administered every three years to children in all public schools in grades six, nine, and twelve. Results from the 2007 survey show that 16% of males and 13% of females in 9th grade used a tobacco product at least once during the past month. This percentage increased to 42% of males and 27% of females in 12th grade. When asked about "frequent use of any tobacco product," usage dropped considerably with 6% of male and 3% of female 9th graders, as well as 18% male and 11% female 12th graders, responding affirmatively. "Frequent binge drinking in the past year" was reported by 5% of males and 3% of females in 9th grade, as well as 24% of males and 12% of females in 12th grade.[27] Results from the next survey (2010) will be available during this calendar year and should provide good comparison data on tobacco and alcohol use in those age groups. The MN Youth Tobacco Survey, administered every four years to a smaller sample of young people, may provide useful supplementary smoking data.

Reducing Child Injury and Death

Child maltreatment in Minnesota is assessed within a framework in which all reports on alleged abuse/maltreatment are evaluated either by traditional methods (formal investigation in which approximately half of alleged cases become "determined" cases and are processed through the court system) or "alternative" assessment, an informal strengths-based model in which a determination of abuse/neglect is not made. Instead, families are provided with needed services that address both their strengths and weaknesses. One of Minnesota's

[26] Minnesota Student Survey, 2007. MDH.
[27] Minnesota Student Survey, 2007. MDH.

ten state performance measures for 2005-2010 addresses the incidence of cases of determined child maltreatment by persons responsible for a child's care. The rate of determined cases has actually been declining from 6.0 per 1,000 children under age 18 years in 2004 to 4.9 per 1,000 children in 2007. Our targeted objective was 6.0 in 2007, and we have exceeded our goal on this measure. However, one must also take into account the newer method of family assessment put into place by the Minnesota Department of Human Services in recent years, which removes the more optimistic, workable families from formal processing through the court system in favor of informal assessment; thus, they do not appear as "determined" cases.

Reducing injuries to children and teens is also a high priority in Minnesota. All injury rates for children 14 years old and younger—both fatal and nonfatal—have improved over the past six years; however, the pattern of decline has varied. Progress has not advanced in a straight line. In 2002 there were 203.7 injuries per 100,000 children ages 14 years and under; that rate increased slightly in 2004 and 2005 but receded again in 2006 and 2007 (188.3 and 193.0, respectively). The rate of nonfatal injuries due to motor vehicle crashes in this age group was 23.5 per 100,000 children in 2002, reaching a low of 14.2 in 2006 and rising again in 2007 to 22.8 per 100,000 children in that age range.[28]

In 2007, the death rate due to unintentional injuries among children aged 14 years and younger was 7.1 per 100,000 children in that age group, down from 10.0 in 2002. The unintentional injury death rate specifically due to motor vehicle crashes for children age 14 and under has also been decreasing steadily, from 4.2 deaths per 100,000 in 2002 to 1.9 deaths per 100,000 children in that age range in 2007.[29]

Promoting Optimal Mental Health

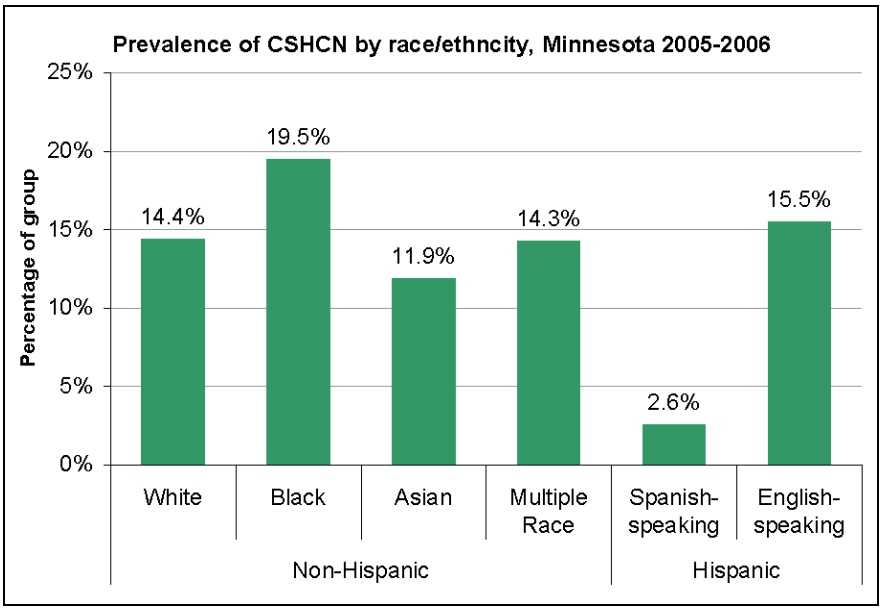
Although emotional and mental health are difficult to measure, especially for young people, its ramifications are pervasive and can be severe. Suicide is the extreme endpoint of disturbed mental health and as such it is a critical issue for young people today. Minnesota was able to reduce the rate of suicide deaths among youth ages 15-19 years old from 10.0 deaths per 100,000 persons in that age range during 2004 to 7.3 deaths per 100,000 youths in 2008.[30] Minnesota's objective (NPM #16) was 8.5 deaths per 100,000 youth ages 15-19 years by 2008, and that goal was met and exceeded.

Children and Youth with Special Health Care Needs

The population of children in Minnesota estimated to be in need of special health care services during 2008 is 180,669, or approximately 14.4% of the total state population age 17 and under (n=1,254,644).[31] Nationally, 13.9% of children are estimated to have special health care needs. Prevalence of children and youth with special health care needs (CYSHCN) in Minnesota becomes greater after the age of six, which corresponds with the entry of most children into the education system. Prior to age six, only 8.7% of children in the state were found to need special health care services. From ages 6 through 17, however, the percentage of CYSHCN increased markedly, from 15.6% at age 6 to18.6% at age 17. Typically, a greater number of males than females require special health care services at nearly all ages. In Minnesota, 17.3% of males require such services, compared with 11.4% of females.

In terms of racial/ethnic prevalence, the Black population in Minnesota has the highest proportion of CYSHCN (19.5%), while Asian and Spanish-speaking Hispanic communities have the lowest percentage (11.9% and 2.6%, respectively). The White population is in the mid-range at 14.4%. Due to a large influx of Asians and Hispanics in recent years, many of whom do not speak English, it is likely that some families with CYSHCN may not be completely aware of their children's needs or knowledgeable about special services; thus, the prevalence of CYSHCN in these ethnic communities may be underreported.

[28] Unpublished data from the Injury and Violence Prevention Unit. MDH.
[29] Unpublished data from the Injury and Violence Prevention Unit. MDH.
[30] Minnesota Center for Health Statistics. (2010). 2008 Minnesota Health Statistics. St. Paul, MN: MDH
[31] National Survey of Children with Special Health Care Needs (SLAITS survey), 2005-06.



Regarding income level, children with special health care needs appear to be spread evenly across all poverty levels in Minnesota, from 0-400% FPL or higher. Among the Minnesota families responding to a recent SLAITS survey (2005-06), 18.3% said their child does cause financial problems for the family, and nearly one-quarter (23.8%) said they paid $1,000 or more out-of-pocket in medical expenses per year for their special needs child.

Improving Access to Quality Health Care and Needed Services

Although two-thirds (66.3%) of parents stated that the insurance they have for their special needs child is adequate, an additional 10% reported that their child was either without insurance at the time of the survey or was without insurance at some point during the past year (n=12,346 children). Health insurance is essential for early screening and intervention. Nearly half (48.0%) of Minnesota CYSHCN age 6 to 11 years report allergies, and more than one-third (36.1%) of CYSHCN age 12 to 17 years have asthma.[32] Referrals from primary care to special service providers are needed in many of these cases.

Children and youth with special health care needs include those children and youth with mental health disorders as a primary or secondary health condition. In Minnesota, nearly one-quarter (23.3%) of all CYSHCN are reported to have anxiety, depression, eating disorders and/or other emotional problems, compared with 21.1% of CYSHCN nationally. The prevalence of mental and emotional disorders among CYSHCN tends to increase with age. In Minnesota 17% of CYSHCN ages 0-5 years had one or more mental/emotional disorders, increasing to 20.3% between ages 6 to 11 and 28.3% for ages 12 to 18 years.[33]

Caregiver burden is high among CYSHCN families, especially those coping with mental and emotional disorders; 40% of such families report this type of stress. At least 29% of Minnesota's CYSHCN are in need of mental health services. For families who live in rural areas, there is a severe shortage of skilled mental health providers and little or no access to mental health services. These families also experience greater social stigma than urban dwellers when they attempt to seek mental, emotional or behavioral health care for their children.

[32] National Survey of Children with Special Health Care Needs (SLAITS survey), 2005-06.
[33] National Survey of Children with Special Health Care Needs (SLAITS survey), 2005-06.

Nevertheless, slightly more than half (51.8%) of Minnesota families of CYSHCN ages 0 to 18 years old said they received coordinated, ongoing, comprehensive care within a medical home, or "health care home" as it is referred to legislatively in Minnesota. In addition, 60.3% of CYSHCN parents report that they partner in the decision-making process for their children at all levels and they are satisfied with services they receive. An impressive 90.7% of CYSHCN families said the community-based service systems in Minnesota are organized so they can use them easily.[34] This speaks well for Minnesota's health services capacity as well as its ease and accessibility for those in need of service.

Strengths and Challenges for CSHCN in Minnesota

According to rankings on 15 performance indicators, and achievement of the six Core Outcomes for CYSHCN, created by the Maternal and Child Health Bureau (2005-06), Minnesota is strong and/or achieving high performance in addressing the needs of its CYSHCN when compared with other states.[35] A few examples from the survey are listed below.

Minnesota is "Significantly higher than US" in the following areas:

1. CYSHCN who receive coordinated, ongoing comprehensive care within a medical home.
2. CYSHCN whose families have adequate public or private insurance to pay for services.
3. Youth with special health care needs who receive services necessary to make appropriate transitions to adult health care, work, and independent living.

Minnesota is "Significantly lower than US" (*with lower equaling better performance*) in these 5 areas:

1. CYSHCN with 11 or more days of school absence due to illness.
2. CYSHCN whose conditions affect their activities usually, always, or a great deal.
3. CYSHCN without any personal doctor or nurse.
4. CYSHCN without family-centered care.
5. CYSHCN whose families spend 11 or more hours per week providing and/or coordinating their child's health care.

These performance measures speak strongly to Minnesota's commitment to provide appropriate and usable services for children with special health care needs. However, one area which Minnesota needs to address is the financial concerns of CYSHCN families. The amount which Minnesotans pay out of pocket in medical expenses for their child with special health needs is significantly higher than other states, as are CYSHCN-related conditions which cause financial hardship for these families (e.g., transportation costs; loss of work time/employment; caregiver burden/respite care; mental health care). The percentage of children with unmet needs varies significantly by race and by age with black children much more likely than white non-Hispanic children to have an unmet need for services and young children being more likely than older youth to have an unmet need for services.

Cross-Cutting Strengths and Needs

At the end of the previous five-year cycle, Minnesota findings show that the majority (7 out of 10) of priority issues identified in the 2005 State Performance Measures have improved. These areas include: comprehensive health care for children and adolescents (including well-child care, immunizations, and dental health); reduction in determined cases of child maltreatment; improved access to comprehensive mental health screening, evaluation and treatment for CYSHCN; early identification and intervention for CYSHCN; improved access to care and needed services for CYSHCN; and slightly lower rates of unplanned pregnancies and teen pregnancies/births.

[34] National Survey of Children with Special Health Care Needs (SLAITS survey), 2005-06.
[35] National Survey of Children with Special Health Care Needs (SLAITS survey) State Ranking Maps, 2005-06. Data Resource Center for Child and Adolescent Health web site.

Areas that still need improvement include: additional reduction in unplanned pregnancies and teen pregnancies/births; increase in early and adequate prenatal care; elimination of alcohol use during pregnancy; reduction of sexually transmitted diseases among adolescents; and further decrease in the child/adolescent suicide rate. Major progress is also needed in the elimination of racial and ethnic health disparities across all population groups and nearly all issues. Perhaps the most pervasive and most difficult area in which to achieve substantial improvement will be the latter.

SECTION 4: MCH Program Capacity by Pyramid Levels

The capacity assessment provides an overview of services most directly connected to Title V funding. This may include both services funded directly by Title V and those services that influence (or are influenced by) Title V activities.

Direct Services

Title V funds in Minnesota are not used to deliver primary medical care services at the state level. However, multiple programs at the state level provide support to local health departments and community providers in the implementation of direct services. Most of this support is discussed under Infrastructure-Building Services.

Local Health Department Direct Services: In Minnesota, the public health responsibilities that are shared between state and local governments are specified in the Local Public Health Act (Chapter 145A). Fifty-three locally-governed Community Health Boards (CHB) oversee local health departments that work in tandem with MDH to fulfill public health responsibilities. This interlocking, statewide system is critical to improving the health of Minnesotans, especially the MCH populations.

Every part of Minnesota is served by one of 53 CHBs. Twenty-eight counties function as single-county CHBs, 57 counties cooperate in 21 multi-county or city-county CHBs, and four metropolitan cities have their own CHB (see Attachment 10 for map of CHBs).

Two-thirds of Title V block grant funds are distributed to local health departments through the Local Public Health Act. These funds are used at the local level to support some direct services, including WIC clinics, family planning services, family home visiting, etc.

Minnesota's local health departments are required to report annually on their progress toward the achievement of a number of outcome measures through the Local Public Health Planning and Performance Measurement Reporting System (PPMRS). One of the measures asks local health departments to identify if they have a "program" to address specific issues (a program is defined as having objectives and a budget and/or dedicated staff hours) or if they provide health promotion or education activities. The information in Table 2 represents those areas most closely related to the maternal and child health activities at the local level (2009 PPMRS data).

Table 2

Programs that address:	Local health departments with a program	Local health departments providing health promotion or education activities	Local health departments with no activities or services
Infant, child and adolescent growth and development	96%	4%	0%
Pregnancy and birth	95%	5%	0%
Injury	71%	23%	6%
Nutrition (excluding WIC)	63%	26%	1%
Unintended pregnancies	62%	27%	10%
Oral/dental health	62%	26%	11%
Alcohol	55%	30%	15%
Other drug use	44%	30%	26%

Mental health (including suicide)	42%	37%	21%
STD/STI	38%	44%	18%
Violence	29%	34%	37%

While some of these programs are direct services, provided one-on-one to individuals, they may also include components of broader community-based activities (i.e. population-based activities).

Local health departments also provide a number of additional services to assure access to health care services, either by providing those services directly or through contracts. These include:

- 100% provide family home visiting
- 99% provide C&TC outreach
- 99% provide immunization clinics
- 95% provide Follow-Along Program
- 95% provide WIC clinics
- 86% provide early intervention service coordination for children with special health needs
- 53% provide C&TC clinics
- 32% provide family planning clinics
- 29% provide dental care
- 15% provide medical care

Family Home Visiting: The 2007 legislature amended the Family Home Visiting statute originally passed in 2001 (Minnesota Statutes, section 145A.17) and increased Temporary Assistance for Needy Families (TANF) funding to local health departments and tribal governments to support the services provided under the statute. The goal of Minnesota's Family Home Visiting Program is to foster healthy beginnings, improve pregnancy outcomes, promote school readiness, prevent child abuse and neglect, reduce juvenile delinquency, promote positive parenting and resiliency in children, and promote family health and economic self-sufficiency for children and families.

- All local health departments provide some level of home visiting services.
- Minnesota currently has five Nurse-Family Partnership projects covering 17 of Minnesota's 87 counties.
- Fifteen percent of home visiting clients are prenatal clients. Local health departments promote the initiation of prenatal care in the first trimester. Some local health departments provide free pregnancy testing with referrals for appropriate services.
- Nearly half of the local health departments report using a tool to screen for maternal depression. Programs also provide education, support and referrals around maternal mental health issues.
- 95 percent all family home visiting programs use a tool for developmental screening, while 90 percent use a tool for social/emotional screening.
- A 2010 report on Minnesota's Family Home Visiting Program can be found at: www.health.state.mn.us/divs/fh/mch/fhv/documents/2010FHVlegreportweb.pdf

Child and Teen Check-ups (C&TC – EPSDT in Minnesota): Over half of Minnesota's local health departments provide C&TC clinics. Children (newborn through the age of 20) enrolled in Minnesota Care or Medicaid are eligible for C&TC. The clinics offer comprehensive and periodic screening or well-child checkups. Periodic examinations or screenings are delivered according to a set schedule, the periodicity schedule, assuring that health problems are diagnosed and treated early, before they become more complex and treatment more costly. C&TC services are also available from primary care providers. Additionally, 99 percent of Minnesota's local health departments provide C&TC outreach. This involves assuring that families are aware of C&TC services and receive those services through the local health department of other local providers.

The Follow-Along Program (FAP): Most local health departments (95 percent) provide periodic tracking and monitoring of the health, development, and social emotional development of children birth to three through the FAP. More that two-thirds of the local health departments provide universal tracking. This involves offering the service to all families, regardless of risk. The remainder provide tracking for children with risk factors. The FAP also provides anticipatory guidance and education to families about the development of their child and

information on healthy development including activities to do with their children to encourage typical development and healthy behaviors. The FAP is a cooperative arrangement between the MDH and local FAP managing agencies.

Family Planning: While only approximately one-third of local health departments provide family planning clinics, there are additional family planning services available in Minnesota. Minnesota uses state general funds and federal TANF funding to support Family Planning Special Projects (FPSP) grants. A total of $10.7 million dollars in FPSP grants were awarded over two years beginning July 1, 2009 to 25 agencies (some local health departments) representing all regions of the state. Multiple agencies within a region receive funding. These funds may be used for public information, outreach, and family planning method services (both medical and non-medical). FPSP primarily serves men, women and teens with limited access to services due to barriers such as poverty. State funds also support a family planning and sexually transmitted infection (STI) hotline staffed by individuals trained in information, referral, family planning, and STI counseling. Information on the hotline is mailed annually to Medicaid and Minnesota Care recipients.

The Minnesota 1115 Waiver program, Minnesota Family Planning Program, is an expansion of access to family planning services through Medicaid. The waiver allows the state to operate outside of the normal Medicaid requirements – it is an expansion of an already existing program that allows people who would not ordinarily meet criteria for services to access family planning services only. All Minnesota residents between the ages of 15 and 50 who have incomes at or below 200% of federal poverty guidelines are eligible.

Hearing Screening: Every child diagnosed with a hearing loss receives a call from a parent who has a child already identified as having a hearing loss. The parent guides are able to direct parent-to-parent support linking families with resources in their area. Minnesota Hands & Voices has parent guides in all regions in the state.

Newborn screening: The Newborn Blood Spot Screening Program tests samples taken from newborns, notifies the primary physician of positive test results, tracks the results of confirmatory testing and diagnosis and links families with appropriate resources. This MDH program is operated as a partnership between the Public Health Laboratory Division and the MCYSHN program. Short-term tracking (prior to point of confirmatory diagnosis) is the responsibility of the public health lab with lab staff providing education and information to the provider community.

MDH Development and Behavior Clinics: State funding for the Development and Behavior clinics has been discontinued. MCYSHN district staff continue to work with providers and families to identify options for children and their families to receive multidisciplinary assessments in or close to their own areas. In several communities provider/parent groups have developed frameworks for the continuation of multidisciplinary team assessment “clinics” utilizing local resources and providers. MCYSHN district staff are supporting this planning and helping these groups identify and connect with appropriate public/private funders.

Workforce and Service Shortages

Local health departments in Minnesota, like other health organizations, are faced with staffing shortages. In 2009, 30 percent of local health departments had positions that were difficult to fill (2009 PPMRS). The majority of these positions were nursing and paraprofessional positions. The vast majority of those positions could not be filled due to budgetary restrictions.

In 2008, the local public health system employed 3,016 full-time equivalents (FTEs). These staff include a variety of job classifications. Ninety-nine percent of local health departments employed public health nurses, accounting for 29 percent of the system workforce. Together, public health nurses and other nurses represented nearly 40 percent of the workforce. The other large job classifications were administrative support (14 percent) and paraprofessionals (9 percent). Fifteen FTE epidemiologists were in the local public health system workforce in 2008. Only two local health departments outside the seven-county metropolitan region employed epidemiologists.

One quarter of local health departments had less than 15 total FTEs. The median number of FTEs was 25 with a range of three to 487 FTEs. The two largest local health departments accounted for 27 percent of the all FTEs and employed more FTEs than the 45 smallest departments combined. Most of the local health departments employing more than 55 FTEs were located in the metro area.

In addition to shortages in the local public health workforce, local health departments have identified a number of gaps in health care providers or services in their communities:

- 86% indicate a lack of mental health providers
- 79% indicate a lack of dental providers
- 78% indicate a lack of dental services
- 75% indicate a lack of mental health services
- 48% indicate a lack of chemical health providers
- 44% indicate a lack of chemical health services
- 27% indicate a lack of health care specialists
- 15% indicate a lack of primary care providers
- 36% indicate a lack of family planning/STI services.

Many local health departments work on addressing those gaps in services. However, the challenge to meet the increasing needs of high-risk families remains.

Enabling Services

A number of activities in Minnesota are designed to enhance access to basic health care and public health services. These activities attempt to break down barriers in obtaining services for the MCH populations.

Local Health Department Enabling Services: Minnesota's local health departments work to address barriers to health care services. In 2009, 100 percent of Minnesota's local health departments identified gaps in health care services or barriers to health care access. Of those, 92 percent worked on addressing gaps or barriers. Table 3 highlights those gaps that most significantly impact the MCH populations.

Table 3

Health care services/access barrier or gap	Percentage of LHD identifying this issues as a gap	Percentage of LHD addressing this gap
Lack of insurance	85%	73%
Transportation	85%	61%
Income	73%	18%
Basic life needs	52%	34%
Cultural competency of providers	29%	18%

Following is a list of examples of actions taken by local health departments to improve accessibility of health care services:

- Promote refugee health services
- Streamline transportation services by enhancing reimbursement for volunteers
- Expand WIC hours and staffing
- Train local providers on mental health screening
- Collaborate to increase access to mental health providers
- Facilitate mobile dental clinics
- Expand dental varnishing programs
- Work with local clinics to increase dental access to uninsured and underinsured
- Work with local hospitals to decrease emergency room visits among the uninsured
- Implement school-based immunization clinics

- Collaborate on tele-mental health services
- Connect pregnant women to financial workers through family home visiting programs
- Offer lead screening at WIC clinics
- Provide incentives for early prenatal care
- Help new immigrants access medical services
- Provide interpreter services for WIC and family home visiting clients

Local health departments conducted a number of activities to address social conditions and cultural competence. Almost all (90 percent) of local health departments participated in collaborations with community organizations that worked to improve social conditions that affect health. This included homeless collaboratives, early childhood initiatives, refugee projects, underage substance abuse councils, economic assistance and housing support, and project to address food insecurity in children. Again, almost all (90 percent) reported taking actions to improve health care and health promotion services by making them more culturally competent by translating materials, using interpreters, training and diversifying staff.

MAZE Trainings: One effort to support the adequate and appropriate use of insurance for children is the MDH MAZE training. MAZE stands for "Taking the Maze out of Funding." The trainings, designed for parents and providers, address eligibility criteria and benefits coverage for Minnesota's publicly-funded health insurance programs. The content of these trainings is updated annually to include changes from each legislative session. Over the past five years (2004-2009) nearly 5,400 people have been trained in 240 trainings. Trainings conducted beginning late 2009 used a new format, with "family stories" representing a variety of family situations. These were done throughout the training so the audience could interact more with the materials and practice finding potential funding resources.

The Eliminating Health Disparities Initiative (EHDI): In 2001, the Minnesota Legislature passed landmark legislation, the Eliminating Health Disparities Initiative (EHDI), to address persistent health disparities in populations of color and American Indians. The MDH has the statutory responsibility for awarding and administering approximately $10 million biennially in competitive grants to local programs and statewide projects; challenging them to develop effective strategies and solutions for eliminating health disparities in seven health priority areas: breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and STI's, immunization, infant mortality and violence and unintentional injuries. In addition, federal TANF funds are directed to address disparities in the area of healthy youth development (teen pregnancy prevention) through the EHDI.

American Indian Infant Mortality Report: The Minnesota American Indian Infant Mortality Review Project was undertaken to address concerns about the Native American infant mortality disparity, gain new insight into medical, social, and environmental factors that contribute to infant mortality, and develop recommendations for improving systems of care and services provided during pregnancy and infancy. The project was done through a partnership between the MDH, tribal and urban Indian community agencies, the Great Lakes Inter-Tribal Epidemiology Center, and the Bemidji Area Office of the Indian Health Service. The report (www.health.state.mn.us/divs/fh/mch/mortality/documents/amindianreport.pdf) documents the process and findings of the infant mortality review and includes recommendations. Community Action Teams are implementing actionable strategies that will reduce the number of infant deaths within Minnesota's American Indian community.

In January of 2009 the MDH published a broader report on Disparities in Infant Mortality (www.health.state.mn.us/divs/chs/infantmortality/infantmortality09.pdf). This report describes the current status of infant mortality in Minnesota, summarizes efforts to address infant mortality, and discusses the ongoing need to reduce racial and ethnic disparities.

MCYSHN Information and Assistance Line: The MCYSHN programs continues to staff a toll free information and assistance line that serves as a resource for parents to help them find and access services for their children. The information and assistance line provides resources and ideas for varying approaches to

enhance communication and partnership between families and providers. Effort is being put into enhancing this information through a web-based format. Materials for families include resources developed by the MCYSHN program, materials and links to other organizations serving families in Minnesota and material developed by the Regional Genetics collaborative.

Minnesota Parents Know Website: This comprehensive website provides a variety of resources to help link families with information about child development, screening services and early intervention. The Minnesota Parents Know website was developed specifically for parents to provide up-to-date, research-based information on child growth and development from birth through grade 12 and includes an online referral section (Help Me Grow) for parents, providers, and other caregivers to refer children for further evaluation with growth and development concerns. The website also provides current immunization schedules and information. The web site can be accessed at www.parentsknow.state.mn.us. This information is available in multiple languages.

Help Me Grow (Part C): Part C of the Individuals with Disabilities Education Act (IDEA) is a federal entitlement program for infants and toddlers with developmental disabilities and their families. Minnesota's Part C system, Help Me Grow, is a partnership between the Departments of Education, Health, and Human Services designed to provide, facilitate, and coordinate early intervention services. Families who have an eligible infant or toddler learn how to help their child grow and develop from local service providers and by accessing needed resources. The MCYSHN 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. Some of these responsibilities are carried out through the Follow-Along Program.

Health Care Home: A "medical home," legislatively known as a "health care home" in Minnesota, is an approach to primary care in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities. The development of health care homes in Minnesota is part of the ground-breaking health reform legislation passed in May 2008. The legislation includes payment to primary care providers for partnering with patients and families to provide coordination of care.

C&TC Outreach: C&TC coordinators in every county and in some tribal governments provide timely information to eligible families and children about the health care benefits of the C&TC program. Coordinators encourage and assist families in accessing C&TC services. Nearly all (99 percent) of local health departments provide outreach for C&TC.

Family Involvement: The MDH programs serving the MCH populations continue to enhance partnership with families. The MCYSHN program is working with families through the development and implementation of a coordinated Family Involvement Plan. This plan is being developed in partnership with Family Voices of Minnesota and Minnesota Hands and Voices.

The MCH Advisory Task Force includes five consumer representatives. The Task Force provides advice to the commissioner of health on matters related to all MCH populations. The involvement of parents and consumers on the Task Force assures connection to the real needs of families and enhances the states ability provide services. Two parents on the Task Force also serve as family delegates and family mentors to the Association of MCH Professionals (AMCHP).

Autism and Developmental Disabilities Learning Collaborative: The MDH is conducting collaborative learning sessions on autism and other developmental disabilities to improve linkages between families, physician practices and community resources. The purpose of the learning collaborative is to improve systems of care for children birth through eight years who have, or who are at risk for, autism and other developmental disabilities. This will be accomplished through improved collaboration and coordination of screening, evaluation, service referrals and resources at the community level.

Hearing Screening: The MDH is working with representatives from the Minnesota Departments of Education and Human Services, Minnesota Hands and Voices, and Commission of Deaf, DeafBlind and Hard of Hearing Minnesotans to produce four bilingual 60 minute television video broadcasts on Early Hearing Detection and Intervention. The project is being produced with Emergency Community Health Outreach (ECHO). ECHO is a leader in multi-language health, safety, civic engagement and emergency readiness communication. ECHO bridges the gap for immigrants and refugees in Minnesota. Each video broadcast, which will include a question-and-answer segment with guests who are native speakers, will be broadcast during 2010 and placed for an indefinite period on the ECHO web site.

Translation of Materials: MDH and local health departments provide materials and programs in English and other languages to address multiple MCH needs. This includes, but is not limited to, materials on: newborn hearing screening, newborn screening, sleep safety, early childhood screening, educational resources, home safety checklists, immunization information, parenting, injury, etc.

Population-Based Services

The following activities highlight preventive and population-based services available for the entire population in Minnesota. These programs provide examples of programs that address the needs of the MCH populations as a whole, not individuals.

Local Health Department Population-Based Services: Many of the programs described under Direct Servies provided by local health departments have components of population-based service as well as direct service. Local health departments currently report activities by program or health promotion/education activities, as shown in Table 2.

Statewide Health Improvement Partnership (SHIP): The 2008 Minnesota Legislature passed comprehensive legislation to support the SHIP initiative. SHIP provides funding ($47 million over the next two years) through grants to local health departments and tribal governments across Minnesota. Grantees are required to create community action plans, assemble community leadership teams, and establish partnerships. Grantees utilize policy, systems and environmental changes in four settings: schools, work sites, health care and community. SHIP efforts focus on obesity (through physical inactivity and unhealthy eating) and tobacco as the key risk factors to target interventions in fiscal years 2010-2011. Local health departments and tribal governments are encouraged to integrate interventions that address the needs of pregnant women and secondhand smoke, and obesity in children.

Minnesota Organization on Adolescent Pregnancy Prevention and Parenting (MOAPPP): MOAPPP is a non-profit agency that works closely with the MDH as the statewide leader in promoting adolescent sexual health, preventing adolescent pregnancy, and gaining support for adolescent parents. MOAPPP provides resources for parents, teens, educators, health care providers, youth workers, media professionals and policy makers. MOAPPP, with funding from the MDH, supports the Teen Outreach Program (TOP). MOAPPP provides training and technical assistance on service learning and teen pregnancy prevention. TOP is being implemented across the state of Minnesota. Currently 14 sites have been trained to facilitate the program aimed at teens ages 12-18.

Suicide Prevention Program: The MDH Suicide Prevention Program is primarily educational in nature and is part of the MDH public health approach to mental health. This program does not provide or oversee publicly funded mental health or substance abuse treatment. Additionally, MDH supports the suicide awareness grant program. This funding provides grants to local health departments, tribal governments and non-profit organizations for suicide awareness. This funding has allowed the MDH to provide information to the public and, periodically, grants to local communities for the implementation of proven effective prevention strategies. The current grantees work to increase public awareness about suicide and suicide prevention; educate family members, faith communities, service providers, employers, school staff, coaches, students and others on the

warning signs of suicide and how to encourage help-seeking; and foster community collaboration to prevent suicide and promote access to suicide prevention services.

Safe and Asleep Campaign: The Minnesota's *Safe and Asleep in a Crib of Their Own* campaign was launched in July 2007, and continues as a partnership between the MDH and the Minnesota Sudden Infant Death Center of Children's Hospitals and Clinics. Additional partners include the Department of Human Services Child Mortality Review Panel, the Minnesota Association of Coroners and Medical Examiners, Twin Cities Healthy Start, the Cradle of Hope Program, the Minnesota Chapter of the American Academy of Pediatrics and local health departments. The goal of this campaign is to help parents understand that infants are safest when sleeping in a crib of their own.

Shaken Baby Syndrome: Minnesota legislation to reduce the incidence of abusive head trauma to infants (Shaken Baby Syndrome) requires birthing hospitals to educate parents of newborns on definitions and prevention strategies before the baby leaves the hospital. MDH staff developed materials and identified videos required for birthing hospitals to educate parents of newborns on the dangers of shaking an infant or young child. MDH staff distributes "Babies Cry" cards to local health departments and tribal governments to further remind parents and other caregivers of newborns how to safely manage inconsolable crying of young infants.

Maternal Depression: Postpartum depression education legislation, passed in 2005, requires that hospitals, physicians and other professionals providing prenatal care and/or delivery services provide new parents and other family members written information about postpartum depression. Materials, which include a brochure and fact sheet, continue to be available for download on the MDH web site. These materials are available in multiple languages including Spanish, Hmong, Somali and Russian. The materials include information about postpartum depression as required by the legislation. The MDH also provides technical assistance and review of materials developed by hospitals and other health care providers to assure all such materials comply with the educational requirements specified in the legislation.

The Great Start Minnesota project is another effort to address maternal depression. This project promotes screening for maternal depression in pediatric clinic settings. Effective January 1, 2010, the Minnesota Health Care Program (MHCP) began providing reimbursement for maternal depression screening as a separate service when performed during a C&TC or other pediatric visit.

Help Me Grow: Help Me Grow is the statewide public awareness initiative for services under the Individuals with Disabilities Education Act (IDEA) for infants and toddlers ages birth to three through Part C of the Act, and for ages three to five years through Part B619 of the Act. This initiative has a new name, logo and branding for unified early intervention services and early childhood special education programs, the development of numerous marketing materials in several languages, the establishment of a new toll-free Help Me Grow information and referral number, and an online referral process.

At the local level, there are currently 95 local Interagency Early Intervention Committees that provide Help Me Grow services statewide. Each committee includes representatives from early childhood special education, county health and human services agencies, other early childhood organizations and parents of children with disabilities. The most recent child count states 4,579 infants and toddlers were being served under Part C.

Minnesota Thrive Initiative: The Minnesota Thrive Initiative engages a diverse cross-section of community members to create networks of local services and resources that help to ensure young children are ready for kindergarten and school success. The networks provide technical assistance, training and financial resources to design and implement a local system that supports the healthy social and emotional development of young children.

Early Childhood Family Education (ECFE): ECFE is a program offered through Minnesota's public schools for all families with children between the ages of birth through kindergarten entrance. ECFE works to strengthen families by enhancing the ability of all parents to provide the best possible environment for their child's learning

and growth. ECFE is offered in all 338 school districts in Minnesota and four tribal schools. During the 2007-2008 academic year, 98,060 parents and 92,703 children attended regular parent/child weekly sessions. Of this total, 66 percent of the parents and 70 percent of the children participated in one or more regular parent-child weekly sessions and/or home visits including 2,997 children with disabilities and developmental delays. As funding declines at the local level, district ECFE programs may be a target for reduction.

Infrastructure-Building Services

Due to the complex nature of services to MCH populations it is often difficult to separate programs into purely population-based services or infrastructure-building services. Many programs supported by, and supportive of, Title V activities provide infrastructure-building services (e.g. policy development, training) but also support population-based services (e.g. statewide education campaigns). To decrease redundancy, some programs listed in this section may include population-based services and activities but are not included in both areas.

Local Health Department Infrastructure-Building Services: Local health departments undertake a number of infrastructure building services to support the MCH populations. All local health departments report having staff with knowledge and expertise in MCH/family planning. In 2009, 23 percent of Minnesota's local health departments were involved with research directed by a university or other research organization. Some examples include support of evidence based practice in public health, participation in worksite wellness studies, studies to enhance the use of data to inform public health practice, and participation in the National Children's Study.

Thirty-eight percent of local health departments report helping to develop significant community or legislative policies. This included action on sexual violence policies, tobacco ordinances, work on SHIP legislation, and work on pregnancy substance abuse reporting laws.

All local health departments report participation in collaborative/partnership efforts to improve community health and address public health issues. Over half (68 percent) report being engaged in up to 25 collaborative groups in their communities.

Maternal and Child Health (MCH) Section: The MCH Section provides 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 programs within the MCH Section (many described below) strive to improve the health status of children and youth, women and their families. The MCH Section provides administrative and program assistance to local health departments, tribal governments, schools, voluntary organizations, and private health care providers. In addition, MCH programs are involved in a number of collaborative activities to strengthen and enhance partnerships. The overall role of the MCH Section within Minnesota's health care delivery environment is to: assess the health needs of mothers, children, and their families; use that information to advocate effectively on their behalf in the development of policies concerning organizational and operational issues of health systems; and advocate for programs and funding streams which have the potential to improve their health. In addition, the MCH Section has focused on quality assurance of public sector health services, assurance of targeted outreach and service coordination for hard-to-reach and high-risk populations, and community health promotion.

Minnesota Children and Youth with Special Health Needs (MCYSHN) Section: The MCYHSN section is the MDH program accountable for the successful performance of core public health functions on behalf of children and youth with special health needs, their families and communities. Connecting children and families with necessary services and resources is an essential public health service provided by MCYSHN. MCYSHN provides health information about many chronic illnesses and disabilities; follow-up with families whose infants have been diagnosed with metabolic or endocrine disorders, infants with confirmed hearing loss and infants identified with a birth defect through the Birth Defects Information System; and enhances community partnerships through the MCYSHN district consultants located throughout the state to provide specialized consultation and support to enhance positive outcomes for children/youth with special health needs and their families. The program works with the MCH Section, the public health laboratory, health care home, and

epidemiology programs. The program also works with the Departments of Commerce, Education, Human Services, the Commission on the Deaf, DeafBlind and Hard of Hearing, the Minnesota State Council on Disabilities, the American Academy of Pediatricians-Minnesota Chapter, PACER, Family Voices, Hands and Voices and the University of Minnesota.

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

Autism-Related Activities: The MDH provides consultation, data analysis and dissemination and policy development around autism and autism spectrum disorders. This includes the development of community collaborative teams to improve screening and evaluation systems. This work is done in partnership with the Departments of Education and Human Services, the University of Minnesota, the Minnesota Chapter of the American Academy of Pediatrics Autism Society Minnesota and community clinics.

Birth Defects Registry Information System: This system gathers data on 45 major birth defects in the two largest counties in Minnesota (Hennepin and Ramsey). Staff supporting this system provide assessment, referral, data analysis and surveillance. The work is done in collaboration with the MCYSHN program, local health departments and the March of Dimes to assure follow-up, education and outreach.

Child and Teen Check-Ups (C&TC): Under a contract with the Department of Human Services, staff provide technical assistance, consultation, education and training for public and private providers of the C&TC program. C&TC is administered by the Department of Human Services. C&TC (EPSDT in Minnesota) is the well child exam program for children birth to 21 years who are eligible for Medicare/Medicaid. Staff also provide best practice well child screening recommendations to the Department of Human Services C&TC program. Minnesota Early Head Start and Head Start programs, administered by the Department of Education, also follow the federal EPSDT/C&TC guidelines and training. Training and consultation is provided to local health departments and tribal governments. Other partners in C&TC include Migrant Head Start Programs and other Head Start/Early Head Start programs and the Minnesota Chapter of the Academy of Pediatrics.

Interagency Developmental Screening Task Force: The Minnesota Interagency Developmental Screening Task Force was convened in spring 2004 to assure the quality and effectiveness of, and provide a standard of practice for, the developmental component of the screening of children birth to age five. Partners include the Minnesota Departments of Education and Human Services and the University of Minnesota Irving B. Harris Center for Infant and Toddler Development. Developmental and social-emotional screening instruments that meet evidence-based criteria for instrument purpose, developmental domains, reliability, validity and sensitivity/specificity are considered for recommendation.

Early Childhood Screening: MDH **s**taff provide technical assistance, consultation, education/training to those who perform early childhood screenings (ECS) and to the Minnesota Department of Education, Early Learning Services. ECS is the mandated preschool screening program administered by the Department of Education. MDH staff train on several of the required and optional components of ECS such as vision, oral/dental health, hearing, developmental and socio-emotional screening as well as physical growth (weight, height), immunization review and health history.

Family Home Visiting Program: MDH staff provide technical assistance and support to local health departments and tribal governments regarding maternal child health and home visiting program planning, implementation and evaluation. This work is done in close collaboration with local partners (local health departments, tribal governments), MDH programs (C&TC, the Office of Minority and Multicultural Health, injury prevention, MCYSHN), multiple committees, and other state organizations including the Minnesota Association of Infant and Early Childhood Mental Health, Prevent Child Abuse-Minnesota, the National

Alliance for Mental Illness-Minnesota, and the Minnesota Sudden Infant Death Center. Much of the work is guided by the Family Home Visiting Steering Committee, the Family Home Visiting Evaluation Work Group, and the Family Home Visiting Training Work Group.

Family Planning: The Family Planning Special Projects Grants provides funds to eligible nonprofit agencies, local health departments, and other governmental agencies to provide family planning services to women and men who have barriers to accessing these services such as poverty, lack of insurance, race, age or culture. MDH staff provides consultation, technical assistance and support for implementation of best practices. This work is done in close collaboration with the MDH HIV/STD staff, the family planning grantees, the MDH Office of Minority and Multicultural Health and the Department of Human Services.

Follow-Along Program (FAP): The FAP is a partnership between MDH and local health departments and tribal governments for the a population based, primary prevention tracking and monitoring system of children birth to three to assure that developmental/ health/social emotional issues are identified early and potentially eligible children are referred for health and early intervention services. It also provides anticipatory guidance to families on normal growth and development. MDH staff provide consultation and training to local health departments implementing the program.

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

Injury and Violence Prevention (IVP): The IVP Unit collects, aggregates and analyzes injury, violence, trauma morbidity and mortality data. These data are made available broadly to support program and policy initiatives. The IVP Unit works with the MCH, suicide prevention, and MCHSN programs. The IVP Unit also works with multiple other partners outside of MDH, including numerous state and advocacy agencies.

Minnesota Early Childhood Comprehensive System (MECCS): The purpose of MECCS is to build and implement statewide early childhood comprehensive systems that support families and communities in their development of children that are healthy and ready to learn at school entry. These systems should be multi-agency and comprising the key public and private agencies that provide services and resources to support families and communities in providing for the healthy physical, social, and emotional development of all young children. The overall goal of the MECCS program is to coordinate early childhood systems for children from birth to five years of age.

Minnesota Immunization Information Connection (MIIC): MICC 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. MIIC provides clinics, schools and parents with secure, accurate and up-to-date immunization data. MIIC users can generate reminder cards when shots are coming due or are past due 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 MIIC through Minnesota's birth record process. An immunization information packet is given to all new parents in the hospital. They are given a toll-free number to call with questions or if they do not want to participate in MIIC.

Minnesota Premature Infant Health Network: The Minnesota Premature Infant Health Network brings together community and health organizations, faith-based groups, health care providers and parents to increase

quality health care access and awareness around premature infant health issues. The network examines the unique health issues of premature infants face. The Minnesota Chapter of the March of Dimes co-chairs the network. The network is currently approximately 50 members including several staff from the MDH. The network currently has four subgroups: resources, best practices, public policy and community health workers.

Newborn Screening Follow-Up: The goal of the newborn follow-up program is to build the capacity of all systems (medical, education, parent to parent support, and other community service systems) that serve families and children with diagnosed conditions found through newborn screening so that they are connected to needed resources for the best possible child and family outcomes. MDH staff provide assessment and referral, consultation, technical assistance and policy development. The program works closely with the Public Health Laboratory Newborn Screening Program, primary care providers, local health departments, audiologists, and other specialty providers.

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

Pregnancy Risk Assessment Monitoring System (PRAMS): PRAMS is an ongoing, population-based surveillance system monitoring women's health. The purpose of PRAMS is to enhance understanding of maternal behaviors and their relationship with adverse pregnancy outcomes. PRAMS data can also be used to aid in the development and assessment of programs designed to identify high-risk pregnancy and reduce adverse pregnancy outcomes and to inform policy in Minnesota. PRAMS works with staff in several MDH programs, including newborn screening follow up, WIC, family home visiting, infant mortality, and adolescent health. A key partner is the Center for Health Statistics (vital records) for birth information. PRAMS also works closely with the March of Dimes, the Great Lakes Epidemiology Center Inter-Tribal Council and the University of Minnesota. PRAMS is completely dependent on the collaborative partnership with the Center for Health Statistics to draw the sample for data collection and analysis.

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

State System Development Initiative (SSDI): SSDI is funded through the federal Maternal and Child Health Bureau to build capacity of state MCH programs to collect, link and use data for needs assessment, program planning and evaluation, quality improvement, and policy development. Collaboration occurs among multiple partners to establish or discover shared goals. Of note is a growing activity of partnering with local health departments around their capacity to link and share data and the evolving broader e-health.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC): The WIC program is a nutrition program for pregnant, breastfeeding and postpartum women, infants and children up to age five. The purpose of the program is to improve the nutrition status of this population through nutrition assessment, nutrition education and a targeted food package. MDH provides support, consultation and technical assistance to local WIC programs and vendors. The WIC program works closely with numerous state and local organizations, including the Minnesota Grocer's Association, Institute for Agriculture and Trade Policy, National WIC Association, University of Minnesota School of Public Health, Minnesota Breastfeeding Coalition, nearly all the tribes in Minnesota, and local health departments. The WIC program also has many successful partnerships

within MDH, including connecting WIC and immunization activities at the local level, and working regularly with the MCH, MCYHSN programs.

SECTION 5: Selection of State Priority Needs

The methodology used to select the state priority needs and final state performance measures is outlined in Section 1: Process for Conducting Needs Assessment. This section will describe the *results* of the various steps in more detail. The entire process was designed to implement a number of decision points to gradually narrow the priorities. This process also highlighted the need to assure that results accurately captured the needs of the MCH populations and the state as a whole.

List of Potential Priorities

The list of potential priorities for Minnesota began with over 100 issues. The sources for these issues included issues identified through the 2000 and 2005 needs assessment processes, input from stakeholders, expertise of MCH and MCYSHN staff, Healthy People 2010, and other assessment processes taking place. These issues were organized by the three target populations. This comprehensive list was shared with MCH and MCYSHN program staff. Staff consolidated, removed or reworded/clarified the issues. The leadership team then reviewed the issues and discussed if the potential priorities should be discussed as a generic issue or qualified in the positive or negative (for example: oral health vs. lack of access to oral health or access to oral health). The decision was made to use the issue without qualifiers.

Methodologies for Ranking/Selecting Priorities

The modified and consolidated list now included 79 issues in the three target population groups and became part of a web-based survey that was broadly distributed. The survey was organized by the three target populations. However, some topics were included in each list. If an issue was applicable to all populations they were included in each. This allowed stakeholders to complete the survey for only those target populations they choose. The survey also included minimal demographic information about each respondent. The complete survey, including all of the topics and the demographic information collected can be found in Attachment 1.

Survey Respondent Characteristics

A total of 867 people responded to the survey. Table 4 shows the demographic characteristics the 867 survey respondents.

Table 4

Primary Affiliation	Frequency	Percent
Local Public Health	207	23.88
School	107	12.34
Parent/Grandparent	95	10.96
Community-Based Organization	90	10.38
Local Social Services	71	8.19
State Agency	68	7.84
Other	58	6.69
Health Care Provider	41	4.73
Clinic	36	4.15
University/College	29	3.34
Advocacy Organization	26	3.00
Hospital	24	2.77
Tribal Government	10	1.15
Health Plan	5	0.58
TOTAL	**867**	**100**

Primary Geographic Focus	Frequency	Percent
County/Tribal Government	418	48.21
Statewide	255	29.41
Other	194	22.38
TOTAL	**867**	**100**
Gender	**Frequency**	**Percent**
Female	792	91.35
Male	75	8.65
TOTAL	**867**	**100**
Race and Ethnicity	**Frequency**	**Percent**
White	814	93.89
Black/African American	13	1.50
American Indian	9	1.04
Hispanic or Latino	7	0.81
White, Hispanic or Latino	5	0.58
White, American Indian	5	0.58
Other (specify),American	5	0.58
Asian/Pacific Islander	4	0.46
Black/African American, Hispanic or Latino	1	0.12
Black/African American, American Indian	1	0.12
White, Asian/Pacific Islander	1	0.12
White, Black/African American	1	0.12
American Indian, Hispanic or Latino	1	0.12
TOTAL	**867**	**100**

Survey Responses by MCH Target Population

The survey asked respondents to identify their top five priorities for each of the target populations. In essence, each respondent had up to five "votes" for each target population accounting for a total of 12,375 priority votes. Respondents could not choose a topic more than once. Respondents were also provided an "other" category to include issues that were not on the survey. This "other" category could not be used to consolidate multiple topics into one. Table 5 shows the ranking of survey topics by MCH population.

Table 5

Pregnant Women, Mothers and Infants			
Rank	**Topic**	**Frequency**	**Percent**
1	Early and adequate prenatal care	423	10.35
2	Health insurance	357	8.74
3	Infant developmental, social and emotional screening	316	7.74
4	Maternal mental health screening, assessment and treatment	302	7.39
5	Comprehensive well baby care	269	6.59
6	Breastfeeding initiation and duration	247	6.05
7	Linkage to community resources	230	5.63
8	Substance/alcohol use during pregnancy	227	5.56
9	Primary preventive health care	177	4.33
10	Male/father involvement in reproductive health and parenting	161	3.94
11	Infant abuse and neglect	154	3.77
12	Health disparities in mothers and infants	145	3.55
13	Planned pregnancies and child spacing	140	3.43
14	Domestic and sexual violence screening	103	2.52
15	Low birth weight and preterm births	98	2.40
16	Tobacco use during pregnancy	98	2.40
17	Immunizations	90	2.20
18	Other	86	2.11
19	Preconception and interconception care	70	1.71
20	Environmental toxins exposure	50	1.22
21	Infant mortality	42	1.03
22	Infant sleep safety	39	0.95
23	Sexually transmitted infections and HIV screening	35	0.86

24	Dental health for women	34	0.83
25	Newborn hearing screening	33	0.81
26	Medical complications during pregnancy	29	0.71
27	Very low birth weight infants delivered at facilities for high-risk deliveries and neonates	29	0.71
28	Newborn blood spot screening	25	0.61
29	Genetic counseling	16	0.39
30	Anemia/iron deficiency during pregnancy	15	0.37
31	Infant injuries (falls, poisoning, drowning)	15	0.37
32	Folic acid levels during pregnancy	13	0.32
33	Weight gain during pregnancy	9	0.22
34	Maternal and infant motor vehicle injury	8	0.20
TOTAL		**4085**	**100**

Children and Adolescents

Rank	Topic	Frequency	Percent
1	Mental health screening, assessment and treatment	362	8.67
2	Comprehensive healthcare, well child care	360	8.62
3	Developmental, emotional, social screening	359	8.60
4	Health insurance	319	7.64
5	Nutrition and physical activity	315	7.54
6	Child abuse and neglect	288	6.90
7	Teen pregnancy and teen birth rate	279	6.68
8	Alcohol and drugs use	223	5.34
9	Healthy youth development	217	5.20
10	School readiness	211	5.05
11	Violence (e.g., sexual assault, bulling, cyber-bulling)	206	4.93
12	Obesity	195	4.67
13	Dental health	138	3.31
14	Child care	126	3.02
15	Immunizations	99	2.37
16	Sexually transmitted infections (STI) and HIV	94	2.25
17	Suicide	72	1.72
18	Chronic disease/conditions	61	1.46
19	Tobacco use	61	1.46
20	Other	50	1.20
21	Unintentional injuries (e.g., burns, poisoning, sports, falls)	36	0.86
22	Environmental hazards	30	0.72
23	Motor vehicle injuries (e.g., traffic, non-traffic, pedestrian)	30	0.72
24	Acute and infectious diseases	26	0.62
25	Hearing loss	18	0.43
TOTAL		**4175**	**100**

Children and Youth with Special Health Care Needs

Rank	Topic	Frequency	Percent
1	Early intervention for young children with special health care needs	443	10.77
2	Early identification of special health care needs	398	9.67
3	Training and family support for children with behavioral issues	362	8.80
4	Access to needed care and services	330	8.02
5	Families receive needed services	319	7.75
6	Health insurance	303	7.36
7	Community-based support for children with behavior disorders	287	6.97
8	Mental health treatment	184	4.47
9	Developmental, social, emotional screening	181	4.40
10	Transition to adulthood	158	3.84
11	Knowledge of child development	128	3.11
12	Parents as decision making partners	126	3.06
13	Health care/medical homes	119	2.89
14	Provider capacity and education to meet the needs of CYSHCN	117	2.84
15	Mental health screening	106	2.58
16	Social isolation of children and families	103	2.50
17	Organized system of care for CYSHCN	101	2.45
18	Safe and stable environments for CYSHCN	98	2.38

19	Home care services	63	1.53
20	Other	55	1.34
21	Maltreatment or abuse of CYSHCN	44	1.07
22	Dental health for CYSHCN	40	0.97
23	Condition specific health information	33	0.80
24	Quantify disease prevalence, issues and concerns of the population	17	0.41
TOTAL		**4115**	**100**

The leadership team analyzed the results of this survey. The decision was made to move forward the topics that received greater than five percent of the survey "votes" in each of the three target populations. This narrowed the list of potential priories to 21. Health insurance was included in all three MCH populations and infant and child developmental, social and emotional screening and comprehensive well baby/child care was included in two of the MCH populations. The remaining topics included:

- **Pregnant Women, Mothers and Infants**
  1. Breastfeeding initiation and duration
  2. Comprehensive well baby/child care
  3. Early and adequate prenatal care
  4. Health insurance
  5. Infant and child developmental, social and emotional screening
  6. Linkage to community resources
  7. Maternal mental health screening, assessment and treatment
  8. Substance/alcohol use during pregnancy
- **Children and Adolescents**
  1. Alcohol and drugs use
  2. Child abuse and neglect
  3. Comprehensive well baby/child care
  4. Health insurance
  5. Healthy youth development
  6. Infant and child developmental, social and emotional screening
  7. Mental health screening, assessment and treatment
  8. Nutrition and physical activity
  9. School readiness
  10. Teen pregnancy and teen birth rate
- **Children and Youth with Special Health Care Needs**
  1. Access to needed care and services
  2. Community-based support for children with behavior disorders
  3. Early identification of young children with special health care needs
  4. Early intervention for young children with special health care needs
  5. Families receive needed services
  6. Health insurance
  7. Training and family support for children with behavioral issues

Prioritization by Stakeholders

As noted previously, fact sheets were developed for each of these 21 topics. These fact sheets served as background information on each topic for a day-long stakeholder retreat. After discussing each of the topics, participants completed a prioritization worksheet (see Attachment 5). This worksheet asked participants to rank (from 1 to 5) each of the issues based on six criteria. Three of these criteria were "fact-based" criteria and three of the criteria were "opinion-based" criteria. In addition, the criteria were weighted. The criteria included:

- Seriousness of the Issue (fact-based)
- Evidence-Based Strategies (fact-based)
- Current Resources (fact-based)

- Momentum for Change (opinion-based)
- Return on Investment (opinion-based)
- Ease of Measurement (opinion-based)

The definitions of the criteria and its weighed value can be found in Attachment 6. Table 6 shows the issue, its frequency from the survey, its average score from the prioritization by stakeholders and its average weighted score.

Table 6

Pregnant Women, Mothers and Infants			
Issue	**Survey Ranking**	**Average Prioritization Score**	**Average Weighted Prioritization Score**
Early and adequate prenatal care	1	1	2
Health insurance	2	2	1
Infant and child developmental, social and emotional screening	3	5	5
Maternal mental health screening, assessment and treatment	4	7	7
Comprehensive well baby/child care	5	3	3
Breastfeeding initiation and duration	6	4	4
Linkage to community resources	7	8	8
Substance/alcohol use during pregnancy	8	6	6
Children and Adolescents			
Issue	**Survey Ranking**	**Average Prioritization Score**	**Average Weighted Prioritization Score**
Mental health	1	6	5
Comprehensive well baby/child care	2	5	6
Infant and child developmental, social and emotional screening	3	4	4
Health insurance	4	1	1
Nutrition and physical activity	5	2	2
Child abuse and neglect	6	8	8
Teen pregnancy	7	7	7
Alcohol and drug use	8	10	10
Healthy youth development	9	9	9
School readiness	10	3	3
Pregnant Women, Mothers and Infants			
Issue	**Survey Ranking**	**Average Prioritization Score**	**Average Weighted Prioritization Score**
Early intervention for young children with special health care needs	1	2	2
Early identification of young children with special health care needs	2	1	1
Training and family support for children with mental illness	3	6	4
Access to needed care and services	4	7	7
Families receive needed services	5	5	5
Health insurance	6	3	3
Community-based support for children with mental illness	7	4	6

Examining Current Measures

The leadership team used the information from the stakeholder prioritization exercise as one of many factors to consider when determining the issues to include as state priority needs. The framework for decision making was an algorithm, described previously, to guide the process.

At this point in the process one of the primary decision points was to determine: 1) if a national performance measure was in place to measure the issue; and 2) if so, did it adequately measure what Minnesota wanted to know about the issue. Of the 21 issues considered, ten did not have a related national performance measure, four had national performance measures that were viewed as adequate and seven had related national performance measures that were viewed as not adequate. Table 7 summarizes this process.

Table 7

ISSUE	National Performance Measure	Is the NPM adequate for Minnesota?
Pregnant Women, Mothers and Infants		
Early and adequate prenatal care	**NPM 18:** Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	**Yes**
Health insurance	**NPM 13:** Percent of children without health insurance.	**No**
Infant developmental, social and emotional screening		
Maternal mental health screening, assessment and treatment		
Comprehensive well baby care	**NPM 7:** Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.	**No**
Breastfeeding initiation and duration	**NPM 11:** The percent of mothers who breastfeed their infants at 6 months of age.	**Yes**
Linkage to community resources		
Substance/alcohol use during pregnancy	**NPM 15:** Percentage of women who smoke in the last three months of pregnancy.	**No**
Children and Adolescents		
Mental health screening, assessment and treatment	**NPM 16:** The rate (per 100,000) of suicide deaths among youths aged 15 through 19.	**No**
Comprehensive healthcare, well child care	**NPM 7:** Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.	**No**
Developmental, emotional, social screening		
Health insurance	**NPM 13:** Percent of children without health insurance.	**Yes**
Nutrition and physical activity	**NPM 14:** Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.	**Yes**
Child abuse and neglect		
Teen pregnancy and teen birth rate	**NPM 8:** The rate of birth (per 1,000) for teenagers aged 15 through 17 years.	**Yes**
Alcohol and drugs use		
Healthy youth development		
School readiness		
Children and Youth with Special Health Needs		
Early intervention for young children with special health care needs		
Early identification of special health care needs	**NPM 1:** The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.	**No**

	NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge.	**No**
Training and family support for children with behavioral issues (mental illness)		
Access to needed care and services		
Families receive needed services	**NPM 2:** The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)	**No**
Health insurance	**NPM 4:** The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey) **NPM 13:** Percent of children without health insurance.	**No**
Community-based support for children with behavior disorders (mental illness)	**NPM 5:** Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)	**No**

Selecting State Priorities

The leadership team wanted the priorities for the needs assessment to reflect the comprehensive nature of the Title V block grant in its entirety. The leadership team felt that identifying and focusing on ten state performance measures provided a limited picture of the complexity of the issues addressed and measured in the block grant. The leadership team chose to look at the following items and categorize them into broad goals and priorities for the state:

- the 21 potential priority issues for the state;
- the national performance measures;
- the national health outcome measures;
- the national health status indicators; and
- the national health system capacity indicators.

These items were organized into two overarching goals and seven broad priority needs for Minnesota:

Overarching Goal 1: Increase health equity and reduce health disparities for pregnant women, mothers and infants, children and adolescents, and children and youth with special health care needs.
Overarching Goal 2: Focus efforts on activities that result in positive outcomes across the lifespan.

Priority Need 1: Improve Birth Outcomes
Priority Need 2: Improve the Health of Children and Adolescents
Priority Need 3: Promote Optimal Mental Health
Priority Need 4: Reduce Child Injury and Death
Priority Need 5: Assure Quality Screening, Identification and Intervention
Priority Need 6: Improve Access to Quality Health Care and Needed Services
Priority Need 7: Assure Healthy Youth Development

The outcome of the categorization of these items is shown in Attachment 11: Issues by Priority Need. Following is a brief overview of each of the goals and priority needs for Minnesota:

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

Minnesota is widely recognized as one of the healthiest states in the nation. In rankings of insurance rates, access to healthcare, premature death, cardiovascular disease deaths, and smoking rates, Minnesota is at or near the top among all states. Despite the overall health status of the state, Minnesota's populations of color and American Indians continue to experience poorer health and disproportionately higher rates of illness and death.

Disparities exist within each of Minnesota's priority needs. The purpose of this overarching goal is to provide direction to Minnesota in addressing these disparities. As noted in the capacity assessment, several MDH and local public health programs are working to reduce disparities in health status. Over the next five years, Minnesota will continue to monitor progress for specific populations and the state as a whole.

OVERARCHING GOAL 2: Focus efforts on activities that result in positive outcomes across the lifespan.

Events early in life, even prenatally, can affect health throughout a person's life. MCH systems must begin to consider how activities to support pregnant women, infants, and children and families can positively influence health across the lifespan. This overarching goal will help Minnesota explore how activities to address each priority need can results in optimal lifelong health for the target populations.

PRIORITY NEED 1: Improve Birth Outcomes

This priority addresses the need to assure that women have healthy and planned pregnancies that result in positive birth outcomes. It includes addressing issues such as substance and alcohol use during pregnancy; assuring that women have access to early and adequate prenatal care; working to reduce teen pregnancy and the teen birth rate; assuring that women and babies have access to high risk newborn care; working with pregnant women to assure their babies are born at a healthy weight; and reducing infant mortality.

PRIORITY NEED 2: Improve the Health of Children and Adolescents

This priority addresses the need to assure that children and adolescents have access to all of the health care services needed for optimal growth and development. This includes assuring access to comprehensive well child care, including dental care; that infants are breastfed; that children have lives unaffected by alcohol and drugs use; that children are physically active and eating healthy; and that youth have information to keep them free from sexually transmitted diseases.

PRIORITY NEED 3: Promote Optimal Mental Health

This priority addresses not only the growing need to clarify the role in public health in promoting optimum mental health in children, but also assuring that women receive proper screening and assessment following birth. This priority also addresses the need to assure that families of children with mental illness or behavior disorders receive the training and community support they need to best meet the needs of their children.

PRIORITY NEED 4: Reduce Child Injury and Death

This priority addresses consequences of child injury and death. This includes not only child abuse and neglect but also injury and death due motor vehicle accidents, violence and unintended injury.

PRIORITY NEED 5: Assure Quality Screening, Identification and Intervention

This priority addresses the need to assure that infants and children are screened early and often to assure early identification of developmental, social and emotional needs. This also addresses the need to assure that once an issue has been identified, the child receives services as early as possible to promote the best possible outcome.

PRIORITY NEED 6: Improve Access to Quality Health Care and Needed Services

This priority address the need to assure that pregnant women, infants, children, adolescents and children with special health care needs have access to the care and services they need. This includes access to needed community services and resources (including specialty care and services for children with special health care needs), adequate health insurance and access to a health care home.

PRIORITY NEED 7: Assure Healthy Youth Development

This priority addresses the need to assure the overall health of youth and adolescents in a positive manner that allows them to meet their personal and social needs and build the skills and competencies to allow them to be successful. This priority builds on the strengths of youth versus the reduction of negative behaviors.

These goals and state priority needs were approved by the MCH Advisory Task Force on March 12, 2010. They will serve as the framework for MCH activities for the next five years. The priority needs are broad and more inclusive of the multiple issues addressed by public health. Additionally, these measures encompass all three target populations. Each MCH population crosses multiple priority needs. The measures associated with these priorities are discussed below.

Priorities Compared with Prior Needs Assessment

The entire needs assessment process was designed to address the current needs of the MCH populations in Minnesota and to more broadly reflect the comprehensive nature of the Title V block grant. Priorities from the previous needs assessment process were included in the list of potential priorities and considered by the leadership team throughout the process. Many of these priority needs are included in the broader priority needs for the next five years. Table 8 shows the 2005-2010 priority needs and their relationship to the 2010-2015 priority needs.

Table 8

Minnesota 2005-2010 Priority Needs	Status in 2010-2015
Pregnant Women, Mothers, and Infants	
Promote planned pregnancies and child spacing	Continues to be addressed in **Priority Need 1:** Improve Birth Outcomes
Eliminate racial and ethnic health disparities in mothers and infants	Continues to be addressed in **Overarching Goal 1:** Increase health equity and reduce health disparities for pregnant women, mothers and infants, children and adolescents, and children with special health care needs.
Assure early and adequate prenatal care	Continues to be addressed in **Priority Need 1:** Improve Birth Outcomes
Children and Adolescents	
Prevent teen pregnancy and sexually transmitted infections	Continues to be addressed in **Priority Need 1:** Improve Birth Outcomes and **Priority Need 2:** Improve the Health of Children and Adolescents and **Priority Need 7:** Assure Healthy Youth Development
Prevent child abuse and neglect	Continues to be addressed in **Priority Need 4:** Reduce Child Injury and Death
Promote mental health for children and adolescents, including suicide prevention	Continues to be addressed in **Priority Need 3:** Promote Optimal Mental Health and **Priority Need 7:** Assure Healthy Youth Development
Assure that children and adolescents receive comprehensive healthcare, well child care, immunizations, and dental care	Continues to be addressed in **Priority Need 2:** Improve the Health of Children and Adolescents
Children with Special Health Care Needs	
Improve access to comprehensive mental health screening, evaluation and treatment for CSHSN	Continues to be addressed in **Priority Need 3:** Promote Optimal Mental Health and **Priority Need 5:** Assure Quality Screening, Identification and Intervention
Improve early identification of and intervention for CSHCN	Continues to be addressed in **Priority Need 5:** Assure Quality Screening, Identification and Intervention
Improve access to care and needed services for CSHCN	Continues to be addressed in **Priority Need 6:** Improve Access to Quality Health Care and Needed Services

Priority Needs and Capacity

Section 4: MCH Program Capacity by Pyramid Levels provides a comprehensive overview of direct, enabling, population-based, and infrastructure MCH capacity in Minnesota. The assessment of program capacity was also discussed in Section 1, Step 3.

Minnesota currently has the capacity to address the seven identified priority needs. There is always concern regarding the inadequacy of resources and funding to fully address all of the needs identified through the process. However, two needs that are the most pronounced in their lack of resources are Promote Optimal Mental Health and Assure Healthy Youth Development. The public health role in mental health has been emerging over the last several years. Tremendous amounts of resources are justifiably devoted to the treatment of mental health issues in children. More resources need to be devoted to the prevention and early identification of mental health issues in children.

Healthy youth development is an emerging issue. The need to address the overall health of youth and adolescents is difficult to measure due to the multiple contributing factors that affect youth development. More resources need to be devoted to promoting the positive aspects of youth development versus the reduction of negative behaviors.

MCH Population Groups

As noted above, the seven priority needs are broad and more inclusive of the multiple issues addressed by public health and encompass all three MCH populations. Each MCH population crosses multiple priority needs. Additionally, each MCH population is equally represented in the state performance measures (see below).

Priority Needs and State Performance Measures

Following the identification of the seven priority needs, the leadership team undertook a process to select the state performance measures. Seventeen issues within seven priority needs remained. These issues included only those issues that: 1) were above 5 percent in the stakeholder survey results; and 2) did NOT have a National Performance Measure that adequately measures what Minnesota needs to know about this issue.

Efforts were made to select priority issues to measure from each *priority area* and equitably representing all *three MCH target populations*. The leadership team, in consultation with staff, discussed each of these issues to determine if data are currently available to measure progress on performance (unless there is compelling evidence that new data are needed) and if the issue is one that the work of the Title V program (MDH and local public health) can significantly impact.

Based on these discussions, ten issues were selected to be measured as state performance measures. These state performance measures are not intended to be the only representative measure for that priority need. These measures fill a gap in the measures currently available to monitor Minnesota's progress in addressing the priority needs.

The final state performance measures and target population they address are included in Table 9. The goal for each issue can be found in Form 16. A complete listing of all national and state measures and their relationship to each priority need can be found in Attachment 11: Issues by Priority Need.

Table 9

Issue	MCH Target Population	State Performance Measure
Priority Need 1: **Improve Healthy Birth Outcomes**		
Substance/alcohol use during pregnancy	▪ Pregnant women, mothers and infants	**NEW State Performance Measure #1:** Percentage of women who did not consume alcohol during the last three months of pregnancy.
Priority Need 2: **Improve the Health of Children and Adolescents**		
Comprehensive well baby and well child care	▪ Pregnant women, mothers and infants ▪ Children and adolescents	**REVISED State Performance Measure #2:** Percentage of children enrolled in Medicaid who receive at least one recommended Child and Teen Checkup (C&TC) visit (EPSDT is known as C&TC in Minnesota).
Priority Need 3: **Promote Optimal Mental Health**		
Mental health screening, assessment and treatment	▪ Children and adolescents	**NEW State Performance Measure #3:** Percentage of Minnesota children birth to 5 enrolled in Medicaid who received a mental health screening using a standardized instrument as part of their Child and Teen Checkup (C&TC) visit (EPSDT is known as C&TC in Minnesota).
Priority Need 4: **Reduce Child Injury and Death**		
Child abuse and neglect	▪ Children and adolescents	**REVISED State Performance Measure #4:** Rate of cases of child maltreatment.
Priority Need 5: **Assure Quality Screening, Identification, and Intervention**		
Infant and child developmental, social and emotional screening	▪ Pregnant women, mothers and infants ▪ Children and adolescents	**NEW State Performance Measure #5:** The number of children enrolled in the Follow-Along Program.
Early intervention for young children with special health care needs	▪ Children and youth with special health care needs	**NEW State Performance Measure #6:** Percentage of children under the age of one year participating in early intervention through Part C of the Individuals with Disabilities Education Act.
Priority Need 6: **Improve Access to Quality Health Care and Needed Services**		
Linkage to community resources	▪ Pregnant women, mothers and infants	**NEW State Performance Measure #7:** Percentage of participants in Minnesota's family home visiting program referred to community resources that received a family home visitor follow-up on that referral.
Access to needed care and services	▪ Children and youth with special health care needs	**NEW State Performance Measure #8:** Percentage of children and youth with special health care needs that have received all needed health care services.
Health insurance	▪ Pregnant women, mothers and infants ▪ Children and adolescents ▪ Children and youth with special health care needs	**NEW State Performance Measure #9:** Percentage of families of children age 0-17 that report costs not covered by insurance are usually or always reasonable.
Priority Need 7: **Assure Healthy Youth Development**		
Healthy youth development	▪ Children and adolescents	**NEW State Performance Measure #10:** By 2013, collaborate with other state agencies to identify a state performance measure and benchmark to monitor positive youth development in Minnesota.

SECTION 6: Outcome Measures - Federal and State

The leadership team considered the national outcome measures as well as all national measures in the needs assessment process and the identification of state priority needs. The capacity assessment clearly indicates that efforts are being made in Minnesota address the national outcome measures. The national outcome measures address fetal, infant and child death. Multiple programs contribute to addressing these outcomes. Additionally, two priority areas, Improve Healthy Birth Outcomes and Reduce Child Injury and Death, are inclusive of these outcomes. Minnesota has chosen not to develop any state outcome measures for this five-year period.

Attachments

Attachment 1: 2010 Title V Needs Assessment Stakeholder Survey

Attachment 2: Sample 2010 Needs Assessment Fact Sheet

Attachment 3: Stakeholder Retreat Agenda

Attachment 4: Stakeholder Retreat Participants

Attachment 5: Retreat Prioritization Tools (3)

Attachment 6: Expanded Criteria Definitions

Attachment 7: Capacity Assessment Tool

Attachment 8: Decision Tree for Selecting State Priorities

Attachment 9: Title V Needs Assessment Data Sources

Attachment 10: Minnesota CHB Map

Attachment 11: Issues by Priority Need

Attachment 1

Minnesota's 2010 Title V (MCH) Block Grant Needs Assessment

The purpose of the needs assessment is to identify and establish Minnesota's priorities for the work to be carried out over the next 5 years under the Title V Block Grant. As part of this assessment, the Minnesota Department of Health (MDH) is soliciting your views about the health of the maternal and child and children and youth with special health needs populations in your community and about key issues that affect their health. The needs assessment will help the MDH identify priorities for three target populations regarding the need for:

- Preventive and primary care services for **pregnant women, mothers and infants** up to one year
- Preventive and primary care services for **children and adolescents** age 1 to 21
- Services for **children and youth with special health care needs** (those who have or are at increased risk for a chronic physical, developmental, behavioral or emotional condition and who also require health and related services of a type or amount beyond that required by children generally).

Use of Survey Results

The information you provide will be combined with other responses and used by the MDH to describe the broad range of potential needs, leading to a set of priority issues that will be addressed in Title V Block Grant activities during 2011-2016. We are asking you to provide information about yourself to assure that we reach a broad and diverse group of individuals with interest in maternal and child health and children and youth with special health care needs. Providing your name and e-mail address is optional. If you choose not to provide this information, your comments will be anonymous. State law requires that the MDH provide survey responses to anyone requesting this information. This would include your name and e-mail address if you have provided it.

Taking the Survey

The survey is comprised of information about you (demographic information) and items that you will need to rank. To do this, you will need to:

1) Identify your top 5 priority needs for each of the three target populations, and
2) Rank your top 5 choices from 1-5 (with 1 being most important) in each of the three target populations.

You must rank 5 priorities for a target population; however you are not required to provide rankings for all three target populations.

The survey allows you to add "Other Needs" that are not listed. If you add an "Other Need" to any of the priority lists, it must be included in your top 5 ranking to be part of the survey results.

Do not combine priorities already listed to create a new priority. Combined priorities can not be counted in the analysis of this survey results.

It should take you approximately 10 minutes to complete the survey.

TO COMPLETE THE SURVEY ONLINE: www.health.state.mn.us/divs/cfh/na/2010NeedsAssessment.html.

Questions? Send an e-mail to health.titleV@state.mn.us.

Tell Us About Yourself (Please complete all fields unless noted as optional)

Name (optional): _____

E-mail Address (optional): _____

Zip code: _____

Race/Ethnicity (check all that apply):

- ☐ White
- ☐ Black/African American
- ☐ African
- ☐ American Indian
- ☐ Asian/Pacific Islander
- ☐ Hispanic or Latino
- ☐ Other (specify: _____)
- ☐ Unknown

Age:

- ☐ 18 or younger
- ☐ 19-24
- ☐ 25-44
- ☐ 45-64
- ☐ 65+

Gender:

- ☐ Male
- ☐ Female

Primary Affiliation (check only one):

- ☐ Advocacy Organization
- ☐ Clinic
- ☐ Community-Based Organization
- ☐ Grandparent
- ☐ Health Care Provider
- ☐ Health Plan
- ☐ Hospital
- ☐ Local Public Health
- ☐ Local Social Services
- ☐ Parent
- ☐ School
- ☐ State Agency (specify: _____)
- ☐ Tribal Government
- ☐ University/College
- ☐ Other (specify: _____)

Primary Geographic Focus (check only one):

- ☐ Statewide
- ☐ County/Tribal Government (specify: _____)
- ☐ Other (specify: _____)

Pregnant Women, Mothers and Infants

- Identify your top 5 priority needs for Pregnant Women, Mothers and Infants.
- Rank your top 5 choices from 1-5 (with 1 being most important) for this target population.
- If you do not see a priority need on the list, record that need in "Other Need." If you add an "Other Need" it must be included in your top 5 ranking.
- Do not combine priorities already listed to create a new priority.

Rank	Priority Needs
	Anemia/iron deficiency during pregnancy
	Breastfeeding initiation and duration
	Comprehensive well baby care
	Dental health for women
	Domestic and sexual violence screening
	Early and adequate prenatal care
	Environmental toxins exposure
	Folic acid levels during pregnancy
	Genetic counseling
	Health disparities in mothers and infants
	Health insurance
	Immunizations
	Infant abuse and neglect
	Infant developmental, social and emotional screening
	Infant injuries (falls, poisoning, drowning)
	Infant mortality
	Infant sleep safety
	Linkage to community resources
	Low birth weight and preterm births
	Male/father involvement in reproductive health and parenting
	Maternal and infant motor vehicle injury
	Maternal mental health screening, assessment and treatment
	Medical complications during pregnancy
	Newborn blood spot screening
	Newborn hearing screening
	Planned pregnancies and child spacing
	Preconception and interconception care
	Primary preventive health care
	Sexually transmitted infections (STI) and HIV screening
	Substance/alcohol use during pregnancy
	Tobacco use during pregnancy
	Very low birth weight infants delivered at facilities for high-risk deliveries and neonates
	Weight gain during pregnancy
	Other Need 1
	Other Need 2
	Other Need 3

Children and Adolescents

- Identify your top 5 priority needs for Children and Adolescents.
- Rank your top 5 choices from 1-5 (with 1 being most important) for this target population.
- If you do not see a priority need on the list, record that need in "Other Need." If you add an "Other Need" it must be included in your top 5 ranking.
- Do not combine priorities already listed to create a new priority.

Rank	Priority Needs
	Acute and infectious diseases
	Alcohol and drugs use
	Child abuse and neglect
	Child care
	Chronic disease/conditions
	Comprehensive healthcare, well child care
	Dental health
	Developmental, emotional, social screening
	Environmental hazards
	Health insurance
	Healthy youth development
	Hearing loss
	Immunizations
	Mental health screening, assessment and treatment
	Motor vehicle injuries (e.g., traffic, non-traffic, pedestrian)
	Nutrition and physical activity
	Obesity
	School readiness
	Sexually transmitted infections (STI) and HIV
	Suicide
	Teen pregnancy and teen birth rate
	Tobacco use
	Unintentional injuries (e.g., burns, poisoning, sports, falls)
	Violence (e.g., sexual assault, bulling, cyber-bulling)
	Other Need 1
	Other Need 2
	Other Need 3

Children and Youth with Special Health Care Needs

- Identify your top 5 priority needs for Children and Youth with Special Health Care Needs.
- Rank your top 5 choices from 1-5 (with 1 being most important) for this target population.
- If you do not see a priority need on the list, record that need in "Other Need." If you add an "Other Need" it must be included in your top 5 ranking.
- Do not combine priorities already listed to create a new priority.

Rank	Priority Needs
	Access to specialty care and services
	Community-based support for children with behavior disorders
	Condition specific health information
	Dental health for CYSHCN
	Developmental, social, emotional screening
	Early identification of special health care needs
	Early intervention for young children with special health care needs
	Families receive needed services
	Health care/medical homes
	Health insurance
	Home care services
	Knowledge of child development
	Maltreatment or abuse of CYSHCN
	Mental health screening
	Mental health treatment
	Organized system of care for CYSHCN
	Parents as decision making partners
	Provider capacity and education to meet the needs of CYSHCN
	Quantify disease prevalence, issues and concerns of the population
	Safe and stable environments for CYSHCN
	Social isolation of children and families
	Training and family support for children with behavioral issues
	Transition to adulthood
	Other Needs 1
	Other Needs 2
	Other Needs 3

Attachment 2

Minnesota Department of Health Fact Sheet: **Title V (MCH) Block Grant**
Pregnant Women, Mothers and Infants
Children and Adolescents
Children and Youth with Special Health Care Needs

September 2009

Health Insurance

About the Title V Block Grant

The federal Title V Maternal and Child Health (MCH) Block Grant helps states ensure the health of all mother and children. As part of Minnesota's Title V Block Grant activity requirements, the MDH conducts a statewide needs assessment every five years. The needs assessment provides guidance to Title V activities for the next five years by identifying priority issues. This fact sheet describes one of Minnesota's priority issues.

Seriousness of the Issue

Insurance Coverage
In 2006, nearly 93% of all Minnesotans had some type of health care coverage.[1] This included:

- 67.5% were insured through employer-sponsored coverage or purchase individual policies
- 24.6% were insured through a public program (e.g., Medicare, Medical Assistance (MA), General Assistance Medical Care (GAMC), or MinnesotaCare)
- 7.4 % (374,000 people) were uninsured, and
- 11.3% were uninsured at some point during the year.[1]

In 2007, 71.3% of the uninsured in Minnesota were employed. Of those, 33% held temporary or seasonal jobs, 44.9% worked 31-40 hours per week and 28.8% worked more than 40 hours.[1]

According to the Kaiser Family Foundation, 81% of the uninsured in the US had either part-time or one or more full-time workers.[2]

Insurance Coverage for Children
Over 19% of children aged 0-17 are covered by public insurance and 6% are uninsured. For the 18-24 age group, 16.5% are covered by a public program and 18.7% are uninsured.[1]

Fewer Minnesota children aged 0-5 years were uninsured in 2007 (4.8%) than in 2004 (7%). The trend was the same for public insurance. However, the opposite trend occurred for children aged 6-17 years with 4.6% uninsured in 2004 and 6.6% uninsured in 2007. The percentage of children in this age group on public insurance remained the same.[1]

According to the National Survey of Children's Health for children aged 0-17, in 2007 87% of Minnesota's uninsured children were uninsured for the entire year and 13% were either currently uninsured or had periods of no coverage during the year.[3]

Families with children make up 70% of the Medical Assistance enrollment. This has remained stable over the last 10 years.[1]

Disparities
As the following table shows, disparities in insurance coverage exist for Minnesota's racial and ethnic populations. This table shows trends in health insurance coverage by race and ethnicity from 2004 to 2007.[1]

	Yr	Private	Public	Uninsured
White	04	70.1%	23.7%	6.2%
	07	69.2%	24.4%	6.4%
Black	04	40%	45.2%	14%
	07	46.5%	38.8%	14.7%
Asian	04	63.5%	26.5%	10.1%
	07	75%	18.8%	6.3%
American Indian	04	38.1%	39.9%	22%
	07	32.2%	51.9%	16%
Hispanic/ Latino	04	38.8%	32.2%	31%
	07	47.4%	33.5%	19%
All	04	67.2%	25.1%	7.4%
	07	67.6%	25.2%	7.2%

As noted earlier, 6% of Minnesota's children age 0-17 had no insurance coverage in 2007. However, when looking at race, 4.8% of White children had no insurance, while 12.8% of non-White children were uninsured.[1]

Insurance and Prenatal Care
As part of the Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS) survey, women are

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Maternal and Child Health Section
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St. Paul, MN 55164-0882
(651) 201-3760
www.health.state.mn.us

asked about their health and health care prior to and following pregnancy. In 2007, 19.4% of all women who recently had a live birth indicated that they did not have public or private insurance prior to their pregnancy. However, when looking at race/ethnicity 13.6% of White women, 20.5% of Black women, 70.1% of Hispanic women, and 39.3% of American Indian women indicated they did not have insurance prior to their pregnancy. In women under that age of 24, approximately 2 out of 5 did not have insurance prior to pregnancy.[4]

Access and Adequacy of Care

The uninsured were less likely than those with private insurance to get their care at a private clinic or doctor's office (72% compared to 97%) but significantly more likely than those with private coverage to get care at a free or public health clinic (15% vs. 1.5%) or an emergency room (11% vs. 1.5%). These findings from the 2007 Minnesota survey are similar to findings for prior years.[5]

The National Survey of Children's Health found that of those Minnesota children 0-17 that were currently insured, 31.3% said that the insurance was not adequate. In contrast, when asked if their insurance benefited the child's needs, 92.4% responded "usually" or "always." When asked if the insurance allowed them to see the needed health providers, 94.9% responded "usually" or "always." However, when asked if the out-of-pocket expenses were reasonable for the child's care, only 45.4% responded "usually" or "always" with the remainder indicating that the cost were never/sometimes reasonable (26.7%) or they either had no out-of-pocket expenses (27.9%).[3]

According to the 2005 National Survey of Children with Special Health Care Needs (CSHCN) (latest available data), 30% of Minnesota insured CSHCN had inadequate insurance.[6] Estimates of inadequate insurance in this survey were derived by responses to three questions: Does the child's health insurance offer benefits or cover services that meet the child's needs? Are costs not covered by the child's health insurance reasonable? Does the child's health insurance allow him/her to see the providers he/she needs?

Out-of-Pocket Costs

The average annual health insurance premium for private insurance in Minnesota (for both single and family coverage) more than doubled between 1997 and 2006. While the employer contribution assumes much of this cost, the employee share has more than doubled and the employer share has been increasing only slightly.[1] During that same time, wages and income increased by only 30-40%.[7]

Nearly 90% of those with incomes below 100% of the Federal Poverty Guidelines (FPG) spent 10% or more of their income on health care. In comparison, only 9% of Minnesotans with incomes above 300% FPG spent more than 10% of their income on health care.7

In 2007, total spending per enrollee in a private health plan increased by 5.6 % (from $3,879 to $4,095), which was the lowest rate of increase in the last decade. In contrast, enrollee out of pocket costs increased by 13.7%, the highest rate of increase since 2002. The share of total cost paid by enrollees represented 15.1% of total spending in 2007, compared to 10.1% in 2000.[8]

Out-of-Pocket costs for families of CSHCN also keep rising. Twice as many families with CSHCN paid more than $5,000 for out-of-pocket costs in 2005 than in 2001; and twice as many paid more than $1,000 in 2005 than in 2001.[6] Affordability and adequacy of coverage become significant family policy issues because one out of five families with children have one or more children with a special health need.

Evidence-Based Strategies

There is a large body of research that is virtually unanimous in its conclusions about the impact of insurance on the health of children and adults. As stated both simply and succinctly by the Kaiser Commission on Medicaid and the Uninsured: "Health Insurance Matters".[9] As noted in the overview of that document, lack of insurance compromise's the health of individuals because they are less likely to receive preventive care, more likely to be hospitalized for avoidable health problems, less likely to receive timely diagnoses, and more likely to delay needed treatment.

In addition, lack of insurance also affects the financial well being of families by increasing family exposure and vulnerability to the high cost of health care and out-of-pocket costs.

One strategy to address lack of health insurance and adequate health insurance is to advocate for adequate health insurance coverage in either public or private programs for all children and adolescents. Policy makers should continue to explore ways to ensure that Minnesotans have access to affordable, high quality health insurance coverage.

Additionally, due to the significant disparities that exist in health insurance coverage among Minnesota's racial and ethnic minorities, there is a need to develop and promote health services and systems of care designed to eliminate disparities and barriers across the MCH population.

Current Resources and Capacity

Minnesota's local health departments (LHDs) work to increase the number of clients enrolled in health insurance programs. In 2008, 88% of LHD identified that "Lack of Insurance" as a barrier to health care services.[10]

Through interaction with clients in various programs, LHD are able to monitor those programs in which they routinely assess the health insurance status of clients; and those programs in which they refer clients without insurance to appropriate insurance resources. The following table presents the data from 2008 for programs that most significantly impact the health insurance status of women and children:

Service	Assessed	Referred
Family planning clinics	75%	88%
Early intervention service coordination for CSHN	91%	93%
WIC clinics	92%	95%
Family home visiting	96%	94%
CTC Outreach	88%	88%
Follow-along program	72%	79%

Another effort to support the adequate and appropriate use of insurance for children is the MDH MAZE training. 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. In 2007-08 staff trained 978 people in 45 trainings. Over the past 5 years (2003-2008) nearly 5,000 people have been trained in 213 trainings.

Minnesota participates in the Early Childhood Comprehensive System (ECCS). 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.

[1] MDH, Health Economic Program, Minnesota Health Care Markets Chartbook. http://www.health.state.mn.us/divs/hpsc/hep/index.html
[2] Kaiser Family Foundation http://www.kff.org/about/kcmu.cfm
[3] National Survey of Children's Health. *2007 Data.* http://www.nschdata.org/Content/#
[4] MDH, Minnesota Pregnancy Risk Assessment Monitoring System (2009). *2007 Data Tables.*
[5] MDH, Health Economic Program, Access to Care and Health Status Among Uninsured Minnesotans, 2007. http://www.health.state.mn.us/divs/hpsc/hep/index.html
[6] National Survey of Children with Special Health Care Needs. *2005 Data* http://cshcndata.org/Content/Default.aspx
[7] MDH Health Economics Program, Health Insurance Affordability Study, January 2009.
[8] Private Health Insurance Trends in Minnesota, 2007. MDH Health Economic Program Issue Brief, September 2008.
[9] Kaiser Family Foundation. *The Uninsured: A Primer-Key Facts About Americans Without Health Insurance.* December, 2003.
[10] MDH, Office of Public Health Practice, Local Public Health Planning and Performance Measurement Reporting System. *2008 Data.* http://www.health.state.mn.us/ppmrs/analysis.html

Attachment 3

Title V (MCH) Block Grant
Needs Assessment Stakeholder Meeting

September 10, 2009
9:00 am to 4:00 pm
Snelling Office Park, Mississippi Room
1645 Energy Park Drive, St. Paul

Meeting objectives:

- Discuss and prioritize issues for each of the target populations
- Provide input to the Minnesota Department of Health on priority issues and contributing factors

AGENDA

9:00 **Welcome and Introductions**

9:30 **Meeting Overview**
- Purpose of the meeting
- Overview of Title V and the needs assessment process

10:00 **Break**

10:15 **Discussion of Issues (by target population groups)**
- Review of fact sheets
- Discussion of priority issues
- Discussion of prioritization criteria

11:45 **Lunch and prioritization survey**

12:45 **Problem Mapping Exercise (by target population groups)**
- Introduction to problem mapping method
- Identify/analyze factors that contribute (positively or negatively) to one or two priority issues

Short break at natural stopping point; resume

3:30 **Wrap Up and Next Steps**
- Plans for results of today's meeting
- Follow-up steps
- Meeting evaluation

4:00 **Adjourn**

Attachment 4

Title V (MCH) Block Grant
Needs Assessment Stakeholder Meeting
September 10, 2009

Participant List by Group

Group 1: Pregnant Women, Mothers and Infants

Karen Adamson
Hennepin Co. Public Health
MCH Advisory Task Force

Kenneth Bence
Medica
MCH Advisory Task Force

Julie Burns
St. Louis Co. Public Health
MCH Advisory Task Force

Kathleen Fernbach
MN SIDS Center, Children's Hospital of Minnesota

Candy Kragthorpe
MN Association for Children's Mental Health

Monica Lee
Park Ave Family Practice

Roxana Linares
Centro

Verónica Martinez
Centro

Diane O'Conner
U of M, Center for Woman's Health

Doriscile O'Neal
Minneapolis Dept. of Health and Family Support
Twin Cities Healthy Start
MCH Advisory Task Force

Rosemond Owens
CentraCare Health System
MCH Advisory Task Force
OMMH Advisory Committee

Deb Purfeerst
Rice Co. Public Health
MCH Advisory Task Force

Mary Rossi
Minnesota State University at Mankato, School of Nursing

Jill Wilson
Hennepin Co. Public Health
Hennepin Co. Breastfeeding Coalition

Noya Woodrich
Division of Indian Work

MDH Staff:

Marisa Bargsten
Epidemiologist
Data and Epidemiology Unit

MaryJo Chippendale
Family and Woman's Health Unit
Maternal and Child Health Section

Cheryl Fogarty
Infant Mortality Consultant
Maternal and Child Health Section

Sharon Hesseltine
Child Development Specialist
Maternal and Child Health Section

Lola Jahnke
Follow-Along Coordinator
MN Children and Youth with Special Health Needs Section

Group 2: Children and Adolescent

Shannon Bailey
Dakota Co. Public Health

Kodjo Bossou
Mayo Preventive Medicine Fellow
St. Paul-Ramsey County Public Health

Kathy Brothen
MN Department of Education
MCH Advisory Task Force

Susan Castellano
MN Department of Human Services
MCH Advisory Task Force

Jill Farris
MN Organization for Adolescent Pregnancy, Prevention & Parenting

Coral Garner
Minneapolis Dept. of Health and Family Support
MCH Advisory Task Force

Linda Hanson
Polk Co. Public Health
MCH Advisory Task Force

Joel Hetler
U of M, Center for Excellence in Children's Mental Health
MCH Advisory Task Force

Neal Holton
St. Paul-Ramsey Co. Public Health
MCH Advisory Task Force

Nancy Jost
West Central Initiative Foundation

Dru Osterud
MN Department of Human Services

Chris Reif
U of M, Family Medicine/Community Health

Mary Vanderwert
MN Department of Education, Head Start

Megan Waltz
Ready4K

MDH Staff

Phyllis Brashler
Suicide Prevention Coordinator
MN Children and Youth with Special Health Needs Section

Penny Hatcher
Child and Adolescent Health Unit
Maternal and Child Health Section

LuAnne McNichols
Director of Public Health Nursing
Office of Public Health Practice

Jennifer O'Brien
Adolescent Health Coordinator
Maternal and Child Health Section

Lynnea Piotter
Child Health Consultant
Maternal and Child Health Section

Group 3: Children and Youth with Special Health Care Needs

Marion Aikin Medical Home Parent	**Deborah Harris** Parent	**Joän Patterson** U of M, School of Public Health MCH Advisory Task Force
Lydia Caros Native American Community Clinic MCH Advisory Task Force	**John Hoffman** Parent MCH Advisory Task Force	**Allison Senogles** Parent MCH Advisory Task Force
Glenace Edwall MN Department of Human Services, Children's Mental Health	**Becky Hoot** Olmsted Co. Public Health	**Wendy Ringer** PACER Center
Mary Hartnett Commission of Deaf, DeafBlind, and Hard of Hearing Minnesotans	**Candace Lindow**-Davies MN Hands & Voices	
	Jacki McCormack Arc Greater Twin Cities	
MDH Staff		
Karen Anderson MN Children and Youth with Special Health Needs Section	**Barb Dalbec** Newborn and Child Follow-Up Unit MN Children and Youth with Special Health Needs Section	**John Hurley** Manager MN Children and Youth with Special Health Needs Section
Nancy Blume Community and Systems Development Unit MN Children and Youth with Special Health Needs Section	**Shawn Holmes** Part C Coordinator MN Children and Youth with Special Health Needs Section	**Sarah Thorson** Research Policy and Analysis Unit MN Children and Youth with Special Health Needs Section

Other MDH Staff

Pat Adams Assistant Commissioner	**Maggie Diebel** Director Community and Family Health Division	**Janet Olstad** Assistant Director Community and Family Health Division
Laurel Briske Manager Maternal and Child Health Section	**DeeAnn Finley** MCH Planner Maternal and Child Health Section	**Judy Punyko** State MCH Epidemiologist Data and Epidemiology Unit

Attachment 5

Minnesota Department of Health
Title V Needs Assessment Prioritization Tool

⚜ *Pregnant Women, Mothers and Infants* ⚜

Participant Name:						
Directions: Rate (from 1 to 5) each of the priority issues for this target population based on the following criteria. For criteria definitions, see the Expanded Criteria Definitions handout.						
Criteria ➔ / **Priority Issue⬇**	**Seriousness**	**Evidence-based Strategies**	**Current Resources**	**Momentum for Change**	**Return on Investment**	**Ease of Measurement**
Breastfeeding initiation and duration	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Comprehensive well baby/child care	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Early and adequate prenatal care	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Health Insurance	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Infant and child developmental, social and emotional screening	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Linkage to community resources	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Maternal mental health screening, assessment and treatment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Substance/alcohol use during pregnancy	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Minnesota Department of Health
Title V Needs Assessment Prioritization Tool

⚜ *Children and Adolescents* ⚜

Participant Name:
Directions: Rate (from 1 to 5) each of the priority issues for this target population based on the following criteria. For criteria definitions, see the Expanded Criteria Definitions handout.

Criteria ➔ / **Priority Issue⬇**	**Seriousness**	**Evidence-based Strategies**	**Current Resources**	**Momentum for Change**	**Return on Investment**	**Ease of Measurement**
Alcohol and drugs use	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Child abuse and neglect	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Comprehensive well baby/child care	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Health insurance	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Healthy youth development	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Infant and child developmental, social and emotional screening	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Mental health screening, assessment and treatment	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Nutrition and physical activity	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
School readiness	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Teen pregnancy and teen birth rate	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Minnesota Department of Health
Title V Needs Assessment Prioritization Tool

⚜ *Children and Adolescents with Special Health Care Needs* ⚜

Participant Name:						
Directions: Rate (from 1 to 5) each of the priority issues for this target population based on the following criteria. For criteria definitions, see the Expanded Criteria Definitions handout.						
Criteria ➔ / **Priority Issue⬇**	**Seriousness**	**Evidence-based Strategies**	**Current Resources**	**Momentum for Change**	**Return on Investment**	**Ease of Measurement**
Access to specialty care and services	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Community-based support for children with behavior disorders	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Early identification of young children with special health care needs	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Early intervention for young children with special health care needs	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Families receive needed services	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Health insurance	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Training and family support for children with behavioral issues	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Attachment 6

Title V (MCH) Block Grant
Needs Assessment Stakeholder Meeting
September 10, 2009

Expanded CRITERIA DEFINITIONS

Criterion A: Seriousness of the Issue (Weight: 3)

Expanded Definition: This criterion considers the number of people affected and the changes in that number over time (trends). It considers if targeting a problem affecting a large number of individuals could have a greater impact on the health of the community than one affecting a relatively small number of people. It also addresses if one or more population subgroups (as defined by race, ethnicity, income, insurance status, gender or geography) have significantly worse illness or condition when compared to another group. It also considers.

Rating Scale:
1 = Few individuals affected and no group is disproportionately affected
2 = Moderate number of individuals affected in particular subgroups
3 = Moderate number of individuals affected across the entire population
4 = Large number of individuals affected in particular subgroups
5 = Large number of individuals affected across the entire population

Criterion B: Evidence-Based Strategies (Weight: 2)

Expanded Definition: This means that there is a good chance that the strategies used to intervene in the identified problem will result in an improvement in outcomes. The strategies are shown in research literature, by experts or by local experience to be promising, innovative or proven. This criterion is intended to incorporate three concepts: 1) the existence of a promising or proven strategy, 2) the impact of the strategy (narrow = not affecting a broad array of problems, broad = affecting multiple problems with one strategy) and 3) the ease with which the strategies can be implemented.

Rating Scale:
1 = No known strategies are available
2 = Promising strategies with narrow impact
3 = Proven strategies with narrow impact
4 = Promising strategies that are easy to implement with broad impact
5 = Proven strategies that are easy to implement with broad impact

Criterion C: Current Resources (Weight: 1)

Expanded Definition: This means that there are resources available to address this issue. It can include activities currently taking place at the state or local level to address this issue. It also considers the stability of the resources currently devoted to this issue and the likelihood of additional resources becoming available.

Rating Scale:
1 = No resources are available
2 = No resources are available, but limited resources could be redirected
3 = Limited resources are available
4 = Limited resources are available and these can have an impact on the issue
5 = Ample resources are available

Criterion D: Momentum for Change (Weight: 1)

Expanded Definition: This means that there is an environment that is aware and supportive of choosing an issue as a priority and of directing resources towards improving outcomes associated with this issue. It incorporates the concepts of the importance of the issue to community members or policy makers as well as the potential for communicating the importance of the problem to these groups. It considers if the issue is considered preventable by the community and policy makers.

Rating Scale:
1 = Problem not perceived as important to community or policy makers
2 = Problem not perceived as important but severity can be conveyed to these groups
3 = Recognized as a problem by community but no support from policy makers
4 = Recognized as a problem by both community and policy makers
5 = Strong across the board support to direct resources to intervene

Criterion E: Return on Investment (Weight: 1)

Expanded Definition: This means that there is an appropriate anticipated payoff for the investment of resources devoted to address this issue. This investment could include money, time or other resources that are used to address the issue.

Rating Scale:
1 = Low or high investment, no return
2 = High investment, low return
3 = Low investment, low return
4 = High investment, high return
5 = Low investment, high return

Criterion F: Ease of Measurement (Weight: 2)

Expanded Definition: This means that this issue can be defined clearly enough to identify indicators of change. In addition, consistent data is available to measure the impact of strategies on this issue.

Rating Scale:
1 = No direct or proxy measures available
2 = No direct measures, proxy measures are available but difficult to obtain
3 = Direct data is available but it is difficult to obtain
4 = Proxy data is readily available and easy to obtain
5 = Direct data is readily available and easy to obtain

Minnesota Department of Health
Title V Needs Assessment Capacity Assessment

CRITERIA DEFINITIONS:

A. **Current Activity:** Does MDH or local public health currently conduct activities to address this issue? Are these activities adequate to address this issue?

B. **MCH/PH Responsibility:** Does responsibility for addressing this issue lie primarily within state and/or local MCH/PH? Are there others with equal of greater responsibility for this issue?

C. **Current Resources:** Are the resources devoted to this issue sufficient? Is it probable that more resources can be acquired? Are these resources stable and likely to remain available to address this issue?

D. **Ease of Measurement:** Are measurements available to monitor this issue? Are consistent data available for measure outcomes on this issue? Do we have a measure that will tell us if we are successful?

E. **Political Will:** Will the political environment support this issue? Is addressing this issue politically feasible?

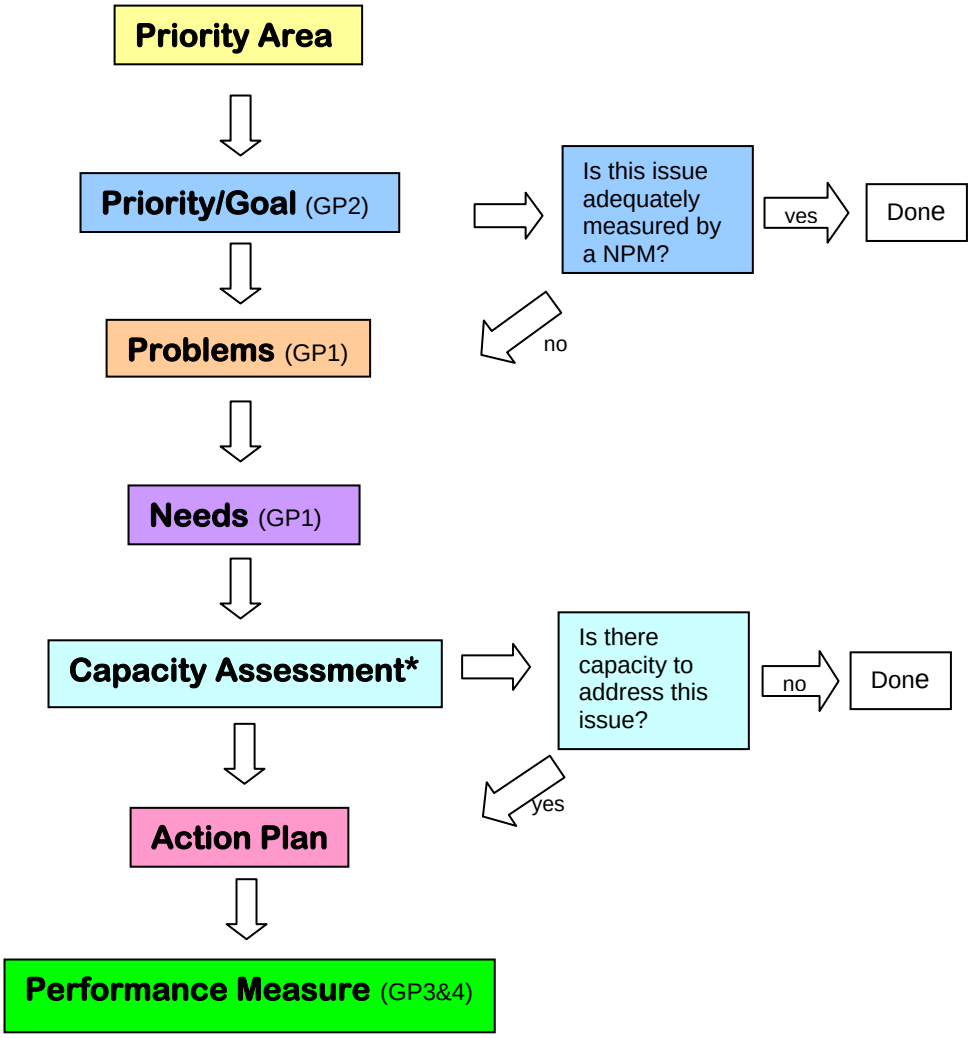
F. **Potential for Change:** Is the environment supportive of choosing this issue and (re)directing resources to address it? Is there significant potential to improve the role of public health in addressing this issue?

1 = minimally 2 = partially 3 = substantially 4 = fully

Priority Issue / Criteria	Comprehensive well baby/child care	Child abuse & neglect	Health insurance (PWMI)	Infant & child develop, social & emotional screening	Linkage to community resources	Maternal mental health screening, assessment & treatment	Substance/ alcohol use during pregnancy	Alcohol and drugs use	Healthy youth develop.	Mental health screening, assessment & treatment	School readiness
Current Activity	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
MCH/PH Responsibility	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Current Resources	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Ease of Measurement	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Political Will	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Potential for Change	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
PRIORITY	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N	Y N

Attachment 8

Decision Tree for Selecting State Priorities



Guiding Principles:

1. Disparity issues will be integrated into the problems and needs.
2. If a national performance measure (NPM) or outcome measure (OM) is sufficient to measure progress on the issue, preference will be given to using that NPM instead of creating a new state performance measure.
3. Data that are currently available will be selected to measure progress on performance measures unless there is compelling evidence that new data are needed.
4. Partnerships with existing programs (including LPH) will be considered during the development of performance measures.

***Capacity Assessment:**

- Does MDH or local public health currently conduct activities to address this issue?
- Should MDH or local public health do something about this issue (i.e., is it a public health responsibility)?
- Do other stakeholders address this issue?
- Are the resources devoted to this issue sufficient?
- Is it probable that more resources can be acquired?
- Are measurements available to monitor this issue?
- Will the political environment support this issue?
- What is the potential for change (e.g. is this an emerging issue)?

Attachment 9

2010 Title V Needs Assessment
Data Sources

Pregnant Women, Mothers and Infants

- Centers for Disease Control and Prevention, National Center for Health Statistics
- National Survey of Children's Health
- National Survey of Children with Special Health Care Needs
- Minnesota Department of Health, Center for Health Statistics
- Minnesota Department of Health, Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS)
- Minnesota Department of Health, Health Economic Program
- Kaiser Family Foundation
- Minnesota Department of Health, Office of Public Health Practice, Local Public Health Planning and Performance Measurement Reporting System
- US Census Bureau
- Minnesota Department of Education
- Urban Institute
- U.S. Department of Health and Human Services, Office of the Surgeon General, SAMHSA
- Minnesota Department of Health, Office of Rural Health and Primary Care
- Minnesota Department of Health, Follow Along Program Report.
- Minnesota Department of Human Services, C&TC Participation Report
- Minnesota Department of Health, Family Home Visiting Program
- Minnesota Child Health Improvement Partnership
- Centers for Disease Control and Prevention, Breastfeeding Report Card
- Minnesota Department of Health, Minnesota WIC Report
- Annie E. Casey Foundation, Kids Count Data Center
- Children's Defense Fund
- Nurse-Family Partnership
- Minnesota Department of Health, Positive Alternatives Program
- National Institute on Drug Abuse

Children and Adolescents

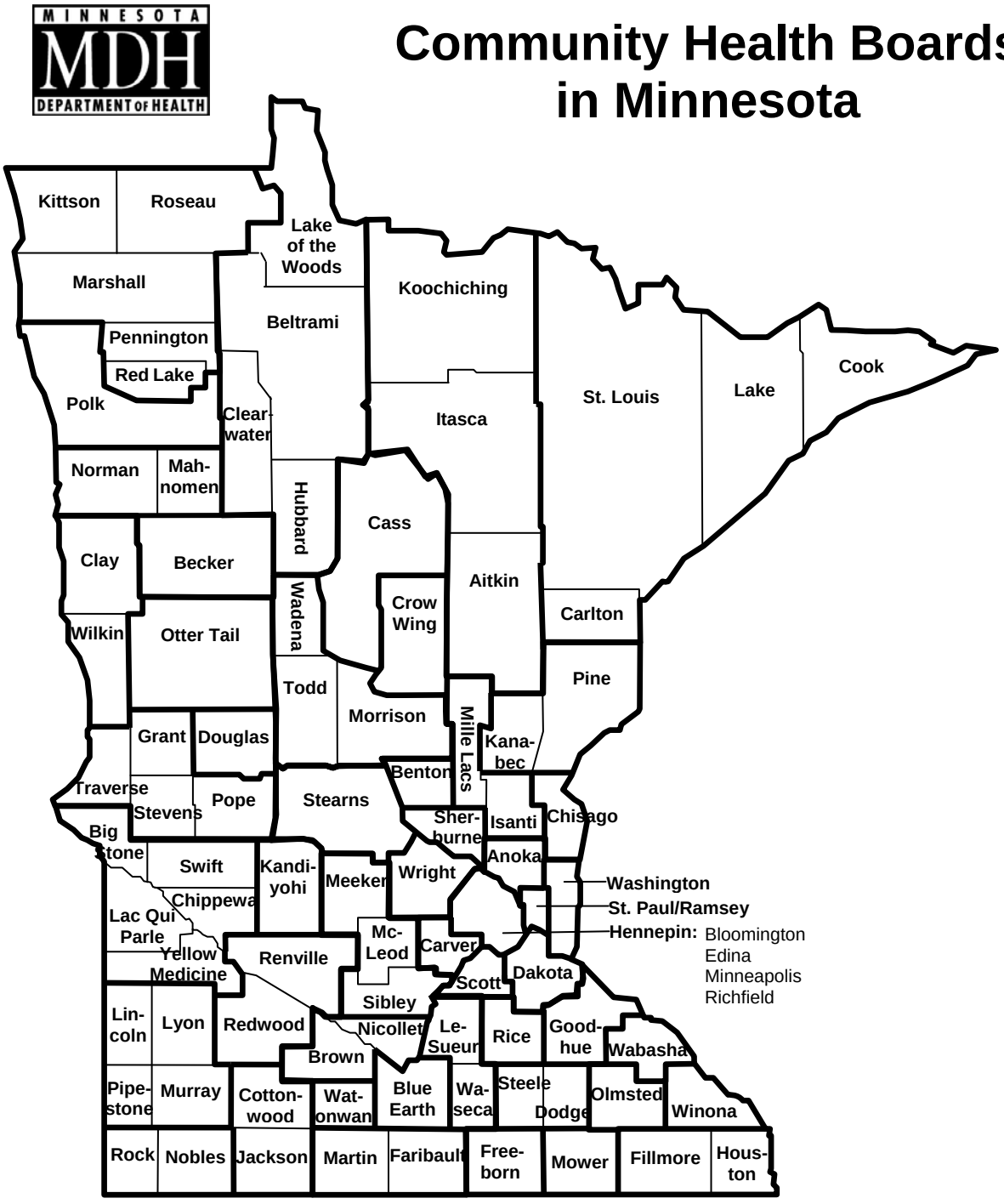
- U.S. Census Bureau
- Minnesota Departments of Education
- National Survey of Children's Health
- Center for Child and Adolescent Health
- Minnesota Department of Health, Office of Rural Health and Primary Care
- Centers for Disease Control and Prevention, Pediatric Nutrition Surveillance System Report
- Centers for Disease Control and Prevention, National Center for Health Statistics

- Minnesota Departments of Education, Health, Human Services and Public Safety, Minnesota Student Survey
- Minnesota Department of Human Services, Minnesota's Child Welfare Report
- Minnesota Department of Human Services, Minnesota Child Mortality Annual Report
- Minnesota Organization on Adolescent Pregnancy, Prevention, and Parenting
- Minnesota Department of Health, Family Home Visiting Program
- University of Minnesota, Minnesota College Student Health Survey
- Wilder Research
- Minnesota Department of Education, Kindergarten readiness study
- Minnesota Department of Education, Early Childhood Screening
- Minnesota Department of Education, School Readiness Program
- Minnesota Department of Education, Head Start
- Minnesota Department of Education, Early Childhood Family Education Program

Children with Special Health Care Needs

- National Survey of Children with Special Health Care Needs
- Office of Special Education Programs, Data Accountability Center
- Minnesota Department of Health, Follow Along Program
- Minnesota Department of Education, Early Childhood Family Education Program
- Minnesota Department of Health, Title V Block Grant State Narrative for Minnesota
- National Survey of Children's Health
- Minnesota Department of Health, Center For Health Statistics
- U.S. Department of Health and Human Services, Center for Medicaid and Medicare Services
- Centers for Disease Control and Prevention, National Center for Health Statistics
- Minnesota Department of Health, Minnesota Children with Special Health Needs Information and Referral Service
- Children's Defense Fund
- Minnesota Departments of Education, Health, Human Services and Public Safety, Minnesota Student Survey
- Minnesota Department of Human Services, Community Mental Health Reporting System

Attachment 10



Attachment 11

Title V (MCH) Block Grant
Issues by Priority Needs

PWMI: Pregnant Women, Mothers and Infants	**C&A**: Children and Adolescents	**CSHCN**: Children with Special Health Care Needs
Definition of measures: SPM = State Performance Measures NPM = National Performance Measures	HSI = Health Status Indicators HOM = Health Outcome Measures HSCI = Health System Capacity Indicators	

Overarching Goals	Overarching Measures
Overarching Goal 1: Increase health equity and reduce health disparities for pregnant women, mothers and infants, children and adolescents, and children with special health care needs.	**HSI 06A&B:** Infants and children aged 0 through 24 years enumerated by sub-populations of age group, race, and ethnicity. **HSI 07A&B:** Live births to women (of all ages) enumerated by maternal age, race and ethnicity. **HSI 10:** Geographic living area for all resident children aged 0 through 19 years **HSI 11:** Percent of the State population at various levels of the federal poverty level **HSI 12:** Percent of the State population aged 0 through 19 years at various levels of the federal poverty level **HSCI 09A:** The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.
Overarching Goal 2: Focus efforts on activities that result in positive outcomes across the lifespan.	

Issue	Target Pop	Was this a priority from the survey?	Current National and State Measures
Priority Need 1: Improve Birth Outcomes			
Substance/alcohol use during pregnancy	PWMI	YES	**NEW State Performance Measure #1:** Percentage of women who did not consume alcohol during the last three months of pregnancy. **NPM 15:** Percentage of women who smoke in the last three months of pregnancy.
Early and adequate prenatal care	PWMI	YES	**NPM 18:** Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. **HSCI 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.
Reduce teen pregnancy and teen birth rate	C&A	YES	**NPM 8:** The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
High risk newborn care	PWMI	NO	**NPM 17:** Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
Birth weight	PWMI	NO	**HSI 01A:** The percent of live births weighing less than 2,500 grams **HSI 01B:** The percent of live singleton births weighing less than 2,500 grams **HSI 02A:** The percent of live births weighing less than 1,500 grams **HSI 02B:** The percent of live singleton births weighing less than 1,500 grams.
Infant mortality	PWMI	NO	**HOM 1:** The infant mortality rate per 1,000 live births. **HOM 2:** The ratio of the black infant mortality rate to the white infant mortality **HOM 3:** The neonatal mortality rate per 1,000 live births. **HOM 4:** The post-neonatal mortality rate per 1,000 live births. **HOM 5:** The perinatal mortality rate per 1,000 live births plus fetal deaths.
Priority Need 2: Improve the Health of Children and Adolescents			
Comprehensive well baby/child care	PWMI CA	YES	**REVISED State Performance Measure #2:** Percentage of children enrolled in Medicaid who receive at least one recommended Child and Teen Checkup (C&TC) visit (EPSDT is known as C&TC in Minnesota). **NPM 7:** Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Alcohol and drugs use	CA	YES	**HSCI 09B:** The ability of States to monitor tobacco use by children and youth.
Breastfeeding initiation and duration	PWMI	YES	**NPM 11:** The percent of mothers who breastfeed their infants at 6 months of age.
Nutrition and physical activity	CA	YES	**NPM 14:** Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.
Oral Health	CA	NO	**NPM 9:** Percent of third grade children who have received protective sealants on at least one permanent molar tooth. **HSCI 07B:** The percent of EPSDT eligible children Medicaid aged 6 through 9 years who have received any dental services during the year.
Asthma	CA	NO	**HSCI 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.
STD/STIs	CA	NO	**HSI 05A:** The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia. **HSI 05B:** The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.
Priority Need 3: **Promote Optimal Mental Health**			
Maternal mental health screening, assessment and treatment	PWMI	YES	
Mental health screening, assessment and treatment	CA	YES	**NEW State Performance Measure #3:** Percentage of Minnesota children birth to 5 enrolled in Medicaid who received a mental health screening using a standardized instrument as part of their Child and Teen Checkup (C&TC) visit (EPSDT is known as C&TC in Minnesota). **NPM 16:** The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
Training and family support for children with behavioral issues/mental illness	CSHCN	YES	
Community-based support for children with behavior disorders/mental illness	CSHCN	YES	
Priority Need 4: **Reduce Child Injury and Death**			
Child abuse and neglect	CA	YES	**REVISED State Performance Measure #4:** Rate of cases of child maltreatment.
Motor vehicle injury or death	CA	NO	**NPM 10:** The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children. **HSI 03B:** The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger. **HSI 03C:** The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years. **HSI 04B:** The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger. **HSI 04C:** The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.
Injury	CA	NO	**HSI 03A:** The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger. **HSI 04A:** The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.
Child death	CA	NO	**HOM 6:** The child death rate per 100,000 children aged 1 through14. **HSI 08A&B:** Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity.
Priority Need 5: **Assure Quality Screening, Identification, and Intervention**			
Infant and child developmental, social and emotional screening	PWMI CA	YES	**NEW State Performance Measure #5:** The number of children enrolled in the Follow-Along Program. **HSCI 02:** The percent Medicaid enrollees whose age is less than one year who received at least one initial or periodic screening. **HSCI 03:** The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year who received at least one periodic screen.

Early identification of young children with special health care needs	CSHCN	YES	**NPM 12:** Percentage of newborns who have been screened for hearing before hospital discharge.
Early intervention for young children with special health care needs	CSHCN	YES	**NEW State Performance Measure #6:** Percentage of children under the age of one year participating in early intervention through Part C of the Individuals with Disabilities Education Act. **NPM 1:** The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.
Priority Need 6: **Improve Access to Quality Health Care and Needed Services**			
Linkage to community resources	PWMI	YES	**NEW State Performance Measure #7:** Percentage of participants in Minnesota's family home visiting program referred to community resources that received a family home visitor follow-up on that referral.
Families receive needed services	CSHCN	YES	**NPM 5:** Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.
Access to specialty care and services	CSHCN	YES	**NEW State Performance Measure #8:** Percentage of children and youth with special health care needs that have received all needed health care services. (National Survey of CSHCN) **HSCI 08:** The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program.
Health insurance	PWMI CA CSHCN	YES	**NEW State Performance Measure #9:** Percentage of families of children age 0-17 that report costs not covered by insurance are usually or always reasonable. **NPM 4:** The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. **NPM 13:** Percent of children without health insurance. **HSI 09A&B:** Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity **HSCI 05:** Comparison of health system capacity indicators for Medicaid, Non-Medicaid, and all MCH populations in the State. **HSCI 06:** The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women. **HSCI 07A**: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.
Families partner in decision making	CSHCN	NO	**NPM 2:** The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.
Access to a medical home	CSHCN	NO	**NPM 3:** The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
Priority Need 7: **Assure Healthy Youth Development**			
Healthy youth development	CA	YES	**NEW State Performance Measure #10:** By 2013, collaborate with other state agencies to identify a state performance measure and benchmark to monitor positive youth development in Minnesota.
School readiness	CA	YES	
Transition to adulthood for CSHCN	CSHCN	NO	**NPM 6:** The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.