Annual Report to the Commissioner
MATERNAL AND CHILD HEALTH ADVISORY TASK FORCE
April 2019
Maternal and Child Health Advisory Task Force Annual Report

Minnesota Department of Health
Maternal and Child Health
PO Box 64882
St. Paul, MN 55164-0882
Phone 651-201-3760 // Fax 651-201-3590
health.mch@state.mn.us
www.health.state.mn.us

To obtain this information in a different format, call: 651-201-3760.
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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 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 as ex-officio members. Ex-officio members must qualify as a representative in one of three statutory categories. The chair of the Task Force forwards recommended ex-officio members to the Commissioner for appointment.

Membership

Consumer Representatives

Carolyn Allshouse (Family Voices of Minnesota) **MCH Area(s) of Expertise:** Minnesota Health Care Programs

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. Tricia 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.

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 both as 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.

Jayne Whiteford - MCH Area(s) of Expertise: Jayne was appointed as a consumer representative in 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. In that position, 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 Department of Health) MCH Area(s) of Expertise: Stephanie was reappointed to the MCH Advisory Task Force in 2012 and has expert knowledge in early childhood and school readiness, targeted home visiting, infant mortality prevention, safety net services, and community engagement. She is an MCH Advisory Task Force Executive Committee member.

Susan Morris (SCHSAC Representative) MCH Area(s) of Expertise: Susan has been a part of the Task Force Team since 2013. Susan is an Isanti County Commissioner, past Chair of the Association of Minnesota Counties, and has extensive experience in local governance and public health.

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 was appointed to the task force in 2018. She is a Public Health Nurse. Tamiko has experience in case management, screening, early intervention and referral, community outreach and engagement, birth equity, and mental health and wellness promotion.

Professional Representatives

Kenneth Bence, (Association of Residential Resources Minnesota) MCH Area(s) of Expertise: Kenneth was appointed to the task force in 2012, and has provided a breadth of knowledge regarding Medicaid managed care, community collaboration, health equity
improvement, and gun violence prevention. He is an MCH Advisory Task Force Executive Committee member.

**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.

**Aida Miles,** (University of Minnesota, School of Public Health) **MCH Area(s) of Expertise:** Having served on the MCH Advisory Task Force since 2016, Aida brings many skills to the task force, including extensive knowledge in pediatric nutrition and nutrition interventions for children and youth with special healthcare needs, childhood obesity prevention and treatment, and pediatric feeding disorders. Additional areas of expertise include client-centered counseling (Motivational Interviewing) and creating inclusive and accessible teaching environments for youth through the use of Universal Design for Learning. She is an MCH Advisory Task Force Executive Committee member.

**Dr. Michelle O’Brien,** (HealthPartners Health Center for Women) **MCH Area(s) of Expertise:** Michelle 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.

**Krista Post** (Postpartum Counseling Center in Minneapolis) **MCH Area(s) of Expertise:** Krista has been a part of the MCH Advisory Task Force since 2016. She brings expertise in reproductive and maternal mental health, and experience training rural medical providers in perinatal mental health, with skills in leadership and public presentations.

**Ex-officio Members**

**Dr. Amos Deinard** (American Academy of Pediatrics, Minnesota Chapter) **MCH Areas(s) of Expertise:** Dr. Deinard was appointed to the Task Force in 2016 with expertise pertaining to pediatrics, including pediatric oral health.

**Nancy Hoyt Taff** (HealthPartners, Public Health Programs Manager) **MCH Areas(s) of Expertise:** Nancy was appointed to the Task Force in 2014. She has experience with Minnesota Health Care Programs.

**Pat Lang** (PACER Center) **MCH Area(s) of Expertise:** She has experience in family advocacy, medical and health systems, and experiential knowledge as a parent of a child with special health care needs.

**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.

**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.

**Cindi Yang** (Department of Human Services, Child Care Services Division) **MCH Area(s) of Expertise:** Cindy was appointed to the task force in August 2015. She has expertise in the promotion of child wellbeing and family self-sufficiency through the delivery of quality child care and child development and economic support services to children and families.

**Activities**

The MCH Advisory Task Force held quarterly meetings throughout 2018. At its first meeting in 2018, members elected Deb Purfeerst as Chair and Michelle O’Brien as Chair-elect. MDH staff, along with Chair Purfeerst, provided orientation for new members appointed in 2018: Eugene Nichols, Tamiko Ralston and Jayne Whiteford.

The work of the Task Force is governed by a set of operating procedures approved by the membership. During 2018, the task force members were engaged in the following activities:

1) Developed the Task Force 2018-2019 work plan
2) Provided input to Minnesota’s State Action Plan for the MCH Title V Block Grant 2019 Application
3) Provided feedback on the proposed communication plan for the FY2020 Title V MCH Block Grant Five-Year Needs Assessment
4) Worked with the Community Partnership Department at MDH for assistance in its recruitment efforts to diversify membership, reflective of communities experiencing health disparities
5) Reviewed preliminary results from the MCH 5-Year Needs Assessment Discovery Survey, and strategized how to use this information, along with the expertise and knowledge of task force members, to advance maternal and child health in Minnesota
6) Reviewed and discussed the Office of the Legislative Auditor 2018 report on Minnesota’s early childhood programs
7) Selected the 2018 Betty Hubbard MCH Leadership Award recipients at the statewide and community levels, for outstanding contributions to maternal and child health in Minnesota

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. Presentation topics included community and regional issues related to rural hospital closures; increasing lack of access to obstetrical services in rural communities; autism spectrum disorder; and Dakota County’s Birth to Age 8 Collaborative initiative.

Recommendations

The MCH Advisory Task Force (MCHATF) identified 14 areas of concern impacting the health of children and families in Minnesota. In an effort to streamline recommendations, members participated in a prioritization process at the December 2018 meeting. Recommendations were prioritized based on three criteria: feasibility, equity, and urgency.

The resulting six top recommendations prioritized by the members are listed below. The remaining recommendations are listed in Appendix II.

1. **Compensation for MCH Advisory Task Force 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 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.

2. **Support continuation of the Health Care Access Fund at current levels or more**

   The Health Care Access Fund (HCAF) was created in 1992 to provide health coverage for the working poor through MinnesotaCare and other health care programs for low-income residents, to contain health care costs and to improve the quality of health care services. The HCAF has paid for health care for about 80,000 Minnesotans. This comes through subsidized insurance for those with incomes between 138 percent and 200 percent of the federal poverty level. It has also provided funds for the expansion of Medicaid coverage under the Affordable Care Act and most recently paid for a 2017 reinsurance program that enabled a reduction in premiums for the nine percent of residents who buy through the individual market or benefit from policies purchased through the small group market.

   The MCHATF recommends MDH support continuation of the Health Care Access Fund and the health care provider tax at current levels or more, which sunsets December 31, 2019. Loss of funding would jeopardize access to health care for thousands of low-income Minnesotans and put the health and well-being of Minnesota’s communities at risk.

3. **Create additional reimbursement to increase availability of immediate post-partum LARC**

   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 structure for hospitals and other institutional supports to encourage IPP LARCs. Per 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.

The American College of Obstetrics and Gynecologists (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.

4. Establish a FIMR (Fetal Infant Mortality Review) process for infant deaths, to include stillbirths

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. 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.

5. Support funding for provider education related to 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 impacts 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 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 patients in organizational planning, creating safe environments, preventing secondary trauma in staff, building a trauma-informed workforce, involving patients in the treatment process, screening for trauma, training staff in trauma-specific treatments, and engaging referral sources and partner organizations. Resources are needed for training health and human services providers and to begin the organizational change process to become trauma informed.


6. Support implementation of Tobacco-21 statewide

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 currently under consideration in the Legislature would prohibit 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. Thirty-one 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.\textsuperscript{v}

The following organizations also support raising the tobacco sale age to 21: American Cancer Society Action Network, American Heart Association, American Lunch Association, ClearWay Minnesota\textsuperscript{sm}, 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.\textsuperscript{vi}

\textsuperscript{i} Callaghan, P. (2019, February 06). The tax that pays for MinnesotaCare is set to expire at the end of the year. So far, legislators can’t agree on a plan to replace it. Retrieved February 13, 2019, from https://www.minnpost.com/state-government/2019/02/the-tax-that-pays-for-minnesotacare-is-set-to-expire-at-the-end-of-the-year-so-far-legislators-cant-agree-on-a-plan-to-replace-it/


\textsuperscript{iii} www.health.mn.gov/tobacco


\textsuperscript{v} Kassed Schneider S., et al. Community reductions in youth smoking after raising the minimum tobacco sales age to 21. Tob Control. 2015.

\textsuperscript{vi} Raising the Minimum Sale Age | Tobacco Prevention and Control. (n.d.). Retrieved February 13, 2019, from http://www.health.state.mn.us/tobacco21
APPENDIX I

Fetal Infant Mortality Review Process

Data Gathering
- Fetal death records
- Birth and death certificates
- Autopsy reports
- Hospital records
- Social services
- Family/maternal interviews
  Case summaries prepared and forwarded to Case Review Team

Case Review
- Convene a case review team (CRT) of interdisciplinary mix of community experts
- CRT review and analyze individual case summaries
- Develop recommendations to create system changes
- Forward recommendations to Community Action Team (CAT)

Changes in Community Systems
- Change at the systems- and community-level are expected when the CAT implement interventions
- When interventions at the systems- and community level are strengthened, infant mortality rates should decline over time.

Community Action
- Community Action Team (CAT) typically made up of individuals with considerable power and influence
- CAT uses recommendations put forward by CRT to develop and implement solutions to address systems- and community-level problems
- For example, community-based interventions and policies

APPENDIX II

Additional MCH Advisory Task Force Recommendations

1. **Dedicate revenue from the tobacco tax to fund the state’s Quit Line, since tobacco settlement funds are due to expire in 2020.**

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

2. **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.

3. **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.

4. **Maintain ongoing financial support for evidence-based family home visiting (EBFHV) in Minnesota.**

   The positive outcomes from EBFHV are well researched. The current funding amount needs to be maintained for evidence-based family home visiting, and portions should not be redirected to support non-evidence based family home visiting.

5. **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.
6. Ongoing funding support for preventative services, including early intervention, 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.

7. 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.

8. Summary Recommendations from Stillbirth Workgroup Adopted by Task Force:

- MN Stillbirth/Fetal Death data should be tracked, reported and included in the annual MDH Vital Statistics Report.
- There should be a service (similar to services historically provided by the MN SIDS Center), to provide support, information, and assistance for families who experience a stillbirth.

Currently there is no funding or legislative authority to do this work. Stillbirth rates have not declined in over 10 years. Numbers for stillbirths remain about the same: 350 per year in Minnesota.

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.