Community and Family Health Annual Report 2016

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INTRODUCTION

Research has shown that the health of individuals throughout life is greatly influenced by experiences early in life. The Community and Family Health (CFH) Division at the Minnesota Department of Health (MDH) focuses its efforts on helping to ensure that the environments into which children are born and grow up create the conditions that allow them to be as healthy as possible throughout childhood and into adulthood. Of particular focus are families that experience the greatest disparities in health outcomes – families living in poverty, families of color and American Indians, and children and youth with special health needs. The CFH Division works to improve factors that best promote a child's success.

We help ensure that pregnancies are planned and healthy *so that*

Babies are born healthy and have safe, stable, and nurturing relationships and environments *so that*

They develop physically, mentally, emotionally and socially on track throughout childhood and adolescence *so that*

They can become productive and fulfilled members of families, communities and society!

More specifically, we

- Increase the proportion of pregnancies that are planned so families are better prepared to raise a child.
- Improve the health of women so babies are born healthy.
- Improve outcomes for children by giving them the healthy food they need for a strong body and brain.
- Support families at risk for child abuse and neglect, poor health, and poor school performance.
- Help young children develop the skills they need to be ready for kindergarten.
- Identify children with special needs early so they can receive the services and support they need to perform better in school and life, and reach their full potential.
- Support adolescents and their families so they are better prepared to do well in school and to graduate.

It's in the experience of the most vulnerable Minnesotans – women, infants and children of color, American Indians, those experiencing poverty, and those with special health needs – that the negative impact of health inequities is most evident. While this report provides only a snapshot of the work we do, it highlights activities that illustrate the breadth of our work and the commitment of our very competent staff to reducing health disparities and improving outcomes for all Minnesota families.

Maggie Diebel
Director, Community and Family Health Division

STARTING EARLY MATTERS

Neuroscience and behavioral research confirm that the foundation for future relationships, health, and the capacity to learn and thrive throughout life begins before birth and is strongly influenced by what happens prenatally and during the first three years of life. The importance of a healthy birth, safe, stable, nurturing relationships and environments, and social and economic security is critical to a thriving childhood and a healthy future.

During pregnancy and the first three years of life, the brain is developing and forming neural pathways at its most rapid rate of the entire life course.[1] While genes are responsible for basic architecture of the brain, experiences and environment play critical roles in developing the capacity and functionality of the brain.

Too many pregnant and parenting families with infants and toddlers in Minnesota live in poverty and face significant adversities such as having a teen parent, living in unstable housing, being hungry, being at risk for abuse and neglect, living with parental substance abuse, living with a parent experiencing mental illness, or living with racial and other forms of discrimination.[2]

A healthy start in life is more likely when pregnant and parenting families with young children have equitable opportunities for health including having healthy food and breastfeeding supports, safe and stable housing, preconception and prenatal care, parenting supports, developmental screening for children and maternal depression screening for mothers, transportation supports, and more. [3]

[1] Center on the Developing Child at Harvard University (2010). *The Foundations of Lifelong Health Are Built in Early Childhood.* http://www.developingchild.harvard.edu

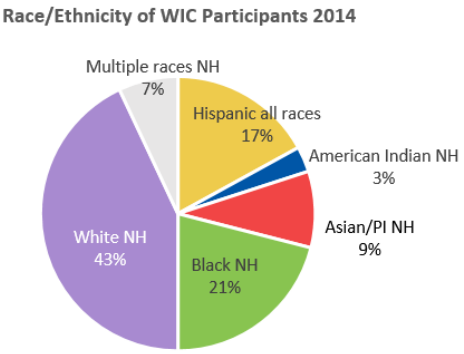
[2] Minnesota Department of Health (2014). *The Earliest Opportunities Matter* http://www.health.state.mn.us/divs/cfh/program/pto3/content/document/pdf/opportunities.pdf

[3] *Ibid*.

Advancing Health Equity in the WIC Program

WIC aims to improve lifelong health outcomes

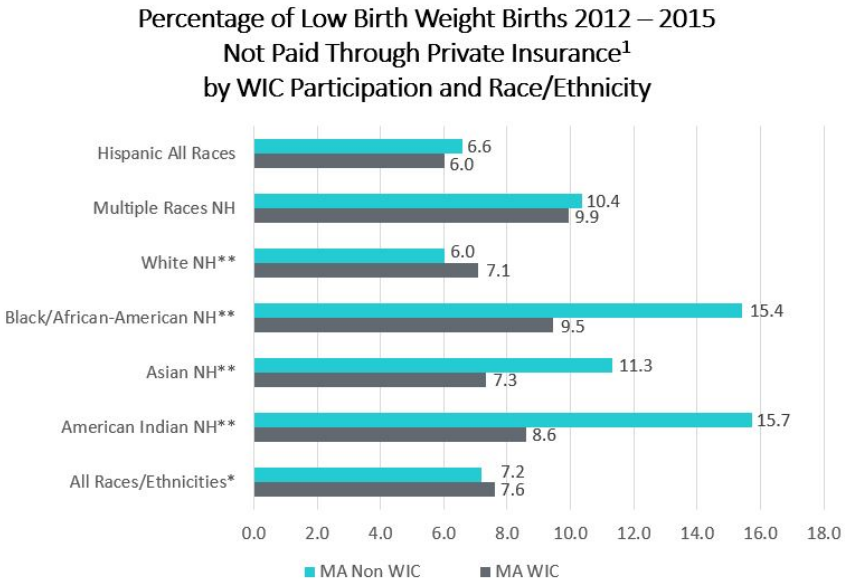
The Supplemental Nutrition Program for Women, Infant and Children (WIC), housed within CFH, is a public health nutrition program for pregnant and postpartum women, infants and children up to age five. WIC provides nutrition assessment and counseling, breastfeeding support, referrals into other health and social services, and healthy foods. The nutrition services provided by the MN WIC Program are intended to support positive birth outcomes, promote healthy growth and development, increase breastfeeding rates and reduce rates of obesity and anemia.



WIC interventions target the preconception period through the first five years of life. Through grants to Local Public Health, Tribal Governments and Community Action Programs throughout the state, WIC serves almost half of all infants born in Minnesota, and a large majority of low-income, food insecure and other vulnerable families.

WIC participants have better birth outcomes than nonparticipants

The services and benefits of WIC reduce racial disparities in birth outcomes such as rates of *low birth weight*. American Indian and Black/African American women who participate in WIC have significantly lower rates of *low birth weight* compared to similar women who do not participate in WIC.



** p <0.0001 * p<0.05
[1] includes Medicaid (74%), Tricare/Champus/other/unknown (20%), uninsured (6%)

Breastfeeding promotion and support in Minnesota WIC

Breastfeeding protects maternal and infant health in many ways, both short and long term. Providing support to individuals and reducing environmental barriers to breastfeeding reduces health disparities and can contribute to the health of the broader community. *Healthy Minnesota 2020* identifies breastfeeding as one of three factors related to the priority "Capitalize on the opportunity to influence health in early childhood." Healthier mothers and infants benefit society by reducing health care costs. If 90% of families breastfed exclusively for six months, Minnesota could save an estimated $130 million per year in health care costs. Breastfeeding also contributes to healthy weight status for both mother and child.

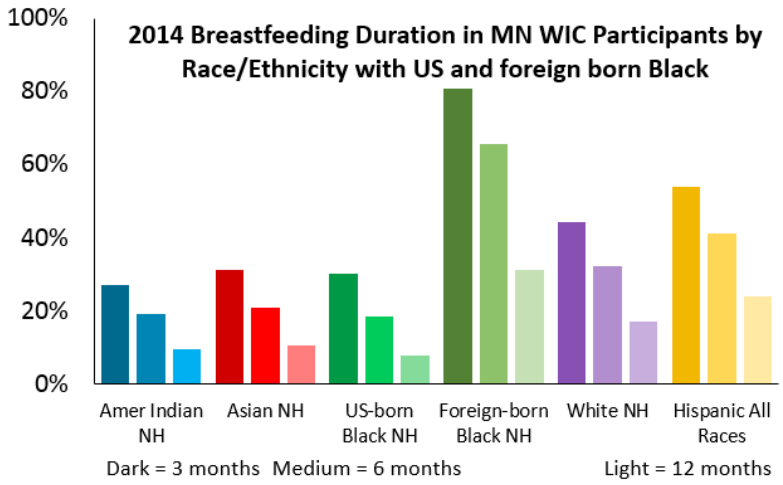
Infants' Health Indicator Breastfeeding	Most Current Map	Reference Year 2012 Totals by County	Most Current Year 2014 Totals by County	Progress Direction
Initiation		76.0 %	80.0 %	Improved
Duration 1 month		57.7 %	61.7%	Improved
Duration 3 months		43.2 %	47.3 %	Improved
Duration 6 months		32.1 %	34.9 %	Improved
Duration 12 months		13.6 %	17.9 %	Improved

WIC tracks health measures by race/ethnicity

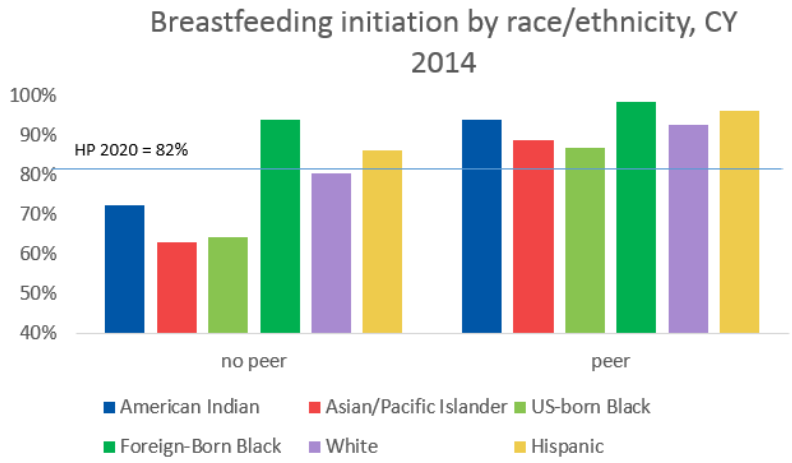
WIC reports on many health outcomes, including breastfeeding, weight status, anemia and other pregnancy risk factors. This information can be found in the WIC data wheel.

Disparities in breastfeeding rates are dramatic but improving. While progress is being made, disparities in breastfeeding rates between racial and ethnic groups remain a challenge. WIC works in partnership with others in MDH, other state agencies, state and local breastfeeding coalitions, hospitals, clinics, cultural organizations, La Leche League, and many others to support women in overcoming barriers in meeting their breastfeeding goals.

WIC has increased its ability to track by cultural identity and country of origin within race/ethnicity categories. Some racial categories span disparate communities. For example, the racial category "Black/African American" includes those who identify as African American as well as those who identify as Somali or Liberian. The ability to separate breastfeeding rates by US-born and non-US born Black/African American uncovers previously hidden health disparities.

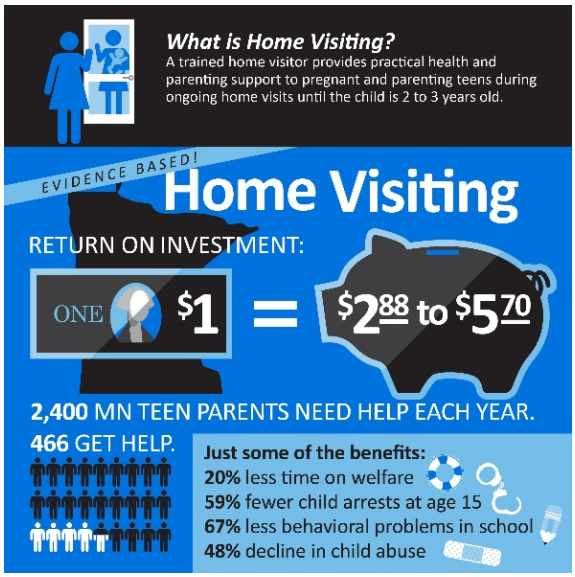


The WIC Peer Breastfeeding Support Program decreases disparities in breastfeeding initiation rates. Peer Counselors are mothers who have breastfed an infant and are trained to help other WIC mothers with common breastfeeding questions. Peers are hired from the communities they will serve, so they share a culture and language. Peer program participants have higher initiation rates than those not receiving peer support, and exceed the Healthy People 2020 goal of 82% for breastfeeding initiation. Due to limited funds, peer program support is not available in all WIC programs. As funding permits, additional peer programs are added.



Pregnant and Parenting Teens: One Population that Benefits from Family Home Visiting

For at least 100 years, home visiting has been used as a service delivery strategy to improve the health and well-being of families. The goal of Minnesota's Family Home Visiting (FHV) 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 health and economic self-sufficiency for children and families.



Providing services to pregnant and parenting teens is a priority area for home visiting services given the strong evidence for poor outcomes for both teen parents and children born to teen parents. These poor outcomes include higher rates of prematurity, low birthweight, and developmental delays; lower high-school graduation rates; and lifelong and intergenerational poverty. [4,5] This is a critical time period to intervene in both the young mother's and the child's life. Evidence-based home visiting is an effective upstream intervention that can serve as a key link to other early childhood interventions and community supports such as quality child care, special education and other services that collectively will make a difference in the lives of parents and children.

- Teens who become pregnant are less likely to complete high school or the equivalent
- Daughters born to teen parents are more likely to become teen parents
- Sons born to teen parents are more likely to become incarcerated.[2]

QUOTES FROM TEENS

"I don't have to let the way I was raised determine the quality of mother I can be for my children."

"Thank you! You have been the biggest blessing to us this far. Your support has kept me going. You are very special to us and I don't believe we'd be this successful without you."

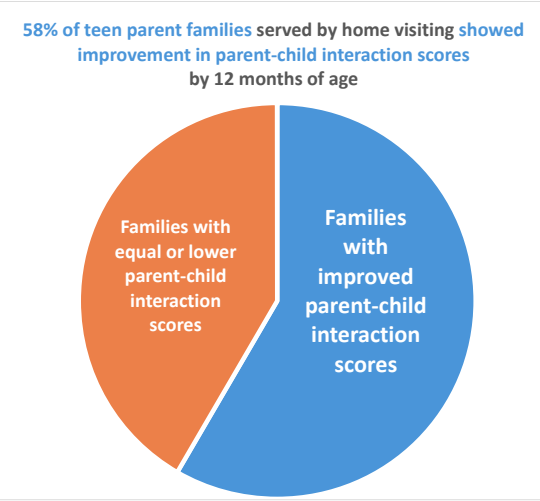
The CFH Division, through the FHV Section, provides oversight, guidance and statewide evaluation of family home visiting programs administered at the local level. Grants are distributed to local public health departments and tribal governments. Pregnant and parenting

[4] Terry-Humen, E., Manlove, J., and Moore, KA, (2005). Playing Catch-Up: How Children Born to Teen Mothers Fare, The National Campaign to Prevent Teen Pregnancy: Washington, DC

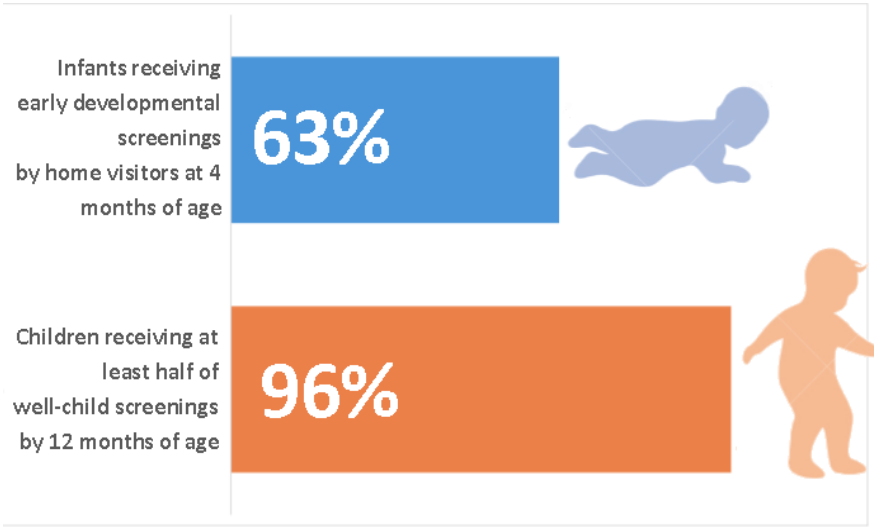
[5] Hoffman, S.D., (2006) *By the Numbers: The Public Costs of Adolescent Childbearing.* The National Campaign to Prevent Teen Pregnancy: Washington, DC.

teens who are at or below 200 percent of federal poverty guidelines, or who reside in high-risk communities, are eligible to be served by these programs.

Providing evidence-based support to young mothers and their children can have a major positive impact on their lives and can mitigate some common consequences of teen pregnancy.



Infants and children who are screened early and periodically for developmental and social emotional delays have a better chance of receiving any early intervention that may be needed. Family home visiting programs coordinate with the family's primary care provider to assure screening happens. Knowing what to expect at a certain age and being able to recognize a child's cues about when he or she is tired, hungry, excited, happy, confused or distressed makes a big difference in a caregiver's confidence and the child's sense of security. In 2014, 149 caregivers were observed at least twice by home visitors who used standardized tools to measure changes in the quality of caregiver-child interaction by the time the child was 12 months old. Of those caregivers, 58 percent had improved scores for one or more aspects of caregiver-child interaction at the second observation.



Success Stories

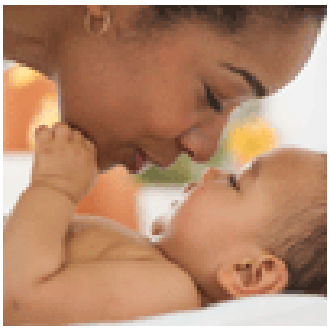
For a teen mother, enrolling in a family home visiting program can make a positive difference for both her and her child. Minnesota already has some great real-life examples of these positive outcomes.

A High School Junior is exclusively breastfeeding her 4 ½ month old daughter.

A 17 year old pregnant mom was not attending school and was living in unstable housing. Since enrolling in family home visiting, she has found stable housing, is attending classes for her GED and is exclusively breastfeeding her 3 ½ month old son.

A High School junior is employed part time while attending school. She has worked hard to get ahead in credits and will now be able to attend college as a PSEO student next fall. Her daughter is 10 months old.

A pregnant 18 year old was sleeping on the couch in a two bedroom trailer with her mom, dad, brother, and two nieces when she enrolled in family home visiting. The father of her baby was in jail. She was not in school and had only completed the 10th grade. Since enrollment in family home visiting, she has returned to school, found her own housing and has been accepted into a program that will help pay for her rent while she is attending school.



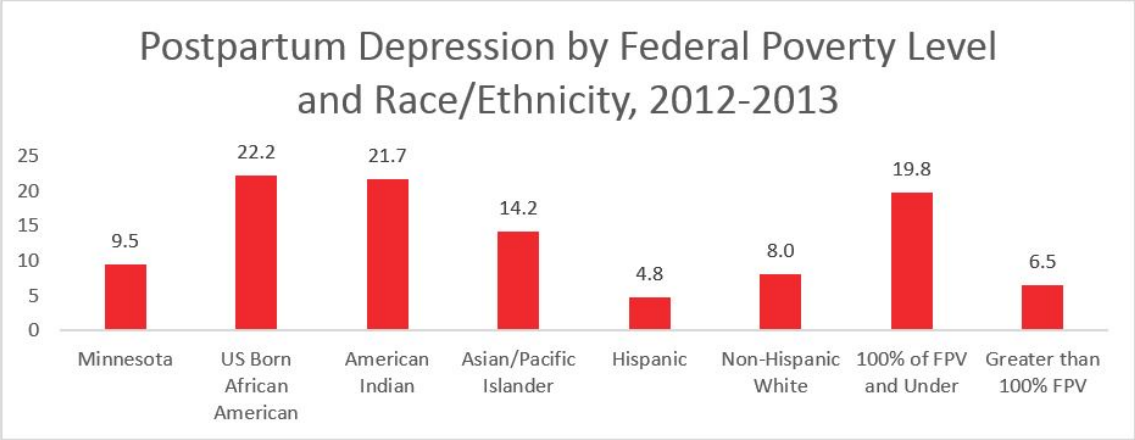
Since enrolling in family home visiting, a teen who is home schooled decided she wanted to breastfeed her infant and asked her nurse home visitor to help her learn more. She is also improving her math skills as she would like to go to college and someday become a nurse.

Investing in home visiting ensures a strong foundation and better outcomes for pregnant and parenting teens and their children. Starting early matters and provides lasting benefits to these families.

Pregnancy and Postpartum Depression and/or Anxiety

The most common problems during and after pregnancy – clinical depression and/or anxiety – can lead to negative health outcomes for both babies and mothers. The presence of postpartum depression can have adverse effects on child development, both before and after birth. Pregnant women that are depressed produce higher levels of stress chemicals during pregnancy that reduce fetal growth and are associated with an increased risk for premature birth.[6] Postpartum depression can make it harder for caregivers to provide the love and care necessary to make infants feels safe and secure. Insecurity can result in higher levels of stress chemicals within the baby that can adversely affect development and alter the immune system, making it more difficult to learn and increasing susceptibility to infections.

In Minnesota, and nationally, only a small fraction of women who have pregnancy or postpartum depression are diagnosed, and only a subset of those receive effective treatment. Women of color, American Indian women, and women with low incomes have higher rates of depression and anxiety.



FPV: Federal Poverty Level - All Races exclude Hispanic ethnicity
Source: Pregnancy Risk Assessment Monitoring System (PRAMS), 2012-2013, Minnesota

Through policy changes, professional education, targeted provider outreach, and specific efforts to increase access to treatment for women of color and American Indians, CFH has led

[6] Diego, M. A., Field, T., Hernandez-Reif, M., Schanberg, S., Kuhn, C., & Gonzalez-Quintero, V. H. (2009). Prenatal depression restricts fetal growth. *Early Human Development*, **85**, 65-70.

the way nationally in the push to connect women with effective treatment. One of the first steps is ensuring that all women are adequately screened in pregnancy and during the postpartum period.

In 2016, CFH completed a quality improvement project focused on implementing postpartum depression screening during infant well child visits, now a nationally recommended best practice.

Key outcomes of the Postpartum Depression Screening project include:

- 2,885 women were screened for postpartum depression and 203 were referred for treatment (some who showed a concern were treated by the screening provider, when appropriate).
- Increase in number of screens allowed (billable) for women in the postpartum year.
- Two large health systems are incorporating the screening and referral practice into 27 clinics.
- Publication of "Clinical Guidelines for Implementing Universal Postpartum Depression Screening in Well Child Checks," that is being adopted by the American Academy of Pediatrics.
- Creation of "My Maternal Wellbeing Plan" an education tool designed to support mothers in maintaining positive mental health during and after pregnancy.

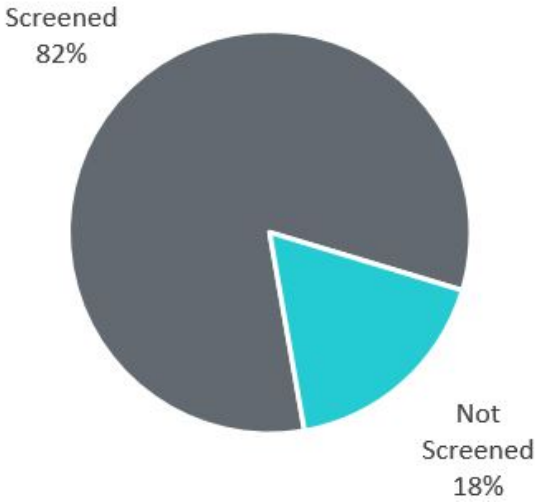
The guidelines and algorithms for pediatric providers developed under the project, proved so useful that MDH launched an additional round of quality improvement with a broader scope of organizations. The current project supports nine teams that include community organizations, local public health agencies, and pediatric, family medicine, labor and delivery, and OB/GYN practitioners. These teams, along with an advisory group, will implement universal screening and referral in their settings and develop guidance for others.

Although health providers and community stakeholders, along with most women, are aware of this important issue, there are still many barriers to accessing successful and appropriate treatment. CFH updated the Pregnancy and Postpartum Depression Fact Sheets and Wellbeing Plan in seven languages and has begun outreach to birthing hospitals. The Maternal Mental Health Advisory Group, initially created to advise the quality improvement project but now has a broader scope that includes statewide education and policy, has developed key messages for health providers to use in talking with women about pregnancy and postpartum depression and anxiety.

In an effort to specifically address the gap in accessible treatment for women of color and Native American women, the Maternal Wellbeing Program was created with a Community Innovation Grant from the Bush Foundation. Currently, three pilot projects are serving women in the Karen community in St. Paul, African and African American women in Minneapolis, and American Indian women in the broader Bemidji region. The grantees have tested a variety of mental health and wellbeing screening tools and built partnerships with mental health providers to strengthen referrals.

CFH has also led the state in incorporating universal postpartum depression screening within local family home visiting programs. The FHV Section provides training and resources to home visitors on depression screening, referrals, and ongoing support. In 2014, 82% of postpartum women served by local public health family home visiting programs were screened for postpartum depression at least once before their infant turned 3 months old. Home visitors are in an ideal position to help new mothers access treatment, and to provide long-term support for continuing or completing treatment.

Percent of postpartum women enrolled in family home visiting that were screened for postpartum depressive symptoms at least once between the birth of their infant and 3 months postpartum in 2014



Source: Family Home Visiting Reporting and Evaluation System (FHVRES) and Nurse Family Partnership Efforts to Outcomes (NFP-ETO) system, as of December 07, 2015. Data are limited to clients in public health family home visiting programs, who were active during Calendar Year 2014.

MAKING SURE KIDS ARE ON THE RIGHT TRACK

The first years of a child's life are a time of rapid growth and development. Most children will reach specific developmental and social-emotional milestones, such as walking, talking and playing with others, within a targeted age range. However, some children may need extra help to catch up and stay on track. It is essential to provide support for a child experiencing delays as early as possible to reduce or completely avoid any long-term impact to the child's development. Supporting caregivers with early childhood guidance and age-appropriate developmental resources is an important step to assuring that any concerns are recognized as early as possible. By accessing timely health and nutrition services, periodic developmental screening, and supportive community programs, children will be better able to reach their growth and development milestones, stay on track with other children their age, and achieve their greatest potential.

Promoting Healthy Early Childhood Development through Screening

Early intervention for developmental and social-emotional delays makes a real difference for children's health and educational outcomes, and for family well-being. Prenatally and in the first three years of life, the child's developing brain is more sensitive both to harm (for example, lead in the environment) *and* to help (such as early intervention services). Standardized developmental and social-emotional screening is a proven and efficient way to identify children who may need more comprehensive evaluation, and who could benefit most from early intervention.

The CFH Division is focused on ensuring routine and periodic developmental and social-emotional screening for all infants, toddlers, and young children in Minnesota. This includes providing practical resources like training and technical assistance, and ensuring that our public screening and referral systems are coordinated across state agencies, programs and systems.

Coordination

Minnesota Interagency Developmental Screening Task Force

The Minnesota Interagency Developmental Screening Task Force convenes staff from MDH, Department of Human Services (DHS) and Minnesota Department of Education (MDE). Maternal and Child Health (MCH) staff within CFH facilitate regular meetings of the Task Force, and provide in-depth psychometric review of standardized screening instruments. Other CFH staff participate in the Task Force as well, to ensure coordination, quality, and alignment of screening activities across programs.

Early Childhood Comprehensive Systems

The work of Minnesota's Early Childhood Comprehensive Systems (ECCS) federal grant culminated in 2016. MCH staff convened public and private early childhood partners to ensure cohesive state systems for universal developmental and social-emotional screening, referral, and linkage to services for young children and their families. Outcomes included:

- Development of a training toolkit for public screening programs on developmental and social-emotional screening and referral:
  - This curriculum is current, aligned, and approved by the Minnesota Department of Health (MDH), the Department of Human Services (DHS) and the Minnesota Department of Education (MDE). It is available on the Training webpage of the Task Force website.

- Guidance for communication and coordination between clinics and schools for early intervention referrals:
  - The Sharing Child Information to Coordinate Early Childhood Special Education Referrals fact sheet provides guidance for clinic primary care providers and school early childhood special education staff on communication and coordination of early intervention referrals. It clarifies data privacy requirements for sharing information throughout the process.
- Better understanding of child care providers' role in screening:
  - A statewide survey of licensed family and center-based child care providers showed that standardized screening is relatively rare in this setting, and that child care providers would like to partner with local screening programs to help support universal screening. More information is available online in the full report: An Important Partnership in Child Development: Child Care Providers and Screening Programs, or briefer summary report.
- Support of electronic screening initiative:
  - Children and Youth with Special Health Needs (CYSHN) and Maternal and Child Health (MCH) staff supported an electronic screening pilot project in collaboration with the MDE under the Race to the Top Early Learning challenge grant. A variety of screening programs (clinics, Head Start, public health, and educational) across the state piloted an electronic version of the Ages and Stages Questionnaires (ASQ) for developmental and social-emotional screening. The focus was on equity for families with English language and literacy limitations, and on cross-sector coordination of screening and referral. The

majority of the pilot sites successfully implemented electronic screening in their programs, and both challenges and benefits were identified for programs and families.

- Moving toward centralized access to existing services:
  - Community and Family Health (CFH) continues to work across the MDH and with MDE and DHS on the implementation of expanded Help Me Grow, to ensure centralized, "no-wrong-door" access to existing services that support healthy child development.

Consultation and collaboration

MCH nurse specialists provide consultation to the DHS Child and Teen Checkups program through an interagency agreement. In 2016, the Child and Teen Checkups Periodicity Schedule, which guides pediatric preventive health care services for Medicaid-eligible children, was updated by DHS, in consultation with MCH staff to more clearly outline recommendations for developmental, social-emotional, autism, and maternal depression screenings. Medicaid policy was also updated to allow for increased screening for maternal depression in infant well child visits.

Significant work occurs across programs in CFH. The FHV and CYSHN Programs recommend and routinely provide developmental and social-emotional screening and referrals, and help connect families to needed services. By 12 months of age, 96% of infants served by these programs have received at least half of their well-child visits, and at least 58% of these infants have been screened for developmental delay by four months. CYSHN staff provide technical assistance and consultation to local Follow Along Programs that provide developmental and social emotional screening for infants and toddlers up to age three using the ASQ and ASQ-SE screening questionnaires. Follow Along Programs, implemented in eighty Minnesota counties, vary in whether they are universal or targeted to specific children, and in how frequently screening surveys are sent to families.

Training

In addition to the training toolkit developed through ECCS, CFH staff continue to coordinate within MDH and across agencies to provide in-person training on developmental and social-emotional screening, referral, and links to screening programs across the state. The Minnesota Interagency Developmental Screening Task Force and ECCS work have helped to ensure that training is aligned across state agencies and various programs, and is current, evidence-based, and impactful. CFH staff are also coordinating with the University of Minnesota (UMN) Institute for Child Development, UMN School of Medicine, Minnesota Academy of Pediatrics, and other partners to develop an Infant and Toddler Mental Health electronic training module that will be piloted and evaluated with pediatric residents, and then made available statewide to health care providers.

Quality Improvement

Minnesota engaged in an 11-month clinical quality improvement learning collaborative, the Assuring Better Child Health and Development (ABCD) Family Medicine Project, to improve

screening, referral, and feedback processes for children ages birth to five with suspected developmental or social-emotional delays. This work was led by MCH staff, with Race to the Top Early Learning Challenge funding.

The clinic teams, led by medical providers, worked with local schools and public health staff to set system-wide screening schedules with standardized, state-recommended tools, and to increase communication regarding hard to reach families. Seven of the teams included parent partners (family members of children who had or were currently using early intervention services). Working with partners from MDE and Help Me Grow (the state's early childhood special education referral system), teams were able to increase screening, strengthen referrals, and move forward on closing the feedback loop.

Fourteen clinic teams joined the project, reaching over 16,000 children. Key sustained accomplishments of the project teams included:

- Implemented standard referral to Help Me Grow from the Neonatal Intensive Care Unit at Sanford Bemidji Hospital
- Built a community stakeholder team to address barriers specific to Hmong families in north Minneapolis at NorthPoint Health & Wellness Center
- Set a system-wide screening schedule for all Hennepin County Medical Center Clinics
- Providers trained on referring children to Help Me Grow at sick visits (not only at well child visits)
- Used a public health nurse to follow up with families visiting the Cass Lake Indian Health Board emergency room who were behind on their well child visits and screening
- Mailed out screens from Mayo Clinic Kasson to families pre-visit and for those children who were missing screens (a surprising 30% return!)

CYSHN Navigator: Connecting Families to Resources for their Children and Youth with Special Health Needs

Easy and effective connections to needed services are essential to the health and well-being of CYSHN. Approximately one in five households in Minnesota have a child or youth with a chronic physical, mental, emotional or behavioral health need and could benefit from family-friendly tools that enable easy navigation to a wide variety of medical, psychosocial, educational and other support resources.

To address this need, the CYSHN Section developed the CYSHN Navigator in collaboration with the MDH and DHS and with help from families, providers and professionals. A statewide online resource directory tool, the Navigator helps to direct families, and health as well as other providers to services and supports for children and youth with special health needs. Through the site, families are able to directly search for a known service or providers, or can instead navigate through topic questions toward a resource list tailored to their child or youth with special health needs.

The CYSHN Navigator:

- Helps families define needs and connect with diagnosis specific and other needed resources locally.
- Helps professionals identify local resources.
- Connects families with specialists who can answer questions and help find needed services via phone or live chat.
- Connects families of CYSHN with other parents who are trained in helping guide families through the systems and services that support children and youth with special health needs.

During the 2016 summer, the CYSHN Navigator went live and was promoted at the Minnesota State Fair. While still live, it is currently undergoing functional updates to improve the tailoring of resource lists relevant to families of CYSHN. As the site evolves, resource listings will continue to expand in response to family and provider input. Through continuous quality improvement of the site, families of CYSHN will gain easier access to needed local services and supports to improve the health and wellbeing of their child or youth with a special health need.

Minnesota Student Parent Support Initiative

MDH was funded by the U.S. Department of Health and Human Services, Office of Adolescent Health to implement the Minnesota Student Parent Support Initiative.[7] The Initiative has three goals: Expectant and parenting teens and young adults will accomplish their post-secondary education goals; they will maintain positive health and well-being for themselves and their children; and the participating institutions of higher education will increase their capacity to serve expectant and/or parenting college students. These students are referred to as student parents.

Pursuit of post-secondary education is a public health issue because educational attainment is associated with better health outcomes.[8] Adults with greater educational attainment are more likely to rate their health as very good.[9] For both men and women, more education typically means longer life. College graduates can expect to live at least 5 years longer than individuals who have not finished high school.[10] Adolescent pregnancy and/or parenting can negatively impact educational advancement. According to the Minnesota[11] Pregnancy Risk Assessment Monitoring System (PRAMS) survey, 33.9% of new mothers who report having a high school education or less also report that their pregnancy was not intended compared to 15.8% who were graduates from college or graduate school. Thirty three percent of student parents participating in this initiative, reported their first pregnancy as a teenager.[12]

To better serve these and other non-traditional students, MDH granted awards to nine institutions of higher education[13] to provide academic, health and social services for expectant and/or parenting students and their children. These include a private university, tribal colleges,

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[7] The project described was supported by Grant Number 6SP1AH000022-04-01 from the U.S. Department of Health and Human Services.

[8] Robert Wood Johnson Foundation, Issue Brief, September 2009.

[9] Behavioral Risk Factor Surveillance System Survey

Survey Data, 2005-2007.

[10] National Longitudinal Mortality Study, 1988-1998.

[11] Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS), Minnesota Department of Health, Division of Community and Family Health, Maternal and Child Health. These data were made possible by grant number 5U01DP003117-05 from the Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.

[12] Minnesota Student Parent Support Initiative, Minnesota Department of Health, 2015

[13] Currently funded institutions' names are available at www.health.state.mn.us/divs/cfh/program/studentparent/programgrant.cfm

community and technical colleges, and state universities. Each institution has created a Student Parent Center, or expanded their existing Student Parent Center's services. Center staff have expertise working in higher education or social work and are trained to make referrals to local services and agencies, and understand intimate partner violence.

A student parent program participant describes his inspiration for continuing his education beyond high school:

> *"My young daughter inspires me to pursue a college degree, set a good example, and make a better life for us."*
>
> *Eric, EMT and Nursing Student*
> *Pine Technical and Community College*

A variety of methods are used to recruit students to the Centers including referrals from professors and local community partners, as well as word of mouth. All services at the Student Parent Centers are self-selected and voluntary. The student decides which services will best serve his or her needs related to academic, financial and family responsibilities. Services include academic advising, voluntary evidence-based health screenings for alcohol and tobacco use, depression, and intimate partner violence, and referrals to additional assistance or services if needed. Child care is provided, when possible.

Under the grant, 926 expectant and parenting students participated in one, two or three semesters of student parent program activities. Twenty nine percent of these students were referred to academic advising, and 16% for tutoring services. Regarding vocational services, 11% were referred to employment services, 8% to job training opportunities, and 11% for career counseling services.[14] Of the 784 student parents who reported their class re-enrollment plans, 560 (71%) indicated they had registered for courses in the following semester, 164 (21%) had not registered and 8% were un-reported.[15]

[14] Minnesota Student Parent Support Initiative, Minnesota Department of Health, 2015.

[15] Ibid.

MONITORING & IMPROVING

Improving the well-being of mothers, infants, and *children, including children and youth with special health needs,* is an important public *health* goal for Minnesota. Monitoring and quality improvement is integral to the work of CFH and consists of continuous action that leads to measurable improvement in services and, ultimately, the health of the population. The three programs highlighted in this section – identifying the unique needs of children and youth with special health needs, mapping care coordination in Minnesota, and training in Family Home Visiting – display important ways monitoring is used to consistently identify opportunities to improve both the services we provide and the health of the populations we serve.

Identifying the Unique Needs of Children and Youth with Special Health Needs

Children and youth with special health needs and their families have unique needs. The Early Hearing Detection and Intervention (EHDI) and Birth Defects (BD) programs are working together to align data collection processes in order to identify those needs and help families access the care and services necessary to achieve the best possible outcomes.

Since 2010, the EHDI program has contracted with Minnesota Community Health Boards to identify and address the needs of families when a child is newly identified as deaf or hard of hearing. In 2012, the BD Program also joined in the contract to address the needs of children born with a congenital birth defect. Local Public Health (LPH) nurses contact families of children who are D/HH or have a birth defect to conduct nursing assessment and connect them to available resources.

In 2014, a pilot project was started to develop a standardized assessment. The Omaha System is a research-based, standardized documentation system that is meant to be used across the continuum of care at the individual, family and community level. It provides a structure and standard assessment tool to identify and document needs and outcomes in a simple and comprehensive manner. The areas of support needed most often are:

- Income
- Communication with Community Resources
- Caretaking/Parenting
- Growth and Development
- Health Care Supervision

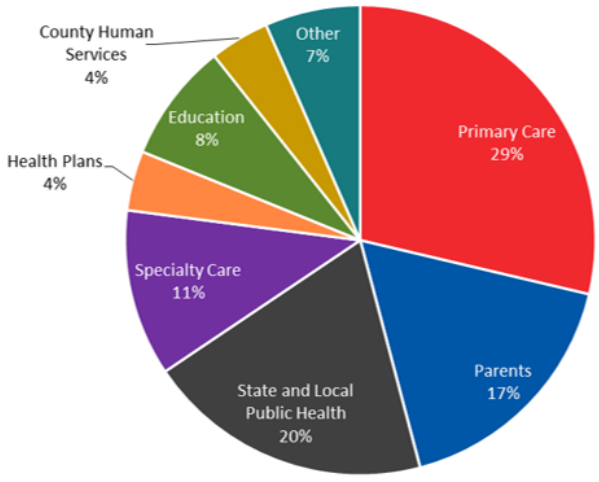
By monitoring needs and resources provided, such as early intervention services and using a standardized researched-based nurse assessment, we better understand the benefits of early utilization of services and the role they play in primary and secondary prevention of developmental delays for children with birth defects or hearing loss. We will also be better able to track health, social and behavioral needs of families affected by a birth defect or hearing loss, and assure they are receiving appropriate services.

In the summer of 2016, a second pilot group began evaluating the ease of use of the pathway, developing training tools for a full state roll out, and developing the pathway into a secure electronic reporting system. All contracted Community Health Boards (CHB) will use the pathway to report to the EHDI and BD programs in 2017. This information will help MDH and stakeholders develop local and statewide strategies to address the most common barriers that families face.

Mapping Care Coordination in Minnesota

Children and youth with special health needs and their families benefit from a wide variety of medical, psychosocial, educational, and support resources. Without effective care coordination, these services and supports can become fragmented or duplicative, causing unnecessary stress and frustration. Understanding what is available and how it varies across the state is necessary to begin systems improvements around care coordination. The 2011-2012 National Survey of Children's Health found that only 56% of families of CYSHN who needed help reported receiving effective care coordination. In addition, families and providers frequently say that there is a great deal of confusion about *who* is supposed to be doing *what* when it comes to coordinating care. These findings were the catalyst behind CFH efforts to conduct systems mapping across the state.

Statewide Participants in Care Coordination Mapping



During the summers of 2015 and 2016, the CYSHN Section conducted a state-wide systems assessment and action planning process around care coordination. The purpose of the process was twofold: 1) to assess what is occurring regionally around the provision and receipt of care coordination services, and 2) to bring systems players together as a means of fostering connections and networks.

A total of 125 stakeholders from six regions across the state participated in the assessment process. Participants represented the following areas: parents of CYSHN, education, Head Start/Early Head Start, Interagency Early Intervention Committees, family organizations, health

plans, home care, local public health, mental health, primary care, specialty care, school nurses, and state agency staff.

Increased understanding of what is occurring around care coordination

A mixed-methods approach was used to conduct the assessment. First, each stakeholder was led through the process of creating their own individual Systems Support Map. Then the information from the individual maps was aggregated using the Circle of Care Modeling (CCM) approach to create a Regional Care Coordination Framework. The regional frameworks were then combined to form a Statewide Framework. All frameworks identified the various partners providing care coordination services, their primary responsibilities, and their common wishes on how to improve the system. The approach positioned CYSHN and their families at the center of the system; the roles of care coordinators and their responsibilities were then modeled around the family. By mapping out the various partners providing care coordination and their responsibilities, participants were able to expand their understanding of what families are experiencing in care coordination, and were also able to determine areas where the infrastructure needs to be strengthened to improve care coordination for CYSHN and their families.

Recommendations on how to improve care coordination

Primary recommendations suggested by participants included:

- More services available to families (especially in rural Minnesota)
- More appropriate, stable, and secure funding for services and care coordination so that lower caseloads can be assigned to workers
- Improved communication/collaboration between care team members (including the family)
- Implement an easier process for obtaining Releases of Information from families
- Implement medical records that span multiple systems and are family friendly
- Simplify processes for obtaining financial assistance for insurance
- Have a primary point of contact for care coordination – a "coordinator of the coordinators"
- Allocate more funding for more support for families – especially peer-to-peer support
- Promote the importance of care coordination amongst the general public
- Develop a statewide centralized resource directory

Increased collaboration between Care Coordinators

One of the intended outcomes of the care coordination systems assessment was increased connections and collaboration between care coordinators. Anecdotal evidence from meeting evaluations and follow-up surveys suggests that the connections and networks increased as a result of the meetings. One example….

> *"At the meeting, I met a pediatric care coordinator from a primary care clinic. About a week later, one of her colleagues contacted me because we had a shared patient who was on our [specialty care] rehabilitation unit. I was able to connect the colleague with*

the staff from our unit who were working with the family, and they were able to hold a care conference over the telephone. If it hadn't been for that connection made at the meeting, I don't think that the shared planning would have occurred, and the family wouldn't have had such a smooth transition back home."

More information on the care coordination mapping process and findings can be found on the Mapping Care Coordination in Minnesota Website.

Family Home Visiting – Training

The goal of the FHV 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. Outcomes improve with the use of well-trained professionals implementing an evidence-based FHV model with fidelity. The FHV Section within CFH offers training, professional development, and other related resources that support best practice in home visiting, including planning and state-wide capacity-building to ensure family home visiting services are an integral component of a comprehensive early childhood system for local and tribal health agencies.

A continuous quality improvement approach is taken to make training more accessible, both geographically and financially, to local public health and tribal health home visiting programs. Efforts have included:

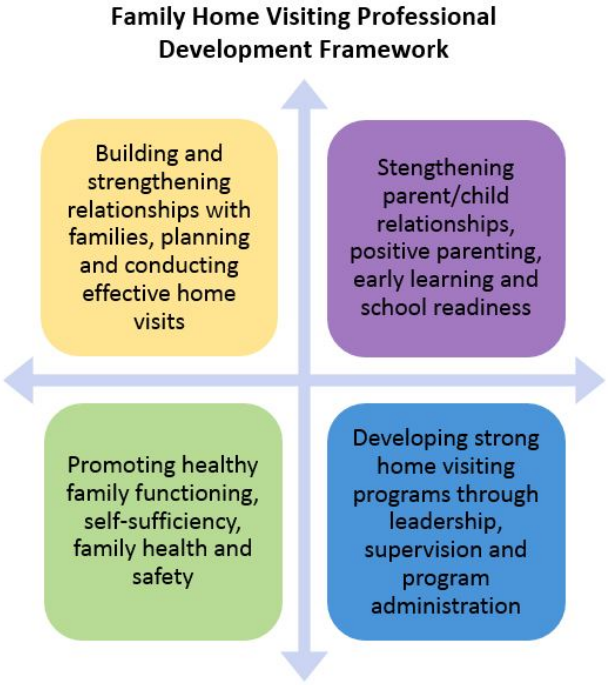
- Continuing to offer a high level of quality training throughout the state
- Opening training registration 12 months in advance to allow sites adequate planning time
- Increasing the use of technology, such as webinars and other e-learning programs, to reduce travel and time barriers to training

QUOTE FROM LOCAL PHN

"The training we have been able to receive on the Growing Great Kids curriculum has added so much to our visits with families. It is much appreciated"

As a result, in 2016, the FHV Section provided ten in-person trainings and seven webinar trainings in addition to Community of Practice/Consultation opportunities for both the Nurse-Family Partnership and Healthy Families America evidence-based models. Over 1000 home visiting staff from around the state participated.

The FHV Section relies on a wide range of expertise to deliver a menu of professional development. Curriculum developers and contractors include Great Kids Inc., Healthy Families America, Nurse-Family Partnership, Futures Without Violence, Prevent Child Abuse America, Brookes Publishing, NCAST, and How to Read Your Baby. Valued partners, who offer their specific expertise through consultation or co-presenting include the Minnesota Coalition for Battered Women, Minnesota Coalition Against Sexual Assault & Rape, University of Minnesota Medical School and School of Public Health, Center for Early Education & Development, and LifeTrack. An ever growing array of E-Learning Courses, including "Teen Parenting and Family Spirit", are made available on-line.



Currently, there are 16 in-person trainings offered by the FHV Section in addition to numerous webinar opportunities. Future plans include launching a Baseline Training for New Home Visitors and Supervisors in partnership with LifeTrack.

CONCLUSION

The activities described in this report highlight only a few of the activities the Community and Family Health Division engages in to help ensure that all families living within Minnesota communities have the opportunity to create their own healthy futures. Research shows that starting early matters and that we must provide the support needed to help make sure kids are on the right track. We do this through continuous monitoring and improving the way we carry out our work, with the understanding that the interplay of risk and protective factors such as socioeconomic status, toxic environmental exposures, health behaviors, stress and nutrition influence health throughout the course of our lives.