DEPARTMENT OF HEALTH

2019-2020 Report to the Commissioner

MATERNAL AND CHILD HEALTH ADVISORY TASK FORCE

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Maternal and Child Health Advisory Task Force Annual Report

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Maternal and Child Health Advisory Task Force Overview

The Maternal and Child Health (MCH) Advisory Task Force was created by MN Statute 145.8811 in 1982, and reestablished in 2012. The MCH Advisory Task Force charge is 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. The Task force is also charged with establishing, in consultation with the Commissioner, statewide outcomes that will improve the health status of mothers and children.

By statute, the MCH Advisory Task Force is comprised of 15 members, five representatives each in three categories: consumer, professional and community health board. All statutory task force members are appointed by the Commissioner of Health. In order to make the Task Force representative of the constituents it serves and a sound resource for the Commissioner on topics identified by the Task Force or the Commissioner, additional individuals or organizations may be invited by the Executive Committee to serve on the Task Force in an ex-officio membership capacity. Ex-officio members must qualify as a representative in one of the three statutory categories. The chair of the Task Force forwards recommended ex-officio members to the Commissioner for appointment.

Membership

Consumer Representatives

Bryn Basri - ***MCH Area(s) of Expertise:*** Bryn has served on the MCH Advisory Task Force since 2017. She has experience with children with special needs, healthcare administration, research, and maternal and infant health. Bryn has worked as a doula and childbirth educator, and she has managed a family and specialty clinic.

Tricia Brisbine (Family Voices Minnesota) ***MCH Area(s) of Expertise*****:** Tricia has served on the MCH Advisory Task Force since 2014. She is the parent of a child with special healthcare needs. She has a great deal of experience navigating health systems, financial and insurance resources, and support systems within the community, the state and nationwide. Tricia currently works as the Program Coordinator for Parent to Parent of Minnesota – Family Voices of Minnesota.

Bonnie Fairbanks (Leech Lake Human Services) ***MCH Area(s) of Expertise*****:** Bonnie has served on the MCH Advisory Task Force since 2015. She has expertise as a Cultural Advisor and has a profound knowledge of promoting healthy pregnancies as well as healthy birth outcomes.

Janet Morales - ***MCH Area(s) of expertise*****:** Janet has personal experience with stillbirth, perinatal loss and pregnancy after loss support groups, breastfeeding, milk donation, and parenting a child with special health needs. Janet was appointed as a consumer representative in 2019.

Jayne Whiteford - ***MCH Area(s) of Expertise*****:** Jayne has been a consumer representative since 2018. She has experience with Minnesota Health Care Programs, developmental disabilities and mental illness services, in addition to personal experience with high-risk pregnancy, NICU, and early intervention services. She also has skills in research, community interventions, social work, translating program policies into practice, and rural and urban health.

Community Health Board Representatives

Jane Auger (Hennepin County Public Health) ***MCH Area(s) of Expertise*:** Jane was appointed to the MCH Advisory Task Force in 2014. She is the Maternal and Child Health Supervisor at Hennepin County Human Services and Public Health. Jane manages several child health programs, including Hennepin Healthy Families, the Follow Along Program, Eliminating Health Disparities Initiative and Birth Defects Information System. She serves as a liaison between early childhood activities and Hennepin County. Jane brings expertise in local public health, and program management.

Stephanie Graves (Minneapolis Health Department) ***MCH Area(s) of Expertise*:** Stephanie was reappointed to the MCH Advisory Task Force in 2020 and has expert knowledge in early childhood and school readiness, targeted home visiting, infant mortality prevention, safety net services, and community engagement.

Debra Purfeerst (Rice County Public Health) ***MCH Area(s) of Expertise*:** Deb was appointed to the MCH Advisory Task Force in 2012. She has 35 years of experience in rural public health, and currently serves as Rice County CHS Administrator and Public Health Director. Deb provides expertise in local public health and governance, and targeted family home visiting. Deb is an MCH Advisory Task Force Executive Committee member – Chair.

Tamiko Ralston (Saint Paul-Ramsey County Public Health) ***MCH Area(s) of Expertise*:** Tamiko is a Community Health Board Representative and was appointed to fill an Open Seat vacancy in 2018. She was reappointed to a second term, effective January 2020. Tamiko is a Public Health Nurse with experience in case management, screening, early intervention and referral, community outreach and engagement, birth equity, and mental health and wellness promotion. Tamiko coordinates the Birth Equity Council for Ramsey County.

Chera Sevcik (Human Services of Faribault & Martin Counties) ***MCH Area(s) of Expertise*:** Chera is the Community Health Administrator for Faribault & Martin County CHB overseeing family home visiting Women Infant and Children supplemental nutrition program, environmental health, elderly care coordination, Child and Teen Check-up, health promotion, Statewide Health Improvement Program, disease prevention and control, and public health emergency preparedness. Chera was appointed to the task force as a Community Health Board Representative in 2019 and is currently serving her first four-year term.

Professional Representatives

Paige Anderson Bowen (West Side Community Health Services) ***MCH Area(s) of Expertise***: An MCH Advisory Task Force member since 2017, Paige brings knowledge about community-based health care delivery, maternal and child health consulting, program design, global health, MCH program management, monitoring and evaluation, family planning/reproductive health, health equity, social determinants of health, and health care access.

Dr. Diane Banigo (D.I.V.A. Moms/Minnesota Community Care/East Side Family Clinic) ***MCH Area(s) of Expertise*:** Dr. Banigo brings experience and expertise in women's health, prenatal care, community-based health care and reproductive health. She was appointed in November 2019 to fill an Open Seat vacancy for a Professional Representative.

Andrea MacArthur (Innova Engagement) ***MCH Area(s) of Expertise*:** Andrea has expertise in community-based health care delivery, program design, MCH program management, monitoring & evaluation, family planning/reproductive health, health equity, social determinants of health, and health care access.

Dr. Michelle O'Brien (HealthPartners Health Center for Women) ***MCH Area(s) of Expertise*:** Dr. O'Brien was appointed in 2012, and has expertise in the medical care of women and children. Her background includes prenatal care, breastfeeding support/promotion, substance use disorders (including opiate use disorder) in pregnant and parenting women, trauma informed care, and resilience/mindfulness/mental wellbeing. Michelle is an MCH Advisory Task Force Executive Committee member – Chair-elect.

Elizabeth Taylor-Schiro - ***MCH Area(s) of Expertise*:** Elizabeth comes to the committee with academic experiences in the fields of human development, evaluation studies, and public health; and personal experiences with adverse education and health outcomes for mothers and children. She is passionate in creating partnerships with parents and families in attempt to guide their child and family toward optimal health and educational outcomes

Ex-officio Members

Carolyn Allshouse (Family Voices of Minnesota) ***MCH Area(s) of Expertise*:** *Minnesota Health Care* Programs. Carolyn has held an Ex-officio membership on behalf of Family Voices of Minnesota since 2018.

Carol Grady (Saint Paul Public Schools) ***MCH Area(s) of Expertise*:** Having served on the Task Force since 2005, Carol has extensive experience with the disability caregiver community as both a consumer and educator, having had a child with special needs. Carol has another child with a chronic condition (epilepsy) as well as expertise with school health as a licensed school nurse. She is an MCH Advisory Task Force Executive Committee member.

Nancy Hoyt Taff (UCare) ***MCH Areas(s) of Expertise*:** Nancy has been on the Task Force since 2014. In her employment with HealthPartners, along with serving on the Council of Minnesota Health Plans, she has several years of experience with Minnesota Health Care Programs.

Pat Lang (PACER Center) ***MCH Area(s) of Expertise*:** Pat has experience in family advocacy, medical and health systems, and experiential knowledge as a parent of a child with special health care needs. Pat serves in an Ex-officio membership on behalf of PACER Center.

Eugene Nichols - ***MCH Areas(s) of Expertise*:** Eugene was appointed to the task force in 2018 with experience serving on the Ramsey County's Healthy Families America advisory committee advocating for mothers with children between ages 0-5, Ramsey County Community Health Advisory Council, and was the Board Chair for Open Cities Health Center, a federally-qualified health center whose goal is keeping the whole family healthy by ensuring access to health care.

Jaime Slaughter-Acey (University of Minnesota School of Public Health, Division of Epidemiology & Community Health) ***MCH Area(s) of Expertise*:** Jaime's areas of expertise are health equity, maternal and child health/perinatal epidemiology, social determinants of health, racism, colorism, life-course perspective, perinatal health, women's health, prenatal care, and prenatal home visiting. Jaime was appointed as an alternate to Jamie Stang, the Ex-officio member representing the University of Minnesota, School of Public Health. Jaime has served in this role since 2018.

Jamie Stang (University of Minnesota School of Public Health, Division of Epidemiology & Community Health Center for Leadership Education in MCH Public Health, Leadership Education & Training Program in MCH Nutrition) ***MCH Area(s) of Expertise*:** Having served on the Task Force since 2014, Jamie has years of experience with prenatal, postpartum and maternal health issues, obesity prevention in MCH populations, type 2 diabetes prevention in MCH populations, and continuing education and leadership education in MCH.

Maisha Giles (Better Futures Minnesota) ***MCH Area(s) of Expertise*:** Maisha's area of expertise is children's mental health, behavioral health, and substance use disorder services. Maisha is new to the task force and began serving her ex-officio membership in 2019.

Megan Waltz (Minnesota Department of Human Services) ***MCH Area(s) of Expertise*:** Megan brings several years of experience in early childhood systems, maternal/child health, promotion of wellbeing and prevention of maltreatment, and health equity. Megan in also new to the task force and began serving as the Department of Human Services ex-officio member in 2019.

Activities

The work of the MCH Advisory Task Force is governed by a set of Operating Procedures approved by the membership. The MCH Advisory Task Force held its quarterly meetings throughout 2019. During the course of the year, the Executive Committee sent recommendations for appointment to Open Seats to Commissioner Malcolm.

In 2019, the task force members were engaged in the following activities:

1) Served as members of the Title V MCH Block Grant Needs Assessment Leadership Team:
    a. Provided feedback and guidance throughout the Needs Assessment Process
    b. Applied criteria-based ranking to narrow the cross-cutting potential priorities for community-based selection
    c. Applied criteria-based ranking to select final domain-specific Title V priorities
    d. Approved and reviewed Minnesota Title V priorities
2) Created a membership sub-committee to develop a recruitment plan and criteria for selecting candidates to ensure diversity and inclusivity when filling vacancies (Open Seats).
3) Participated in a discussion on the draft Preschool Development Grant (PDG), "Picturing a Stronger Minnesota for Families with Young Children" and provided input on what is most important in building a stronger Minnesota for families with young children.
4) Solicited nominations and selected the 2019 Betty Hubbard MCH Leadership Award recipients for outstanding contributions to maternal and child health in Minnesota at the statewide and community levels.
5) Hosted the 2019 Betty Hubbard MCH Leadership Award Ceremony and Reception to present the award and recognize, along with family and friends, the award recipients.

In order to stay abreast of current issues and populations experiencing health inequities and disparities, subject matter experts were also invited to task force meetings to present on trends or emerging issues negatively impacting health outcomes for Minnesota mothers, children and families. In addition to the presentation on the PDG, other presentation topics included community and regional issues related to maternal injury related-deaths and women's mortality trends and Minnesota Bio-monitoring Program.

Recommendations to the Commissioner of Health

Based on our participation in each phase of the statewide comprehensive Title V MCH Block Grant Five-Year Needs Assessment process, from the planning phase in 2018 through the final prioritization and approval phase in 2019, the MCH Advisory Task Force (MCHATF) is submitting the following priority areas where-focus and efforts by the Commissioner are needed:

1) To improve the health of all Minnesotans; and

2) To ensure that communities and people are thriving and everyone has what they need to attain optimal mental well-being and health

During the five-year needs assessment process, data placements (i.e., stories) and detailed data sheets were developed that inform why these priorities are important and provide data that support the identified priority needs. Our recommendations below describe the areas of concern only. For further information about each of the needs assessment priority areas, you may view and access the detailed data sheet associated from the Title V Needs Assessment website at: Title V Needs Assessment Priority Needs Data Sheets (https://mn365.sharepoint.com/teams/MDH/bureaus/hib/cfhd/TitleVMCHBlockGrant/Forms/By%20DocType.aspx).

The MCHATF's recommendations follows each priority area discussion and indicate action to be taken according to the following three classifications:

1. **MDH POLICY**
   Policy recommendation relating to the governance of the department of Health as well as the policies and programs it oversees. Developed and implemented independently by MDH staff and the Commissioner.
2. **LEGISLATIVE ACTION**
   Policy recommendation requiring legislative action or approval of the state legislature and subsequent approval by the Governor. The Commissioner works directly with the Governor to implement the recommendation.
3. **COLLABORATION**
   Recommendation to work with individuals, community groups, MDH, and other state and county organizations to develop a policy, program or legislative recommendation. May require legislative action prior to implementation.

Accessible and Affordable Health Care

Comprehensive, quality health care services are important for promoting and maintaining health throughout the lifespan. Access to health care is impacted by household finances, insurance coverage, geographic availability, and timeliness of entry into services. Poor access to health care services can result in unmet health needs, lack of preventive services, hospitalization, and increased financial burden. Equally as important as access is the alarming rising costs of health care.

In 2017, Minnesota saw one of the largest one-time increases in the rate of people without insurance, jumping from 4.3 percent in 2015 to 6.3 percent – leaving approximately 349,000 Minnesotans without health insurance coverage. Data from the Minnesota Health Access Survey displays how historical disparities in coverage experienced by certain population groups persisted in 2017. Unlike the universal improvement seen in uninsurance rates across demographic groups in 2015, in 2017 some groups maintained their coverage gains, while others lost ground.

Accessible and Affordable Health Care Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Reduce barriers to participation in Minnesota Health Care Programs, such as not instituting a work requirement.		X	X
Continued support of ACA Individual Products		X	X

Access to Services and Supports for Children and Youth with Special Health Needs

In Minnesota, 17.7% of children and youth (ages 0-17) have special health needs, which includes a range of chronic physical, developmental, behavioral, and emotional conditions.[1] These children and youth depend on a variety of services that are provided not only by the health care system, but by other systems, as well; these services may include dental, specialized therapies, counseling, medical equipment, special education services, community-based services and more.[2] In addition, only about 23% of MN youth with special health care needs receive the support they need when transitioning from pediatric to adult health care (MDH White Paper on the Transition from Pediatric to Adult Health Care, July 2019).

Access to Services and Supports for CYSHN Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Convene a workgroup that includes parents and youths with experiential knowledge to create a clear, sustainable, translatable policy for CYSHN to receive supports and services that can be applied and adopted to meet individual needs of each recipient/client/patient during normal times and in times of disaster.	X	X	X

Adolescent Suicide

Minnesota has a higher suicide rate (14.8 per 100,000) than the national rate (13.1 per 100,000) among adolescents and young adults (ages 15-24). The suicide rate for Minnesota youth has been higher than the United States average for a long time. In Minnesota, suicide is the second leading cause of death for young people ages 10-24. In 2016, 111 Minnesotans between the ages of 10 and 24 died of suicide, representing roughly 15 percent of all suicides in the state in that year. Data from the 2016 Minnesota Student Survey shows that of 8th, 9th and 11th graders, 17 percent of female students and 8 percent of male students reported either seriously considering attempting or attempting suicide in the last year – **that's over 14,000 students**.

[1] Child and Adolescent Health Measurement Initiative. 2016-2017 National Survey of Children's Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by Cooperative Agreement U59MC27866 from the U.S. Department of Health and Human Services, Health Resources and Services Administration's Maternal and Child Health Bureau (HRSA MCHB). Retrieved 04/04/2019 from www.childhealthdata.org. CAHMI: www.cahmi.org.

[2] Rosen-Reynoso, Myra, et al. "Disparities in Access to Easy-to-Use Services for Children with Special Health Care Needs." *Maternal and Child Health Journal*, vol. 20, no. 5, 2016, pp. 1041–1053.

Suicide is not experienced equally across age groups, genders or geography in Minnesota. We know that the suicide risk increases with age from 10-24, peaking at 33.1/100,000 at age 23. Suicide rates for MN youth are similar to US rates between the ages of 10 and 12, but there is a sharp increase in rates in MN starting at age 12 years, during the transition from childhood into adolescence. The peak at 23 years of age occurs around another time of life transition for many youth, as they transition from late adolescence into adulthood. Rates of suicide are significantly higher among MN males compared to females, particularly between the ages of 18-24 when the rates for males are about 5 times higher than for females.

There are large race/ethnicity disparities in suicide, with American Indian adolescents experiencing the highest rate of suicide. In Minnesota, American Indian and Alaska Native youth experience suicide rates that are nearly 3 times that of youth of other races. Minnesota is also starting to see an increase in suicides among Black youth, which is similar to what is being found nationally. American Indian youth in Minnesota have the highest rate of suicide (28 per 100,000) followed by White (8.8 per 100,000), Black (7.6 per 100,000), and Asian (6.7 per 100,000) youth.[3] Young people living in rural Minnesota also have significantly higher suicide rates when compared to their urban peers.

Adolescent Suicide Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Advocate for funding for comprehensive suicide prevention programming that targets youth 10-24 years of age, particularly those at highest risk (American Indian and Black males, American Indian females and youth living in rural areas).		**X**	**X**

American Indian Family Health

American Indians have, for generations, been intentionally and systematically violated in every way. The trauma experienced has been reinforced by government policies, racism and oppression, and economic systems that purposefully denied access to safety, health care, food, education, employment and dignity.[4] "Repeated and ongoing violation, exploitation, and deprivation have a deep, lasting traumatic impact, not just at the individual level but on whole populations, tribes and nations. This is what is known as collective trauma, historic trauma, and intergenerational trauma."[5]

American Indian women, children and families experience worse outcomes than other populations in Minnesota. These disparities are caused by historical trauma, racism and continued colonial practices and policies that are barriers to opportunity and thriving. The American Indian child poverty rate in 2016 was 36 percent compared to 14 percent of all Minnesota children living in poverty.[6] 51.4 percent of

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[3] Centers for Disease Control and Prevention. (2017). Preventing Suicide: A Technical Package of Policy, Programs, and Practices. Retrieved from https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf.

[4] Franco, F. (2018). Childhood Abuse, Complex Trauma, and Epigenetics. Retrieved May 2019. https://psychcentral.com/lib/childhood-abuse-complex-trauma-and-epigenetics/.

[5] Villanueva, E. (2018). Decolonizing wealth: Indigenous wisdom to heal divides and restore balance (First edition.). Oakland, CA: Berrett-Koehler Publishers, Inc.

[6] Minnesota Department of Health. 2017 Minnesota Statewide Health Assessment. http://mncm.org/wp-content/uploads/2018/01/2017-Health-Equity-of-Care-Report_unencrypted-1.pdf .

American Indian children are growing up in single mother families.[7] Only 50 percent of American Indian youth will graduate from high school.[8] Compared to white children, American Indian children in Minnesota are 18 times more likely to be placed in out-of-home care.[9]

American Indian Family Health Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Actively pursue and include American Indian community members/experts in roles within divisions, programs and projects to ensure the American Indian population is represented and involved in program/project/funding planning and implementation (Indigenous evaluator for PDG grant as a part of MDE is one example of this)	**X**		**X**
Require historical and intergenerational trauma and American Indian history training for all MDH employees and council/workgroup/task force members	**X**		
Ensure that a specific amount of funding is dedicated to American Indian populations across all grants and programs	**X**		
Invest in and partner with community organizations focused on addressing disparities in American Indian children, mothers, and family systems to allow community member engagement in MDH activities	**X**		**X**
Support legislation to make racism a public health issue		**X**	

Boys and Young Men

Engaging boys and young men in public health efforts is incredibly important. Despite work being done by public health agencies, community-based organizations, and others to engage this population in education, services, and programs, it remains critically important to attend to the needs of boys and young men. Historical trauma, systemic racism, socially influenced gender roles, and stigma around men seeking mental health care has led to widespread systems-level failures that have left boys and young men underserved and struggling with higher rates of substance use, suicide, mental health struggles, and victimization compared to girls and young women.[10]

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[7] Minnesota Health Care Programs. Minnesota Department of Human Services. (2017). Prevalence of Neonatal Abstinence Syndrome and Maternal Opioid Abuse During Pregnancy.

[8] Minnesota Department of Education. (2018). Minnesota's Graduation Rate Hits New High, Gaps Closing Over Time. https://content.govdelivery.com/accounts/MNMDE/bulletins/1de1f38.

[9] Children and Family Services. Minnesota Department of Human Services. (2017). Minnesota's Out-of-Home Care and Permanency Report, 2016. Retrieved May 21, 2019. https://mn.gov/dhs/assets/2017-10-out-of-home-care-and-permanency-report_tcm1053-321462.pdf .

[10] Rice, S.M., Purcell, R., & McGorry, P.D. (2018). Adolescent and Young Adult Male Mental Health: Transforming System Failures Into Proactive Models of Engagement. *Journal of Adolescent Health 62*(3): S9-S17.

- In Minnesota, the male rate of suicide increased by 9 percent from 2016 to 2017 while the female rate dropped 10 percent during the same period of time.[11]
- Boys and young men are more likely to experience violence and be involved with the juvenile justice system with males representing 67 percent of all arrests of juveniles in Minnesota in 2016.[12]
- African American boys and young men are 8 times more likely to be the victims of homicide and have the highest likelihood of being killed by police.[13]

Doing nothing to address this important social dilemma will place future generations of African American young men at risk. The pervasive school to prison pipeline only serves private enterprise and ignores the healthy maturation of an entire segment of Minnesota society. Social justice reform, including sentencing reform guidelines post incarceration (removal of fines once the debt to society has been paid via prison time), must be addressed. Disparities in all conditions of the Social Determinants of Health combined with structural racism must be addressed with urgency.

Disparities in the experience of violence and associated negative health outcomes can be traced to historical trauma and systemic racism, which over time has resulted in the health disparities seen today. Preventing or diminishing the impacts of mental illness, experience of violence, and disparities in incarceration as boys and young men age into adulthood requires extensive efforts to address the health of boys and young men during early childhood and adolescence.[14]

Boys and Young Men Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Continue collaboration with the City of St. Paul, County Commissioners, District Community Council, Ramsey County Public Health, and community leaders and advocates seeking alternative solutions to incarceration	X		X
Advocate for sentencing guidelines reform with the Governor.		X	

Care during Pregnancy and Delivery

Having a healthy pregnancy and access to quality birth facilities are the best ways to promote a healthy birth and have a thriving newborn. Getting early and regular prenatal care is vital. Prenatal care is the health care that women receive during their entire pregnancy. Prenatal care is more than doctor's visits and ultrasounds; it is an opportunity to improve the overall well-being and health of the mom, which directly affects the health of her baby. Prenatal visits give parents a chance to ask questions, discuss concerns, treat complications in a timely manner, and ensure that mom and baby are safe during

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[11] Heinen M & Roesler J. (2018, December). Suicide in Minnesota, 1999-2017 - Data Brief. Saint Paul, MN: Minnesota Department of Health. Retrieved from https://www.health.state.mn.us/communities/suicide/documents/2017suicidedatabrief.pdf.

[12] Results First (2018, February). Juvenile Justice Benefit-Cost Analysis. Saint Paul, MN: Minnesota Department of Management and Budget. Retrieved from https://mn.gov/mmb-stat/results-first/juvenile-justice-report.pdf.

[13] Liberman, A.M. & Fontaine, J. (2015, February). Reducing Harms to Boys and Young Men of Color from Criminal Justice System Involvement. Retrieved from https://www.urban.org/sites/default/files/publication/39551/2000095-Reducing-Harms-to-Boys-and-Young-Men-of-Color-from-Criminal-Justice-System-Involvement.pdf.

[14] Centers for Disease Control and Prevention. (2019, February 27). Violence Prevention Risk and Protective Factors. Retrieved from https://www.cdc.gov/violenceprevention/youthviolence/riskprotectivefactors.html.

pregnancy and delivery. Receiving quality prenatal care can have positive effects long after birth for both the mother and baby. When it is time for the mother to give birth, having access to safe, high quality birth facilities is critical.

In 2017 in Minnesota, only 77.1 percent of women received prenatal care within their first trimester of pregnancy. Approximately 1 in 30 or 2,289 infants were born to a woman who received late (care that started in the 3rd trimester) or no prenatal care at all. Disparities are seen in the adequacy of prenatal care utilization across race/ethnicity. Less than half of births to American Indian mothers receive the recommended adequate/intensive prenatal care utilization.

Care during Pregnancy and Delivery Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Promote healthy pregnancy by working to increase access to quality prenatal care, providing education on the importance of early and regular prenatal care and increasing the availability of safe, high quality birthing facilities.	X		X
Remove barriers to receiving prenatal care by increasing access to reliable transportation and affordable healthcare	X		
Increase support for and address barriers to reimbursement for doula care and services, especially organizations such as Integrated Care for High Risk Pregnancies (ICHRP), Ninde Doula Program and Doula Dads that work with populations experiencing the highest disparities		X	

Comprehensive Early Childhood Systems

Human brains grow faster between the ages of 0-3 than any other point in life, forming more than one million new neural connections every second.[15] "When babies have nurturing relationships, early learning experiences and good nutrition, those neural connections are stimulated and strengthened, laying a strong foundation for the rest of their lives. When babies do not get what their growing brains need to thrive, they do not develop as they should. This leads to life-long developmental, educational, social, and health challenges."[16] The quality of babies' early nurturing and learning experiences has a lasting impact on their life-long learning and success. When we invest in infants, toddlers, and their families, we ensure a strong future for us all.

Minnesota families need easier access to health care, mental health services, early care and education, and local services and resources that are culturally honoring and support health, development, and safety. In Minnesota, public health and human services operate under local control with services delivered at the county-and Tribal-level in Minnesota's 87 counties and 11 Tribal nations. Education, Part C, and Part B services operate in over 300 independent school districts. Eleven tribal nations offer culturally relevant services, but are often unknown or ignored as potential referral resources by outside providers. Anecdotes from statewide providers consistently indicate that services

[15] Share the Think Babies Message. Retrieved from: https://www.thinkbabies.org/take-action/toolkit/key-messages/
[16] Final Report. (2015). Help Me Grow National Center. Help Me Grow Minnesota Leadership Team.

are unavailable, unknown, or hard to access, but there is no statewide data that defines actual service gaps and barriers.

Formal recommendations from local partners to the State in 2016 confirmed the need for a centralized system for resource navigation, referral and follow-through, and documentation of gaps and barriers in the system.[17] Tribes in Minnesota recommended a distinct approach for tribal and urban Indian services, and recommended that each tribal nation be approached separately for their degree of interest and involvement.[18]

Comprehensive Early Childhood Systems Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Partner in implementation of Minnesota's Preschool Development Grant with community organizations, including tribal nations and urban American Indian specific communities, and provide additional support to community hubs	X		X
Provide additional ongoing support for community organizations and state agency programs to utilize Help Me Connect platform			X
Dedicate funds to complete a systemic needs assessment to identify service gaps and barriers	X		
Support state legislation to make racism a public health issue	X	X	X

Housing

Every person living in Minnesota should have a safe, affordable place to live in a thriving community. But not all do. Minnesota is facing a housing crisis. Home prices increased 8.9 percent from 2017 to 2018 alone with homes in Minnesota 26% more expensive than homes in neighboring states. In the rental market, a healthy vacancy rate is 5 percent, but in Minnesota the statewide rate ranges from 2.2 percent to 4 percent in the Twin Cities metro.

A household is considered housing cost-burdened when 30% or more of their monthly gross income goes to paying for housing; 26% of households in Minnesota were housing cost-burdened in 2017.[19] As the cost of owning a home increases in Minnesota, there are less affordable rental homes and apartments every year. Minnesota has seen dramatic rent increases over the past few years with rents rising hundreds of dollars a month, sometimes doubling, leaving renters unable to afford their homes. This often leads to displacement, with people needing to double up with family and friends, seek temporary shelter, live in their cars, or live on the streets until they can find a new apartment. Homelessness can cause interruptions in employment, education issues for kids, and poorer health

[17] Final Report. (2015). Help Me Grow National Center. Help Me Grow Minnesota Leadership Team.

[18] Summary notes from meetings with tribal representatives in June 2015 and November 2015.

[19] Minnesota Compass. *Cost-Burdened Households*. Retrieved April 2019. https://www.mncompass.org/housing/cost-burdened-households#1-6930-g.

outcomes. When (and if) families do secure housing, over half of the lowest-income families in Minnesota spend more than 50 percent of their income on housing costs.[20]

Most Americans spend about 90 percent of their time indoors; with an estimated two-thirds of indoor time in the home.[21] Infants and young children spend even more time indoors and at home, making them especially vulnerable to household hazards. Homes that are not free from physical hazards contribute to infectious and chronic diseases, injuries and poor childhood development.[22] For example:

- Poor quality housing conditions like water leaks, bad ventilation, dirty carpet, and pest infestation can lead to increases in mold, allergens and mites which are associated with poor health; specifically asthma exacerbation. Approximately 40 percent of diagnosed asthma among kids is believed to be attributable to exposures where they live.[23]
- Although the danger of lead has been known for many years, it remains one of the most common environmental hazards for children. Exposure to lead is most likely to happen in the home. Children under the age of six, particularly those ages 1 to 3, and pregnant women are most vulnerable to the harmful impacts of lead. There is no safe level of lead in the body, and testing is important because there are often no identifiable symptoms following exposure. Lead testing is **not** universal in Minnesota, though children at greater risk of exposure (i.e. children under six, living in houses built before 1978, living in poverty) are targeted for testing. Children with lead poisoning can experience learning, behavior and health problems. Adults with lead poisoning can suffer from high blood pressure, kidney damage, and fertility problems.[24]

While there are many different housing-related issues in need of attention in our state, this recommendation is focused on housing safety, affordability and stability.

Housing Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Provide financial and staff support to the MDH Calling All Sectors Project whose goal is to ensure that no child is born into homelessness	**X**		

[20] More Places to Call Home: Investing in Minnesota's Future. Report of the Governor's Task Force on Housing August 2018. Retrieved March 30, 2019. https://mnhousingtaskforce.com/sites/mnhousingtaskforce.com/files/document/pdf/Housing%20Task%20Force%20Report_FINALa.pdf.

[21] Robert Wood Johnson Foundation. *Where we live matters for our health: the link between housing and health*. Retrieved April 2019. http://www.commissiononhealth.org/PDF/e6244e9e-f630-4285-9ad7-16016dd7e493/Issue%20Brief%202%20Sept%2008%20-%20Housing%20and%20Health.pdf.

[22] Robert Wood Johnson Foundation. *Where we live matters for our health: the link between housing and health*. Retrieved April 2019. http://www.commissiononhealth.org/PDF/e6244e9e-f630-4285-9ad7-16016dd7e493/Issue%20Brief%202%20Sept%2008%20-%20Housing%20and%20Health.pdf.

[23] Robert Wood Johnson Foundation. *Where we live matters for our health: the link between housing and health*. Retrieved April 2019. http://www.commissiononhealth.org/PDF/e6244e9e-f630-4285-9ad7-16016dd7e493/Issue%20Brief%202%20Sept%2008%20-%20Housing%20and%20Health.pdf.

[24] Minnesota Department of Health Report to the Minnesota Legislature 2019. *Lead poisoning prevention programs biennial report.* Retrieved April 2019. https://www.health.state.mn.us/communities/environment/lead/docs/reports/bienniallegrept.pdf.

Housing Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Work across state agencies and departments to push for housing legislation that decreases housing costs and increases availability of affordable housing			X
Support state legislation to make racism a public health issue and utilize resources to assess how racism is at the foundation of housing issues		X	

Infant Mortality

Infant mortality is widely used as an international measure of overall population health. Compared to other developed countries, the United States has a higher infant mortality rate.[25] Infant mortality is a multifactorial societal problem often linked to factors that affect an individual's physical and mental well-being, including maternal health, socioeconomic status, quality and access to medical care, and public health practices. It can adversely affect families and communities, both socially and emotionally, often resulting in depression, grief, and guilt. Families may suffer from long-term psychological distress, which can lead to partner separation or divorce. Grieving parents also face isolation from friends and family.[26],[27]

The infant mortality rate is over two times greater for infants born to African American/black mothers (9.0/10,000), American Indian mothers (10.5/10,000) and Other/Unknown mothers (13.3/10,000) than non-Hispanic white, Asian/Pacific Islander or white mothers in Minnesota. Preterm birth and low birthweight are leading causes of neonatal infant mortality (the first month of life), while sudden infant death syndrome is the leading cause of postneonatal mortality. Stress related to racism and discrimination leads to changes in the body that can increase the rate of neonatal infant mortality. The development of gestational hypertensive disorders or gestational diabetes also increases the risk of preterm birth and neonatal mortality. Both of these conditions are more common among women of color and among women who enter pregnancy at a high pre-pregnancy weight or who have pre-existing hypertension or type 2 diabetes. Social determinants of health, such as poverty and housing instability, contribute to postneonatal mortality.[28]

The infant mortality rates among of African Americans/blacks in Minnesota vary greatly depending on the mother's birth country. From 2012-2016, African Americans/black mothers born in the United States have an infant mortality rate double (12.4 per 1,000) that of foreign-born mothers (6.7 per 1,000).[29]

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[25] MacDorman M.F., Mathews T.J., Mohangoo A.D., & Zeitlin J. (2014). International comparisons of infant mortality and related factors: United States and Europe, 2010. *National vital statistics reports,* 63(5). Retrieved from https://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_05.pdf.

[26] Murphy, S., Shevlin, M., & Elkit, A. (2012). Psychological consequences of pregnancy loss and infant death in a sample of bereaved parents. Journal of Loss and Trauma, 19(1), 56-69. doi: 10.1080/15325024.2012.735531.

[27] Murphy, S., Shevlin, M., & Elkit, A. (2012). Psychological consequences of pregnancy loss and infant death in a sample of bereaved parents. Journal of Loss and Trauma, 19(1), 56-69. doi: 10.1080/15325024.2012.735531.

[28] Kim, D., Saada, A. (2013). The social determinants of infant mortality and birth outcomes in western developed nations: A cross-country systematic review. *Environmental Research and Public Health, 10(6),* 2296-2335. Retrieved from: https://www.mdpi.com/1660-4601/10/6/2296/htm.

[29] Advancing health equity in Minnesota. (2014). *Minnesota Department of Health*. Retrieved from: https://www.health.state.mn.us/communities/equity/reports/ahe_leg_report_020114.pdf.

Rates of infant mortality are also higher than the state average in Ramsey County and several outlying counties in MN.

Infant Mortality Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Advocate for continued/increased funding for evidence-based home visiting programs that target mothers and infants at risk for infant mortality		X	
Support legislation to reinstate the Fetal Infant Mortality Review process.		X	
Advocate for universal free well-woman visits for women of reproductive age which address both mental and physical health risk factors related to infant mortality.		X	

Mental Well-Being

Mental well-being is more than the absence of illness. Mental well-being is about having fulfilling relationships, utilizing strengths, contributing to community and being resilient, which is the ability to bounce back after setbacks.[30] Mental well-being is a core ingredient for success in school, work, health, and community life. Poor mental well-being, with or without the presence of mental illness, is a risk factor for: chronic disease (cardiovascular, arthritis), increased health care utilization, missed days of work, suicide ideation and attempts, death, smoking, drug and alcohol abuse, physical inactivity, injury, delinquency, and crime.[31]

Physical health and mental well-being are intertwined. When we experience physical illness, injury or pain it has a negative impact on our mental well-being and improving our physical health can improve our mental well-being. Poor mental well-being is also a risk factor for mental illness. Mental disorders are the most common cause of disability in the U.S. contributing 19 percent of all years lost to illness, disability, or premature death.[32] Poor mental well-being may precede or exacerbate mental illness. People with poor mental well-being but no current mental illness are three to six times more likely to develop mental illness in the next ten years.[33]

Mental well-being is not experienced equitably throughout the state's population. Data from the Minnesota Student Survey shows Minnesota youth experiencing economic hardship report dramatically lower rates of well-being than youth not experiencing economic hardship. Youth who identify as LGBTQ also report dramatically lower rates of well-being than their straight peers. Mental well-being is measured in Minnesota Student Survey by combining multiple components of well-being to create an overall well-being score (i.e. positive identity, social competency, personal growth, empowerment,

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[30] Herman, H, Saxena, S, Moodie, R (2005). Promoting Mental Health-Concepts, Emerging Evidence, Practice. World Health Organization Retrieved from http://www.who.int/features/factfiles/mental_health/en/.
[31] Minnesota Department of Health. Mental Health Promotion. Retrieved from https://www.health.state.mn.us/communities/mentalhealth/.
[32] Minnesota Department of Health. Mental Health Promotion. Retrieved from https://www.health.state.mn.us/communities/mentalhealth/.
[33] Minnesota Department of Health. Mental Health Promotion. Retrieved from https://www.health.state.mn.us/communities/mentalhealth/.

social integration, educational engagement, and positive family, community, teacher and peer relationships).[34] (2019 MSS)

Mental Well-Being Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Provide communities with information, resources, and supports to cultivate and sustain positive relationships and increase mental well-being	**X**	**X**	**X**
Develop and support programs that provide opportunities to nurture mental well-being and build resilience.	**X**	**X**	**X**

Parent and Care Giver Support

A parent can be any figure in a child's life that provides care, safety, and security for a child. Parental figures can be biological, adopted, foster parents, grandparents, or other primary caregivers. Parental support and education positively impact parents and families. Supporting parents can benefit the parent-child relationship, help families meet their physical, emotional, and financial needs, and improve health outcomes for children and parents. The type of support needed and wanted can vary across families – one family may experience certain activities as supportive, another family may wish for other forms of educational support.

According to the Zero to Three National Survey, 48 percent of all parents don't feel they are getting the support that is needed when they are stressed with nearly 60 percent of single mothers reporting receiving inadequate support.[35]

The importance of other personal relationships outside of the immediate family cannot be understated as community connection is beneficial to caregiver health as well.[36] Parents need a network of supportive relationships, strategies for coping with stress, resources, knowledge, and an understanding of child development. Parents and caregivers who have resources and support are more likely to provide safe and healthy homes for their children and families.

> *"[Minnesota women, children, and families need] support. I think the community would benefit immensely from finding ways to support mothers in parenting. By providing relief when needed (childcare, mental health support)." – Needs Assessment Discovery Survey Respondent*

Supporting caregivers can have numerous positive downstream effects on the health of children by reducing family separation.[37] Parents need a network of supportive relationships, strategies for coping with stress, resources, knowledge, and an understanding of child development. Unfortunately, a lack of

[34] Reitzner, Michelle M., (2014). Signature Well-being: Toward a More Precise Operationalization of Well-being at the Individual Level. *Master of Applied Positive Psychology (MAPP) Capstone Projects.* Paper 64. Retrieved from http://repository.upenn.edu/mapp_capstone/64.
[35] Zero to Three. (2016). National Parent Survey Overview. Retrieved from https://www.zerotothree.org/resources/1425-national-parent-survey-report.
[36] Hardie-Williams, K. (2016, May 3). The Importance of Community Support in Raising Children. Retrieved from https://www.goodtherapy.org/blog/importance-of-community-support-in-raising-children-0503165.
[37] McDonell, J.R., Ben-Arieh, A., & Melton, G.B. (2015). Strong Communities for Children: Results of a multi-year community-based initiative to protect children from harm. *Child Abuse & Neglect 41*: 79-96.

these critical supports can cause otherwise well-intentioned parents to engage in abuse or neglect. Parents and caregivers who have resources and support are more likely to provide safe and healthy homes for their children and families and reduce the need for out of home placement following confirmed instances of abuse of neglect.[38]

The parent-child relationship and the environment of the family- which includes all primary caregivers- are foundational to a child's well-being and healthy development. The impact of parents is critical during the first years of life when a child's experiences are almost entirely created and shaped by caregivers and their family environment. Parents' knowledge of child development has been shown to lead to more quality parent-child interactions and engagement in practices that promote their child's healthy development.

Parent and Care Giver Support Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Create a policy that keeps in mind the importance of family and caregivers in the care and service of all children, including CYSHN they care for. This includes rules for providing consistent, continuous care for the physical and mental health of everyone and outlines rules and respite possibilities for caregivers that allow them to maintain standards of care for themselves as well as their CYSHN client/family member.	X	X	

Compensation for Consumer Representatives

In order to encourage active participation and attendance at MCHATF meetings from its consumer representatives, the MCHATF recommends that MDH propose legislation requesting the five community representatives—not attending in a professional capacity and not paid to attend by an employer—receive compensation for their attendance. The compensation would acknowledge the value and expertise of community members. Some state committees provide stipends to consumer representatives for their time, or reimburse for childcare or transportation. The MCHATF would like their consumer members to receive the same consideration and be compensated for their time attending task force meetings.

Compensation for Consumer Representative Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Support compensation for MCH Advisory Task Force consumer representative members	X	X	

Long Acting Reversible Contraceptives (LARCs)

In order to make Immediate Post-Partum (IPP) Long Acting Reversible Contraception (LARCs) more available to Minnesota women in hospital settings, the MCHATF recommends a change in payment

[38] McDonell, J.R., Ben-Arieh, A., & Melton, G.B. (2015). Strong Communities for Children: Results of a multi-year community-based initiative to protect children from harm. *Child Abuse & Neglect 41*: 79-96.

structure for hospitals and other institutional supports to encourage IPP LARCs. Per the American College of Obstetrics and Gynecologists (ACOG), this includes:

1) education and training of clinicians and hospital staff re: LARC's;
2) ensuring necessary supplies on hand (minimal instruments);
3) ensuring that patient informed consent starts prenatally, and be reaffirmed before insertion;
4) assuring avoidance of reproductive coercion;
5) hospital pharmacy supply stock; and
6) Medicaid and others payers to provide separate payment.[39]

The ACOG has confirmed that it is safe to insert LARCs immediately postpartum after the delivery of the placenta, for either vaginal or cesarean birth or after an abortion, or within 48 hours of giving birth. Doing so eliminates the need for scheduling an office visit and taking a pregnancy test for later contraceptive prescriptions, as well as reducing unintended pregnancies if contraception is not obtained.

LARCs have been approved by the Food and Drug Administration, are highly effective, quickly reversible, and do not interfere with lactation. Their use is effective in reducing unintended pregnancy; currently Minnesota's unintended pregnancy rates are estimated to be about 36%. LARCs have very low failure rates, and a reduced likelihood of noncompliant use. Generally, there are very few contraindications, such as age or previous pregnancies, for their use. Although there has been an increase in the use of LARCs for Minnesota Health Care Program recipients, usage remains low.

**Hospitals will implement only if paid separately from hospital DRG.*

LARC Reimbursement Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Create additional reimbursement to increase availability of immediate post-partum LARC	X		X

Fetal Infant Mortality Review (FIMR) Process

Currently there is not a FIMR process in Minnesota, though a process was in place historically. Minnesota is experiencing substantial disparities in fetal and infant death rates. Implementing a FIMR process could help improve the opportunity to understand and address infant mortality rates and provide more information about fetal deaths, for example, why rates are higher for some groups of people in Minnesota. This process can lead to and inform actions to reduce fetal and infant deaths, achieving greater health equity in our state. It will require both funding and legislation for the authority to do the work.

For the period of 2012 to 2016, Minnesota's infant mortality rates per 1,000 live births varied widely by mother's race/ethnicity, from 9.3 among infants born to Black/African American mothers, 10.3 among infants born to American Indian mothers, compared to 4.1 among infants born to White mothers. While there had been a downward trend in infant mortality in MN in past years, there has not

[39] American College of Obstetricians and Gynecologists. Immediate postpartum long-acting reversible contraception. Committee Opinion No. 670. Obstet Gynecol 2016; 123:e32-7.

been further improvement for the past few years (MN Center for Health Statistics, Infant Mortality). Furthermore, in 2016, there were 375 fetal deaths and 354 infant deaths in Minnesota.

Reinstating the FIMR statute would provide the Minnesota Department of Health access to prenatal care and delivery medical records, birth and death records, coroner reports and contact information for the family when there is a fetal death or infant death. Without access to this comprehensive information, understanding disparities in fetal and infant deaths, and possible solutions to reduce disparities is challenging. The recommendation would be that the Department of Health conduct mortality reviews for all fetal and infant deaths in racial and ethnic communities experiencing disproportionately high mortality rates and a sample of other fetal and infant deaths in the state for comparison.

FIMR is a continuous quality improvement methodology and community-based process developed by the American College of Obstetricians and Gynecologists and the Maternal and Child Health Bureau. A visual representation of the FIMR process can be found in Appendix I.

FIMR Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Establish a FIMR (Fetal Infant Mortality Review) process for infant deaths, to include stillbirths	**X**		**X**

Trauma-Informed Care

Environments with overwhelming stress, sometimes called toxic stress, can shape a person's brain chemistry and functioning in a way that negatively influences lifelong health, social, and economic outcomes, especially when experienced during childhood (0-18). Adverse Childhood Experiences (ACES) are well-documented sources of stress, such as child abuse and neglect, domestic violence, parental substance abuse, and caregiver incarceration. ACES are linked to poor health and social outcomes throughout the lifespan. For example, Minnesotans with three or more ACEs are over three times more likely to experience depression and anxiety. Childhood trauma is ubiquitous; more than 55% of Minnesota adults experienced at least one ACE and 21% had three or more**.** Social conditions such as institutional racism, and Social Determinants of Health can also be a source of toxic stress.

Ensuring health and human service providers understand and recognize the impact of trauma and historical trauma is a foundational step towards trauma informed care, including clinical and non-clinical staff. Trauma-informed care also includes other steps to fully shift organizational and clinical policies and practices. Key ingredients for trauma-informed care include: engaging families in organizational planning, creating safe environments, preventing secondary trauma in staff, building a trauma-informed workforce, involving families in determining interventions, screening for trauma, training staff in trauma-specific treatments, training on systemic racism, and engaging referral sources and partner organizations.

Minnesota has been awarded a three-year $26.7 million federal Preschool Development Grant (PDG), Dec 2019- Dec 2022. The grant will focus on the state mission of addressing racial, geographic, and economic inequities, so all children in Minnesota are born healthy and able to thrive. One of the goals outlined in the PDG includes identifying the capacity and training needs to implement effective, culturally responsive and trauma-informed community-based services. These resources are needed for training health and human service providers and to begin the organizational change process to become trauma informed.

Trauma Informed Care Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Support funding for provider education related to trauma informed care		**X**	**X**

Reference: Center for Health Care Strategies, Inc. Key Ingredients for Trauma-Informed Care https://www.chcs.org/resource/key-ingredients-trauma-informed-care/.

Ban/Restriction on all Nicotine Flavors including Menthol

Youth tobacco use is on the rise again for the first time in 17 years; 26% of surveyed high school students reported tobacco use in the past 30 days, and approximately 20% used e-cigarettes in the past 30 days. E-cigarette use among high school students is up 50% since 2014, and is a top reason that Minnesota is seeing this increase, along with aggressive e-cigarette marketing to younger demographics, and the menthol flavoring, which is attractive to youth. Nicotine interferes with brain maturation, cognitive development, and mental health, particularly on a developing adolescent brain. Adolescent nicotine exposure can lead to heavy tobacco use and risk of addiction to other substances, which is a significant public health concern.

In Minnesota, the Tobacco-21 (T-21) bill passed in the Legislature and signed by the Governor in May 2020. This bill is similar to the Federal legislation that was signed into law in early 2020 and prohibits those under 21 years from buying tobacco. A study conducted in Minnesota found that increasing the legal age to purchase tobacco to 21 years old would decrease smoking initiation among 15 to 17 year-olds by 25%, and among 18-year-olds by 15%. Increasing the age gap between young people and those who can legally purchase tobacco will reduce youth access to all tobacco products including e-cigarettes, hookah, and cigars. More than 70 Minnesota counties and cities and many other states have raised the sales age of tobacco to 21. In Needham, Massachusetts, the sales age was raised to 21 in 2005; since then, they have seen an almost 50% decrease in tobacco use among high school students.

T-21 for the State of Minnesota will reduce access to tobacco products and decrease smoking initiation among young Minnesotans, thereby preventing challenging tobacco addictions, secondary and tertiary health issues from developing. Menthol and flavors is still attractive for young people and must be addressed, as tobacco companies continue to entice young people to use tobacco products by marketing novel delivery methods for flavored nicotine and menthol. Price reduction by issuing redeemable coupons via social media continues to be a threat to efforts toward reducing youth smoking. The following organizations also support reducing youth initiation to tobacco: American Cancer Society Action Network, American Heart Association, American Lunch Association, ClearWay Minnesota℠, Minnesota Academy of Family Physicians, and Service Employees International Union (SEIU) Minnesota State Council. Supporting the T-21 bill for the State of Minnesota would reduce access to tobacco products and decrease smoking initiation among Minnesota youth, preventing challenging tobacco addictions from forming and secondary and tertiary health issues.[40]

Additionally, ongoing services to support cessation are important to improve health outcomes for children and youth, in addition to adults.

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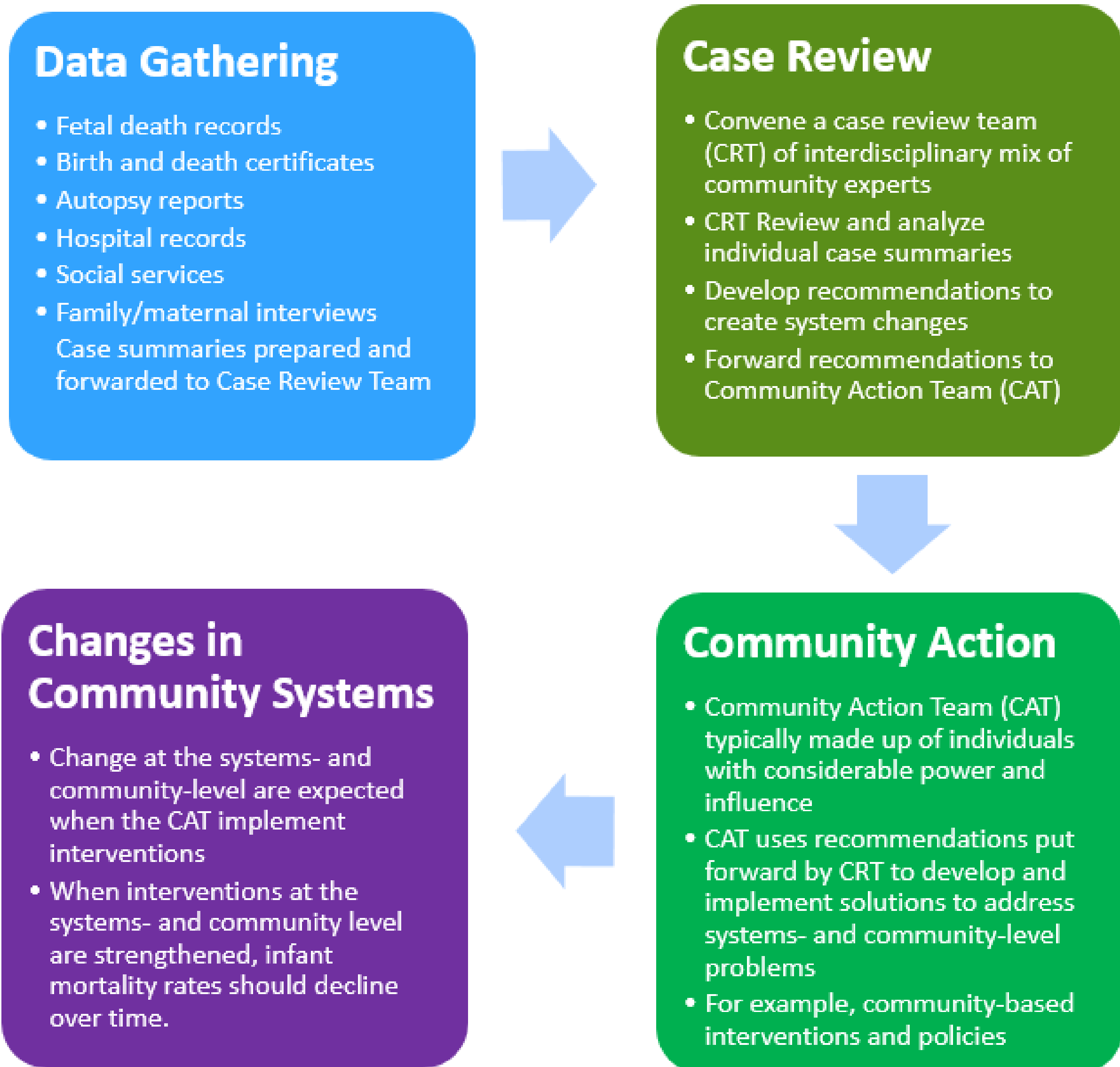
[40] Raising the Minimum Sale Age | Tobacco Prevention and Control (n.d.). Retrieved February 13, 2019 from http://www.health.state.mn.us/tobacco21.

Ban/Restriction on Flavored Nicotine Products, including Menthol Recommendation(s)	MDH Policy	Legislative Action	Collaboration
Advocate for the governor's support for total restriction/ban on all flavored nicotine products including menthol	**X**	**X**	
Support the continued funding of the state's Quit Line		**X**	

APPDENDIX I

Fetal Infant Mortality Review Process



Source: Fetal and Infant Mortality Review Manual: Guide for Communities, National Fetal and Infant Mortality Review Program. Second Edition.

APPENDIX II

Additional MCH Advisory Task Force Recommendations

1. Support increase of funding for fluoride varnish, sealant application, and other dental services. Consider the use of emergent workforce personnel to deliver the service.

Many providers will not accept Medical Assistance (MA) for dental service reimbursement. Individuals on MA are placed on long wait lists, resulting in lack of dental care, or individuals are required to travel long distances to receive dental care. Preventative dental care should be readily available for those on Medical Assistance plans, to prevent health problems later. Medical Assistance funding for dental care needs to be at an amount that adequately covers cost of care and that providers are willing to accept.

2. Review risks related to lack of rural hospital OB services and necessary supports to hospital staff in rural areas, to ensure safe prenatal/OB services.

More than half of Minnesota's 60 counties that are considered rural have no hospital-based obstetrics department. The consequences of losing hospital-based OB services are higher preterm births and the potential for out-of-hospital births with all the risks that entails. Potential perinatal impacts are increased stress, cost, transportation issues, and laboring and delivery en route. In some areas of Northern Minnesota, women travel 110-140 miles to give birth, which can have significant impact on safe OB care.

3. Collaborate with DHS in an effort to increase Medical Assistance reimbursement rates.

Minnesota Medicaid has a long history of low reimbursement rates and being unofficially subsidized by private insurance coverage. Medical Assistance reimbursements have not kept up with the cost of providing care. Statistics point toward home care for medically fragile kids' safety and better health outcomes, yet we continue to underfund and do not pay caregivers properly to do that. Our current health care system cannot handle the medical transition to adult care for medically complex kids who are living longer and home care staff/support is at a critical level, forcing families to quit jobs in order to take care of their children.

4. Ongoing funding support for preventative services, including, early childhood education, and preschool scholarships for low-income families, including access to quality childcare, particularly for low-income families.

Limited scholarships are currently available to support low-income children to attend quality preschool programs. More scholarship availability is needed to support children most at need and who are lacking these opportunities. In addition, there is a need to assure quality childcare access statewide and with adequate funding support for low-income children.

5. Increase access to chemical and mental health services statewide.

There is a current shortage of mental and chemical health providers and facilities in Minnesota. This creates lengthy wait times to see providers and/or individuals are required to travel great distances for care. In particular, there are critical shortages of child and adolescent chemical/mental health providers and services.

General principles supported by the task force:

- As a task force we support ongoing funding for evidence-based practices, including family home visiting, prenatal substance use, chemical health, mental health, etc.
- As a task force, we acknowledge the need for adequate financial support and systems in place related to social determinant of health (housing, income, healthcare access, transportation, and education) to ensure all families and children are safe and have stable environments within which to live and grow.
- As a task force, we support ongoing funding for preventative services, including early interventions, early childhood education, and preschool scholarships for low-income families, including access to quality childcare and infant day care.