Maternal and Child Health Services Title V Block Grant

Minnesota

FY 2026 Application/ FY 2024 Annual Report

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Table of Contents

I. General Requirements

I.A. Letter of Transmittal

July 14, 2025

Laura Kavanagh, M.P.P
Associate Administrator (Acting)
U.S. Department of Health and Human Services
Health Resources and Services Administration
Maternal and Child Health Bureau
Division of State and Community Health
5600 Fishers Lane, Room 11N35
Rockville, MD 20857

Dear Ms. Kavanagh:

Minnesota is pleased to submit to you the 2026 Title V Maternal and Child Health (MCH) Block Grant application and 2024 annual report. This document illustrates the ways Minnesota has used Title V funding to promote and improve the health and well-being of mothers, children, youth, and families including children with special healthcare needs (CSHCN).

If you have questions related to Minnesota's application and annual report, please contact me at 651-201-3594 or noya.woodrich@state.mn.us. If there are questions related to the budget documents, please contact Meredith O'Brien at 612-860-9533 or Meredith.obrien@state.mn.us.

I look forward to feedback on our annual report and application in October.

Sincerely,

Noya Woodrich

Noya Woodrich,
Director
Child and Family Health Division
PO Box 64975
St. Paul, Minnesota 55164-0975

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms",* OMB NO: 0915-0172; Expires: December 31, 2026.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Minnesota's Title V Program

The Title V Maternal and Child Health (MCH) Block Grant – a federal-state partnership between the State of Minnesota and the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau – aims to promote and improve the health and well-being of women, infants, youth, and families, as well as children with special healthcare needs (CSHCN).

Title V is the only federal program focused solely on improving the health of all mothers and children – authorized in the 1935 Social Security Act to give states flexibility in meeting the unique needs of their children and families.

Minnesota's Title V program is committed to delivering systems of care and support that are:

- Within a public health service model.
- Data-driven and evidence-informed.
- Community- and family-led.
- Helping all MCH populations to achieve their full health potential.

Figure 1. Systems of care and support

The Child and Family Health (CFH) Division – within the Minnesota Department of Health (MDH) – serves as the state-level administrator of the Title V MCH Block Grant, carrying out the required activities set forth by federal legislation.

Minnesota's Title V program partners with the state's 52 Community Health Boards (CHBs) – 53 beginning January 1, 2026 – comprised of 87 local public health (LPH) agencies – who receive two-thirds of Minnesota's Title V funding – to carry out the core public health functions of assessment, assurance, and policy development with a local-state impact. Examples of some of the activities carried out by CHBs through the Title V program include:

- Providing education and outreach on breastfeeding and lactation.

- Implementing Family Home Visiting services.
- Completing developmental screening and connecting families to needed services.

Most of Minnesota's Title V efforts focus on either (1) enabling people to access care or improve health outcomes, or (2) focus on developing the infrastructure to ensure people can access care and live healthy lives – **less than 10% of Title V funding goes toward direct services.**

Due to the intersectional nature of public health work to meet the needs of Minnesota's mothers, children, and families, including CSHCN, the Minnesota Title V program partners with:

- Divisions and programs across the Minnesota Department of Health
- Governor's Children's Cabinet
- Minnesota Department of Children, Youth, and Families
- Minnesota Department of Education
- Minnesota Department of Human Services – including Minnesota's Title XIX Medicaid Program
- Minnesota Housing Finance Agency
- Minnesota Management and Budget

2025 Needs Assessment and State Action Plan

Every five years, Minnesota's Title V Program is federally required to conduct a comprehensive, statewide needs assessment to gather information on the health and well-being of the state's MCH populations. The needs assessment keeps Minnesota's Title V program and partners apprised of emerging and ongoing issues, as well as provides direction on its' priorities, strategies, and activities over a five-year period. Additionally, the needs assessment is completed in partnership with families, community organizations, public health professionals, and others across the state to more thoroughly understand the needs of mothers, children, and families living in Minnesota through their stories and experiences.

The goal of Minnesota's 2025 statewide Title V MCH Block Grant needs assessment and action planning was to better understand strengths, gaps in services, and needs of MCH populations; and to strengthen partnerships for effective implementation of strategies addressing the needs of Minnesota's mothers, children, and families to improve maternal and child health outcomes, including those of CSHCN.

The information collected through the needs assessment is used to identify statewide priorities, drive strategic action planning, and set criteria for how best to allocate resources. Seven priorities were identified for 2026-2030 Minnesota State Action Plan. Figure 2 shares an overview of these priorities, as well as the strategies developed to address each priority through Title V as outlined from HRSA and federal and state legislation.

Figure 2. Minnesota Title V 2026-2030 State Action Plan

MINNESOTA TITLE V

2026-30 Action Plan

Priority: Healthy infants, families, and communities

Improve the wellbeing of families with pregnant women and infants through supports and services that are community-based and responsive to individual needs and experiences.

Strategies:

- Amplify resources, services, and supports that are responsive to community needs and foster the health and wellbeing of families with pregnant women and infants.
- Collaborate with trusted community organizations and partners to maximize resources that promote the health and wellbeing of pregnant women and infants.
- Promote and strengthen development and broad representation in the workforce supporting infant and perinatal health.
- Enhance and integrate knowledge of the impact of parental mental health and intergenerational experiences on perinatal/infant health.

Priority: Child mental health and wellbeing

Increase the number of children who are screened for and connected with mental, behavior, and wellbeing resources and services that are responsive to individual needs and experiences.

Strategies:

- Amplify resources, screening, training, services, and supports that are responsive to and address the needs of children and their communities.
- Ensure children from all populations and geographic areas have access to mental health and wellbeing promotion, screening, and resources.
- Provide resources and support for school-based health centers and school nurses to address mental health and wellbeing for children in schools.
- Increase capacity of the child health workforce to provide wellbeing and mental health support across the state.

Priority: Coordinated support and access for children and youth with special health needs

Expand awareness of available services and improve access to high-quality, family-centered supports that help children, youth, families, and care teams address health and development in ways that reflect their needs and preferences across settings.

Strategies:

- Strengthen family-centered, evidence-informed supports, services, and resources.
- Involve families and caregivers in shaping, implementing, and improving programs and services.
- Collaborate across systems to remove and reduce barriers to simplify family navigation and improve access to resources and supports.
- Support local efforts to provide services and resources in ways that meet family needs and preferences.

Priority: Adolescent mental health and wellbeing

Increase adolescent-centered mental health and wellbeing resources and upstream-focused, universal supports.

Strategies:

- Amplify resources, services, and supports for adolescents who are medically underserved and at greater risk for poor health outcomes.
- Build community capacity to support and increase access to adolescent-centered physical and mental health resources and supports.
- Nourish transformation of systems, environments, and norms that support adolescents in self and community care.
- Promote change in societal attitudes by challenging stigma and harmful beliefs toward adolescent mental health and illness.

Priority: **Comprehensive perinatal systems of care**

Ensure perinatal women have access to systems of care and care navigation that are comprehensive, high quality, and responsive to individual needs and experiences.

Strategies:

- Enhance resources, services, and supports that are responsive to community and individual needs and experiences to improve birth experiences for populations who are medically underserved and at greater risk for poor health outcomes.
- Broaden virtual and in-person services for perinatal women.
- Strengthen health literacy and system navigation by providing community-responsive resources, services, and supports.
- Improve quality and availability of family-centered mental health and substance use disorder services and resources for perinatal women.

Priority: **Community health drivers**

Address the key drivers and underlying conditions that influence the health of Minnesota's families and communities.

Strategies:

- Amplify resources, services, and supports that are responsive to community needs and support the health and wellbeing for all.
- Strengthen the capacity of public health professionals and community leaders to effectively address community health drivers, such as housing and early childhood systems of care, using a public health lens.
- Vitalize Title V activities to address community health factors to improve MCH outcomes and access to care across the life course.
- Ensure data produced and reported through Title V highlight meaningful differences in maternal and child health outcomes, explore root causes, discuss their impact, and provide recommendations for improving health across MCH populations.

Priority: **Optimal systems and policies**

Support transformation of systems and policies that drive priorities for improving health outcomes, reducing differences, and optimally serving MCH populations in Minnesota.

Strategies:

- Amplify community responsive resources, services, and supports to address systems and policies to support the health and wellbeing of MCH populations who are medically underserved and at greater risk for poor health outcomes.
- Develop and mobilize strong interagency, multisector, and community partnerships to respond to unevenn trends in maternal and infant deaths through targeted interventions.
- Build workforce and partner capacity to promote systems and policies that optimally serve all MCH populations in Minnesota.
- Engage partners and interest holders to promote family engagement and partnership across all sectors.

Minnesota Department of Health | Child and Family Health Division
health.cfhcommunications@state.mn.us | 651-201-3589
www.health.state.mn.us/communities/titlev/index.html

August 2025

To obtain this information in a different format, call 651-201-3589.

How federal Title V funds support state maternal and child health (MCH) efforts

Title V MCH Block Grant and match funds, provide core funding for local and statewide MCH efforts. Two-thirds of Minnesota's Title V funds are distributed to the state's 52 Community Health Boards (CHBs) (53 beginning January 1, 2026), comprised of 74 local public health (LPH) departments representing 87 counties. This is governed by Minnesota Statute § 145.88-145.883 (https://www.revisor.mn.gov/statutes/cite/145.88), which also directs the use of these funds to programs that address needs of MCH populations, including children with special health care needs (CSHCN). CHBs conduct regular community health assessments to determine needs, priorities, and programming within their geographic area. Each year, CHBs submit:

- A work plan of activities funded through Title V and match funds for the upcoming FFY.
- A budget that allocates Title V and match funds for their upcoming FFY planned activities.
- Annual reporting of Title V and match fund activities, including previous FFY expenditures and populations data.

One-third of Minnesota's Title V funds support Minnesota Department of Health (MDH) staff who provide leadership to state MCH programs and policies and provide technical assistance to CHBs. Specifically, 20.40 FTEs within the Child and Family Health Division (CFH) are supported with Title V dollars. The CFH Division leads Title V MCH Block Grant activities and is where Minnesota's Title V Director, MCH Director, CSHCN Director, and Coordinator are housed. The MCH and CSHCN Sections within the CFH Division lead Title V efforts – collaborating with the Family Home Visiting (FHV), and Women, Infants, and Children (WIC) Sections, as well as with other MDH programs.

This distribution of Title V funds helps create more consistent and fair access to support at the program, community, and state/policy levels. Title V funds support the general MCH and CSHCN populations and the funds given to CHBs are flexible for use in addressing unmet needs in communities in the following areas:

- Improved Pregnancy Outcomes
- Family Planning
- Children with Special Health Care Needs – Ages birth to 22
- Child and Adolescent Health – Ages 1 to 22
- Infant Health – Ages 0 to 1

Locally identified priorities focus on supporting populations that experience barriers to services and resources, particularly individuals and families who are considered high risk and/or low income. At the state/policy level, staff in positions supported by Title V dollars engage with community, with a focus on understanding the unique challenges faced by different populations. The level of engagement, including how much input or decision-making communities have in shaping work, varies by staff and program with compensation provided for their expertise and time when possible. Some staff are also engaged in policy work informed by community priorities and seek to expand funding and support for efforts that strengthen the ability of communities to share their experiences and inform decisions across sectors and systems.

Success story

Community input and family engagement are integral to community health boards (CHBs) in the process of identifying the use of federal Title V funds and, in FFY 2024, were critical for one CHB working with local school districts to develop and deliver student- and classroom-specific sexual health curriculum. Input from health teachers was gathered about the content covered in their human development unit, which provided a foundation for the CHB's Public Health Specialist's lessons. They also gathered input to understand student and caregiver concerns and sensitivities, students' preferred learning styles, appropriate preparation for the delivery settings, accessible presentation mediums, and demographics of the learner groups. Presentation materials featured a balanced mix of visuals and text to cater to different learning styles, while interactive elements engaged participants and reinforced key messages. Additionally, knowledge of other community organizations' sexual health content delivery was leveraged to avoid redundancy and ensure a cohesive approach.

During education sessions, the Public Health Specialist engaged directly with students to assess their baseline knowledge by asking about the language and terms they typically use to describe sexual health concepts. This allowed the Public Health Specialist to align the language and explanations with the students' understanding while introducing and emphasizing the importance of anatomically correct terminology. The Public Health Specialist also inquired about the sources of students' current sexual health knowledge to tailor future presentations effectively, addressing gaps or misconceptions. These steps ensured that the program was not only evidence-based but also contextually appropriate and responsive to the needs of the community. This included using neutral language and imagery that featured a variety of identities which fostered a sense of belonging. Comprehensive language was emphasized to make the content relevant to individuals regardless of anatomy, ensuring topics like sexually transmitted infections, contraception, consent, healthy relationships, and pregnancy prevention were applicable to all. The materials were also tailored to be age-appropriate, with time allocated for questions to address varying levels of background knowledge. Additionally, ground rules were established to set a respectful tone, creating a safe space to explore a range of feelings and experiences. This multifaceted strategy ensured all participants could meaningfully engage with and benefit from the education provided.

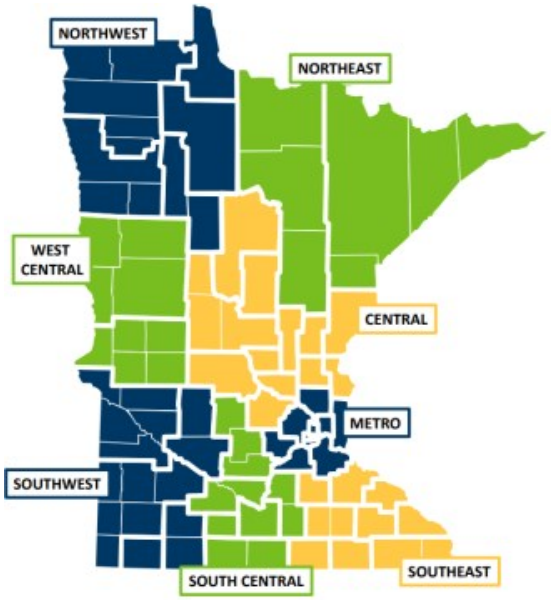
State Description

MINNESOTA – THE LAND OF 10,000 LAKES

Demographics and geography

Minnesota is a medium-sized state, covering slightly over 84,000 square miles across 87 counties and 11 Tribal Nations, often referenced across eight regions of service (Figure 1).

Figure 1. Map of Minnesota State Community Health Services Advisory Committee Regions



In 2023, 5,761,530 people lived in Minnesota, with over half of residents living in the seven-county Minneapolis-St. Paul metropolitan area; and, while for most of the twentieth century, Minnesota had a relatively homogenous population, the twenty-first century has seen a shift in the composition of the general population.

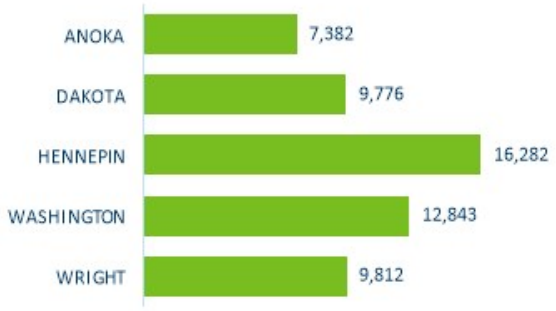
In 2023 Minnesota was home to:

- 76.9% White
- 7.9% Black or African American
- 5.5% Asian
- 1.4% American Indian
- 6.5% Hispanic or Latino
- 3.4% Two or More Races

There were 61,737 live births in Minnesota in 2023, continuing the trend down from the peak of 73,675 in 2007.

Although birth rates are at historic lows, Minnesota had a population growth rate of 7.6% between 2010 and 2020, adding 402,569 residents (net) and Minnesota's population grew an additional 1.6 percent since the decennial census in 2020.

Figure 2. Counties that added the most net residents between 2020 and 2023



Most growth has been in the seven-county Twin Cities metropolitan area. The fastest growing counties by population between 2010 and 2020 (net growth) are shown in figure 2.

Minnesota's age distribution is like the United States overall. By 2035, the number of those ages 65+ is expected to surpass the number of those under 18 for the first time in history.

In 2023, Minnesota was home to **1,448,755 children under age 18** – representing **23% of the population**.

While Minnesotans aged 18-64 are most of the present-day workforce, children under eighteen represent the workforce of the future and their preparation is critical to the continued economic success of the state.

Minnesota has an educated population with a high percentage (94%) of adults have a high school diploma or higher and a significant portion also holding a bachelor's degree or higher.

Key demographic changes in MN include:

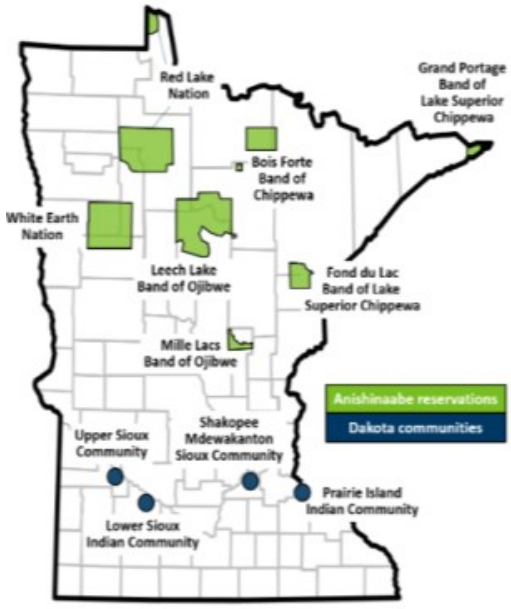
- an aging population
- decreasing birth numbers
- growth concentrated in urban areas

These changes will impact the need for and type of healthcare services, housing, education, business, commerce, and social services.

Tribal Nations and Communities in Minnesota

As of 2023, approximately 167,400 people in Minnesota identified as American Indian and/or Alaska Native (either alone or in combination with one or more other races) representing 2.9% of the state's population. About 40,333 (30%) American Indians lived on a reservation/community according to 2017-2021 Census estimates, while approximately 50,870 (37.9%) American Indians/Alaskan Natives live in the Minneapolis-St. Paul metro area. The additional 32.1% of American Indians live in greater Minnesota.

Figure 3. Tribal Nations and Communities in Minnesota



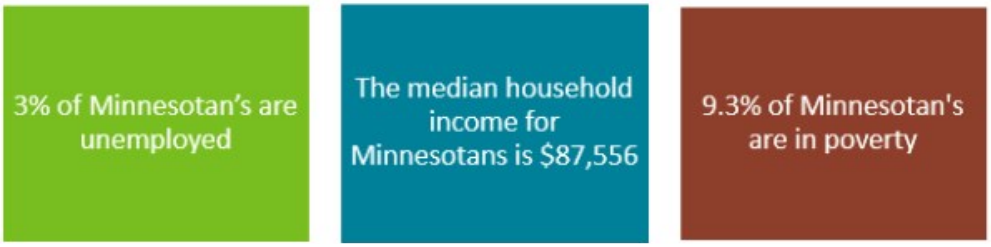
Minnesota is home to 11 federally recognized tribal nations and communities.

Anishinaabe (Ojibwe) Tribes	Dakota (Sioux) Communities	Urban American Indian Communities
1. Bois Forte Band of Chippewa 2. Fond du Lac Band of Lake Superior Chippewa 3. Grand Portage Band of Lake Superior Chippewa 4. Leech Lake Band of Ojibwe 5. Mille Lacs Band of Ojibwe 6. Red Lake Nation 7. White Earth Nation	1. Lower Sioux Indian Community 2. Prairie Island Indian Community 3. Shakopee-Mdewakanton Sioux Community 4. Upper Sioux Community	1. Bemidji 2. Duluth 3. Minneapolis – St. Paul (Twin Cities) 4. This includes the Little Earth of United Tribes Community and the Mendota Mdewakanton Dakota Tribal Community – neither federally recognized tribes.

Economics

A state's economy plays a crucial role in shaping the quality of life for its residents, with indicators like poverty rates and unemployment levels offering key insights into its overall health and stability.

Figure 4. Minnesota is doing better than the national average on unemployment, household income, and poverty



Minnesota's seasonally adjusted unemployment rate dropped to 3% in MN in 2024 and is lower than the national unemployment rate of 4.1%. In 2023, 9.3% of Minnesotan's are in poverty, down 0.3 points from 2022 and ranked third lowest among the states, tied with Colorado.

Unique strengths and challenges

Minnesota has many unique strengths and challenges within the systems that support and impact the health status of its MCH population, including CSHCN. Minnesota is consistently cited among the top 10 states for overall health, best run state, and best state to raise a family. However, these high rankings can overlook important gaps in health and wellbeing that exist across different communities, especially when considering factors like where people live, their income level, or background.

Availability and access to health care and supportive services

Minnesota's healthcare system ranks in the top in overall performance according to the Commonwealth Fund. Minnesota coordinates a comprehensive set of health insurance options intended to help meet the health and wellbeing needs of Minnesotans. However, not everyone in the state has equal access to health insurance care based on their demographic factors like economic situation and geographic location. According to the most recent Minnesota Health Access Survey, around 3.8% of Minnesotans lacked health insurance coverage in 2023. The maintained high rate of coverage seen since 2019 was consistent with levels experienced after the full implementation of the Affordable Care Act in MN in 2014 when 95.3% of Minnesotans had health insurance coverage.

Minnesota Health Care Programs (MHCP) provide health care coverage to eligible families with children, adults, people with disabilities, and seniors. MHCP include Medical Assistance (MA) and MNCare (MNCare). These programs are administered by the MN Department of Human Services (DHS).

MHCP financed 43.4% of all births (27,759 infants) in 2022, down slightly from 43.9% in 2018.

Minnesota is home to many excellent hospitals, including the number one ranked hospital in the United States, according to U.S. News and World Report – the Mayo Clinic. As of Nov. 2023, there were 127 community state licensed hospitals with 16,139 beds, of which 76 are designated Critical Access Hospitals (CAHs). CAHs are smaller hospitals (fewer than 25 beds), mostly in rural areas, which receive higher reimbursement from Medicare, if they maintain certain services. Unfortunately, Minnesota hospitals are finding it increasingly difficult to sustain themselves. Since 2000 the number of community hospitals in the state decreased by 5.9% (from 135 to 127). For more information on systems of care and support see sections on *System of Care for Mothers, Children, and Families.*

Minnesota Department of Health

The mission of the Minnesota Department of Health (MDH) is to *protect, maintain and improve the health of all Minnesotans* – and its' vision is one where all communities are thriving, and all people have what they need to be

healthy.

MDH holds responsibilities in the areas of:

- Health protection – including environmental health and infectious disease epidemiology, prevention and control
- Health improvement – including child and family health, health promotion and chronic disease, and injury prevention and mental health
- Health policy and regulation across health systems
- Public health strategy and partnership
- Emergency preparedness and response
- Public Health Practice – including management of the local public health grant (MN Statute § 145A.131), CDC federal infrastructure grant, foundational public health responsibilities grant, and Minnesota state infrastructure fund (Innovation projects).

Healthy Minnesota Partnership

MDH facilitates the Healthy Minnesota Partnership, which brings together partners to improve the health and quality of life for people, families, and communities. The Health Minnesota Partnership vision is that all people in Minnesota enjoy healthy lives and healthy communities. The partnership is responsible for developing a statewide health improvement plan based upon a statewide health assessment completed every five year – the 2024 Statewide Health Assessment gave us the most recent picture of the health and wellbeing of populations across the state. The statewide health assessment set the stage for the 2025-2029 Healthy Minnesota: Statewide Health Improvement Framework which identified health priorities for the state.

Read about how the Minnesota Title V program is connecting with the Healthy Minnesota Partnership and the 2025-2029 Health Minnesota: Statewide Health Improvement Framework in the *Needs Assessment* section.

Minnesota's Government

Children's Cabinet

Minnesota's Children's Cabinet is an interagency partnership the Governor tasked with making Minnesota the best place for children to grow up. The Children's Cabinet was established in 1993 (MN Statute § 4.045) and is a broad interagency partnership of 22 state agencies that utilizes a whole-family systems approach to support the healthy development of children and families. The Children's Cabinet engages with two external advisory bodies: Children's Cabinet Advisory Council and the State Advisory Council for Early Education and Care. These groups, made up of individuals with the perspective of youth and families, underrepresented communities, and tribal and county leadership, provide guidance to inform the priorities and activities of the Children's Cabinet. The State Title V MCH Director represents MDH on the State Advisory Council for Early Education and Care.

The Children's Cabinet established work groups of Assistant Commissioners, Division Directors, and subject matter experts from each agency, to address the priorities. The CFH Division Director, along with Title V staff, participate fully in these initiatives, bringing subject matter expertise; coordination of data; and programs and services to the work.

Legislative Updates

The 2025 Legislative Session witnessed Minnesota's most divided legislature in state history. The House and Senate were narrowly divided along party lines, with significant conversation during hearings on the future of bills passed during Minnesota's 2023-2024 biennium. Nonetheless, budget bills were passed that continue to be centered around programs and policies that support the health, wellbeing, education, and economic security of families and generally support Governor Walz's goal to make Minnesota the best state in the nation for kids to grow up. Among the many provisions that the Legislators passed the following during the first (budget planning) year of the Minnesota 2025-2026 biennium[1][2]:

- An increase in per specimen fee for newborn screening and follow-up services newborns who screen positive.
- Repeal of the sunset date for Minnesota's Newborn Hearing Screening Advisory Committee to enable continuation of the committee.
- A revision to the statute governing Minnesota's Maternal Child Health Advisory Committee now allows community members to be fairly compensated for their time spent on committee activities.
- Strengthened Minnesota's statute to require, rather than allow Maternal Death studies within the limits of available funding.
- Creates certification criteria and process for midwives through the Minnesota Board of Nursing.
- Policy goals to increase well child visits and maternal depression screening rates.
- Expands definition of "child" in Children's Mental Health Act to include a person 18 to 21 years of age receiving continuous children's mental health targeted case management services.
- Establishes a family supportive housing grant program to help families and children maintain safe and stable housing.
- Helps ensure the safety of Minnesota's school children by allowing the Department of Health to issue epinephrine standing orders for use in schools.

MDH will work closely with partners in the state enterprise, community, local public health, health professionals, and other stakeholders to quickly start-up many of these programs. With the robust new investment, MDH's Title V program will expand in future reports and plan to reflect new grantees, partners, and activities.

Maternal and Child Health Advisory Committee

The Maternal and Child Health Advisory Committee (formerly the Maternal and Child Health Advisory Task Force) was created by the Minnesota Legislature in 1982 (MN Statute § 145.8811) to advise the Commissioner of Health on:

1. The health care needs of mothers and children throughout the state of Minnesota.
2. The type, frequency, and impact of maternal and child health services provided to mothers and children under existing maternal and child health care programs.
3. Program guidelines and criteria considered essential to providing an effective maternal and child health care program to populations below the federal poverty threshold and at risk of not having access to essential health care services and fulfilling the purposes of the state and federal maternal and child health statutes.
4. The use of federal and state funds available to meet maternal and child health needs.

5. Priorities for funding the following maternal and child health services:
    - Prenatal, delivery and postpartum care;
    - Comprehensive health care for children, especially from birth through five years of age;
    - Adolescent health services;
    - Family planning services;
    - Preventive dental care;
    - Special services for children with chronic illness or disabilities; and,
    - Any other services that promote the health of mothers and children.
6. Establish statewide outcomes that will improve the health status of mothers and children.

The committee consists of 15 legislatively authorized members appointed by the Commissioner of Health to four-year terms with equal representation in three categories:

- Professional representatives with expertise in maternal and child services;
- Community health boards representatives; and,
- Consumer representatives interested in the health of mothers and children.

For a complete list of members please refer to the MCH Advisory Task Force webpage.

Title V MCH Block Grant Specific Statutes

MN Statutes § 145.88 – 145.883 lay out requirements for the distribution of Minnesota's federal Title V Maternal and Child Health Block Grant award. Statutory language allows the Commissioner of Health to retain up to one-third of the block grant to:

- Meet federal requirements of a statewide needs assessment and prepare the annual federal block grant application and report.
- Collect and disseminate statewide data on the health status of mothers and children.
- Provide technical assistance to local public health in meeting statewide outcomes.
- Evaluate the impact of maternal and child health activities on the health status of mothers and children.
- Provide services to children under age 16 receiving benefits under Title XVI of the Social Security Act.
- Perform other maternal and child health activities as listed in federal code for the MCH block grant and as deemed necessary by the Commissioner of Health.

The remaining two-thirds of the approximately $9.1 million awarded annually to MN is distributed by formula to Community Health Boards (CHBs) that provide local public health services across the state. In addition, the statute requires that CHBs provide at least a 50% match for the Title V funds they receive. Title V funds allocated to local public health agencies must be used for programs that:

- Address the highest risk populations, particularly those with a high rate of infant mortality and children with low birth weight.
- Specifically consider the needs of pregnant women whose age, medical condition, maternal history or chemical use substantially increases the likelihood of complications associated with pregnancy and childbirth.
- Address the health needs of young children who have or are likely to have a chronic disease or disability or special medical needs.
- Provide family planning and preventive medical care for specifically identified populations of focus.
- Address child and adolescent health issues.
- Address child abuse and neglect prevention, reducing juvenile delinquency, promoting positive parenting and resiliency in children, and promoting family health through public health nurse home visits.
- Address nutritional issues of women, infants, and young children through WIC clinic services.

[1] https://mn.gov/governor/newsroom/press-releases/#/detail/appId/1/id/579302
[2] 2023 Legislative Wins for Children & Families (mn.gov)

III.B.2. State Title V Program

III.B.2.a. Purpose and Design

Partnership and Leadership

The Child and Family Health (CFH) Division at the Minnesota Department of Health (MDH) provides collaborative public health leadership that works to support and strengthen systems to ensure the health and well-being of Minnesota's children, families, and communities. The CFH Division serves as the state-level administrator of the Title V MCH Block Grant, ensuring the responsibilities set forth by the federal Maternal and Child Health Bureau are met.

Minnesota Title V program's purpose and commitment is to provide a strong foundation for family and community health systems across the state and support access to and delivery of quality health care services for mothers, infants and children, including children with special health care needs (CSHCN). Minnesota's Title V program is committed to be community and family-centered, as well as data-driven and evidence-informed. Key partnerships include the state's 87 local public health (LPH) agencies – who receive two-thirds of Minnesota's Title V funding – to carry out the core public health functions of assessment, assurance, and policy development.

Minnesota Title V Program Frameworks

Minnesota Title V recognizes that the health and well-being of mothers, infants, and children, including CSHCN, and their families is determined by a variety of interconnecting factors – not just on individual behaviors or medical care. As such, the Minnesota Title V Program is guided by the following conceptual frameworks in its planning and implementation.

Maternal and Child Health Pyramid of Health Services

Minnesota's Title V efforts primarily focus on the Public Health Services and Systems or Enabling Service levels of the Title V MCH Pyramid, with relatively little direct services continuing to be covered by block grant funding (less than 10% of federal Title V funding goes toward direct services). This means that most of our efforts focus on either 1) enabling people to access care or improve health outcomes, or 2) focus on developing the infrastructure to ensure people can access care and live healthy lives. Public health services and systems are activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development, including the 10 essential public health services.

Source: Association of Maternal and Child Health Programs, Leading State Maternal and Child Health Programs: A Guide for Senior Managers - AMCHP

The 10 Essential Public Health Services (and framework for the delivery of MCH services)

“A 1988 Institute of Medicine (IOM) Report defined the core functions of public health as assessment, policy development and assurance. In operationalizing the core public health functions and in ensuring that the unique needs of mothers and children were addressed, the MCH community worked with the Public Health Service and the IOM to identify 10 “Essential Public Health Services” in 1994. Since that time, the 10 Essential Public Health Services have provided a framework for the delivery of MCH services,” including those in Minnesota.

The following strategies for MCH program planning were developed through a crosswalk of the 10 Essential Public Health Services with the purpose of the Title V MCH Block Grant:

1. Conduct ongoing assessment of the changing health needs of the MCH population to drive priorities for improving positive health outcomes and reducing disparities for MCH populations.
2. Expand surveillance and other data systems capacity to support rapid investigation of emerging health issues that affect the MCH population.
3. Inform and educate the public and families about the unique needs of the MCH populations.
4. Mobilize partners, including families and individuals, at the federal, state and community levels in promoting shared vision for leveraging resources, integrating and improving MCH systems of care, promoting quality public health services and developing supportive policies.
5. Provide expertise and support for the formation and implementation of state laws, regulations and other policies pertaining to the health of the MCH population (e.g., perinatal regionalization/risk appropriate care and suicide prevention).
6. Integrate systems of public health, health care and related community services to ensure optimal access and coordination to achieve maximum impact.
7. Promote the effective and efficient organization and utilization of resources to ensure access to necessary comprehensive services for CHSCN and families through public health services, systems, and population health efforts.
8. Educate the MCH workforce to build capacity to ensure innovative, effective programs and services and the efficient use of resources.
9. Support or conduct applied research resulting in evidence-based policies and programs.
10. Facilitate rapid innovation and dissemination of effective practices through quality improvement and other emerging methods.
11. Provide services to address unmet needs in health care and public health systems for the MCH population (i.e., gap-filling services for individuals).

Foundational Public Health Services (FPHS)

“The FPHS framework outlines the unique responsibilities of governmental public health and can be used to explain the vital role of governmental public health in a thriving community; identify capacity and resource gaps; determine the cost for assuring foundational activities; and justify funding needs.” The FPHS framework recognizes that to provide opportunities for all communities to be healthy, the following foundational capabilities are needed by governmental public health: assessment and surveillance; community partnership development; organizational competencies; policy development and support; accountability and performance management; emergency preparedness and response; and communications. Supported by this strong infrastructure, one of the foundational areas of the FPHS framework is Maternal, Child, and Family Health, which is described as “core public health services that support healthy pregnancies, safe births, and strong starts for children…efforts help prevent health problems early and support lifelong health for children and families.”

Community Health Factors and Systems Building

Minnesota Title V acknowledges that there are the non-medical factors that influence health outcomes, including the conditions in which people are born, grow, work, live, worship, and age. These conditions include a wide set of forces and systems that shape daily life and impact health outcomes of individuals and communities, such as economic policies and systems, development agendas, social norms, social policies, and political systems. To strengthen the public health capacity of Minnesota and to ensure all MCH populations have a chance to achieve optimal health, the following community health factors need to be addressed: education access and quality; health care and quality; neighborhood and built environment; social and community context; and economic stability.

Source: Center for Disease Control Public Health Gateway | CDC

Multilevel Life Course Model

The life course model of public health is the awareness of the long-term impact of events throughout life (e.g., fetal development, childhood, adolescence, adulthood) have on one's health in later stages of life. A multilevel life course model of public health considers these life events as when impact factors occur – the life course level – as well as where in a system or environment these factors occur – or the sociological level.

Community and Family Engagement

> [Communities] must be supported in working alongside public health departments to identify priorities and design, implement, and evaluate programs to address the multifactorial causes of poor health.
>
> - *The Community as a Full Partner: A New Model for Public Health*

This is a core guiding principle of the Minnesota Title V program and a practice that Minnesota continually works to implement as we build our understanding of the communities across the state, including how governmental public health can partner with increased responsiveness, reciprocity, and effectiveness. Community and family engagement requires trust-building, power-sharing, and support to strengthen community and family capacity to engage in roles and spaces where decision-making is happening. Minnesota aims to build this trust and capacity in partnership with communities, families, and the organizations that are in and serve them to be a healthier and thriving state.

Minnesota Statewide Health Improvement Framework

The Healthy Minnesota Partnership came into being to develop innovative public health priorities, goals, objectives, and strategies to improve the health of all Minnesotans, and to ensure ownership of these objectives and priorities in communities across the state of Minnesota. The efforts of the Healthy Minnesota Partnership focus on the health of the state as a whole, and the membership of the partnership reflects a broad spectrum of interests. *Healthy Minnesota 2022* emphasizes creating conditions that allow people to be healthy, conditions that assure a healthy start and create environments that support health throughout life. The Partnership identified three priorities to guide their work to improve health and well-being across Minnesota – 1) the opportunity to be healthy is available everywhere and for everyone, 2) places and systems are designed for health and well-being, and 3) all can participate in decisions that shape health and well-being. Each of the priorities has two key conditions to track using an array of indicators. Minnesota has strived to apply the Healthy Minnesota 2022 Partnership's framework into all our CFH Division and Title V work.

In 2025, the Healthy Minnesota Partnership released an updated framework that continues to use a systems level approach to describe how MDH, its cross-sectoral partners, and the community it serves, work together to improve population health in Minnesota. The revised framework includes three priorities for 2025-2029. Minnesota Title V aims to collaborate with the partnership and others to align the 2025-2030 Title V state action plan with these priorities.

III.B.2.b. Organizational Structure

Organizational Structure

The Child and Family Health Division within the Minnesota Department of Health (MDH) administers the Minnesota Title V Program – administering two-thirds of the Title V funding by formula to 52 (53 beginning January 1, 2026) community health boards, comprised of 87 local public health agencies, per Minnesota Statute § 145.88.

The Minnesota Title V Program is fortunate to have both their maternal and child health (MCH) and children with special health care needs (CSHCN) counterparts in the same agency, bureau, and division – allowing for ease of accessibility and collaboration across the various programs and services offered between these two bodies of work. The primary Title V staff who are responsible for management and administration of the Title V program, who sit within the Child and Family Health Division, include the: Title V Director, Title V MCH Director, Title V CSCHN Director, Title V Coordinator, and SSDI Coordinator.

Included within the same division – the Child and Family Health Division – with the Maternal and Child Health (MCH) Section and CSHCN Section, are also the Family Home Visiting Section and the Women, Infant, and Child (WIC) Section. Across these sections, Title V and Title V Match funding is utilized to support many MCH and CSHCN, as well as cross-cutting positions and efforts, including:

- Birth Defects Information System
- Child and Adolescent Health initiatives
- CSHCN Capacity Building, Policy and Program Planning
- Cytomegalovirus (CMV) Education and Outreach
- Deaf and Hard of Hearing Programs
- Drug Overdose Grant activities
- Family Home Visiting
- Family Planning
- Fetal Alcohol Syndrome activities
- Follow Along Program
- Healthy Babies Grant work
- Healthy Beginnings Grant activities
- Infant Mortality Prevention and Infant Health Initiatives
- Long term follow-up program for children diagnosed with a newborn screening condition
- Maternal Mortality Reviews
- Midwife/Doula Capacity Building
- Model Jails – supporting children with parents who are incarcerated
- Pregnancy and Substance Use Prevention activities
- Pregnancy Risk Assessment and Monitoring
- School Based Health Clinics and Nurse activities
- Sexual and Reproductive Health Services
- State abstinence education program
- State Systems Development Initiative (SSDI)
- Women’s Health initiatives

See the *State Description* for more details about the Minnesota Department of Health, as well as the children with special health care needs component within the agency; *Financial Narrative* for more information about the programs and activities that Title V and Title V Match funding supports; and *Impacts of Organizational Structure* for more information about collaboration and alignment of resources of the State within the Child and Family Health Division, under the direction of the Title V MCH and CSHCN Directors. Additionally, organizational charts are attached to the report/application for illustration of the placement of Minnesota's Title V program within the state department of health.

III.B.3. Health Care Delivery System

III.B.3.a. System of Care for Mothers, Children, and Families

System of Care for Mothers, Children, and Families: Overview and Framing

Minnesota's Title V program works to advance the health and wellbeing of mothers, children, and families by strengthening the broader system of services, including supporting the state's public health infrastructure, coordination, and connections families need to navigate care successfully.

The Minnesota Title V program collaborates with local public health agencies, health care providers, family organizations, and state and community partners to improve service access, reduce system fragmentation, and ensure that families have the information and resources necessary to support their children. Efforts are often focused on strengthening and supporting the capacity, tools, and systems to deliver supports and services by and for local public health professionals, health care providers, and community-based organizations.

We approach this work using both well-established and emerging evidence-informed public health frameworks, including the life course model, the social-ecological framework, and principles from national initiatives such as the *10 Essential Public Health Services (and framework for the delivery of MCH services)*. These frameworks help inform how we understand families' experiences and guide strategic planning across systems and life stages. See *Purpose and Design* for more information about the frameworks and principles used to guide Minnesota's Title V program.

Public Health Role and Infrastructure

The Minnesota Title V program operates as a public health leader and systems partner, providing infrastructure support, strategic coordination, and technical expertise to improve the functioning of the statewide system of care for mothers, children, and families. Our team includes professionals with experience in public health nursing, data and evaluation, systems planning, and family and community engagement.

Minnesota Title V strengthens the public health infrastructure that supports MCH populations by:

- Collecting and analyzing data to monitor needs, identify gaps, and guide decision-making.
- Supporting professional development through training, technical assistance, and shared learning.
- Convening cross-sector partners to align strategies and foster coordinated planning.
- Promoting effective practices that enhance access, coordination, and responsiveness.

Minnesota Title V staff facilitate a range of advisory groups, steering committees, and collaborative workgroups to guide planning and implementation efforts across our programs. These groups bring together partners from public health, health care, community-based organizations, family-led groups, state agencies, and other sectors involved in serving MCH populations. This collaborative structure ensures that planning is informed by on-the-ground perspectives and that tools, policies, and strategies are co-designed with those most directly impacted by the systems and services we support. In addition to convening our own groups, Minnesota Title V staff also participate in statewide and interagency advisory councils led by other agencies, helping ensure that public health perspectives

are integrated across broader systems planning.

A cornerstone of this work is Minnesota Title V's partnership with the state's local public health (LPH) agencies, which serve as trusted, community-based partners. Minnesota's 74 local public health agencies make up the 52 community health boards (CHBs) (53 beginning January 1, 2026) who receive two-thirds of Minnesota's federal Title V block grant funding and provide a range of services and supports across every county in Minnesota, including, but not exhaustively:

- Adolescent Health Promotion
- Breastfeeding and Lactation Support
- Child and Teen Checkups
- Developmental Screening and Early Intervention
- Family Home Visiting
- Family Planning
- Immunizations
- School Health
- STD and Pregnancy Testing
- Vaccine Clinics
- WIC Services and Supports

Minnesota Title V supports this local infrastructure by providing ongoing training and technical assistance and works intentionally with MDH's Public Health Practice team to collaboratively and comprehensively address the needs of local public health in the provision of services and supports to local communities.

Comprehensive Systems of Support

In strengthening the broader systems of support for Minnesota's mothers, children, and families, Minnesota Title V addresses key MCH issues, including access to quality services, prenatal and postpartum care, maternal morbidity and mortality, stillbirth, newborn screening, infant mortality, and preventive and primary care services for children and adolescents, immunizations, injury prevention, oral health, behavioral and mental health, bereavement care, and/or substance use, and more. For example, Title V and Title V match funding are used to support staff and efforts, including the following:

- Birth Defects Information System
- Child and Adolescent Health initiatives
- CSHCN Capacity Building, Policy and Program Planning
- Cytomegalovirus (CMV) Education and Outreach
- Deaf and Hard of Hearing Programs
- Drug Overdose Grant activities
- Family Home Visiting
- Family Planning
- Fetal Alcohol Syndrome activities
- Follow Along Program
- Healthy Babies Grant work
- Healthy Beginnings Grant activities
- Infant Mortality Prevention and Infant Health Initiatives
- Long term follow-up program for children diagnosed with a newborn screening condition

- Maternal Mortality Reviews
- Midwife/Doula Capacity Building
- Model Jails – supporting children with parents who are incarcerated
- Pregnancy and Substance Use Prevention activities
- Pregnancy Risk Assessment and Monitoring
- School Based Health Clinics and Nurse activities
- Sexual and Reproductive Health Services
- State abstinence education program
- State Systems Development Initiative (SSDI)
- Women's Health initiatives

These initiatives, as well as others that address key MCH issues, are detailed throughout the 2024 Annual Report and 2026 Annual Application. Additionally, please reference *Impact of Organizational Structure* for information about additional programs and MCH issues being addressed through the advantageous location of Minnesota's Title V program in the Child and Family Health Division within the Minnesota Department of Health. Some key systems components are shared next.

Family Planning

The Minnesota Family Planning Program (MFPP) and Sexual and Reproductive Health Services (SRHS) – formerly Family Planning Special Projects (FPSP) – provide vital family planning services to low-income/underserved people.

Established by the Minnesota Legislature in 1978, the MFPP grant funds support essential pre-pregnancy family planning services for people with the least access. In 2023, the state legislature enacted several changes to the program, effective July 1, 2023, including changing the name of the program to SRHS. Funding is focused on people who would have difficulty accessing services because of barriers such as poverty, discrimination, lack of insurance, or transportation. The legislature's 2023 actions also included extending eligibility to the 11 American Indian tribes in the geographic area of Minnesota. Grants are awarded to counties, cities, community health boards, tribes, or 501(c)(3) non-profit organizations to provide family planning services in communities throughout the state. The legislature also removed the prohibition on using funding to provide services to unemancipated minors in schools. Effective July 1, 2023, the SFY 2024 appropriation increased to $13,500,125 million per year.

The SRHS program is administered by MDH and provides pre-pregnancy family planning services for people whose incomes are below the federal poverty level and placed at increased risk for unintended pregnancy. MDH receives state and federal funding for Temporary Assistance to Needy Families (TANF) to provide statewide family planning services and infrastructure support to clinics that provide family planning services. In 2024, SRHS reached around 145,073 people through outreach activities and provided 20,315 clients a range of contraceptive methods – with 17.7 % of clients choosing Tier 1 (most effective), long-acting reversible contraceptives. Over 500 people received medically accurate education and support finding healthcare through the Minnesota Sexual Health Hotline, which is fully funded by SRHS.

The MFPP, administered by DHS, is an insurance program that pays for family planning services and transportation services to and from providers of family planning service for people between 15 and 50 years old, who are not eligible for other public programs, and who have an income at or below 200% of the FPL.

Family Home Visiting (FHV)

FHV is a voluntary, home-based service ideally delivered prenatally through the early years of a child's life. FHV provides social, emotional, health-related, and parenting support and information to more than 6,500 of Minnesota's

families that are low income or limited availability of health services, and links them to appropriate resources. By participating in home visiting, some examples of services a family may receive are:

- Connections/referrals for pregnant women to prenatal care.
- Early support to parents in their role as a child's first teacher.
- Help in creating a safe and healthy environment for a young child to thrive in.
- Parenting skills and support that decrease the likelihood of child abuse.

FHV services in Minnesota are supported by several funding streams, including state, federal, and local resources. At the state level, MDH oversees and distributes funding for home visiting services provided under TANF funding, the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, Minnesota evidence-based home visiting funding, and Minnesota's Nurse-Family Partnership legislation. Funding administered by MDH is granted to Community Health Boards, tribal governments, and non-profit organizations. Local tax levies and MA reimbursement also fund FHV in Minnesota. All 52 Community Health Board Title V grantees administer home visiting services in their communities.

Women, Infants, and Children (WIC) Special Supplemental Nutrition Program

WIC is a special supplemental nutrition program for pregnant and post-partum women, infants, and children up to age 5 who have an increased risk of developing malnutrition and meet specific income guidelines or who are enrolled in TANF, SNAP or Medicaid. The program is funded by USDA and provides the following services to influence lifetime nutrition and health behaviors:

- Nutrition Services & Breastfeeding Support
  - Participants receive an individualized nutrition assessment along with education and referrals to community resources.
  - WIC promotes and supports breastfeeding, including exclusive breastfeeding for the first six months of an infant's life.
  - WIC supports healthy diets and infant feeding practices. These practices can help prevent obesity and anemia among other benefits.
  - Many local WIC programs provide peer breastfeeding support to mothers and infants.
- Healthy Foods
  - WIC provides healthy foods including fruits, vegetables, whole grains, and low-fat dairy. The WIC food package contributes to healthy diets, which aid in preventing obesity and chronic disease.

During FFY2025, an average of 101,300 low-income women, infants, and children up to age five participated monthly in the Minnesota WIC program. In 2024, Minnesota WIC served an estimated 37.5% of all infants born in Minnesota.

Hospitals

Minnesota is home to many excellent hospitals, including the number one ranked hospital in the United States, according to U.S. News and World Report – the Mayo Clinic. As of November 2024, there were 125 community state licensed hospitals with 16,139 beds, of which 76 are designated Critical Access Hospitals (CAHs). CAHs are smaller hospitals (fewer than 25 beds), mostly in rural areas, which receive higher reimbursement from Medicare, as long as they maintain certain services. Unfortunately, Minnesota hospitals are finding it increasingly difficult to sustain themselves. Since 2000 the number of community hospitals in the state decreased by 5.9% (from 135 to 127).

Perinatal women living in rural areas have experienced declining availability of hospital services – 12 counties lost hospital birth services between 2012 and 2022.[1] From 2019-2020, there was a 5% decrease in birthing hospitals in Minnesota. On average, women travel 12.2 miles (17 minutes) to the nearest birthing hospital. 14.1% of women don't

have a birthing hospital within 30 minutes of their residence. In 2023, 19.5% of counties were maternity care deserts.[2] This is especially concerning because giving birth in a hospital without obstetric services can lead to higher rates of hemorrhage, emergency surgery, and maternal death. Continued disruption to rural hospitals' ability to offer birth services further deepens disparities in access to prenatal and birth care. As detailed more in the 2024 Annual Report and 2026 Annual Application, Minnesota Title V staff are partnering with the Office of Rural Health and Primary Care, as well as with Local Public Health agencies, to determine how to address these issues in rural care access and quality.

Additionally, Minnesota's hospitals voluntarily participate in a statewide trauma system by attaining designation as a Level 1, 2, 3, or 4 trauma hospital. These designation levels reflect the resource capabilities of the hospital (with Level 1 facilities having the most capabilities). As of 2024, around 99% of Minnesotans lived within 60 minutes of a trauma hospital[3], which is an important predictor of survival after sustaining a traumatic injury or needing life-saving care.

Health Care Homes (HCHs) and Behavioral Health Homes

HCHs, designed to coordinate care among the primary care team, specialists, and community services, are a cornerstone of Minnesota's bipartisan health reform efforts of 2008. The voluntary program continues to support primary care providers, families, and patients who work in partnership to improve health outcomes and quality of life for patients, including those with chronic conditions or disabilities. By 2014, Minnesota's HCH efforts reduced Medical Assistance (MA) – Minnesota's Medicaid program – costs by 9% and helped to reduce inpatient hospital admissions, hospital outpatient visits, skilled nursing facilities and pharmacy costs.

Behavioral Health Homes (BHHs) were implemented in 2016 for eligible people with serious and persistent mental illness, emotional disturbance, or severe emotional disturbance - a subpopulation of persons known to have a higher likelihood of experiencing poor health outcomes and fragmented care. BHH services build upon the successes of HCH and create a comprehensive care coordination service that integrates physical health, mental health, the health concerns of substance use, long-term services and supports, and social services. As of 2025, there are currently 50 provider locations certified to provide BHH services.

Healthcare Insurance Environment

Minnesota's healthcare system ranks in the top half of states in overall health system performance according to the Commonwealth Fund.[4] Minnesota coordinates a comprehensive set of health insurance options intended to help meet the health and well-being needs of Minnesotans.

Insurance Coverage and Cost

According to the most recent Minnesota Health Access Survey, around 96.2% of Minnesotans had health insurance coverage in 2023. The maintained high rate of coverage seen since 2019 was consistent with levels experienced after the full implementation of the Affordable Care Act in MN in 2014 when 95.3% of Minnesotans had health insurance coverage.

Despite high levels of insurance coverage, some communities still face challenges getting the coverage they need. In 2023, many families continued to find health care too expensive.The uninsured were more likely to be a young adult (age 18 to 34), in a lower income bracket, or have a high school education or less.

MN Health Care Programs (MHCP)

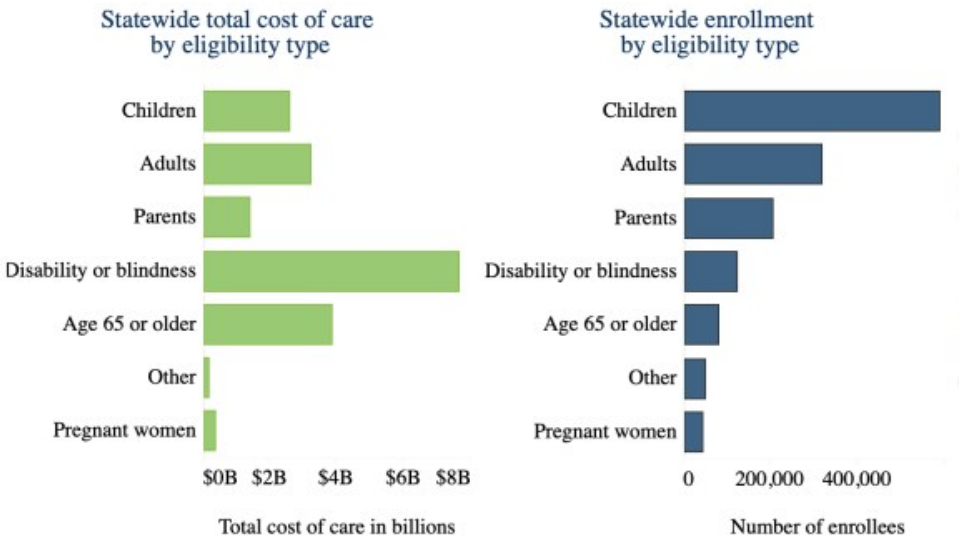
MHCP provide health care coverage to eligible families with children, adults, people with disabilities, and seniors. MHCP include Medical Assistance (MA) and Minnesota Care (MNCare). These programs are administered by the Minnesota Department of Human Services (DHS). MHCP financed 43.4% of all births (27,759 infants) in 2022, down

slightly from 43.9% in 2018.

Medical Assistance

Medical Assistance (MA), Minnesota's Medicaid Program, is a state and federal program that provides health insurance that covers a broad array of health services for people, including families and children with low-incomes, older adults, and people with disabilities. MA covers one out of every four Minnesotans, a monthly average of 1.3 million people. As the third largest insurer in the state after self-insured employer-based coverage and Medicare, it makes up nearly 16% of the state's health insurance market. The composition of enrollees is 65% families with children, 15% seniors and people with disabilities, and 20% adults without children (Figure 3). Children ages 0-18 are the single largest group, making up 49% of total enrollment.

Figure 3. Total Cost and Enrollment Counts by Eligibility Type, 2023[5]



Income eligibility requirements for MA vary by age (Table 1). If someone makes more than the income limit, they may still be eligible for coverage using a spenddown (a cost-sharing approach that allows people with incomes greater than the applicable limit to "spend down" their excess income to the appropriate income limit by deducting certain health care expenses).

Effective Jan. 1, 2024, or upon federal approval and completion of state implementation requirements (whichever is later), a child under 19 years of age eligible for MA must remain eligible for 12 months. Effective Jan. 1, 2025, 12-month continuous eligibility will be extended to include children under age 21, and children under age six will remain eligible for MA without interruption from the time they are first determined eligible up until the month they reach six years of age. Continuous eligibility ensures that children who are already enrolled in MA do not lose their coverage due to administrative hurdles or minor fluctuations in their family's income[6].

Table 1. MN's Income Eligibility Levels for Medicaid

Population	Income Eligibility Level, based on Federal Poverty Level (FPL)
Infants up to 2 years old	283% FPL
Pregnant women	275% FPL
Children 2 – 18 years old	275% FPL
Parents Children 19-20 years old Adults under 65 years old	133% FPL (>133% - 200% FPL income eligibility for MinnesotaCare)
Adults 65 years old and older People who have a disability or are blind	100% FPL

Most Minnesotans enrolled in MA receive services through managed care organizations, with the remaining enrollees receiving services through the traditional fee-for-service system (FFS), where providers receive a payment from the DHS directly for each service provided to an enrollee. Individuals who remain on FFS are primarily those who are not required to enroll in managed care or who have chosen to opt out of managed care. In general, this includes those with disabilities, people who are eligible with a spenddown, children receiving adoption assistance, and American Indians who live on a federally recognized reservation.

The American Rescue Plan Act, signed into law in March 2021, gives states the option to extend the Medicaid and Children's Health Insurance Program (CHIP) postpartum periods for pregnant women from 60 days to 12 months. This option makes Medicaid and CHIP funds available for states to provide coverage during an extended postpartum period. This gives providers opportunities to assess physical recovery from pregnancy and childbirth, and to screen for and provide care to address conditions that can lead to morbidity and mortality in the later postpartum period. High quality, comprehensive postpartum care should address chronic health conditions (e.g., diabetes or hypertension), mental health and psychological well-being (e.g., postpartum depression, interpersonal violence), and family planning. Postpartum visits are also a time for providers to counsel individuals on nutrition, breastfeeding, tobacco and other drug use, and other preventive health issues that affect both the postpartum woman's longer-term health and that of the infant. The 2021 Minnesota legislature enacted a law to adopt this option provided and extend the MA and CHIP-funded MA postpartum period effective July 1, 2022. Though this policy does not apply to MNCare, or to Emergency Medical Assistance (EMA) which covers labor and delivery costs.

Minnesota Care (MNCare)

MNCare is a state and federal program that provides a low-cost health insurance option to people who do not have access to affordable employer-sponsored health insurance and have higher income levels than those eligible for MA. MNCare coverage is more affordable and comprehensive than insurance available on the individual market, delivering a broader set of benefits than those required by federal law, including dental, vision and comprehensive behavioral health services. Minnesota is one of two states with this type of insurance coverage program, which is known as a Basic Health Program. On average, 107,000 Minnesotans purchase their coverage through MNCare, who pay no more than $80 a month in premiums and are guaranteed low out-of-pocket costs. Income eligibility is for adults with incomes over 133% federal poverty line (FPL) up to 200% of FPL.

Additional Assistance for Families of Children with Disabilities

Minnesota allows parents who have a child with a disability the option to obtain MA through the Katie Beckett provision under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) if they are over the Medicaid income limit. Prior to this, families of children with disabilities who needed MA coverage but wanted care at home faced significant eligibility barriers due to the consideration of the income and assets of the parents. Oftentimes, parents with a household income above eligibility requirements would have to place their child with a disability in an institutional setting to be able to obtain MA. Under Minnesota's TEFRA program, higher income families raising a

child with a disability can access MA by paying a fee. The payment amount is determined using a sliding scale based on the family's annual adjusted gross income. Fees do not exceed the cost of services delivered. However, during the 2023 legislative session, legislation was passed in Minnesota to provide parental fee relief – including the elimination of parental fees under both MA TEFRA and Home and Community-Based Services (HCBS) waivers[7].

Children's Health Insurance Program (CHIP)

CHIP supplements existing federal Medicaid funds that provide health care coverage for low-income families (Table 2). When the program was created in 1997, Minnesota already covered most of the children Congress intended to cover through CHIP. Therefore, the Minnesota Legislature chose to use CHIP funds to extend benefits to a small group of children who did not have coverage at the time (children under age 2 with family incomes between 275% and 283% of the FPL). Over time, Minnesota obtained a federal Section 1115 waiver to allow the state to use CHIP funds to add coverage for parents of some children on MA and Congress revised the Title XXI of the Social Security Act to allow states to extend CHIP coverage to pregnant women who were ineligible for MA.

Table 2. Populations Covered by Federal CHIP Funding in MN

Population	Income Eligibility
Infants under 2 years old	> 275% FPL – 283% FPL
Pregnant women ineligible for MA	Up to 278% FPL
Children on Medicaid	> 133% FPL – 275% FPL

Advanced Premium Tax Credit

Another public program that assists with health care coverage is the Advanced Premium Tax Credit, a federal program that reduces the cost of premiums for individual health insurance based on income, available through federal or state marketplaces, such as MNsure (Minnesota's health insurance marketplace). In 2024, a record number of Minnesotans signed up for private health insurance plans using MNsure, Minnesota's official health insurance marketplace. At the close of MNsure's annual open enrollment period on Jan. 15th, 167,163 people had successfully signed up for private health plans for 2025.

Healthy Start Performance Improvement Project

Five Minnesota Health Plans – Blue Plus, Health Partners, Hennepin Health, South Country Health Alliance, and UCare – launched the Healthy Start Performance Improvement Project in 2021. The project focuses on ensuring a "healthy start" for Minnesota children and families by improving services provided to pregnant women and infants and making sure all communities have the same opportunities for good health. The project includes working with a wide variety of partners to improve access to and coordination of resources to help mothers and children get the right care at the right time in the right setting. The aim is to close healthcare disparities in the following:

- Timely prenatal and postpartum care
- Well Child visiting in the first 30 months of life
- Childhood immunization status
- Low birth weight.

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[1] https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/ruralhealthcb2022.pdf
[2] 2024 Minnesota Women's Health Report Card | Leadership Education in Maternal & Child Public Health
[3] https://www.health.state.mn.us/facilities/ruralhealth/docs/summaries/ruralhealthcb2022.pdf
[4] The Commonwealth Fund: 2023 Scorecard on State Health Performance.
[5] Who Medicaid and MNCare Serve Dashboard

[6] Advocates for New Policies During MN Legislative Session | Gillette Children's (gillettechildrens.org)
[7] Advocates for New Policies During MN Legislative Session | Gillette Children's (gillettechildrens.org)

III.B.3.b. System of Services for CSHCN

System of Services for CSHCN: Overview and Framing

Minnesota's Title V program for Children with Special Health Care Needs (CSHCN) works to advance the health and wellbeing of CSHCN from birth through adulthood. Our work centers on strengthening the broader system of services—not providing direct clinical care—but supporting the public health infrastructure, coordination, and connections families need to navigate care successfully.

In many cases, our efforts are focused on serving those who serve CSHCN and their families—such as local public health professionals, health care providers, educators, and community-based organizations—by building the capacity, tools, and systems they rely on to deliver responsive, coordinated support. The Minnesota Title V CSHCN program collaborates with local public health agencies, health care providers, family organizations, and state and community partners to improve service access, reduce system fragmentation, and ensure that families have the information and resources necessary to support their children.

We approach this work using well-established public health and child development frameworks, including the life course model, the social-ecological framework, and principles from national initiatives such as the *Blueprint for Change*. These frameworks help inform how we understand families' experiences and guide strategic planning across systems and life stages.

Public Health Role and Infrastructure

Minnesota's Title V CSHCN work is led by the Children and Youth with Special Health Needs and Disabilities (CYSHND) Section at the Minnesota Department of Health (MDH). The Minnesota Title V program operates as a public health leader and systems partner, providing assessment, infrastructure support, strategic coordination, and technical expertise to improve the functioning of the statewide system of care for CSHCN. Our team includes professionals with experience in public health nursing, data and evaluation, systems planning, and family and community engagement.

Rather than providing direct services, Minnesota Title V strengthens the public health infrastructure that supports CSHCN by:

- Collecting and analyzing data to monitor needs, identify gaps, and guide decision-making.
- Supporting professional development through training, technical assistance, and shared learning.
- Convening cross-sector partners to align strategies and foster coordinated planning.
- Promoting effective practices that enhance access, coordination, and responsiveness.
- Representing MDH in national and statewide interagency councils and advisory groups to ensure CSHCN needs are reflected in broader systems planning.

As part of our regular practice, Minnesota Title V staff facilitate a range of advisory groups, steering committees, and collaborative workgroups to guide planning and implementation efforts across our programs. These groups bring together partners from public health, health care, education, community-based organizations, family-led groups, state agencies, and other sectors involved in serving children and youth with special health needs. This collaborative structure ensures that planning is informed by on-the-ground perspectives and that tools, policies, and strategies are co-designed with those most directly impacted by the systems and services we support. In addition to convening our own groups, Title V also participates in statewide and interagency advisory councils led by other agencies, helping ensure that public health perspectives are integrated across broader systems planning. We also engage in cross-

agency initiatives focused on improving care coordination, expanding access to behavioral health services, and strengthening the transition to adulthood for youth with special health needs.

A cornerstone of this work is Minnesota Title V's partnership with all local public health (LPH) agencies, which serve as trusted, community-based partners. These agencies conduct follow-up for children identified through newborn screening, hearing screening, developmental screening, and birth defects surveillance. Minnesota Title V supports this local infrastructure by:

- Providing training and technical assistance.
- Hosting a Condition Follow-Up Community of Practice to improve consistency across counties.
- Coordinating an annual Local Public Health CSHCN Conference focused on professional development and systems improvement.

Through this collaboration, Minnesota Title V helps ensure that children receive timely, coordinated follow-up and are connected to services such as primary care, early intervention, and community supports.

System Performance: Six Core Outcomes

1. Family-Professional Partnership

Minnesota recognizes families as central partners in their child's care. In the 2022–2023 National Survey of Children's Health (NSCH), 87.5% of families of CYSHCN in Minnesota reported receiving family-centered care, and 86.8% felt they were usually or always involved in shared decision-making.

Title V supports family engagement in multiple ways:

- Including family members on advisory councils, steering committees, and grant review panels.
- Embedding family partnership expectations into Title V-funded contracts and initiatives.
- Supporting the Family Support Organization Collaborative (FSOC), which builds capacity of family-led organizations across Minnesota.

These efforts help ensure that policies, tools, and practices reflect the priorities of families and that their voices inform system improvements.

2. Medical Home

According to the 2022-2023 NSCH, only 44% of Minnesota's CSHCN are reported to be receiving coordinated, ongoing care within a medical home, and only 57.7% are receiving needed care coordination. In response, MDH established the Pediatric Care Coordination Community of Practice (CoP)—a statewide initiative with over 700 members from 51 counties. The CoP promotes best practices in care coordination, improves cross-sector communication, and builds capacity among providers.

Minnesota Title V also collaborates with Minnesota's Health Care Homes program—jointly managed by MDH and the Department of Human Services—as they work to certify clinics that meet standards for whole-person, team-based, coordinated care. Minnesota Title V has worked closely with Health Care Homes and the Minnesota Rare Disease Advisory Council to explore sustainable financing models for pediatric care coordination within Health Care Homes, particularly for children with complex conditions.

3. Adequate and Continuous Insurance

While most CSHCN are covered by insurance, only 58.7% are considered to have both adequate and continuous coverage. Out-of-pocket costs and coverage gaps remain concerns for many families. For example, 38.3% of families reported spending more than $1,000 annually on medical, dental, or vision expenses.

Minnesota Title V supports state-level collaboration with Minnesota's Medicaid program and other partners to explore strategies to improve coverage and reduce costs for families. This includes examining sustainable models for care coordination and transition-related services. These conversations are particularly important for families managing complex or multiple care needs.

4. Early and Continuous Screening

Minnesota is recognized nationally for its leadership in newborn screening and early identification of special health needs. The state's newborn screening program includes over 60 conditions and is supported by a well-established infrastructure for follow-up and referral. Local public health agencies play a central role in ensuring that families of children identified through newborn screening, hearing screening, developmental screening, and birth defects surveillance receive timely connection to appropriate services.

Despite these strengths, opportunities remain—particularly in developmental screening within primary care settings. According to the 2022–2023 National Survey of Children's Health, only 56.4% of Minnesota children ages 9–35 months received a developmental screening through their doctor's office in the past year.

To help address this gap, the Minnesota Title V program partners with local public health agencies to implement the Follow Along Program—a statewide public health initiative that offers developmental and social-emotional screening outside of clinical settings. The program supports early identification by monitoring developmental milestones and connecting families to services when concerns are identified.

Minnesota Title V also supports outreach strategies that promote awareness and participation in screening efforts. These include partnerships with community connectors and Family Health Ambassadors, who work with families to increase understanding of child development and the value of early screening. These strategies are especially important for reaching families who may not access traditional screening through medical settings.

Through these efforts, the Minnesota Title V program helps ensure that all families—regardless of setting—have the opportunity to monitor their child's development and access supports as early as possible.

5. Access to Community-Based Services

Families often face challenges accessing timely, community-based services. In Minnesota, 44% of families of CSHCN report frustration in trying to access care. Contributing factors include:

- Long waitlists for services;
- Difficulty navigating across systems;
- Staffing shortages, particularly in direct care roles; and,
- Varying eligibility criteria and coverage across programs.

To address these issues, Minnesota Title V supports:

- Efforts to promote trauma-responsive and family-centered care practices.
- Cross-system communication improvements.
- Professional development and resource-sharing across clinical and community settings.

Public health is also exploring new ways to collaborate around workforce development, recognizing the critical role of direct support professionals in helping families maintain stability and access care in their communities.

6. Transition to Adult Care

Health care transition remains an area of significant need. According to the 2022-2023 NSCH, 76.4% of youth with special health needs in Minnesota do not receive transition supports.

To address this, Minnesota Title V leads a Health Care Transition Learning Collaborative in partnership with a major specialty health system in Minnesota. This effort brings together clinical partners, families, and systems leaders to build shared tools, improve care planning, and promote smoother transitions.

Minnesota Title V also participates in interagency initiatives to align health care, education, and employment services for youth. Recent efforts include development of a statewide transition framework and toolkit, person-centered planning pilots, and support for special interest groups such as school health nurses working at the intersection of health and special education.

Serving High-Need and Medically Underserved Populations

In Minnesota, approximately one in five families includes a child or youth with a special health care need. This is not a niche population— CSHCN are part of every community and interact with every major service system, including health care, education, mental health, social services, and community programs. Supporting this population is a matter of statewide importance.

The system of care must work well for all families—regardless of where they live, how complex their child's needs may be, or what types of services they rely on. At the same time, some families face more challenges in getting timely, coordinated care. These include:

- Families who live in rural or frontier areas and must travel long distances to access services.
- Families managing complex or multiple conditions that require frequent appointments or specialist care.
- Families who experience difficulties with communication, service navigation, or understanding eligibility requirements.

To improve access and responsiveness statewide, the Minnesota Title V program:

- Partners with local public health agencies to provide follow-up and connection to community-based support to families.
- Supports a wide range of family-led and community-based organizations to serve as trusted navigators and connection points.
- Provides training and technical assistance to improve service delivery across systems.

- Uses data from multiple sources—including (but not limited to) family surveys and local public health follow-up data—to understand where gaps exist and identify areas for improvement.

This approach helps ensure the system works for all CSHCN and that every family—regardless of where they live or what services they need—can access timely, coordinated care that supports their child's health, development, and well-being.

System Coordination and Recent Change Efforts

Minnesota's Title V program supports long-term planning and coordination across major focus areas such as care coordination, mental health, and caregiver support. Minnesota Title V staff work to identify patterns across systems and lead improvements in how services are delivered and coordinated—especially where processes or structures create barriers for families. Minnesota Title V supports statewide planning in areas such as:

- Improving care coordination across health and community services.
- Developing a cross-agency transition framework and shared learning events.
- Implementing efforts focused on improving access to behavioral health in pediatric care.
- Conducting outreach and providing support to family-serving organizations.
- Partnering with local and state agencies to reduce duplication and streamline navigation tools.

These efforts reflect Minnesota's commitment to building a system that is easier to use, more consistent, and more responsive to real-world needs.

Opportunities and Next Steps

Minnesota Title V continues to build on a strong foundation while identifying new areas for innovation and improvement. Key opportunities include:

- Expanding care coordination infrastructure and shared tools/learning models, such as the Pediatric Care Coordination CoP.
- Strengthening professional development for local public health and other frontline staff serving CSHCN.
- Supporting sustainable partnerships with family- and community-led organizations that serve CSHCN.
- Improving data systems and information sharing.

Persistent challenges include limited provider availability, difficulty coordinating across sectors, and the need for more sustainable infrastructure to support long-term planning and continuity of care. Minnesota's Title V CSHCN program is committed to addressing these issues through collaborative planning, targeted infrastructure investments, and continued partnership across public health, education, health care, and family-serving systems.

See the 2024 Annual Report/2026 Annual Application Plan for more details on activities related to Minnesota's system of services for CSHCN.

III.B.3.c. Relationship with Medicaid

Relationship with Medicaid

Minnesota's Medicaid Program

Minnesota's Medicaid program (Medical Assistance) is the third largest insurer in the state, covering nearly one out of every four Minnesotans. Minnesota Medicaid covers a broad group of people and services beyond the minimum standards set in federal law. This includes expanding coverage to higher-income children and adults and covering long-term care in the home and community instead of an institutional setting. Minnesota also covers populations in need of services who would

otherwise be ineligible for Medicaid because of their income level. This includes providing improved access to Medicaid for children with disabilities by paying a parental fee, for people diagnosed with breast or cervical cancer through the state's cancer screening program (Sage), and for families in need of family planning services.

Most Minnesotans enrolled in Medicaid receive services through the state's contracted managed care organizations (MCO), which include both health maintenance organizations and county-based purchasing plans. The remaining enrollees receive services through the traditional fee-for-service system. Enrollees who remain in fee-for-service primarily consist of those who are not required to enroll in managed care or who have chosen to opt out of managed care. In general, this includes:

- People with disabilities
- People who are eligible through using a spenddown
- People with "cost-effective" health insurance
- Children receiving adoption assistance
- American Indians who live on a federally recognized reservation.

In June 2023, per the federal government, Minnesota and other states returned to standard Medicaid eligibility procedures, including an annual eligibility review and renewal process. This rollback presented challenges for potential loss of coverage and impacts on overall health and well-being. Minnesota Department of Human Services (DHS) – Minnesota's Medicaid Program deliverer – developed a comprehensive plan to support mitigation of the loss of eligible coverage and help ineligible Minnesotans connect with other health care coverage options. For more information, please see the *State Description* and *System of Care for Mothers, Children, and Families.*

Title V – Medicaid Interagency Agreement (IAA)

The Minnesota Department of Health (MDH) upholds an ongoing, collaborative relationship with the Minnesota Department of Human Services (DHS), which houses the state's Medicaid program - called Medical Assistance (MA).

Updated last in 2024, the Title V – Medicaid Interagency Agreement (IAA) includes information on the responsibilities of both parties inherent in this collaboration. The IAA outlines requirements of both MDH and DHS in coordinating and enhancing efforts related to MCH populations, which include:

- Participate in advisory or work groups (sponsored by each agency) that focus on topics related to MCH.
- Participate in one annual joint meeting to:
  - Coordinate departmental policies/procedures that impact health services or delivery of health services to MCH populations.
  - Identify how departments can work together to identify at-risk women of childbearing years, pregnant women, children, and youth in need for support or services that promote optimal health.
  - Identify areas where the departments could enhance or maximize efforts targeting the MCH population.
  - Share appropriate and relevant data, through separate data use agreements, affecting health status or the delivery of health care services to MCH populations, including children with special health needs.

MDH and DHS Coordination

Beyond the IAA, MDH and DHS collaborate with one another to address needs within MCH populations and help improve the health care delivery system.

Minnesota received federal approval to use Medicaid dollars to pay for services through its home and community-based services waiver programs. These services became a Medicaid state plan option in 2005. Waivers cover services for people who need the level of care provided at a hospital or nursing facility but choose to receive such care in home or community-based settings. For children with special health care needs (CSHCN), this can include receiving personal care assistance or respite care in the home or community. Home and community-based waivers are coordinated within DHS in the Disability Services Division. Title V CSHCN staff partner with Disability Services Division staff on projects related to transition to adulthood, family to family support, and children with medical complexity.

Many CSHCN, especially those with complex medical conditions, are not enrolled in managed care – as it is not mandatory in Minnesota. In addition, there are no specific quality measures in the managed care contracts related to those with special health care needs who are under the age of 18 years old. This means that MCOs may not have effective mechanisms in place to assess the quality and appropriateness of care for CSHCN. The Title V CSHCN program collaborates with Medicaid and MCOs to resolve this gap in the system – possibly by introducing language to incorporate into MCO contracts specifically related to CSHCN.

The Title V CSHCN program also partners with DHS related to the delivery of services and supports for children identified with autism spectrum disorder (ASD). In 2013, the Minnesota Legislature passed a law to create an Early Intensive Developmental and Behavioral Intervention (EIDBI) Benefit. The federal Centers for Medicare and Medicaid Services approved a revised State Plan Amendment for the EIDBI Benefit in 2017. The purpose of the EIDBI Benefit is to provide medically necessary early intensive intervention for children and youth with ASD and related conditions, as well as:

- Educate, train, and support their parents and families;
- Promote people's independence and participation in family, school and community life; and
- Improve long-term outcomes and the quality of life for people and their families.

Title V staff actively collaborate with DHS in the development, implementation, and promotion of the EIDBI Benefit. Title V staff serve on various advisory committees related to ASD and the benefit, which has a policy-level impact on the services and supports accessible for children with ASD and their families.

III.B.4. MCH Emergency Planning and Preparedness

Maternal and Child Health (MCH) Emergency Planning and Preparedness

Overview

The Minnesota Department of Health (MDH) is ready to respond whenever a public health emergency occurs. The Emergency Preparedness and Response (EPR) Division coordinates preparedness activities and assists MDH, local public health agencies, hospitals, health care organizations, tribes and public safety officials in their efforts to plan for, respond to, and recover from public health emergencies. The department maintains readiness by annually reviewing its written emergency operations plan (EOP), working together with partners to create and sustain emergency planning, response and recovery systems, and conducting emergency simulation exercises several times a year. Key responsibilities include the following:

- Manages Minnesota's Health Alert Network – a notification system designed to quickly distribute urgent information from public health to thousands of health professionals – doctors, nurses, and other key partners across Minnesota.
- Provides education and training materials used to build the capacity of state and local public health professionals.
- Coordinates emergency, surge capacity, behavioral health, and volunteer health planning among Minnesota's 140 hospitals.
- Prepares and supports the Department Operations Center, and the use of the Incident Command System which is used by MDH to coordinate the comprehensive response to events.

All MDH staff are required to take Introduction to the Incident Command System (IS-100) and Introduction to Continuity of Operations (IS-1300). Staff are also encouraged to take additional Incident Command courses. All organizational units of MDH have response and/or recovery responsibilities—including planning for response to disaster incidents and business continuity incidents—and the Child and Family Health (CFH) Division leadership, including Title V funded staff, developed the priority list of services and required staff for a business continuity incident. Information on how to meet the needs of MCH populations, including identified underserved women, infants

and children are in specific annexes to the EOP based on the type of incident. CFH Division staff, including Title V funded staff, are included in the business continuity incident plan and participate in emergency planning and are deployed to response activities with local public health, community organizations and other partners based on need.

To learn more about the Minnesota's Center for Emergency Preparedness and Response (EPR) visit our website at: About EPR - Minnesota Dept. of Health (state.mn.us).

Lessons Learned

Public health emergency responses in Minnesota in the past five years have revealed critical gaps in emergency preparedness for maternal and child populations that impacted the state's ability to adequately assess and respond to MCH population needs. A review of surveillance data, policies, and frontline stories during public health emergencies between 2020-2024 in Minnesota highlighted the disproportionate impact to people with disabilities and perinatal populations – including reduced access to timely, quality perinatal services and supports, i.e., policies that denied birth doulas entry into labor and delivery units. These critical gaps need to be addressed with statewide systems preparedness enhanced in anticipation of future public health emergencies and negative impacts to CSHCN and perinatal health of mothers, infants, and their families.

The Minnesota CSHCN program developed an After-Action Summary Response to public health emergencies in 2020-2024 and initiated a plan for systems change within MDH to:

- build capacity and infrastructure that will permit MDH staff to better see and understand system forces and power dynamics that contribute to negative health outcomes for people with disabilities and their critical role in addressing the concerns.
- improve collection and collation of disability data and report and disseminate this information, as well as needs identified.
- build community competency of MDH staff and health professionals through community engagement, institutional representation, and training to foster successful systemic change.

To examine gaps in perinatal health of mothers and infants further and begin exploring paths to mediation with partners, including the Emergency Preparedness and Response (EPR) Division, the Minnesota Title V team has conferred with EPR staff. While the recent policy and funding landscape federally and in Minnesota has inhibited staff capacity to move this work forward more swiftly, the Minnesota Title V team is looking forward to continued collaboration to bring the lens of MCH populations into public health emergency response, particularly around doulas and midwives in the planning of hospital emergency response plans.

III.C. Needs Assessment

III.C.1. Five-Year Needs Assessment Summary and Annual Updates

III.C.1.a. Process Description

Process Description

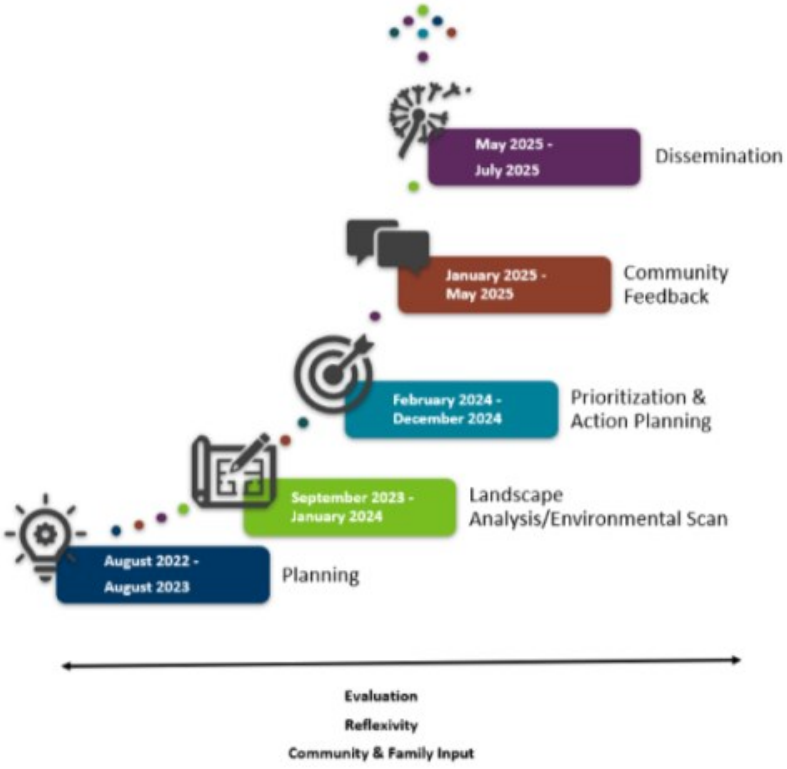
The goal of Minnesota's 2025 statewide Title V Maternal and Child Health Block Grant needs assessment and action planning was to improve maternal and child health outcomes, including those of CSHCN, by better understanding strengths, gaps in services, and needs of target populations; and to strengthen partnerships for effective implementation of strategies addressing the needs of Minnesota's mothers, children, and families. The information collected through the needs assessment is used to identify statewide priorities, drive strategic action planning, and set criteria for how best to allocate resources.

Planning, Implementation, Evaluation

Timeline

Planning, implementation, and evaluation of Minnesota's 2025 Title V needs assessment and action planning process occurred across five phases from August 2022 through July 2025, as shown in Figure 1.

Figure 1. 2025 Title V Maternal and Child Health Needs Assessment and Action Planning Timeline



During **phase one – the planning phase** – the Minnesota Title V team developed the overall needs assessment process and timeline, drafted initial materials for use across the other four phases – including guiding frameworks, analysis templates, and recruitment materials – and formed the internal working group which was made up of staff from across the Child and Family Health (CFH) Division.

In June 2022, Minnesota hired its first ever state Title V Coordinator – and much of the planning phase was dedicated to the Title V Coordinator connecting with Minnesota's Title V interest holders, including CFH Division

staff, local public health (LPH) representatives, members of advisory bodies, and staff across the Health agency, as well as other state agencies, to build an understanding of what different interest holder groups understood about Title V and were hoping to gain from the upcoming needs assessment.

Out of this exploration in the planning phase, the consensus across interest holder groups was that there was an interest in understanding the role and purpose of Title V in Minnesota – including what are the roles of individuals within Title V – as well as how to utilize Title V to strengthen relationships with LPH and community-based organizations.

During **phase two – the landscape analysis** – the Minnesota Title V team collected and analyzed over 160 documents from programs across the state – including community health improvement plans, programmatic needs assessments, organizational strategic plans, and others – with the aim to gather information on the current landscape of maternal and child health needs across the state. Many of these efforts summarized in the documents were conducted in partnership with representation from communities across Minnesota.

These documented efforts were analyzed for the priorities and strategies identified in their communities and what community engagement looked like. Findings from the landscape analysis were used as the foundation for phase three of the needs assessment.

Additionally, during phase two, a steering committee was developed through an application process to help guide phases three through five of the 2025 needs assessment and action planning process, including codeveloping the Title V priorities, strategies, activities, and measures. Members were interest holders both internal and external to the Minnesota Department of Health and made up of representatives from LPH, state government agencies, health systems, and community/family members, with expertise across the six population domains: infant/perinatal health, child health, adolescent health, children and youth with special health needs, women/maternal health, and cross-cutting/systems building.

During **phase three – prioritization and action planning** – findings from the landscape analysis in phase two were used by Title V staff, the internal working group, and the steering committee to develop seven state priorities for 2025-2030, strategies to address each priority, specific activities within each strategy, and measures to monitor progress and change for each priority selected. During this phase, the Minnesota Title V team conducted the *Title V Connections Tour*, meeting one-on-one with 41 of the 51 community health boards across Minnesota who represent the state's LPH system and who make up the 51 grantees in Minnesota[1]. More about the *Title V Connections Tour* is described in the methods section.

The Minnesota Title V team, in phase three, also conducted a prioritization survey that went out to CFH Division staff, LPH staff, and Title V community partners. This survey asked these interest holders, based on the findings from the landscape analysis, what they thought Minnesota should prioritize for each population domain for the next five years.

During **phase four – public feedback** – the Minnesota Title V team, the internal working group, and the steering committee sough feedback from community members across Minnesota about the drafted priorities, strategies, activities, and measures through listening sessions with LPH and CFH Division staff, as well as a community feedback survey that went out to the broader population of Minnesotans.

During **phase five -dissemination** – the Minnesota Title V team, the internal working group, and the steering committee integrated community feedback from phase four to develop written reflections on the needs assessment processes, findings, and plan for next steps, as well as other formats to disseminate back to Minnesota's

communities.

Evaluation

The Minnesota Title V Team conducted an ongoing, quasi-process evaluation of the 2025 needs assessment and action planning process. The following questions were used to guide the needs assessment and action planning process implementation and evaluation:

1. What do Minnesota's mothers, children, and families – including CSHCN – need to thrive physically, mentally, emotionally, and spiritually?
2. What barriers and challenges do Minnesota's mothers, children, and families – including CSHCN – experience that prevent them from thriving physically, mentally, emotionally, and spiritually?
3. What is the capacity (systems, structures, policies, processes) of the Minnesota State Enterprise, Minnesota Department of Health, CFH Division, LPH, and Community Organizations to meet the needs of Minnesota's mothers, children, and families in order for them to thrive physically, mentally, emotionally, and spiritually?
4. How is the Title V Minnesota team meaningfully integrating intersectional, trauma-informed, and people centered frameworks and practices in the 2025 Title V Needs Assessment planning and implementation processes and structure?
5. How is the Title V Minnesota team embedding systems transformation in the 2025 Title V Needs Assessment planning and implementation processes and structure?

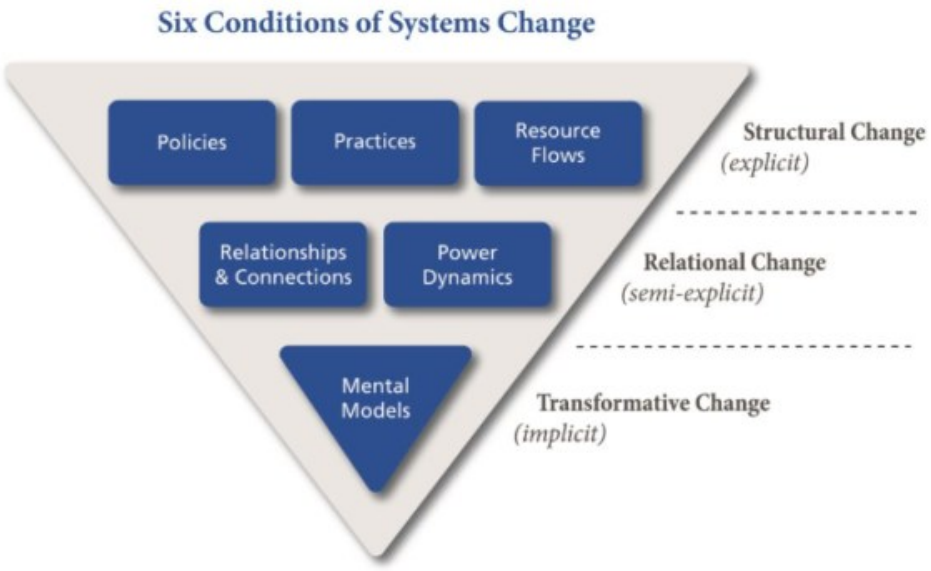
Data was collected organically at each internal working group and steering committee meeting to remind participants of the guiding questions and assess whether we needed to pivot and/or modify our work and trajectory. Additionally, interest holders, including LPH and CFH division staff were continuously asked to provide feedback through one-on-ones, post presentations and during the needs assessment data collection events (i.e., listening sessions and surveys). The broader population of Minnesotans were also assessed for their understanding related to the guiding questions through the community feedback survey.

To ensure ongoing, continuous evaluation of the needs assessment and action planning process, participants (i.e., Title V team, internal working group, steering committee) grounded the implementation process in guiding principles based on emergent strategy[2], as well as reflexivity that included care for the self and others during complex times[3].

Methodology and framework

Minnesota used a mixed methods approach to assess the strengths and needs of communities, families, and individuals living in Minnesota. The approach, like our Minnesota Title V work generally, was rooted in the social ecological model in which multiple levels of influence (individual, interpersonal, organizational, community, and policy) impact the health of communities. As the Minnesota team thought about what it meant to transform systems using the needs assessment and action planning process, the work was guided by the Water of Systems Change, recognizing that there are six conditions to shift at three levels: explicit (structural), semi-explicit (relational), and implicit (transformative)[4] (Figure 2).

Figure 2. The Water of Systems Change Framework



Overall, the approach was guided by principles of emergent strategy[5] to plan, implement, and evaluate a needs assessment and action planning process that was:

Fractal – The relationship between small and large, recognizing patterns and moving from micro to macro level; or acknowledging that pieces of a whole system.

Adaptative (Intentional Adaptation) – How we change and how we are connecting to purpose.

Interdependence & Decentralization – Who we are and how we share, including attention to the distribution of power; as well as meeting needs in a variety of ways and striving for mutuality.

Nonlinear & Iterative – Attending to the pace and pathways of change, including stepping outside of comfort and going beyond; operating at the scale of transformation.

Resilience & Transformation– Transforming root causes, while acknowledging and understanding current realities and dynamics; while looking for alternative ways to address harm and impacts, with an attention to generative conflict.

Creating More Possibilities – How we move towards life through collective impact and collaboration.

Leadership Structure

Minnesota established a clear leadership structure in conducting the needs assessment and action planning process, that acknowledged different levels, styles, and roles of leadership. Three groups of leadership worked collaboratively to guide various components of the process, including the Minnesota Title V team of staff, an internal working group, and external steering committee.

Figure 3. Conceptual Model of the Title V Needs Assessment Leadership Structure

Title V Team

The Title V team of staff were key staff who lead the Minnesota Title V work. These staff were responsible for guiding the overall needs assessment and action planning process to ensure it was in line with HRSA requirements and guidance for the Title V MCH Block Grant, as well as Minnesota Department of Health policies and procedures.

Internal Working Group

The internal working group was composed of staff from across the CFH (CFH) Division, with intentional representation from bodies of work across the Division, including Maternal and Child Health, CSHCN, WIC/SNP, FHV, operations, communications, health equity, and systems. The role of the internal working group was to support coordination of activities within each phase of the needs assessment and action planning process to ensure we were building connection to the areas of work happening within the CFH Division and providing insight and expertise from individual area of work to guide activities within each phase.

External Steering Committee

The external steering committee was composed of individuals external to the CFH (CFH) Division (apart from one individual, who we wanted to continue to make connections to the work of the CFH Division). A call for applications of interest was sent out to the broader public via email listservs, newsletters, existing advisory bodies, and share-out during external meetings. Twenty-five individuals were selected based on two factors: role in the maternal and child health landscape (LPH, state government agency, health systems, community organizations, and community/family representatives) and area of expertise based on the Title V population domains. Individuals were selected to ensure a broad representation across these two factors. Once selected to the steering committee, individuals then self-grouped based on these two factors into sub-groups based on the Title V population domains, where much of the needs assessment and action planning work was carried out.

Lists of the names and roles of members of each of these three groups who comprised the leadership structure are included in an attachment.

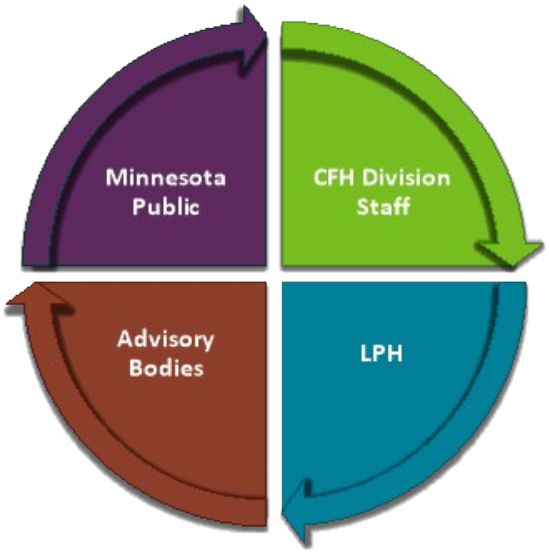
Interest Holder Engagement

The Minnesota Title V program acknowledges that to advance MCH outcomes and assure that MCH populations achieve their full health potential, we need to work together in authentic, collaborative, and innovative ways. This is the only way that we will be able to make significant change in reducing the disparities in our communities.

Therefore, we have taken a collaborative, community-focused approach toward our 2025 needs assessment and action planning process. The foundation of this approach rests in the belief that solutions lie within the community and as such, the focus is on engaging with the community to ensure that we are planning and implementing programs and initiatives that will have the greatest impact and benefit.

The Minnesota Title V team identified four broad groups of interest holders that we wanted to ensure were meaningfully engaged throughout the needs assessment and action planning process, including: CFH Division Staff, LPH, advisory bodies related to the Title V needs assessment and action planning activities, and the general Minnesota public. Each of the four groups were engaged through active participation throughout each phase, tailored to each group's interest and areas of connection to the Minnesota Title V work.

Figure 4. Conceptual Model of Collaboration Across Title V Needs Assessment and Action Planning Interest Holder Groups



Methods

The Minnesota Title V team values participatory decision-making in the creation of priorities, strategies, and implementation of public health activities for mothers, children, and families in Minnesota. In putting these values into practice, the Minnesota Title V team gathered, analyzed, and utilized data through a variety of methods, including:

- Completing a landscape analysis of maternal and child health work and community priorities across Minnesota.
- Hosting the *Title V Connections with LPH* listening tour, conducting one-on-one conversations with 41 of the 51 community health boards (Title V grantees) in Minnesota.
- Conducting a prioritization survey with LPH, CFH Division staff, and Title V community partners.
- Holding listening sessions with LPH and CFH Division staff centered on each Title V population domain. In all, there were six listening sessions with LPH and eight listening sessions with CFH Division staff.
- Conducting a community feedback survey for the broader population of Minnesota, which requested participants to provide feedback on the drafted Title V action plan for 2025-2030.

Each step in the process resulted in responsive evolvement to the 2025 needs assessment and action planning, including continued alignment and realignment across the systems supporting the work of Title V in Minnesota.

Landscape Analysis

Summary

Between September 2023 and January 2024, the Minnesota Title V team conducted a landscape analysis to develop a base understanding of the current landscape of needs and priorities for Minnesota's maternal and child health (MCH) populations, including CSHCN and their families. This included the review and analysis of 160 documents on topics relevant to MCH and CSHCN populations in Minnesota. Documents were reviewed using an analysis rubric developed by the Minnesota Title V team. Data collected using the analysis rubric was then qualitatively analyzed to create a final list of themes and sub-themes used to describe the current landscape of needs and priorities for Minnesota's MCH and CSHCN populations.

Process

All documents were selected based on relevance to MCH and CSHCN populations directly, or indirectly via connection to community health factors that impact MCH and CSHCN populations. Community health factors included the following five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. A large selection of the documents were sought out intentionally to include in the landscape analysis, while others were sought and included by putting out calls to staff across the CFH Division and their community partners, including task forces, work groups, and other similar groupings. Under Minnesota's LPH Act (Minn. Stat. § 145A), LPH agencies are required to conduct a community health assessment and improvement plan every five years. Additionally, all nonprofit hospitals across the U.S. states and territories are required to conduct a community health needs assessment every three years. Between these two statutory requirements, 51 community health boards, and 83 non-profit hospitals covering all regions of Minnesota completed a community health assessment in the past five years that we were able to utilize in the landscape analysis.

Documents were reviewed using an analysis rubric developed by the Minnesota Title V team. The analysis rubric, described further in the next section *Analysis Criteria*, was completed in Microsoft Lists for each document reviewed. Data collected using the analysis rubric was then qualitatively analyzed, using inductive constant comparison, to develop 21 emerging themes. Finally, themes were clustered conceptually, and sub-themes were developed, to create a final list of 13 themes, as well as sub-themes, used to describe the current landscape of needs and priorities for Minnesota's MCH and CSHCN populations.

Analysis Criteria and Findings

An analysis rubric was developed by the Minnesota Title V team, using Microsoft Lists, with a mixture of multiple selection/choice and open-ended questions for members of the Minnesota Title V team to review each document for data collection methods and sources, community partners and level of community engagement, integration of community health factors, and findings including strategies and activities identified.

Qualitative analysis of the analysis rubric data, from the review and analysis of the 160 documents, resulted in 21 emerging themes. These themes were then clustered further based on similar topics as well as capacity for the Minnesota Title V team and system, including LPH, to implement as a priority theme versus a sub-theme. Thirteen themes were ultimately selected that were then brought forward into the next phase of the needs assessment and action planning process.

Title V Connections with LPH Listening Tour

Forty-one out of 51 community health boards (Title V grantees) completed a one-on-one visit with CHB Title V staff and the Minnesota Title V Team (Title V Coordinator, Title V MCH Director, Title V CSHCN Director, Division Director, WIC Section Manager, FHV Section Manager), in March – July 2024. While Title V MCH Block Grant dollars have been funded to CHBs statutorily since 1986, this was the first time to anyone's knowledge that these visits between CHBs and state Title V staff had occurred. As such, the purpose of these visits were to re-establish a foundation for ongoing relationship building between Title V state staff and LPH. While each visit started with a presentation overview of the history, purpose, and guidelines of the Title V MCH Block Grant – federally and in state context – and there was opportunity for general technical assistance, most of the time in these visits was used for CHBs to reflect on the following questions:

What are some successes that Title V has helped support, or that you are wondering if Title V can support in the future?

What are some challenges that you've experienced in the management and implementation of Title V funds and activities?

How can MDH Title V staff support your Title V efforts?

What positive impact have you seen Title V have in your community?

What are challenges that your community members are facing that Title V could potentially help address?

How can MDH Title V staff support your Title V efforts in community?

Considering the six population domains, which of the themes found in the needs assessment shared resonate with what you are…

Seeing as issues facing your community?

Work that you are doing in your agency to address issues your community is facing?

What's missing that you are seeing in your community and/or you are doing in your agency to address issues your community is facing?

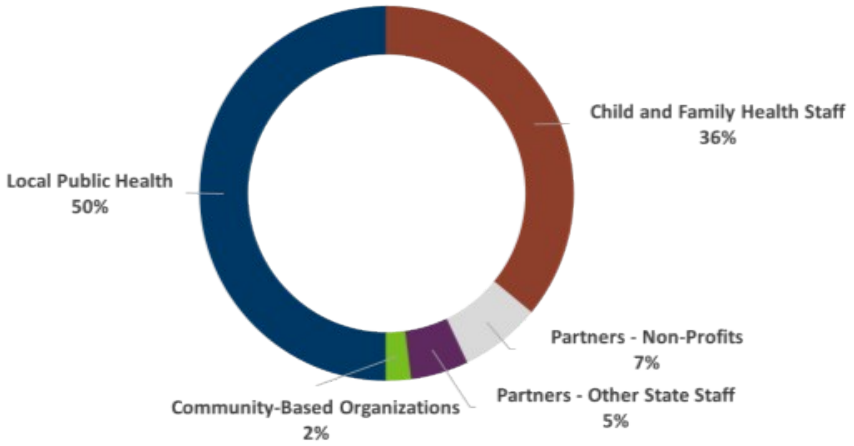
What are some of the projects/activities that you are doing to address issues your community is facing?

Reflections and questions that arose from these conversations with LPH informed the needs assessment and action planning process as well as ongoing Title V efforts in Minnesota aiming to bolster alignment, collaboration, and connection between and within LPH and Minnesota Title V state staff.

Prioritization Survey

In the Spring of 2024, the Minnesota Title V team conducted a prioritization survey with LPH, CFH Division staff, and Title V community partners to solicit input on which of the themes that arose out of the landscape analysis, interest holders thought our Minnesota Title V team should prioritize for the next five years, for each population domain. Three versions of the survey were developed with the same questions, but the language was tailored to each of these three groups of interest holders. The survey received over 300 responses between the three groups – 107 responses were from CFH Division staff, 150 responses came from LPH representatives, and 56 came from Title V community partners.

Figure 5. Prioritization Survey Results by Interest Holder Group



Out of the prioritization survey responses, seven draft priorities were developed. The internal working group and external steering committee worked for the next nine months to further develop these priorities, as well as develop drafted strategies and measures to address the priorities, based on the input from the prioritization survey, Title V Connections Tour, the landscape analysis, and additional epidemiologic data.

Listening Sessions

The best way to understand and address the needs of communities is to ensure voices from those communities are a part of the process. It is just as critical to ensure we include the perspectives of those who implement programs and policies so that we are not overpromising communities. These key implementors are also a part of community and bring expertise about systems, funding, and policies. We cannot address needs in Minnesota's communities without having these important voices at the table. In Minnesota, the key implementors of the Title V program include staff from 52 Community Health Boards (CHB) and more than 170 staff in the CFH Division at the Minnesota Department of Health.

In 2025, listening sessions were conducted with over 200 key implementors to gather input on priorities, strategies, and measures for the 2025 Title V Needs Assessment and action planning process. Six listening sessions were held for LPH representatives – each listening session focused on one Title V population domain, including the cross-cutting/systems building domain. Eight listening sessions were offered for CFH Division staff. Like the LPH listening sessions, each listening session focused on one Title V population domain, including the cross-cutting/systems building domain; however there were two additional listening sessions held because the Title V team decided to conduct a listening session for each of the cross-cutting/systems building priorities, and an additional women/maternal health session was held to accommodate for staff unable to attend the first session and requested an additional session to provide input.

Attendees were provided priority briefs ahead of time to provide context to each population domain's draft priority, as well as the drafted strategies. During the listening session, attendees were asked "Does the priority resonate with you and your partners?" and "Does anything about this priority make you hesitate and why?" For each strategy, attendees were asked "How do you and your partners currently do work to this strategy?" For the overall priority and strategies, attendees were asked, "How do you think this will impact health disparities?" and "What gaps are there between what you see your community facing and what is being addressed in this action plan?"

In recognition of different learning and feedback styles and needs, the Title V team offered a variety of engagement activities during the listening sessions. For the listening sessions with CFH Division staff, the Title V team used polls to gather quantitative feedback, as well as the chat feature in Microsoft Teams and Microsoft Word online to provide

opportunities for staff to provide direct and instant feedback to the drafted priorities and strategies. The team also utilized both small and large groups to gather feedback, as well as an additional one-week period of time to provide additional asynchronous feedback in the documents.

For the listening sessions with LPH, the Title V team were forced to get creative in how they were gathering feedback due to restrictions for LPH to be able to engage with State run applications and software such as Microsoft Word, in real time. The team decided to utilize Padlet to allow LPH listening session attendees to engage in real time, providing written feedback in conjunction with the conversation occurring utilizing Microsoft Teams.

Community Input Survey

Once the Title V team integrated feedback from the listening sessions held with LPH and CFH Division staff into the drafted priorities and strategies, we were then able to draft our 2026-2030 Title V MCH State Action Plan and gather feedback from the broader Minnesota communities. The goal of the community input survey was not focused on getting public input on the priorities and strategies specifically, rather the Title V team wanted to gather insight into a broader question of how the public understood and felt seen in the Title V maternal and child health landscape, as represented by the drafted 2026-2030 action plan. In 415 completed surveys there were a range in responses on how people see themselves, their family and/or their community within the Title V Action Plan.

> *"Child and adolescent mental health/wellbeing is important to me as the mom of 3 boys."*
>
> *"I see it making resources for myself and my children easier to access and understand. I see it benefitting the community by putting the needs of kids and families as a priority."*
>
> *"I am a community provider who tries to raise awareness for the supports needed in my community....In short, my community needs a lot more support."*

Data huddles

To conclude the fourth phase of the needs assessment and action planning process, after integrating feedback from the public feedback survey, the Title V team conducted data huddles with key data/epidemiological/evaluation staff throughout the CFH Division to finalize the evidence-based strategies for each of the Title V population domains. Each data huddle was focused on a Title V population domain and staff brought in their expertise and input related to data they are already working with or would like to work with related to programs throughout our division, or with partners. This particular part of the needs assessment and action planning process was a teaser into what the Title V team is hoping to continue as a part of the ongoing needs assessment work in interim years 2-4 – our goal is to build out action learning groups made up of key interest holders to Minnesota Title V to support further alignment and systems integration with our Title V measures, strategies, and priorities to advance maternal and child outcomes and reduce health disparities.

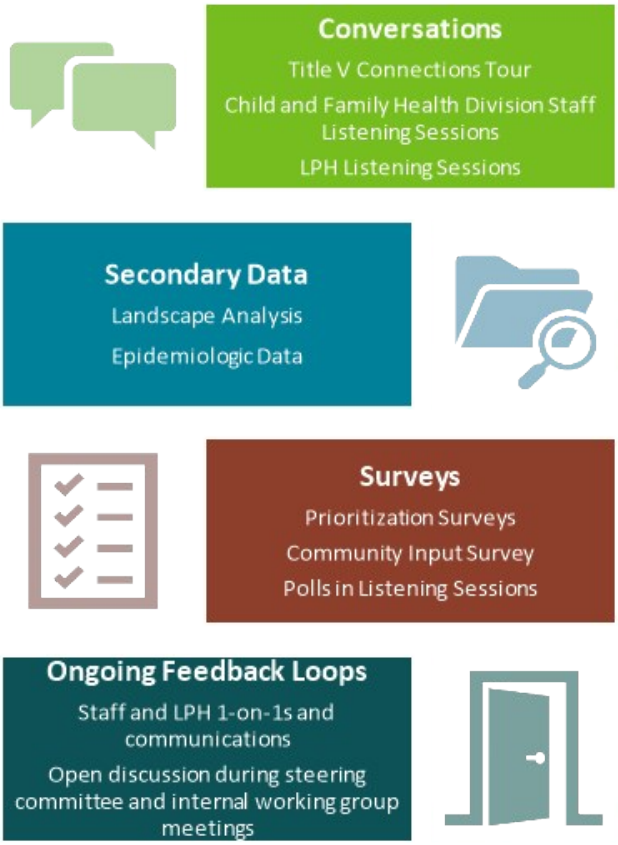
Data Sources

The Minnesota Title V Team was fortunate to have an abundance of data sources accessible for the needs assessment and action planning process, and the team was intentional about ensuring that the process was consistently utilizing a variety of these resources to gather multiple perspectives and affirm decision-making. All data – whether quantitative, qualitive, single story, or large data set – was treated with equal value and deference – all data contributed to decision-making and was representative of multiple interest holders, knowledge, and experiences.

As shown in Figure 6, data was sourced in four broad categories, including through conversations, secondary data sources, surveys, and ongoing feedback loops. Some of the data sources included the Title V Connections with LPH

Tour conversation, feedback and direct engagement in listening sessions, secondary documents and data sources the prioritization survey, the community input survey, polls in listening sessions, ongoing LPH and CFH Division Feedback, and open discussion during steering committee and working group meetings.

Figure 6. Data Sources



Additionally, as much as possible, the Title V team aimed to produce data collection tools, as well as collect and analyze data, that could be utilized beyond the needs assessment and action planning process and beyond the Minnesota Title V team. Any tools that were developed for the needs assessment and action planning process, including data collection tools, and aggregated data collected and analyzed were shared with CFH Division staff to utilize for their own program purposes. The team also relayed the information to LPH that they could request these tools at any time.

We wanted to ensure that the Title V team was putting reciprocity into action by making these resources available for others to use, particularly those who had invested time and engagement into the needs assessment and action planning process, i.e., CFH Division staff and LPH.

[1] *Note: As of January 2025, Minnesota now has 52 community health boards/Title V grantees. As of January 2026, Minnesota will have 53 community health boards/Title V grantees. Depending on the year, language might reference either 51, 52, or 53 community health boards.*
[2] Emergent Strategy – Adrienne Maree Brown
[3] Using Reflexivity to Build Relationships, Trust, & Connection in Challenging Times and Beyond by Elizabeth Taylor-Schiro
[4] The Water of Systems Change - FSG
[5] Emergent Strategy – Adrienne Maree Brown

MCH Population Health and Wellbeing

Overview

Minnesota continues to be recognized as a top state in the nation for families to live and for high quality of life, health, and wellbeing[1], however, the opportunity to be healthy is not available everywhere or for everyone in Minnesota. Community health drivers, including a person's geography and other demographic factors, continue to determine a person's health status. Like Senator Paul Wellstone would say, "We all do better, when we all do better." – and we can do better as a state.

"We all do better, when we all do better."

Sen. Paul Wellstone

Over the past three years, Minnesota has worked in partnership with families, communities, and public health professionals across the state to better understand the needs of mothers, children – including CSHCN – and families in Minnesota. On this journey we have built and strengthened integral relationships with these interest holders while not only furthering our understanding of their strengths and needs, but also of our own strengths and needs as the Minnesota Title V program. Throughout this process, we have heard and seen repeatedly the impact of community health drivers on health outcomes across and within communities and families.

Community health drivers (economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context) have a major impact on people's health, wellbeing, and quality of life.

Community health drivers have a greater influence on health outcomes than individual choices and contribute to wide health differences across Minnesota's MCH populations.

We have also heard and seen the resilience and knowledge within communities and family systems. Communities know how to prevent and address factors that influence negative health outcomes when they have comprehensive and consistent supports and resources in place. Trust is not only integral to relationship-building to understand strengths and challenges within communities, it is integral to developing solutions from within and led by the very communities, families, and individuals most impacted by disparate MCH health outcomes and the factors influencing them. The Minnesota Title V team collaborated intentionally with members of and service providers working within these communities throughout the 2025 needs assessment and action planning process. The Minnesota Title V team also believes it is vital to recognize that the Child and Family Health Division staff – who are a part of and connected to the Title V program – are members of various communities and families themselves; and they bring that lens with them to the work they do as a part of the Division and as a part of Title V.

It is these three underlying themes – the impact of community health drivers, community and family resilience, and community experience – that were interwoven throughout the 2025 needs assessment and action planning process not only in the data that our team was uncovering and collecting, but also in the approach to the process itself. (*See the Purpose and Design section of the report for more information about the approach to the 2025 Needs Assessment and Action Planning Process.)* However, these three components, detailed below, were clearly evident as rising themes in the data that we collected and analyzed.

Identification of MCH Populations' Strengths and Needs

Between September 2023 and January 2024, the Minnesota Title V team conducted a landscape analysis to

develop a base understanding of the current landscape of strengths, needs and priorities for Minnesota's maternal and child health (MCH) populations, including CSHCN and their families. This included the review and analysis of 160 documents on topics relevant to MCH and CSHCN populations in Minnesota. Documents were reviewed using an analysis rubric developed by the Minnesota Title V team. Data collected in the analysis rubric was then qualitatively analyzed to create a final list of themes and sub-themes describing the current landscape of needs and priorities for Minnesota's MCH and CSHCN populations.

An important note to highlight about the landscape analysis and themes identified is that though the analysis, the Title V team was not only working to identify needs and gaps, but any topics that were identified multiple times whether it was positively or negatively attributed. By the end of the needs assessment and action planning process, the priorities and strategies selected were developed with underpinnings of both strengths and needs already present within them. As such, **many of the priorities and strategies can be viewed as both strengths and needs to various degrees within communities across Minnesota.** The ongoing needs assessment and action planning process will aid the Minnesota Title V team in deciphering the level to which a community's strengths and/or needs impact their ability to address a given priority through the strategies that have been developed.

Qualitative analysis of the data, from the review and analysis of the 160 documents, resulted in 21 emerging themes, including the following:

- Systems and Policies
- Drugs and Substance Use
- Mental Health and Wellbeing
- Youth Mental Health and Wellbeing
- Chronic Disease, including Cancer and Diabetes
- Violence and Violence Prevention
- Housing Stability, Access, and Affordability
- Healthy Weight and Obesity
- Healthy Lifestyle and Healthy Behaviors
- Healthy Families and Healthy Communities
- Access to Care and Care Coordination, including healthcare and health insurance affordability
- Oral Health and Dental Care
- Childcare
- Senior Health
- Climate Change and the Environment
- Health Education
- Infectious Disease Prevention

These themes were then clustered further based on similar topics as well as capacity for the Minnesota Title V team and system, including local public health, to implement as a priority theme versus a sub-theme. Thirteen themes were ultimately selected that were then brought forward into the next phase of the needs assessment and action planning

process. Many sub-themes were also noted, which served as one source of data during the next stage of the needs assessment process that dealt with prioritization of and development of strategies to address identified priority needs. The 13 identified priority themes, and examples of sub-themes, included the following:

- Systems and Policies
    - Example sub-themes: community engagement infrastructure, collaborating across entities and sectors, employee retention and professional development, engagement with Tribal Nations, expanding the birthing support workforce, data collection efforts
- Drugs and Substance Use
    - Example sub-themes: opioid use and misuse, electronic nicotine delivery systems, use and exposure, providers and services for substance use; youth drug and substance use
- Mental Health and Wellbeing
    - Example sub-themes: access to individual and community services, health support, self and neighborhood safety, social connectedness and belonging, youth suicide, youth leadership
- Violence and Violence Prevention
    - Example sub-themes: domestic violence, intimate partner violence, human-trafficking, incarceration, bullying
- Housing Stability, Access, and Affordability
    - Example sub-themes: homelessness, affordable housing, access to housing, safe housing
- Healthy Lifestyle and Healthy Behaviors
    - Example sub-themes: physical wellness, healthy eating, healthy living access and barriers, safe technology use, support to prevent burnout, risky youth behaviors, teen pregnancy, non-institutional learning spaces and resources, academic and technology learning
- Healthy Families and Communities
    - Example sub-themes: community infrastructure, community resilience, building community health and wealth, holistic (min, body, spirit) care, families and caregiver support, supportive schools and communities, parenting, affordable and accessible childcare, oral health and dental care, infectious disease prevention
- Access to Care and Care Coordination
    - Example sub-themes: access to healthcare, paying for healthcare, specialty care, preventive services, virtual care, care coordination, transition planning, health literacy, emergency care, doula services, prenatal care, family planning, resource navigators
- Community Health Drivers
    - Example sub-themes: Socioeconomic differences, internet access, transportation, economic opportunities and security, financial stress, food security and access, affordable and nutritious foods
- Health Education
    - Example sub-themes: health literacy, preventive health education, sexual and reproductive health education

Through collective and individual input from local public health staff, Child and Family Health Division staff, Title V

community partners, the Minnesota Title V team, the internal working group, the steering committee, and the Maternal and Child Health Advisory Task Force (Maternal and Child Health Advisory Committee as of July 1, 2025), these 13 themes were then prioritized into seven priorities. Sub-themes, secondary population level data from additional sources, input from the previously mentioned interest holders, analysis of current Title V block grant efforts, and identified gaps were taken into consideration when selecting the final seven priorities, as well as the strategies developed to address them.

Strength/Need Context by Population Domain

This section describes the final priorities and strategies that were selected – considering integrated individual and community perspectives of both strengths and needs. There is also a short provision of some of the context related to each population domain within the state of Minnesota, as related to the uncovered strengths and needs.

Infant/Perinatal Health

Infant mortality is widely used as an international measure of overall population health. The United States has a higher infant mortality rate than other developed countries despite spending more on health care.[2] Infant and fetal mortality are a multifactorial societal problem often linked to factors that affect an individual's physical and mental wellbeing, including maternal health, socioeconomic status, quality and access to medical care, and public health practices.

The health of families and communities plays a crucial role in reducing infant mortality. When families have access to quality healthcare, nutritious food, safe sleeping options, safe housing, and supportive services, infants are more likely to thrive. Healthy communities, healthy families, healthy pregnancies, and strong parent-infant bonds are essential foundations for infant wellbeing.

Priority

Healthy infants, families, and communities: improve the wellbeing of families with pregnant women and infants through supports and services that are community-based and responsive to individual needs and experiences.

Strategies

1. Amplify resources, services, and supports that are responsive to community needs and foster the health and wellbeing of families with pregnant women and infants.
2. Collaborate with trusted community organizations and partners to maximize resources that promote the health and wellbeing of pregnant women and infants.
3. Promote and strengthen development and broad representation in the workforce supporting infant and perinatal health.
4. Enhance and integrate knowledge of the impact of parental mental health and intergenerational experiences on perinatal and infant health.

Child Health

Childhood is a period of rapid development in language and motor skills and social-emotional processing. Mental health and wellbeing are essential, as it supports children's ability to learn, grow, and reach their full potential. Minnesota faces significant challenges in having a coordinated and efficient system of care for children and their families. Minnesota children are more like to be flourishing than the national average in early childhood, but school aged children are less likely met all flourishing items than the national average.

Priority

Child mental health and wellbeing: Increase the number children who are screened for and connected with mental, behavior, and wellbeing resources and services that are responsive to individual needs and experiences.

Strategies

1. Amplify resources, screening, training, services, and supports that are responsive to and address the needs of children and their communities.
2. Ensure children from all populations and geographic areas have access to mental health and wellbeing promotion, screening, and resources.
3. Provider resources and support for school-based health centers and school nurses to address mental health and wellbeing for children in schools.
4. Increase capacity of the child health workforce to provide wellbeing and mental health support across the state.

Adolescent Health

Minnesota consistently ranks among the healthiest states for children and adolescents. In many reports displaying data overtime shows that youth today have healthier behaviors than they did 25 years ago.[3] Data from Minnesota Student Survey shows that more youth today than ever before report wearing seatbelts, and fewer report that they smoke cigarettes, consume alcohol, take drugs, have sex, and do these things in combination. Despite reductions in risky behaviors, there has been large increases in female students of reporting long-term mental health, behavioral, or emotional problems (6 months or longer). There also has been an increase in males but less significantly. At the same time mental wellbeing, factors that help youth with resilience, has been consistently decreasing since 2016.

Priority

Adolescent mental health and wellbeing: increase adolescent-centered mental health and wellbeing resources and upstream-focused, universal supports.

Strategies

1. Amplify resources, services, and supports for adolescents.
2. Build community capacity to support and increase access to adolescent-centered physical and mental health resources and supports.
3. Nourish transformation of systems, environments, and norms that support adolescents in self and community care.
4. Promote change in societal attitudes by challenging stigma and harmful beliefs toward adolescent mental health and illness.

Children with Special Health Care Needs

Approximately 26.1% of Minnesota's children and youth have physical, developmental, behavioral, or emotional conditions that require more services than typically needed. Despite the broad range of services available, many families report difficulty navigating and accessing the care their children need. Challenges such as limited provider availability, long wait times, unclear points of entry, and lack of coordination across systems can lead to delays in care or missed services altogether. This experience is reflected in statewide performance data. Only 14.2% of CYSHCN in Minnesota are reported to be receiving care within a well-functioning system. Given these challenges, Minnesota has prioritized improving access and strengthening coordination for CSHCN.

Priority

Coordinated support and access for CSHCN: Expand awareness of available services and improve access to high-quality, family-centered supports that help children, youth, families, and care teams address health and development in ways that reflect their needs and preferences across settings.

Strategies

1. Strengthen family-centered, evidence-informed supports, services, and resources.
2. Involve families and caregivers in shaping, implementing, and improving programs and services.
3. Collaborate across systems to simplify family navigation and improve access to resources and supports.
4. Support local efforts to provide services and resources in ways that meet family needs and preferences.

Women/Maternal Health

Comprehensive, quality services are essential for ensuring the health and wellbeing of both women and their infants throughout pregnancy, childbirth, and the postpartum period. Comprehensive perinatal systems integrate medical, behavioral, and social services to provide coordinated, high-quality care that addresses the full spectrum of needs. By connecting prenatal care, labor and delivery, postpartum support, and community resources, comprehensive systems help improve birth outcomes, promote more consistent care across populations, and support families during a critical time of transition. Investing in such systems not only enhances individual and community health but also contributes to long-term societal benefits by laying a strong foundation for early childhood development.

Priority

Comprehensive perinatal systems of care: Ensure perinatal women have access to comprehensive systems of care and care navigation that are comprehensive, high quality, and responsive to individual needs and preferences.

1. Enhance resources, services, and supports that are responsive to community and individual needs and experiences to improve birth experiences for perinatal women.
2. Broaden virtual and in-person services for perinatal women.
3. Strengthen health literacy and system navigation by providing community-responsive resources, services, and supports.
4. Improve quality and availability of family-centered mental health and substance use disorder services and resources for perinatal women.

Cross-Cutting/Systems-Building

Addressing key drivers and underlying conditions that influence the health of Minnesota's families and communities is important because these drivers, such as income, education level, early childhood education/care, affordable housing, and access to healthy food, all greatly impact our population's health outcomes. Social and economic conditions are one of the biggest contributors to health differences. According to the Trust for America's Health (TFAH), research shows that a person's health, including their ability to make healthy choices, is impacted by where they live, their income, their educational attainment, and other factors.

Priority #1

Community Health Drivers: address the key drivers and underlying conditions that influence the health of Minnesota's families and communities.

Strategies

1. Amplify resources, services, and supports that are responsive to community needs and support the health and wellbeing for all.
2. Strengthen the capacity of public health professionals and community leaders to effectively address community health drivers, such as housing and early childhood systems of care, using a public health lens.
3. Vitalize Title V activities to address community health factors to improve maternal and child health outcomes and access to care across the life course.
4. Ensure data produced and reported through Title V highlight meaningful differences in maternal and child health outcomes, explore root causes, discuss their impact, and provide recommendations for improving health across MCH populations.

Optimal systems and policies are essential for creating a society where everyone has the opportunity to thrive, regardless of their background, location, or socioeconomic status. Everyone deserves access to necessary resources and opportunities. Systems that function optimally recognize that individuals and communities have different needs and therefore may require different levels of support to achieve similar outcomes. Ultimately, optimal systems strengthen society as a whole by promoting social cohesion and shared prosperity.

Priority #2

Optimal systems and policies: support transformation of systems and policies that drive priorities for improving health outcomes and optimally serving MCH populations in Minnesota.

Strategies

1. Amplify community responsive resources, services, and supports to address systems and policies to support the health and wellbeing of MCH populations.
2. Develop and mobilize strong interagency, multisector, and community partnerships to respond to uneven trends in maternal and infant deaths through targeted interventions.
3. Build workforce and partner capacity to promote systems and policies that optimally serve all MCH populations in Minnesota.
4. Engage partners and interest holders to promote family engagement and partnership across all sectors.

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[1] States With the Least Healthy (And Healthiest) Populations – Forbes Advisor

[2] Petrullo, J. US Has Highest Infant, Maternal Mortality Rates Despite the Most Health Care Spending. AJMC. January 31, 2023.

[3] Minnesota Department of Health. (2014). Minnesota Student Survey 1992-2013 Trends. Minnesota Department of Health. https://www.health.state.mn.us/data/mchs/surveys/mss/docs/trendreports/msstrendreport2013.pdf

III.C.1.b.ii. Title V Program Capacity

III.C.1.b.ii.a. Impact of Organizational Structure

Impact of Organizational Structure

The Minnesota Title V Program is fortunate to have both their maternal and child health (MCH) and children with special health care needs (CSHCN) counterparts in the same agency, bureau, and division – allowing for ease of accessibility and collaboration across the various programs and services offered between these two bodies of work. The primary Title V staff who are responsible for management and administration of the Title V program, who sit within the Child and Family Health Division, include the: Title V Director/Title V MCH Director, Title V CSCHN Director, Title V Coordinator, and SSDI Coordinator.

As shared in other areas of this report, the Minnesota Title V program is uniquely situated within the state and within the state health agency to provide and assure services and supports within each of the Title V population domain areas. The Minnesota Title V program is housed with the Minnesota Department of Health's (MDH) Child and Family Health Division.

MDH holds responsibilities in the areas of:

- Health protection – including environmental health and infectious disease epidemiology, prevention and control.
- Health improvement – including child and family health, health promotion and chronic disease, and injury prevention and mental health.
- Health policy and regulation across health systems.
- Public health strategy and partnership.
- Emergency preparedness and response.

Within these areas of responsibility, MDH houses many critical programs that influence the delivery of Title V in Minnesota through partnership and collaboration including:

- Minnesota Women, Infants, and Children (WIC) Program
- Family Home Visiting – including TANF and MIECHV.
- The Public Health Laboratory and Newborn Screening Program
- Health Policy including Health Care Homes, and Rural Heath and Primary Care
- Infectious Disease Epidemiology, Prevention and Control (IDEPC)
- Injury Prevention and Mental Health

- Health Promotion and Chronic Disease Prevention
- Office of statewide health improvement initiatives – including the Health Minnesota Partnership.
- Public Health Emergency Preparedness.
- Public Health Practice – including management of the local public health grant (MN Statute § 145A.131), CDC federal infrastructure grant, foundational public health responsibilities grant, and Minnesota state infrastructure fund (Innovation projects).

The CFH Division serves as the state-level administrator of the Title V MCH Block Grant, ensuring the responsibilities set forth by the federal Maternal and Child Health Bureau are met. The CFH Division is made up of five sections and programs and grants, including the following:

Director's Office and Operations
Administrative and Financial Operations
Preschool Development Grant
Title V MCH Block Grant
State Systems Development Initiative

Maternal and Child Health Section
Adolescent Health
Cannabis and Substance Use Prevention in Pregnancy
Child and Teen Checkups Program (Minnesota's EPSDT Program)
Early Childhood Systems
Infant Health and Mortality
Infant Safe Sleep
Maternal Access Program - Doula and Midwifery
Maternal Mortality Review Committee
Maternal Health Innovations Grant
Mental Health Promotion
Minnesota Model Jail Practices Learning Community
Minnesota Perinatal Quality Collaborative
Minnesota Personal Responsibility Education Program (PREP)
Minnesota Sexual Risk Avoidance Education Grant Program (SRAE)
Pregnancy Risk Assessment Monitoring System (PRAMS)
Reimagine Black Youth Mental Health Initiative (RBYMH)
School-Based Health Clinics
School Nursing
Sudden Unexpected Infant Deaths (SUID)

Sexual and Reproductive Health Services Grant (SRHS)

Student Parent Support Center

CSHCN Section

Birth Defects Monitoring and Analysis

Birth Defects Prevention

Care Coordination Community of Practice

Early Hearing Detection and Intervention (EHDI)

Family Support Organization Collaborative

Follow Along Program (Developmental Screening)

Longitudinal Follow-up for Newborn Screening Conditions

Minnesota's Integrated Care for Early Childhood Initiative

Minnesota Pediatric Mental Health Care Access Project

Outreach and Education for Congenital Cytomegalovirus (cCMV)

WIC/Supplemental Nutrition Program Section

Commodity Supplemental Food Program

Minnesota WIC Program

WIC Breastfeeding Peer Counselor Program

Family Home Visiting (FHV)

Evidence-Based Home Visiting

Maternal, Infant, and Early Childhood Home Visiting (MIECHV)

Nurse-Family Partnership

Promising Practices

Strong Foundations

Temporary Assistance for Needy Families (TANF)

While not exhaustive, this list demonstrates the close proximity of Minnesota's Title V team to key programs and funding that support and address the priorities and strategies selected through the 2025 needs assessment and action planning. However, while the close proximity allows to streamlined access, partnership, and collaboration, the Minnesota Title V team recognizes the importance of partnership and collaboration across and within sectors. There are a number of formal and informal opportunities that Title V staff and partners take advantage of to collaborate across the health department and with other state agencies, as well as with community organizations, health systems, education systems, and community/family members.

The CFH Division, for example, is home to the following professional advisory groups:

- Maternal and Child Health Advisory Committee*
- Maternal Mortality Review Committee*
- Minnesota Integrated Care for Early Childhood Initiative Community Advisory Council*

- Minnesota Interagency Developmental Screening Task Force*
- Minnesota Perinatal Quality Collaborative*
- Newborn Hearing Screening Advisory Committee*
- Newborn Screening Advisory Committee*
- Task Force on Pregnancy Health and Substance Use Disorders*
- WIC Advisory Group*

Other Divisions in MDH are home to the following professional advisory groups:

- Administrative Uniformity Committee
- Advisory Council on Wells and Borings
- Clean Water Council
- Commercial Tobacco Cessation Advisory Committee
- Community Solutions Advisory Council*
- Environmental Health Specialist/Sanitarian Council
- Environmental Health Tracking & Biomonitoring Advisory Panel
- Environmental Laboratory Certification Program Advisory Committee
- Health Care Homes Advisory Committee*
- Health Care Workforce and Education Committee
- Healthy Minnesota Partnership
- Hearing Instrument Dispenser Advisory Council
- Home Care Provider Advisory Council
- Metro Immigrant and Refugee Health Network
- Minnesota Arthritis Advisory Group
- Minnesota Asthma Advisory Committee
- Minnesota Cancer Reporting System (MCRS) Scientific Peer Review Committee
- Minnesota Cancer Surveillance System Advisory Group
- Minnesota Cardiovascular Health Alliance
- Minnesota Collaborative Lead Education and Assessment Network
- Minnesota e-Health Initiative Advisory Committee
- Minnesota Diabetes Prevention Network Advisory Committee
- Minnesota Diabetes Surveillance and Data Review Subcommittee
- Minnesota Human Trafficking Task Force
- Minnesota Immunization Practices Advisory Committee
- Minnesota Occupational Health and Safety Surveillance Program Advisory Workgroup
- Minnesota State Suicide Prevention Task Force

- Nuclear Regulatory Commission Agreement State Rule Advisory Group
- Palliative Care Advisory Council
- Psychedelic Medicine Task Force
- Rural Health Advisory Committee
- Rural Hospital Flexibility Program Advisory Committee
- Sexual Violence Prevention Network
- Speech-Hearing Work Group
- Speech-Language Pathologist and Audiologist Advisory Council
- State Community Health Services Advisory Committee (SCHSAC)
- State Preventive Health Advisory Committee
- State Trauma Advisory Council
- Tribal Health Directors
- Tuberculosis Advisory Committee
- Water Supply Systems and Wastewater Treatment Facilities Advisory Council

These lists, while not comprehensive, represent an overwhelming capacity for the Minnesota Title V team and partners to collaborate and address the priorities and strategies in the 2025-2030 Title V state action plan. Those groups with an asterisk indicate those that Minnesota Title V staff participate on and/or lead.

Additionally, these lists do not account for the external and numerous advisory bodies, including working groups, task forces, collaboratives, and communities of practice that those funded under Title V and Title V match dollars engage in to deepen understanding of areas within the MCH landscape and work across siloes to improve outcomes for Minnesota's women, children, and families. Some examples of these non-MDH groups that Minnesota Title staff engage in include:

- Association for Maternal and Child Health Programs Committees
- Children's Mental Health Subcommittee of the Statewide Advisory Council on Mental Health
- Governor's Council on Developmental Disability
- Interagency Coordinating Council (Part C of IDEA)
- Minnesota Breastfeeding Coalition (MBC) Finance, Governance, Events Planning, Next Gen Lactation and Membership subcommittees
- Minnesota's Early Intensive Developmental and Behavioral Intervention Advisory Group (re: Autism)
- Minnesota Juvenile Justice Advisory Committee
- Minnesota Rare Disease Advisory Council
- Minnesota State Suicide Prevention Task Force
- University of Minnesota Institute on Community Integration Advisory Council

Impact of Agency Capacity

While not all activities are led by the Minnesota Title V team, or those funded through Title V and/or Title V Match dollars, there is work across systems that addresses each of the priorities and strategies through the 2025 Title V needs assessment and action planning process. As a systems/infrastructure building initiative, the Minnesota Title V program aims to increase the capacity of state, local, and tribal public health systems to address the needs of Minnesota's women, children, and families, including CSHCN, and to build the infrastructure needed to improve health in target populations. Title V is not meant to support the work of improving outcomes for all MCH populations alone, though it can serve to be both a strong leader and supporter in efforts throughout Minnesota to address the needs of MCH populations. In fact, the Minnesota Title V team strives for collaboration and sharing so that we are not the only ones engaging in an initiative – we are stronger together. These principles are reflected throughout the 2024 report and 2026 application/plan when activities are labeled as state versus local Title V work, and whether it is Title V connected or supported.

As shared in other areas of this report, the Minnesota Title V program is opportunistically situated within the state and within the state health agency to provide and assure services within each of the Title V population domain areas. The Minnesota Title V program is housed with the Minnesota Department of Health's (MDH) Child and Family Health Division and the Child and Family Health Division serves as the state-level administrator of the Title V MCH Block Grant, ensuring the responsibilities set forth by the federal Maternal and Child Health Bureau are met. The Minnesota Title V program administers two-thirds of the Title V funding by formula to 52 (53 beginning January 1, 2026) community health boards, comprised of 87 local public health agencies, per Minnesota Statute § 145.88. The funding structure of Title V in Minnesota presents both strengths and challenges. On one hand, most of the funding goes toward supporting and strengthening the local public health infrastructure to meet families and community members where there are at in order to meet the needs of our MCH populations.On the other hand, the amount of funding allocated to the state of Minnesota divided first into thirds, with two-thirds then being divided by formula to community health boards, often little funding is then available for a lot of work both at the state and local level. This can be challenging when such meaningful and exhaustive work is done to conduct a comprehensive needs assessment and action planning for MCH populations, including CSHCN, in the state every five years, but there is not a large funding stream to support all that could be done to meet the need identified, including the priorities and strategies in each population domain. This challenge is also why the Minnesota Title V team finds it critical to partner and collaborate, when possible, to maximize resources, including workforce capacity.

As shared throughout the 2024 report and 2026 application/plan, there are a significant number of opportunities that the Minnesota Title V team, including at the state and local levels, utilize to build partnership and collaboration across and within sectors. We would not be able to move the efforts of Title V forward within Minnesota without these critical partnerships. This is becoming particularly important as we are having to consolidate efforts and funding while continuing to address the needs of all communities in our state.

III.C.1.b.ii.c. Title V Workforce Capacity and Workforce Development

Minnesota Title V Workforce Capacity and Workforce Development

Minnesota acknowledges that achieving the best possible health results for maternal and child populations depends on building and maintaining a capable and representative workforce—one that reflects the makeup of communities across the state. Strengthening Minnesota's workforce requires a multifaceted approach in addition to recruitment and retention, including understanding and being responsive to the training and development needs for Minnesota Title V staff and partners, as well as innovations in staffing structures that include key partnerships and pathways to the maternal and child health (MCH) workforce.

Recruitment and Retention of Staff

The Minnesota Department of Health (MDH) hires approximately 200 employees every year to fulfill its mission of

protecting, maintaining, and improving the health of all Minnesotans. MDH, including the Child and Family Health Division (CFH), recruitment efforts have expanded in recent years with an aim to increase the representation of its' workforce to be reflective of the makeup of communities across the state. This has included strengthening hiring practices, including outreach efforts.

Responses from MDH's 2020 Employee Engagement Survey, with an 84% response rate, provide guidance on areas the CFH Division can focus on, including the following:

- 77% of respondents reported being highly satisfied/satisfied in *Overall Employee Satisfaction*
- 81% of respondents indicated that having a "Good relationship with immediate supervisor" was the most important to their job satisfaction, followed by "Flexible working conditions (e.g., flex schedule, telecommute)" (77%), and "Good relationships with co-workers (72%)
- 64% of respondents indicated they have "Adequate training opportunities available"
- 35% of respondents indicated "Career advancement opportunities exist at MDH"
- 73% of respondents reported "Very Likely/Likely" that *If they had a choice between working at MDH or somewhere else, they would remain working at MDH through the next 12 months.*
- 53% of respondents indicated *Overall, my division/office works to actively create an environment that cultivates and/or champions…my growth as an employee*
- 47% of respondents indicated *Overall, my division/office works to actively create an environment that cultivates and/or champions…my leadership development as an employee*

In 2021, the CFH Division aimed to increase employee engagement and satisfaction through the development of several workgroups, as indicated by staff interest through a division-wide employee survey. The following groups were created, with active membership and engagement in 2024:

- *Collaboration and Connections Workgroup* – whose aim is to improve communication, increase the exchange of ideas, and create a sense of community among staff through modeling collaborative behavior; support a sense of community; provide opportunities to enhance collaborative skills; create a cooperative culture; and foster team building by sharing strategies, activities, and tools for teams to use in their work together.
- *New Employee Orientation Workgroup* – whose aim is to create a welcome platform for new staff get connected to other staff, as well as opportunities and resources. The work of this workgroup includes updating the CFH New Employee Manual and revisions to the orientation of new CFH Division staff, as needed.

Connecting with Leadership

The Division Director for Child and Family Health, Noya Woodrich, offers a monthly "Time with Noya" to all staff in the Division. This is an informal time for folks to gather and ask questions of Noya and get answers. She typically starts the meeting with a brief presentation, i.e. "A day in the life" and then opens it up for questions. This is one way in which to connect with the Division Director informally and in a friendly setting, and these have been well attended by Division staff.

The MDH Commissioner of Health, Dr. Brook Cunningham, offers a quarterly agency meeting during which she gives an update on key areas of interest to the workforce. She typically will share some high-level updates about the goings on in the Department then leaves some time to answer frequently asked questions.

Training and Professional Growth Opportunities

MDH is committed to fostering a learning environment in which employees develop professionally and personally.

MDH encourages building key competencies within our workforce – including key public health competencies – by providing an array of internal opportunities for learning and professional development, as well as encouraging external learning opportunities that fit staff goals and responsibilities.

The Workforce Development Team within the Human Resources Department at MDH is responsible for developing and carrying out MDH's Workforce Development Plan. The Workforce Development team builds key competencies within the MDH workforce by providing a range of training, services, and resources. Additionally, the Learning and Development Team within the Workforce Development Team *"is committed to empowering employees by providing growth and development opportunities".*

Employee development is an ongoing process which includes a variety of activities and experiences designed to improve and/or increase the skills, knowledge, and abilities of employees. Employees are required to develop individual development plans as a part of their annual performance review process. Individual development plans include development goals and an action plan of the learning activities the employee will complete to meet those goals. Typical learning activities include classroom instruction, independent study, e-learning, project or task force assignments, supervisory coaching, on-the job training, orientation, job rotation, and attending conferences.

Representation of MDH on Local, State, and National advisory bodies

CFH staff, additionally, participate on advisory bodies at the local, state, and national level to deepen understanding of areas within the MCH landscape and work across siloes to improve outcomes for Minnesota's women, children, and families. In particular, Minnesota Title V staff engage on numerous advisory bodies, including working groups, task forces, collaboratives, and communities of practice. See *Impact of Organizational Structure* for more information.

Workforce Innovation

Student Internships

The CFH Division is committed to the growth and development of emerging public health professionals – particularly those with interest in MCH – through partnerships with local higher education institutions, as well as national programs. These opportunities create pathways for learning and connection for students interested in a public health career and are supported across the Division. The following are examples of student partnerships in all five sections of the Division.

- *Division-wide* - Through partnership with the University of Minnesota's (UMN) Center for Leadership in MCH, CFH regularly has several students on deployments from the Center during their graduate studies. These students work closely with CFH employees on special project during their 1-2 years with the Division. Additionally, the Divisions regularly hires student workers to provide support to a variety of programs and projects.
- *Director's Office* –Through partnership with UMN's Center for Leadership in MCH and the National MCH Workforce Development Center's Title V student interns and workers have supported Title V Needs Assessment and epidemiology work. For example, during the 2023-2024 and 2024-2025 academic years, three students worked closely with our Title V staff to support data analysis, research, writing, and other activities relevant to the annual Title V report/application plan and 2025 needs assessment.
- *MCH Section* - Through partnership with UMN's Center for Leadership in MCH, student interns and workers have supported critical MCH public health initiatives including developing a survey that will be used to capture doulas' experiences working throughout the state and conducting a literature review on fetal development and reproductive health. Additionally, the MCH Section has a Memorandum of Understanding (MOU) in place with Metro State University to host nursing students as part of their clinical practice requirements, as well as begun

conversations with St. Thomas University's School of Nursing to host nursing students as part of community experiences for women's health and pediatric courses. Student Workers are critical to MCH work.

- *CSHCN Section* - Through partnership with UMN's Center for Leadership in MCH and other Minnesota colleges, student interns and workers regularly support staff and programs within the CYSHN Section on a variety of projects.

  Additionally, CSHCN staff take advantage of opportunities to provide reciprocal learning by serving as mentors through the UMN School of Public Health and providing annual lectures to nursing and public health students at the UMN School of Nursing, UMN Center for Leadership Education, and Gustavus Adolphus College.

- *Women, Infant, and Children (WIC) Section* – Through partnership with UMN's Center for Leadership in MCH, Public Health AmeriCorps, and the National MCH Workforce Development Center's Title V Intern program, student interns and workers regularly support staff and programs within the WIC Section on a variety of projects.

- *Family Home Visiting (FHV) Section* – Through various partnerships, student interns and workers regularly support staff and programs within the FHV Section on a variety of projects. Additionally, FHV staff take advantage of opportunities to provide reciprocal learning by serving as mentors through the UMN-Master of Public Health program.

External Workforce Development Opportunities

MDH and CFH foster a learning environment by supporting external workforce development opportunities for staff with to build capacity for meeting program, community, and MCH population needs. Several key partners that Minnesota Title V staff have continued to seek growth and technical assistance opportunities with, and are currently engaged with, include the following:

- *CityMatCH* – Minnesota Title V and other CFH Division staff are participating in CityMatCH's Alignment for Action Learning Collaborative for Region 5.

- *Maternal Health Learning & Innovation Center* – Through a Supporting State-led Maternal Health Innovation Grant from HRSA, MDH's Innovations for Maternal Health Outcomes in Minnesota (I-MOM) staff are participating in a Learning Institute & Leadership Academy sponsored by the Maternal Health Learning & Innovation Center.

- *Public Health AmeriCorps Members*- MDH has expanded its cohort of AmeriCorps members throughout the department. This has created career pathway programs, allowing members to see if they are interested in governmental public health or to get established in governmental public health.

- *National Maternal and Child Health Workforce Development Center Learning Journey*– Minnesota Title V and other Division staff have participated in workforce development projects through the National Maternal and Child Health Workforce Development Center. Projects connected team members to tools, resources, and support for tackling a self-identified challenge they'd like to address related to Minnesota Title V populations.

MCH Epidemiology Workforce

The Child and Family Health (CFH) Division has four sections and the director's office. CFH has a total of 20 full-time equivalent (FTE) epidemiology staff with the job classifications of epidemiologist or research scientist (see Table 1). All epidemiologists within in the CFH Division have a Master's or Doctorate in Public Health (or something similar) with coursework in epidemiology and biostatistics. CFH's research scientists' also have a Master's or Doctorate in Public Health or related field with experience with statistical programming software and research/evaluation coursework.

Within CFH, Minnesota also has an additional 6.0 FTEs that are analysts or data support positions. These positions include student workers and others who are not in a job classified as an epidemiologist or research scientist but do

perform other analytic, evaluation, or system/database support work.

Table 1. Epidemiology Workforce Counts by Full-Time Equivalent (FTE)

CFH Section	*Epidemiology and Research Scientists FTEs*	*Other Analyst and Data Support FTEs*
Directors Office (DO)	1.0	0.2
Maternal and Child Health (MCH)	4.0	2.0
Children and Youth with Special Health Needs (CYSHN)	7.0	1.0
Family Home Visiting (FHV)	4.0	1.3
Women, Infant, and Children (WIC)	4.0	1.5
Total	20.0	6.0

Minnesota also has additional MCH Epidemiology workforce located in other divisions within MDH. Specifically, CFH has close partnerships and/or pays for analyst/evaluation positions with Injury and Violence Prevention (with our Violent Maternal Deaths grant), the Newborn Screening Lab, the Lead Program, and Minnesota Center of Health Statistics which adds to Minnesota's MCH Epidemiology workforce. When necessary, CFH also contracts with external evaluators.

Minnesota's current MCH epidemiology workforce capacity is growing and improving. We have long had strength in epidemiologic support for grants and to meet program requirements but have had little capacity for additional analysis and research projects needed to describe and study the Minnesota's maternal and child health populations. Ideally both our MCH and CSHCN section epidemiology teams recommend that we would need at least 2.0 additional FTEs to reach full capacity.

Our division has longevity in our MCH Epidemiology workforce with many staff working long tenures with our division. In a survey completed in early 2024 epidemiology staff reported the best assets for recruiting and retaining epidemiologists included: job benefits, the opportunity to work remotely, job security, flexible schedule, and job interests/fulfillment.

III.C.1.b.ii.d. State Systems Development Initiative (SSDI)

State Systems Development Initiative (SSDI)

The primary aim of the Minnesota SSDI is to develop, enhance, and expand data capacity of Maternal and Child Health (MCH) programs, including children with special health care needs (CSHCN), to ensure access to policy and program relevant information and data to make informed decisions. Specifically, Minnesota's SSDI program's four goals are:

Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming.

Goal 2: Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant

programming and policy development, and assure and strengthen information exchange and data interoperability.

Goal 3: Enhance the development, integration, and tracking of community health factors to inform Title V programming.

Goal 4: Develop and enhance capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats.

The Minnesota Department of Health (MDH) works to *protect, maintain, and improve the health of all Minnesotans*. The SSDI and Title V MCH Block Grant programs, which reside in the Child and Family Health Division at MDH, work to promote and improve the health and wellbeing of women, children, youth, and families.

Minnesota SSDI program provides essential support in applying these principles into the work of the Title V MCH program. The SSDI program leads the work of ensuring our Title V MCH Block Grant is data-driven by improving the availability, timeliness, and quality of MCH data in Minnesota. SSDI is essential to support the data needs for the Title V MCH Block Grant application, annual plan, and needs assessment, by allowing Minnesota to continue to strengthen access to, and linkage of, MCH datasets and to enhance the integration and tracking of health access across communities and community health factors. Minnesota's SSDI program will work towards developing and enhancing Minnesota's capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats.

Some highlighted project activities and accomplishments include:

- Completion of the 2025 Title V MCH Block Grant Needs Assessment including the Action Plan and National Performance Measure (NPM) selection and alignment.
- Supported the administration of the 2025 Minnesota Student Survey (MSS) a long-running survey of Minnesota students in grades 5, 8, 9, and 11 that tracks a wide variety of youth behaviors, risk and protective factors and outcomes related to education, health, safety and well-being. It is the only comprehensive source of information on the experiences our young people face in Minnesota.
- Minnesota invested in the oversampling of the 2023 and 2024 NSCH data collection to improve sample size and improve estimation across all indicators with a larger analytic sample.
- Minnesota continued the utilization of the MMRIA database for Minnesota's review committee and data collection efforts around maternal mortality. We continue to improve access to data with our Medicaid data sharing agreement. A lot of work has gone around releasing the next Maternal Mortality Report which will include 3 new years of data and has an improved and more detail than the previously updates 2019 Minnesota's Maternal Mortality Report. New report coming soon!
- Maintained and added more CFH staff to our data sharing agreement with Minnesota's Vital Records Office to access full birth, infant death, fetal death, and maternal death files including any linked out-of-state birth and fetal death records to include for statistical analysis. This agreement provides CFH with vital records 15 days after the end of each month.
- The SSDI Project Director serves as MDH's Data Coordinator for the P20W longitudinal data system, providing oversight and input into its design and implementation. The P20W data system includes Minnesota's Early Childhood Longitudinal Data System (ECLDS) and Statewide Longitudinal Education Data System (SLEDS). ECLDS is an innovative tool that combines data collected by Minnesota's Department of Education, the Department of Human Services and the Department of Health into one online, interactive database. It shows children's growth and achievement in relation to their participation in a variety of educational and social programs over time. ECLDS studies outcomes over the life course and enhances the state's ability to answer

broad and meaningful questions about outcomes for Minnesota's young children.

Goals and Objectives

The project activities and accomplishments include:

Goal 1: Strengthen capacity to collect, analyze, and use reliable data for the Title V MCH Block Grant to assure data-driven programming.

- Completion of the 2025 Title V MCH Block Grant Needs Assessment including the Action Plan and National Performance Measure (NPM) selection and alignment.
- Assured that all data necessary for the Title V MCH Block Grant application and annual report is received, reviewed to assure quality, entered appropriately and consistently within the application, and disseminated to program staff as needed including:
  - Compiling and analyzing data.
  - Drafting narrative that provides a concise analysis of data trends for each of the population domains.
  - Completing data forms.
  - Developing field notes to explain data and data trends.
  - Preparing detail sheets for SOMs, SPMs, or ESMs.
- Reviewed and revised the National Performance Measures (NPM), State Performance Measures (SPM), and Evidence-based/informed Strategy Measures (ESM) to continuously improve our alignment with our Priority Areas.
- Built and supported REDCap database to collect Title V MCH Block Grant data from Local Public Health agencies (recipients of two thirds of Minnesota's Title V MCH Block Grant funding).

Goal 2: Strengthen access to, and linkage of, key MCH datasets to inform MCH Block Grant programming and policy development and assure and strengthen information exchange and data interoperability.

- Minnesota invested in the oversampling of the 2023 and 2024 NSCH data collection to improve sample size and improve estimation across all indicators with a larger analytic sample.
- Supported the administration of the 2025 Minnesota Student Survey (MSS) a long-running survey of Minnesota students in grades 5, 8, 9, and 11 that tracks a wide variety of youth behaviors, risk and protective factors and outcomes related to education, health, safety and well-being. It is the only comprehensive source of information on the experiences our young people face in Minnesota. Continued to analyze outcomes for youth experiencing homelessness, substance use, parental incarceration, and mental wellbeing.
- Maintained and added more CFH staff to data sharing agreement with Minnesota's Vital Records Office to access full birth, infant death, fetal death, and maternal death files including any linked birth and fetal death records to include out-of-state records for statistical analysis. This agreement provides CFH full data 15 days after the end of each month.
- Provided oversight and input in the design and implementation of Minnesota's P20W longitudinal data system.
- Partnered to support the Department's data collection efforts to monitor community health factors.
- Maintained consistent, direct access to standard datasets that inform MCH program planning, evaluation, and improvement.

Goal 3: Enhance the development, integration, and tracking of community health factors to inform Title V programming.

- Creation of a Health of American Indian Families in Minnesota data book which provides a snapshot of data to facilitate informed decision-making around policies and programs that serve American Indian families to improve MCH outcomes.

- Co-led the Health Measurement Workgroup, which meets quarterly to provide a venue for the division of Child and Family Health data, research, and epidemiologic staff to discuss, share, and learn more about ways to improve our data work and understand how community health drivers and demographics influence outcomes.
- Worked closely with the Center of Health Statistics to support the Department's data collection.
- Provide Minnesota-specific data by various demographic breakdowns.
- Develop and track performance measures that can be used to assess the progress of Title V programs, policies, or initiatives in achieving optimal health for all.
- Attended trainings and provided training to MCH staff, partners, and community members to strengthen data capacity for understanding and addressing system and community health drivers that influence outcomes.

Goal 4: Develop and enhance capacity for timely MCH data collection, analysis, reporting, and visualization to inform rapid state program and policy action related to emergencies and emerging issues/threats.

- Collaborated with Vital Records office to do continuous quality improvement to enhance identification of maternal mortality cases and regularly sent updates to vital records office of any data quality or errors found to aid in quality improvement efforts. Specifically continuing to improve quality improvement with providers on reporting and completing death certificate and the pregnancy check box.
- Continuing quality improvement projects focused on improving identification, acquisition, and timeliness of record requests for current case reviews.
- Updated MMRIA data to include 2019 in Minnesota's Maternal Mortality Report.
- Partner with Medicaid using their data to enhance Maternal Mortality reviews and surveillance.
- Successfully gained access to law enforcement reports and incident reports related to the subject of data.
- Participated in multiple maternal mortality surveillance, MMRIA, and Maternal Mortality Review committee activities and webinars.
- Continued to monitor and analyze Maternal Mortality data.

III.C.1.b.ii.e. Other Data Capacity

Other MCH Data Capacity Efforts

MDH Data Vision

The MDH Data Vision Project, launched in 2023, was done in partnership with communities, partners, Local Public Health, and Tribal Nations.

MDH's data systems support strategic goals by being consistent, transparent, responsive, and community-centered whenever public health data is collected, analyzed, used, or shared. This project is creating a roadmap for the agency, so our data systems will better serve community.

Help Me Connect

MN Help Me Connect (www.helpmeconnectmn.org) launched in May 2021 as an interactive directory that connects expectant families and families with young children to services in their local communities that support healthy child development and family well-being. Families and professionals can search a database of over 16,000 available programs and services available in Minnesota and eleven Tribal Nations, such as healthy development and screening resources, early learning and childcare programs, pregnancy support services, disability resources, basic needs, and more.

Over 200,000 users visited the site in 2024 with top key word searches for diapers, housing, transportation, Early Childhood Family Education, autism, mental health and crisis.

Trends from web site analytics, feedback surveys, and ongoing community engagement activities continue to

determine and prioritize technical improvements and content additions. Recent enhancements include a new search engine and a referral system for professionals to connect families directly to community organizations.

The Help Me Connect program moved to a new state agency – the Department of Children, Youth and Families – in January 2025 with a variety of programs from the Departments of Human Services, Education, and Public Safety that focus on early childhood and family support services. Interagency collaboration with MDH will continue long-term to maintain connections and assure information on Help Me Connect is maintained and updated consistently.

Early Childhood Longitudinal Data System (ECLDS)

ECLDS is an innovative tool that combines data collected by Minnesota's Department of Education, the Department of Human Services, and the Department of Health into one online, interactive database. It shows children's growth and achievement in relation to their participation in a variety of educational and social programs over time. ECLDS studies outcomes over the life course and enhances the state's ability to answer broad and meaningful questions about outcomes for Minnesota's young children.

Maternal Mortality Review Committee (MMRC)

The Women's Health Unit, within the Maternal and Child Health section, facilitates the MMRC operations and planning. In 2019, Minnesota partnered with CDC to implement the CDC's Maternal Mortality Review Information Application (MMRIA) to assist with standardizing the review process. In 2021, the authorizing statute was amended to formally enshrine the MMRC allowing the Commissioner of Health to appoint 25 members to the committee. The revised statute also provides authority for MDH to request records pertaining to the pregnancy-associated death from law enforcement, Medicaid, behavioral health services, child protective services, housing, prescription monitoring programs, family home visiting, and women, infants, and children (WIC). In 2024, MDH Title V Staff applied for and received the CDC Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM). This five-year award will support MMRC activities through September 2029.

The purpose of the ERASE MM grant is to help states promptly identify pregnancy-associated deaths and abstract clinical/non-clinical data into MMRIA. Through the MMRC, Minnesota reviews pregnancy-associated deaths (death during or within one year of pregnancy, regardless of the cause) of Minnesota residents, systematically and comprehensively to:

- identify if the deaths were related to the pregnancy;
- identify the underlying cause of death;
- identify factors that contribute to the death (i.e., contributing factors); and
- develop recommendations to prevent future maternal deaths.

Maternal Mortality Review Information Application (MMRIA) database

MMRIA helps Maternal Mortality Review Committees (MMRCs) organize available data and perform the critical steps necessary to comprehensively identify, assess, and analyze maternal mortality cases. MDH has successfully incorporated use of MMRIA since gaining access in 2019. The database has been utilized for all review committee meetings since 2019. Selected data collected for cases reviewed before 2019 have also been entered into MMRA (2014-2016 cases). For sustainability, MDH staff and medical abstractors have attended national Centers for Disease Control and Prevention (CDC) trainings and monthly office hours for up-to-date changes to the database.

Minnesota joined the CDC State Vitals and MMRIA Data Integration Pilot project in the spring of 2021. This pilot tested the feasibility of importing death records and linked birth/fetal death records, as applicable, for all PMSS-identified pregnancy-associated deaths into MMRIA. As a result of the pilot, MDH successfully identified maternal deaths occurring in 2021 and has continued receiving imports of death records linked birth/fetal death records from

CDC.

In September of 2021, MDH executed a data sharing agreement with CDC which allows Minnesota maternal mortality data to be shared back to CDC to provide a nationwide understanding of current maternal health trends. Using MMRIA improves the ability to collect standardized data, including standardized indicators (e.g., pregnancy-related deaths), which is an important step toward fully understanding the causes of maternal mortality and eliminating preventable maternal deaths.

Pregnancy Risk Assessment Monitoring System (PRAMS)

MN PRAMS has been a surveillance project between MDH and CDC since May 2002. The program randomly selects approximately 125-150 new mothers each month who had given birth within two to six months to survey. PRAMS is a population-based survey designed to collect information about the behaviors and experiences of perinatal women before, during, and immediately after pregnancy.

MN PRAMS was selected and awarded funding by the Council of State and Territorial Epidemiologists (CSTE) to implement a supplemental questionnaire from May 2022 through March 2023. Factors like food insecurity, housing, access to health care, social support, and transportation barriers can have a major impact on the immediate and long-term health of pregnant and recently postpartum women and their infants, and for the 2022 survey year, MN PRAMS included these measures on the survey.

The MN PRAMS team worked closely with partners, stakeholders, and the PRAMS Advisory Steering Committee to solicit feedback, review, and discussion of potential questions and/or changes to current questions for the new Phase 9. Phase 9, which includes a web option for completing the survey online, rolled out successfully June 1st, 2023.

National Survey of Children's Health (NCHS)

The NSCH provides rich data on multiple, intersecting aspects of children's lives—including physical and mental health, access to quality health care, and the child's family, neighborhood, school, and social context. In 2023 and 2024, Minnesota invested in the oversampling NSCH data collection aiming to improve estimation across all indicators with a larger analytic sample.

Minnesota is also looking forward to the work NSCH is doing following sampled families from 2018-2019 into 2023-2024 to learn more about the impact of public health emergencies that occurred in 220-2024 on development, social-emotional development, mental health, etc. – data will be available for Minnesota use in 2025.

Research Electronic Data Capture (REDCap)

Data for multiple MCH grants/programs are collected and managed using REDCap tools hosted at MDH. REDCap is a secure, web-based software platform designed to support data capture for research studies, providing 1) an intuitive interface for validated data capture; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for data integration and interoperability with external sources. REDCap allows our MCH research/epidemiologists to create and manage data collection tools without the need to budget for high IT costs and puts the control back into the programs. It has been instrumental in improving how MCH collects data, especially from grantees. MCH programs that have utilized REDCap for data collection include:

- Title V MCH Block Grant Community Health Board Annual Report Submission
- Family Planning Special Projects Grants
- Personal Responsibility Education Program Sub-Grants
- Sexual Risk Avoidance Education Program Sub-Grants
- Positive Alternatives grants

- WIC and Family Home Visiting (FHV) use for trainings, evaluation, and more.

Information for Home Visiting Evaluation (IHVE) Data System

IHVE (pronounced “ivy”) is the Family Home Visiting (FHV) data system, which went live in January 2020. All FHV grantees receiving Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding, state Evidence-Based Home Visiting funding, state Nurse-Family Partnership expansion funding, or TANF Community Health Board funding are required to submit data to IHVE. IHVE is designed to exchange data with electronic health record (EHR) and case management systems used by home visiting programs across Minnesota, to reduce data entry burden for FHV grantees. IHVE-compatible data collection forms are embedded in Nightingale Notes and PH-Doc, two EHR systems used by nearly all Minnesota Local Public Health agencies, as well as Client Track, a case management system used by non-profit agencies implementing FHV programs. MDH also maintains a set of IHVE data collection forms in the MDH REDCap system for FHV grantees that do not have an electronic health record or case management system with the capability of submitting data to IHVE.

Minnesota Public Health Data Access & Birth Defects Information System

In partnership with epidemiologists from Minnesota Environmental Public Health Tracking program, CFH birth defects staff helped to build interactive maps, charts, and queries with data on multiple health and environment topics, including birth defects and other birth outcomes. Statewide 5-year prevalence of over 50 specific birth defects identified in live births born in 2015 or later are available through the Minnesota Public Health Access website: https://data.web.health.state.mn.us/birth. Staff have also added new data query functionality including statewide and regional data, which are available beginning with the 2013 birth cohorts. Birth defects data can also be broken out by race/ethnicity categories. In 2018, legislation passed that allows stillbirths to now be routinely reviewed for birth defects; 2019 is the first birth cohort to include birth defects identified in both stillbirths and live births.

Efforts to Improve Identification of Stillbirths with Birth Defects

To identify birth defects in stillbirths, the birth defects program began by reviewing mothers’ charts for 2019 Fetal Death Reports filed through the MN Office of Vital Records. The program now routinely requests reports of prenatal or delivery records from reporting facilities related to delivery outcomes indicating stillbirth or pregnancy care after intrauterine fetal demise. The Birth Defects Program evaluates this source for identifying stillbirths with birth defects. To date, no additional birth defect cases have been identified from these facility reports. The use of multiple data sources (both Fetal Death Reports and facility reports) helps to ensure the completeness of identification of stillbirths with birth defects.

Birth Defect Reporting Interoperability Project Began in May 2023

As part of a CDC grant, the birth defects program completed an interoperability readiness assessment. After the assessment, it was determined that expanding electronic case reporting (eCR) to birth defects would be an opportune first step toward interoperability. Since MDH and MN.IT already support eCR through connections with APHL Informatics Messaging Services (AIMS) and the Reportable Conditions Knowledge Management System (RCKMS), the birth defects program is leveraging the use of the existing technology, allowing for a quicker and more manageable lift both internally and with external partners. There are currently many manual processes for receiving and processing potential case reports from reporting facilities, which take considerable time each month; implementing eCR for select birth defects conditions will not only increase timeliness of reporting, but will allow the birth defects program to better understand how interoperability can be best utilized for program needs.

Newborn Screening Follow-up

Newborn Screening Systems Quality Improvement (QI) Project

In August 2023, Minnesota completed the final year of a 4-year project that was funded by the Association of Public Health Laboratories/NewSTEPs to improve the Minnesota Newborn Screening (NBS) system by expanding and aligning long-term follow-up (LTFU) data collection across MDH blood spot, Critical Congenital Heart Disease (CCHD), and Early Hearing Detection and Intervention (EHDI) LTFU.

Sickle Cell Data Collection Program (SCDC)

Minnesota is one of 11 states implementing a sickle cell disease surveillance system via a 3-year cooperative agreement with CDC. The MDH Health Promotion and Chronic Disease division leads the cross-divisional project team with support from CSHCN section staff and Health Economics programs. Minnesota has continued to work to develop data sharing agreements with clinical partners and our state Medicaid partner, the Minnesota Department of Human Services (DHS).

Women, Infant, and Children (WIC)

WIC provides data reports, maps and fact sheets on many topics, including birth outcomes, breastfeeding, WIC participation, weight status, growth and anemia among pregnant participants, infants, and children up to age five. MN WIC continues to expand its reporting by cultural identity, has increased its capacity to monitor food benefit utilization, including the ability to monitor food benefits to determine what foods are being redeemed and at which stores, as well as track trends in new certifications and drop offs by WIC participants. Technology advances include an online WIC application, interactive tableau data dashboards and use of texting to increase outreach to medical assistance participants not on WIC.

III.C.1.b.iii. Title V Program Partnerships, Collaboration, and Coordination

Program Partnerships, Collaboration, and Coordination

Minnesota's Title V program has worked to develop organizational relationships and leverage federal and state resources to improve health care delivery for MCH populations in the state. The Title V program has served as champion in some initiatives and as an active partner and supporter on others. Some examples are described here.

Local Public Health – Community Health Boards

The Community Health Services Act of 1976 redesigned Minnesota's public health system. Prior to 1977, over 2,100 local boards of health existed to serve Minnesota's communities. Now called the Local Public Health Act, the legislation delineates the responsibilities of the state (MDH) and city and county governments in the planning, development, funding, and delivery of public health services. This partnership enables state and local governments to combine resources to serve public health needs in an efficient, cost-effective way, and is the infrastructure for nearly all public health efforts in the state. A Community Health Board (CHB) is the legal governing authority for local public health. The number of CHBs in the state has varied slightly over time but is currently at 52, increasing to 53 in 2026. CHBs work in partnership with MDH to prevent diseases, protect against environmental hazards, promote healthy behaviors and healthy communities, respond to disasters, ensure access to health services, and assure an adequate statewide public health infrastructure. Under the Local Public Health Act, CHBs address and implement the essential local public health activities and assure that a community health assessment and plan are completed, that community health needs are prioritized in a manner that includes community participation, and that needed public health services are developed and implemented.

Minnesota Statute § 145.88 distributes, by formula, two-thirds of Minnesota's federal Title V MCH Block Grant allocation to CHBs.

Child and Teen Checkups Program

The Title V Program has a policy-level partnership with the Department of Human Services' Medicaid program regarding the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit – called Child and Teen Checkups (C&TC) in Minnesota. C&TC provides comprehensive and preventive health care services for children

enrolled in Medicaid. As discussed in the Child Health Domain of this application, DHS has an interagency agreement in place with MDH to provide statewide consultation, training, and technical assistance to DHS, C&TC providers, and others who provide preventive child health screenings and referral. MDH staff work with DHS and the Minnesota Chapter of the American Academy of Pediatrics to ensure state Medicaid policy aligns with best practices on screening, referral, and treatment.

Pediatric Mental Health Access Program (PMHAP)

The PMAHP aims to equip primary care providers to screen for and respond to mental health concerns in children and adolescents. MDH partners with the Department of Human Services, the Minnesota Chapter of the American Academy of Pediatrics, and PrairieCare (a community-based mental health service provider) to implement the PMHAP. The program supports the enhancement of a statewide Psychiatric Assistance Line (PAL), administered by PrairieCare, which provides triage, referrals, and psychiatric consultations to pediatricians and other primary care providers who need assistance in serving children and youth with mental health concerns.

An additional component of Minnesota's PMHAP is the development of the Mental Health Collaboration Hub (MHCH). The MHCH includes the combination of an online portal and weekly video calls that help connect youth and families in psychiatric or behavioral health "boarding situations" to safe and healing mental health treatment options in the community. The MHCH has worked to reduce the number of children and adolescents who are being boarded in hospitals and emergency departments across the state by identifying optimal care pathways in real time. Using the online portal and regular video calls, Minnesota will be better able to monitor trends in boarding as well as identify opportunities for improving access to care. We will be better able to understand if there are key characteristics in children and youth who are waiting extended periods of time for care (i.e., aggression, co-occurring developmental concerns, etc.) and then use those findings to help advocate for increased availability of treatment services in the community.

Minnesota's Early Childhood Comprehensive Systems Initiative

Minnesota is a recipient of an Early Childhood Comprehensive Systems: Health Integration Prenatal-to-Three Program grant from HRSA. Minnesota's project, titled the Minnesota Integrated Care for Early Childhood Initiative (MN-ICECI), is a community-led, collective effort that aims to create more cohesive and responsive early childhood health systems for African American children (ages 0 – 3 years old) and their families. The project started in August 2021, and its goals (described in detail in the Child Health Domain) include:

- Community-Driven Leadership
- Shared Understanding and Vision
- Health System Change
- Financial and Policy Change

The MN-ICECI prioritizes early identification of social, emotional, and developmental needs in young African American children to connect them with essential resources. To achieve this, families play a central role in driving system changes through implementation of the Family Ambassador Corps. Family Ambassadors are individuals with experience in navigating the early childhood system; they build upon their knowledge and skills to take on meaningful leadership roles within programs, agencies, and communities. They serve as a "parent voice" to help shape the direction of services for themselves and other families.

Minnesota Autism and Developmental Disabilities Monitoring (MN-ADDM) Network

MDH has a Joint Powers Agreement (JPA) in place with the University of Minnesota to facilitate collaboration on Minnesota's ADDM grant, which helps us to estimate the number of children with autism spectrum disorder (ASD) and other developmental disabilities. The MN-ADDM Network study monitors the prevalence of ASD and intellectual disabilities in parts of Anoka, Hennepin, and Ramsey counties. We use information from this study to better understand the characteristics of children with ASD, learn if the condition is more common in some groups as compared to others, and assess the impact of ASD and other conditions on children, families, and communities.

MDH partners with the University to engage in awareness, educational, and outreach activities through a variety of platforms. The state's CDC Learn the Signs, Act Early (LTSAE) Ambassador is associated with the ADDM project, and we partner with LTSAE to collaborate on outreach efforts to promote early screening and identification of ASD.

Minnesota Perinatal Quality Collaborative (MNPQC)

The MNPQC is a network of organizations, medical providers, content experts, and community voices lead by the Minnesota Perinatal organization in partnership with MDH. The MNPQC seeks to improve perinatal and infant health outcomes with an emphasis on improving health for all birthing women. The MNPQC is a critical partner for the I-MOM (Innovations in Maternal Outcomes in Minnesota) program funded by a 5-year grant from the Health Resources and Services Administration (HRSA). One key goal of the I-MOM program is to identify and implement AIM (Alliance for Innovation on Maternal Health) patient safety bundles by providing training to support quality improvement initiatives designed to improve perinatal health outcomes.

The MNPQC began their first AIM bundle focused on the care for pregnant and postpartum women with substance use disorder. The MNPQC provided a platform for multiple innovation strategies through implementing a quality improvement model with technical assistance activities designed to support a successful AIM program. Technical assistance sessions were held with 12 hospital teams from six health systems with over half of the hospitals located outside of the metro area. The MNPQC works in partnership with the I-MOM data team and the MNPQC data workgroup to navigate data challenges to support timely AIM data submissions.

More information on the MNPQC is included in the Women/Maternal Health domain of this application.

Healthy Start Performance Improvement Project

Five Minnesota Health Plans – Blue Plus, Health Partners, Hennepin Health, South Country Health Alliance, and UCare – launched the Healthy Start performance improvement project in 2021. The project focuses on ensuring a "healthy start" for Minnesota children and families by improving services provided to pregnant women and infants. The project includes working with a wide variety of partners to improve access to and coordination of resources to help mothers and children get the right care at the right time in the right setting. Ultimately, the aim is to close healthcare disparities in the following:

- Timely prenatal and postpartum care
- Well Child visiting in the first 30 months of life
- Childhood immunization status
- Low birth weight.

Transforming Maternal Health (TmaH) Model

In January 2025, Minnesota was selected through an application process as one of fifteen states to participate in the TMaH Model through 2035, through the Centers for Medicate & Medicaid Services. The Minnesota state Medicaid program and Minnesota Department of Health are partnering to lead implementation of the TmaH model to address gaps in maternal health care and reduce associated health disparities. More details will become available as the project is moved further into the pre-implementation period, and toward implementation.

More information on the TMaH Model is included in the Women/Maternal Health domain of this application.

III.C.1.b.iv. Family and Community Partnerships

Family and Community Partnerships

The Child and Family Health Division (CFH) – which houses Minnesota's Title V program – acknowledges that families and community members offer valuable insight and knowledge based upon their experience of the systems that they engage with. Communities and families hold the solutions to their own community and family needs. Community engagement in Minnesota occurs via multiple avenues, examples of which are discussed next.

CFH Strategic Planning

For the current block grant cycle, Minnesota focused on engaging with community throughout the needs assessment and strategic planning process, including determining priority needs, strategies to address the priority needs, and activities at the local and state level. This was accomplished through a variety of methods, including:

- Developed a steering committee made up of representatives from partner organizations at the community, city, county, and state level – in addition to internal MDH staff.
- Sought input from community partners and community and family representatives utilizing surveys tailored to each group.
- Sought input from local public health representatives and CFH Division staff through listening sessions.

Collaboratively, the priorities, strategies, and activities were developed into a state action plan to guide the work of Minnesota Title V for the current five-year cycle. The steering committee was central in our efforts to collaborate with our partners and community and family representatives to ensure a variety of voices were represented and co-leading the development of the five-year action plan

CSHCN Outreach and Prevention Unit

The CSHCN Section in the CFH Division at MDH contains the Outreach and Prevention Unit. The purpose of this Unit is to:

- Provide support to local and tribal health and their partners with technical assistance and evaluation related to children with special health needs/disabilities.
- Design and implement public health prevention strategies to reduce the risks of birth defects, including cCMV prevention.
- Work with partners to develop and share information and resources for children with special health needs, particularly those identified through MDH programs (e.g., Newborn Screening, Birth Defects Monitoring).
- Connect families of CSHCN to services and supports through grants to Community Health Boards.
- Enhance the public health workforce capacity to serve CSHCN through training and technical assistance.

Funding Family Support

As discussed in the CSHCN domain, Minnesota's Early Hearing Detection and Intervention (EHDI) Program oversees and administers state grant funding to a statewide family-to-family support organization to implement a statewide parent support program for families of children who are deaf or hard of hearing. The program utilizes trained parents of children who are deaf or hard of hearing as parent guides. The guides are located throughout Minnesota. Parent guides contact each family of a child newly identified as deaf or hard of hearing through the state's EHDI program to provide ongoing parent support, information and referral, education, and networking opportunities.

Building Family Organization Capacity to Support Caregivers of CSHCN.

The Title V CSHCN program has shifted our approach in supporting caregivers of children with special health needs and disabilities; moving away from supporting just one organization to provide parent-to-parent support and moving toward a model that connects and strengthens capacity of all organizations who are serving families. The approach uses a collective impact framework to foster relationships between organizations and the CSHCN section to better support organizations serving families and caregivers and align efforts to transform systems.

The section convened a group of community organization leaders and to codesign and complete an environmental scan aimed at better understanding challenges and barriers faced by family support organizations. The findings of the environmental scan are discussed in the CSHCN domain of this report and have been used to develop an engagement plan intended to support a network of family-serving organizations to learn together, align, and integrate actions to achieve systems change.

Maternal and Child Health Advisory Committee

The MCH Advisory Committee is a legislatively authorized advisory group to the Commissioner of Health on the health and well-being of mothers and children throughout the state. In addition to participation in the ongoing Title V needs assessment process and providing recommendations and feedback on the state's action plan and annual application, the task force develops and implements strategies to encourage broad community representation in its membership to better engage with and serve Minnesota's populations. Several ongoing activities of the committee related to community engagement include:

- Identify and implement ways to increase family engagement in committee activities.
- Share family stories to demonstrate issues that impact Minnesota's families and children.
- Engage with CSHCN and their families to identify gaps, assess services available to families, and provide feedback to the Title V CSHCN program.
- Coordinate activities with the State Community Health Services Advisory Committee (SCHSAC) as appropriate.
- Actively recruit committee membership that is representative of an array of voices from Minnesota.

Perinatal Sub-committee

The Perinatal Sub-Committee (PSC) was successfully established as an action-based committee of the existing state Maternal and Child Health Advisory Committee in early 2023. The core of this work is to center the experience of perinatal women and to be action oriented. Recruitment from Minnesota populations most impacted by MCH disparities has been crucial to the development of the PSC. Additionally, members of local and/or statewide programs with clinical perinatal expertise were recruited from the Maternal Mortality Review Committee (MMRC), Minnesota Perinatal Quality Collaborative (MNPQC), local public health, and other state agencies.

PSC expectations are to:

- Center perinatal women and their experiences in all decision making.
- Share leadership roles by statewide initiatives with community representation as co-chairs.
- Create action-based priorities that build on and align existing efforts across communities.
- Lead the development of a unifying strategic plan.

The committee is completing the final review of recommendations and is planning community engagement sessions to gather feedback on the strategic plan. After a strategic plan is finalized, action-oriented and topic-specific work groups will be developed to implement these strategies. In addition, there will be a community-based organization RFP to support and reinforce the fact that our communities have the solutions. These grants honor the fact that several organizations are doing successful work to address perinatal health but are not always funded at the appropriate level. These organizations are instrumental partners in impacting change for Minnesota's MCH populations.

Minnesota Maternal Mortality Review Committee (MMRC)

The Minnesota Maternal Mortality Review Committee (MMRC) is a 25-member group authorized in Minnesota Statutes 145.901 and reviews all pregnancy-associated deaths in Minnesota. The commissioner of health appoints members to serve on the review committee for three years. Members appointed to the committee have a shared mission to help guide recommendations that influence state guidelines and policies and ultimately reduce preventable perinatal deaths in Minnesota.

The committee's members, include representation of multiple regions of Minnesota and member organizations such as: community-based programs, persons with experience of maternal morbidity, doulas, nurses, maternal health practitioners, obstetricians, maternal fetal medicine specialists, midwives, nurse practitioners, social work, family practice medicine, critical care, cardiology, substance use specialists, psychiatry, mental health services, family home visiting, public health, Tribal health, federally qualified health care centers, medical examiners, health leadership, insurance payor, substance use treatment professionals, domestic violence, and individuals serving perinatal women in all regions of Minnesota.

Minnesota Suicide Prevention Taskforce

The Minnesota Suicide Prevention Taskforce—described further in the Adolescent Health domain—is a group comprised of multi-sector stakeholders from both public and private sectors that live or work in the state of Minnesota. Members of the taskforce include, or may include but are not limited to, the following: Minnesota Department of Human Services, Minnesota Department of Public Safety, Minnesota Department of Education, Minnesota State Colleges and Universities, University of Minnesota and other agencies, organizations, and institutions across the State of Minnesota as well as community members, and youth interested in being a voice for suicide prevention. In FFY2024, the Taskforce had a combined membership of 90 plus members, including two youth currently serve on the taskforce and six young people who are contracted. The Taskforce is responsive for developing and updating the State Suicide Prevention Plan and, in 2022, Minnesota conducted listening sessions with some MN youth to help inform the current iteration of the State Suicide Prevention Plan.

Youth-Specific Engagement

Brooklyn Bridge Alliance for Youth

Minnesota has a partnership with the Brooklyn Bridge Alliance for Youth (BBAY) described further in the Adolescent Health Report. Youth engagement is a foundational part of the BBAY work. The partnership with the BBAY includes:

- youth board members;
- annual youth participatory research that directs their work; and,
- youth leadership teams.

Community Restoring Urban Sexual Health Youth Council (CRUSH)

The Annual STI (Sexually Transmitted Infections) Testing Week steering committee offers the opportunity for youth engagement through the Community Restoring Urban Sexual Health Youth Council (CRUSH). The steering committee is a partnership of clinics, youth-serving organizations, state and local public health agencies, and community members aiming to address the increasing rates of STIs in Minnesota. Additionally, Minnesota Sexual and Reproductive Health Services staff are members of the steering committee. The purpose is to come together as a collective to promote prevention and testing, as well as heighten the awareness about the epidemic of STDs/STIs and related cancers. The event also promotes awareness about Minnesota's chlamydia epidemic; where to go for no cost or low-cost STD/STI testing/treatment; and educate about the importance of preventing STDs/STIs and HIV. The CRUSH youth council are a visible presence each year; youth assist with developing age-appropriate outreach materials, themes for t-shirts and other teen friendly swag/promotional items, assembling and disseminating safer sex tool kits, and the development of social media outreach post for Instagram, Facebook, and twitter. Teens also participate on an annual local Radio Show to broadcast the event and assist with recruitment. Each year they are responsible for overseeing a local event including pre- and onsite registration, assisting with testing, and tabling outreach activities at the event.

Evergreen Youth and Family Services

A Minnesota Personal Responsibility Education Program (MN PREP) grantee located in rural Minnesota, Evergreen Youth and Family Services provides *Rock Sober* – a youth peer-support group to provide input in programming. Youth give feedback on the relevance and effectiveness of curricula, supplemental activities and required federal adult preparation subjects, both the content and presentation/staff facilitation. They also give feedback on how to best meet needs that emerge during presentations and which community services they find comfortable, accessible, and helpful. Rock Sober takes a harm reduction and strengths-based approach to sexual and chemical health. Youth are placed in leadership roles, while the program coordinator assumes the role of facilitator. Youth are encouraged to have ownership of the program, lead groups, propose and plan activities, and hold each other accountable.

Participants have taught lessons on American culture and how provided skills on how to stay sober, as well as sexual health prevention. They have also taught lessons from Live it! (MN PREP approved curriculum) in Rock Sober groups and programming.

Teen Health Empowerment Council

Teen Health Empowerment Council, a MN PREP grantee project through a local school based clinics program, were trained in as peer educators. They supported outreach activities at two additional MN PREP local sites, local public high schools, by promoting the clinic events, providing tabling/exhibiting activities during the lunch hours, resource fairs, and encouraging friends to participate in the Annual STI (Sexually Transmitted Infections) Statewide testing event.

Check Yo' Self Crew (CYC)

The Check Yo' Self Crew (CYC), supported through a MN PREP grantee, is a group of peer educators and serve as an advisory council. CYC members who have successfully completed the{Project MARS Curriculum (Motivating Adolescents to Reduce Sexual Risk, PREP evidence-based curriculum) provide direct input on:

1. Where and when (specific dates and times) the PREP curriculum should be delivered in school or a recommended community setting.
2. What aspects of the curriculum and/or related subject matter seems dated and/or irrelevant; on what portions of the curriculum spur the most meaningful discussions--with the most powerful impact.
3. Provide recommendations on how the program can continually reach more young people, virtually or in-person.

III.C.1.c. Identifying Priority Needs and Linking to Performance Measures

Identifying Priority Needs and Linking to Performance Measures

Minnesota's Priority Needs

Seven Title V 2025-2030 priority areas were identified during Minnesota's prioritization process. The priorities reflect seven new priorities from the previous five-year reporting cycle (2020-2025). Many of Minnesota's new priority needs are related to priority needs in the previous five-year reporting cycle; the 2025 Needs Assessment process shows us the need to focus our efforts on upstream factors contributing to health and work to better align our work across systems.

The new priorities and NPMs support the continuation of work on current MCH priorities including infant mortality, comprehensive early childhood systems, adolescent suicide, and cross-cutting priorities. It is anticipated that existing strategies to address these priorities will evolve in the next cycle and will include enhanced upstream strategies. Some of the upstream strategies implemented in the next cycle were incubated through action plans for some of the current priorities, such as adolescent suicide and infant mortality.

Figure 1. Minnesota's 2025-2030 Priorities

Methodologies Used to Select Minnesota's Priorities

A prioritization survey was employed to solicit input on which of the themes that arose out of the landscape analysis Minnesota should prioritize for the next five years. Three versions of the survey were developed with the same questions, but the language was tailored to each of these three groups of interest holders (i.e., local public health, Child and Family Health Division staff, and Title V community partners).

The survey collected demographic information about each respondent then and provided a blub on how to consider the prioritization questions.

Survey Question Example:

For each population, based on your experience (professional and personal), please select the priority that you believe is the most important area to focus our Title V work over the next five years. Enter in additional priorities if there is something that you believe we should focus on but doesn't fit into the options provided.

Each domain gave 2-3 priority options with a description of the priority. These priority options were created from the work of the Title V 2025 Needs Assessment Steering Committee. This committee was provided a list of priority themes that arose out of the landscape analysis and then worked in small groups based on the Title V population domains to prioritize from this list their top two to three themes based on their own experience and expertise, as well as provided definitions based on the landscape analysis results.

The survey received over 300 responses between the three groups – 107 responses were from Child and Family Health Division staff, 150 responses came from local public health representatives, and 56 came from Title V community partners.

Performance Measure Framework

Minnesota utilized many voices to inform our selection of performance measures to track our progress on our priority needs. Minnesota first worked with the Steering Committee to select the measures that they believed would do the most to track improvement of the priority including NPMs and allowing them to list any measures they thought would measure success. This aligned with the work the Steering Committee was doing around strategy selection.

We completed a similar, more intensive process done in seven listening sessions with MDH staff – each domain got its own time so staff could participate in more than one domain to provide input. From these discussions, polls, and comments gathered during this feedback period we selected the national performance measures and strategies that most aligned with the priorities selected in the Needs Assessment.

The Title V team provided an overview of the Title V performance measure framework and how to use measures to drive improvement in the priority need. Many Steering Committee members and staff jumped straight to outcome measures, so the Title V team frequently recentered discussions around the performance framework and the importance of measuring intermediate measures like national performance measures and evidence-based/informed strategy measures to drive improvement and aid in accountability.

After NPMs were selected and strategies were mapped/aligned, Title V staff reviewed the evidence research on the NPM selected with the aim at driving improvement. Title V staff focused key strategies that best aligned with the selected NPM using the National Center for Education in Maternal and Child Health MCH Best Evidence Tools. Then the Title V team conducted data huddles with key data/evaluation staff throughout the Child and Family Health Division, making sure to include all data specialists that had knowledge about the data collected for the strategies that were identified as either evidence-informed or evidence-based. From these meetings Evidence-based/informed Strategy Measures (ESMs) were selected. Minnesota's NPMs and linked ESMs are highlighted in figure 2.

Figure 2. Minnesota's NPMs and Linked ESMs

MDH will continue to work with stakeholders to improve and add to our performance measure framework. To learn more about the proposed strategies for addressing Minnesota's new priorities and how our selected national and state performance measures help drive improvement, see the 2026 Application Year Plans

Emerging Issues

Public Health Communication

Communicating public health effectively faces several significant challenges, including a fragmented system of information sources, declining trust in institutions, and the spread of misinformation. These factors can hinder the dissemination of accurate health information and erode public confidence in health guidance.

The growing trend of declining trust in health institutions, coupled with increased skepticism towards expert advice and the rapid spread of inaccurate or false information (misinformation) and deliberately misleading information (disinformation) poses a major threat to public health. These narratives can undermine public health campaigns and lead to harmful behaviors.

Community and Family Engagement

> [Communities] must be supported in working alongside public health departments to identify priorities and design, implement, and evaluate programs to address the multifactorial causes of poor health.
>
> - *The Community as a Full Partner: A New Model for Public Health*

This is a core guiding principle of the Minnesota Title V program and a practice that Minnesota continually works to implement as we build our understanding of the communities across the state, including how governmental public health can partner with increased responsiveness, reciprocity, and effectiveness. Community and family engagement requires trust-building, power-sharing, and support to strengthen community and family capacity to engage in roles and spaces where decision-making is happening; and with the challenge mentioned pertaining to public health communication, this has become increasingly difficult. Minnesota, however, will continue efforts to build this trust and capacity in partnership with communities, families, and the organizations that are in and serve them in order to be a healthier and thriving state.

Please see *Process Description* and *Population Health and Wellbeing* for more details on emerging issues that were not selected as priorities.

III.D. Financial Narrative

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$9,146,460	$9,255,161	$9,146,460	$9,477,092
State Funds	$6,859,845	$6,941,371	$6,859,845	$7,107,819
Local Funds	$3,302,014	$3,098,338	$3,250,708	$3,187,322
Other Funds	$31,402,838	$29,173,165	$31,430,576	$25,777,365
Program Funds	$8,601	$41,745	$41,858	$3,934
SubTotal	$50,719,758	$48,509,780	$50,729,447	$45,553,532
Other Federal Funds	$101,779,606	$88,534,250	$137,938,480	$117,416,055
Total	$152,499,364	$137,044,030	$188,667,927	$162,969,587

	2024		2025	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$9,255,161	$9,456,167	$9,477,092	
State Funds	$6,941,371	$7,092,125	$7,107,819	
Local Funds	$3,143,734	$3,604,037	$3,298,515	
Other Funds	$31,994,105	$32,705,824	$31,644,144	
Program Funds	$41,744	$3,934	$3,934	
SubTotal	$51,376,115	$52,862,087	$51,531,504	
Other Federal Funds	$138,318,969	$125,778,782	$154,697,123	
Total	$189,695,084	$178,640,869	$206,228,627	

	2026	
	Budgeted	Expended
Federal Allocation	$9,456,167	
State Funds	$7,092,125	
Local Funds	$1,627,944	
Other Funds	$2,680,042	
Program Funds	$3,934	
SubTotal	$20,860,212	
Other Federal Funds	$0	
Total	$20,860,212	

III.D.1. Expenditures

Financial narrative - expenditures

Minnesota's FFY2024 expenditures fully met federal Title V MCH Block Grant requirements. At least 30% of federal funds supported CSHCN, and at least 30% of federal funding provided preventive and primary care for children and adolescents, as specified in Section 501(a)(1)(D). Minnesota did not exceed the 10% administrative requirement at 4.8%. Minnesota's Maintenance of Effort (1989 [Section 505(a) (4)]) of $6,184,197 was met and Minnesota exceeded federal match requirements of three dollars for every four dollars received. Minnesota's FFY2024 Title V award was $9,456,167, of which we project all of it would be expended, and state and local match totaled $36,464,947 as reported on Form 2.

The Community Health Services Act of 1976 redesigned Minnesota's public health system. Prior to 1977, over 2,100 local boards of health existed to serve Minnesota's communities. Now called the Local Public Health Act, the legislation delineates the responsibilities of the state (MDH) and city and county governments in the planning, development, funding, and delivery of public health services. This partnership enables state and local governments to combine resources to serve public health needs in an efficient, cost-effective way, and is the infrastructure for nearly all public health efforts in the state. A Community Health Board (CHB) is the legal governing authority for local public health. The number of CHBs in the state has varied slightly over time but is currently at 52, changing to 53 in 2026. CHBs work in partnership with MDH to prevent diseases, protect against environmental hazards, promote healthy behaviors and healthy communities, respond to disasters, ensure access to health services, and assure an adequate statewide public health infrastructure. Under the Local Public Health Act, CHBs address and implement the essential local public health activities and assure that a community health assessment and plan are completed, that community health needs are prioritized in a manner that includes community participation, and that needed public health services are developed and implemented.

Minnesota Statute § 145.88 distributes, by formula, two-thirds of Minnesota's federal Title V MCH Block Grant allocation to CHBs. State law requires CHBs to provide at least a 50% match for the federal Title V MCH Block Grant funds they receive each year, leveraging additional funding for local MCH efforts. Local tax dollars, other state grants and private insurance reimbursements predominately make up match requirements.

By state statute, CHBs must use Title V MCH Block Grant funds for low-income populations experiencing risk factors to address health disparities, health services, and other health-related issues as described below:

1. High rate of infant mortality or children born with low birth weight.
2. Increased likelihood of complications during pregnancy.
3. Children who have or are likely to have a chronic disease or disability or special health need.
4. Access to subsidized family planning services.
5. Frequency and severity of childhood and adolescent health issues.
6. Preventing child abuse and neglect, reducing juvenile delinquency, promoting positive parenting and resiliency in children, and promoting family health and economic sufficiency through public health nurse home visiting.
7. Nutritional issues of women, infants, and young children through WIC clinic services.

While Minnesota statute broadly directs the use of these funds, local public health agencies conduct their own needs assessments and allocate or move funding between populations or types of services provided to meet emerging community needs or to respond to critical MCH issues. This ability to respond to emerging community needs or public health emergencies can result in variations between federal fiscal years as to populations served or types of service provided using Title V funds.

All CHBs report using all or a portion of their Title V funds to support their home visiting programs. More than half of CHBs use Title V funds to help support the Follow Along Program (described further in the Child Health Annual Report and Application Plan). About a fourth of CHBs use Title V funds to support access to family planning services. Other activities identified on CHBs annual work plans include breastfeeding support, injury prevention, adolescent health promotion activities, including school-based clinics, as well as public health assessment, case management, and referral services for CSHCN.

Minnesota Statute § 145.882 subd. 2 directs up to one-third of Minnesota's federal Title V MCH Block Grant allocation for state efforts to:

1. Meet federal requirements of a statewide needs assessment every five years and prepare the annual federal application and report.
2. Collect and disseminate statewide data on the health status of mothers and children.
3. Provide technical assistance to CHBs in meeting statewide outcomes.
4. Evaluate the impact of maternal and child health activities on the health status of Minnesota's mothers and children.
5. Provide services to children under age 16 receiving benefits under Title XVI of the Social Security Act.
6. Perform other MCH activities as deemed necessary by the Commissioner of Health.

Of the $43,405,920 retained to support the MCH and CSHCN programs within MDH, all will be expended by the end of the grant period and $485,338 went to meet MDH's indirect rate of 28% in SFY2024 and 23.2% in SFY2025. Retained funding supported key positions within the Child and Family Health Divisions's Director's Office and MCH and CSHCN programs, including coverage of shared resources that support program activities and inter-agency efforts targeted at children and their families.

Minnesota's contribution to meet Title V MCH Block Grant match requirements totaled $36,464,947 from state and fee supported MCH programs under the administration of the CFH Division and local public health contributions. Table 1 below details the expenditures for FFY2024 from state/fee funds, which help meet match requirements.

Table 1. Expenditures Meeting Title V Match Requirements, FFY2024

Budget Area	Expenditure Amount
Division Management	$753,515
Fetal Alcohol Syndrome	$2,000,000
Birth Defects Information System	$418,338
Family Planning	$7,855,948
State MCH	$430,507
Positive Alternatives – pregnancy support program	$3,656,000
Newborn Bloodspot, Heart, and Hearing Screening	$1,386,911
CSHCN program grant funding	$88,930
Families with Deaf Children operations/grants/hearing aid loan bank	$805,699
Women's Right to Know	$174,590
Education Now & Babies Later	$52,000
Maternal Mortality Reviews	$184,270
Healthy Babies Grants	$260,000
Anti-Racism Curriculum Grants	$294,000
Cytomegalovirus (CMV)	$152,208
Family Home Visiting	$17,658,676
Midwife and Doula	$293,355

In addition, $125,778,783 in other federal funds were expended for maternal and child health activities. The majority of these federal funds supported WIC programmatic activities ($111,434,947). Please refer to Form 2 for a detailed list of all federal grant funds expended in FFY2024.

Because of the broad coverage of Minnesota's public programs, limited medical and dental services have been provided using Title V MCH Block Grant funds. CHBs are required to utilize Medicaid, and third-party reimbursement before using Title V funds and annually report the amount of third-party reimbursement and Medicaid reimbursement received. The Overview of the State provides a summary of the numerous public health programs offered in Minnesota.

On Form 2, FFY24 Annual Report of Funds Expended, there were four discrepancies exceeding 10% from what was budgeted. Field notes were completed on each of the following forms (1,5):

Form 1 – Federal Allocation

1. Preventive and Primary Care for Children: MDH was able to reduce administrative costs and redirect to Preventive and Primary Care for Children due to administrative staff vacancies. The administrative work was completed by staff who were funded with State dollars until the vacancies were filled.
2. Title V Administrative Costs: MDH was able to reduce administrative costs and redirect to Preventive and Primary Care for Children due to administrative staff vacancies. The administrative work was completed by staff who are funded with State dollars until the vacancies were filled.
3. Other Funds: Fewer funds were spent on other State programs, resulting in a reduction in the Other Funds category during this reporting period.

Form 5 – Program Income: Program income varies from year to year based on local Community Health Board expenditures reported. Program income is client fees that are collected by local public health and varies depending on who they are serving.

Please refer to FFY2024 expenditure information in Form 2 (MCH Budget/Expenditure Details), Form 3a (Budget and Expenditure Details by Types of Individuals Served), and Form 3b (Budget and Expenditure Details by Types of Services) for further detail.

How Title V Funds Supported Family Engagement Activities

Minnesota's MCH and CSHCN programs are in a key position to influence, leverage and enhance this broad array of federal funding directed at Minnesota's MCH population. Furthermore, the combination of Title V funds with state and federal funding enables CHBs, nonprofits and tribes, largely through grants and contracts, to provide robust programming and reach to MCH populations, including CSHCN and their families.

As an example, in Fall 2023, MDH partnered with Children's Minnesota, Gillette Children's Specialty Health Care, and others, to host a Supporting Family Caregivers Forum event. The event brought together 150 caregivers, family support organization staff, nonprofit personnel, health care professionals, policy makers, and state agency staff. The focus was on how to support family caregivers of children and youth with special health needs across multiple sectors. Attendees delved into the 2022 National Strategy to Support Family Caregivers. They also explored ways to support and learn from caregivers regarding decisions affecting them and their family members.

To better understand the needs of community-based family support organizations in an effort to revise the MDH approach to funding organizations more broadly, the CSHCN program completed an environmental scan. From March to August 2023, 45 organizations took part in an environmental scanning process that included both an online survey and phone interviews. The survey, developed in collaboration with family support organizations, revealed four key themes and six actionable items that will be addressed this next budget period. This initiative will be continued in FFY26 to implement the action steps identified. *For more information, see the 2024 Title V Report and 2026 Title V Application Plan.*

Financial narrative - expenditures

Please refer to budget information in Form 2 (MCH Budget/Expenditure Details), Form 3a (Budget and Expenditure Details by Types of Individuals Served), and Form 3b (Budget and Expenditure Details by Types of Services. These forms and their field notes provide additional details and explanations about the Minnesota's Title V MCH Block Grant budget.

Minnesota's federal Title V Maintenance of Effort of $6,184,197, and projected match requirements of $7,092,125, can be fully met using state general fund and fee-based appropriations (see below for a listing of the programs). Funds are budgeted for the MCH and CSHCN Directors and other key staff to attend at least one national MCH/CSHCN meeting and the required Block Grant Application/Annual Report review that may resume onsite in Chicago.

For the FFY2026 Title V MCH Block Grant budget application, we continue to align our administrative costs to align with the MCHB definition as suggested by reviewers at the 2020 annual review meeting and allocate those across the program areas (pregnant women and infants, CSHCN, and child and adolescent health) within the grant to more accurately reflect the administrative costs incurred by each area. We also account for funds spent on infant health into the Child and Adolescent area per the technical assistance received from MCHB staff. This enables us to meet the 30%-30%-10% requirements.

Two-thirds of the Title V MCH Block Grant are distributed by formula to all local public health agencies, called Community Health Boards (CHBs). These CHBs submit annual budgets and work plans, and report on expenditures of their federal Title V MCH Block Grant funding. Significant changes can occur between budgets and expenditures as CHBs may redirect funds during the year to respond to critical local needs or emerging health issues. This can create fluctuations in the populations served, total numbers of individuals served, and the types of services provided. This flexibility in funding may result in line-item differences of greater than 10% in block grant budget and actual expenditures. CHBs must provide a 50% match for the Title V MCH Block Grant funding they receive, and this funding supports almost half of Minnesota's total federal match requirements.

State law allows the state to retain up to one-third of the federal MCH Block Grant. The state also supports all the indirect charges for the Title V MCH Block grant from the state portion of the funding.

The FFY2026 Title V MCH Block Grant supports 28 positions, which equals 20.40 Full-Time Equivalent (FTE) positions within the CFH Division, with some fluctuations due to personnel changes and intermittent hiring of student workers. Title V funding is budgeted to cover key positions within the MCH and CSHCN Sections and Directors Office, important statewide initiatives, and the MDH indirect rate. This essential funding enables the state to provide critical expertise in the delivery of MCH health programs at the local level, supports important state responsibilities, and provides oversight and monitoring of the grant. Positions fully or partially covered by federal funds include:

- Title V CSHCN Director
- MCH Assistant Section Manager
- SSDI Coordinator
- MCH Epidemiologist
- Title V Coordinator
- Family Planning Coordinator
- Adolescent Health Coordinator
- School Health Nurse Consultant
- Child and Adolescent Health Supervisor
- Women's Health Supervisor

- CSHCN Capacity Building Unit Supervisor
- CSHCN Policy and Program Planners
- CSHCN Coordinated Care Systems Specialist
- Health Educator (MCH)
- Follow Along Program Coordinator
- Financial specialists (6)
- Administrative assistant
- IT specialist /website support of MCH and CYSHN programs
- Student workers (3)

Additionally, the Title V MCH Block Grant funding supports initiatives that bring the CFH Division into state policy discussions, promote, monitor, and improve Minnesota's MCH populations, advance family engagement efforts, and support collaboration between state agencies. This includes supporting staffing of the Children Cabinet, which is comprised of key state agency commissioners and charged with creating a system that supports pregnant and parenting families.

The FY2023 legislative session provided approximately $23 million in new state general funds to the Child and Family Health Division to support new programs serving MCH populations. For more detail on these legislative wins, See *State Description: Legislative Priorities and Wins*. The following state appropriations augment the match from CHBs to fully meet federal match and Maintenance of Effort requirements and demonstrate the state and federal partnership with MCHB:

State Fiscal Year (SFY) 2025 General Revenue Funds (total $7,092,125):

- Healthy Beginnings Grants ($1,151,000)
- Healthy Beginnings ($701,125)
- School Based Health Clinics ($) ($1,300,000)
- SGSR Newborn Hearing ($2,203,000)
- State funding for management, supervisory and administrative support ($1,737,000)

Funding Challenges and Updates

Federal Title V MCH Block Grant funds have remained relatively consistent while salaries and fringe benefits have increased 10% over the biennium (2023-2025). As a result of those rising costs, some administrative staff were moved onto state funds that were underutilized in some programs decreasing our administrative costs and reallocated that funding to Preventive and Primary Care for Children. Vacancies also created some saving in administrative costs and the work was covered by state funded staff.

The 2025 legislative session added four maternal and child health grant initiatives with one time funding which will allow expansion of our MCH activities to complement our Title V budget activities. Those new legislative items are outlined in the *State Description: Legislative Priorities and Updates* and will be reflected in the next Title V budget reporting period.

In response to a fluctuating financial and legislative landscape, including emerging budgetary considerations at federal and state levels, there is a reduction in the budgeted amounts reported for FFY2026 in comparison to previous reporting/application periods.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Minnesota

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview (Optional)

State Action Plan Introduction

The following domain narratives provide updates on Minnesota's Title V work at the state and local level. The Minnesota team has continued to strengthen the many partnerships already in place with local public health and community organizations, as well as develop new partnerships to broaden opportunity and reach for community engagement and empowerment as it relates to maternal and child health. Reviewers from the 2023 annual Title V report review/meeting indicated that it would be helpful for our Minnesota team to clarify our role in the work we describe, and reviewers from the 2024 annual Title V review/meeting indicated the addition of these in the 2023 report/2025 application were helpful. As such, for the 2024 reporting/2026 application year, we have again given a designation to each activity within the narratives based on the following categories:

Title V Supported: Fully or partially funded Title V activities.

Title V Connected: Activities that Child and Family Health Division staff engage in but aren't led or funded directly through Title V. These activities may include those funded through Title V match funding.

Additionally, activities within each strategy area have been separated into two buckets based on whether they are "state Title V" work or "local Title V" work.

III.E.3 State Action Plan Narrative by Domain

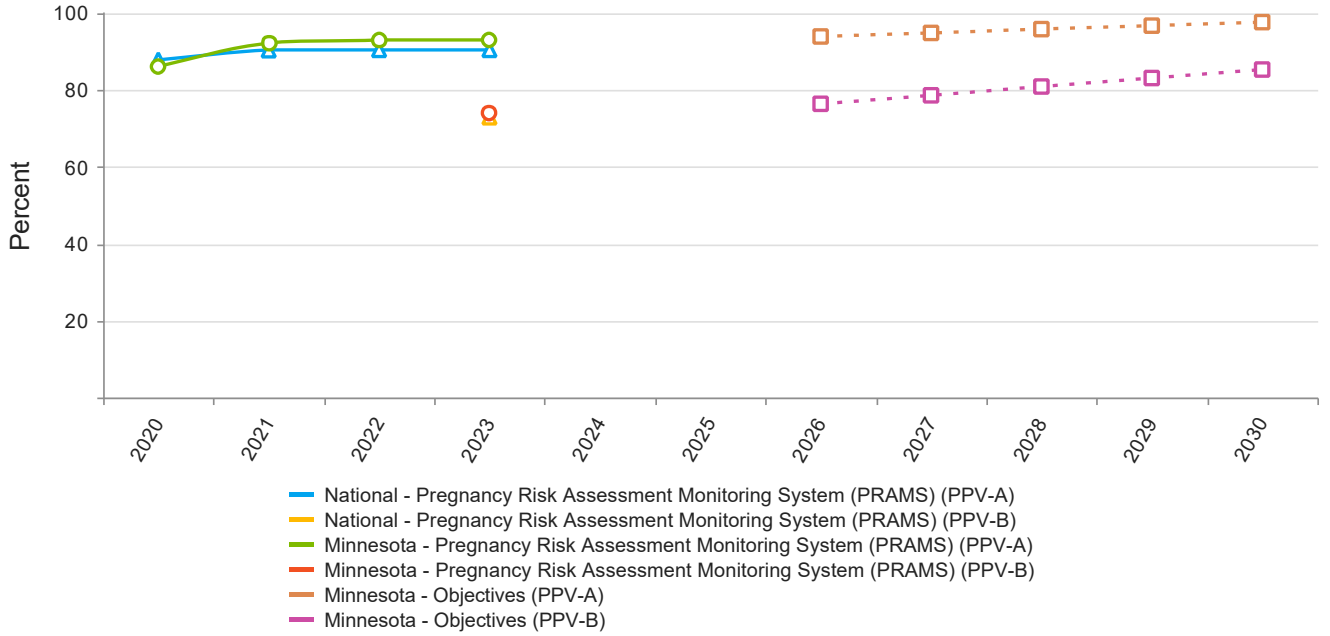
If a Priority Population is selected for an NPM, then this section will display only the data associated with the Priority Population in the charts, data tables, and field notes. Additional NPM data are available in the Form 10 appendix.

Women/Maternal Health

National Performance Measures

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	92.2	92.9
Numerator	55,698	52,972
Denominator	60,382	57,013
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	93.8	94.7	95.7	96.6	97.5

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	86.0	74.1
Numerator	47,301	38,709
Denominator	55,022	52,239
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	76.3	78.5	80.8	83.0	85.2

Evidence-Based or –Informed Strategy Measures

ESM PPV.1 - Percentage of families who could benefit from family home visiting services that are currently served.

Measure Status:	Active

Baseline data was not available/provided.

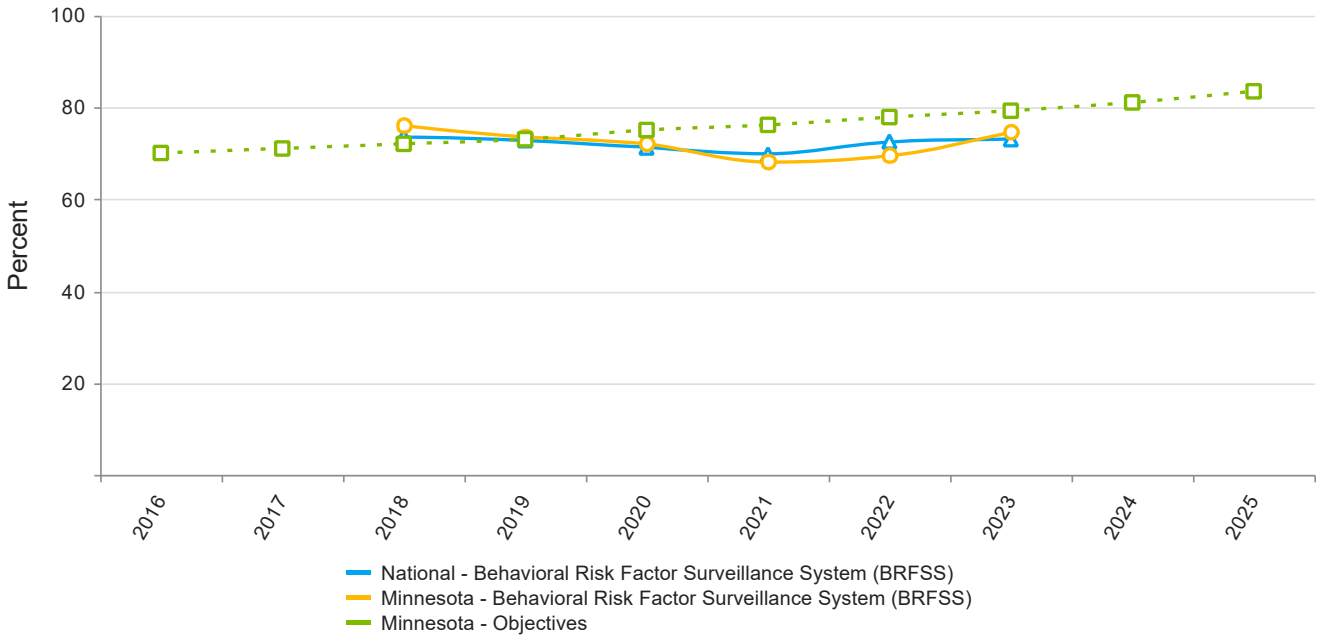
Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	12.0	14.0	16.0	18.0	20.0

State Action Plan Table

State Action Plan Table (Minnesota) - Women/Maternal Health - Entry 1	
Priority Need	
Comprehensive perinatal systems of care	
NPM	
NPM - Postpartum Visit	
Five-Year Objectives	
By 2030, increase the percentage of women who receive postpartum checkups within 12 weeks of giving birth by 5% and receive the recommended care components by 25% (98% and 82.5%, respectively).	
Strategies	
Enhance resources, services, and supports that are responsive to community and individual needs and experiences to improve birth experiences for populations who are medically underserved and at greater risk for poor health outcomes.	
Broaden virtual and in-person services for perinatal women.	
Strengthen health literacy and system navigation by providing community-responsive resources, services, and supports.	
Improve quality and availability of family-centered mental health and substance use disorder services and resources for perinatal women.	
ESMs	**Status**
ESM PPV.1 - Percentage of families who could benefit from family home visiting services that are currently served.	Active
NOMs	
Maternal Mortality	
Neonatal Abstinence Syndrome	
Women's Health Status	
Postpartum Depression	
Postpartum Anxiety	

2021-2025: National Performance Measures

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV Indicators



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	75	76.1	77.8	79.2	81
Annual Indicator	73.6	71.9	68.2	69.3	74.5
Numerator	704,572	691,348	661,628	674,973	728,498
Denominator	957,132	961,095	969,970	974,404	977,708
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM WWV.2 - Number of hospitals that are actively participating in Minnesota Perinatal Quality Collaborative (MNPQC) initiative focused on the Alliance for Maternal Innovation (AIM) bundle on substance use disorders (SUDs).

Measure Status:			**Active**	
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			10	16
Annual Indicator			9	16
Numerator				
Denominator				
Data Source			MNPQC	MNPQC
Data Source Year			FY2023	FY2024
Provisional or Final ?			Final	Final

Care during pregnancy and delivery

WOMEN/MATERNAL HEALTH REPORT 2024

Description: Increasing accessible, quality health care during pregnancy and delivery.

Background

Minnesota's five-year 2020 comprehensive needs assessment identified a significant area of need in increasing accessible, quality health care during pregnancy, making care during pregnancy and delivery the women's health priority area for the state.

It is important for all women to have access to reliable and quality preventive care throughout the life course. Well-woman visits are essential to a woman's overall health and well-being and can address a range of physical and mental health concerns. They may also include healthy diet education, screening for chronic diseases, screening for sexually transmitted infections, vaccinations, and mental health screening.

Annual well-woman visits give women the opportunity to discuss their health with their provider, as well as prevent and identify serious health concerns before they become life threatening.

Adequate and regular prenatal care visits early on and during the entire pregnancy is crucial to the health of mothers and babies. Data from MN birth records shows that babies of mothers who do not get prenatal care are three times more likely to be born low birth weight and five times more likely to die than those born to mothers who do get care. Receiving quality prenatal care can have positive effects long after birth for both individuals. Prenatal care is more than practitioner visits and ultrasounds; it is an opportunity to improve the overall well-being and health of the perinatal woman which directly affects the health outcomes of the baby. Further, prenatal visits give parents a chance to ask questions, discuss concerns, identify and treat complications in a timely manner, and ensure that the perinatal woman and baby are safe during pregnancy, delivery, and postpartum. Having a healthy pregnancy and access to quality prenatal, delivery, and postpartum care facilities are one of the best ways to promote a healthy birth and have a thriving mother and baby.

In 2023, 78.7% of perinatal women in MN received prenatal care within their first trimester of pregnancy. Additionally, approximately 75.7% of perinatal women received adequate or adequate plus prenatal care (based on the Adequacy of Prenatal Care Utilization Index). There are many reasons why people do not get timely and/or quality care during pregnancy.

In MN, the Pregnancy Risk Assessment Monitoring System (PRAMS) survey identifies barriers to care from the mother's perspective. The leading causes respondents gave for not getting prenatal care as early in their pregnancy as they wanted were:

- The doctor or my health plan would not start care as early as I wanted (29%)
- I couldn't get an appointment when I wanted one (28%)
- I didn't know I was pregnant (21%)
- Too many things going on (21%)
- Didn't have enough money or insurance to pay for my visits (19%)

Other barriers mentioned by PRAMS survey respondents included being unable to take off time from work, not having transportation to get to the care they needed, and not being able to find anyone to take care of their children. Healthcare services do not occur in a bubble; the ability to access and the quality of healthcare services are

interrelated with other factors such as transportation, finances and employment, insurance, childcare, and others.

Implementation of the following strategies and activities, in partnership with statewide stakeholders, supported access to comprehensive, family focused, whole person care and services, equips providers with the resources and skills needed to work with communities, and shifts policy priorities to reduce systemic barriers.

Measuring success

Objective

By 2025, Minnesota aims to increase the percentage of women receiving a preventative medical visit in the past year by 10% from 75% in 2020 to 83.4% in 2025.

National Performance Measure

Preventive medical visit

Percent of women, ages 18 through 44, with a preventive medical visit in the past year.

An annual well-woman visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies.[1] According to data from the Behavioral Risk Factor Surveillance System, 74.5% of women had a well-woman visit in 2023. This is up from 69.3% of women reporting they received well-woman visits in 2022.

Evidence-Informed Strategy Measures

Substance use disorder (SUD) AIM Bundles

Number of hospitals that are actively participating in MN Perinatal Quality Collaborative (MNPQC) initiative focused on the Alliance for Maternal Innovation (AIM) bundle on substance use disorders.

Members of the MNPQC recognize the importance of the issues addressed by the AIM, which is a national data-driven maternal safety and quality improvement initiative. AIM's work aligns well with the MNPQC core initiatives, and formal involvement in the AIM Program aligns MN's efforts with other states' activities. The issues are relevant to discussions on quality improvement in MN as supported by the MN Maternal Mortality Review Committee (MMRC) and MNPQC steering committee. The MNPQC steering committee had identified the initiative focused on opioid use disorder as a priority within the MNPQC strategic plan with intentions to model the AIM opioid / substance use disorder bundle.

The MNPQC led the state's official enrollment in AIM in the Spring of 2022. The proposed AIM bundle for this opportunity was on Care for Pregnant and Postpartum Women with Substance Use Disorder led by the MNPQC substance use disorder workgroup, Mother/Infant Opioid and Substance use Treatment and Recovery Effort (MOSTaRE).

The MOSTaRE project workgroup reached out to every major health system in MN and invited them to nominate one representative hospital to participate in the project. This recruitment approach ensured that the knowledge gained could later be disseminated across the entire health system and most hospitals in MN could benefit from learnings in this initiative. Sixteen health systems participated in the initiative in FFY2024. Hospitals created their team of champions that could include obstetric and NICU clinicians and staff, Labor & Delivery managers, hospital administrators, SUD community treatment and support partners, and quality improvement experts. Teams at these hospitals or health systems championed practice changes during monthly Zoom calls.

Strategies and activities

WMH Strategies

1. Expand Family-Focused, Community-Based Policy and Funding.
2. Integrate Health and Social Services to Optimize Cross-Sector Collaboration.
3. Strengthen and Expand Responsive, Trauma-Informed Care for Women of Childbearing Age.

WMH Activities

STATE TITLE V

Supported

Minnesota Pregnancy Risk Assessment Monitoring System (MN PRAMS)

The Minnesota Pregnancy Risk Assessment Monitoring System (MN PRAMS) is a surveillance project between MDH and CDC. MN PRAMS began operating in 2002 and has been running continuously, collecting data on maternal behaviors and experiences before, during, and immediately after childbirth. The goal of MN PRAMS is to improve the health of mothers and babies in Minnesota by reducing the risk of adverse birth outcomes like low birthweight, preterm birth and maternal mortality. PRAMS provides data not available from other sources and allows states, their Title V programs, and CDC the ability to monitor changes in maternal and child health indicators such as unintended pregnancy, prenatal care, breastfeeding, smoking, and infant health. Additionally, PRAMS serves as a primary data source for many Title V national performance measures. Minnesota uses Title V funds to support MN PRAMS operations, in addition to the funds provided by CDC.

Data from MN PRAMS has been shared widely and served as the foundation of many reports. Currently, PRAMS staff are analyzing from CDC's social determinants of health (SDOH) supplement to create a data book for release in the upcoming year.

Connected

Address Maternal Opioid Misuse through the MOSTaRE Initiative (Mother/Infant Opioid Substance Use Treatment and Recovery Effort)

In 2023, the state's mandatory reporting laws for pregnant women using substances changed, and providers are exempt from the mandatory reporting of people who use a controlled substance during pregnancy. These significant policy changes in Minnesota reduce systemic barriers to addiction services and care-seeking support for birthing people by addressing these on-going health needs.

A key recommendation from the Minnesota Maternal Mortality Review Committee was "to support statewide improvements for perinatal women who have substance use disorders, including adequate identification of substance use in the birthing population, referral to services and support groups, and increased funding to expand treatment and access to treatment throughout the state". The Minnesota Perinatal Quality Collaborative (MNPQC) created a pressing priority to address the opioid crisis and impact of substance use disorders (SUDs) on perinatal women and infants.

MNPQC engages with hospitals and providers to promote and participate in AIM; plan and implement AIM bundles; and expand the number of facilities reporting AIM data. MNPQC's first AIM bundle was on Care for Pregnant and Postpartum Women with Substance Use Disorder led by their substance use disorder (SUD) workgroup. MNPQC implemented the AIM bundle through an innovation strategy of a hybrid quality improvement model to reach all areas of the state and improve direct clinical care and workforce training. The MNPQC MOSTaRE initiative focused on

perinatal SUD emphasizing family-centered care and addressing prevention and treatment of substance exposure during and after pregnancy for both perinatal women and their infants. The active phase of MOSTaRE initiative implementation concluded in early October 2023. Data was collected from nine hospital teams including seven health systems statewide. Seven of the hospitals were located outside of the Minneapolis-St. Paul metro area. Of the health systems involved, there was potential reach across sixteen hospitals. A final report on the MOSTaRE initiative was finalized in April 2024 and posted via the MOSTaRE webpage.

Address Violent Maternal Deaths through Surveillance and Evidence-Based Intervention

Staff partnered with MDH's Injury and Violence Prevention Section (IVPS) on a maternal violent death project funded by the Office on Women's Health. This five-year grant (2021-2026) is designed to reduce deaths among pregnant and postpartum women due to violence with specific interventions around suicide, homicide, and domestic violence. This project aims to 1) enhance surveillance of violent maternal deaths and 2) expand the evidence-based Confidentiality, Universal Education and Empowerment, Support (CUES) intervention.

The project team worked closely with the Maternal Mortality Review Committee, Minnesota Perinatal Quality Collaborative, and other local organizations toward achieving these goals, and engaged in the following activities in FFY2024:

Continued Violent Death Reviews using an updated review protocol.

Created an internal maternal violent death database and worked to improve reporting forms.

Continued partnerships with the MNPQC and intervention partners to develop and disseminate resources on maternal violence in Minnesota.

Included in the draft MMRC report a section focused on violent maternal deaths which will be publicly available and shared with MMRC members and partners.

Conducted informant interviews through a contract – which reflects a recommendation from the CDC for MMRC partners to use informant interviews for comprehensive case reviews.

Developed a dissemination and information sharing plan for data connected to this grant.

Reimbursed MMRC members for participation in this the small sub-working group.

Formed meaningful connections with medical examiners, including relationship-building through visits to county medical examiners' offices.

Develop and Implement a Cannabis and Substance Misuse Prevention and Education Program

In 2024, the Maternal and Child Health section at MDH was legislatively (Minnesota Statute 144.197) tasked with developing a cannabis and substance misuse prevention and education program for women who are pregnant, plan to become pregnant, or who are breastfeeding. There are two components of this work:

. A soft launch that aimed to meet the needs in communication gaps within the Maternal and Child Health section after the legalization of cannabis. The maternal and child health section has developed a fact sheet, provider resource document, and a Women, Infants, and Children (WIC) rack card. To create and distribute these materials, staff completed the following in 2024:

Convened an internal work group to review existing research, provide insights, and share feedback on messaging.

Audited existing materials with references to cannabis use during pregnancy and breastfeeding.

Conducted interviews with other states that have developed cannabis prevention and education campaigns to learn about key findings, language recommendations, etc.

Developed external messaging.

2. A larger prevention and education campaign, encompassing the audiences of both the Child and Family Health division and the Injury Prevention and Mental Health division.

Expand Access to Prenatal Care through Doula and Midwifery Services

The Dignity in Pregnancy and Childbirth Act (144.1461) was passed by the Legislature in 2021 to address inequities in maternal health care, calls on the state to increase the availability of, and access to, doula and midwifery services by removing barriers to communities disproportionately affected by maternal and infant morbidity and mortality. To help improve health in pregnancy and postpartum outcomes, MDH hired a Maternal Care Access Coordinator to develop a strategic plan and to develop and implement policies, activities, and programs, with community input, aimed at expanding access to prenatal care, doula, and midwifery services by working with internal and external partners and stakeholders.

In FFY2024, the Maternal Care Access Coordinator finalized the review of frameworks created by community doulas that aims to improve the doula certification process and reimbursement in Minnesota. Community input and assessment was implemented to reflect the suggestions outlined by the community doulas and other partners for improving the process and expand organizations for required training for birth doulas. Additionally, the Maternal Care Access Coordinator assessed the access to midwife services for communities experiencing the highest rates of disparate pregnancy outcomes. This information will be used to inform cross-sector collaborations with internal and external stakeholders working to advance policies and systems changes to remove barriers to access for doula and midwife services such as trainings, certification, and reimbursement.

Additionally, MDH recognizes the community-informed solutions are needed to identify opportunities and gaps connecting individuals to birthing services and resources that support optimal health outcomes. MDH contracted with a research and evaluation firm to develop a survey aimed at building a more comprehensive profile of doulas and birth workers in Minnesota. For the purposes of this survey, a doula or birth worker is defined as someone who provides continuous physical, emotional, and informational support to a perinatal woman before, during, and after childbirth to help them achieve the healthiest, most satisfying experience possible. The goal of this work is to develop a better understanding of doulas and birth workers in the state, identify barriers to becoming or practicing as a doula and gaps in service, and opportunities to improve access by building on strengths of the doula and birth worker workforce. In FFY2024, MDH and the contractor compiled, analyzed, and created a summary report of the final survey results.

Expand and Improve the MN Maternal Mortality Review Project (MMMRP)

The MMMRP's goal is to improve the health outcomes of perinatal women through maternal mortality and morbidity reviews. The MMMRP houses the Maternal Mortality Review Committee (MMRC), which reviews maternal death cases and develops recommendations to prevent future deaths. With new legislative changes in July 2021, the MMRC formally became recognized as a State Advisory Committee to be appointed by the commissioner of health and sits within MDH. In 2022, appointments were finalized, and orientation was offered for members of the newly formed MMRC. Included in this new membership were annual plan agreements to support members representing communities disproportionately impacted by maternal mortality ($2,500 per member).

The MMRC engaged in the following activities in FFY2024:

Multiple case years were entered into the national database used for maternal mortality data (MMRIA).

Analysis on those case years (2017-2021) was started, including data we had not been able to analyze (due to small numbers).

A plan for our first ever 5-year report was developed and launched.

Staff participated in outreach efforts involving community partners who will be highlighted in the 5-year report

Data entry became more timely during this reporting period.

New committee members were appointed to the MMRC

There were no new maternal deaths reviewed during this reporting period, but analysis was conducted for cases from 2020 and 2021.

Dissemination of MMRC recommendations focused on SUD was done by the MMRC facilitator and 1 co-chair at the MNPQC & MHA joint perinatal summit

Requesting of records was expanded/improved through several actions including: mapping the current process, onboarding a student worker to the process, updating the process, developing new partnerships for records requests, engaging in a project to get direct access to MMRC records, and developing a new data sharing agreement.

Implement and Evaluate the IMPLICIT Model to Screen for Maternal Risk Factors During Well-Child Visits

Minnesota contracted a local evaluation and research firm to recruit and implement the IMPLICIT model in clinics throughout the state over the course of five years. In FFY2024, the contractor worked with the national IMPLICIT network to continue the implementation and education of the model to Minnesota clinics. This includes, but is not limited to measuring change following implementation, increase data management and reporting, and increase capacity of building the program. Clinics sites were recruited during the five-year grant period, growing the network's reach in Minnesota. FFY2024 marks the end of the five-year grant cycle.

Throughout the course of the grant, three separate 18-month cohorts have been recruited. Prior to FFY2024, the first two cohorts were recruited, with 2 clinics in cohort 1 and 1 clinic in cohort 2. At the start of FFY2024, the clinic in cohort 2 was coming to a finish. At the start of FFY2024, 2 of the 3 clinics in cohort 3 began the 18-month pilot. One clinic serves urban families in the greater metro area. The second clinic is located in rural Minnesota. The last clinic in cohort 3 began shortly after the first 2 clinics due to implementation issues surrounding staffing and record management. This clinic is a pediatric mobile unit serving families who may have transportation barriers. Past and current participating clinics have begun sustainability planning as the grant period comes to an end. Common barriers include leadership buy-in, staff capacity, and integrating electronic health records for the mother-baby dyad in the same visit.

For the clinics, this has been an innovative way to have multiple staff learn new QI practices and determine site champions to lead this work after funding is completed. The IMPLICIT Network continues to provide technical assistance and data support to participating clinics.

As the grant comes to a close, the contracted local evaluation and research firm is tasked with writing and completing a comprehensive report to cover the course of the grant, including clinic data, summary of implementation, common barriers, and sustainability planning.

Implement the Enhancing Outcomes for Pregnant/Postpartum Families Impacted by Substance Use Disorder Grant

In 2023, the Minnesota Legislature passed the Comprehensive Drug Overdose and Morbidity Prevention Act. As a part of this legislation, in 2024, MDH awarded the Enhancing Outcomes for Pregnant/Postpartum Families Impacted by Substance Use Disorder Grant to four grantees across the state of Minnesota. The grantees worked to identify, address, and respond to drug overdose and morbidity in those who are pregnant or have just given birth through multitiered approaches including:

Apply NAS monitoring efforts

implement substance use disorder-related recommendations from the maternal mortality review committee

collaborate with interdisciplinary and professional organizations that focus on quality improvement initiatives related to substance use disorder

promote medication-assisted treatment options; and,

support programs that provide services in accord with evidence-based care models for mental health and substance abuse disorder.

Additionally, we are working to enhance the system used for birth defects to monitor and track NAS/NOWS. These systems are already widely used by hospitals and providers and collect case information with little burden on the reporters. To inform public health interventions for populations impacted by NAS, MDH has contracted with a vendor to conduct an environmental scan to identify current practices and gaps.

Implement the Healthy Beginnings, Healthy Families Act

In July 2023, Healthy Beginnings, Healthy Families Act passed in the Minnesota Legislature to ensure the health and wellbeing of young children and their families. This 18-million-dollar investment over 4 years includes advancing perinatal health and wellbeing through advancing community and partner strategies.

One key investment in partnership as a leading solution have been demonstrated in supporting programs and/or organizations such as a state perinatal quality collaborative. Minnesota legislation identified the need of a nonprofit organization to support efforts that improve maternal and infant health outcomes. The Minnesota Perinatal Organization (MPO) is the nonprofit organization that leads the MNPQC. The MNPQC grant is to create or sustain a multidisciplinary network of representatives of health care systems, health care providers, academic institutions, local and state agencies, and community partners that will collaboratively improve pregnancy and infant outcomes through evidence-based, population-level quality improvement initiatives. The grant program started early fall 2023 with a program timeline through June 2026.

Implement the Task Force on Pregnancy Health and Substance Use Disorder

The 2023 MN Legislature established the Task Force on Pregnancy Health and Substance Use Disorders with the purpose of recommending protocols for when physicians, advance practice registered nurses, and physician assistants should administer a toxicology test and requirements for reporting prenatal exposure to a controlled substance. Beginning July 1, 2023, the MN Department of Health contracted facilitators who assisted with the Task Force appointment process and meeting requirements outlined by the legislature. The Task Force was composed of 20 appointed members representing a variety of perspectives including medical providers, social services agencies, Tribal representatives, people in community, and representatives from state agencies. The Task Force met eight times between the October 2023 and October 2024 to share perspectives, develop working groups, gather research, and seek community input to ensure their recommendations aligned with best practice and were guided by the purpose of improving health outcomes for infants and families. The Task Force concluded with the completion of their final recommendations which were submitted to the legislature by December 1, 2024. Highlights from the recommendations include changing the law that classifies prenatal substance use as child maltreatment, implementing universal screening for substance use, conducting toxicology testing when it serves a medical purpose, developing plans of safe care early in pregnancy, and creating a uniform process for notification and reporting. For the full report, please visit Task Force on Pregnancy Health and Substance Use Disorders.

Strengthen and Expand the Minnesota Perinatal Quality Collaborative (MNPQC)

Minnesota became an AIM state in Spring of 2022 and the MNPQC, co-led by MDH, was eager to take the next step in statewide quality improvement efforts for maternal health outcomes. The MNPQC, in partnership with the state maternal health innovation team – Maternal Health Outcomes in MN (I-MOM), is primarily responsible for coordinating AIM implementation and is undergoing exploratory opportunities to develop the data platform to

increase efficiency and reduce burden with hospital partners. The grant program provided five-year funding support to the MNPQC to lead the establishment of an AIM data infrastructure, including data collection portals, reporting, engagement of hospitals/providers, and expand AIM bundles being implemented in Minnesota.

In FFY 2024, MNPQC maintained the data infrastructure for hospitals to submit AIM metrics in alignment with the SUD bundle. MNPQC uses the quality improvement platform, SimpleQI. This tool allows each hospital team access to input health system measures, baseline/monthly data reports, and run charts. MNPQC uses the Institute for Healthcare Improvement Model for Improvement called the Plan, Do, Study, Act (PDSA) cycle. The PDSA process supports teams to timely assess applied interventions within their health systems. Teams are provided data and reporting tools, and data benchmarking and analysis. The intent is hospitals would submit AIM data metrics via SimpleQI that then allows MNPQC to export data to submit into the AIM data portal. However, through ongoing technical assistance via AIM, the MNPQC is navigating the best plan forward to streamline data entry across platforms to minimize burden on hospitals to enter data across multiple data platforms. To further streamline data collection across shared partners, MNPQC has been in discussion with the Minnesota Hospital Association to consider incorporating the process and structural measures from this project into MHA's established data collection process. With this infrastructure for data collection, future initiatives on perinatal outcomes related to SUD will be more feasible and sustainable.

MNPQC dedicated time to program plan for maintenance phase and continued to provide technical assistance with participating teams through monthly resource sharing and email connections to sustain progress gained in the active phase.

MNPQC held their first maintenance phase call in January 2024. This ongoing activity fulfills AIM technical assistance, training, and sharing quality improvement success to promote participation. Within the AIM SUD maintenance phase, quarterly calls for hospital teams foster continued knowledge exchange and a forum for feedback. MNPQC recommends that hospital teams continue to report and track their data internally to assess progress and identify opportunities for continued improvement. MNPQC continues to provide rolling recruitment to allow a phased approach to onboard hospitals systems to be responsive in their readiness to commit to a quality improvement initiative.

Additionally, the Early Hearing Detection and Intervention (EHDI) Community of Learning was held in May 2024 – July 2024. This learning community sought to address gaps in early hearing care to increase timeliness of hearing diagnosis after referring on newborn hearing screening and strengthen referral follow-up procedures. A report shared findings of their initiative - 2024 EHDI COL Report.

Strengthen State Capacity to Improve Maternal Health Outcomes

In FFY2023, MDH was awarded a new HRSA grant on the State Maternal Innovation and Data Capacity Program – creating the I-MOM project (Innovations for Maternal Health Outcomes in Minnesota). The purpose of the I-MOM project is to support state capacity to improve maternal health through quality services, a skilled workforce, enhanced data quality and capacity, and innovative programming that aims to reduce maternal mortality and severe maternal morbidity.

I-MOM activities in FFY2024 included innovative programing, increased data capacity, implementation of AIM statewide quality improvement care initiatives, and support for building a skilled perinatal health workforce to reduce perinatal morbidity and mortality, and goals include:

. Build a shared vision for perinatal health: Bring together perinatal health partners, specifically engaging community partners, to create alignment among goals, priorities, and actions to enhance access to a skilled workforce and improve outcomes.

!. Improve data access and expand surveillance: Increase timely, high-quality state perinatal health data to support

surveillance and inform the development of innovative perinatal health programs.

5. Improve the collection, reporting and analysis of AIM data: Identify and implement quality improvement bundles (through AIM) and provide training to support quality improvement initiatives designed to improve maternal health outcomes.

As a part of the I-MOM project, MDH established a Perinatal Sub-Committee under the existing Maternal and Child Health Advisory Committee which supported development of Minnesota's first Perinatal Health Strategic Plan. The I-MOM Project Planner led project management and implementation of the I-MOM project in FFY2024 and will continue until the end of the grant period, including collaboration with Title V staff and the MCH Advisory Committee Perinatal Sub-Committee.

This FFY2024, the Perinatal Sub-Committee (PSC) was intentional to build an action-based work group through the existing state Maternal and Child Health Advisory Committee. Members of local and/or statewide programs with clinical perinatal expertise were recruited including MMRC, MNPQC leadership, local public health, other state agencies while engaging community to ensure representation from around the state.

The PSC members demonstrate strong ownership based on their commitment to participation at biweekly meetings, applying their expertise before, during and after meetings and representing their member roles outside of the PSC setting. Through the leadership provided by the co-chairs and Maternal Health Innovations Planner, PSC has made amazing strides to build rapport, establish trust within community partners, and create well-defined roles across their membership.

Additionally, exploration about a Severe Maternal Morbidity project occurred during this timeframe, including reviews of current literature and projects on severe maternal morbidity, development of a scope of work, and drafting of a request for proposals.

LOCAL TITLE V

Supported

Provide Comprehensive Health and Well-Being Support to Women, Perinatal Women, and Their Families Through Family Home Visiting (FHV)

The Family Home Visiting (FHV) program in Minnesota demonstrates an impressive and comprehensive strategy to support families and strengthen community health outcomes. FHV is an effective upstream intervention that serves as a key link to other interventions and community supports and is a notable contributor to improved maternal and infant health outcomes. FHV services in Minnesota are supported by several funding streams including state, federal and local resources. At the state level, MDH oversees and distributes funding for home visiting services provided under Temporary Assistance to Needy Families (TANF) funding, the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, Minnesota Evidence-based Home Visiting, and Minnesota's Nurse-Family Partnership legislation. Together, these funding streams support home visiting programs across the state that serves upwards of 7,200 families.

The outlined partnership with Title V staff in FFY2024 adds even more layers of thoughtful planning, with efforts like:

Expanding community responsive services.

Strengthening connections to community resources.

Promoting essential health services for women and families.

Facilitating cross-sector collaboration with primary care providers.

Utilizing validated tools for screenings and timely referrals.

Empowering families with vital health and developmental information.

This strategic approach not only addresses immediate needs of families, but builds a strong foundation for long-term family and community well-being.

[1] Committee on Gynecologic Practice. ACOG Committee Opinion Number 755: Well-woman Visit. Obstet Gynecol. 2018 Oct 132(4):e181-e186. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/10/well-womanvisit

Comprehensive perinatal systems of care

WOMEN/MATERNAL HEALTH PLAN 2026

Description: Ensure perinatal women have access to systems of care and care navigation that are comprehensive, high quality, and responsive to individual needs and experiences.

Background

Comprehensive, quality services are essential for ensuring the health and wellbeing of both birthing people and their infants throughout pregnancy, childbirth, and the postpartum period. Comprehensive perinatal systems integrate medical, behavioral, and social services to provide coordinated, high-quality care that addresses the full spectrum of needs. By connecting prenatal care, labor and delivery, postpartum support, and community resources, comprehensive systems help improve birth outcomes, promote more consistent care across populations, and support families during a critical time of transition. Investing in such systems not only enhances individual and community health but also contributes to long-term societal benefits by laying a strong foundation for early childhood development.

Having a healthy pregnancy with access to quality birth facilities is the best ways to promote a healthy birth and have a thriving newborn. Once a woman is pregnant access to quality, early, and regular prenatal care is vital. Prenatal care is more than doctor's visits and ultrasounds; it is an opportunity to improve the overall wellbeing and health of the pregnant woman which directly affects the health of their baby.

The postpartum period is a critical time for parents and infants, setting the stage for a lifetime of health and wellbeing.[1] During this period, families are adapting to multiple physical, social, and psychological changes – including recovering from childbirth, adjusting to changing hormones and family dynamics, lack of sleep, and learning to feed and care for their newborn.

The essential access to care and support during the perinatal period is impacted by household finances and geographic availability. Poor access to needed services can result in unmet health needs, lack of preventive services, hospitalization, and increased financial burden.

> *"A 6 weeks post-partum visit is way too late to address issues that come up after delivery. It is such a huge life change that I feel like it should be around 2-3 weeks post-partum. In my first pregnancy, I had lots of complications after delivery (hives, some depression, diastasis recti, very sore nipples from breastfeeding that I couldn't wear a shirt or bra, etc.). If I went in to see my OB sooner, it would have been better. Now, delivering my 2nd baby this year, I knew more but I still believe that postpartum support and help for mothers can be improved." - Minnesota PRAMS Survey Respondent*

Measuring success

Objective

By 2030, increase the percentage of women who receive postpartum checkups within 12 weeks of giving birth by 5% and receive the recommended care components by 25% (98% and 82.5%, respectively).

National Performance Measure

Postpartum Visit

Percent of women who attended a postpartum checkup within 12 weeks after giving birth and B) Percent of women who attended a postpartum checkup and received recommended care components.

The postpartum visit is important way to improve maternal health by offering screening, counseling, and health care services management including family planning services and preliminary screening for depression/anxiety. The postpartum period is a critical time for parents and infants and this measure of one touchpoint in a comprehensive perinatal system of care.

Minnesota's goal for FFY2026 is that 93.9% of women attend a postpartum checkup within 12 weeks after giving birth and of those that attended the visit 69.3% received all the recommended care components.

Evidence-Informed Strategy Measures

Family Home Visit

Percentage of families who could benefit from family home visiting services that are currently served.

Family home visiting is a voluntary, home-based service ideally delivered prenatally through the early years of a child's life. It provides social, emotional, health-related and parenting support and information to families and links them to appropriate resources.

Family home visiting programs can increase access and the likelihood that new mothers will receive postpartum care.[2] Trained home visitors can screen for maternal conditions, help postpartum participants make and attend medical appointments, and provide access to community services. Programs that meet the federal guidelines and include postpartum care as a performance measure are likely to increase the rate of postpartum visit attendance.

Strategies and activities

Through the 2025 statewide Title V needs assessment and action planning, the strategies and activities below have been highlighted to focus on for the 2026-2030 Title V grant cycle of work specific to the women/maternal health (WMH) population domain.

WMH Strategies

1. Enhance resources, services, and supports that are responsive to community and individual needs and experiences to improve birth experiences perinatal women.
2. Broaden virtual and in-person services for perinatal women.
3. Strengthen health literacy and system navigation by providing community-responsive resources, services, and supports.
4. Improve quality and availability of family-centered mental health and substance use disorder services and resources for perinatal women.

WMH Activities

STATE TITLE V

Supported

- **Collaborate with Office of Rural Health for data support with definitions in their work, understanding**

birthing facility experiences in greater MN and closure of labor/delivery services

Reoccurring internal collaboration with staff from the Office of Rural Health and Primary Care (ORHPC) and MDH Maternal and Child Health section. Established in 2023, the Title V Coordinator, State MHI Project Director, and Maternal Access Coordinator regularly attend monthly meetings to discuss obstetrics access in rural health facilities. ORHPC submitted a data request to I-MOM Data Team for data on emergency room deliveries, specifically at hospitals without birthing services. There are opportunities to expand connections with shared partnerships via Title V, doula and midwife services programming, and through the MNPQC with an emphasis on developing rural specific quality improvement technical assistance with health facilities (birthing and non-birthing).

The I-MOM Data Team presented the results to ORHPC, discussed limitations, and identified next steps. Data Team also shared a map, created by I-MOM, showing locations of labor and delivery unit closures across the state, using data provided by ORHPC. It was suggested that the two teams continue to work together and consider ways to collaborate on data to release a joint product. Through this developing partnership, a data staff member from ORHPC agreed to help with internal testing of I-MOM's data dashboard.

- **Implement the Grief and Loss Support Grant with Trusted Community Organization**

Minnesota will continue to partner with a trusted community organization that addresses parents' mental health needs after a perinatal loss, which ideally helps their mental health/coping for future pregnancy, or for the other infant(s)/siblings if the loss was a multiple gestation. The organization will continue outreach to community-based groups and organizations to provide a comprehensive overview of the types of grief and loss services provided, as well as the process used by the organization to connect grieving families to the resources and services they may need.

Connected

- **Address Violent Maternal Deaths**

Minnesota is partnering with MDH's Injury and Violence Prevention Section (IVPS) on a maternal violent death project funded by the Office on Women's Health (OWH). This five-year grant (2021-2026) is designed to reduce deaths among pregnant and postpartum women due to violence with specific interventions around suicide, homicide, and domestic violence. This project aims to 1) enhance surveillance of violent maternal deaths, and 2) expand the evidence-based Confidentiality, Universal Education and Empowerment, Support (CUES) intervention.

The project team will continue working closely with the MMRC, MNPQC, and other local organizations toward achieving these goals, and will engage in the following activities in FFY2026:

- Continue Violent Death Reviews using an updated review protocol. Implement an internal maternal violent death database and quality improvement of reporting forms.
- Continue partnership with the MNPQC and intervention partners to develop and disseminate resources on maternal violence in MN.
- Focus reporting for violent maternal deaths to be shared with MMRC members and partners.
- Develop a dissemination and information sharing plan for data connected to this grant.
- Reimburse MMRC members for participation in this the small sub-working group.
- Form meaningful connections with medical examiners, including relationship-building through visits to county medical examiners' offices.
- Develop an implementation tracker of recommendations related to maternal violence prevention created during

the MVDR workgroup members.

- **Develop and Implement a Cannabis and Substance Misuse Prevention and Education Program**

The Maternal and Child Health section at MDH has been legislatively (Minnesota Statute 144.197) tasked with developing a cannabis and substance misuse prevention and education program for women who are pregnant, plan to become pregnant, or who are breastfeeding. There are two components of this work:

1. A soft launch that aimed to meet the needs in communication gaps within the Maternal and Child Health section after the legalization of cannabis. The maternal and child health section has developed a fact sheet, provider resource document, and a Women, Infants, and Children (WIC) rack card.
2. A larger prevention and education campaign, encompassing the audiences of both the Child and Family Health division and the Injury Prevention and Mental Health division. As a part of this larger campaign, the Maternal and Child Health section developed an RFP on cannabis and substance misuse prevention for pregnant and breastfeeding women as well as youth under 25. The goal of the RFP is to engage with identified audiences and develop messaging that can be used for a future education and awareness campaign. The total funding available for this project is up to $2,000,000 for through June 2026, with up to $1,300,000 for pregnant and breastfeeding women and $700,000 for youth under 25.

- **Enhancing Outcomes for Pregnant and Postpartum Families Impacted by Substance Use Disorder Grant**

In 2023, the Minnesota Legislature passed the Comprehensive Drug Overdose and Morbidity Prevention Act. As a part of this legislation, MDH awarded 4 grantees across the state of Minnesota through the Enhancing Outcomes for Pregnant/Postpartum Families Impacted by Substance Use Disorder Grant. The Grantees are to identify, address, and respond to drug overdose and morbidity in women who are pregnant or have just given birth through multitiered approaches including NAS monitoring efforts; implement substance use disorder-related recommendations from the maternal mortality review committee; collaborate with interdisciplinary and professional organizations that focus on quality improvement initiatives related to substance use disorder; promote medication-assisted treatment options, and support programs that provide services in accord with evidence-based care models for mental health and substance abuse disorder.

Minnesota aims to enhance the system used for birth defects to monitor and track NAS/NOWS. These systems are already widely used by hospitals and providers and collect case information with little burden on the reporters. To inform public health interventions for populations impacted by NAS, MDH has contracted with a vendor to conduct an environmental scan to identify current practices and gaps.

Ongoing grant support will be provided to grantees implementing maternal mortality recommendations, as well as increasing access to medication-assisted treatment options, addressing stigma around substance use during pregnancy, collecting baseline data, and applying quality improvement methods to measure and report efforts to improve maternal health outcomes for women with a substance use disorder. During this time the Minnesota will be in the initial strategic planning stage of a NAS surveillance system to be integrated within birth defects monitoring.

- **Explore Provision of Telehealth and Mobile Health Services in Rural Communities**

The ORPHC connected the MDH MCH section between University of Minnesota partnering with Homeward Health on a grant funded project to evaluate a mobile provider model that will offer prenatal care in rural communities. In MNPQC, LINK hospital participants reported limited availability of local behavioral health providers, long wait times, and difficulty ensuring closed-loop referrals. MNPQC connected teams to peer institutions with strong referral workflows and is exploring telehealth partnerships as a long-term strategy. MCH staff connect regularly with ORHPC to stay informed on rural health partners leading OB simulation. Opportunities include connections with the MNPQC, MN Hospital Association, and family practice providers.

The UMN team, through the Center for Learning Health System Sciences and the Medical School, is partnering with Homeward Health, a rural healthcare and mobile health provider in Minnesota and Michigan, on an ARPA-H-funded program called PARADIGM. The program aims to revolutionize rural healthcare through implementing mobile care delivery platforms - outfitted vehicles with modular equipment - that bring hospital-level services directly to underserved, rural communities. The goal is to develop and implement care via three vehicles in rural areas in Minnesota and Michigan, and for our UMN team to evaluate clinical effectiveness.

The services on each vehicle and the areas of deployment are still under consideration, but are currently projected to be prenatal and postpartum care (without labor and delivery), and advanced wound care. Currently, we are helping Homeward Health in mapping potential deployment areas across Minnesota, including identifying potential healthcare systems/clinics with whom to partner, and engaging with community organizations to develop an implementation plan. Homeward plans to use the coming year to develop community and health system partnerships to create a program that best meets community health needs.

- **Grow the Help Me Connect – Doula Registry**

Minnesota's Help Me Connect Online Navigator and Referral System launched in May 2021 as an online navigator to connect expectant families, families with young children birth to 8 years of age, and professionals serving these families to services in their local communities that support healthy child development and family wellbeing. Families and professionals can search a database of over 14,000 available programs and services closest to the family's home address under topics such as healthy development and screening resources, early learning and childcare programs, pregnancy support services, disability resources, basic needs, and more. The online resource is also available is Spanish, Somali and Hmong.

Minnesota worked with the Help Me Connect team to develop content for a new Pregnant and Expectant Families category that launched August 2023, which also highlighted the challenges and opportunity to connect families to doula and birth worker services through Help Me Connect. This led to the creation of a searchable database that welcomes doulas to submit their information into a survey to be displayed on HMC. Doulas voluntarily share a variety of information about their services, most notably, their language and cultural specializations, which allows visitors to the site to select doulas based on their own criteria. The Help Me Connect program moved to a new state agency – the Department of Children, Youth and Families – in January 2025 with a variety of programs from the Departments of Human Services, Education, and Public Safety that focus on early childhood and family support services. Interagency collaboration between the Department of Health and the Help Me Connect program will continue long-term to maintain connections and assure information on the Help Me Connect platform is maintained and updated consistently.

- **Implement Maternal Health Innovations Grant – Innovations for Maternal Health Outcomes in Minnesota (I-MOM)**

In FFY2023, MDH was awarded a new HRSA grant on the State Maternal Innovation and Data Capacity Program – creating the I-MOM project (Innovations for Maternal Health Outcomes in Minnesota). The purpose of the I-MOM project is to support state capacity to improve maternal health through quality services, a skilled workforce, enhanced data quality and capacity, and innovative programming that aims to reduce maternal mortality and severe maternal morbidity. Goals include:

1. Build a shared vision for perinatal health: Bring together perinatal health partners, specifically engaging community partners, to create alignment among goals, priorities, and actions to enhance access to a skilled workforce and improve outcomes.
2. Improve data access and expand surveillance: Increase timely, high-quality state perinatal health data to support surveillance and inform the development of innovative perinatal health programs. Improve the

collection, reporting and analysis of AIM data: Identify and implement quality improvement bundles (through AIM) and provide training to support quality improvement initiatives designed to improve maternal health outcomes.

3. As a part of the I-MOM project, MDH established a Perinatal Sub-Committee under the existing Maternal and Child Health Advisory Task Force which supported development of Minnesota's first Perinatal Health Strategic Plan. The I-MOM Project Planner will continue to lead management and implementation of the I-MOM project in FFY2026, including collaboration with Minnesota Title V staff and the MCH Advisory Committee Perinatal Sub-Committee.

- **Implement Maternal Mortality and Morbidity Review Program**

The goal of Maternal Mortality and Morbidity Review Program is to improve the health outcomes of pregnant women and includes the Maternal Mortality Review Committee (MMRC), which reviews maternal death cases and develops recommendations to prevent future deaths. The Maternal Mortality and Morbidity Review Program activities for FFY2026 include the following:

- Analyze multi-year data and provide demographics, geographic burden, distribution of death, and cause of death, to inform change of practice or policies.
- Review all pregnancy- associated maternal deaths within 18 months of date of death, and document findings and decisions in the Maternal Mortality Review Information Application (MMRIA) to assist with ongoing analysis.
- Expand community member representation on the MMRC. Disseminate committee findings, analysis, and recommendations to internal and external stakeholders annually. Disseminate a report on 5 years of maternal mortality reviews including recommendations to (internal and external) stakeholders.
- Develop targeted reports on leading causes of death in MN for specific stakeholder groups including providers and policy makers.
- Track the implementation of MMRC recommendations at multiple levels.
- Collaborate with partners to strategically develop statewide actionable interventions to reduce contributing factors identified by the case reviews.
- Promote recommendations from our community action team (perinatal subcommittee) to identify strategies and resources needed for the community to implement recommendations to improve pregnancy outcomes.
- Train, and cross-train, internal staff on data management and system processes to improve timely access to case information, abstraction, and data entry.
- Invest in community driven interventions to address maternal mortality and build upon communities' approaches in maternal health.
- Improve case identification and completion of record collection in partnership with Department of Human Services, other divisions within MDH, the MN Hospital Association, State Medical Examiners, and Law Enforcement entities.
- Develop feasible processes and systems to collect and analyze maternal morbidity data to identify leading causes of morbidity in the state.
- Tailor quality improvement interventions, in conjunction with the MNPQC, to target and address maternal mortality and morbidity.
- Implement an informant interview protocol through a contract with external partners – which reflects a

recommendation from the CDC for MMRC partners to use informant interviews for comprehensive case reviews. (Qualitative data gathered from the interviews are used to supplement medical records and other records abstracted for MMRC to review).

- Expand the Hear her campaign to additional populations, their loved ones, and care providers.
- **Implement the IMPLICIT Model to Screen for Maternal Risk Factors During Well Child Visits**

For many years, the CSHCN and MCH sections in the CFH Division have collaborated on birth defects prevention grants and continue to focus on interconception care and optimizing postpartum mothers' point of contact with providers through well-child visits. The IMPLICIT model utilizes time in the well-child visit to incorporate maternal risk assessments for mothers and birthing persons to improve birth outcomes. The model includes foci on four behavioral risks affecting future birth outcomes: smoking, depression, family planning and birth spacing, and multivitamin with folic acid use. Not only does this promising practice allow collaboration to integrate services, provide needed services and education to care givers, it also encourages providers to improve their understanding of quality improvement and implementing and evaluating evidenced-based practice in their role. Minnesota plans to continue and expand the evidence-based IMPLICIT model (Interventions to Minimize Preterm and Low Birth Weight Infants using Continuous Quality Improvement Techniques) in Minnesota.

The national IMPLICIT Network developed, assessed, and integrated this evidence-based model for the past 10 years, and are working in partnership with MDH and the March of Dimes to disseminate this interconception model. In FFY2026, MDH will award a new IMPLICIT grant through an RFP process to continue this important activity through 2028.

- **Implement the Perinatal Subcommittee Strategic Plan**

In August 2022, Minnesota was awarded a State Maternal Health Innovation and Data Capacity Program Grant, which requires creating and implementing a strategic plan that includes activities outlined in the state's most recent Title V strategic plan. The Perinatal Sub-Committee (PSC), was established as a subgroup of the Maternal and Child Health Advisory Committee. It is a multidisciplinary and community-led committee that is building a shared vision for perinatal health.

The PSC finalized their strategic plan in October 2024, and now serves as a living document to guide the work of Innovations for Maternal Health Outcomes in Minnesota (I-MOM) and other projects. Among the 13 recommendations in the perinatal health strategic plan, are:

- Access to Substance Use Disorder (SUD) and Mental Health Services
- Funding for Substance use Disorder and Mental Health

Community Action Teams (CATs) are being developed to implement actions to address the strategic plan recommendations. The PSC and our partners will participate in evaluating the implementation of the strategic plan; and provide leadership in updating activities and aligning new innovative maternal health programs such as expansion of doula, community health workers, midwife services, and telehealth to address the strategic plan recommendations.

- **Implement the Sexual and Reproductive Health Services Grant Program**

The SRHS program is administered by MDH and provides pre-pregnancy family planning services for people whose incomes are below the federal poverty level and placed at increased risk for unintended pregnancy. The program supports essential pre-pregnancy family planning services for people of reproductive age who experience barriers, whether geographic, financial, or other, in access to such services. In 2023, eligibility was expanded to include the 12 Minnesota tribes in the geographic area of Minnesota. Grantees provide responsive:

- Education and outreach on medically accurate sexual and reproductive health information.
- Contraceptive counseling, provision of contraceptive methods, and follows-up.
- Screening, testing, and treatment of sexually transmitted infections and other sexual or reproductive concerns.
- Referral and follow-up for medical, financial, mental health, and other services in accord with a service recipient's needs.

- **Partner to Implement the Transforming Maternal Health Model (TMaH)**

In January 2025, Minnesota was selected through an application process as one of fifteen states to participate in the TMaH Model through 2035, through the Centers for Medicate & Medicaid Services. The Minnesota state Medicaid program and Minnesota Department of Health are partnering to lead implementation of the TmaH model to improve maternal health care.

Minnesota' s Maternal Care Access Coordinator and Maternal Health Innovations Coordinator are the MDH representatives serving on the TMaH team. More details will become available as the project is moved further into the pre-implementation period, and toward implementation.

- **Promote the Hear Her Campaign**

The Hear Her Campaign was created by CDC to expand awareness and conversation around pregnancy-related complications and warning signs. Beginning in April 2024, Minnesota partnered with CDC to launch the campaign across the state and contracted with an advertising firm to maximize reach. Outreach occurred via social media, search engine advertising, radio, and direct emailing from MDH to clinical partners. The campaign message was accessible to families of childbearing age and their support people, as well as clinicians who care for this population. This was an extremely successful campaign that ran from April 18 to August 31, 2024, receiving widespread coverage, including media attention. During the MDH Hear Her campaign, the webpage received 31,917 visitors resulting in 4,193 clicks to CDC resources on maternal risk factors. In FFY2026 Minnesota will continue to partner with CDC's Hear Her Campaign along with the advertising firm, which has been a successful source of information for our communities and partners. MDH will provide outreach to communities impacted by maternal mortality and provide free materials (via CDC) to clinics, acute care facilities, and community organizations as requested.

- **Provide Holistic Health and Wellbeing Support to Women, Pregnant Women, and Their Families Through Family Home Visiting (FHV)**

FHV is an effective upstream intervention that serves as a key link to other interventions and community supports and is a notable contributor to improved maternal and infant health outcomes. FHV services in Minnesota are supported by several funding streams including state, federal and local resources. At the state level, MDH oversees and distributes funding for home visiting services provided under Temporary Assistance to Needy Families (TANF) funding, the federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, Minnesota Evidence-based Home Visiting, and Minnesota's Nurse-Family Partnership legislation. Together, these funding streams support home visiting programs across the state that serves upwards of 7,200 families.

The Family Home Visiting (FHV) program in Minnesota demonstrates an impressive and comprehensive strategy to support families and strengthen community health outcomes.

In FFY2026, Minnesota will:

- Implement promising practices and evidence-informed strategies to reach communities with limited access to family home visiting services.
- Connect families to needed community services.

- Promote the importance of well-women visits, prenatal and postpartum care, and strive to assure that the women served have health insurance and are connected to a primary care provider.
- Work closely with primary care providers to encourage cross-sector collaboration to provide a comprehensive approach to caring for families during pregnancy and after the birth of their child.
- Support parents early in their role as a child's first teacher and foster parenting skills that decrease the risk of child abuse.
- Help parents develop safe, stable, and nurturing environments that support healthy development.
- Provide screening, using validated tools, for: depression during the postpartum period; intimate partner violence, parent-child interactions, and developmental and social emotional concerns for children – and, subsequently, make appropriate referrals.
- Provide health information and encouragement to families including, but not limited to, family planning, breastfeeding and child nutrition, and child growth and development.
- This strategic approach not only addresses immediate needs of families but builds a strong foundation for long-term family and community well-being.
- **Support Implementation of St Lukes Plus One Doula Program**

The Plus One Doula Program at St. Luke's offers patients the opportunity to receive a partial or full scholarship to hire a doula through Doulas of Duluth. This program helps patients include a doula as part of their pregnancy, birth, and postpartum care team. Doulas provide valuable support throughout pregnancy. Having a doula can lead to a better overall experience during childbirth, a lower chance of complications during labor, fewer negative outcomes, reduced risk of maternal health issues, faster labor progression, up to a 40% reduced likelihood of needing a C-section for low-risk pregnancies, and fewer interventions during labor such as epidurals. Minnesota's Maternal Care Access Coordinator will continue providing support toward implementation of this program.

LOCAL TITLE V

Supported

Increase Representation of Communities Served within Program Staff and Implementation

LPH agencies in FFY2026 will continue to increase representation of the communities the serve within their program staff and implementation. Local public health agencies use various strategies to recruit and retain staff that reflects the communities they serve and hire staff from communities to serve in community-centric roles, such as community health strategists and community health workers. One approach to increasing community representation is when interviewing candidates to work in local public health programs:

make sure interview panels have a broad representation.

exclude names of candidates.

invite community members be part of the panel.

Providing Program Services and Resources that are Responsive to Family and Community Needs

LPH agencies and their staff recognize the impacts of community health drivers on individuals, families, and communities and aim to implement their programs with this understanding and the lens that no family or community is the same. Rather, individuals, families, and communities are best served when programs, services, and resources are responsive and flexible to their needs and preferences. In FFY2026, local public health agencies will continue to offer program supports, services, and resources with this responsiveness and flexibility by offering telehealth visits; providing visits based on family preferences such as in the home, clinic, library, coffee shop, etc.; offering options for phone visits when needed; offering appointment times outside of the typical 8-4:30 business day; partnering to

provide mobile clinic services; and providing flexibility to accommodate for illness or bad weather, particularly during the winter months and in rural areas of Minnesota. Additionally, local public health staff have learned from families that they might prefer to meet within a group setting either explicitly or in addition to their one-on-one visits – which has led some local public health agencies to offer group connections. For example, one community health board offers monthly gatherings for pregnant or parenting families to share a meal and receive an educational topic in the evenings.

Uplifting Local Resources, Supports, and Services that are Responsive to Individual, Family, and Community Needs

LPH agencies rely on their ability to collaborate with partner organizations, particularly local community organizations, in order to establish referral partnerships and responsively meet the needs of the individuals, families, and communities they serve. While many local public health agencies offer resources and referrals through established and evolving resource lists, some local public health agencies integrate further resource referrals and activities that aim to address systems families are navigating. For example, one community health board works with families to document their experiences with perinatal providers and systems through a resource app. Another community health board works across five counties to continuously update and provide a resource list to all those receiving their services. This particularly community health board works in partnership with child and teen checkup providers, local family services agencies, and local medical providers to regularly update this resource list and ensure they are all providing the same information to individuals and families. These initiatives will continue in FFY2026.

Connected

Provide Family Centered Coaching Services

One community health board provides and will continue providing in FFY2026 family centered coaching services to pregnant women through partnership with a community-based organization. Family centered coaching utilizes strategies and tools to provide comprehensive services to families that are responsive to their needs and experiences, including addressing impacts of community health drivers.

Utilize Community Co-Design to Increase Prenatal Care Access

Community Co-Design is a participatory design process that incorporates community input at every stage of the process from beginning to end. For one Local public health agency, they have utilized community co-design to increase prenatal care access by increasing the number of doulas available to residents, as well as mapping providers and resources and their responsiveness to communities. They will continue these efforts in FFY2026.

[1] ACOG Committee Opinion. Optimizing Postpartum Care.

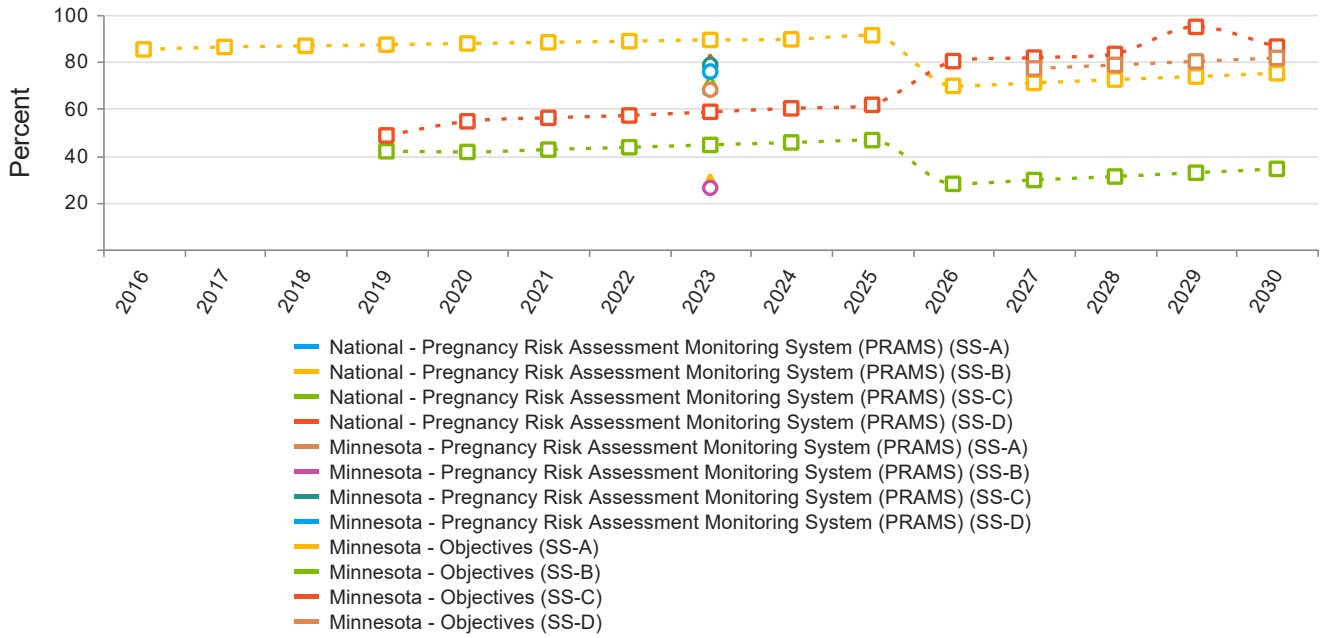
[2] Benefits of In-Home Visits for New Moms: A Literature Review

Perinatal/Infant Health

National Performance Measures

NPM - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep - SS

Indicators and Annual Objectives



NPM - A) Percent of infants placed to sleep on their backs - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	87.5	88	88.5	89	89.3
Annual Indicator	86.0	86.4	90.3	90.3	68.1
Numerator	52,364	50,486	53,992	53,992	36,022
Denominator	60,905	58,449	59,811	59,811	52,859
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	69.5	70.8	72.2	73.5	74.9

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	41.5	42.5	43.5	44.5	45.5
Annual Indicator	39.6	43.5	39.7	39.7	26.4
Numerator	23,128	24,690	22,771	22,771	13,993
Denominator	58,448	56,809	57,410	57,410	53,020
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	28.0	29.6	31.1	32.7	34.3

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	54.5	56	57	58.5	60
Annual Indicator	59.2	63.8	69.4	69.4	78.4
Numerator	34,627	36,646	39,928	39,928	42,792
Denominator	58,484	57,453	57,494	57,494	54,562
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	80.0	81.5	83.1	94.6	86.2

NPM - D) Percent of infants room-sharing with an adult during sleep - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	75.4
Numerator	41,673
Denominator	55,274
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	76.9	78.4	79.9	81.4	82.9

Evidence-Based or –Informed Strategy Measures

ESM SS.1 - Proportion of mothers who were told by a healthcare provider to place their baby on his or her back to sleep

Measure Status:	Inactive - This measure is no longer collected on MN PRAMS.

State Provided Data				
	2021	2022	2023	2024
Annual Objective			95.1	95.8
Annual Indicator	94.3	93.7	100	100
Numerator	55,097	55,862	55,248	55,248
Denominator	58,451	59,592	55,248	55,248
Data Source	MN PRAMS	MN PRAMS	MN PRAMS	MN PRAMS
Data Source Year	2020	2021	2022	2022
Provisional or Final ?	Final	Final	Final	Final

ESM SS.2 - Proportion of organizations that distribute cribs and/or provide safe sleep education within communities across Minnesota.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10.0	12.0	14.0	16.0	18.0

State Action Plan Table

State Action Plan Table (Minnesota) - Perinatal/Infant Health - Entry 1	
Priority Need	
Healthy infants, families, and communities	
NPM	
NPM - Safe Sleep	
Five-Year Objectives	
By 2030, increase the percentage of infants - placed to sleep on their backs by 10%; - placed to sleep on a separate sleep surface by 30%; - placed to sleep without soft objects or bedding by 10%; and - room-sharing with an adult during sleep by 10%.	
Strategies	
Amplify resources, services, and supports that are responsive to community needs and foster the health and wellbeing of families with pregnant women and infants.	
Collaborate with trusted community organizations and partners to maximize resources that promote the health and wellbeing of pregnant women and infants.	
Promote and strengthen development and broad representation in the workforce supporting infant and perinatal health.	
Enhance and integrate knowledge of the impact of parental mental health and intergenerational experiences on perinatal and infant health.	
ESMs	**Status**
ESM SS.1 - Proportion of mothers who were told by a healthcare provider to place their baby on his or her back to sleep	Inactive
ESM SS.2 - Proportion of organizations that distribute cribs and/or provide safe sleep education within communities across Minnesota.	Active

NOMs

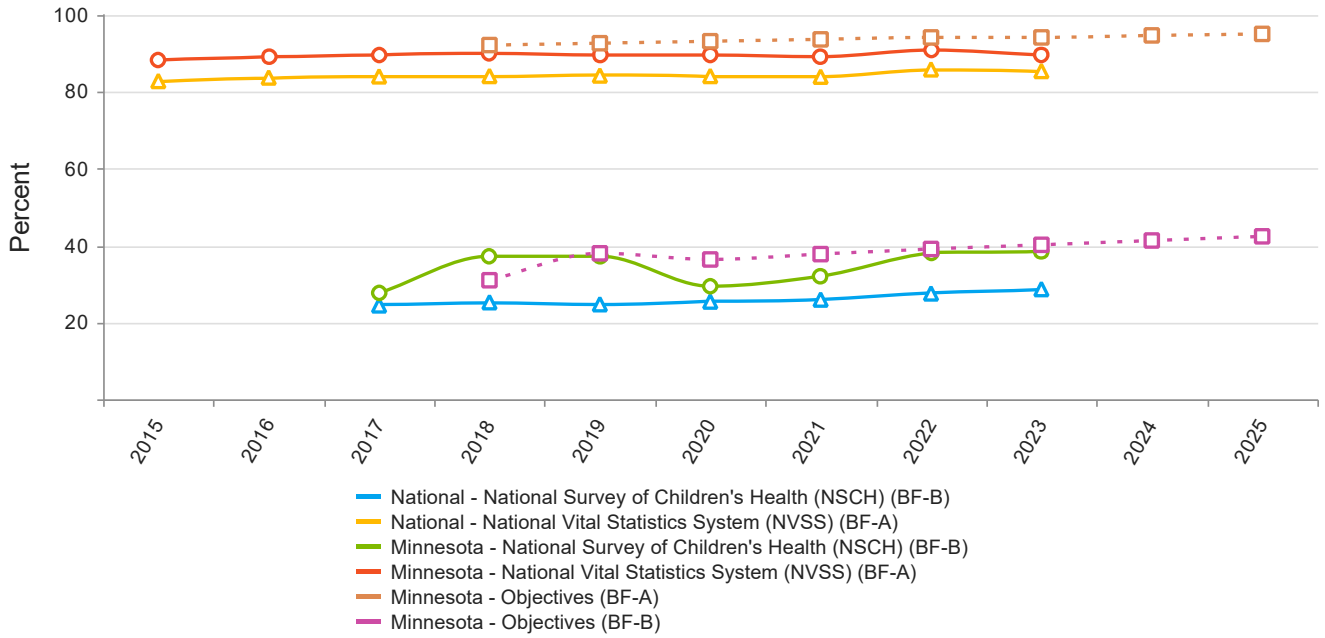
Infant Mortality

Postneonatal Mortality

SUID Mortality

2021-2025: National Performance Measures

2021-2025: NPM - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF Indicators



2021-2025: NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	94	94.5
Annual Indicator	90.7	89.6
Numerator	55,751	53,126
Denominator	61,487	59,265
Data Source	NVSS	NVSS
Data Source Year	2022	2023

2021-2025: NPM - B) Percent of infants breastfed exclusively through 6 months - BF

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	40.2	41.3
Annual Indicator	38.2	38.3
Numerator	65,138	66,064
Denominator	170,646	172,580
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM BF.1 - Percent of births delivered at MDH Breastfeeding-Friendly Maternity Centers

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		28.3	29	29.4	30.1
Annual Indicator		17.4	26.9	13.2	10.4
Numerator		11,341	17,743	8,292	6,226
Denominator		65,138	66,010	62,636	59,694
Data Source		Vital Records and MDH's Accreditation Database	Vital Records and MDH's Accreditation Database	Vital Records and MDH's Accreditation Database	Vital Records and MDH's Accreditation Database
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Infant mortality

INFANT/PERINATAL HEALTH REPORT 2024

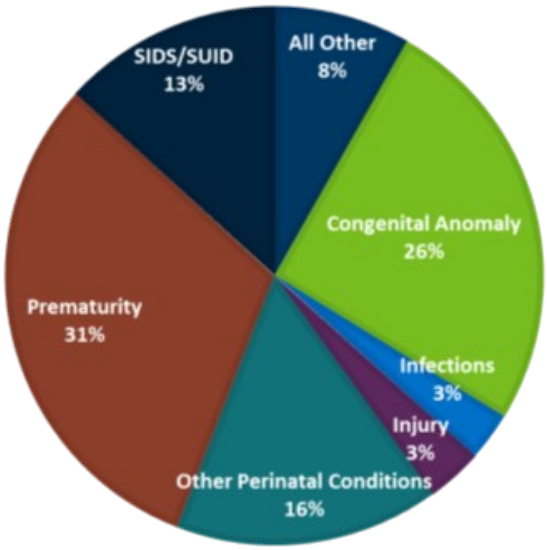
Description: Reducing the number of infants that die before their first birthday.

Background

Infant mortality is a multifaceted societal problem that affects the health and well-being of individuals, family systems, and communities. Some factors that have been connected to and influence infant mortality occurrences include maternal health, family socioeconomic status, quality and access to medical care, and knowledge about and support to implement public health best practices such as breastfeeding and safe sleep.

294 infants born in MN in 2023 died before their first birthday.

Figure 3. Leading Causes of Infant Mortality, 2019-2023



Data Source: Linked Birth-Infant Death MN Resident Period Cohort Data File

Minnesota aimed to accelerate declines in infant mortality by addressing prematurity, congenital anomalies, other perinatal conditions, and SUID/SIDS (including preventative practices such as breastfeeding and safe sleep). These four causes of infant mortality made up 85.6% of all infant deaths between 2019-2023 (figure 3).

Measuring success

Objective

- By 2025, Minnesota (MN) aims to increase the percentage of infants who have been breastfed ever by 5% and increase the percentage of infants breastfed exclusively through 6 months by 20%.
- By 2025, MN aims to increase the percentage of infants placed to sleep on their backs by 5%; increase the percentage of infants placed to sleep on a separate sleep surface by 15%; and increase the

percentage of infants placed to sleep without soft objects or bedding by 15%.

- By 2025, MN aims to reduce the overall SUID rate by 15% and reduce the SUID rates between whites and African Americans and American Indians by 15%.

National Performance Measure

Breastfeeding

A) Percent of infants who are ever breastfed; B) Percent of infants breastfed exclusively through 6 months.

Research shows breastfeeding offers many health benefits for infants and mothers. From birth, breastfeeding provides the baby with antibodies that protect against and reduce the risk of health issues caused by viruses and bacteria, such as upper respiratory infections, influenza, asthma, and eczema. Breastfeeding exclusively has been shown to be a protective factor against SIDS, and if possible, mothers should exclusively breastfeed or feed with expressed human milk for 6 months, in alignment with recommendations of the American Academy of Pediatrics (AAP). However, any breastfeeding has been shown to be more protective against SIDS than no breastfeeding. According to 2023 data from National Immunization Survey (NIS), the percent of infants who were ever breastfed was 89.6%. Data from 2022-2023 National Survey of Children's Health (NCHS) shows that 38.3% of infants who are exclusively breastfed through 6 months.

Safe Sleep

A) Percent of infants placed to sleep on their backs; B) Percent of infants placed to sleep on a separate approved sleep surface; C) Percent of infants placed to sleep without soft objects or loose bedding; D) Percent of infants room-sharing with an adult during sleep.

Sleep-related infant deaths account for the largest share of infant deaths after the first month of life. There is a heightened risk of SIDS when infants are placed to sleep on side or stomach sleep positions, so AAP recommends the back sleep position (Table 1). To further reduce SUID, the AAP has expanded recommendations for a safe sleep environment to include, among other practices, using a separate firm sleep surface (e.g., crib or bassinet) without soft objects or loose bedding.

Table 1. Minnesota National Performance Measure Safe Sleep (SS), 2018-2022

Year	Percent of infants placed to sleep on their backs	Percent of infants placed to sleep on a separate approved sleep surface	Percent of infants placed to sleep without soft objects or loose bedding	Percent of infants room-sharing with an adult during sleep
2023	68.1%	26.4%	78.4%	75.4%

Data Source: Pregnancy Risk Assessment Monitoring System (MN PRAMS)

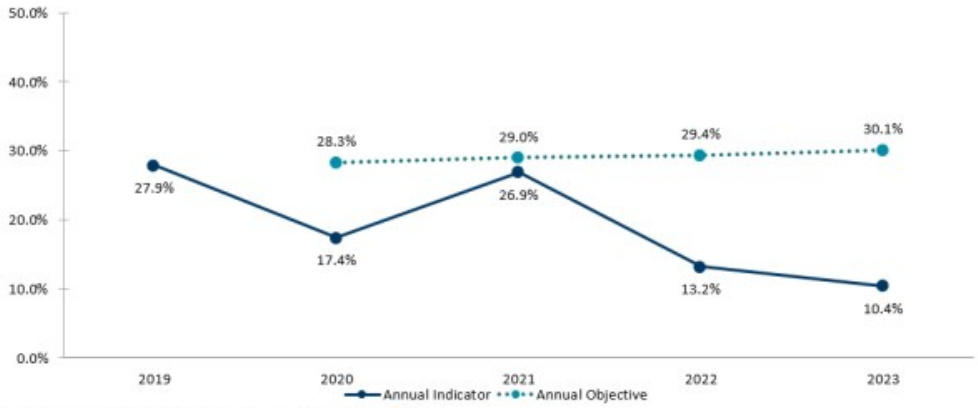
Evidence-Based/Informed Strategy Measures

Breastfeeding-Friendly Birth Centers

Percent of births delivered at MDH Breastfeeding Friendly Birth Centers.

Minnesota works toward policy and systems changes that foster optimal infant health outcomes for the state. Supporting baby-friendly hospitals and birth centers[1], as well as environments, policies, and practices conducive to breastfeeding, are two avenues that Minnesota is fostering toward optimal infant health outcomes. MDH's Breastfeeding Friendly Birth Center (BFFBC) Recognition Program recognizes birth centers across the state that have taken steps toward implementing the Ten Steps to Successful Breastfeeding, and, in partnership with the Minnesota Breastfeeding Coalition, MDH convened the monthly community of practice- 10 Steps Learning Collaborative for Birth Centers.

Figure 1. Percent of births delivered at MDH Breastfeeding-Friendly Maternity Centers



Data Source: MN Vital Records and MDH's Accreditation Database

As illustrated in Figure 1, the percentage of infants born in breastfeeding-friendly recognized birth centers decreased as several large hospital systems chose not to redesignate. These hospital systems cite cost and patient evaluations as reasons to not re-designate. However, two hospitals were re-designated to continue their commitment from 2020-2025 and two other facilities have partially completed Breastfeeding-Friendly Birth Center recognition requirements.

Safe Sleep Promotion

Proportion of mothers who were told by a healthcare provider to place their baby on their back to sleep.

Safe sleep modeling occurs when hospitals develop, implement, maintain, and enforce a safe sleep policy that aims to prevent sleep-related injuries and deaths. Additionally, staff in turn serve as role models for safe sleep by intentionally conveying messages and cues to parents that promote sleep safety for infants.

In 2022, 97.7% of mothers were told by a healthcare provider to place their baby on their back to sleep. This measure was removed from phase nine PRAMS survey, so 2022 data is the most recent data available.

Strategies and activities

IPH Strategies

1. Apply Community-Specific and Community-Based Best Practices Activities.
2. Improve Data Collection and Evaluation.
3. Facilitate Policy and Systems Changes to Reduce Infant Mortality.

IPH Activities

STATE TITLE V

Supported

Advocate to establish a Fetal and Infant Mortality Review (FIMR)

In 2001, the statute authorizing the Commissioner of Health to conduct a FIMR was repealed. Without the legislation in place, MDH lacks statutory authority to establish a FIMR process and committee. Since 2014, there have been several legislative proposals to reinstate the FIMR without success.

MDH continues to educate and advocate for reinstating a Fetal and Infant Mortality Review (FIMR) in Minnesota during this reporting period. During the 2024 legislative session, MDH was unsuccessful in efforts to propose this action. MDH continued to provide education and information broadly on infant mortality in Minnesota and the importance of a FIMR in better understanding the factors contributing to infant mortality and identify opportunities for policy, systems and environmental changes.

Improve Data-Sharing Between MDH and Partners

Despite Minnesota's strict data privacy laws, during FFY2024, staff obtained aggregated vital registration data (e.g., births, infant deaths, and stillbirths), as well as data from other sources such as PRAMS, and the SUID SDY Case Registry to support our own internal programmatic and planning efforts. Data obtained from these sources were also shared in summary form with our external partners and with the public at-large through multiple platforms and formats such as in presentations, on the radio, in meetings, in press releases and on social media. Examples of these include:

In November 2023, MDH staff and partners discussed strategies/best practices that are based on AAP safe sleep recommendations to prevent sleep-related sudden unexpected infant deaths (SUID) on KMOJ Radio.

In June 2024, staff was interviewed by the Health Chatter Podcast about the status of infant mortality in Minnesota and the U.S. During this presentation, staff shared the most currently available data on infant mortality in Minnesota.

During Infant Safe Sleep Week in Minnesota from November 12-18, 2023, MDH published a press release, which called on health officials and pediatricians to emphasize the ABCs of safe sleep during patient visits, and promoted NICHD's Clear the Crib Challenge. The press release include data from the SDY Case Registry on the number of infant deaths that occurred in Minnesota in 2021, and data from PRAMS which showed an increase in the proportion of mothers who reported not using soft bedding in their infants' sleep space from 48% in 2016 to 69.4% in 2021.

Partner to Implement Grief and Loss Support Grant

Minnesota utilized Title V and state birth defects prevention funds to issue an RFP and partner with a trusted community organization to provide support to parents after a perinatal loss. The organization provides outreach to community-based groups and organizations to inform them about the types of grief and loss services provided, as well as the process used by the organization to connect grieving families to the resources and services they may need.

Connected

Establish the MN Partnership to Prevent Infant Mortality (MPPIM)

MDH began implementation of the provisions of the Healthy Beginnings, Healthy Families Act, including creating a statewide multisectoral partnership to address the leading causes of infant mortality. MDH developed a new grant program, that awarded a total of 37 grants in April-May 2024 across Minnesota to American Indian Tribes, community health boards/local public health, and community-based organizations to design and deliver programs that address the leading causes of infant mortality in Minnesota including preterm birth, sleep-related infant deaths, birth defects, and social determinants of health. Through this grant program, a network of supports has been developed and structures to connect grantees, provide training and technical assistance, and support innovation in this work.

Expand Community-Based Infant Mortality Prevention Education

During FFY2024, MDH distributed both safe sleep materials created in-house by MDH and those of partner organizations such as the NICHD. As such, MDH distributed 1,640 safe sleep books in English and Spanish, 1,250 safe sleep quick cards in English and Spanish, 200 tummy time flyers in English, and approximately 800 of the NICHD's, What Does a Safe Sleep Environment Look Like? flyer in English and Spanish. These materials were distributed at multiple venues, including conferences and community gatherings, and were shared with local public health agencies, Tribal health agencies, and community-based social services non-profit organizations whenever they requested them.

MDH also collaborated with partners to further define strategies that support infant health outcomes. MDH staff attended and participated in the Healthy Black Pregnancies Board of Directors meetings, where they provided updates on infant mortality and stillbirth activities at MDH and in the U.S. Staff also presented information on perinatal health topics. In Fall 2023, for example, staff presented data on infant mortality and stillbirths at two separate committee meetings, which were attended by 12-13 committee members at each meeting.

Expand Folic Acid Awareness

In September 2024, MDH led the National Birth Defects Prevention Network's (NBDPN) Folic Acid Awareness Week (FAAW) alongside their regular state programming. This week is dedicated to increasing public awareness around the importance of folic acid during pregnancy. Outreach included a national-level webinar and Q&A, social media, and tabling at a well-attended public event.

Expand Infant Health Grants

During FFY2024, MDH awarded infant health and mortality prevention grants to 37 grantees across Minnesota,

including community-based organizations, local public health agencies/community health boards, and Tribes through the Healthy Beginning, Healthy Families program, that was created in 2023. Grantees are all addressing leading causes of infant mortality through their programs, including providing safe sleep prevention education, provision of cribs and other safe sleep materials, and incorporating culturally relevant practices to reach populations disproportionately impacted by infant mortality and sleep related causes of infant mortality.

Additionally, the Minnesota Legislature ended the Positive Alternative (PA) grant program in June 2023, which, among other activities, provide safe sleep education and cribs to families in Minnesota. While this source of funding is no longer available, MDH will continue to support community-owned safe sleep education and support through new infant health grants under the Healthy Beginnings, Healthy Families program, which was created by the Legislature in 2023.

Positive Alternative (PA) transition grants were awarded to four organizations that continued to promote safe sleep practices through education and provision of safe sleep materials across Minnesota. These grants completed on June 30, 2024.

Foster Support and Recognition from State Leadership

Key leaders have demonstrated an investment in perinatal health through state priorities to address maternal and infant health – as was demonstrated at the Celebrating 50 years of WIC at the MN WIC 2024 Training Conference: Step into the Future of WIC. Kate Franken, Minnesota WIC Director and National WIC Association Board Chair, opened the September 2024 conference and provided closing remarks. Minnesota Lieutenant Governor Peggy Flanagan shared a recorded video message to provide welcome remarks, expressing acknowledgement and thanks to state and local WIC staff for their work in serving Minnesota Families.

There were 490 WIC staff from across Minnesota registered with representation of 81 of Minnesota's 87 local agencies – or 93% of our local agencies – in attendance. This opportunity for local, state, and national attendees to hear from leadership voice and passion demonstrated our state possibilities to make policy and system changes that impact our communities through improving infant and perinatal health.

Implement a Perinatal Health Strategic Plan for MN

In 2022, MDH drafted Vision 2030: A Plan to Improve Perinatal Health Outcomes in Minnesota (I-MOM), which included a mission, vision, values, guiding principles, and recommendations that were organized under five priority areas. The priority areas were Healthy Equity, Healthy Preconception, Pregnancy, and Postpartum, Infant health and Safety, Healthy, Safe Families and Communities, and Advance Data and Evaluation. In 2022, MDH was awarded the State Maternal Health Innovation and Data Capacity Program. Because one of requirements of the grant is to develop and implement a statewide perinatal health plan, MCH leadership decided to transfer the Vision 2030 plan over to the I-MOM project for it be incorporated into their perinatal health plan. As a result, the Vision 2030 plan as initially drafted was never published as standalone document.

The State Maternal Health Innovation and Data Capacity Program Grant, Innovations for Maternal Health Outcomes in Minnesota (I-MOM), has co-led the Perinatal Health Sub-committee (PSC). PSC finalized a draft list of recommendations for the Perinatal Health Strategic Plan. The PSC analyzed ten existing recommendation reports such as Title V, MMRC, and community-led initiatives. The PSC identified six main themes and worked collaboratively to edit and add recommendations under each theme. A final draft to HRSA was submitted end of September 2024.

The PSC expressed a need to receive community input on the results of the compiled recommendations. The PSC will lead a multi-pronged approach to receive feedback via 1) a survey to the public, 2) PSC member led conversations to their organizations and networks, and 3) through partnerships with community-based organizations. This community feedback will be applied to the plan to support as a "living" resource.

Implement CDC Grant to promote Infant Safe Sleep

In fall 2023, Minnesota Department of Health was awarded a five-year multi-component grant from the Centers for Disease Control and Prevention (CDC) to improve case ascertainment, data completeness, and timeliness of sudden unexpected infant deaths (SUID) in Minnesota. An important component of this grant is to conduct listening sessions in the African American/Black and the American Indian populations understand factors that impede and/or facilitate infant safe sleep practices. Through this grant, MDH conducted a statewide assessment among birthing hospitals, clinics, local public health agencies, and nonprofit organizations to gather information on their level of safe sleep promotional activities, and prevention resources being distributed among the populations they serve. Both activities were planned during FFY24 in partnership with the Infant Safe Sleep Community Leadership Team for implementation in FFY25, and the results of the listening session will culminate in a strategic/action plan which will be implement in community action teams. The Infant Safe Sleep Community Leadership Committee is the advisory arm of the project, and it is comprised of 20 passionate infant safe sleep champions with both lived and professional experience in MCH.

Implement Universal Congenital Cytomegalovirus (cCMV) Newborn Screening and Prevention

In 2021, the Minnesota legislature passed a law known as the Vivian Act – named for Vivian Henrikson who was identified with congenital cytomegalovirus (cCMV) shortly after birth. The Vivian Act directs the Commissioner of Health to:

Make information about cCMV, including preventative measures, available to health care providers, women who may become pregnant, expectant parents, and parents of infants.

Establish an outreach program to educate women who many become pregnant, expectant parents, and parents of infants about cCMV.

Raise awareness for cCMV among health care providers.

Require the Advisory Committee on Heritable and Congenital Disorders to review cCMV for possible inclusion on Minnesota's newborn screening panel.

MDH established its outreach program at the beginning of 2023 and throughout FFY2024 has coordinated a wide variety of outreach, awareness, and prevention projects. They began universal newborn screening for cCMV in February 2023, becoming the first state to do so.

Starting in January 2024, MDH contracted with a vendor to develop media and physical materials for a widespread campaign. The campaign launched in June 2024 and has reached thousands of Minnesotans to raise awareness about cCMV. Data shows an increase in website traffic to pages with helpful information on cCMV. Additionally, MDH staff have attended numerous conferences and community events to educate professional and public audiences about cCMV; as well as participated in and hosted webinars for a variety of professional audiences. MDH continues to host the cCMV Consortium, which engages with professional stakeholders who aid MDH in establishing and improving follow up of newborns screening positive for cCMV.

Increase the Number of MDH Breastfeeding-Friendly Recognized Birth Centers

Maternity hospital practices and policies can undermine maternal and infant health by creating barriers to supporting a parent’s decision to breastfeed. When birthing facilities implement the World Health Organization’s Ten Steps to Successful Breastfeeding, they have the tools to give parents the information, confidence, and skills necessary to successfully initiate, and continue, to breastfeed their babies. Parents who get the support they need in the hospital are much more likely to continue breastfeed once they return home. With funding from Statewide Health Improvement Partnership (SHIP), staff from the MBC facilitated a 10-Step Learning Collaborative (10-SLC) to work on

implementation of the WHO's Ten Steps. The 10-SLC brought together staff from hospitals across the state to work on a minimum of two steps, utilizing the MDH Breastfeeding-Friendly Birthing Center 5-Star Recognition Program guidance and tools. Initially, four hospitals were regularly engaged with the collaborative's monthly meetings. By the end of 2023, participation increased from 4 to 10 facilities. Thirteen facilities received mini-grants to implement breastfeeding friendly projects for birthing centers or workplaces.

Increase the Number of Safe Sleep Certified Hospitals

In FFY2022, staff conducted a survey of all 84 birthing hospitals in Minnesota to determine whether they had a hospital safe sleep policy in place, provided safe sleep training for their staff, or provided safe sleep education to birthing families before they are discharged from the hospital. MDH used the information gathered from the survey to further encourage hospitals to become safe sleep certified.

During FFY2024, one additional hospital received safe sleep designation through the National Hospital Safe Sleep Certification Program, which brings the total number of safe sleep certified hospitals across the state to four. MDH recognized the hospital in the press release that was published during Safe Sleep Week. Two other birthing hospitals are considering receiving safe sleep certified in the next year. MDH will continue to reach out to hospitals to encourage them to receive safe sleep designation.

Promote Culturally Specific Policy for Cradleboard Usage in Licensed Childcare Settings

In 2023, the Governor signed legislation into law which authorized the Minnesota Department of Human Services (DHS) to grant a variance to license childcare settings in Minnesota that seek permission to use a cradle board in their setting when requested by a parent or guardian for cultural reasons. This law is pursuant to Minnesota Statutes, sections 245A.1435 (g) and 245A.16, subd. 1 (a) (9). MDH staff provided technical assistance to DHS for statute revisions related to licensed childcare providers requesting a variance to use cradleboards for cultural reasons when a parent requests one – a cradleboard is a traditional baby-carrier used by many Indigenous populations. The revised language calls for MDH and DHS to create a cradleboard variance form in partnership with tribal social service agencies. MDH assisted DHS with finalizing the cradleboard language and the form, and the language, which passed during the 2023 legislative session, became effective on January 1, 2024.

During FFY2024, MDH and DHS staff met to discuss the contents of the variance form, and MDH staff provided technical assistance and feedback on the document. After DHS approves a licensed childcare setting's request for the variance, DHS issues terms for the safe use of a cradleboard to the childcare provider that they must follow. DHS developed these terms in partnership with Tribal welfare agencies and MDH. The variance request form is now published on DHS's website for downloading or viewing.

Promote Infant Sleep Safety through Infant Safe Sleep Messaging

Minnesota observed Infant Safe Sleep Week November 12-18, 2023. During Safe Sleep Week the Governor released a proclamation, which declared the week safe sleep week in Minnesota, and provided an opportunity for individuals, organizations, government entities, health care facilities, and coalitions to promote awareness and education about safe sleep practices to ensure that infants are safe when they sleep or nap. The proclamation stated that infant mortality is a multi-factorial, complex societal problem that requires a response from across many sectors and disciplines to address conditions that negatively affect birth outcomes. Factors include maternal health and wellbeing, housing and job insecurity, environmental toxins, lack of social support and community connections, and a lack of access to health care.

Other activities during Safe Sleep Week included a press release, which called on health officials and pediatricians to emphasize the ABCs of safe sleep during patient visits, and promoted NICHD's Clear the Crib Challenge, throughout the week. The press release was carried by eleven local newspapers and radio stations across the state. During Safe Sleep Week, MDH also posted social media messages on Facebook, Twitter, and Instagram that

promoted safe sleep practices. There were approximately 39,000 views of these messages across all platforms. Additionally, staff announced Infant Safe Sleep and Infant Mortality Week in Minnesota, as well as safe sleep trainings for FHV nurses/home visitors in FHV Tuesday Topics e-newsletter, in the MNPQC newsletter, in the CHS mailbag, and on GovDelivery. The FHV Tuesday Topics e-newsletter alone is sent to more than 8,000 subscribers.

MDH also promoted infant health messages at conferences such as the AWHONN Minnesota Chapter conference in Spring 2024, the March of Dimes Walk for Babies event in May 2024, and partnered with partnered with federally qualified health centers and a local perinatal health coalition to distribute safe sleep resources. In total, MDH distributed 1,640 safe sleep books in English and Spanish, 1,250 safe sleep quick cards in English and Spanish, 200 tummy time flyers in English, and approximately 800 What Does a Safe Sleep Environment Look Like? flyer in English and Spanish.

Additionally, during FFY2024, MDHstaff shared safe sleep information, messages, and other useful resources from organizations that promote infant safe sleep such as MDH, NICHD, NICHQ, First Candle, CDC, CPSC, and AAP via mailing lists and emails with our external partners so that they can also share this information with others in their networks.

Provide Community-Centered Support for Breastfeeding

In 2024, MN WIC trained local agency WIC staff in breastfeeding skills using the USDA Breastfeeding Curriculum, and 314 MN WIC staff were trained in advanced lactation courses. Additionally, MN WIC tabled at the Minnesota Breastfeeding Coalition Annual Conference and the Black and Brown Birthing Summit to share more information about WIC breastfeeding services.

MDH staff conducted the following activities:

Supported collaboration with community partners to develop breastfeeding materials and expand outreach to targeted communities. The collaborative efforts involved meaning-making with community-specific data, determining community-specific data to share, and discussing community-driven strategies to support breastfeeding.

Collaborated with the Minnesota Breastfeeding Coalition (MBC) to provided financial and technical support to the Hmong Breastfeeding Coalition (HBC) to provide community-specific breastfeeding education.

Participated on the MBC Finance, Governance, Events Planning, and Membership subcommittees. The coalition has statewide reach and is instrumental in policy, systems, and environment change (PSE). MDH will continue to foster connections with other community organizations pursuing PSE changes designed to improve perinatal health and breastfeeding and to reduce infant and maternal morbidity and mortality.

Collaborated with the MDH Statewide Health Improvement Partnerships (SHIP) program to support local breastfeeding coalitions, and to mentor organizations to achieve workplace, public health, and childcare designation as MDH Breastfeeding-Friendly facilities.

Continued to work with contractor on the Strengthening MCH Partners Collaboration Initiative – which aims to improve collaboration to improve birth and breastfeeding outcomes. The initiative partnered with WIC local agencies and local public health to strengthen local networks and improve community partnership coordination, with an emphasis on building relationship with local hospitals and clinics.

Strengthened connections with community organizations to identify community-specific needs and opportunities around breastfeeding and lactation support and education.

Partnered with FHV programs to encourage use of their funding to provide breastfeeding counselor training for home visitors, make referrals to the MN WIC Peer Breastfeeding Support programs, and actively partner with

local breastfeeding coalitions.

Provide Professional Development Support to Emerging and Established Lactation Professionals

Efforts to diversify the community of lactation professionals in MN continued in 2024. The MBC made progress on the Next Gen project, a continuation of a partnership between Ramsey County WIC, Regions Hospital, Hennepin County WIC, Hennepin County Medical Center, and Methodist Hospital to support candidates who are completing health science courses, lactation education and mentorship through the hospital and WIC to meet the requirements to sit for the IBLCE exam. The Next Gen project is providing resources and support to the learning cohort, including in FFY2024 over $10,000 in stipends to cover tuition, exam prep and fees, and costs of acquiring mentorship hours. In addition, MBC is coordinating with area hospitals to establish internships for cohort members and working on finding funding to provide paid internships.

Provide Trainings to Promote Protective Factors for Infant Health

In December 2023, MCH staff provided a presentation/training on the AAP safe sleep recommendations to 74 home visiting nurses/home visitors who work with families in Greater Minnesota. In addition to the reviewing the recommendations, the presentation/training included safe sleep data from PRAMS and SUID data from the MDH Sudden Death in the Young Case Registry.

In 2024, FHV provided a safe sleep presentation for public health nurses/home visitors and other health professionals working with families with over 150 in attendance. This training was an opportunity to remind home visiting staff and others about the AAP safe sleep recommendations so that they can better communicate with families receiving home visiting and other services about infant sleep safety.

Additionally, to promote protective factors for infant health, FHV staff continued to encourage FHV programs to use grant funds for staff to become lactation counselors, which may support the initiation and duration of breastfeeding. FFY2024 57% (171/298) of infants whose mothers participated prenatally in MIECHV funded FHV programs received some amount of breast milk at six months of age.

Reduce Modifiable Risk Factors for Birth Defects through the IMPLICIT Model

For many years, the CSHCN and MCH sections of the CFH Division have collaborated on birth defects prevention grants. The current prevention grant focus is on interconception care and optimizing postpartum mothers' point of contact with providers through well-child visits. The IMPLICIT (Interventions to Minimize Preterm and Low birth weight Infants using Continuous Improvement Techniques) model utilizes time in the well-child visit to incorporate maternal risk assessments for mothers and birthing persons to improve birth outcomes by identifying risk factors for birth defects for future pregnancies. The model includes foci on four behavioral risks affecting future birth outcomes: smoking, depression, family planning and birth spacing, and multivitamin with folic acid use. Not only does this promising practice allow collaboration to integrate services and provide needed services and education to care givers, it also encourages providers to improve their understanding of quality improvement (QI) and implementing and evaluating evidenced-based practice in their role.

Minnesota contracted a local evaluation and research firm to recruit and implement the IMPLICIT model in clinics throughout the state over the course of five years. In FFY2024, the contractor worked with the national IMPLICIT network to continue the implementation and education of the model to Minnesota clinics. This includes, but is not limited to measuring change following implementation, increase data management and reporting, and increase capacity of building the program. Clinics sites were recruited during the five-year grant period, growing the network's reach in Minnesota. FFY2024 marks the end of the five-year grant cycle.

Throughout the course of the grant, three separate 18-month cohorts have been recruited. Prior to FFY2024, the first two cohorts were recruited, with 2 clinics in cohort 1 and 1 clinic in cohort 2. At the start of FFY2024, the clinic in

cohort 2 was coming to a finish. This clinic is a Federally Qualified Health Center in Minneapolis, serving low income and under insured families in the greater metro area. At the start of FFY2024, 2 of the 3 clinics in cohort 3 began the 18-month pilot. One clinic serves urban families in the greater metro area. The second clinic is located in rural Minnesota. The last clinic in cohort 3 began shortly after the first 2 clinics due to implementation issues surrounding staffing and record management. This clinic is a pediatric mobile unit serving families who may have transportation barriers. Past and current participating clinics have begun sustainability planning as the grant period comes to an end. Common barriers include leadership buy-in, staff capacity, and integrating electronic health records for the mother-baby dyad in the same visit.

For the clinics, this has been an innovative way to have multiple staff learn new QI practices and determine site champions to lead this work after funding is completed. The IMPLICIT Network continues to provide technical assistance and data support to participating clinics.

As the grant comes to a close, the contracted local evaluation and research firm is tasked with writing and completing a comprehensive report to cover the course of the grant, including clinic data, summary of implementation, common barriers, and sustainability planning.

LOCAL TITLE V

Supported

African American Babies Coalition (AABC)

MDH continued to manage the AABC grant to improve pregnancy and birth outcomes in African American communities. During FFY2024, AABC:

- Launched an innovative book vending machine at a local elementary school in December 2023. There was a ribbon cutting ceremony, which was attended by local elected leaders as well as the superintendent from St. Paul Public Schools; this initiative received press coverage on WCCO television, a local CBS affiliate.
- Completed a training curriculum that includes the All About Me, ACES, and Historical Trauma Training modules, and the Maternal Mental Health curriculum.
- Hosted a workshop that focused on the experiences of perinatal women while incarcerated. A total of 38 participants attended the event.
- Implemented a Healthy Birthing Campaign based on program outcomes, learnings, and insights from the community. Two of the products that resulted from this project are a 12-page booklet and posters, which were distributed at the 2024 Birth Summit.

Connected

Implement Positive Alternatives (PA) Grant Program

The PA grant program, was a statewide initiative that supported, encouraged, and assisted women to carry their pregnancies to term by offering local resources to develop and maintain family stability and self-sufficiency. PA grantees provided birthing and postpartum women with information on, referral to, and assistance with securing necessary services to promote healthy pregnancies and care for their babies after birth or in making an adoption plan. Necessary services included medical care, nutrition services, housing assistance, adoption services, education, and employment assistance, including services that support the continuation and completion of high school, childcare assistance, parenting education and other related support services. During FFY24, the number of grantees in this program reduced from 27 to 4 and the grants were awarded as transitions grants that completed in June 2024, when the program was discontinued.

In FFY2024, PA provided:

Car seat safety instruction and distribution of car seats to 50 families.

Parenting education to 370 clients.

Crib safety education and safe sleep materials including cribs and pack-n-plays provided to 828 clients.

318 material supports services provided such as diapers, maternity clothes, and infant care items.

4,139 client services in all categories across 4 PA grantees.

Promote and Support Breastfeeding through Community Engagement

MN WIC supported ten local agencies with grants up to $5,000 to support breastfeeding related projects. Projects included:

Beltrami County started a breastfeeding support group. Support groups were hosted with partners from Bemidji Area Breastfeeding Coalition, Northwest Indian Community and Development Center (NWICDC), Sanford Health, Leech Lake and Red Lake Indian Health Service. Support groups were held in several locations across the county to reach more families in need. Partnering with local indigenous lactation consultants and hosting the meetings at various community locations helped build access and culturally specific support.

Meeker, McLeod, Sibley County Health Services used funding to create a lactation education course in English and Spanish to provide to WIC participants and community partners.

Hubbard County purchased breastfeeding books to use for WIC outreach to community partners including libraries, churches, Early Childhood education and support groups. Included with the books was information about WIC breastfeeding support, and an offer of support for expanding breastfeeding friendly space in each location. As a result of outreach, the local library is working with public health to create more breastfeeding friendly spaces for families visiting the library.

Cass County WIC also purchased breastfeeding books to use in partnership with Family Spirit home visiting and at the Leech Late Tribal Annual Welcome Babies event. This outreach effort improved continuity of care for American Indian families by increasing communication between agencies and programs.

Fillmore County WIC partnered with their county libraries to create lactation education material packs for adults and children. These books and resources were highlighted by the library and will be available for patrons for years to come.

Le Sueur County WIC used funds to purchase tools to improve lactation education in WIC and lactation support items to provide to WIC and family home visiting participants to support increased initiation and duration of breastfeeding.

Nicollet county continued its billboard outreach promoting breastfeeding and WIC. The billboards used the same design which depicts real, diverse families breastfeeding, along with the tagline “Breastfeeding: Good for baby, Good for you!”. Continued outreach strengthens the message and expands the reach into new areas of the county. In addition to billboards, Nicollet County received funding to help establish a lactation support group in their community. The group leaders are Community Health Workers that are from the local Spanish and Somali speaking community.

Isanti County WIC hosted the second annual community baby shower/resource fair to promote breastfeeding resources and support services in their local community and spread the word about the new Baby Café. The event was a great success with 112 people attending and 15 organizations sharing resources at tables during the event.

Todd County and Des Moines Valley Community Health Board both received funding to improve continuity of care

between local hospital and clinic staff and WIC/public health. Both projects provided outreach to hospital and clinic staff by visiting and providing information on the public health programs available and supported advanced lactation training for at least one staff member in the community healthcare workforce. This outreach and education effort resulted in strengthened continuity of care for lactation in these communities.

Olmsted County WIC strengthened partnerships between Mayo clinic and the public health department by providing a virtual outreach and education session to Mayo clinic staff. This outreach effort was recorded to reach the most staff possible. This collaboration supports increased continuity of care between the Mayo clinic and hospital and local public health.

Provide Supports for Healthy Pregnancy and Parenting Outcomes through the African American Babies Coalition (AABC)

The AABC is a local community group through the Wilder Foundation focused on improving birth outcomes in Black and Brown communities. In 2021, the MN State Legislature allocated a total of $520,000 grant to the AABC for state FY 2022 and 2023. In 2023, the State Legislature awarded AABC-Wilder Foundation an additional $520,000 to continue its work into FY2027. The funds aim to:

Provide community-driven training and education on community-informed best practices to support healthy development of babies during pregnancy and postpartum.

Build capacity, train, educate, and improve practices among individuals, from youth to elders, serving families with members who are Black, Indigenous, or people of color during pregnancy and postpartum.

During FFY2024, Wilder-AABC has made significant and outstanding progress in building capacity, which has allowed them to successfully implement several activities in their work plan. Notable accomplishments by Wilder-AABC include that they:

Became an affiliate site of the Family Spirit Home Visiting program and began implementing the Family Spirit program—an evidence-based curriculum/program which seeks to improve outcomes during pregnancy and early childhood and hired new staff to implement the curriculum.

Expanded their partnership with Global Health Alliance to lay the foundations of a training for community-specific perinatal navigators that focused on the Birthing Fruition Health Care module.

Launched the innovative book vending machine at Maxfield Elementary in St. Paul in partnership with St. Paul Public Schools and Saint Paul Promise Neighborhoods in December 2023. There was a ribbon cutting ceremony at Maxfield Elementary, which was attended by local elected leaders as well as the superintendent from St. Paul Public Schools; this initiative has received press coverage on WCCO television.

Completed training curricula, including the All About Me, ACES, and Trauma Training modules, and the Maternal Mental Health curriculum.

Joined the Birth Justice Collaborative and hired an additional staff member focused on promoting doula access and doula business development. This will help Wilder-AABC to expand their work to increase the number of practicing doulas of color in communities.

Convened the Safer Birth Consortium, which meets twice per year to discuss what is happening in the community, identify gaps in the maternal health space, and discuss ways to collaborate in advancing maternal health equity. A total of 22 individuals attended both meetings.

Hosted a workshop that focused on the experiences of pregnant and birthing mothers while incarcerated. A total of 38 participants attended the event.

Implemented a Healthy Birthing Campaign based on program outcomes, learnings, and insights from the

community. Two of the products that resulted from this project are a 12-page booklet and posters, which Wilder distributed at the 2024 Birth Summit.

[1] Baby-Friendly USA - About (babyfriendlyusa.org)

Healthy infants, families, and communities

INFANT/PERINATAL HEALTH PLAN 2026

Description: Improve the wellbeing of families with pregnant women and infants through supports and services that are community-based and responsive to individual needs and experiences.

Background

Infancy (children under the age of 1) sets the foundation for a child's long-term wellbeing. The early years of a child's life are a time of rapid growth and development. The health of families and communities plays a crucial role in reducing infant mortality. When families have access to quality healthcare, nutritious food, safe sleeping options, safe housing, and supportive services, infants are more likely to thrive. Healthy communities, healthy families, healthy pregnancies, and strong parent-infant bonds are essential foundations for infant wellbeing. At the community level, investments in maternal health, mental health support, clean environments, and optimal healthcare systems help address the community drivers that contribute to infant mortality. By promoting the health and stability of families and the environments in which they live, we create the conditions necessary for infants not just to survive, but to grow and flourish.

> *"As a mom, I struggle knowing I have to work so my family can continue to live (I make the most money) but I also want to be home with my new baby to help her grow and continue breastfeeding as my work is demanding and my milk supply has dropped." – Minnesota PRAMS respondent*

When families struggle to get the support they need, infants don't get the stable, healthy start that is critical for their growth, development, and long-term wellbeing. It's important to focus on community-led solutions, that build local capacity, leading to more resilient and adaptable systems and creating more meaningful and lasting change.

Measuring success

Objective

By 2030, increase the percentage of infants
- placed to sleep on their backs by 10%;
- placed to sleep on a separate sleep surface by 30%;
- placed to sleep without soft objects or bedding by 10%; and
- room-sharing with an adult during sleep by 10%.

National Performance Measure

Safe Sleep

A) Percent of infants placed to sleep on their backs; B) Percent of infants placed to sleep on a separate approved sleep surface; C) Percent of infants placed to sleep without soft objects or loose bedding; D) Percent of infants room-sharing with an adult during sleep.

In Minnesota, sleep related deaths are the fourth leading cause of infant mortality, accounting for approximately 12-13% of infant deaths each year. Community support plays a vital role in preventing sleep-related infant deaths, which are often linked to unsafe sleep environments and a lack of awareness about safe sleep practices. When communities provide education and resources that are respectful of families' values, traditions, and lived experiences, families are better equipped to create safe sleep spaces—such as placing babies on their backs, using firm approved sleep surfaces, avoiding soft or loose bedding, and room-sharing with an adult during sleep. Data from the Sudden Unexpected Infant Death (SUID) and Sudden Death in the Young (SDY) Case Registry show that of the 214 SUIDs that occurred in Minnesota between 2019-2023, 96% (N=206) were linked to unsafe sleep factors such as having soft bedding/toys or someone else in the infant's sleep space.

Receiving community support and education is essential for preventing and reducing infant mortality. Minnesota's goals for FFY2026 are:

- 69.5% of infants are placed to sleep on their backs;
- 28.0% of infants are placed to sleep on a separate sleep surface;
- 80.0% of infants placed to sleep without soft objects or bedding by 10%; and
- 76.9% of infants room-sharing with an adult during sleep by.

Evidence-based/informed Strategy Measures

Safe Sleep Support and Education

Proportion of organizations that distribute cribs and/or provide safe sleep education within communities across Minnesota.

Through the Healthy Beginnings, Healthy Families Act and the Minnesota Partnership to Prevent Infant Mortality, Minnesota is supporting community-led solutions, that build local capacity by funding eligible entities to improve infant health outcomes by implementing locally relevant, data-driven strategies and activities to address the leading cause or causes of infant mortality in Minnesota, including sleep-related sudden unexpected infant deaths (SUIDs). Support from local organizations, healthcare providers, and peer networks can also help reduce barriers like lack of cribs or misinformation. By investing in community-based programs and partnerships that promote safe sleep, we can empower families with the knowledge and tools they need to protect their infants and reduce preventable tragedies.

Minnesota has selected this strategy measure to track the organizations that are providing these essential safe sleep services in community-based settings.

Strategies and activities

Through the 2025 statewide Title V needs assessment and action planning, the strategies and activities below have been highlighted to focus on for the 2025-2030 Title V grant cycle of work specific to the infant/perinatal health (IPH) population domain.

IPH Strategies

1. Amplify resources, services, and supports that are responsive to community needs and foster the health and wellbeing of families with pregnant women and infants.
2. Collaborate with trusted community organizations and partners to maximize resources that promote the health and wellbeing of pregnant women and infants.
3. Promote and strengthen development and broad representation in the workforce supporting infant health and perinatal health.
4. Enhance and integrate knowledge of the impact of parental mental health and intergenerational experiences on perinatal and infant health.

IPH Activities

STATE TITLE V

Supported

Implement Grief and Loss Support Grant with Trusted Community Organization

Minnesota will continue to partner with a trusted community organization that addresses parents' mental health needs after a perinatal loss, which ideally helps their mental health/coping for future pregnancy, or for the other infant(s)/siblings if the loss was a multiple gestation. The organization will continue outreach to community-based groups and organizations to provide a comprehensive overview of the types of grief and loss services provided, as well as the process used by the organization to connect grieving families to the resources and services they may need.

Strengthen Capacity and Connection of Family Support Organizations

Minnesota has shifted our approach in supporting caregivers of CSHCN – moving away from supporting just one organization to provide parent-to-parent support and moving toward a model that connects and strengthens capacity of all organizations who are serving families. The approach uses a collective impact framework to foster relationships between organizations and the CSHCN section to better support organizations serving families and caregivers and align efforts to transform systems. The section convened a group of community organization leaders and to codesign and complete an environmental scan aimed at better understanding common challenges and barriers faced by family support organizations. The findings of the environmental scan have been used to develop an engagement plan intended to support a network of family-serving organizations to learn together, align, and integrate actions to achieve systems change through a family support organization collaborative. The long-range plan is to build capacity of organizations so that we can work collectively to engage in policy and systems change efforts.

Connected

Addressing Intergenerational Mental Health through Family Home Visiting

Minnesota works to support the integration of family home visiting (FHV) into the state's comprehensive early childhood system through partnerships with local public and tribal health, and non-profits, to increase capacity for communities to promote the healthy development of children, secure attachments between caregivers and children, increase self-sufficiency and safety of families with infants, and improve pregnancy outcomes. Minnesota supports implementation of seven home visiting models, including: Nurse-Family Partnership, Healthy Families America, Family Spirit, Parents as Teachers, Family Connects, Early Head Start, and Maternal Early Childhood Sustained

Home Visiting. FHV models contain curricula that address parent education on child development, safe sleep, social and behavioral health, and mental health and wellbeing of caregivers, among other topics. Family home visitor also screen and provide referrals for infant mental health. Additionally, some grantees have it in their grant to specifically work with infant mental health specialists.

Community-Specific Breastfeeding Outreach, Supports, and Workforce

Community-specific Breastfeeding Outreach

Minnesota will continue to support collaboration with partners to develop breastfeeding materials and expand outreach to targeted MCH communities. The collaborative efforts with each of these communities will involve developing a better understanding of the meaning behind the community-specific data, determining community-specific data to share, and discussing community-driven strategies.

Plans for FFY2026 include connecting with community to ask for community feedback on what topics related to breastfeeding the community would like more information about, as well as general outreach and community connection through events and activities.

Access to Pasteurized Donor Milk

The Minnesota Milk Bank for Babies will continue its efforts to increase the proportion of vulnerable infants receiving pasteurized donor human milk through research into barriers to acceptance of donor milk in communities, development of community responsive education materials and education of health care workers in supporting infant feeding.

Strengthening the Lactation Workforce

The Minnesota Breastfeeding Coalition will continue its efforts to broaden and strengthen the lactation workforce through its NextGen project. The NextGen project provides funding and support to lactation supporters to become internationally board-certified lactation consultants.

Foster optimal infant health outcomes in Minnesota

Minnesota currently has four hospitals that have received safe sleep certification through four the Crib for Kids® National Safe Sleep Hospital Certification Program. Two are certified at the silver level, and two have received designation at the gold level. MN's goal is to increase the number of safe sleep certified hospitals in FFY2026. To do this, in the coming year, staff plan to:

Explore collaboration with non-profits in MN that currently collaborate with Crib for Kids to distribute cribs to families in need while in the hospital to determine strategies to encourage hospitals to become certified.

Explore working with larger hospitals, health systems and health plans on possible trainings, resource identification and supports for postpartum mothers.

Recognize hospitals publicly that have become safe sleep certified during Safe Sleep Week in MN.

Additionally, Minnesota will continue work on policy and systems changes aimed at fostering optimal infant health outcomes in Minnesota. Strategies to support Baby-Friendly hospitals and breastfeeding, will include meeting with the Minnesota Breastfeeding Coalition and Minnesota WIC staff to discuss what hospitals identified as needs in implementing the requirements. Minnesota will work with the Department of Human Services and other community partners to support legislation to increase Medicaid reimbursement to Baby-Friendly Hospitals to help hospitals recover costs for implementing activities for certification, as well as reward hospitals for saving Medicaid money by improving infant health outcomes.

Implement the CDC Infant Mortality Prevention Grant – Safe Sleep Collaborative

In FFY2023, the Maternal and Child Health Section and the Injury and Violence Prevention Section at MDH were awarded a five-year multi-component CDC grant to improve case ascertainment, data completeness, and

timeliness of sudden unexpected infant deaths (SUID) data. As part of this grant, Minnesota's first Safe Sleep Collaborative was developed and listening sessions were held in 2024. The project aims to build off the listening sessions feedback to finalize a safe sleep strategic/action plan and Community Action Teams to implement priority recommendations. These activities will be advised by an interdisciplinary Community Safe Sleep Leadership Team comprised of 15 community members who will oversee the planning and implementation phases of the project in partnership with MDH. In FFY2026, the collaborative will draft and publish a safe sleep strategic/action plan that is informed by the results of the listening sessions and the SWOT analysis.

Implement the IMPLICIT Model to Screen for Maternal Risk Factors During Well Child Visits

For many years, the CSHCN and MCH sections in the CFH Division have collaborated on birth defects prevention grants and continue to focus on interconception care and optimizing postpartum mothers' point of contact with providers through well-child visits. Minnesota plans to continue and expand the evidence-based IMPLICIT model (Interventions to Minimize Preterm and Low Birth Weight Infants using Continuous Quality Improvement Techniques) in Minnesota. The IMPLICIT model utilizes time in the well-child visit to incorporate maternal risk assessments for mothers and birthing persons to improve birth outcomes. The model includes foci on four behavioral risks affecting future birth outcomes: smoking, depression, family planning and birth spacing, and multivitamin with folic acid use. Not only does this promising practice allow collaboration to integrate services, provide needed services and education to care givers, it also encourages providers to improve their understanding of quality improvement and implementing and evaluating evidenced-based practice in their role.

The national IMPLICIT Network developed, assessed, and integrated this evidence-based model for the past 10 years, and are working in partnership with MDH and the March of Dimes to disseminate this interconception model. Additionally, Minnesota contracted a local evaluation and research firm to recruit and implement the IMPLICIT model in clinics throughout the state over the course of 5 years.

Implement the Minnesota Partnership to Prevent Infant Mortality Grant

The Healthy Beginnings, Healthy Families program was codified into the Minnesota state legislature in 2023. Through the infant health grants offered by this program, MDH will continue to support community-led safe sleep education and support, with an aim to reduce infant mortality by decreasing the incidence of sleep-related tragedies among infants through use of specific, community-based best practices.

In FFY2026, MDH will promote consistent safe sleep messaging statewide and collaborate with our community partners and the Minnesota Partnership to Prevent Infant Mortality grantees to expand community-based infant mortality prevention and specific resources for populations at greatest risk of experiencing an infant death.

Implement Universal Congenital Cytomegalovirus (cCMV) Newborn Screening and Prevention

During FFY2026, Minnesota will continue implementing the cCMV Prevention and Outreach strategic plan, which includes:

- Maintenance and evaluation of a CMV media campaign that is aimed at the general public. There will be materials that are specifically catered for our priority populations. Our contractor will create an evaluation report to determine the effectiveness of this campaign.
- The CMV Outreach and Prevention team will establish and continue connecting with key partners and trusted messengers to collaborate in reaching priority audiences.
- MDH will establish a presence at community events to spread awareness of CMV.
- The CMV Nurse Specialist will continue to engage with healthcare providers that might serve pregnant women and their families to disseminate important information that should relayed to their patients.
- Attend professional conferences to create a network of key professionals and spread awareness on how CMV may be relevant to their careers.

Host webinars for a variety of audiences in order to provide long form content surrounding CMV awareness.

Establish key partnerships with childcare providers.

Foster relationships in the Deaf and Hard of Hearing Community through professionals and families.

Continue to implement and improve universal cCMV screening as part of the Newborn Screening Program.

Improve Collaboration to Improve Birth and Breastfeeding Outcomes

In FFY2026, Minnesota WIC will aim to improve collaboration to improve birth and breastfeeding outcomes through various partnerships, including the following:

Minnesota WIC will collaborate with the MDH Statewide Health Improvement Partnerships (SHIP) program to support local breastfeeding coalitions, and to mentor organizations to achieve workplace, public health, and childcare designation as MDH Breastfeeding-Friendly facilities.

Minnesota will continue to work with contractor on the Strengthening Maternal and Child Health (MCH) Partners Collaboration Initiative. The initiative will partner with WIC local agencies and local public health to strengthen local networks and improve community partnership coordination, with an emphasis on building relationship with local hospitals and clinics.

Strengthen connections with community organizations, including the Twin Cities Regional Breastfeeding Coalition, the MNPQC, the Minnesota Perinatal Organization and the BECC is ongoing.

Aim to improve breastfeeding rates through MN WIC's Peer Breastfeeding Support Program (PBSP). PBSP will continue documenting in the WIC Information System to improve continuity of care across the WIC staff team.

Partner with family home visiting programs to encourage use of their funding to provide breastfeeding counselor training for home visitors, make referrals to the Minnesota WIC Peer Breastfeeding Support programs, and actively partner with local breastfeeding coalitions.

Partner with Minnesota Breastfeeding Coalition to continue exploring the feasibility of a certificate program in lactation at St. Catherine University, which would provide the prerequisites required for certification as an IBCLC.

Increase the Number of MDH Breastfeeding-Friendly Recognized Birth Centers

With funding from the Statewide Health Improvement Partnership (SHIP), Minnesota Breastfeeding Coalition staff will continue to facilitate a 10-Step Learning Collaborative (10-SLC) to work on implementation of the World Health Organization's Ten Steps to Successful Breastfeeding. The 10-SLC brings together staff from hospitals and free-standing birth centers across the state to work on a minimum of two steps, utilizing the MDH Breastfeeding-Friendly Birthing Center 5-Star Recognition Program guidance and tools. SHIP is updating their breastfeeding strategies to include supporting facilities in implementing breastfeeding friendly birthing center practices to sustain the efforts of the 10-SLC through ongoing public health programs.

Partnering with Communities to Support Infant Safe Sleep Practices

To ensure that infant mortality prevention strategies reach Minnesota families, we plan to collaborate with existing community-based infant mortality initiatives to further define strategies that support infant health promotion. We will use these partnerships to engage families from these communities for their input and recommendations for strategies to reduce the incidence of preterm birth, low birth weight, and birth defects, and to support infant safe sleep practices within their communities. Using this community input will help build interventions tailored to meet

each community's unique needs and strengths and provide a foundation to expand other activities to promote infant health and reduce infant mortality.

Minnesota will continue to use social media and other communication methods to disseminate information and resources to improve infant health and safety practices. Minnesota will also explore the possibility of presenting infant health promotion information (on infant safe sleep and shaken baby prevention to middle and high school students, since some students may have younger siblings, are sometimes babysitters for neighbors, friends, and relatives, or may become parents themselves.

Additionally, Although Minnesota has its own safe sleep campaign, the agency participates in the National Institute of Child Health and Development's (NICHD) Safe to Sleep campaign, including NICHD's safe sleep resources that target the public, parents, caregivers, grandparents, racial/ethnic groups, and health care providers. In addition to distributing the NICHD's resources, Minnesota will continue to disseminate the comprehensive safe sleep resources it has developed in house.

Provide support to parents of infants who are Deaf and Hard of Hearing.

Minnesota's Early Hearing Detection and Intervention (EHDI) Program oversees and administers state grant funding to Minnesota Hands and Voices to implement a statewide parent support program for families of children who are deaf or hard of hearing. The program utilizes trained parents of children who are deaf or hard of hearing as parent guides. The guides are located throughout Minnesota. Parent guides contact each family of a child newly identified as deaf or hard of hearing through the state's EHDI program to provide ongoing parent support, information and referral, education, and networking opportunities. The Minnesota EHDI Parent Support Program will continue throughout the upcoming project period. Minnesota Depart of Health's grant with Minnesota Hands and Voices continues through FFY2027.

Support the Minnesota Perinatal Quality Collaborative and AIM Bundles

The Minnesota Perinatal Quality Collaborative (MNPQC) is a network of organizations, medical providers, content experts, and community voices lead by the Minnesota Perinatal organization in partnership with Minnesota Department of Health. The MNPQC seeks to improve perinatal and infant health outcomes with an emphasis on improving health for all birthing experiences. The MNPQC is a critical partner for the I-MOM (Innovations in Maternal Outcomes in Minnesota) program funded by a 5-year grant from the Health Resources and Services Administration (HRSA). One key goal of the I-MOM program is to identify and implement AIM (Alliance for Innovation on Maternal Health) patient safety bundles by providing training to support quality improvement initiatives designed to improve perinatal health outcomes. The MNPQC began their first AIM bundle focused on the care for pregnant and postpartum women with substance use disorder. The MNPQC provides a platform for multiple innovation strategies through implementing a quality improvement model with technical assistance activities designed to support a successful AIM program. Technical assistance sessions are held with hospital teams across half a dozen health systems, including in implementation of interventions that build on team requirements to complete state required trainings. The MNPQC works in partnership with the I-MOM data team and the MNPQC data workgroup to navigate data challenges to support timely AIM data submissions.

LOCAL TITLE V

Supported

Increase Representation of Communities Served within Program Materials, Resources, and Implementation

LPH agencies in FFY2026 will continue to increase representation of the communities they serve within their

program materials, resources, and implementation. Local public health agencies aim to reflect the communities they serve within the implementation of programs through translation of program documents and resources in different languages and developing materials specifically aimed to educate staff on working within specific communities. For example, one community health board has developed information sheets on each of the communities they serve to more responsively meet the needs of these communities. To increase building proficiency with family home visiting staff on the use of translators, one community health board will be continuing work in FFY2026 to offer training to staff on the use of interpreters within program implementation to improve the quality of interactions with families.

Strengthen Partnerships to Build Cross-Sector Collaborations for Services, Supports, Resources, and Referrals

LPH agencies in Minnesota recognize the importance of building and sustaining strong relationships with community partners, including those across sectors, to develop and deliver programs and services that are appropriate for and responsive to individual and family needs. Example of how LPH agencies are and will continue to do this include:

A five-county perinatal collaborative that aims to provide pregnant and postpartum resources to families. Within this larger collaborative is the Perinatal Substance Use Disorder and Mental Health Collaborative that includes partners from public health, clinics/hospitals, mental health providers, substance use disorder treatment providers, families, and local tribes. The goal is to build a strong multidisciplinary continuum of services for birthing people with SUD and mental health issues.

Invite collective input and efforts through action work groups that include community partners and families.

Connect with Community Health Workers working within local hospitals or hire community health workers to partner with local hospitals.

Participate in collaborative outreach efforts including multi-partner community fairs (E.g., Multi-lingual Resource Fair, Family Wellness Fair); one-on-one connections with area clinics and providers to educate them regarding LPH and partners' services for pregnant moms; ongoing referral partnership with local hospitals who provide referrals of new moms and local public health visits them in the hospital after birth; conduct outreach regularly with clinics, WIC, social services in partnership with community advisory board; and meet annually with local pediatric providers to explain services that are offered.

Participate in trusted messenger program which is a community engagement model that is a partnership between LPH and local community organizations to share community responsive resources and referrals.

Collaborate with school districts to provide breastfeeding education and support.

Partner with local early childhood programs and early childhood family education to enhance communication and referrals, provide program information during parenting classes, and provide a welcome baby class to expecting families.

Present with a local partner at Lunch and Learns for pregnant and parenting families.

Support Professional Development for Emerging and Established Local Public Health Staff and Partners

LPH staff and their partners recognize that there is a need for continuous learning and development for public health professionals to appropriately and responsively address the needs of the individuals, families, and communities they are working with. LPH agencies and partners across the state support professional development for staff in a variety of ways, including the following examples, and will continue to do so in FFY2026:

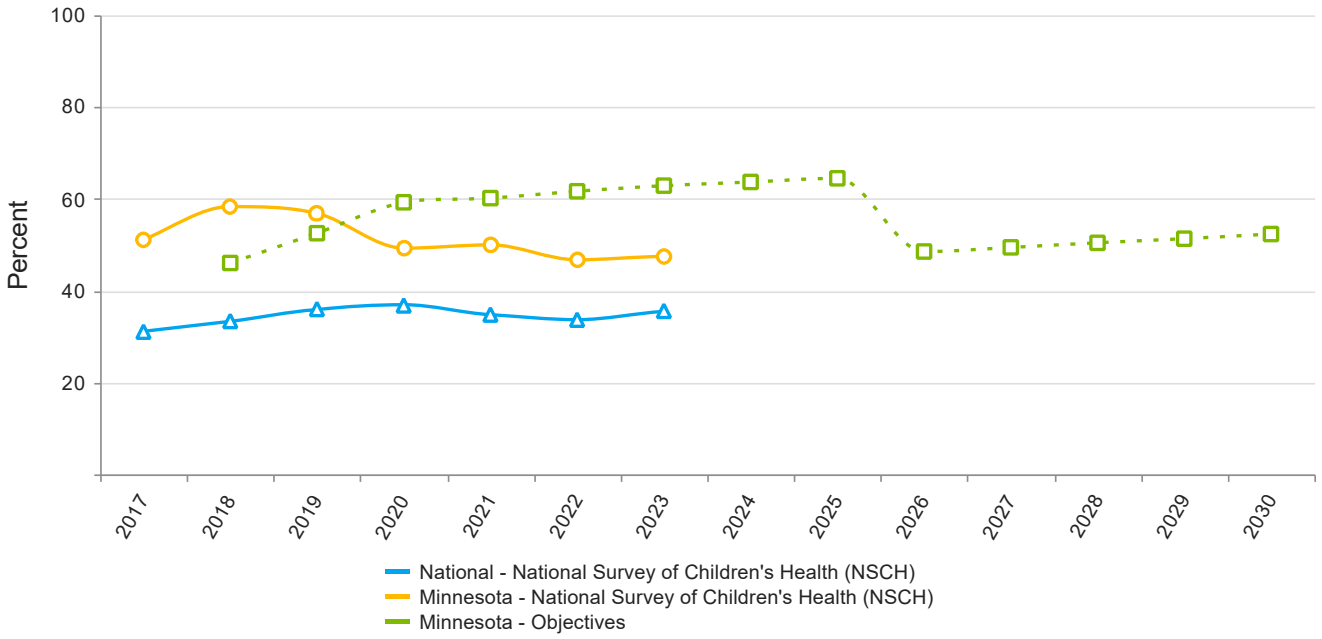
The Minnesota Breastfeeding Coalition (MBC) fosters the leadership development of representatives from communities throughout the state through continued partnerships with local WIC offices, health systems, and birthing centers. Funding will be sought for development of a long-term, sustainable pathway for increased

representation in lactation leadership in Minnesota.
Enhancing our training opportunities, including aiming to complete the Mothers and Babies training and the Circle of Security training.
Provide differential for language skills used with families to provide program services.
Include objectives with their strategic plan focused on staff recruitment, retention, and development.
Continue host and mentor nursing students from local colleges and universities.
Adding a family health team lead position to support staff and allow more time for continuous quality improvement (CQI) initiatives.
Train public health nurses who conduct family home visiting in perinatal mental health through Perinatal Support International.
Offer grants to child welfare social workers, clinic/hospital nurses, and mental health providers in the community for professional development.
Exploring the feasibility of hiring a mental health therapist to be on the team of home visitors.
Staffed get trained in maternal mental health.
Contract-service agreement with community liaison from community being served.
Schedule regular family home visiting group consultation time with infant mental health provider.
Provide group reflective consultation with an infant mental health consultant.

National Performance Measures

NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	59.2	60.1	61.6	62.8	63.6
Annual Indicator	57.5	48.7	48.7	46.8	47.5
Numerator	102,904	88,434	77,155	74,250	75,127
Denominator	178,996	181,694	158,549	158,739	158,050
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	48.5	49.4	50.4	51.3	52.3

Evidence-Based or –Informed Strategy Measures

ESM DS.1 - Percent of developmental/social-emotional screens that were completed electronically through the Follow Along Program (FAP) in the past year.

Measure Status:	Inactive - Replaced

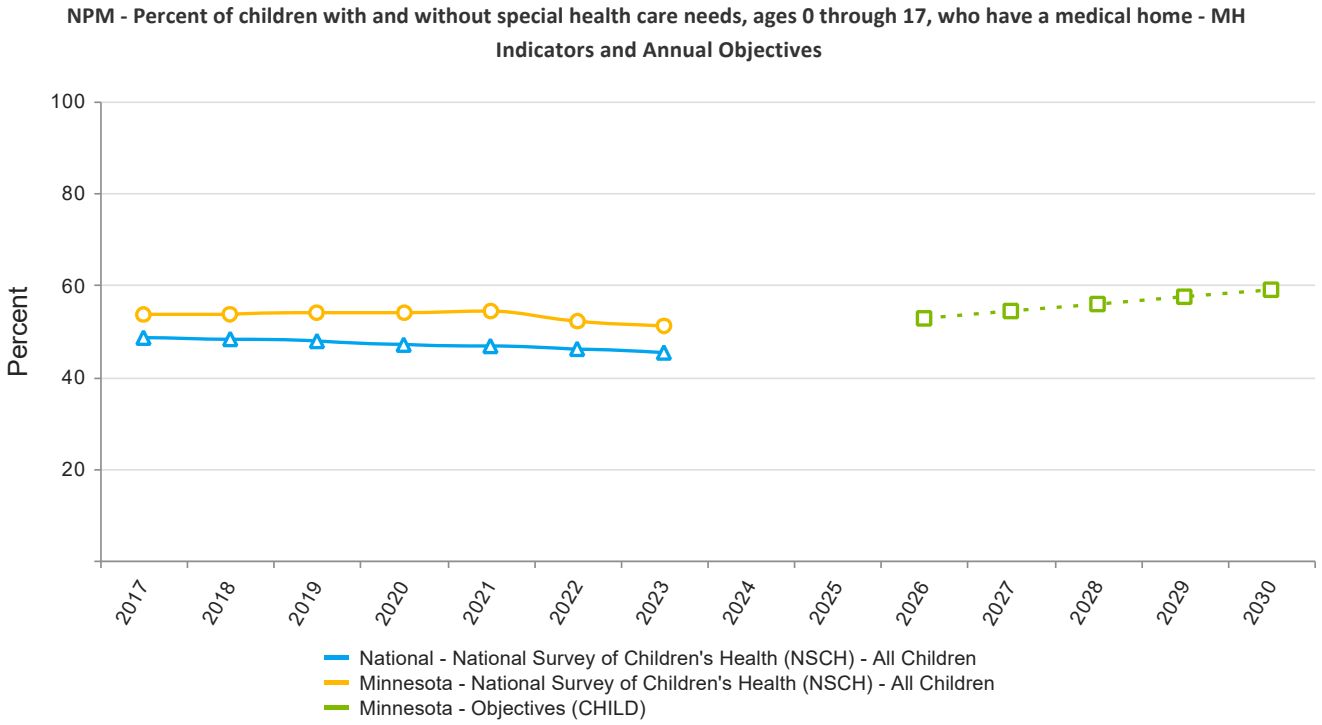
State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		15	15	16	18
Annual Indicator		2.6	6.2	4.5	5.1
Numerator		480	997	687	940
Denominator		18,533	16,089	15,231	18,318
Data Source		Follow Along Program Data	Follow Along Program Data	Follow Along Program Data	Follow Along Program Data
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

ESM DS.2 - Percent of developmental/social-emotional screens that were completed through the Follow Along Program (FAP) in the past year.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	41.0	42.0	43.0	44.0	45.0



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	52.0	51.2
Numerator	675,201	662,037
Denominator	1,299,339	1,292,206
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	52.7	54.3	55.8	57.4	58.9

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Percent of care coordinators reporting increased knowledge in serving CSHCN and their families after participating in Community of Practice (CoP) webinars.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	70.0	72.0	74.0	76.0	78.0

State Action Plan Table

State Action Plan Table (Minnesota) - Child Health - Entry 1

Priority Need

Child mental health and wellbeing

NPM

NPM - Developmental Screening

Five-Year Objectives

By 2030, increase the percentage of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool by 10%.

Strategies

Amplify resources, screening, training, services, and supports that are responsive to and address the needs of children and their communities.

Provide resources and support for school-based health centers and school nurses to address mental health and wellbeing for children in schools.

Increase capacity of the child health workforce to provide wellbeing and mental health support across the state.

ESMs	Status
ESM DS.1 - Percent of developmental/social-emotional screens that were completed electronically through the Follow Along Program (FAP) in the past year.	Inactive
ESM DS.2 - Percent of developmental/social-emotional screens that were completed through the Follow Along Program (FAP) in the past year.	Active

NOMs

School Readiness

Children's Health Status

State Action Plan Table (Minnesota) - Child Health - Entry 2

Priority Need

Child mental health and wellbeing

NPM

NPM - Medical Home

Five-Year Objectives

By 2030, increase the percentage of children who have a medical home by 15%.

Strategies

Ensure children from all populations and geographic areas have access to mental health and wellbeing promotion, screening, and resources.

ESMs	Status
ESM MH.1 - Percent of care coordinators reporting increased knowledge in serving CSHCN and their families after participating in Community of Practice (CoP) webinars.	Active

NOMs

Children's Health Status

CSHCN Systems of Care

Flourishing - Young Child

Flourishing - Child Adolescent - CSHCN

Flourishing - Child Adolescent - All

Comprehensive Early Childhood Systems

CHILD HEALTH 2024 REPORT

Description: Ensuring Minnesota has systems that link young children and their families to all the support and services they need.

Background

Minnesota's five-year comprehensive needs assessment identified a significant area of need in ensuring Minnesota has systems that link young children and their families to all the support and services they need. It is Minnesota's child health priority area.

Minnesota is focused on enhancing coordination and connections between families and services across a multitude of early childhood settings, to ensure that Minnesota has systems that link young children and their families to all the support and services they need.

Every family should have an equal opportunity to access health care, mental health services, early care and education, and local services and resources that are culturally honoring and support health, development, and safety. However, Minnesota faces significant challenges in implementing a coordinated and efficient system of care for children and their families. The array of early childhood programs is complex and fragmented, due in part to differences in the way programs are funded and variations in their eligibility and other requirements, making the early childhood system in Minnesota difficult to navigate.

This complexity is especially troubling as we know that health impacts start early in the lifespan in Minnesota. More work is needed to address barriers that influence these health impacts, including:

- Poverty rates (100% Federal Poverty Level) – 29% of African American/Black and 43% of American Indian children (ages 1 through 9) in MN are living in poverty compared with only 8% of Asian and Pacific Islander and 5% of white children.[1]
- Economic and food assistance rates – 88.5% of African American/Black and 79.3% of American Indian/Alaska Native kindergarteners received economic assistance and/or food assistance, while only 30.3% of white kindergartners received assistance.[2]
- Infant mortality rates – American Indian and African American pregnant women experience infant mortality at a higher rate (13.5 and 10.3 per 1,000 live births respectively), when compared to white mothers (3.1 per 1,000 live births).[3] These families are more than 3 times more likely to experience this outcome.
- Developmental and social-emotional screening rates – Data from Minnesota Health Care Programs shows that American Indian and white children consistently having the lowest rates compared to children of other races. American Indian children have a screening rate of 31.8%. This is comparted to rates around 40% for the rest race/ethnicities.[4] Children living in rural areas also experience lower rates of screenings.
- Out-of-Home Care – As of 2022, American Indian children in MN were 16 times more likely to experience out-of-home care than white children in the state.[5]
- Math and Reading Proficiencies – Math and reading proficiency is much lower for American Indian, Hispanic, and African American/Black children, with reading proficiency at 30.9%, 27.9%, and 28.0 % respectively. This is compared to reading proficiency of White children, which is at 56.4% as of 2023-2023 school year. A similar trend is seen with math scores, with American Indian, Hispanic, and Black children having 36.6%, 34.5%, and 33.0% math proficiency respectively, compared to 70.9% for white children.[6]

Many projects and grants over the last ten years have worked to develop and improve comprehensive early childhood systems across government agencies in MN. Formal recommendations in 2016 from local partners to the state, along with the results of an audit by the Office of Legislative Auditor in 2018, confirmed the need for a centralized system for resource navigation, referral and follow-through, and documentation of gaps and barriers in the system. During the recent *Preschool Development Birth to Five Grant* (PDG) needs assessment and strategic planning process, parents and providers shared their perspectives on the current assets and barriers that impact families who are experiencing racial, geographic, and economic inequities. Recommendations gathered through the Title V Needs Assessment confirmed the importance of this work and elevated this as a priority for MDH and stakeholders to focus on in the 2020 Title V five-year needs assessment.

Additionally, in 2019, Governor Walz and Lt. Governor Peggy Flanagan, re-launched MN's Children's Cabinet, originally established in 1993, with the commitment to "Placing Children at the Center of Government".[7] MN's Children's Cabinet is an interagency partnership of 22 state agencies working to bring efficiency and effectiveness to state government efforts to improve child and youth outcomes. The Cabinet utilizes a results-based accountability lens in these priority areas:

- Healthy Beginnings (addressing infant and maternal mortality)
- Child Care and Early Education
- Mental Health and Wellbeing
- Housing Stability
- Child Wellbeing

"The Cabinet works to take data-driven and results-oriented approach to coordinating, streamlining programs, aligning strategies, and promoting action and accountability of MN's efforts to ensure that each and every MN child, no matter race or zip code, is prepared to be a leader of tomorrow."[8]

In MN, public health and human services operate under local control with services delivered at the county- and tribal-level in MN's 87 counties and 11 tribal nations and communities. Similarly, early education intervention services for infants and toddlers with special health care needs and their families operate in over 300 independent school districts. Tribal nations offer locally provided services that reflect the values and traditions of their communities. Anecdotes from statewide providers consistently indicate that services are unavailable, unknown, or hard to access, but there is no comprehensive statewide data that defines actual service gaps and barriers.

Measuring success

Objective

By 2025, increase the percentage of children receiving developmental screening by 10%.

National Performance Measure

Developmental Screening

Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year.

The 2022-2023 National Survey of Children's Health (NSCH) shows that 47.5% of children living in MN, ages 9-35 months, received a parent-completed developmental screening. This slightly higher than NSCH data from 2021-2022 and but not back to the levels seen prior to 2020.

Evidence-Informed Strategy Measures

Electronic Developmental/Social-Emotional Screening

Percent of developmental/social-emotional screens that were completed electronically through the Follow Along Program (FAP) in the past year.

MN is tracking the percent of developmental and social-emotional screens completed electronically through the Follow Along Program (FAP), as compared to those completed on paper. The FAP helps identify developmental and social-emotional needs in young children by using the Ages and Stages Questionnaires®, Third Edition (ASQ®-3) and the Ages & Stages Questionnaires®: Social-Emotional, Second Edition (ASQ®:SE-2) at age-appropriate intervals.

During the FFY2024, a total of 18,318 screens were conducted through the FAP. Of those, 940 were completed electronically – representing approximately 5.1% of all screens.

This measure was selected based on input from early childhood partners and public health staff who identified electronic access to screening tools as a way to improve convenience for families, reduce administrative burden for providers, and promote more timely support and referral. In particular, electronic screening was viewed as a promising strategy to support family access to recommended periodic screenings.

While interest in electronic screening has been high, adoption has remained low for several reasons:

- **Platform navigation challenges**: Many local agencies have found it difficult to transition from paper-based to electronic systems due to the complexity of setup and lack of dedicated IT support.
- **Family usability concerns**: The current ASQ online platform does not allow families to pause and return to a partially completed screening, which limits flexibility—especially for those with time constraints or limited device access.
- **Voluntary participation**: Counties are not required to use the electronic platform, and many have opted to continue using familiar paper-based processes.
- **Data and process alignment**: Shared data collection and tracking protocols are still being developed collaboratively between MDH and local public health agencies.

Strategies and activities

CH Strategies

1. Coordinate Access to Comprehensive, Family-Centered Early Childhood Services Activities.
2. Maximize and Increase Funding to Support Statewide Programs that Serve Families Who are Pregnant and Parenting Young Children Activities.

Activities

STATE TITLE V

Supported

Increase Access to Developmental and Social-Emotional Screening and Follow-Up

Follow Along Program (FAP)

During FFY2024, Minnesota Department of Health (MDH) continued to administer the FAP in partnership with local public health (LPH) agencies through ongoing grant agreements. The program provides families periodic

developmental and social-emotional screenings for children from birth through age three, with some counties extending services through kindergarten. Families also receive follow-up guidance and connection to community resources as needed.

Through funds from the state's Healthy Beginnings, Healthy Families Act, MDH provides a base award to community health boards (CHBs) to implement the FAP – these funds go toward distributing the screening tools to families, scoring them, and following-up when concerns are noted. Currently, all but six counties have decided to accept these funds and are implementing the program. Many counties also report using a portion of the Title V funds allocated to them to support implementation of the FAP. The program serves over 11,800 children across the state with 3,962 new enrollments between January 2022 and December 2024, over 92,000 developmental screenings were sent to families. In addition, over 1,600 referrals were made to Part C/Early Childhood Special Education, and nearly 1500 referrals made to primary care providers. There were over 4000 new enrollments to FAP in 2024.
MDH advanced its multi-year effort to evaluate and strengthen the FAP by incorporating feedback from families, LPH staff, and early childhood system partners. Activities during the reporting period focused on the developing and initiating an enhanced program model designed to improve access, streamline processes, and support long-term sustainability. This work was supported by state legislative funding secured in a previous session.

Key components of the updated model developed during FFY2024 included:

- Planning for a centralized intake and screening process to promote timely access to appropriate resources.
- Maintaining strong local leadership for follow-up and community-based referrals.
- Strengthening coordination with community-based organizations to ensure materials and services are responsive to the needs of families.
- Expanding efforts to raise awareness of the program and reduce participation barriers across different regions and communities.

MDH also collaborated with Brookes Publishing, the developer of the Ages and Stages Questionnaires® (ASQ®-3 and ASQ®:SE-2), to begin incorporating additional questions designed to help identify children and families who might need added support due to experiences of potentially traumatic events.

Development also continued on a new data system to improve data collection, streamline local reporting, and support future interoperability with other early childhood systems – while maintaining strong protections for family information.

Electronic Developmental and Social-Emotional Screening

During FFY2024, MDH continued to offer counties access to the ASQ® Online screening system, which allows families to complete screenings electronically and enables local agencies to review results and provide appropriate follow-up. While participation in the electronic platform remained voluntary, interest among counties continued to grow.

To support implementation, MDH facilitated regular virtual Open Office Hour sessions for participating agencies. These sessions provided opportunities for counties to share experiences, address implementation barriers, and explore strategies for improving coordination. Feedback gathered during these sessions informed ongoing planning for a potential statewide screening portal aimed at supporting more consistent and accessible screening across Minnesota.

MDH also shared input from families, providers, and community partners – gathered through FAP coordination and Office Hour discussions – through its participation in Brookes Publishing's national ASQ® Online Community of Practice. This feedback contributed to ongoing improvements to the ASQ® online platform.

While technical assistance for the electronic screening platform was provided directly by Brookes Publishing, MDH continued to serve as a connector between local agencies and Brookes staff, helping ensure participating counties could access the support and resources needed for effective implementation.

CSHCN staff also collaborated with the Help Me Connect (HMC) Coordinator to explore how electronic screening tools could be integrated into broader early childhood navigation platforms, including the new HMC Navigator.

Promote Best Practices in Developmental Screening through Child and Teen Checkups (C&TC)

MDH provided monthly consultation with Minnesota Department of Human Services (DHS) on policy to drive improvements in developmental and mental health screening and referral for Minnesota's C&TC program - Minnesota's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. MDH did this work through an interagency agreement with DHS to provide consultation, training, and technical assistance to DHS, C&TC providers, and others across the state who provide child preventive health screenings and referral.

In FFY2024, Minnesota:

Continued to emphasize developmental and mental health screening as recommended components for C&TC visits (birth through age 20), and for postpartum screening during infant well visits.

Conducted 28 trainings (Developmental and Social-Emotional Screening and Best Practices in Well Child Screening trainings) for health care providers, local public health, school nurses and early childhood screeners.

Provide training to state university nurse practitioner programs on C&TC developmental, social-emotional, and autism screening including guidance on referral process and resources.

Co-led the Minnesota Interagency Developmental Task Force with the Minnesota Department of Education.

Hosted and revised the Task Force's webpages.

Contracted with Metre to help the State of Minnesota develop consistent screening messaging in plain language. The messaging tools developed can be used by providers in various areas to spread awareness of the importance, benefits, and requirements of development and social-emotional screening. Created a communications toolkit and report.

Helped plan a cultural adaption/norming and dissemination project for the Ages & Stages Questionnaires, Third Edition (ASQ-3) and Ages & Stages Questionnaires: Social-Emotional, Second Edition (ASQ:SE-2) for American Indian Families in Minnesota. Drafted a funding proposal to obtain funding for this project.

Collaborated on Minnesota Interagency Autism Workgroup to improve the reach of screening, evaluation, and treatment resources related to autism and other developmental delays.

Participated on the MDH Early Childhood Workgroup to focus on increasing developmental and social-emotional screening.

Promote Connections between Family Home Visiting (FHV) and Early Childhood Systems

Minnesota FHV grantees include activities in their annual workplan to meet the objective of receiving community input and participant/family voice to continually inform and improve programs. Many grantees meet this objective through forming a community advisory board that includes representation from community partners who are part of the early childhood system. Progress on meeting this objective is discussed at grantee site visits and is reported on in their narrative reports. *Introduction to Using the Ages and Stages Questionnaires* training was offered quarterly to train more than 110 home visitors. This training includes information on referrals and connections to early childhood services that benefit families.

Promote the Implementation of Family Home Visiting Models that Support Families with Young Children

During FFY2024, MDH FHV staff continued to routinely connect with LPH agencies to review FHV models, explore options to maximize funding, and focus efforts to promote access to a broader population of families with young children.

Through a combination of state and federal funding, MDH FHV continues to award over $25 million to support evidence-based models of family home visiting to 44 community health boards, 4 tribal nations and 17 non-profits. In FFY2024, there was at least one evidence-based program funded in all 87 Minnesota counties.

An additional $3 million in state funding was granted to support programs continue to support using evidence-informed and promising practices in their implementation of family home visiting, including continued funding for 4 community health boards and 6 non-profits plus start-up funding for 2 new community health boards and 2 new non-profits. These grants support programs to serve priority populations not currently reached including families affected by homelessness, intimate partner violence, substance use disorder, serious persistent mental illness, high-risk pregnancies, and post-partum depression. Promising Practices home visiting programs also support Black, Indigenous, and People of Color (BIPOC) rural and urban underserved communities who need culturally and linguistically appropriate home visiting services. Recipients of Promising Practice funding have increased flexibility in terms of frequency of visits, adaptive FHV models, and staffing models (community health workers, birth and post-partum doulas, peer support recovery specialists, etc.) as compared to programs who have been funded to implement one of the seven evidence-based family home visiting models that have been approved for past competitive FHV funding.

Currently, this funding only serves approximately 10% of families who could benefit from home visiting services.

Connected

Align education and care systems through the Preschool Development Grant

Minnesota's Preschool Development Birth through Five grant is a partnership of the Minnesota Departments of Education, Health, Human Services, and Children, Youth, and Families, along with the Children's Cabinet to align education and care systems across the state. The grant from the U.S. Department of Health and Human Services supports pregnant families and families with children aged 5 and younger. Minnesota was awarded a $24 million Preschool Development Grant Birth-Five Renewal Grant for 2024-2027. The Minnesota Title V team worked closely with the Preschool Development Grant team, especially the Preschool Development Grant Coordinator housed in MDH's Child and Family Health Division. Grant activities were determined through an in-depth needs assessment and strategic planning process – which last took place in 2023-2024.

Champion MN's Integrated Care for Early Childhood Initiative

During FFY2024, CFH staff partnered to implement the Minnesota Integrated Care for Early Childhood Initiative (MN-ICECI), which is funded by an Early Childhood Comprehensive Systems: Health Integration Prenatal-to-Three Program grant from HRSA. MN-ICECI is a collaborative effort focused on strengthening connections across Minnesota's early childhood systems to better support young children (ages 0–3 years) and their families.

The initiative is guided by a representative Community Advisory Council (CAC) and works toward five strategic goals rooted in family partnership, cross-sector collaboration, community voice, and systems improvement. The CAC finalized its Strategic Plan in the Fall 2023 and completed a baseline evaluation in the Fall 2024. The evaluation plan was shaped by input from families and community partners. Findings were shared in two feedback sessions and helped shape revisions to the evaluation plan for the coming year.

The CAC identified the establishment of a Family Health Ambassador Corps as a central strategy to advancing initiative goals. Ambassadors are parents and caregivers with lived experience navigating early childhood systems. Since launching in May 2024, the Ambassador Corps has become a key part of MN-ICECI's approach — offering

family-level support while also contributing to systems learning and improvement.

Ambassadors play dual roles:

Providing trusted peer support and resource navigation to families; and

Sharing family experiences and insights within the CAC and other system-level efforts to strengthen early childhood services.

After an outreach and recruitment process, 17 people applied to serve as Ambassadors. Interviews were completed with 12 candidates, and all 12 were invited to join the inaugural cohort.

Coordinate the MN Help Me Connect (HMC) Online Navigator and Referral System

MN Help Me Connect (www.helpmeconnectmn.org) launched in May 2021 as an interactive directory that connects expectant families and families with young children to services in their local communities that support healthy child development and family well-being. Families and professionals can search a database of over 16,000 available programs and services available in Minnesota and eleven Tribal Nations, such as healthy development and screening resources, early learning and childcare programs, pregnancy support services, disability resources, basic needs, and more. The online resource is available is English, Spanish, Somali and Hmong. Over 200,000 users visited the site in 2024 with top key word searches for diapers, housing, transportation, Early Childhood Family Education, autism, mental health and crisis. Trends from web site analytics, feedback surveys, and ongoing community engagement activities continue to determine and prioritize technical improvements and content additions. Recent enhancements include a new search engine and a referral system for professionals to connect families directly to community organizations.

HMC was adopted into MN State Statute 145.988 during the 2023 legislative session and now receives annual funding of $920,000 to ongoing maintenance, database management and numerous enhancement activities. The Help Me Connect program moved to a new state agency – the Department of Children, Youth and Families – in January 2025 with a variety of programs from the Departments of Human Services, Education, and Public Safety that focus on early childhood and family support services. Interagency collaboration with the Department of Health will continue long-term to maintain connections and assure information on HMC is maintained and updated consistently.

[1] US Census American Community Survey (ACS) Microdata Sample, 2023

[2] MN ECLDS, 2022-2023

[3] 2023 MN Final Resident Linked Birth-Infant Period Cohort Death File

[4] MN Health Care Programs Developmental and Mental Health Screening Data, 2023

[5] MN's Out-of-Home Care and Permanency Report 2022

[6] MN ECLDS, 2022-2023

[7] Executive Order 19-34: 2019_08_07_19-34_tcm1055-397454.pdf (mn.gov)

[8] Children's Cabinet / MN Management and Budget (MMB) (mn.gov)

Child mental health and wellbeing

CHILD HEALTH PLAN 2026

Description: Increase the number of children who are screened for and connected with mental, behavior, and wellbeing resources and services that are responsive to individual needs and experiences.

Background

Childhood is a period of rapid development in language and motor skills and social-emotional processing. Having positive mental health and wellbeing are essential, as it supports children's ability to learn, grow, and reach their full potential. In Minnesota, 81% of children (6 months through 6 years) and 59.9% of children (ages 6-11 years old) are flourishing.[1] Minnesota children are more like to be flourishing than the national average in early childhood, but school aged children are less likely met all flourishing items than the national average. Flourishing is a measure that aims to capture curiosity and discovery about learning, resilience, and self-regulation from the National Survey of Children's Health (NSCH).

Another great metric to track child mental health and wellbeing is measuring kindergarten readiness. The healthy and ready to learn measure from NSCH helps Minnesota understand and identify how many children who would benefit from additional supports. In Minnesota, 68% of children ages 3 through 5 are on track for school readiness, compared with 64.6% nationwide (NSCH, 2022-2023).

> *"A challenge that we've experienced recently is helping our 7-year-old with anxiety. We've got a lot of privilege and time to work with her, but we're just realizing how little support is available in our schools and in the community to help parents and children with challenges. It feels like we make families wait until things are a crisis before there's some kind of community support." – Minnesota Story Collective*

Developmental screenings are important to child health because they can help detect developmental delays in things such as language and motor skills, cognitive abilities, social skills, and emotional processing. The brain is developing quickly during all phases of early childhood, so it is essential to detect and address potential issues as early as possible. According to the National Survey of Children's Health, only 30% of children ages 9-35 months received a parent-completed standardized developmental screening. Identification and treatment of developmental disorders are more effective when addressed during a child's early years so there is great emphasis on being proactive in completed screenings as early as possible and at a certain frequency.

Measuring success

Objective

By 2030, increase the percentage of children who have a medical home by 15% and increase the percentage of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool by 10%.

National Performance Measures

Medical Home

Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Medical Home is one of two Universal National Performance Measures (NPMs) required for all Title V programs. This measure focuses on access to comprehensive, high quality primary care for children and is intended to drive improvements in early identification, ongoing care, and system navigation.

A medical home is an approach to delivering care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and respectful of family preferences and values. All children benefit from care that reflects this model, which supports their preventive, acute, and chronic health needs from infancy through adolescence.

Data from 2022-2023 National Survey of Children's Health (NSCH) shows that 51.3% of all children and youth in Minnesota reported having a medical home. Minnesota's goal for FFY2026 is to increase this to 52.5%.

The medical home model also plays a key role in advancing the state's child health priority of improving mental health and wellbeing. By promoting trusted relationships, consistent care, and strong care coordination, medical homes can help ensure that children are screened for mental and behavioral health needs and connected with trauma-responsive services that reflect family preferences and communication needs. This whole-child approach integrates physical, emotional, and behavioral health to support children's overall development and long-term wellbeing.

Developmental Screening

Percent of children, ages 9 through 35 months, receiving a developmental screening using a parent-completed screening tool.

Developmental screening is a key component of promoting healthy early childhood development. Regular screening helps identify potential delays in areas such as language, motor skills, cognitive development, social interaction, and emotional processing and regulation. Because the brain is developing rapidly in the earliest years of life, early detection and intervention are critical for supporting children's growth, learning, and long-term wellbeing.

As part of the Child Health Domain, Minnesota has selected developmental screening as a NPM to advance our priority of increasing the number of children who are screened for and connected with trauma-responsive services that align with family preferences, values, and communication needs, supporting their mental, behavioral, and emotional wellbeing.

According to the 2022-2023 NSCH, 47.5% of Minnesota children ages 9-35 months received developmental screening in the past year using a parent-completed screening tool. Minnesota's goal for FFY2026 is to increase this to 48.5%.

Routine developmental screening—especially when conducted in settings that center family partnership—helps ensure that concerns are identified early and that families are supported in navigating next steps, whether that includes further evaluation, developmental supports, or early intervention services. Increasing developmental screening rates is one way Minnesota is working to strengthen early identification, expand access to services, and support positive outcomes for all young children and their families.

Evidence-based/informed Strategy Measures

Follow Along Program

Percent of developmental/social-emotional screens that were completed through the Follow Along Program (FAP) in the past year.

This strategy measure aims to improve access to developmental screening, which helps children get access to the support they need in early childhood. The Follow Along Program (FAP), administered by MDH in partnership with local public health (LPH) agencies, provides families with regular opportunities to monitor their child's development through parent-completed screening tools. These include the Ages and Stages Questionnaires®, Third Edition (ASQ®-3) and the Ages & Stages Questionnaires®: Social-Emotional, Second Edition (ASQ®:SE-2), which assess general development and social-emotional milestones.

Families receive the questionnaires at scheduled intervals beginning in infancy and continuing through age three, with some counties extending support through kindergarten. When a completed form is returned, families receive timely feedback, developmentally appropriate activity ideas, and follow-up contact if developmental concerns are identified. Through this process, the FAP supports both early identification of developmental delays and connection to follow-up services or community-based supports when appropriate.

By measuring the percentage of families who return a completed screening tool, this strategy helps assess the extent of family engagement with the FAP. Higher engagement leads to more completed screenings and enables LPH to follow-up with families to support connection to appropriate care – including coordinated and responsive primary care that aligns with the medical home model.

Increasing screening completion through FAP directly supports Minnesota's child health priority to equip families with tools to monitor their child's development, recognize early signs of concern, and access trauma-responsive services that reflect family preferences and needs. This strategy also strengthens local public health infrastructure by fostering trusted, ongoing relationships between families and public health professionals, and by promoting consistent access to early developmental supports.

Strategies and activities

Through the 2025 statewide Title V needs assessment and action planning, the strategies and activities below have been highlighted to focus on for the 2025-2030 Title V grant cycle of work specific to the child health (CH) population domain.

CH Strategies

1. Amplify resources, screening, training, services, and supports that are responsive to and address the needs of children and their communities.
2. Ensure children from all populations and geographic areas have access to mental health and wellbeing promotion, screening, and resources.
3. Provide resources and support for school-based health centers and school nurses to address mental health and wellbeing for children in schools.
4. Increase capacity of the child health workforce to provide wellbeing and mental health support across the state.

CH Activities

STATE TITLE V

Supported

Align education and care systems through the Preschool Development Grant

Minnesota's Preschool Development Birth through Five grant is a partnership of the Minnesota Departments of Education, Health, Human Services, and Children, Youth, and Families, along with the Children's Cabinet to align

education and care systems across the state. The grant from the U.S. Department of Health and Human Services supports pregnant families and families with children aged 5 and younger. Minnesota was awarded a $24 million Preschool Development Grant Birth-Five Renewal Grant for 2024-2027. The Minnesota Title V team works closely with the Preschool Development Grant team, especially the Preschool Development Grant Coordinator housed in MDH's Child and Family Health Division.

Grant activities are determined through an in-depth needs assessment and strategic planning process – which last took place in 2023-2024. Activities to have come out of this process and that the Minnesota Title V team will continue to support in FFY2026 include:

Implementation of Community Resource Hubs/Centers – community based coordinated points of entry that provide community responsive, relationship-based service navigation and other supportive services for expecting and parenting families and youth.

Implementation of the Help Me Connect Online Navigation System.

Implementation of the MN StoryCollective storytelling project that works with community partners to collect stories.

Supporting Community Solutions for Healthy Child Development Grants to fund community solutions to improve the wellbeing of children from prenatal to grade three and their families.

Expand Access to Developmental Screening through Electronic Tools

Minnesota is working to expand access to developmental and social-emotional screening through continued use of the ASQ® Online system and the planned development of a new mobile screening application. This effort supports broader strategies to improve timely screening and follow-up through the Follow Along Program (FAP), in collaboration with LPH and early childhood partners. The ASQ® Online system and mobile screening application will connect with MDH's internal data systems to enhance coordination, streamline data sharing, and better support families and providers.

While electronic use remains limited, families and providers have identified it as a promising strategy to increase convenience, reduce administrative burden, and improve access to timely screening and referrals. At the same time, Minnesota recognizes that a mobile screening application is not the right fit for all families or providers. Some agencies face setup challenges and limited IT support. Families have also experienced usability barriers, such as the current ASQ® Online system not allowing them to pause and return later. Because participation in electronic screening is voluntary, many agencies continue to use familiar and effective paper-based workflows.

Minnesota is therefore pursuing this transition thoughtfully and incrementally, with the goal of expanding access without disrupting trusted local processes. The mobile screening application is being designed to be flexible and user-friendly, offering another option—not a replacement—for how families engage in screening. MDH will continue to prioritize strong relationships with local partners and families, ensuring implementation reflects local needs and preferences.

In FFY2026, Minnesota will continue to support the ASQ® Online system while exploring options for a new mobile screening application as part of the enhanced Follow Along Program model. MDH will work with partners to develop a plan for phased implementation, with the possibility of initiating early use in select counties that are ready to adopt the new system. The mobile screening application will be designed to improve accessibility, ease of use, and coordination with follow-up systems—supporting timely identification of developmental needs and stronger connections to services, while maintaining flexibility for families and providers.

Expand Early Childhood Coordination and Initiatives within the Child and Family Health Division

A new Early Childhood Systems position will be created, shifting how the Child and Family Health division is organizing early childhood work. In early FFY2026, we will be launching a collaborative process to align early childhood priorities across the division, honoring the strong work already underway while also creating a shared path forward.

Strengthen Access to Developmental and Social-Emotional Screening and Follow-up through the Follow Along Program (FAP)

As we move into FFY2026, Minnesota will continue to strengthen access to developmental and social-emotional screening and follow-up through the FAP. As described in the child health 2024 report and ESM sections, the FAP is administered by MDH in partnership with LPH agencies and provides regular parent-completed screening opportunities for families with young children, along with follow-up support and developmental activities.

During FFY2026, MDH will continue to administer the FAP through grant agreements with LPH agencies and will ensure adherence to established program standards. We will also work to strengthen coordination between the FAP, primary care providers, and early intervention programs, helping ensure families receive timely and connected supports when developmental concerns are identified. MDH is also working to expand the availability of the FAP statewide, recognizing that not all counties currently offer the program.

To improve the FAP's reach and relevance for all Minnesota families, MDH is in the process of evaluating and enhancing the program model, with phased implementation beginning in FFY2026. Enhancements are based on ongoing input from families, providers, and community partners and will include:

- Development of a cohesive program brand and updated outreach materials that are clear and family centered.
- Exploration and initial implementation of a mobile application where families can learn about child development, complete screening questionnaires, and access information and supports.
- Continuation of a Community Connector partnership to assist families in navigating early childhood systems – including learning about and enrolling in the FAP. Community Connectors offer direct support to families.

The Community Connector initiative includes grants to eight community-based organizations to pilot and implement this model. The primary goals are to:

- Increase awareness of the FAP among families with young children.
- Support participation by providing navigation assistance and strengthening connections with available services.
- Ensure materials and services are aligned with families' communication needs and local contexts.
- Encourage ongoing engagement by helping families understand and act on screening results and recommendations.

Finally, MDH will begin development of a modernized data system to support more efficient and secure collection, analysis, and use of screening and follow-up data. The system will be designed with interoperability in mind, to enhance alignment with related early childhood systems and support data-informed program improvements over time.

Connected

Implement Promising Practices Grant Program

Through 2023 state legislation, Minnesota was able to begin funding tribal nations, non-profit organizations, and community health boards to expand access to community-based family home visiting programs (FHV) for priority and hard to reach populations through the Promising Practices grant program. Promising Practices program explores flexible and non-model approaches to FHV implementation and service delivery. Priority populations

include families experiencing housing insecurity or homelessness, substance use disorder (SUD), serious persistent mental illness (SPMI), and/or intimate partner violence (IPV); families currently living in a domestic violence shelter; and/or families with limited access to evidence-based or other family home visiting services. Family home visitors seek to understand community health drivers for families by asking what resources are and are not available in their communities, including mental health, healthcare, postpartum depression supports, and early childhood supports. Minnesota will continue supporting Promising Practices grantees in FFY2026.

Provide Technical Assistance to Expand Opportunities for Collaboration Between the Health Care System and Schools

In 2023, Minnesota legislation established funding to support existing and emerging school-based clinics. In 2024, MDH established a School Based Health Center (SBHC) program that awarded funding to six grantees through a competitive RFP process.

Additionally, the Minnesota School Based Health Alliance is a grantee of MDH and provides technical assistance and support for all Minnesota SBHC's. Minnesota will continue to provide support to these grantees in FFY2026.

MDH staff will continue to improve collaboration with schools, school nurses, and SBHCs as primary entry points to improved health care for children. In FFY2026, MDH will:

Continue to support new and emerging school-based health centers.

Build the Capacity of School-Based Health Care in Minnesota – Build the capacity of the Minnesota School-Based Health Alliance (SBHA), a nonprofit organization that supports the sustainability, quality, and expansion of school-based health care near or inside of Minnesota's schools.

Build State Capacity to Address Health Needs of Students– MDH and the Minnesota Department of Education are partnering with the National Association of School Nurses (NASN) to focus on professional development for school nurses to in relation to school nursing practice specifically mental health of student.

The School Nursing Collaborative will plan to continue to develop education and training and practice tools for the school nursing practice as well as promoting and increasing participation in NASN Every Student Counts national data collection.

MDH will continue to host monthly school health webinars, open office hours, and Basecamp.

Improve Data Sharing, Collection, and Use – MDH and MN SBHA are working collaboratively with the National SBHA, and the sponsoring agencies overseeing SBHCs in MN to develop dataset tools that will be made available to schools that are in the planning process for developing a SBHC.

Support School Based Health Centers – In collaboration with the MN School-Based Health Alliance and SBHC sponsoring agencies, Minnesota will support the integration of mental health services, innovation of screening services and tools, and expansion of comprehensive services for school-based health centers across the state.

Support Mental Health and Wellbeing through Family Home Visiting Supports

Family home visiting (FHV) is an effective upstream intervention that serves as a key link to other early childhood interventions and community supports, such as health care, mental health, early intervention, early care and education, and other services that promote healthy child development and collectively make a difference in the lives of children and their families. FHV models and curriculum include information about screening for and accessing mental health services for young children in their training for home visitors, especially around connections to community supports and working closely with primary care providers.

Additionally, family home visiting programs are emphasizing the importance of social connectedness for both parents and children by hosting more group events that bring people together for services and supports. LPH

agencies have reported strong successes with community baby showers and Baby Café's, for example.

The Promising Practices family home visiting program has also encouraged each family home visiting team of grantees to have a designated person as the mental-health and wellbeing resource to promote wellness practices. Funds have been allocated specifically for these mental health and wellness activities.

FHV staff in the Child and Family Health Division will continue provide technical assistance and other supports to LPH agencies implementing FHV in their communities in FFY2026.

LOCAL TITLE V

Supported

Providing Family Home Visiting for Families that Don't Meet Requirements for Other Models or Funding

Family Home Visiting (FHV) provides social, emotional, health-related, and parenting support and information to more than 6,500 of Minnesota's families that are low income or have limited availability of health services, and links them to appropriate resources.

The positive impacts of FHV on children and families' mental health and wellbeing are numerous, yet, LPH continue to see gaps in the funding and models available for children and families that do not meet the necessary requirements. Some community health boards (CHBs) share that Title V is their primary source of funding to provide FHV services, while others utilize it to provide FHV services for families who fall within these gaps, for example families who don't have insurance or use private insurance. CHBs will continue utilizing Title V funds to fill these service gaps for children and families in their communities.

Leverage Limited Capacity in Small Teams

LPH agencies, particularly in rural Minnesota, often have limited workforce capacity due to funding and availability of qualified workers. As such, many, if not all, staff within these agencies work in multiple programs like WIC, child and teen checkups, MCH, TANF, and more, at the local level. While this presents a lot of limitations and impacts for both staff and target populations, it also presents a strength because staff become knowledgeable and familiar with a variety of programs and are able to provider quick referrals and resources. While continuing to operate in limited capacity in the coming FFY, LPH staff will continue to leverage this as opportunities for quick referrals and provision of supports for children and families in need of mental health and wellbeing services and supports.

Partner with Trusted Community Agencies to Serve Local Populations

LPH agencies continue to work closely with local community agencies in effort to serve local populations. For example, one LPH agency has and will continue to work closely with several local community agencies well-known in the community and who serve key populations. This has created a critical network of support and partnership for meeting the needs of these populations that the LPH agency wouldn't have been able to do on their own.

Connected

Establish New and Ongoing Connections to Access Local Populations

Even without strong data infrastructure in many LPH agencies throughout Minnesota, some are able to see that their outreach efforts are not accessing some of the target populations who may benefit from their services and supports. These LPH agencies work creatively to determine methods for reaching these populations and will continue to do so in FFY2026. For example:

Family home visiting public health nurses attend community food pantry events to promote services and provide resources to families, as well conducting outreach in hospital postpartum units.

One LPH agency is working on making new connections with referral agencies and prioritizing outreach in

communities in their jurisdiction that might have less resources available by being outside of the city.
Host Celebrate the Young Child events three times per year with collaboration from early childhood in the local school district which includes inviting partners, specifically mental health providers to talk with parents of children 0-8.

Individual and Team-Based Reflective Practice

Evidence-based home visiting nurses have reflective supervision in all LPH agencies who receive evidence-based home visiting funding. Additionally, LPH MCH teams conduct regular team meetings and case conferences for support. One LPH agency contracts with an Infant Mental Health specialist who attends monthly meetings with the nurses. Other LPH agencies use similar approaches, for example, contracting with Infant Mental Health consultants to assist with reflections on cases with public health nurses individually and as a team.

Others use innovative approaches to include social workers and/or community health workers as partners with the public health nurse. One agency uses a care team approach in their Home Visiting Program partnering social workers and/or community health workers with an MCH nurse to work together with the family. Another agency includes social workers on the FHV team to assist families with getting resources and connect to additional services.

Strengthen Data Infrastructure to Understand Outreach Efforts

Several LPH agencies report that they are and/or aim to continue building their data infrastructure to better understand where their outreach efforts are targeted and impacting versus what geographic areas we serve across all of their Family Health programs (Follow Along, Family Home Visiting, WIC, CTC, etc.) to ensure our geographic outreach to those served matches their goals.

Strengthen Partnerships between Local Public Health and School Based Health Teams

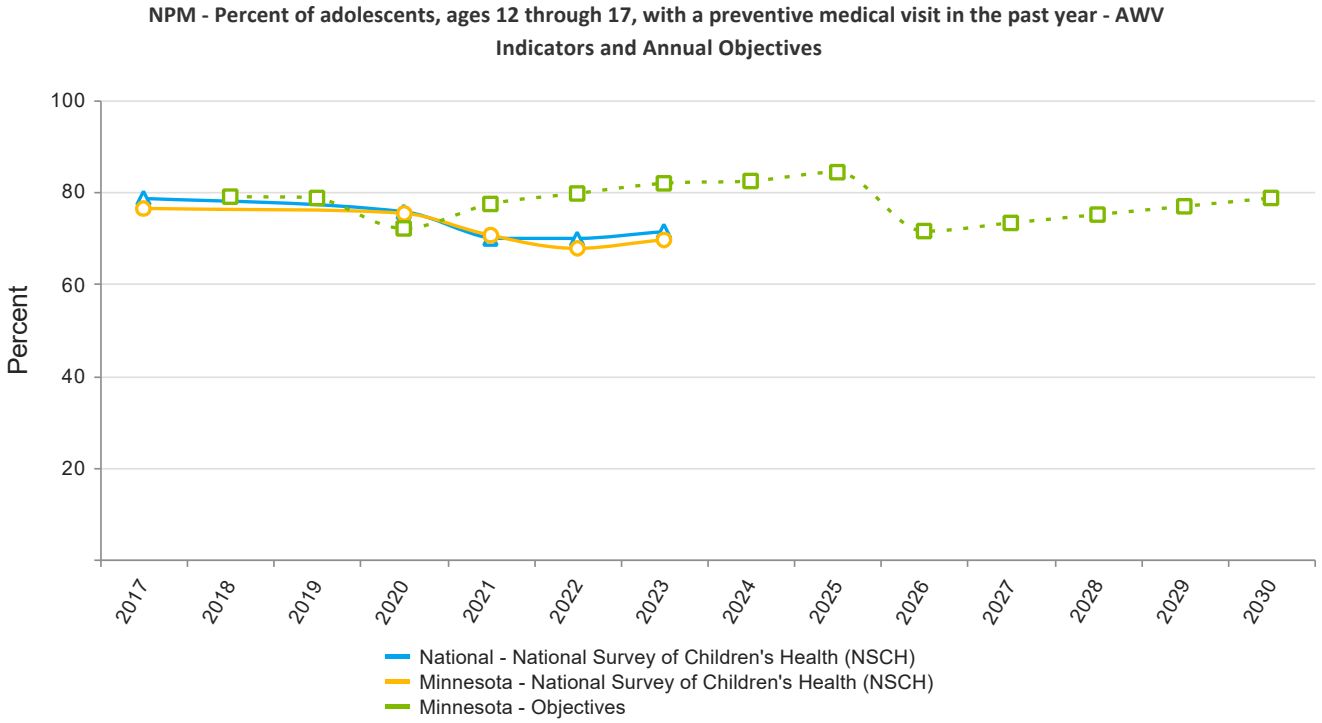
LPH and school-based health teams are creating and continuing to build on strong partnerships across Minnesota, including:

Partnering to provide school-based health in local schools.
Employing school nurses to work within school districts who hold trainings and make referrals to behavioral health in the schools and outside agencies.
Interact on a regular basis with the local schools, including participation in early childhood screenings and assisting with resources and referrals.
Having a public health nurse whose work is dedicated to working on projects to promote health with schools within the county.
Partnering with schools to provide supports for children facing chronic health needs such as asthma.
Staff attend a quarterly regional school nurse meeting to share and learn information.
Expanding new and supporting existing school-based health centers (SBHC) throughout the state.
Supporting grants, technical assistance and training to new and emerging SBHCs throughout the state.
Supporting existing SBHCs through grants, training, and technical assistance.
Collaboratively working with the MN SBHC Alliance technical assistance agency, the MN State Program Office, and the National SBHC Alliance to support MN SBHCs.

[1] A response of "Usually" or "Always" to the question indicate the child meets the flourishing item criteria. To learn more about the development of flourishing measures, see the "Flourishing From the Start: What Is It and How Can It Be Measured?" issue brief.

Adolescent Health

National Performance Measures



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	72	77.3	79.6	81.8	82.3
Annual Indicator	79.3	75.5	70.7	67.6	69.6
Numerator	304,000	306,842	303,301	294,767	309,080
Denominator	383,452	406,593	429,104	435,815	444,075
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	71.4	73.2	75.0	76.8	78.6

Evidence-Based or –Informed Strategy Measures

ESM AWV.1 - Percentage of Child and Teen Checkups (C&TC) where depression screenings are occurring for adolescents enrolled in Minnesota Health Care Programs (MHCP)

Measure Status:	Inactive - Replaced

State Provided Data					
	2020	2021	2022	2023	2024
Annual Objective		65.9	67.2	68.5	69.8
Annual Indicator	64.6	65	66.7	66.6	68.4
Numerator	70,259	58,080	80,787	81,361	89,296
Denominator	108,842	89,322	121,119	122,133	130,582
Data Source	MHCP Data	MHCP Data	MHCP	MHCP	MHCP
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

ESM AWV.2 - Percent of adolescent students who report that they would have done "nothing" and/or "I'm not sure" to take care of your health problems/needs if their school did not have a School Based Health Clinic (SBHC).

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	45.0	45.0	45.0	45.0	45.0

State Action Plan Table

State Action Plan Table (Minnesota) - Adolescent Health - Entry 1	
Priority Need	
Adolescent mental health and wellbeing	
NPM	
NPM - Adolescent Well-Visit	
Five-Year Objectives	
By 2030, increase the percentage of adolescents who received a preventative medical visit in the past year by 13% to 78.6%.	
Strategies	
Amplify resources, services, and supports for adolescents who are medically underserved and at greater risk for poor health outcomes.	
Build community capacity to support and increase access to adolescent-centered physical and mental health resources and supports.	
Nourish transformation of systems, environments, and norms that support adolescents in self and community care.	
Promote change in societal attitudes by challenging stigma and harmful beliefs toward adolescent mental health and illness.	
ESMs	**Status**
ESM AWV.1 - Percentage of Child and Teen Checkups (C&TC) where depression screenings are occurring for adolescents enrolled in Minnesota Health Care Programs (MHCP)	Inactive
ESM AWV.2 - Percent of adolescent students who report that they would have done “nothing” and/or “I’m not sure” to take care of your health problems/needs if their school did not have a School Based Health Clinic (SBHC).	Active

NOMs

- Teen Births
- Adolescent Mortality
- Adolescent Motor Vehicle Death
- Adolescent Suicide
- Adolescent Firearm Death
- Adolescent Injury Hospitalization
- Children's Health Status
- Child Obesity
- Adolescent Depression/Anxiety
- CSHCN Systems of Care
- Flourishing - Child Adolescent - CSHCN
- Flourishing - Child Adolescent - All

Adolescent suicide

ADOLESCENT HEALTH REPORT 2024

Description: Reduce the number of youths who take their own life.

Background

Minnesota's five-year 2020 comprehensive needs assessment identified a significant area of need in reduction of the number of youths who take their own life, making adolescent suicide the adolescent health (AH) priority area for Minnesota.

MN suicide prevention efforts are based on evidence that most suicides are preventable, mental illness is treatable, and recovery is possible with appropriate supports and intervention. The strongest suicide prevention efforts are multifactorial, requiring a combination of familial support, community connection, and behavioral health treatment. According to the 2022 MN Student Survey, 29% of students reporting dealing with long-term (problems lasting 6 months or more) mental health problems (up from 23% in 2019 and 18% in 2016).

MN has seen higher rates of suicide among youth than the national average for a long time. Suicide is the second leading cause of death among people ages 10-24, and is not experienced equally across age groups, genders, sexual orientations, or geography in MN.[1]

There is not one single path that leads to suicide. Many factors can increase the risk of suicidal thoughts and behaviors, such as childhood trauma and adversity, serious mental illness, physical illness, alcohol or other substance use, a painful loss, exposure to violence, social isolation, and easy access to lethal means. Factors such as meaningful relationships, coping skills and safe and supportive communities can decrease the risk of suicidal thoughts and behaviors. Adolescent suicide prevention efforts require improving access to comprehensive mental health services and building communities that support the mental well-being of youth and their families.

A 2024 Kaiser Family Foundation analysis of data from the Teen National Health Interview Survey showed that in 2021 and 2022, 21% of adolescents (ages 12-17) reported experiencing symptoms of anxiety and 17% reported experiencing symptom of depression. The rate of suicide and self-harm among adolescents has decreased in 2022 after peaking in 2018, however there is a possibility that suicides are being underreported due to some being incorrectly labeled as overdoses. In addition, suicide deaths are increasing faster among adolescents of color when compared to their white peers, with American Indian adolescents death rate from suicide being three times higher than white youth (22.2 vs 7.2 per 100,000).[2] There is also a noticeable unmet need for mental health services, especially among female and LGBQ adolescents, with 32% and 35% respectively reporting that they were not receiving the mental health therapy they needed because of the cost, fear of what others would think, and/or just not knowing how to get help.

Measuring success

Objective

By 2025, increase the percentage of adolescents who received a preventative medical visit in the past year by 10%

National Performance Measure

Preventive Medical Visit

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

An annual preventive well visit can help adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease, including mental health issues. Additionally, they can play a role in preventing adolescent suicides. According to the American Academy of Pediatrics:

> *"At well-adolescent visits, adolescents who show any evidence of psychosocial or adaptive difficulties should be assessed regularly for mental health concerns and also asked about suicidal ideation, physical and sexual abuse, bullying, substance use, and sexual orientation."*[3]

Data from the 2022-2023 National Survey of Children's Health (NSCH) shows that 69.6% of adolescents (ages 12 through 17) had a preventive medical visit in the past year. This is down from 77.8% seen in the 2021-2022 data and similar to the data seen in the 2020-2021 data, at 70.7%.

Evidence-Based/Informed Strategy Measure

Depression Screenings

Percent of well-visits where depression screenings are occurring for adolescents enrolled in Minnesota Health Care Programs (MHCP).

Although helping young people prevent depression, suicide, and other problems is a community-wide effort, primary care providers are well situated to discuss risks, provide screening, and offer interventions. Offering screening and follow-up at preventive visits helps ensure that young people receive mental health services and support.

In 2023, the percentage of well-visits where depression screenings are occurring for adolescents enrolled in MHCP was at 68.3%. A total of 89,296 children received mental health screenings.

Strategies and activities

AH Strategies

1. Empower Youth, Young Adults, Families, and Communities to Meaningfully Engage in Creating Solutions to Prevent Suicide Activities.
2. Expand and Improve Postvention Supports Activities.
3. Reduce Access to Lethal Means.

AH Activities

STATE TITLE V

Supported

Partner to Implement the Minnesota Partnership for Adolescent and Young Adult Health (MNPAH) Strategic Plan

During this period, a new State Adolescent Health Coordinator responsible for coordinating MNPAH, was hired. The State Adolescent Health Coordinator partnered with agencies to strengthen youth's overall resiliency and wellbeing. She participated in the Title V Needs Assessment Steering Committee. She also participated in division-wide

mental health strategic planning efforts. This position also led the Child and Adolescent Health Subcommittee of the Maternal and Child Health Advisory Committee. The subcommittee was new this fiscal year, and they focused on establishing their charge, building relationships, and adding members. Alongside supporting adolescent-related MCH efforts at the Advisory Committee, the subcommittee will be the community advisory group guiding MNPAH implementation.

The MNPAH partner newsletter (currently with a subscriber count of over 7000) featured several partners focusing on adolescent mental health and the need for positive connections with supportive adults.

MNPAH promoted high quality, teen friendly health care through sharing of best practices by co-hosting a webinar series on the Radical Healing model. Two of five webinars were hosted during FFY2024.

MDH worked closely with MDE and other interagency partners to plan for and support the Minnesota Student Survey, to be administered in early 2025. The State Adolescent Health Coordinator, with support from MDH epidemiologists, began to create a Data Book designed for community partner use about a variety of health topics, with a significant focus on mental health and wellbeing for adolescents.

Connected

Improving care coordination through centralized resource tools

During FFY2024, MDH continued to collaborate with mental health organizations to implement and maintain the Mental Health Collaboration Hub (MHCH), a real-time database designed to facilitate timely placement for youth in emergency departments. The MHCH remained active throughout FFY2024, hosting weekly case consultation calls with 20–30 participants working together to reduce emergency department boarding and connect youth to appropriate care settings.

As of November 2024, the MHCH included 229 participating organizations and 512 registered users. During the reporting period, 292 children and adolescents (ages 8 to 17) were supported through the MHCH's online portal and collaborative case consultation process. Among participating cases, the average number of days youth spent boarded in emergency departments was reduced by approximately 55%, reflecting significant gains in timely connection to appropriate services and supports.

Partner in Building Capacity of Primary Care Providers in Identifying and Responding to Mental Health Concerns

In September 2021, Minnesota received a five-year American Rescue Plan Act – Pediatric Mental Health Care Access – New Area Expansion grant from HRSA. This grant supports efforts to strengthen the ability of pediatric primary care providers to identify and respond to mental and behavioral health needs in children and adolescents. During FFY2024, key activities included:

Maintaining a collaborative leadership structure. Minnesota convened a Steering Committee in Spring 2023, building on the existing Mental Health Workgroup from the Minnesota Chapter of the American Academy of Pediatrics (MN-AAP). The committee met quarterly throughout the year and included clinical leaders and individuals with firsthand experience navigating pediatric mental health systems.

Enhancing the Psychiatric Assistance Line (PAL). Minnesota continued operating its statewide, legislatively authorized Psychiatric Assistance Line (PAL), which offers clinical consultation and referral support to providers. In early 2024, PAL expanded its team to include specialists in neurodevelopmental conditions, substance use, and perinatal mental health. Staff conducted outreach to primary care providers through conferences and other events, and worked with MDH to update the PAL data system to better track consultation trends and understand common provider needs and child characteristics.

Expanding provider training on pediatric mental health. The MNAAP delivered quality improvement training and support to pediatric providers, focused on effective approaches to identifying and responding to mental health concerns. The training met requirements for Maintenance of Certification (MOC Part 4), and planning began for an additional MOC4 cohort to launch in 2025.

Partner to Implement Identified Strategies from the Minnesota Suicide Prevention State Plan

Minnesota Department of Health (MDH) coordinates the state's suicide prevention efforts per Minnesota Statute, section 145.56 and in accordance with the State Suicide Prevention Plan. MDH Suicide Prevention unit is the lead for Minnesota's suicide prevention efforts and in partnership with others, prioritize suicide prevention statewide.

The MDH suicide prevention unit servers as a leader, convener, and a connector for the Minnesota State Suicide Prevention Taskforce, a large group comprised of experts in mental health promotion, suicide prevention, intervention, and postvention efforts and in partnerships with communities, and state agencies. The State Suicide Prevention Plan is implemented with the help of MDH, state agencies, and community partners. The State Suicide Prevention Plan empowers communities to collaborate and implement a comprehensive approach to suicide prevention. In SFY2024, the Taskforce had a combined member ship of 95 plus members.

The Taskforce is also responsible for developing and updating the State Suicide Prevention Plan and ensuring the goals, objectives and strategies are communicated and met. The current goals of the State Suicide Prevention Plan are to:

Increase individuals, organizations, and communities' capacity to develop and implement a comprehensive approach to suicide prevention.

Promote factors that offer protection for suicidal experience across the individual, relationship, community, and societal levels.

Identify and support individuals who are experiencing mental health challenges or who are having suicidal experiences.

Strengthen access and delivery of care for mental health and suicide.

Connect, heal, and restore hope for those impacted by suicide.

Improve the timeliness and usefulness of data.

The Taskforce, along with its four active subcommittees and several ad-hoc committees are committed to moving suicide prevention efforts forward in MN. The subcommittees have responsibility for implementing the goals and the objectives laid out in the State Plan and are comprised of individuals interested in a specific topic related to one of the goals. The four primary subcommittees' topics are:

Mental Health and Wellbeing – responsible of guiding the implementation of the mental health promotion and suicide prevention strategies.

Intervention – responsible for guiding the implementation of the suicide intervention strategies.

Postvention – responsible for guiding and implementing suicide postvention strategies.

Suicide data action team (SDAT) – responsible for guiding the implementation of the data-related goals and objectives of the state plan.

The ad-hoc committees are developed when there is additional interested in specific topics or a need is identified, and it does not fit within the realm of the other committees.

Partner with Communities to Promote Healthy Youth Decision-Making

Minnesota Personal Responsibility Education Program (MN PREP)

MN PREP is a federally funded grant program that aims to create successful transitions from youth to adulthood through promoting healthy decisions and providing medically accurate, evidence-based quality sexual health education to MN young people ages 14-21. With efforts toward preventing pregnancy and sexually transmitted infections, MN PREP funds organizations through an open-competitive process who serves MN's most vulnerable youth populations at high-risk for teen pregnancy and sexually transmitted infections (STIs), including HIV/AIDS.

MN PREP reached nearly 1,600 young people, including 126 in JDCs, and 140 in alternative school settings.

60% of PREP participants indicated they were more likely to talk to a caregiver about things going on in their life after participating in the program.

80% of PREP participants indicated they were more likely to know what made a relationship healthy after participating in the program.

55% of high school aged PREP participants indicated they were more likely to use a condom after participating in the program.

Minnesota Sexual Risk Avoidance Education Program – Minnesota Healthy Teen Initiative

MN's Healthy Teen Initiative (HTI) program, funded through the federal Title V State Sexual Risk Avoidance Education (SRAE) grant, links program participants to services provided by local community partners that support the safety and wellbeing of youth. In FY2024, MN funded five HTI grantees who serve populations experiencing high rates of teen pregnancies and STIs. Grantees implemented high quality, medically accurate, evidence-based and informed programs to promote healthy youth development, abstinence, and to delay the onset of sexual activity in youth ages 10-14.

MN SRAE reached 1,477 young people and 349 supportive adults.

65% of youth SRAE participants indicated they were more likely to manage their emotions in healthy ways after participating in the program.

67% of youth SRAE participants indicated they were more likely to wait until graduating from high school to have sex after participating in the program.

Caring adult participants reported feeling more confident in their ability to communicate with the young people in their lives about sexual health.

Additional MN PREP and MN SRAE/HTI activities included participating on the planning committee for the annual University of Minnesota – School of Nursing - Adolescent Health Summer Institute (AHSI).

Support Schools to Identify and Partner with Community Resources to Access Appropriate and Timely Services for Youth

According to National School-Based Health Alliance, there is strong evidence that communities that have schools with School Based Health Centers (SBHC) have increased attendance; improved student behavior; increased mental and dental health treatment; higher graduation rates; and improved school learning environments as reported by students, teachers, and parents.

In 2023, the Minnesota Legislature passed a state definition of SBHCs and the first-ever dedicated state funding for SBHCs and infrastructure. In 2024, Minnesota started with 30 established SBHCs and 17 new and emerging clinics throughout the state. With the new legislative funding, MDH was able to award six grants to new and emerging clinics in January 2024, and one grant to the MN School-Based Health Alliance to provide technical assistance.

Train Providers on Adolescent and Young Adult Mental Health Screening

Through the Child & Teen Checkups (C&TC) program, Child/Adolescent Health Nurse Consultants provided guidance and skills-based education on adolescent mental health screening to 273 health care and local public health professionals statewide through two C&TC trainings (Best Practices in Well Child Screening and Converting Sports Physicals into Complete C&TC Visit) and four trainings on communicating with adolescents and parents about mental health in partnership with University of Minnesota Medical School – Center for Healthy Youth Development.

In addition, guidance on MN C&TC standards (including adolescent health) were updated, shared widely, and posted online. Child and Teen Checkups Fact Sheets - MN Dept. of Health) and preliminary plans were started to conduct an expedited C&TC periodicity schedule review to determine if MN should add requirement or recommendation for adolescent suicide screening in response to national standards. Anticipate this process will be complete in Spring 2025.

Staff presented on Minnesota's experience with child and adolescent mental health quality improvement projects to the "Screening for Clinical Depression and Follow-up" state EPSDT cohort managed by the National Academy for State Health Policy (NASHP) on June 2024.

[1] MN Resident Final Death File, 2023

[2] Kaiser Family Foundation

Adolescent mental health and wellbeing

ADOLESCENT HEALTH PLAN 2026

Description: Increase adolescent-centered mental health and wellbeing resources and upstream-focused, universal supports.

Background

Mental wellbeing is more than the absence of illness. Mental wellbeing is about having fulfilling relationships, utilizing strengths, contributing to community, and being resilient, which is the ability to bounce back after setbacks. Mental wellbeing is a core ingredient for success in school, work, health, and community life. Poor mental wellbeing, with or without the presence of mental illness, is a risk factor for chronic disease, increased health care utilization, missed days of school or work, suicide ideation and attempts, death, smoking, drug and alcohol use, physical inactivity, injury, delinquency, and crime.[1]

Physical health and mental wellbeing are intertwined. When we experience physical illness, injury, or pain it has a negative impact on our mental wellbeing and improving our physical health can improve our mental wellbeing. Poor mental wellbeing is also a risk factor for mental illness. Poor mental wellbeing may precede or exacerbate mental illness. People with poor mental wellbeing but no current mental illness are three to six times more likely to develop mental illness in the next ten years.[2] Mental and substance use disorders are the most common cause of disability in the U.S. for adolescences ages 15-24.[3]

> *"We live in a wonderful community that values caring for one another. We have food drives every other week where we are all given access to food and clothing we may be in need of." - MN Story Collective Participant and teen parent*

All adolescents deserve to live in a community that promotes mental wellbeing and provides support. Having good mental wellbeing is associated with reduced risk of injury, chronic disease, substance use and misuse, delinquency, and truancy.[4] Minnesota Student Survey data indicates that mental wellbeing is also an important factor for health indicators such as: suicidal thoughts, self-injury, early sexual intercourse, alcohol consumption, and overall health status.

Measuring success

Objective

By 2030, increase the percentage of adolescents who received a preventative medical visit in the past year by 13% to 78.6%.

National Performance Measure

Preventive Medical Visit

Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year**.**

An annual preventive well visit can help adolescents adopt or maintain healthy habits and behaviors, avoid health-damaging behaviors, manage chronic conditions, and prevent disease, including mental health issues. According to the American Academy of Pediatrics:

> *"At well-adolescent visits, adolescents who show any evidence of psychosocial or adaptive difficulties should be assessed regularly for mental health concerns and also asked about suicidal ideation, physical and sexual abuse, bullying, substance use, and sexual orientation."*

Receiving information and support from trusted providers is essential. Minnesota's goal for FFY2026 is that 71.4% of adolescents have a preventative medical visit in the past year. We are hoping to ensure stability and expand utilization when possible and hope to return to preventive medical visits seen prior to the pandemic.

Evidence-Based or-Informed Strategy Measures

School-Based Health Centers

Percent of adolescent students who report that they would have done "nothing" and/or "I'm not sure" to take care of your health problems/needs if their school did not have a School Based Health Center.

Minnesota children and adolescents benefit from having their health needs addressed in a timely, affordable and competent manner where they spend most of their time- at school. School-Based Health Centers (SBHCs) provide students with high quality medical, mental, and behavioral health services from health care providers trained in child, adolescent and young adult care and development. Research demonstrates that young people are more likely to seek out and use health services that are easy to get to, in a familiar location, and are youth-friendly.

Strategies and activities

Through the 2025 statewide Title V needs assessment and action planning, the strategies and activities below have been highlighted to focus on for the 2025-2030 Title V grant cycle of work specific to the adolescent health (AH) population domain.

AH Strategies

1. Amplify resources, services, and supports for adolescents.
2. Build community capacity to support and increase access to adolescent-centered physical and mental health resources and supports.
3. Nourish transformation of systems, environments, and norms that support adolescents in self and community

care.

4. Promote change in societal attitudes by challenging stigma and harmful beliefs toward adolescent mental health and illness.

Activities

STATE TITLE V

Supported

- **Advance Pediatric-to-Adult Health Care Transition through Statewide Learning and Collaboration**

Minnesota's Pediatric-to-Adult Health Care Transition Learning Collaborative is a statewide initiative focused on improving how youth and young adults with special health needs and disabilities (YSHND) move from pediatric care into adult health care settings. This period—commonly called health care transition—is a critical time when gaps in coordination can lead to disruptions in care. Through this Collaborative, the Minnesota Department of Health (MDH), in partnership with a major specialty health system in Minnesota, works to strengthen provider knowledge, improve alignment across systems, and better support youth and families during this key developmental stage.

The Collaborative brings together health care providers, systems leaders, youth and caregivers, and subject matter experts to share strategies, build connections, and reduce fragmentation across pediatric and adult health systems. With continued coordination from MDH and facilitation by a major specialty health system in Minnesota, the Pediatric-to-Adult Health Care Transition Learning Collaborative will remain a key strategy for supporting youth with special health needs as they move into adult care systems. *See the 2026 CSHCN Plan for more details about this activity.*

- **Support Adolescent and Young Adult Health through the Minnesota Partnership for Adolescent and Young Adult Health (MNPAH)**

MNPAH, convened by MDH, is a group of interest holders representing state, county, schools, community agencies, faith organizations, and those working for and with young people. The MNPAH aims to support Minnesota's overarching adolescent health goals, which are to:

- Improve the health and wellbeing of all adolescents and young adults (ages 10-25 years old)
- Build and maintain strong partnerships with those interested in the health and wellbeing of young people.

To address these goals and inspire action, the MNPAH developed a Strategic Plan with a set of priorities that include:

- Building supportive systems.
- Ensuring access to high-quality teen-friendly health care.
- Having a safe and secure place to live, learn, and play.
- Developing positive connections with supportive adults.
- Providing opportunities for youth to engage.
- Young people who are thriving are less likely to complete suicide, and these priorities aim to support MNPAH's vision of Minnesota being a "place where all young people thrive".

In FFY2026, MDH will partner with MNPAH to support interest holders to support Minnesota's adolescent population through the MNPAH strategic plan.

Connected

- **Foster Youth Leadership and Peer Support**

Some Sexual and Reproductive Health Services (SRHS) grantees build relationships and programs with partners, e.g., schools and shelters, to provide and encourage youth leadership opportunities. Additionally, grantees work to create space for youth to gather and learn from each other through peer support opportunities. Minnesota will continue to support these grantees in FFY2026.

- **Increase Help-Seeking Behaviors in Youth**

According to the Suicide Prevention Resource Center, “By teaching people to recognize they need support – and helping them to find it – you can enable them to reduce their suicide risk.” To help young people, increase help seeking behaviors, we need to decrease barriers to accessing supports.

During FFY2026, MDH will work with partners to:

- lower barriers that youth experience when trying to obtain help by promoting self-help tools and campaigns.
- address social environmental barriers – which might include social/emotional learning to foster peer norms around help-seeking and working to make sure that youth-serving providers (e.g., primary care providers) are providing services that are comprehensive, welcoming, and convenient for teens.

- **Participate in Statewide Efforts to Reduce Emergency Department Boarding and Improve Access to Appropriate Mental Health Care for Youth**

Minnesota’s Title V program will continue to engage as a partner with the Mental Health Collaboration Hub (MHCH), a statewide initiative aimed at reducing prolonged hospital stays for youth who are unable to access timely, appropriate community-based mental health services. The MHCH combines a web-based portal with weekly consultation calls to support the identification of suitable treatment placements for children and adolescents with unmet mental or behavioral health needs.

Through continued participation, MDH will help share insights, monitor emerging patterns, and contribute to collaborative efforts that address barriers to timely care—particularly for youth with complex behavioral health presentations or developmental concerns.

This work supports broader public health goals to enhance understanding of adolescent mental health needs, reduce unnecessary hospitalization, and improve access to care in the least restrictive, most appropriate settings. It also helps normalize timely help-seeking and reinforces the importance of addressing mental health needs with the same attention and urgency as physical health concerns.

- **Partner in Building Capacity of Primary Care Providers in Identifying and Responding to Mental Health Concerns**

In FFY2026, Minnesota will continue implementation of its five-year Pediatric Mental Health Care Access – New Area Expansion grant. This work aims to strengthen the capacity of pediatric primary care providers to identify and respond to mental and behavioral health concerns in children and adolescents.

Planned activities include:

- *Ongoing provider training and consultation.* Minnesota will continue offering Maintenance of Certification Part 4 (MOC4) quality improvement cohorts in partnership with Minnesota chapter of the American Academy of Pediatrics, expanding to include family medicine providers. The Psychiatric Assistance Line (PAL) will continue to provide statewide teleconsultation, with outreach and utilization evaluation guiding future refinements.

- *Evolving leadership engagement to support systems change.* In place of a traditional steering committee, Minnesota will launch a new summit-based structure to engage broader cross-sector partners. These biannual gatherings will inform statewide strategies for improving access to care for youth with co-occurring disabilities and mental health conditions, supporting workforce resilience, and advancing trauma-responsive systems.

FFY2026 efforts will also include sustainability planning, including preparation for the next HRSA funding opportunity. All activities contribute to broader public health efforts to promote early identification, reduce unnecessary hospitalization, and ensure timely, appropriate care for adolescents.

- **Participate on Health Education Standards Committee and Whole School, Whole Community, Whole Child Committee**

The 2024 Minnesota legislative session made changes to state statutes that directly impact K–12 public health education. During the 2024–25 school year, the Minnesota Department of Education is facilitating the creation of the Minnesota K–12 Academic Standards in Health with input from MDH and Minnesota Department of Human Services (DHS) – through the Health Education Standards committee.

The Health Education Standards committee is made up of adult and student members who were selected through an application process. State agency staff are not considered members of the committee but help facilitate subgroups and provide technical assistance and subject matter expertise when appropriate. They are also responsible for providing updates to MDH leadership and stakeholders about this process.

The Whole School, Whole Community, Whole Child interagency committee meets quarterly to strategically network & cross share with state agency divisions and teams that intersect with K-12 schools to support the whole child framework. This interagency committee uplifts the Whole School, Whole Community, Whole Child model that expands on the traditional model of Coordinated School Health and recognizes that health and education are always working together to help students thrive.

- **Partner to Implement the Happiness Practice with Youth**

MDH will continue partnering with local public health (LPH) to consider utilization of a community-led mental health promotion tool – called The Happiness Practice (THP) – with youth. One LPH agency has included this activity in their Drug Free Communities grant and has discussed plans to support sustainability by incorporating a youth employment component, where youth who are trained then get paid to offer THP to others. In FFY2026, MDH will continue partnering with this agency and others to identify strategies that incorporate this model into their programming for youth.

- **Partner to Provide Essential Family Planning Supports through the Sexual and Reproductive Health Services Grant**

The SRHS program is administered by MDH and provides pre-pregnancy family planning services for people whose incomes are below the federal poverty level and placed at increased risk for unintended pregnancy. The program supports essential pre-pregnancy family planning services for people of reproductive age. In 2023, eligibility was expanded to include the 12 Minnesota tribes in the geographic area of Minnesota. Grantees provide:

- Education and outreach on medically accurate sexual and reproductive health information.
- Contraceptive counseling, provision of contraceptive methods, and follows-up.
- Screening, testing, and treatment of sexually transmitted infections and other sexual or reproductive concerns.
- Referral and follow-up for medical, financial, mental health, and other services in accord with a service recipient's needs.

In 2023, in Minnesota, 37% of rural counties have no publicly funded sexual health clinic location in the county itself

and 283,400 Minnesotans who need contraction live in contraceptive deserts[5]. In FFY2026, MDH will continue to support SRHS grantees to provide these essential supports and services, particularly in rural areas of the state.

- **Partner to Provide Specialized Instructional Support for Students through School Nurses**

Minnesota is partnering with the National Association of School Nurses in a project to focus on student mental health through school nurses/health services. Schools and school nurses are increasingly being recognized as community-based asses for students and staff. School nurses are members of the interdisciplinary team of specialized instructional support personnel in schools, and they are public health sentinels essential to expanding access to health care for students. A 2022 statewide survey reported that 29% of school nurses spent 21-30% of weekly time supporting student mental health needs. A strategic plan was developed to provide professional development and identify community resources school nurses could use to support students. This included introduction of the Psychiatric Assistance Line (PALS) and FastTracker resources, as well as multi-tiered systems of support for students with mental health concerns. Minnesota will continue provide support to school nurses, as implemented through the strategic plan, in FFY2026.

- **Promote Healthy Youth Decision-Making through the Minnesota Personal Responsibility Education Program (MN PREP)**

MN PREP is a federally funded grant program that aims to create successful transitions from youth to adulthood through promoting healthy decisions and providing medically accurate, evidence-based quality sexual health education to MN young people ages 14-21. With efforts toward preventing pregnancy and sexually transmitted infections, MN PREP funds organizations through an open-competitive process who serves MN's most vulnerable youth populations at high-risk for teen pregnancy and sexually transmitted infections (STIs), including HIV/AIDS.

Grantees are responsible for incorporating at least three of the following adulthood preparation topics in their programming: healthy relationships, healthy life skills, adolescent development, and/or financial literacy. In FFY2026, MDH will continue to provide oversight and training to six MN PREP grantees who serve youth populations from across the state.

- **Promote Positive Youth Development through Child and Teen Check-Ups**

Postpartum depression screening for any accompanying caregiver is a recommended component in all Child and Teen Checkups (C&TC) well-child visits in children up to 13 months of age. The Minnesota Department of Health C&TC Program will continue to provide training to medical providers who perform C&TC visits on best practices in conducting postpartum depression screening in FFY2026. The training is also available for Head Start staff, LPH C&TC staff, and university-based post baccalaureate advanced practice nurse (nurse practitioner) training programs.

- **Promote Youth Safety and Wellbeing through the Minnesota Sexual Risk Avoidance Education Program – Minnesota Healthy Teen Initiative**

MN's Healthy Teen Initiative (HTI) program, funded through the federal Title V State Sexual Risk Avoidance Education (SRAE) grant, links program participants to services provided by local community partners that support the safety and wellbeing of youth. In FFY2026, MDH will continue to support HTI grantees who serve populations experiencing teen pregnancies and STIs to implement high quality, medically accurate, evidence-based and informed programs that promote healthy youth development, abstinence, and to delay the onset of sexual activity in youth ages 10-14.

- **Support Community Capacity Building to Provide Youth Mental Health Supports**

Minnesota's School-Based Health Center (SBHC) Grants support both new and emerging clinics as well as established clinics throughout the state. As defined in statute, a SBHC is a safety net health care delivery model

that is located in or near a school facility and that offers comprehensive health care, including preventive and behavioral health services, provided by licensed and qualified health professionals in accordance with federal, state, and local law. Many of the SBHCs in Minnesota provide mental health care and crisis management to students in their schools.

Additionally, he Minnesota School-Based Health Alliance supports a Youth Health Council. The Youth Health Council aims to provide a space for students to actively engage in decision-making processes, ensuring their unique perspectives are integrated into the improvement of healthcare services in their schools. The Council is designed to amplify the voices of high school students with a school-based clinic in their schools. We believe in the power of youth to contribute to positive changes in healthcare, and this council is your opportunity to actively participate in shaping the future of school-based healthcare initiatives.

- **Support Implementation of It's That Easy Parent Education Curriculum**

The Minnesota Sexual Risk Avoidance Education Program (SRAE) and Personal Responsibility Education Program (PREP) grantees are funded to facilitate parent education sessions on raising healthy youth through the *It's That Easy: Guide to Raising Sexually Healthy Children* curriculum. The curriculum offers parent educators training and tools to empower parents to:

- Connect with their children.
- Share Their Family's values.
- Engage in meaningful conversations about sex, sexuality, and relationships.

Minnesota will continue to support SRAE and PREP grantees in FFY2026.

- **TALK: Toolkit for Adolescent Care**

Minnesota will continue to partner with the University of Minnesota Center for Healthy Youth Development to promote the TALK toolkit and training. The TALK: Toolkit for Adolescent Care aims to help health care providers more effectively talk with youth and parents about sensitive topics to provide high quality adolescent healthcare. The toolkit provides best practice guidelines and practical conversation guides for both clinicians and parents. The tools are developed alongside professionals, parents and young people to make sure they are reflective of the realities of the individuals who implement and benefit from the tools. Topics include alcohol, vaping, and marijuana; bullying, healthy relationships, healthy sleep, mental health, screen time and social media; and more.

LOCAL TITLE V

Connected

Implement Mind Up Curriculum in Public Schools

School Health teams from LPH agencies partner with local public schools to deliver the *Mind Up* Curriculum. *Mind Up* is a preventative mental health program that equips youth, educators, and families with mental fitness tools that build stronger emotional literacy and improved resilience to face challenges with optimism, strength, and compassion. These efforts will continue in FFY2026.

Partner to Promote Adolescent Wellbeing

LPH agencies remain active in partnering with community organizations and nonprofits to promote adolescent wellbeing in local schools. Examples include:

Partner with a community organization to provide training for local school district staff who work with adolescents with ACEs. The purpose is to implement mentoring programs, facilitate student and parent advisory groups, and collect feedback regarding adolescent wellbeing.

Partner with a local community organization to provide evidence-based and medically accurate education to teens and young adults in local school district. There are over a dozen topics and include: health relationships, mental health 101, social media safety, healthy boundaries, stress management, and more.

Partner to Promote Youth Mental Health

LPH staff are actively engaged and participate in local, regional, and statewide youth mental health councils, which creates opportunities to partner across sectors, including housing and education, to meet the mental health and wellbeing needs of youth. These efforts will continue in FFY2026.

Promote Positive Community Norms

One LPH agency working within the local school system to discuss positive community norms with students, staff and families. This program has been able to highlight most students do not use substances and over time has increased the number of students who do not use. Mental Health education and creating safe environments is also discussed through this curriculum.

Provide Mental Health and Wellness Curriculum in Schools

Some LPH agencies are working with the Minnesota Department of Education to incorporate mental health and wellness into required curriculum, through adolescence, within their local public-school districts. These efforts will continue in FFY2026.

Strengthen Parent-Teen Partnerships in Mental Health

One LPH agency is working with a very active local, community organization to bring mental health curriculum to teens that empower and provide them support to teach their parents about mental health. These efforts will continue in FFY2026.

Support Adolescent Behavioral and Mental Wellbeing through School Health Staff

Some LPH agencies in Minnesota partner with their local school districts to provide and/or support school health staff – including school nurses and psychologists – to provide support and referral for behavioral and mental health and wellbeing. Providing these services and supports in schools helps to fill access gaps for students who have limited transportation, or other barriers to mental and behavioral health resources. One community health board staff a regional suicide prevention coordinator who works closely with the schools to provide mental and behavior health supports.

Support Adolescent Mental and Behavioral Health through Family Home Visiting

Some LPH agencies in Minnesota report utilizing family home visiting services to support pregnant teens. Family home visitor programs utilize various models to provide education, screening for depression/anxiety, and referrals as needed. These programs will continue to be offered in FFY2026.

[1] Mental Wellbeing Matters

[2] Mental Wellbeing Matters

[3] NIH - Leading Causes of Disability

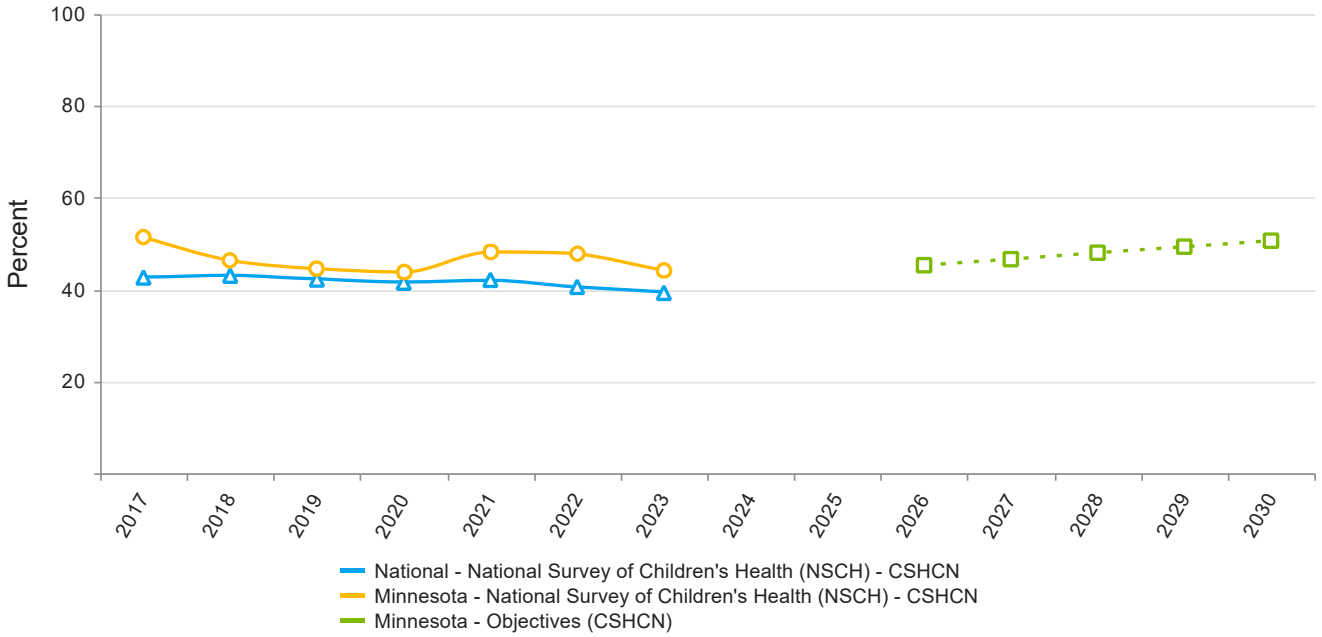
[4] To Flourish or Not: Positive Mental Health and All-Cause Mortality & Mental Health in Adolescence: Is America's Youth Flourishing?

[5] Family Planning Special Projects 2023 Program Fact Sheet

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH Indicators and Annual Objectives



NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2023	**2024**
Annual Objective		
Annual Indicator	48.3	44.0
Numerator	118,835	148,856
Denominator	246,192	338,157
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	45.3	46.6	48.0	49.3	50.6

Evidence-Based or –Informed Strategy Measures

ESM MH.1 - Percent of care coordinators reporting increased knowledge in serving CSHCN and their families after participating in Community of Practice (CoP) webinars.

Measure Status:	Active

Baseline data was not available/provided.

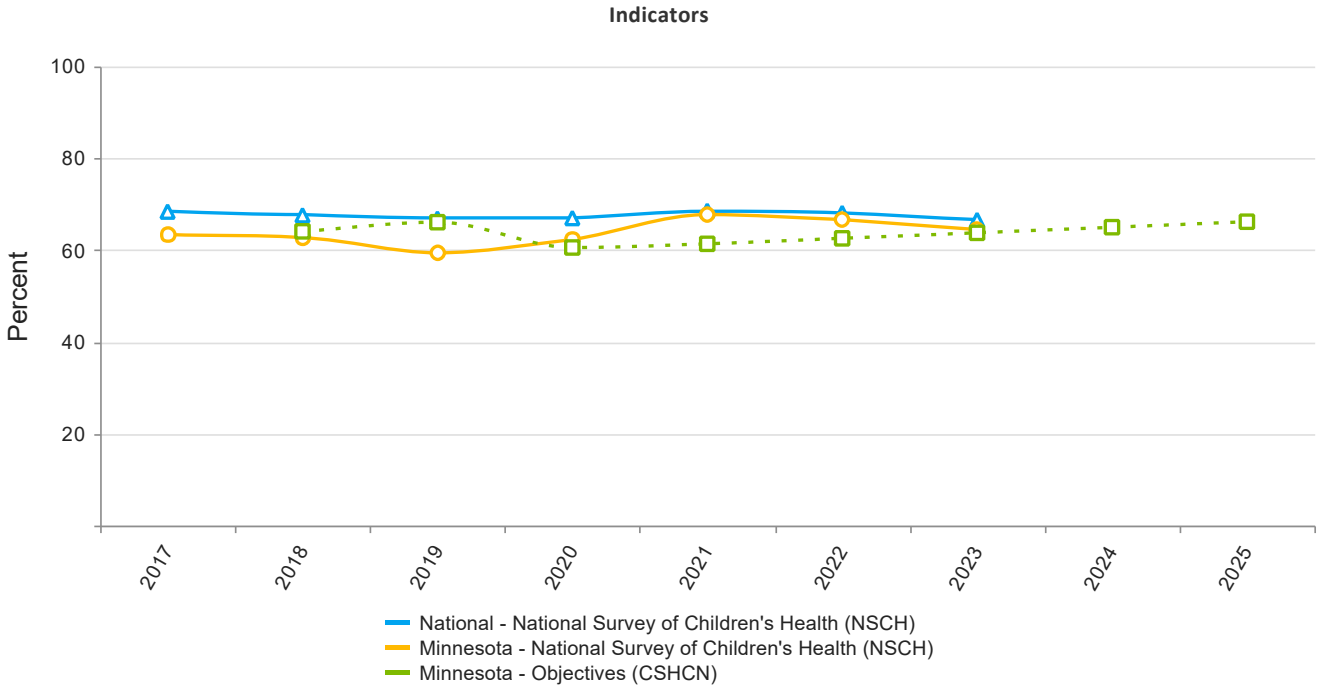
Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	70.0	72.0	74.0	76.0	78.0

State Action Plan Table

State Action Plan Table (Minnesota) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Coordinated support and access for CSHCN	
NPM	
NPM - Medical Home	
Five-Year Objectives	
By 2030, increase the percentage of CSHCN who have a medical home by 15%.	
Strategies	
Strengthen family-centered, evidence-informed supports, services, and resources.	
Involve families and caregivers in shaping, implementing, and improving programs and services.	
Collaborate across systems to remove and reduce barriers to simplify family navigation and improve access to resources and supports.	
Support local efforts to provide services and resources in ways that meet family needs and preferences.	
ESMs	**Status**
ESM MH.1 - Percent of care coordinators reporting increased knowledge in serving CSHCN and their families after participating in Community of Practice (CoP) webinars.	Active
NOMs	
Children's Health Status	
CSHCN Systems of Care	
Flourishing - Young Child	
Flourishing - Child Adolescent - CSHCN	
Flourishing - Child Adolescent - All	

2021-2025: National Performance Measures

2021-2025: NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured - AI



2021-2025: 2021-2025: NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured - AI - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	60.5	61.3	62.5	63.7	64.9
Annual Indicator	59.7	62.4	67.3	66.5	64.4
Numerator	771,820	805,126	865,943	861,769	829,428
Denominator	1,293,684	1,289,616	1,287,332	1,295,564	1,287,773
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

2021-2025: Evidence-Based or –Informed Strategy Measures

2021-2025: ESM AI.2 - Care coordinators reporting increased knowledge in serving CYSHN and their families after participating in Community of Practice webinars

Measure Status:			**Active**	
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			76	77.5
Annual Indicator		43.5	94.3	54.6
Numerator		80	100	77
Denominator		184	106	141
Data Source		Webinar Evaluation	Webinar Evaluation	Webinar Evaluation
Data Source Year		FY2022	FY2023	FY2024
Provisional or Final ?		Final	Final	Provisional

Improve access to services and supports for CSHCN

CSHCN REPORT 2024

Description: Ensuring all children and families have what they need to thrive.

Background

Minnesota's previous five-year comprehensive needs assessment identified access to services and supports for children and youth with special health care needs (CSHCN) as a top priority. This was identified as a key focus area based on the growing number of families reporting challenges accessing timely, appropriate, and coordinated care.

Data from the 2022-2023 National Survey of Children's Health (NSCH) show that approximately 338,351 children and youth in MN (26.1% of those ages 0-17) have health conditions that require more services than typically needed. These conditions may be physical, developmental, behavioral, or emotional in nature and often require care across multiple sectors, including health, education, and community supports.

CSHCN rely on a variety of services and supports such as dental care, specialized therapies, childcare, counseling, home health and respite care, medical equipment, and school-based supports. However, families frequently report difficulty accessing these services due to factors such as long waitlists, complex eligibility criteria, limited provider availability (especially in rural areas), and administrative or financial strain. Service shortages in home health and pediatric mental health are particularly concerning, driven by low reimbursement, workforce turnover, and a lack of specialized training. Families also note challenges related to childcare, transportation, language access, and navigating multiple systems of care.

Families with CSHCN are more likely to delay or forgo care needed than families without special health care needs. According to 2022-2023 NSCH data, 38.1% of CSHCN in Minnesota did not have insurance to that usually or always met their needs. Additionally, these families are more likely to experience high out-of-pocket costs: 38.3% reported paying between $1,000 and $5,000, and 19.5% paid over $5,000 annually for their child's health, dental, and vision care. Broader data from the 2023 Minnesota Health Access Survey showed that 24.5% of residents reporting not accessing needed care due to cost – an increase from 20.2% in 2021.

These access challenges are not evenly experienced. Families with lower incomes and those living in rural areas often face the most limited options. While Minnesota is working to improve access across the state, ongoing system-level gaps continue to affect service delivery, care coordination, and financial sustainability for many families.

Understanding how multiple factors—including geographic location, insurance coverage, and system complexity—interact is essential to improving outcomes for CSHCN. Minnesota's focus on access and coordinated support reflects both the data and the experiences of families and has guided our targeted strategies and performance measures during the last five-year cycle.

Measuring success

Objective

By 2025, increase the percentage of CSHCN who are adequately insured by 10%.

National Performance Measure

Adequately Insured

Percent of children, ages 0 through 17, who are continuously and adequately insured.

Access to adequate health insurance plays a critical role in whether CSHCN receive timely and appropriate services and supports. According to the 2022-2023 NSCH, only 61.5% of CSHCN in Minnesota met the criteria for having both consistent and adequate insurance coverage.

To meet this measure, the child must have:

1. Continuous insurance coverage over the past 12 months, and
2. Current insurance that meets the child's needs, based on the following components:
   - The child currently has health insurance.
   - Benefits usually or always meet the child's health care needs.
   - Insurance usually or always allows access to needed providers.
   - Out-of-pocket expenses costs are either not required or are usually or always considered reasonable by the family.

Inadequate or inconsistent coverage can result in missed care, delayed diagnoses, and increased financial burden. Minnesota has continued to track this measure to inform our planning and to identify opportunities to strengthen access to affordable, comprehensive coverage for CSHCN across the state.

Evidence-Informed Strategy Measure

Increased Knowledge

Care coordinators reporting increased knowledge in serving CSHCN and their families after participating in Community of Practice webinars.

Care coordinators play a central role in supporting CSHCN and their families – particularly in connecting to services, understanding coverage, and managing care across systems. As care coordinators connect, share, and learn from one another, they contribute to improved health outcomes by strengthening the capacity of the broader systems serving CSHCN.

Recognizing this, Minnesota selected the strategy "*Build the Capacity of Communities by Cultivating Knowledge and Improving Collaboration Activities*" to guide its Evidence-Based Strategy Measure (ESM). The activity of focus is the Pediatric Care Coordination Community of Practice (CoP)—a collaborative effort that brings care coordinators together to exchange knowledge, explore promising practices, and strengthen cross-system collaboration.

A key area of emphasis within the CoP is improving access to insurance and financing options that support timely care for families. By fostering peer-to-peer learning and shared problem-solving, the CoP helps build workforce capacity and improve consistency in care coordination practices statewide.

Evaluation data from FFY2024 show that 54.6% of care coordinators strongly agreed that participating in the CoP increased their knowledge in serving CSHCN and their families. This percentage reflects only those who selected "strongly agree" on the post-webinar evaluation. In previous year, MN reported a combined total of "agree" and "strongly agree," which contributed to higher percentages. We are working to ensure consistency in future data reporting.

Strategies and activities

CSHCN Strategies

1. Enhance Centralized Resources to Improve Knowledge of Services and Supports.
2. Build the Capacity of Communities by Cultivating Knowledge and Improving Collaboration.
3. Construct a Competent and Well-Compensated Workforce.

CSHCN Activities

STATE TITLE V

Supported

Advance Interagency Collaboration to Support Youth Transitioning into Adulthood

During FFY2024, MDH continued to advance interagency efforts to improve systems of support for youth as they transition into adulthood. This work reflects ongoing collaboration between MDH and the Departments of Human Services (DHS), Education (MDE), and Employment and Economic Development (DEED), with a shared goal of improving access to coordinated services across health, education, and employment systems.

A key area of focus was expanding the use of person-centered and cross-agency practices in communities supporting youth with behavioral health conditions or complex health needs. Through the Person-Centered Planning and Coordination Pilot Project, MDH and its partners provided local teams with tailored consultation, coaching, and practical tools. These resources helped build both system-level and team-level capacity to support youth and families more effectively.

MDH also contributed to the Employment Capacity Building Cohort (ECBC) by supporting the development of a Minnesota Transition Framework and Toolkit. This resource is designed to guide agencies and providers in supporting youth as they move from school-based to adult service systems. In parallel, a special interest group of school health nurses was convened to explore how health considerations can be more effectively integrated into special education and transition planning processes.

Minnesota's participation in the National Community of Practice for Supporting Families also continued in FFY2024. A cross-agency leadership team – including staff from MDH, DHS, MDE, and DEED – guided statewide efforts to apply the *Charting the LifeCourse* (CtLC) framework in family engagement and systems planning. As a part of this work, the team supported the growth of MN-Connect, a statewide network that promotes shared learning and peer-to-peer collaboration among professionals and families using CtLC. Technical assistance for MN-Connect is provided by the national Community of Practice team.

Collectively, these interagency initiatives reflect Minnesota's ongoing commitment to improving the transition experience for youth with special health care needs—particularly the transition from pediatric to adult health care—and ensuring that families have the information and coordinated support needed throughout this process.

Coordinate Pediatric-to-Adult Health Care Transition Learning Collaborative

In FFY2024, Minnesota continued to coordinate implementation of a statewide Health Care Transition (HCT) Learning Collaborative focused on improving the transition from pediatric to adult health care for youth and young adults with special health care needs. The initiative was launched in FY2023 through a competitive request for proposals and is implemented in partnership with a major specialty healthcare system in Minnesota, which supports facilitation under MDH's direction.

The Learning Collaborative brings together providers, systems leaders, youth and families, and subject matter experts to advance shared learning, improve coordination, and strengthen infrastructure that supports timely and

developmentally appropriate transitions from pediatric to adult health care.

Key activities during FFY2024 included:

- ECHO learning sessions on topics such as supported decision-making, care coordination, and connection to adult outpatient systems.
- A statewide summit focused on trauma-informed, cross-sector planning to improve provider practices and alignment across pediatric and adult health care settings.
- Ongoing collaboration across sectors to address system fragmentation and promote more consistent transition processes.

This initiative reflects Minnesota's long-term commitment to improving the pediatric-to-adult health care transition experience. MDH continues to coordinate this effort to strengthen systems of care for youth with special health needs as they enter adulthood.

Expand Knowledge and Connections through the Minnesota Pediatric Care Coordination Community of Practice

The Minnesota Pediatric Care Coordination Community of Practice (CoP) is an ongoing initiative that strengthens care coordination across systems by building knowledge, skills, and peer connections. Open to all individuals who provide care coordination to children and youth in Minnesota, the CoP supports access to effective, family-centered care for CSHCN.

As of FFY2024, membership includes more than 700 individuals from 51 of Minnesota's 87 counties, representing an array of professional roles and systems, including behavioral health, school health, home visiting, and primary and specialty care.

The CoP offers regular professional development opportunities that support both skill-building and relationship development. In FFY2024, webinars focused on practical topics such as:

- *Understanding the State Medical Review Team (SMRT)* – Covered the disability determination process in Minnesota and how care coordinators can support families through it (445 attendees).
- *Next Steps Following an Autism Diagnosis* – Provided guidance on referrals, family support, and navigating wait times (322 attendees).
- *The Rare Disease Community in Minnesota* – Explored care challenges and resources for families navigating rare disease diagnoses (120 attendees).

Post-webinar surveys showed that over 54.6% of participants strongly agreed their knowledge increased as a result of participating. Evaluation feedback also indicated that the CoP is helping to foster stronger care coordination through new relationships and shared learning. One participant noted:

"I met a pediatric care coordinator from a primary care clinic. About a week later, one of her colleagues contacted me because we had a shared patient… They were able to hold a care conference over the telephone. If it hadn't been for that connection, I don't think the shared planning would have occurred—and the family wouldn't have had such a smooth transition back home."

The CoP website continued to serve as a central access point for tools and resources. While currently undergoing updates, the site previously housed details on upcoming trainings, links to local and state organizations that serve CSHCN, and a curated library of more than 100 resources – including toolkits, research articles, and relevant websites.

These efforts support the long-term goal of building a more connected, competent, and family-responsive care

coordination workforce across Minnesota.

Foster Internal Capacity to Improve Public Health Response for Persons with Disabilities

During FFY2024, MDH worked to strengthen internal coordination and staff development through the Disability Collaborative, a cross-agency initiative that aims to improve how the department addresses the needs of Minnesotans with disabilities across all areas of public health.

The Collaborative serves as a structured forum for MDH staff to share updates, align efforts, and engage in ongoing learning related to disability and health. The group is guided by a charter that supports shared direction, fosters collaboration, and encourages consistent attention to improving responsiveness to the needs of individuals with disabilities.

Disability Data Affinity Group: A key working group under the collaborate, the Disability Data Affinity Group, continued its efforts to improve consistency in how disability-related data is collected, interpreted, and shared within MDH. In FFY2024, the group:

Finalized a draft set of internal recommendations to support more consistent disability-related data practices.

Advanced the development of a data dashboard to make disability-related data more accessible to programs and staff across the department.

Quarterly Meetings and Learning Visits: The Collaborative hosted quarterly meetings to encourage cross-division information sharing and professional learning. Two meetings in FFY2024 included in-person visits to:

Gillette Children's Specialty Healthcare, where staff learned about integrated care models that support children with complex medical needs.

Apple Tree Dental, where staff explored a model for providing accessible dental care to individuals with functional limitations, including children and adults with disabilities.

Growing Participation and Cross-Divisional Engagement: Participation in the Collaborative grew in FFY2024, with new staff members joining from across the department. These efforts are part of MDH's broader aim to build a public health workforce that is better equipped to understand and respond to the needs of Minnesotans with disabilities—both in direct service programs and in population-level strategies.

Participate in the Minnesota Rare Disease Advisory Council to Support Access and Systems Improvements for Individuals with Rare and Medically Complex Conditions

In FFY2024, the MDH continued to participate in the work of the Minnesota Rare Disease Advisory Council (RDAC) through the Title V CSHCN Director, who serves as the Commissioner of Health's designee. The RDAC brings together healthcare providers, researchers, caregivers, individuals with lived experience, health plan representatives, and members of the Minnesota Legislature to share expertise and provide guidance on issues related to rare conditions—such as improving diagnosis, treatment, care coordination, and education.

While MDH does not lead the RDAC, the agency actively contributes to its efforts to strengthen coordination across state systems and improve support for individuals with rare and medically complex conditions.

During FY2024, RDAC focused on operationalizing its work as an independent, Governor-appointed body and pursued policy and programmatic changes to reduce barriers to care and improve system responsiveness. Legislative changes supported by the Council in FY2024 included:

Establishing ongoing operational support for the RDAC to carry out its statutory responsibilities and continue serving as a cross-sector partner in rare disease-related efforts.

Improving access to gene therapies by enabling hospitals to be reimbursed separately for gene products

associated with rare conditions, helping prevent financial losses and supporting provider participation in value-based arrangements.

Requiring coverage of rapid whole genome sequencing (rWGS) for children under 21 receiving intensive care, helping reduce diagnostic delays and improve clinical decision-making.

Streamlining prior authorization processes for specific treatments, including chronic condition care, and establishing reporting requirements to promote timely access to medically necessary services.

MDH will continue to support the Council's efforts to identify system gaps, share relevant data and insights, and contribute to cross-agency strategies that promote access to coordinated, high-quality care for Minnesotans with rare and complex conditions.

Strengthen Capacity for Systems Change through the Family Support Organization Collaborative

Building on the findings from Minnesota's Family Support Environmental Scan (completed in FFY2023), MDH advanced the development of a Family Support Organization Collaborative (FSOC) during FFY2024. Co-designed with input from a dedicated Steering Committee, the FSOC is intended to serve as a shared space for family-serving organizations to connect, exchange ideas, and collaborate on improving systems and services for CSHCN and their families.

The long-term vision for the FSOC is to strengthen the collective capacity of family organizations to contribute to policy and systems-level change. FFY2024 activities focused on building a strong foundation for collaboration, structure, and engagement.

Virtual Gatherings: MDH hosted bi-monthly virtual sessions with representatives from family-serving organizations. These gatherings aimed to:

Build relationships and peer connections among organizations supporting CSHCN and their families.

Facilitate open dialogue between MDH and organizations to share feedback and surface system-level needs.

Explore timely topics such as outreach, engagement, organizational development and resilience, communication strategies, and cross-system collaboration.

Six sessions were held during FFY2024, and each session included:

A Family Support Organization Spotlight, offering a platform for one organization to share a recent innovation, accomplishment, or promising practice

Late-breaking announcements featuring upcoming events, funding opportunities, and trainings

An interactive presentation, often followed by large- and small-group discussions

A brief evaluation survey used to inform planning for future sessions

Topics explored during the FY2024 gatherings included:

October 2023 – Launch and Introduction to the FSOC: Purpose, structure, and member expectations; early discussions on what participants hoped to gain.

December 2023 – Participant-led breakout discussions on outreach and engagement, staffing challenges, service coordination, and perceptions related to disability.

February 2024 – Family organization perspectives on data: how they might use a future dashboard, preferred formats, and what information would be most useful.

April 2024 – Sharing effective strategies for family engagement, identifying common barriers, and brainstorming ideas to strengthen outreach.

June 2024 – Mental health: cultural and systemic factors that affect access, and how to support families when raising mental health concerns with providers.

August 2024 – Supporting families through transitions in service delivery and funding, including changes related to community-based services and supports.

Communications and Outreach: To promote broader awareness and engagement, MDH began developing a communications and outreach plan for the FSOC. This included early planning for a dedicated FSOC presence on the MDH website to share general information and participation opportunities.

Steering Committee and Co-Design: The original FSOC Think Tank formally transitioned into a Steering Committee in FY2024. Members bring a range of professional backgrounds and community perspectives and serve as key partners in the development of the FSOC. Throughout the year, the Steering Committee:

Provided feedback on Collaborative structure, content, and strategy

Shared insight on emerging practices and local priorities

Informed the design of virtual gatherings and related engagement strategies

The Steering Committee met four times in FY2024. MDH also initiated efforts to expand membership.

Dedicated Staff Support: To support the growth and coordination of the FSOC, MDH hired a Caregiver and Community Impact Coordinator in May 2024. This new role is responsible for facilitating FSOC activities, supporting Steering Committee engagement, and strengthening partnerships with family-serving organizations. The coordinator brings personal caregiving experience and systems-level knowledge to help ensure FSOC activities remain responsive to family priorities across the state.

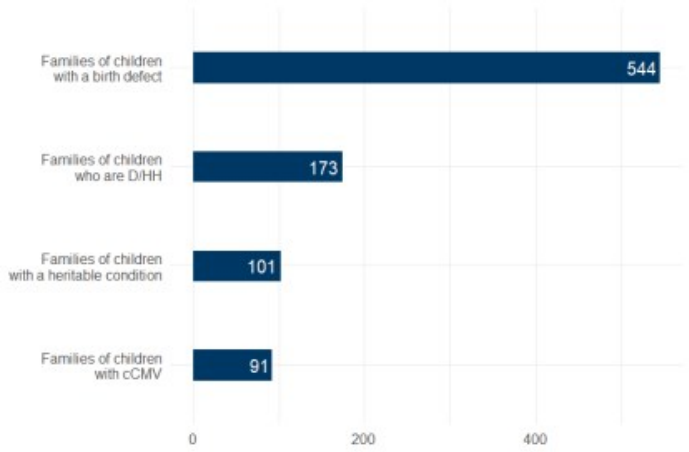
Strengthen Local Public Health Capacity to Support Families of CSHCN

During FFY2024, MDH continued to strengthen local public health (LPH) capacity to support CSHCN through coordinated follow-up activities, training, and technical assistance.

All 87 LPH agencies in Minnesota are contracted to conduct follow-up with families of children identified with a birth defect or condition through newborn screening, including hearing loss, critical congenital heart disease, and heritable conditions identified via blood spot screening. While most follow-up work is supported through non-Title V state and federal funding sources, local Title V funds may supplement these efforts when additional support is needed. MDH's Title V CSHCN team also collaborates closely with LPH nurses to provide technical assistance and systems-level guidance.

In FFY2024, public health nurses contacted more than 1,600 families, conducting assessments, sharing information about available resources, and helping families connect to health care and community-based services. Figure 1 provides information on the number of families who received public health nursing support during FFY2024. Nurses used a shared, secure database to document concerns and record follow-up education and guidance provided. This tool also enables coordination with other MDH programs and family support organizations, reducing delays in service connection.

Figure 1. Families Receiving Public Health Nursing Support in FFY 2024.



To build knowledge and professional connections among LPH staff, MDH hosted the 2024 CSHCN Local Public Health Annual Meeting, a two-day training event held in central Minnesota. Topics included:

- Partnering with Help Me Grow to support developmental monitoring and referral
- Using Charting the LifeCourse tools to plan with children and caregivers
- Supporting language development and communication strategies
- Providing guidance around grief and infant loss
- Reflecting on professional roles and building meaningful connections with families
- Exploring work-life resilience in a keynote by the Minnesota Rare Disease Advisory Council's executive director
- Hearing from a moderated parent panel sharing caregiving experiences
- Highlighting resources through a panel of family support organizations
- Discussing family perspectives through a book study on *Remedies for Sorrow*, written by a Minnesota parent of a child with congenital cytomegalovirus (cCMV).

MDH also provided ongoing technical assistance throughout the year. Onboarding materials for new LPH CSHCN staff were revised and evaluated to support more consistent training and future improvement.

In addition to strengthening current efforts, MDH began laying the groundwork to expand the follow-up model to reach families of children who may be at increased risk for special health care needs, including those experiencing developmental delays or neonatal abstinence syndrome. MDH actively engaged LPH partners in the design process to ensure the expanded model reflects the needs and perspectives of local communities.

Strengthen the Workforce by Supporting the Growth and Sustainability of Family Support Organizations

Family support organizations are a vital part of Minnesota's broader public health and human services workforce. These organizations provide frontline connection, guidance, and support to families of children and youth with special health needs and disabilities. Strengthening their capacity is key to ensuring all children and families have what they need to thrive.

In FFY2024, MDH continued efforts to develop a statewide infrastructure to support the long-term growth, coordination, and sustainability of family-serving organizations. Through the Family Support Organization Collaborative (FSOC), MDH worked to:

- Promote knowledge-sharing and peer learning across organizations.

Deepen collaborative relationships among local leaders who serve families of children with special health needs.

Increase access to tools, resources, and shared strategies that improve the day-to-day effectiveness and resilience of family support staff.

These activities contribute to a more supported and capable workforce by investing in the community-based organizations that families rely on most.

Connected

Collect and Analyze Data to Better Understand the Needs of CSHCN and their Families

To inform planning and strengthen services for CSHCN, MDH continues to collect, analyze, and share data focused on the needs and experiences of families across the state.

National Survey of Children's Health (NSCH) – Oversampling and Analysis

In FFY2024, MDH supported an oversample of Minnesota households completing the National Survey of Children's Health (NSCH), using state funds to increase the number of children in the state sampled as a part of the national protocol. This expanded sample will allow for more detailed analyses on family experiences and system access. Title V-supported staff within the CSHCN program are leading much of the data analysis to inform planning, reporting, and future evaluation.

Oversampling data will also contribute to a broader data dashboard currently in development. While developed separately from the NSCH effort, the dashboard will ultimately incorporate NSCH findings and other relevant data sources to provide a more comprehensive picture of the needs of families of CYSHCN in Minnesota. The dashboard is being built in collaboration with MDH's Data Strategy and Interoperability team and will meet state accessibility and usability standards. Future maintenance and use will be shared by the CSHCN and Child and Family Health programs.

CHSTRONG-KIDS Study – Congenital Heart Defects Survey

Minnesota also participated in the national *Congenital Heart Survey To Recognize Outcomes, Needs, and well-beinG*[RS1][BN2][RS3] *of KIDS* (CHSTRONG-KIDS) study, which surveys caregivers of children with selected congenital heart defects. In FY2024, MDH finalized survey materials—including Somali translations specific to Minnesota's population—and implemented a statewide communications plan to increase awareness among families and providers. Efforts included posters for clinics, newsletter articles, and a project website with frequently asked questions.

By the end of September 2024, outreach was conducted to 2,287 eligible caregivers. More than 700 surveys were completed, resulting in a 36% response rate for completed recruitment cases. Approximately 60% of surveys were completed on paper, and 40% online (available only in English and Spanish). Ten surveys were completed in Spanish. While translated Somali surveys were distributed to eligible caregivers based on early language preference, no Somali-language surveys were completed. Limitations in the web-based platform prevented an online Somali version from being offered.

MDH also submitted de-identified surveillance data to the CDC in May and September 2024. Geocoding of birth addresses began in fall. Minnesota's analysis priorities for this project include:

1. Health care utilization
2. Educational attainment
3. Transition from pediatric to adult care for adolescents with congenital heart defects.

State Newborn Screening System Priorities Program

In July 2023, MDH was awarded the State Newborn Screening System Priorities Program (NBS Propel) grant from HRSA. The program focuses on improving family engagement and system navigation for those affected by conditions identified through newborn screening, beginning with congenital cytomegalovirus (cCMV).

MDH issued a request for proposals (RFP) in November 2024 to identify a contractor to support stakeholder engagement with families of children diagnosed with cCMV and providers serving them. A contract was executed in June 2024. Planning began for a series of focus groups and interviews to better understand common experiences, service coordination needs, and system navigation challenges among families and providers. Findings will inform future improvements in newborn screening follow-up and support efforts.

Coordinate Online Resource Directories with Interagency Partners

To implement this strategy, MDH collaborated with interagency partners to strengthen centralized online resource directories, with particular attention to the needs of families with older children and youth.

Four directories have been the focus of these efforts:

MN Disability Hub: A statewide resource network that assists individuals with disabilities and their caregivers in planning and accessing services. Title V CSHCN Staff provided input on the expansion of child- and youth-focused content, including the integration of *Charting the LifeCourse* materials. The Disability Hub was also featured in a webinar within the Pediatric Care Coordination Community of Practice.

Help Me Connect (HMC): An online navigation tool that connects expectant families, families with young children (birth – age 8), and providers with local community services that support child development and family well-being. Site analytics indicate high user interest in autism-related and developmental resources. CSHCN staff contributed to HMC's development to ensure that resources commonly used by families of CSHCN – including medical, developmental, and mental health needs – are represented. Staff also collaborated with Early Hearing Detection and Intervention and interagency autism workgroups to expand relevant content. **Note: As of January 1, 2025, Help Me Connect is now housed within the newly created Department of Children, Youth, and Families. Title V staff remain engaged as collaborative partners.*

MN Autism Portal: A multi-agency effort to provide accessible, up-to-date information and resources for individuals and families navigating autism spectrum disorder (ASD). CSHCN staff participate in the interagency autism workgroup that informed the development and ongoing content of the portal.

FastTrackerMN: A statewide online tool that provides real-time information about behavioral health providers and resources. It includes details on service availability, treatment options, referral protocols, and recovery and support groups, and is available in English, Spanish, Hmong, and Somali. CSHCN staff have contributed to recent improvement efforts to ensure the tool remains responsive to family and provider needs.

Participate in statewide efforts to reduce emergency department boarding and improve access to appropriate mental health care for children and youth

Throughout FFY2024, MDH collaborated with mental health organizations and state partners to implement and sustain the Mental Health Collaboration Hub (MHCH), a centralized, real-time platform designed to support timely placement of youth in emergency departments who are experiencing mental or behavioral health crises. The MHCH serves as both an online database and a collaborative problem-solving forum, helping to reduce prolonged hospital stays and improve access to appropriate care settings.

Weekly consultation calls were held throughout the year, bringing together 20 to 30 professionals per session from across the state to discuss active cases, share resource information, and coordinate efforts to connect youth to available services. These calls promoted real-time communication between health systems, mental health providers, and care coordinators, supporting more responsive and coordinated care.

As of November 2024, the MHCH included 229 participating organizations and 512 registered users. During the reporting period, 292 children and adolescents (ages 8 to 17) were supported through the MHCH's online portal and collaborative case consultation process. Among participating cases, the average number of days youth spent boarded in emergency departments was reduced by approximately 55%, reflecting significant gains in timely connection to appropriate services and supports.

This work contributes to broader statewide efforts to reduce emergency department boarding, promote continuity of care, and strengthen statewide capacity to respond to youth mental health needs—particularly for those with complex behavioral or developmental profiles.

Partner to Provide Parent-to-Parent Support for Families of Children with Hearing Differences and cCMV

During FFY2024, MDH continued its agreement with Minnesota Hands & Voices (MNH&V), a part of Lutheran Social Service of Minnesota, to provide parent-to-parent support for children who are deaf, deafblind, and hard of hearing (DHH/DB). Each year in Minnesota, approximately 250 infants and children are identified as DHH/DB through newborn screening and diagnostic follow-up.

Under this agreement, trained parent guides from MNH&V connect with families shortly after a child is identified and provide individualized support. This includes information on communication approaches, education planning, and medical considerations for hearing loss. Parent guides share information in a family-centered, non-directive manner to support informed decision-making.

Minnesota has supported this work through ongoing state funding. In 2007, the legislature approved a statutory provision (Minnesota Statutes 144.966 Subd. 3a) authorizing funding for a nonprofit organization to provide support services for families of children who are deaf or hard of hearing.

In 2023, the MDH grant with MNV&V was amended to expand services to include families of children identified with congenital cytomegalovirus (cCMV). This expansion includes support for:

Families of children with hearing loss attributed to cCMV.

Families of children with symptomatic cCMV and typical hearing, who may require continued monitoring for hearing changes.

[RS1]@Brown, Nicole (MDH) is this part intentional?

[BN2]Yes - it's the G in CHSTRONG :)

[RS3]hahaha

Coordinated support and access for CSHCN

CSHCN PLAN 2026

Description: Expand awareness of available services and improve access to high-quality, family-centered supports that help children, youth, families, and care teams address health and development in ways that reflect their needs and preferences across settings.

Background

According to the 2022-2023 National Survey of Children's Health (NSCH), approximately 338,351 children and youth in Minnesota (approximately 26.1% of 0–17-year-olds) have physical, developmental, behavioral, or emotional conditions that require more services than typically needed. These children and youth are considered to have special health care needs (CSHCN), and may require support across multiple settings, including medical care, education, and community-based programs.

Despite the broad range of services available, many families report difficulty navigating and accessing the care their children need. Challenges such as limited provider availability, long wait times, unclear points of entry, and lack of coordination across systems can lead to delays in care or missed services altogether.

One Minnesota parent described the impact this has on daily life:

> *"Ultimately, I am in charge of coordinating EVERYTHING… and I face many challenges in doing so. It all takes so much time…making calls, attending appointments, gathering necessary paperwork...it's a full-time job with no paycheck. It's also time taken away from my other children and my family. Sometimes it's even difficult to know 'who' can help with 'what.'"*

This experience is reflected in statewide performance data. Only 14.2% of CSHCN in Minnesota are reported to be receiving care within a well-functioning system. This is based on indicators that assess whether:

- Families are engaged as partners in care
- The child has access to a medical home
- Preventive medical and dental care is received
- Insurance coverage is continuous and adequate
- Needed services are accessible without delay or difficulty
- (For youth ages 12-17) There is support for transitioning from pediatric to adult health care.

Given these challenges, Minnesota has prioritized improving access and strengthening coordination for CSHCN. This priority will guide strategies and activities to help promote timely care and strengthen systems that support children, youth, and their families.

Measuring success

Objective

By 2030, increase the percentage of CSHCN who have a medical home by 15%.

National Performance Measure

Medical Home

Percent of children with special health care needs, ages 0 through 17, who have a medical home.

Medical home is one of two universal National Performance Measures (NPMs) required for all Title V programs. It reflects a model of care that is family-centered, continuous, comprehensive, coordinated, compassionate, and respectful of each child's and family's needs and preferences. For CSHCN, this model is especially critical given the complexity of their care.

The medical home model promotes strong, ongoing relationships between families and primary care providers. These trusted relationships support consistent care, shared decision-making, and better coordination across the providers and services involved in a child's care. Medical homes also help families navigate complex systems, access necessary services more efficiently, and reduce the burden families often face in managing care along.

In Minnesota, 44% of CSHCN were reported having a medical home in 2022-2023, compared to 39.3% of nationwide. Minnesota's goal for FFY2026 is that 45.3% of CSHCN have a medical home. Improving access to medical homes is central to the state's CSHCN priority of increasing access to care and strengthening care coordination—ensuring that all children and youth have the support they need to thrive.

Evidence-Based/Informed Strategy Measure

Care Coordination Community of Practice – Care Coordinator Professional Development

Percent of care coordinators reporting increased knowledge in serving CSHCN and their families after participating in Community of Practice (CoP) webinars.

In Minnesota, only 57.7% of CSHCN received the care coordination they needed (NSCH, 2022-2023). Care coordination is a foundational element of the medical home model and plays a critical role in connecting families to appropriate services and supports.

To strengthen this function, Minnesota established a Pediatric Care Coordination Community of Practice (CoP) as our primary strategy for our Evidence-Based Strategy Measure (ESM). Through regular webinars and peer-to-peer learning, care coordinators build knowledge, share effective practices, and identify ways to improve system navigation and service access.

This model not only enhances individual skills but also helps build capacity across multiple systems, supporting better outcomes for children and families. A key area of focus includes helping families understand and use their health insurance and identifying financial supports needed to access care.

Strategies and activities

Through the 2025 statewide Title V needs assessment and action planning, the strategies and activities below have been highlighted to focus on for the 2025-2030 Title V grant cycle of work specific to the CSHCN population domain.

CSHCN Strategies

- Strengthen family-centered, evidence-informed supports, services, and resources.
- Involve families and caregivers in shaping, implementing, and improving programs and services.
- Collaborate across systems to simplify family navigation and improve access to resources and supports.
- Support local efforts to provide services and resources in ways that meet family needs and preferences.

CSHCN Activities

STATE TITLE V

Supported

Expand Knowledge and Connections through the Minnesota Pediatric Care Coordination Community of Practice

The Minnesota Pediatric Care Coordination Community of Practice (CoP) is a cornerstone Title V activity that strengthens care coordination systems for CSHCN statewide. The CoP serves as a collaborative learning community for professionals who provide care coordination in clinical, educational, public health, and community-based settings. Through shared learning, resource exchange, and peer-to-peer connection, the CoP builds both individual capacity and system-wide alignment in support of effective, family-centered care.

Beginning in FFY2025, MDH's Title V CSHCN program assumed direct facilitation of the CoP, increasing our ability to align content, outreach, and engagement efforts with broader public health goals. Participation includes over 700 professionals from 51 counties and a wide range of roles, including public health nurses, school nurses, clinic-based care coordinators, social workers, and case managers. Webinars, facilitated discussions, and an online platform (hosted via Basecamp) provide practical opportunities to strengthen professional knowledge, share tools and strategies, and build trusted relationships that support coordinated care.

The CoP is also the foundation for Minnesota's Title V CSHCN Evidence-Based Strategy Measure (ESM). The ESM tracks changes in participants' knowledge and skills after participating in CoP learning activities. By embedding evaluation into the design of the CoP, Minnesota ensures continuous quality improvement and alignment with national MCH priorities around medical home, access, and care coordination.

In FFY2025, Minnesota piloted a new co-design model for the CoP that will be fully implemented in FFY2026. This structure includes two aligned groups:

- A Steering Committee composed of care coordination professionals from across Minnesota who help shape the CoP's content and priorities, and
- An internal MDH Working Group made up of staff from key CSHCN-related programs (e.g., newborn screening, school health, health care homes), who contribute agency expertise and alignment across efforts.

This two-tiered approach supports shared leadership, creates space for community members to shape direction and design, and ensures internal MDH alignment with the broader goals of the CoP.

Planned FFY2026 activities include:

- Expanding family voice by embedding stories and experience into learning sessions and inviting family members to join the Steering Committee.
- Hosting professional development activities focused on best practices in care coordination, shared decision-making, family engagement, and service navigation.
- Conducting ongoing needs assessments to identify gaps and shape training priorities based on the real-world needs of participants.
- Strengthening outreach and promotion to better engage providers and geographic areas, using MDH's internal leadership to guide tailored strategies.
- Maintaining Basecamp as a central hub for communication and peer exchange, including a directory and curated resources.

Continuing robust evaluation efforts tied to our ESM, tracking changes in care coordinator knowledge and perceived capacity.

With enhanced internal leadership, deeper family engagement, and a clear co-design structure, the Pediatric Care Coordination Community of Practice remains a central mechanism for improving care coordination in Minnesota. FFY2026 activities will continue to strengthen this network of support—helping those who coordinate care better connect, learn, and lead on behalf of the children and families they serve.

Explore Sustainable Financing Strategies to Support Systems of Care for CSHCN

For CSHCN, effective care coordination, pediatric-to-adult health care transition supports, and medical home implementation depend on systems and structures that are financially sustainable. In FFY2026, Minnesota's Title V CSHCN program will prioritize foundational relationship-building and exploration to better understand how financing and payment mechanisms—particularly within Medicaid—can support high-quality, family-centered care for CSHCN across the state.

Through efforts like the Pediatric-to-Adult Health Care Transition Learning Collaborative and the Pediatric Care Coordination Community of Practice, MDH has consistently heard from families and providers that implementation challenges often stem from a lack of infrastructure and aligned payment strategies. To meaningfully advance systems change, Minnesota must ensure that effective models of care are also financially feasible and scalable.

FFY2026 will serve as a strategic planning year, with core activities including:

Building and strengthening relationships with Minnesota's Medicaid program (housed within the Department of Human Services): This will include initiating regular communication, deepening shared understanding of Title V priorities and Medicaid priorities, and identifying opportunities for collaborative learning or alignment. These relationships are essential to laying the groundwork for future systems improvements.

Conducting a landscape scan and structured interviews with providers, state agency staff, family organizations, and policy experts to assess:

Existing financing mechanisms that support CSHCN services, such as transition planning and care coordination.

Barriers to implementing and sustaining evidence-informed models like the medical home.

Opportunities for alignment with value-based payment initiatives, including Health Care Homes and Integrated Health Partnerships (IHPs).

Exploring partnership opportunities with existing cross-sector initiatives to identify where MDH's Title V CSHCN team can contribute or collaborate in support of shared goals.

Engaging with the Minnesota Rare Disease Advisory Council (RDAC) and other external partners to explore complementary advocacy roles. These partners are well-positioned to elevate aligned priorities and advance shared goals, especially in spaces where state agencies may face constraints.

Synthesizing learnings and developing a roadmap for future work, including possible policy briefs, technical guidance, or pilot opportunities that can be explored in subsequent years.

This work will be informed by ongoing Title V engagement with families and providers and will center real-world implementation needs. By strengthening relationships, deepening understanding of the financing landscape, and identifying strategic opportunities, MDH will be well-positioned to support sustainable systems change in future years.

Partner with the Rare Disease Advisory Council to Support System Improvements

In FFY2026, Minnesota's Title V program will continue its active participation in the Minnesota Rare Disease

Advisory Council (RDAC) through the Title V CSHCN Director, who serves as the Commissioner of Health's appointed representative. The RDAC is an independent, governor-appointed body charged with advising the state on matters related to rare diseases—including research, diagnosis, treatment, and education. Its membership includes health care providers, health system administrators, researchers, caregivers, individuals with lived experience, health plan representatives, and legislators.

While MDH does not lead the RDAC, the department plays a collaborative role by sharing public health insights, elevating system-level considerations, and supporting policy efforts that aim to reduce barriers for individuals with rare and medically complex conditions. In FFY2026, Title V staff will continue to participate in council meetings and contribute to cross-sector conversations related to access, care coordination, and systems integration.

Specific areas of focus for the coming year will include:

- Continued engagement on issues related to newborn screening, including how Minnesota considers the addition of new conditions to the panel and supports access to treatments following diagnosis.
- Exploration of policy opportunities to improve timely diagnosis and support for care navigation and service coordination for children and families managing rare and complex conditions.
- Participation in collaborative efforts to identify gaps and inform system-level strategies, particularly in areas where advocacy partners like the RDAC can act when state agencies are limited in their ability to do so directly.

In FFY2026, MDH will also work to strengthen its relationship with the RDAC as a strategic partner in broader Title V systems-change efforts. This includes exploring aligned priorities, sharing relevant data and family insights, and identifying ways to ensure that rare disease perspectives are reflected in statewide planning efforts related to medical complexity, transition, and financing.

Strengthen Capacity for Systems Change through the Family Support Organization Collaborative

The Minnesota Family Support Organization Collaborative (FSOC) is a statewide initiative designed to strengthen the capacity of family-serving organizations to contribute to systems and policy change that benefits CSHCN and their families. Co-designed in partnership with a dedicated Steering Committee, the FSOC offers a shared space for peer connection, knowledge exchange, and collaboration across family support organizations. The FSOC also serves as a bridge between MDH's Title V CSHCN program and the community organizations that families rely on most.

In FFY2026, Minnesota will deepen the FSOC's impact through continued co-design, intentional expansion, and broader knowledge-sharing efforts. Specific activities planned for FFY2026 include:

- Hosting virtual FSOC gatherings every other month, building on the current format to support connection, shared learning, and input on systems-level issues.
- Expanding membership of the FSOC Steering Committee.
- Planning and hosting a statewide in-person meeting in spring 2026, with an anticipated focus on healing-centered practices and supporting the workforce.
- Building upon the dedicated FSOC landing page on the MDH website, offering general information, registration for gatherings, and visibility for participating organizations.
- Implementing a structured outreach plan to grow participation among underrepresented organizations and community groups.
- Continuing to work with the Steering Committee as a thought partner, shaping session content, engagement strategies, and priorities for the Collaborative.

Through its emphasis on co-design, relationship-building, and systems alignment, the FSOC is an essential mechanism for strengthening the role of family support organizations in Minnesota's Title V CSHCN work. FFY2026 efforts will continue to build momentum, ensuring this community-led initiative remains a trusted and effective space for collaboration and action.

Strengthen Local Public Health Capacity to Support Families of CSHCN

Minnesota's Title V CSHCN staff collaborate with colleagues in the MDH CSHCN Section to strengthen LPH capacity to provide family-centered follow-up for children identified through newborn screening, birth defects surveillance, and developmental screening. While Title V does not directly fund LPH follow-up activities, Title V-funded staff contribute critical training, technical assistance, and a systems-level perspective to ensure that local implementation is supported and aligned with broader public health efforts.

All 87 LPH agencies in Minnesota are contracted through the MDH CSHCN Section to conduct follow-up with families of children identified with certain conditions. Public health nurses reach out to families to assess needs, offer education, and facilitate connections to relevant services across the health, early childhood, and community support systems. Nurses document concerns and follow-up actions in a shared database, which supports cross-program coordination and helps identify areas for systems improvement.

In FFY2026, MDH will continue implementation of this coordinated follow-up system, including outreach to families of children who may be at increased risk for special health needs—such as those experiencing developmental delays or neonatal abstinence syndrome. Title V CSHCN staff will support these efforts by contributing to implementation planning, engaging local partners, and helping ensure that service delivery reflects both family needs and community context.

Title V staff will also continue supporting capacity-building through activities such as the 2026 Annual LPH CSHCN Meeting—a statewide training event that brings together LPH staff to strengthen professional skills, share insights, and deepen cross-county collaboration. Throughout the year, Title V staff help translate real-world lessons from families and LPH professionals into broader systems learning, contributing to continuous improvement across the state.

In addition, an evaluation and needs assessment will be conducted in FFY2026 to better understand current strengths and opportunities within the follow-up system. Findings will inform strategic planning and guide future technical assistance efforts.

Use Data to Better Understand the Needs of CSHCN and their Families and Drive Programmatic Decision-Making

Reliable, relevant data is essential to understanding family experiences and improving systems of care for CSHCN. In FFY2026, Minnesota's Title V CSHCN program will continue to lead and support a range of data collection and analysis activities designed to inform program planning, support systems learning, and strengthen services across the state.

FFY2026 activities will include continued analysis of Minnesota's National Survey of Children's Health (NSCH) oversample. With data collected in FFY2024 and FFY2025 through a state-funded oversampling initiative, Title V staff will lead targeted analyses to better understand access, quality of care, and family outcomes for CSHCN. These analyses will inform federal reporting, statewide planning efforts, and internal evaluation. Key findings will also be integrated into a new public-facing data dashboard, developed in collaboration with MDH's Data Strategy and Interoperability team. The dashboard will incorporate NSCH data alongside other sources to provide a more complete picture of the needs of families across Minnesota. Dashboard development is being designed to meet state standards for accessibility, readability, and use by stakeholders.

Minnesota will also continue work on the CHSTRONG-KIDS study, a national survey of families of children with congenital heart defects. In FFY2026, MDH will finalize manuscript development focused on Minnesota-specific priorities, including:

Health care use patterns and care coordination gaps,

Educational outcomes and supports, and

The transition from pediatric to adult health care for youth with congenital heart disease.

These analyses will help inform broader system planning, as well as future opportunities to support transition-aged youth with complex medical needs. MDH will also continue working with CDC to complete required data submissions and geospatial analyses.

Additionally, continued partner engagement and data collection activities under Minnesota's Newborn Screening System Priorities Program (NBS Propel) will occur during FFY2026, focused initially on children diagnosed with congenital cytomegalovirus (cCMV). A newly contracted partner will coordinate focus groups and interviews with families and providers, with MDH leading coordination and integration of findings into newborn screening follow-up practices. Activities will center on understanding navigation challenges and identifying opportunities for improving care continuity and family engagement following diagnosis.

Together, these data and evaluation efforts will enhance Minnesota's ability to make informed, family-centered improvements to systems of care for CSHCN in FFY2026 and beyond.

Connected

Advance Interagency Collaboration to Support Youth Transitioning into Adulthood

In FFY2026, Minnesota's Title V CSHCN program will continue to participate in and support cross-agency efforts to improve the experience of youth transitioning from pediatric to adult systems of care. This work reflects strong collaboration between MDH and the Departments of Human Services (DHS), Education (MDE), and Employment and Economic Development (DEED), with a shared goal of strengthening coordinated, person-centered support for CSHCN and their families.

A key focus of this interagency work is expanding the use of person-centered and cross-system planning approaches in local communities. Through the Person-Centered Planning and Coordination Pilot Project, the interagency team has developed a flexible menu of tools and practices that communities can adopt and adapt based on local needs. In FFY2026, efforts will continue to focus on supporting teams working with youth who experience behavioral health challenges or complex disabilities. MDH staff will contribute by offering consultation, sharing resources, and participating in community-level coaching efforts to strengthen implementation and family engagement.

Additionally, MDH will continue contributing to the Employment Capacity Building Cohort (ECBC) and the implementation of Minnesota's Youth in Transition Framework and Toolkit. This framework, developed in partnership with the E1MN initiative and local transition leaders, outlines shared goals and practical strategies to guide professionals in education, health, and employment sectors as they support young people transitioning into adulthood.

A special interest group of school health nurses will also remain active in FFY2026, building on past work to explore best practices in integrating health into special education and transition planning. This group provides an important forum for collaboration and learning among professionals who support students with complex needs.

Minnesota will also continue participating in the National Community of Practice for Supporting Families, a cross-agency initiative that uses the Charting the LifeCourse (CtLC) framework to promote family-centered practices and

systems change. Through this initiative, MDH staff contribute to the leadership of MN-Connect, a statewide network that fosters peer learning and systems alignment across sectors.

Together, these interagency partnerships help improve system navigation, increase access to coordinated supports, and ensure that CSHCN—and their families—are equipped with the information, resources, and relationships they need as they move into adulthood.

Advance Pediatric-to-Adult Health Care Transition through Statewide Learning and Collaboration

Minnesota's Pediatric-to-Adult Health Care Transition Learning Collaborative is a statewide initiative focused on improving how youth and young adults with special health needs and disabilities (YSHND) move from pediatric care into adult health care settings. This period—commonly called health care transition—is a critical time when gaps in coordination can lead to disruptions in care. Through this Collaborative, the MDH, in partnership with a major specialty health system in Minnesota, works to strengthen provider knowledge, improve alignment across systems, and better support youth and families during this key developmental stage.

The Collaborative brings together health care providers, systems leaders, youth and caregivers, and subject matter experts to share strategies, build connections, and reduce fragmentation across pediatric and adult health systems. Using a virtual format based on the Project ECHO® model, the initiative facilitates regular learning sessions on practical approaches to health care transition. Session topics have included supported decision-making, care planning, insurance continuity, trauma-informed practices, and community-based supports. A statewide summit held in a previous year also helped participants from different sectors explore cross-system solutions to common challenges.

Looking ahead to FFY2026, Minnesota will continue to build on this work and deepen its impact through the following activities:

- Coordinate regular learning sessions for health care and community-based providers using the Project ECHO® model. These sessions will focus on best practices for supporting youth as they move from pediatric to adult health care, with an emphasis on real-life case consultation and shared learning.
- Integrate youth and caregiver perspectives by inviting individuals with experience to share their stories or co-facilitate discussions, helping participants connect technical strategies with real-world impact.
- Maintain and strengthen an advisory group of cross-sector partners and families to inform session content, expand reach, and guide evaluation.
- Expand outreach and engagement to involve a broad group of providers, systems partners, and geographic regions across the state.
- Support continuous improvement by collecting participant feedback and tracking changes in provider confidence and understanding of pediatric-to-adult health care transition processes.
- Develop and promote provider tools to help teams apply what they learn to their local context, including checklists, planning templates, and communication strategies.

With continued coordination from MDH and facilitation by a major specialty health system in Minnesota, the Pediatric-to-Adult Health Care Transition Learning Collaborative will remain a key strategy for supporting youth with special health needs as they move into adult care systems. FFY2026 activities will continue to strengthen provider confidence, reduce system gaps, and improve the experiences of families navigating this important phase of care.

Partner to Provide Parent-to-Parent Support for Families of Children with Hearing Differences and cCMV

During FFY2026, MDH will continue its partnership with Minnesota Hands & Voices (MNH&V), a program of

Lutheran Social Service of Minnesota, to provide parent-to-parent support for families of children who are deaf, deafblind, or hard of hearing (DHH/DB), as well as families of children affected by congenital cytomegalovirus (cCMV). Through this agreement, trained parent guides with lived experience will offer individualized, family-centered support to help caregivers navigate early decisions related to communication, education, and care coordination.

Support will be provided shortly after a child's identification through the Early Hearing Detection and Intervention (EHDI) system and will include continued outreach to families of children with hearing loss due to cCMV, as well as those with symptomatic cCMV and typical hearing. MDH will continue to fund and monitor this effort as part of its broader strategy to promote informed decision-making, strengthen family support networks, and ensure early connections to services for young children with hearing-related needs.

Partner with Interagency Teams to Strengthen Online Resource Directories for Families of CSHCN

Minnesota's Title V CSHCN staff collaborate with interagency partners to improve the quality, relevance, and accessibility of centralized online resource directories that serve families of CSHCN. While MDH does not lead the development or maintenance of these platforms, Title V staff play an important role in shaping content to ensure the tools are family-centered, accurate, and includes resources commonly used by families navigating disability, medical complexity, and mental health needs.

In FFY2026, MDH will continue to serve as a contributing partner across four key directories:

Disability Hub MN: Title V staff will continue working with Disability Hub teams to strengthen youth- and family-facing content and promote tools such as Charting the LifeCourse. Disability Hub is also featured within MDH-led initiatives such as the Pediatric Care Coordination Community of Practice, Health Care Transition Learning Collaborative, and Family Support Organization Collaborative to promote broader awareness among providers.

Help Me Connect (HMC): Now housed within the Minnesota Department of Children, Youth, and Families, HMC is an online navigator tool designed for families with young children. Title V staff will remain engaged to ensure the tool reflects the needs of CSHCN families—especially those seeking developmental, medical, or mental health supports. This includes coordinating across internal MDH programs (e.g., EHDI) and external interagency workgroups to continuously improve content.

Minnesota Autism Portal: Through participation in the interagency autism workgroup, Title V staff provide ongoing input to ensure the portal is responsive to the needs of families of children with autism and other neurodevelopmental conditions.

FastTrackerMN: Title V staff will continue contributing to improvement efforts for this real-time behavioral health resource directory to ensure it includes children's mental health providers and is accessible to families and care teams.

These efforts are designed to make online tools easier to use, more comprehensive, and better aligned with the real-life information needs of Minnesota families.

LOCAL TITLE V

Connected

Provide Family-Centered Follow-Up for CSHCN

In FFY2026, Minnesota's local public health (LPH) agencies will continue providing family-centered follow-up for children identified through newborn screening, birth defects surveillance, and developmental screening. Through contracts with the MDH CSHCN Section, all 87 LPH agencies carry out follow-up services designed to connect families with timely, appropriate supports across health, early childhood, and community systems.

Public health nurses play a central role in this work by:

- Reaching out to families following identification of a qualifying condition,
- Conducting assessments to better understand the child's and family's needs,
- Sharing information and education about relevant services and supports,
- Facilitating connections to health care providers, early intervention services, family support organizations, and other community-based resources.

As part of this process, public health nurses often assist families in navigating complex eligibility and service pathways, including helping families understand Medical Assistance options such as TEFRA and supporting referrals to the State Medical Review Team (SMRT) process. They also ensure families are aware of Home and Community-Based Services (HCBS) that may be available to support their child's needs.

LPH staff utilize tools like Help Me Connect to identify and refer families to appropriate services and maintain documentation of concerns and follow-up actions in a shared database. This system helps track support provided, promotes coordination across state and local programs, and informs broader systems improvement over time.

During FFY2026, LPH agencies will also:

- Continue implementing follow-up for families of children at increased risk for special health needs, including those experiencing developmental delays or neonatal abstinence syndrome.
- Provide education to help staff understand and respond to individual family preferences and beliefs that may shape how services are received.
- Adapt outreach and engagement approaches to reflect the unique needs and contexts of different communities and families.
- Participate in statewide training and networking opportunities, such as the 2026 Annual LPH CSHCN Meeting, to build professional knowledge, share promising practices, and collaborate with peers across counties.
- Engage in a statewide evaluation and needs assessment to reflect on local practices, identify strengths and gaps, and inform future planning and quality improvement efforts.

This work is grounded in family-centered, evidence-informed approaches and reflects LPH's ongoing commitment to supporting CSHCN in partnership with state agencies and community partners.

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Number of resources provided to Title V grantees and state staff through the Minnesota Title V Resources and Support Hub.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	15.0	30.0	45.0	50.0	55.0

Evidence-Based or –Informed Strategy Measures

None

SPM 2 - Percent of Minnesotan communities that have a high Area Deprivation Index (ADI)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	29.0	29.0	28.0	27.0	26.0

Evidence-Based or –Informed Strategy Measures

None

State Action Plan Table

State Action Plan Table (Minnesota) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Optimal systems and policies
SPM
SPM 1 - Number of resources provided to Title V grantees and state staff through the Minnesota Title V Resources and Support Hub.
Five-Year Objectives
By 2030, Minnesota aims to have 50 resources provided to Title V grantees and state staff through the Minnesota Title V Resources and Support Hub.
Strategies
Amplify community responsive resources, services, and supports to address systems and policies to support the health and wellbeing of MCH populations who are medically underserved and at greater risk for poor health outcomes.
Develop and mobilize strong interagency, multisector, and community partnerships to respond to uneven trends in maternal and infant deaths through targeted interventions.
Build workforce and partner capacity to promote systems and policies that optimally serve all MCH populations in Minnesota.
Engage partners and interest holders to promote family engagement and partnership across all sectors.
ESMs **Status**
No ESMs were created by the State. ESMs are optional for this measure.

State Action Plan Table (Minnesota) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Community health drivers

SPM

SPM 2 - Percent of Minnesotan communities that have a high Area Deprivation Index (ADI)

Five-Year Objectives

By 2030, decrease the proportion of Minnesota counties that have a high Area Deprivation Index (ADI) by 10%.

Strategies

Amplify resources, services, and supports that are responsive to community needs and support the health and wellbeing for all.

Strengthen the capacity of public health professionals and community leaders to effectively address community health drivers, such as housing and early childhood systems of care, using a public health lens.

Vitalize Title V activities to address community health factors to improve MCH outcomes and access to care across the life course.

Ensure data produced and reported through Title V highlight meaningful differences in maternal and child health outcomes, explore root causes, discuss their impact, and provide recommendations for improving health across MCH populations.

ESMs	Status

No ESMs were created by the State. ESMs are optional for this measure.

2021-2025: State Performance Measures

2021-2025: SPM 1 - Percent of Minnesotans that did not get routine medical care that they needed because of cost

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		7.3	6.7	6.2	5.6
Annual Indicator	7.8	5.4	5.4	7	7
Numerator					
Denominator					
Data Source	Minnesota Health Access Survey	Minnesota Health Access Survey	Minnesota Health Access Survey	Minnesota Health Access Survey	Minnesota Health Access Survey
Data Source Year	2019	2021	2021	2023	2023
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SPM 3 - Proportion of Minnesota adolescents who report staying in a shelter, somewhere not intended as a place to live, or someone else's home because you had no other place to stay in the past 12 months

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		4.4	4.2	4.1	2.5
Annual Indicator	4.4	4.4	2.9	2.9	2.9
Numerator	5,577	5,577	2,966	2,966	2,966
Denominator	125,375	125,375	100,836	100,836	100,836
Data Source	MSS	Minnesota Student Survey	Minnesota Student Survey	Minnesota Student Survey	Minnesota Student Survey
Data Source Year	2019	2019	2022	2022	2022
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SPM 4 - Percent of Minnesota adolescents who report having positive mental well-being - fulfilling relationships, contributing to community, and being resilient

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		37	37.8	39.6	39.7
Annual Indicator		36.7	22.7	22.7	22.7
Numerator			22,890	22,890	22,890
Denominator			100,836	100,836	100,836
Data Source		Minnesota Student Survey	Minnesota Student Survey	Minnesota Student Survey	Minnesota Student Survey
Data Source Year		2019	2022	2022	2022
Provisional or Final ?		Final	Final	Final	Final

2021-2025: SPM 5 - Percent of children, ages 0-17, living with parents who are coping very well with the demands of parenthood

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		65.9	66.5	67.2	67.8
Annual Indicator	63.3	59.4	56.2	56.7	54.2
Numerator			718,858	726,270	689,794
Denominator			1,279,740	1,281,856	1,273,190
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Provisional or Final ?	Final	Final	Final	Final	Final

2021-2025: SPM 6 - Percent of Division staff who have completed the Tribal State Relations Training

Measure Status:			**Active**
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			55
Annual Indicator			66.7
Numerator			104
Denominator			156
Data Source			CFH Managers
Data Source Year			As of May
Provisional or Final ?			Final

Cross-Cutting/Systems Building 2024 Report

ACCESSIBLE AND AFFORDABLE HEALTH CARE

Description: Comprehensive, quality health care services, including Family Planning, that are available and affordable for all.

Background

Minnesota's five-year comprehensive needs assessment identified a significant area of need in comprehensive, quality health care services, including family planning, that are available and affordable for all. Accessible and Affordable Health Care is a cross-cutting priority area for Minnesota.

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, timeliness of entry into services and many more factors. Poor access to health care services can result in unmet health needs, lack of preventive services, hospitalization, and increased financial burden. Just as important as access is the alarming rising costs of health care.

Approximately 3.8% of Minnesotans lacked health insurance coverage in 2023, according to the most recent Minnesota Health Access Survey. The rate of coverage has continued increasing since 2017. Uninsurance rates have decreased by over 30% from 6.1% in 2017 to 3.8% in 2023.

System-wide factors in rural communities continue to negatively affect health outcomes for individuals in these communities. Additionally, providers within a community may still not be accessible if they are not considered "in network" for insurance companies. Minnesotans living in rural areas experience more barriers to accessing health care because of decreased geographic access and health provider shortages. Data from 2024 shows that Minnesota has 121 Health Professional Shortage Areas and 97 Medically Underserved Areas. Rural residents are especially disadvantaged in terms of access to dental care with very few dental providers practicing in greater Minnesota counties.

Differences in access to health care are felt acutely among families of children with special healthcare needs (CSHCN). The cost of health care adversely affects families of CSHCN, with 17.1% of these families struggling to pay for a child's medical bills, compared to 6.8% of families without CSHCN.[1] Taken into consideration with the increased likelihood of parents of CSHCN to have to cut back their work hours or stop working altogether to provide care for their child particularly during the pandemic, the these challenges in accessing and affording health care can have a significant impact on families and their household income.

Measuring success

Objective

By 2025, reduce the percentage of Minnesotans that did not receive routine medical care they needed because of cost by 35%.

State Performance Measure

Routine Medical Care

Percent of Minnesotans that did not get routine medical care that they needed because of cost.

Minnesota's Title V program has chosen to focus priority goals on Minnesotans accessing needed care rather than insurance coverage alone. Therefore, measurement for this priority area is focused on the proportion of Minnesotans reporting an unmet need for medical care due to cost. The MDH Title V program gains access to this data through the Minnesota Health Access Survey (MHAS) hosted by the Health Economics program at MDH. The Minnesota Health Access Survey is a biennial telephone and mail survey that collects information on the health of Minnesotans and how they access health insurance and health care services. The survey measures how many people in Minnesota have health insurance and how easy it is for them to get health care.

The 2023 Minnesota Health Access Survey found that 7.0% of all Minnesotans did not get the routine medical care that they needed because of cost. This is an increase from the 2021 Minnesota Health Access Survey which showed 5.4% of Minnesotans had forgone routine medical care because of cost.

Strategies and activities

AAHC Strategies

1. Recognize and Reduce Differences in Health Care Quality and Access.
2. Expand Access to Health Care by Increasing Availability of Community-Based and Remote services.
3. Improve the Quality of Health Care by Promoting Person and Family-Centered Practices.

AAHC Activities

STATE TITLE V

Supported

Improve Data Available on Minnesotans with Disabilities

Since early 2024, analysis of two pediatric datasets was compiled and provided to create a custom dashboard compiling pediatric disability data for MDH and partners. The dashboard is currently being built manually to comply with accessibility and screen reading standards, and there are plans to have the dashboard managed by CSHCN and CFH.

We have also been in engagement with our community partners to determine appropriate indicators. Consulting partners have included those focused on persons with disabilities with other state agencies such as the Minnesota Department of Employment and Economic Development, Minnesota Department of Human Services, and Minnesota Department of Education.

As of Spring 2025, the dashboard is nearly complete and plans underway to transfer the dashboard onto CSHCN's website and create accessible documents to accompany the dashboard.

Connected

Increase Access to Family Planning

The Family Planning Special Projects grant program (now Sexual and Reproductive Health Services grant) provided funds to increase access to sexual and reproductive health services for people who experience barriers to these services. The goal is to support, sustain, expand, or implement pre-conception reproductive and sexual health programs for people of reproductive age to increase access to and availability of medically accurate sexual and reproductive health services.

In 2023, the Minnesota state Legislature enacted several changes to the FPSP statute to modernize the program and increase access to services. Changes included renaming the program as Sexual and Reproductive Health Services program and grant; expanding eligibility to include the 12 Tribes in the geographic area of Minnesota; removing the prohibition on funding services for unemancipated minors in schools; and adding $7,147,125 to the program, bringing the total annual funding to $13,500,125. A request for proposals (RFP) was started in October 2023 to expand services with existing FPSP grantees and fund new grantees. This resulted in a total of 35 grantees providing services in 69 of Minnesota's 87 counties (79%). In addition, SRHS supports a statewide Sexual Health Hotline - Minnesota Sexual Health Hotline - providing reliable, medically accurate, and confidential information for free via phone, text, and webchat.

In this reporting cycle 142,373 people received SRHS outreach services through 4,604 events, 25,839 received family planning methods and 21,818 received Chlamydia testing with an 7.7% positive rate. Fifty three percent of people receiving SRHS services had incomes less than 100% of poverty and seventy nine percent with incomes less than 250%.

Increase the Availability and Use of Non-traditional Workers

Follow Along Program – Community Connector project

The Follow Along Program (FAP) has partnered with eight community connector organizations throughout Minnesota. The FAP community connectors provide outreach and navigation support to help families enroll in and engage with the developmental screening program, connecting them to follow-up services and resources. Funding for this initiative has strengthened the use of Community Health Workers, including partially funding their FTEs at local public health agencies in two instances.

- Request for Proposals for a Community of Assessment of Strengths and Barriers to Accessing Midwife and Doula Services

MDH recognizes the community-informed solutions are needed to identify opportunities and gaps connecting individuals to birthing services and resources that support optimal health outcomes. MDH contracted with a research and evaluation firm to develop a survey aimed at building a more comprehensive profile of doulas and birth workers in Minnesota. For the purposes of this survey, a doula or birth worker is defined as someone who provides continuous physical, emotional, and informational support to a perinatal woman before, during, and after childbirth to help her achieve the healthiest, most satisfying experience possible. The goal of this work is to develop a better understanding of doulas and birth workers in the state, identify barriers to becoming or practicing as a doula and gaps in service, and opportunities to improve access by building on strengths of the doula and birth worker workforce. In FFY2024, MDH and the contractor compiled, analyzed, and created a summary report of the final survey results.

- Maternal Care Access Coordinator

The Dignity in Pregnancy and Childbirth Act (144.1461) was passed by the Legislature in 2021 to address needs in maternal health care, calls on the state to increase the availability of, and access to, doula and midwifery services by removing barriers to communities disproportionately affected by maternal and infant morbidity and mortality. To help improve health in pregnancy and postpartum outcomes, MDH hired a Maternal Care Access Coordinator to develop and implement policies, activities, and programs, with community input, aimed at expanding access to prenatal care, doula, and midwifery services by working with internal and external partners and stakeholders.

In FFY2024, the Maternal Care Access Coordinator finalized the review of frameworks created by community doulas that aims to improve the doula certification process and reimbursement in Minnesota. Community input and assessment was implemented to reflect the suggestions outlined by the community doulas and other partners for improving the process and expand organizations for required training for birth doulas. Additionally, the Maternal Care Access Coordinator assessed the access to midwife services for communities experiencing the highest rates of disparate pregnancy outcomes. This information will be used to inform cross-sector collaborations with internal and

external stakeholders working to advance policies and systems changes to remove barriers to access for doula and midwife services such as trainings, certification, and reimbursement.

Partner with Minnesota's State Medicaid Program to Identify Populations Most likely to Experience Inequities in Health Settings

In FFY2024, MDH worked strategically to improve collaboration with the state's Medical Assistance (Medicaid) Program to identify opportunities among CSHCN and MCH populations who use Minnesota public health care programs. More specifically, Title V supported staff worked with the state's Medicaid Medical Director to identify gaps and opportunities for improvement Minnesota's Title V and Medicaid programs through finalization and implementation of an updated interagency agreement, including a shared workplan to be updated annually.

Promote and Provide Training on Accessibility in Health Care and Other Community Settings for Children and Adults with Disabilities

In FFY2024, CSHCN staff partnered with colleagues across MDH to launch a webpage focused on supporting disability inclusion in health care settings: www.health.state.mn.us/people/disabilities.html. This resource includes tools and guidance for health care professionals, such as disability etiquette tips, an accessibility self-assessment for providers, and practice resources for dental professionals serving people with disabilities. The webpage reflects MDH's ongoing commitment to improving access, respect, and quality of care for people with disabilities.

Provide Road Map/Technical Assistance to Expand Opportunities for Collaboration Between the Health Care System and Schools

In 2023, the Minnesota Legislature passed a state definition of School Based Health Centers (SBHCs) and the first-ever dedicated state funding for SBHCs and infrastructure. In January 2024, Minnesota started with 30 established SBHCs and 17 new and emerging clinics throughout the state. With the new legislative funding, MDH was able to award six grants to new and emerging clinics. Future grant funding rounds will support both new and emerging clinics along with established on open clinics.

In FFY2024, MDH provided a grant to the Minnesota School- based Health Alliance to partner and provide on-going technical assistance, training, and facilitate a community of practice to MN SBHCs in all stages from exploring, to emerging to running.

Additionally, MDH partnered with the National Association of School Nurses (NASN) to focus on professional development for school nurses in relation to school nursing practice and supporting students' mental health needs.

MDH also worked collaboratives with the National School-based Health Alliance and the Minnesota School-based Health Alliance, and the University of Minnesota, to set up a survey in REDCap for clinics to input their data in an effort support improved data sharing, collection, and use.

Cross-Cutting/Systems Building 2024 Report

AMERICAN INDIAN FAMILY HEALTH

Description: Supporting the wellbeing of American Indian families.

Background

Minnesota's five-year 2020 comprehensive needs assessment identified a significant area of need to support the wellbeing of American Indian families, making American Indian Family Health a cross-cutting/systems building priority area for the state.

Longstanding systemic barriers contribute to poor health outcomes among American Indian women, children, and families, who experience the greatest health challenges in Minnesota. These differences are influenced by historical and ongoing conditions that limit access to opportunity and wellbeing. Barriers within systems have denied American Indians access to adequate health care, employment, and food and nutrition. This has led to greater child poverty rates, a larger number of children growing up in single-parent households, greater rates of placement in out-of-home care, and lower high school graduation rates. In 2023, the American Indian and Alaska Native child poverty rate (ages 1-9) was 43% compared to 6.2% of all Minnesota children living in poverty.[2] Less than 62.8% of American Indian youth graduated from high school in 2024, compared to the overall state graduation rate of 84.2%.[3] Compared to white children, American Indian children in Minnesota are 16 times more likely to be placed in out-of-home care.[4]

Families are central to the healthy physical, social, and emotional development of infants and young children. However, American Indian families in Minnesota face challenges that impact the development of their children and family unit during the critical early years of life. Stressors, such as poverty and adverse experiences, disproportionately affect children and families in economically, socially, and environmentally disadvantaged communities. Frequent exposure to these stressors and adverse experiences increases the likelihood of people facing health outcome differences later in life.

Minnesota acknowledges that American Indian people carry knowledge that has sustained their communities and nations for generations, and that only through authentic engagement and partnership will we see change. MDH recognizes that approaches need to be guided by the communities most affected, and we need to support their efforts and give them enough time and resources to see change. It will take dedication to understanding community context history, community engagement, and state and federal partnerships with American Indian communities in Minnesota to make change.

Measuring success

Objective

By 2025, at least 75% of Division staff will have completed the Tribal State Relations Training.

State Performance Measure

Tribal State Relations Staff Training

Percent of Division staff who have completed the Tribal State Relations Training.

Longstanding factors have contributed to poor health outcomes among American Indian mothers, children, and families.These outcomes are influenced by conditions that create barriers to opportunity and thriving. Tribal leaders across the state have told us they are concerned that the structures and policies within MDH do not address the cultural context of providing services in American Indian communities. To address this concern, Title V staff will promote and support efforts of Division staff to complete the Tribal State Relations Training. During the 2021 legislative session, MN enacted MN Statute 10.65 Government-to-Government Relationship with Tribal Governments. One of the requirements under M.S. 10.65 is that state employees whose work has tribal implications attend Tribal-State Relations Training (TSRT), a course designed to educate state agency staff about American Indian tribal governments, histories, cultures, and traditions and to empower state employees to work effectively with American Indians and Tribal Governments. Participants learn that each Tribal Nation in our state is unique and that it is important to become knowledgeable about the history, culture, and governance of the Tribe as well as the role of

agency's Tribal liaison(s) to authentically and effectively partner with tribes. Currently, 67% of Division staff have completed the TSRT. This is up from 35.7% in FY2023.

Strategies and activities

AIFH Strategies

- Increase Access to Community-Specific Health Services.
- Promote Community Context Proficiency, as Defined by Community.
- Enhance Policies to Improve Health Outcomes.

Activities

STATE TITLE V

Supported

Collaborate with the Office of American Indian Health

In FFY2024, Title V staff worked closely with the Office of American Indian Health to increase our expertise at providing informed, meaningful, and supportive services and resources. Additionally, we continued learning more about how our tribal and urban American Indian communities engage with MDH and what barriers exist in strengthening these relationships, particularly in our Title V work.

Review State Employee Tribal State Relations Training Accessibility and Impact

Minnesota acknowledges the sovereignty of the eleven federally recognized American Indian tribes within Minnesota's geographic borders, and supports their absolute right to existence, self-governance, and self-determination. Recognizing the importance and benefits of communication, consultation and informed decision-making among Minnesota state agencies and elected tribal government officials on matters that have tribal implications, Minnesota enacted MN Statute 10.65 Government-to-Government Relationship with Tribal Governments during the 2021 legislative session. One of the requirements under M.S. 10.65 is that state employees whose work has tribal implications attend Tribal-State Relations Training (TSRT), a course designed to educate state agency staff about American Indian tribal governments, histories, cultures, and traditions and to empower state employees to work effectively with American Indians and Tribal Governments. Participants learn that each Tribal Nation in our state is unique and that it is important to become knowledgeable about the history, culture, and governance of the Tribe as well as the role of agency's Tribal liaison(s) in order to authentically and effectively partner with tribes.

In FFY2023, the percent of Child and Family Health Division staff who complete the TSRT became our new objective and SPM for the Cross-Cutting/Systems Building domain's American Indian Family Health priority. This is an effort to foster staff, including Title V staff, learning and development related to the history and culture of American Indian tribal nations in MN to more authentically and effectively partner with tribal nations and community members.

Successful enrollment into the training has been challenging due to several factors, including:

the high demand for and rapidly reaching capacity of enrollment spots.

supervisor approval for staff to enroll in the TSRT.

awareness of the TSRT and relation to staff's role at MDH.

However, in FFY2024 the MN Department of Transportation (MNDOT), who hosts the TSRT, began offering more frequent opportunities to complete this training – the trainings now occur monthly. Additionally, CFH Division

leadership, including the Title V MCH Director and the Title V CSHCN Director, have been active advocates in encouraging staff to register and attend these trainings, especially with the increased opportunities to attend. This has led to a significant increase in the number of staff who attend the TSRT, as well as generates interest in further learning opportunities.

Connected

Support Family-Centered Evidence-Based Programs and Practices that are Normed in the American Indian Community

Family Spirit is a family home visiting model developed by, with, and for American Indian families. It utilizes a multigenerational strengths-based approach that incorporates American Indian cultural values and an Indigenous conceptualization of health and wellbeing. Minnesota Department of Health (MDH) Family Home Visiting (FHV) provided professional development funding for Minnesota Family Spirit sites in FFY2024. Johns Hopkins Center for Indigenous Health has expanded the Family Spirit model to serve families with children to age five instead of requiring closure at age three – called the Family Spirit Thrive initiative. A multitude of Family Spirit implementation sites shared a need for longer support and services for families experiencing challenges. Training for the pilot study occurred November 2023 and was open to any family home visitors working with Tribal Nations or non-profits in the state who are currently offering the Family Spirit curriculum. The goal is to honor Indigenous values that all relatives are included and provided the same opportunities.

Additionally, MDH FHV provided support to collaborate and organize Family Spirit/Tribal Community of Practice series in FFY2024. FHV assisted with Family Spirit sites survey for ideas, interest, dates, and areas they would like to focus on in peer-led Community of Practice. Ideas included: Interest, frequency, format, topics for future gatherings.

LOCAL TITLE V

Connected

Implement Family-Centered, Evidence-Based Programs and Practices that are Normed in the American Indian Community

A majority of Minnesota's eleven Tribal Nations implemented a variety of services that were culturally-responsive to and led by engagement within their community, as able; however, all Tribal Nations in Minnesota report challenges related to rural living; inaccessibility to basic needs such as food, shelter, transportation; and staff working over capacity due to having to take on many roles for their Tribe.

White Earth's Nurse Family Partnership (NFP) program is Minnesota's only Tribally Maternal, Infant, and Early Childhood Home Visiting (MIECHV)-funded site. They work with MIECHV for technical assistance support and report data to NFP and MIECHV, but not to MDH other than minimum reporting requirements for state funding. Their NFP program staff share that they are maintaining enrollment numbers. They implement another Evidenced-Based Home Visiting Model, Parents as Teachers. The goal is to enroll prenatally into the NFP program, then when they graduate at two yrs old, enroll into the PAT program. This provides eligible families with support through home visiting until the child is five yrs old. White Earth also has several wrap-around programs to serve families experiencing substance use, including housing and both in-patient and out-patient treatment programs.

Fond du Lac also offers the NFP program. Their assessment of their pregnant and parenting population shows a significant number of families who are not eligible to enroll in NFP. In addition, they are finding more young parents who express a desire to include traditional practices. They continue to look for a program that can be delivered by nurses and has a cultural component. They have a very robust billing infrastructure, though some challenges persist. In addition to billing, the program is also funded through some state funding as well as tribal dollars.

Bois Forte partnered with Grand Portage as our first tribal sites receiving the Family Spirit family home visiting training in 2013. They have had consistent staff to utilize the curriculum throughout the years but identified low fidelity as a challenge due to HV staff having to balance many roles. With Strong Foundations FHV funding, Bois Forte has a full-time HV position. This home visitor is implementing the Family Spirit program. Bois Forte has been successfully implementing the Family Spirit program with positive response from their community and leadership.

Grand Portage was the very first active Family Spirit site in Minnesota, enrolling their first participant in 2013. They, along with Bois Forte, were part of a pilot project and still employ one of the nurses trained in that pilot program. With TANF funding, they have continuously utilized the program and maintain an average caseload of 5-10 clients. Their birthrate is 5-10 a year. Substance use disorder among pregnant/parenting women is very low. Their participants are very isolated and must often travel two or more hours each way for any specialty medical care. There is little unemployment, tribal businesses employ most band members. There are two RNs staffing the health office and they address ‘womb to tomb’ healthcare issues in their community.

Red Lake has had staff trained in Family Spirit since 2014. Red Lake secured Strong Foundations funding and have a staffing plan for two full-time community health workers (CHWs) and a supervising PHN with a target caseload of 50 . They have had staffing difficulties to maintain both full-time home visitors. This tribe is in a very isolated region of the state with limited transportation options. Many traditional health practices are resurging, and the community felt Family Spirit was a good fit for their population.

Leech Lake is currently a program on it's own with Strong Foundations. They utilize paraprofessionals under the supervision of an elder/LPN respected in the community. Staff turnover has been a challenge. Tribal leadership and the community are supportive of FHV delivered through the Family Spirit model. More work is needed to develop reporting capabilities and complete quality improvement projects and data.

Mille Lacs secured their own funding independently and are no longer partnering with counties. They are offering Family Spirit with both Strong Foundations and TANF funding. They have had difficulty with staff turnover, however, have still been able to offer the Family Spirit program throughout their three districts. They are involved with continuous quality improvement (CQI) projects.

Lower Sioux does have a Family Spirit program within their HeadStart program. They are not currently funded by Strong Foundations or TANF for their home visiting program.

Upper Sioux has not had staff trained or implemented structured family home visiting programs. In the past, they worked more closely with counties to provide services for their members but are now working on building their own infrastructure and services. They are working on addressing teen pregnancy prevention and early childhood developmental and social emotional screening programs.

Prairie Island recently added a family home visiting program with Family Spirit. They are not currently funded by Strong Foundations or TANF.

Shakopee provides clinic services to members and employees alike. They had expressed an interest in the Family Spirit curriculum several years ago, but to date have not followed up.

Cross-Cutting/Systems Building 2024 Report

HOUSING

Description: Increasing safe, affordable, stable housing for all people living in Minnesota.

Background

Minnesota's five-year 2020 comprehensive needs assessment identified a significant area of need in increasing safe, affordable, and stable housing for all people in Minnesota, making housing is a cross-cutting/systems building health priority area for the state.

Access to safe and affordable housing is connected to every aspect of people's lives and is a critical factor in financial security, academic success, and the health and wellbeing of children, women, and families. Research shows that kids are more likely to do well in school if they aren't worrying about where they will sleep, and adults are more likely to get and keep jobs, achieve financial security, and have good health and wellbeing when they have a secure home. Every person living in Minnesota should have a safe, affordable place to live in a thriving community but not all do.

Housing was consistently one of the most reported needs of children, women, and families throughout the 2020 needs assessment process – the second most stated need from respondent's overall.

> *"[Women, children, and families need] safe, affordable housing. There are many other important things needed to live life to the fullest. But without a safe place to sleep, it's hard to do anything else." – Needs Assessment Discovery Survey respondent*

System-level factors have and continue to have a significant impact on housing and homelessness across the state of Minnesota. Strategies need to focus on addressing the barriers surrounding housing policy and access. Rising housing costs in the face of decreased income means that for many residents, few, if any, have access to affordable housing. 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 poor health outcomes. If families do secure housing, over half of the lowest-income families in Minnesota spend more than 50% of their income on housing costs.

On a single night in January 2022, the annual nationwide point-in-time count of people experiencing homelessness identified 2,960 people in families and 7,917 individuals in Minnesota.[3] These numbers are unchanged from the 2009 and 2020 point in time counts. Homelessness has a disproportionate impact across groups in Minnesota. Compared to the white, non-Hispanic population:

- American Indian people are 30 times as likely to experience homelessness.
- African American people are 12 times as likely to experience homelessness.
- People of mixed race are 7 times as likely to experience homelessness.
- Hispanic people are 3 times as likely to experience homelessness.

Data from the new Minnesota Homeless Mortality Report, 2017-2021 released in 2023 found:

- The rate of death is 3 times higher among people who experience homelessness (PEH) in MN than the general population.
- 20-year-olds experiencing homelessness in Minnesota have the same rate of death as 50-year-olds in the general population.

- Mortality across each racial and ethnic group is higher among PEH than in the general Minnesota population.
- American Indian PEH have 1.5 times higher rates of death than other PEH and 5 times higher rates of death than the general Minnesota population.
- Deaths from substance use are 10 times higher among PEH than the general Minnesota population.
- 1 in 10 substance use deaths in Minnesota are among PEH.
- 1 in 3 of all deaths among PEH are caused by substance use.

Measuring success

Objective

By 2025, decrease the proportion of Minnesota adolescents who report staying in a shelter, somewhere not intended as a place to live, or someone else's home because you had no other place to stay in the past 12 months by 15%.

State Performance Measure

Adolescent Houselessness

Proportion of Minnesota adolescents who report staying in a shelter, somewhere not intended as a place to live, or someone else's home because you had no other place to stay in the past 12 months.

Nearly half of the state's homeless population is comprised of homeless children and youth aged 24 and younger, with approximately one third being children aged 17 or younger (with their parents).[5] There is no one reason for why youth experience homelessness - some are homeless because despite family employment, they cannot afford rent and end up living on the street. Youth experiencing homelessness have a higher risk of being in a gang, using substances, feeling depressed, attempting suicide, or experiencing trauma and violence than their housed counterparts.

To measure progress in the housing priority area, Minnesota is tracking the proportion of Minnesota adolescents who report staying in a shelter, somewhere not intended as a place to live, or someone else's home because you had no other place to stay in the past 12 months, collected every three years in the Minnesota Student Survey (MSS). Data from 2022 MSS showed that 2.9% of 8th, 9th, and 11th grade students reported staying in a shelter, somewhere not intended as a place to live, or someone else's home because you had no other place to stay in the past 12 months.

Strategies and activities

Housing Strategies

1. Expand funding opportunities.
2. Person-centered approach and services.
3. Create and innovate housing.
4. Focus on policy change

Housing Activities

STATE TITLE V

Connected

Increase Access to Safe and Affordable Housing for People who are Pregnant or Parenting Infants

In 2023, approximately 4% of families served through family home visiting were identified as homeless. Family home visitors are a resource for routinely screening for clients and families who are experiencing homelessness. Throughout this reporting period, family home visitors provided referral and support services to community resources to help find stable housing for families who were pregnant or parenting infants and/or young children.

Participate on the Minnesota Interagency Council on Homelessness (MICH) and Engage in Strategic Planning and Implementation

Title V staff participated in the MICH activities throughout FFY2024. The MICH is comprised of 14 state agencies, the Met Council, and the Governor's Office, and is charged with leading MN's efforts to achieve housing stability for people experiencing homelessness in Minnesota. MDH is one of the 14 agencies participating on the MICH, including representation by MDH leadership. MICH developed Heading Home Together, an action plan to prevent and end homelessness, identifying what state agencies can do and is reflective of the input of people who have experienced homelessness, practitioners who work in the field, and Federal policy requirements and guidance.

In May 2021, the MICH recognized homelessness as the most egregious form of housing injustice and committed to focus its next strategic plan on housing and health justice.

As a result of the work in phases one and two (May 2021 – October 2023), MDH committed to a number of action steps as a part of the strategic plan, including the following:

Involve people with experience of homelessness in development, review and dissemination of public health guidance.
Share public health resources and guidance for people facing homelessness and providers on existing MDH webpages.
Elevate homelessness and housing justice in policy and budget decision processes.
Assist Minnesota Housing and Continuums of Care in factoring medical vulnerabilities into the coordinated entry process.
Participate in an interjurisdictional team of partners to review and build on the unsheltered design team report of 2019 to create a more coordinated and systemic response to unsheltered homelessness in the Twin Cities Metro Area as well as support partners across the state, including rural communities and Tribal governments in the development of person-centered, trauma-informed, and a harm-reduction approach to serve people living and/or sleeping outside and the specific needs and considerations of crime victim survivors.

Title V staff remained engaged in this work, including providing input, attending monthly webinars, and connecting with partners for opportunities in alignment of activities and initiatives.

Prioritize the Interconnection between Health, Homelessness, and Housing to Drive Policy and Systems Change

Homelessness and health are interconnected, and MDH recognizes that homelessness and housing instability significantly impact community and MCH population health, MDH created a homeless-specific senior-level position. The Senior Advisor on Health, Homelessness, and Housing was hired in Spring 2022, and to the best knowledge of MDH and the CDC, the Senior Advisor on Health, Homelessness, and Housing is the first position of its kind at a state health department. This position will continue to work with state and local partners on public health and homelessness, including as a lead in the MICH work around the Strategic Plan. In FFY2024, Title V staff worked closely with this staff member to focus on the interconnections between homelessness, housing, and MCH population health.

Provide Adequate, Dignified Shelter Options for Children and Families

MDH, as the state health department, is re-evaluating what it means and what our role in public health is to improve and innovate the provision of adequate, dignified shelter options for children and families. Part of this work has been

developing and strengthening partnerships between MDH and the Minnesota Housing in effort to learn more about the current and ongoing housing and homelessness landscape in Minnesota, as well as to engage in conversations, strategic development, and policy change around the interrelated linkages of MCH populations, housing, and homelessness. Title V staff were a part of this continued engagement and support through FFY2024 including specific attention to: examining the Interconnection between health, homelessness, and housing to support expansion of screening, referral, funding, and other resources for safe and affordable housing that prioritizes pregnant and/or those parenting an infant and are currently or at risk of homelessness.

Cross-Cutting/Systems Building 2024 Report

MENTAL WELLBEING

Description: Ensuring all people living in Minnesota can realize their abilities, deal with day-to-day stress, have meaningful relationships, and contribute to their family and community. This also includes building resilience in those who experience childhood trauma and adversity.

Background

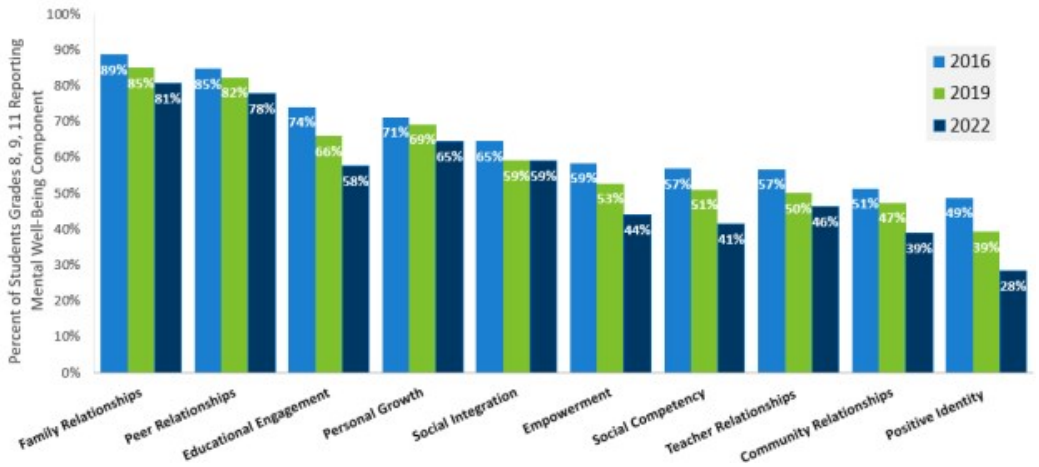
Minnesota's five-year 2020 comprehensive needs assessment identified a significant area of need in ensuring all people living in Minnesota have the opportunity and skills to manage day-to-day stress, have meaningful relationships and contribute to their family and community, including building resilience in those who experience childhood trauma. Mental Wellbeing was selected as a cross-cutting/systems building priority area for Minnesota.

Minnesota recognizes mental wellbeing as more than the absence of illness. Wellbeing is about having fulfilling relationships, utilizing strengths, contributing to community and being resilient, which is the ability to bounce back after setbacks. Mental wellbeing is a core ingredient for success in school, work, health, and community life. Poor mental wellbeing, 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, substance use and misuse, physical inactivity, injury, delinquency, and crime.

Minnesota's efforts to build capacity for mental health promotion and prevention involves working to 1) expand understanding about what shapes mental health, 2) expand community capacity to create change (e.g., leadership development), and 3) focus on policy as key drivers of change. Everyone needs opportunity to learn and practice skills to manage life and engage in the world. Skills to manage stress, find balance and focus, and engage socially are critical components that should be cultivated throughout the lifespan in both formal and informal settings. Skills and experiences that help people feel valuable and engaged in their family, community and economy are also critical.

Mental wellbeing is not experienced the same throughout the state's population. For example, data from the Minnesota Student Survey (MSS) shows Minnesota youth experiencing economic hardship report dramatically lower rates of wellbeing than youth not experiencing economic hardship. Mental wellbeing is measured in the MSS by combining multiple components of wellbeing to create an overall wellbeing score (i.e., positive identity, social competency, personal growth, empowerment, social integration, educational engagement, and positive family, community, teacher, and peer relationships). Figure 2 shows that every mental wellbeing component has gone down from 2016 to 2022 with a drop seen in 2019 and even bigger drops in 2022.

Figure 2. Percentage of Students (Grades 8, 9, 11) Reporting Each Mental Wellbeing Component in 2016, 2019, and 2022



Data Source: MN Student Survey

Additionally, here are large disparities in the number of mental wellbeing components reported by race/ethnicity by Minnesota adolescents. Almost half of non-Hispanic white students reported having eight to ten of the mental wellbeing components, less than 30% of American Indian students reported the same. Overall non-Hispanic whites reported experiencing higher rates of all wellbeing components, except for educational engagement, which is higher among Hmong and Asian/Pacific Islanders.

Measuring success

Objective

By 2025, increase the percentage of adolescents reporting positive mental wellbeing by 10%.

State Performance Measure

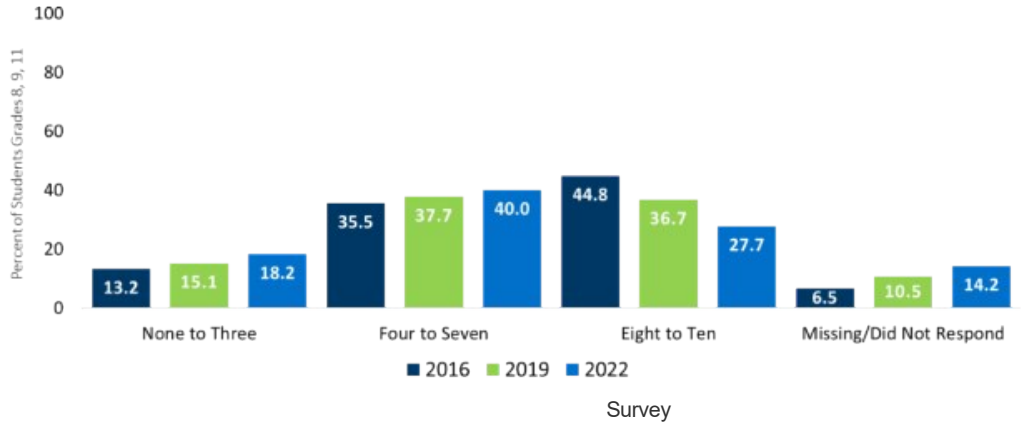
Adolescent Mental Wellbeing

Percent of Minnesota Adolescents who report having positive mental wellbeing being, fulfilling relationships, contributing to community, and being resilient.

With so many factors that make-up mental wellbeing it is difficult to succinctly answer questions about population mental wellbeing with existing data. There are multiple composite measures of mental wellbeing proposed in the research and many commonly agreed upon components of mental wellbeing.[1] Ten components of mental wellbeing are captured in the MN Student Survey: positive identity, social competency, personal growth, empowerment, social integration, educational engagement, and positive family, community, teacher, and peer relationships. Positive mental wellbeing is measured by combining multiple components of wellbeing to create an overall wellbeing score. We are choosing this measure because of how richly it captures the multi-factorial nature of mental wellbeing.

In 2022, 27.7 percent of Minnesota adolescents (grades 8th, 9th, and 11th) reported having high mental wellbeing (i.e., having 8 to 10 of the mental wellbeing components).

Figure 1. Proportion of Minnesota Adolescents reporting mental wellbeing components



Data Source: MN Student

Figure 1 shows the percentage of Minnesota 8th, 9th, and 11th grade students who report experiencing each mental wellbeing component. These data capture Minnesota youth experiences, which are shaped by the opportunities and resources in their community. This offers some tangible ways to think about mental wellbeing and can point to opportunities to improve mental wellbeing by ensuring the environment supports these skills and experiences for all youth.

Strategies and activities

MWB Strategies

1. Help communities build mental wellbeing capacity and resilience.
2. Implement a public health communications campaign on mental wellbeing across the lifespan.
3. Advocate for legislative policies that promote mental wellbeing for everyone.

MWB Activities

STATE TITLE V

Connected

Build Support for Expanding Community-Based Program Models Statewide

Building local capacity to identify and implement community-driven solutions is a key strategy for a public health approach to mental health. A growing movement for community-led mental health supports emerged due to the ongoing mental health crisis, workforce shortages, and inequities in access to care, further advancing holistic mental health approaches.

CFH staff championed this approach since 2019; we spotlighted successful programs, built relationships with national leaders, hosted public dialogues (e.g.2022 Children's Mental Health Summit), sponsored a CFH adolescent health legislative proposal in 2022, and advocated for a similar MDH proposal in 2025. Given the state budget limitations, community-initiated care proposals were not included in the Governor's budget.

The Mental Wellbeing and Resilience Learning Community has hosted 10-12 webinars annually to highlight community-based mental wellbeing strategies in Minnesota since 2017. Though several programs have garnered significant community interest, local leaders have consistently identified a need for additional training and funding to make these programs available and sustainable. With increased awareness of different mental health promotion model programs among key leaders, we can identify opportunities to incorporate them into existing grants or

programs.

Develop an Internal Child and Family Health (CFH) Division Mental Health Workplan

The CFH mental health strategic plan workgroup, which includes members from each section of the CFH Division, started the process by discussing gaps about current efforts. We mapped this against several state plans, then we identified apparent priorities and tried to group these in a meaningful way based on those early conversations.

This did not yield a clear plan that easily included current efforts and goals, nor did it capture the bigger picture fully. Ultimately the group decided to implement a consensus workshop.

In September 2024 we started to plan a half-day consensus workshop to identify strategic priorities. We identified key considerations including: the goals need to encompass the identified gaps, they must include goals that the division can play some role, be comprehensive enough to include current work, be aspirational- not just based on current limitations, and representative- goals should reflect CFH as a whole, although not every section has to be involved in each priority.

Expand Understanding of Key Research and Current Strategies to Support Social Connectedness and Other Factors that Influence Mental Wellbeing

The suicide prevention task force-mental wellbeing workgroup developed a toolkit on how communities can support social connectedness.

The mental wellbeing and resilience learning community continued to highlight Minnesota based initiatives each month, including multiple groups addressing social connectedness in unique ways. Examples include initiatives focused on farm communities, workplace relationships, spiritual-faith cultural healers dialogues, and the Korean football association that is intentionally building an intergenerational community through a youth soccer team.

In support of May Mental Health Month, the University of Minnesota Extension, Minnesota Department of Agriculture and the Department of Health joined forces to bring COMET™ to communities across Minnesota. Together we organized a facilitator training that was hosted in April 2024.

In just two short months, this team supported training for twenty facilitators, who hosted twenty-four COMET™ trainings, reaching over 300 people during May Mental Health Month. COMET™ (Changing Our Mental and Emotional Trajectory) is a short, two-hour program that teaches simple tools to help someone who is struggling shift their mental health trajectory back to a place of wellness and away from the path toward mental health crisis. COMET™ helps people take that next step after noticing someone might be struggling. COMET teaches simple steps to help people practice empathy and active listening, which are critical to building social connections.

Identify Opportunities to Develop and Implement More Formal Marketing Campaigns on Mental Wellbeing, Trauma, and Resilience

Nature to Support Mental Wellbeing

MDH is increasingly promoting access to nature as a strategy to support mental wellbeing. In March, MDH sponsored a cohort of Minnesota specific cohort of youth workers to complete a Forest Therapy Guide training and certification process. Forest therapy is a technique to support intentional active engagement with nature using a mindfulness approach, which can the amplify the role of nature for our wellbeing. MDH applied for an AmeriCorps-Public Health Corp member to help advance access to nature among children and families. The full time Corp member started in September 2024 and will be with MDH through August 2025. They will help bring awareness to this topic and mobilize the forest therapy guide network. MDH continues to engage in both an internal planning team and several interagency workgroups, which are facilitated by the Children's Cabinet and the Department of Nature Resources, to advance the Children's Outdoor Bill of Rights, a cross-agency plan to increase children's access to nature. This includes a mental wellbeing workgroup, which is focusing on how to engage with schools, as well as the

following activities:

Staff participated in a PBS interview regarding the influence of nature on mental health and wellbeing, and the healing forest cohort in June 2024.
Mental health promotion staff advised on the DNR led school mental health conference presentation and a proposed Children and Nature Network conference proposal.
With support from a new Public Health Corps member dedicated to increasing access to nature, we are engaging the recent cohort of forest therapy guides to understand how they are currently implementing and promoting these services within their communities.

As part of the monthly webinar series, MDH hosted several webinars focused on nature or digital wellbeing during the reporting period:

An introduction to Nature Rx and Forest Bathing
NEST- a network for early childhood providers interested in supporting outdoor experiences with young children
Digital wellbeing responding to urgent crisis with practical tools: Maree Hampton from Live More Screen Less

Mental Health Day at the State Fair

MDH partnered with the suicide prevention team to participate in the mental health day at the State Fair. Staff shared resources about mental wellbeing and suicide prevention resources, engaged participants in conversation about what supports their mental health and wellbeing, and coordinated with other participating organizations. The table received less traffic this year because of poor weather and an early shut down for the event.

Partnering with the Minnesota Youth Justice Office and Juvenile Justice Advisory Committee

MDH collaborated with the Minnesota Youth Justice Office and Juvenile Justice Advisory Committee to attend a site visit in Polk County Juvenile Detention Center on April 12, 2024. C&TC staff attended the meeting to promote awareness of C&TC and share information about the importance of screening and intervention services.

Identify Public Health-Focused Recommendations for the State Mental Health Advisory Council Report

MDH staff continue to support the State Mental Health Advisory Council. The 2024 report included the same set of mental health promotion related recommendations as the 2022 report. This included: Expanding access to wraparound through the System of Care initiative, Expanding Family Peer Support opportunities, Growing family support opportunities within schools, and Building community-initiated care to support young people and families.

For Mental Health and Schools workgroup, their working legislative recommendations include: 1) fully fund a permanent per pupil allocation for specialized instructional support personnel and training and identify and implement solutions to the workforce challenges in filling these positions. 2) Increase the mental health licensure requirement for school staff and include a prevention framework and digital mental health, and 3) Include 504 students within the IEP Medicaid Third Party Reimbursement program.

Implement an Outreach Plan for the Existing Minnesota Thrives Tool

Minnesota Thrives is an interactive and collectively sourced database to provide communities with a meaningful list of mental health promotion strategies, opportunities to connect and learn from others doing this work, and a comprehensive picture of current activities and gaps to support mental wellbeing. Minnesota Thrives is highlighted at every monthly Mental Wellbeing and Resilience Learning Community, spotlighting two or more examples and sharing an update on the progress toward the goal of having 1,000 entries added to the database.

In FFY2024, Minnesota continued to post the Minnesota Thrives spotlight, introduce it at the monthly Mental Wellbeing and Resilience Learning Community, and invite specific individuals and groups directly to submit entries to the database. MDH has promoted it at grantee meetings and other public health network meetings. Multiple

community partners regularly utilize the database, but it has been challenging to grow it to its fullest capacity. We remain at under 300 viable entries.

Partner with Key Stakeholders to Develop Shared Objectives and Establish the Minnesota Community Resilience Learning Cohort

MDH and county partners through the State Health Improvement Partnership (SHIP) coordinated for over a year to identify options for community engagement and decision making about steps to prioritize strategies to support mental health promotion. We consulted with numerous experts, including Harvard Professor of Sociology Dr. Matt Lee, who leads a Flourishing Network. Wright County is in the process of implementing a pilot community process to engage in a broad discussion about mental health that includes wellbeing, which flowed from these conversations.

MDH and partners University of Minnesota-Extension and University of Minnesota-Center of Excellence in Public Health completed a second iteration of the mental health socio-ecological model that focused on expanding the societal layer. A comprehensive report, a companion poster, Instagram posts, long-form infographic, and a two-page summary were completed. Student interns developed the companion products and presented at several conferences about the model. Themes from the extensive literature review for the societal level included: pandemics and epidemics, police and immigration systems, cultural and social identity, family norms, basic human needs, and mental health norms.

In November 2023, MDH hosted a gathering for the larger ecosystem to help shift the narrative about mental health and promote investment in protective community resources and community-led policy identification work. Over 720 leaders were invited, 170 people from 123 different organizations registered, and ultimately 150 leaders attended the half-day in-person event. Participants included leaders from local and state government, elected officials, education, health care, foundations, and others.

Partner with Key Stakeholders to Identify Policies and Practices to Support Mental Wellbeing

Reimagine Black Youth Mental Health (RBYMH) initiative completed the policy identification and assessment phases using a consistent youth and community-led approach.

In September 2023 we hosted a summit with over 200 youth. Youth identified 6 Policy themes including:

1. Make sure Black youth are safe at all times. Youth defined this as safety on social media from bullying, safety in community from gun violence, and safety in schools.
2. Change the narrative around mental health to strengthen mental health support for Black families. Address generational trauma. Youth defined this as access to mental health professionals for Black/African parents and free family therapy.
3. Give Black people the space to create our own spaces and have our voices heard. Youth defined this as dedicated spaces for Black students in schools supported by Black adults and more opportunities for Black people to come together in positive ways.
4. Prioritize the needs of Black youth that are defined by Black youth. Youth defined this as access to more food during school and real responses to issues that Black youth bring up.
5. Provide more education on Black history and culture more often, including learning beyond academics. Youth defined this as Black history and culture throughout the K-12 curriculum, not just Black History Month, more books by Black authors, and uplifting Black culture in ways that prepare us for life outside of school.

In January 2024 the RBYMHI hosted a table at 2 schools to pilot a youth survey and engage with youth about the initiative.

In February and March, we hosted youth-led assemblies at local high schools to share transparent data about what took place at and after the Summit and conduct a survey about policy priorities among those identified at the summit.

The initiative established a policy taskforce with Advisory Council members.

Through April 2024 MDH, youth and other task force members conducted research visits with key policy and program leaders. MDH conducted an ecosystem scan of state policies and initiatives that are related to Black youth mental health.

Based on all of this input, the initiative identified three leading policies to focus on including:

1. A school cell phone policy and demonstration project to support digital wellbeing.
2. Developing a funding structure for families to address trauma and access mental health and holistic healing opportunities, and
3. Establishing systemic community support and implementation of youth-led Black Affinity spaces that build youth capacity, engagement, relationships, and positive racial identity.

A shared leadership structure and focus on youth investment are the initiative anchors and have proven effective. State and local partnership activated different networks throughout year two, facilitating effective cross-system communication. The legitimacy of the initiative, based on increasingly broad community support, is built on the transformational approach to youth engagement versus a transactional model.

Promote Policy, System, and Practice Changes to Support Children of Incarcerated Parents

MDH launched the expansion of the program to support children of incarcerated parents in correctional facilities in February 2024. Through both state and federal funding, the Minnesota Model Jail Practices Learning Community includes 7 county jails, 6 community partners, and 3 unfunded partners across 17 counties in Minnesota. All of these sites were selected through a competitive RFP process. In FFY2024, all of the learning community sites were trained in the Parenting Inside Out Curriculum (PIO) and were coordinating implementation of PIO with their populations. MDH partnered with Family Home Visiting and provided a training for 27 participants that were connected through the Model Jail Practices Learning Community in the Circle of Security training on June 25, 2024 to implement with justice-involved families. The Learning Community met in Olmsted County on February 28, 2024 to launch the beginning of the expansion of the Model Jail Practices across Minnesota. The Learning Community continued to meet quarterly during the FFY2024 on April 11, 2024 in Stearns County and on July 24, 2024 in Renville County, 93 county jail staff through the Minnesota Sheriff's Association were trained in the basics of child development and development considerations for jail staff and jail administrators regarding children of incarcerated parents in FFY2024 created by Dr. Rebecca Shlafer.

Cross-Cutting/Systems Building 2024 Report

PARENT AND CAREGIVER SUPPORT

Description: Supporting parents and caregivers socially and emotionally with family-focused activities, policies, and education.

Background

Minnesota's five-year 2020 comprehensive needs assessment identified a significant area of need in supporting parents and caregivers socially and emotionally with family-focused activities, policies, and education. Parent and Caregiver Support is a cross-cutting priority area for the state.

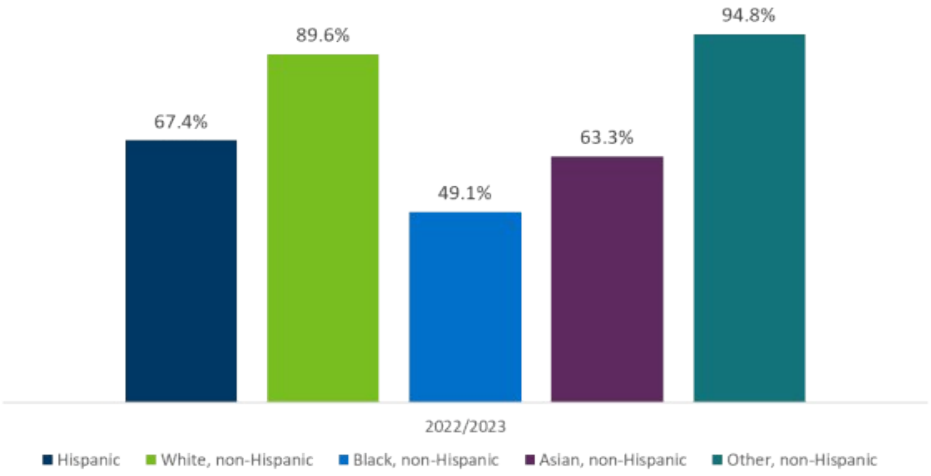
When parents and caregivers receive adequate support, they are more likely to be able to cope with the day-to-day demands of parenthood and build a safe and healthy home environment for their family. A major factor in a

parent/caregiver's ability to provide a safe and healthy home for their children is having needed resources and supports available to them. It is particularly important for parents to get support when they feel overwhelmed or stressed. Parents need a network of supportive relationships, strategies for coping with stress, resources, knowledge, and an understanding of child development. Unfortunately, a lack of these critical supports can cause otherwise well-intentioned parents to become overwhelmed and at times result in abuse or neglect.

There are many reasons why parents and caregivers feel they receive inadequate support in parenting. Partners participating in the Strategy Team related to this priority area reported some of the following contributors to the problem:

- Many parents/caregivers report feeling isolated because they do not have a support system (formal or informal) built around themselves.
- Employers do not provide the wages, flexibility, or paid leave needed to support parents/caregivers.
- There is a lack of resources available to parents related to parenting support and education.
- There is a societal-level stigma against asking for help that prevents parent/caregivers from seeking support or resources – this stigma is particularly pertains to seeking emotional/mental health support.

Figure 2. Proportion of children who have parents that had had someone they could turn to for day-to-day emotional support with parenting or raising children in the past 12 months, by Race/Ethnicity, 2022-2023



Parents and caregivers of color and those who have children with special healthcare needs (CSHCN) are especially impacted by having inadequate support.

The 2022-2023 NSCH found that 82.6% of all children have parents who, during the past 12 months, had someone they could turn to for day-to-day emotional support with parenting or raising children. Emotional help received is significantly higher for children who are non-Hispanic white (89.6%) compared with non-Hispanic Asian (63.3%), Hispanic (67.4%), and non-Hispanic Black children (49.1%) (Figure 2). In addition, parents of CSHCN report spending several hours having to coordinate their child's health care, subsequently then also reporting that they are more likely to have had to quit or change their jobs. They are also less likely to have someone they can turn to for day-to-day emotional support even though they express higher levels of stress (aggravation) in parenthood.

Measuring success

Objective

By 2025, increase the percentage of children, ages 0-17, living with parents who are coping very well with the demands of parenthood by 5%.

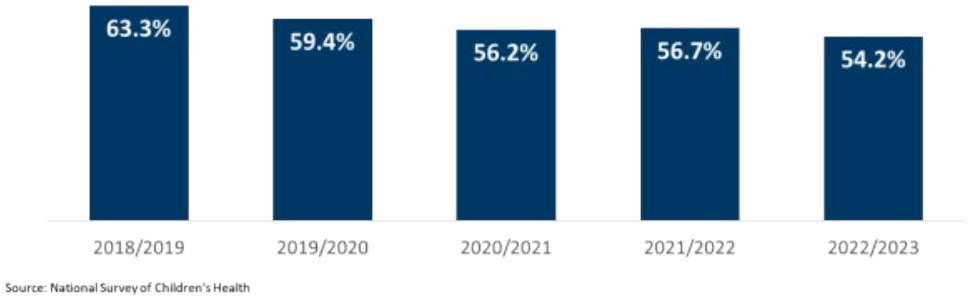
State Performance Measure

Parental Coping

Percent of children, ages 0-17, living with parents who are coping very well with the demands of parenthood.

When parents and caregivers receive adequate support, they are more likely to be able to cope with the day-to-day demands of parenthood and can then build a safe and healthy home environment for their family. According to the 2022-2023 NSCH, only 54.2% of children in Minnesota are living with parents who report they are coping with the day-to-day demands of parenting very well. This is down from 56.2% in 2020-2021, 59.4% in 2019-2020 and 63.3% in 2018-2019 (Figure 1).

Figure 1. Percent of children, ages 0-17, living with parents who are coping very well with the demands of parenthood



Strategies and activities

PCS Strategies

1. Advocate for the redesign of a network of policies and programs to better support families.
2. Build capacity of public health professionals and family home visitors to help improve the mental health, wellbeing, and resilience of families.
3. Build supports for multi-faceted ways for parents/caregivers to connect with one another.

Activities

STATE TITLE V

Supported

Coordinate between Title V and Family Home Visiting (FHV) Initiatives to Serve More Families through FHV

Family Home Visiting (FHV) is a critical and impactful program that strengthens families and communities. By supporting pregnant women and guiding parents through the early stages of their children's development, it not only ensures healthier beginnings, but also sets up families for long-term success. Providing individualized support and connecting families to community resources builds resilience and empowerment.

A major goal of the 2020 five-year block grant cycle was to better coordinate between the MDH Title V and FHV initiatives to ensure we are reaching the most at-risk families with home visiting services. This goal directly aligns with the goals of Minnesota's MIECHV program grant. Coordinating efforts between MDH Title V and FHV initiatives is a strategic move that emphasizes reaching at-risk families effectively. Title V and FHV staff collaborated on the following activities:

Deepening the understanding of home visiting services through Title V funding. This is accomplished through regular contact and check-in meetings with FHV implementing agencies across the state to learn how Title V funding is utilized locally to support pregnant and parenting families.
Prioritizing interagency and cross-divisional collaboration to improve service coordination. Since the last reporting period, FHV and CSHCN staff have convened quarterly to discuss relevant topics affecting the priority populations each section serves. These sessions feature guest speakers/subject matter experts, presentations, and intentional space for group breakout discussion and reflection.
Expanding outreach to hard-to-reach families. This means ensuring that FHV is available in all regions of the state, and that families who wish to receive supportive services can access them.

These initiatives reflect a comprehensive approach to building stronger, healthier families across all of Minnesota.

Providing Training on Postpartum Depression Screening for Health Care Providers

Postpartum depression screening for any accompanying caregiver is a recommended component in all Child and Teen Checkups (C&TC) well-child visits in children up to 13 months of age. In FFY2024, the C&TC program provided nine trainings (Best Practices in Child Health Screening) that addressed postpartum depression screening to 123 health care providers, local public health C&TC and Head Start staff.

Connected

Advocate for Policies that Promote and Support the Wellbeing of Parents/Caregivers

In FFY2024, Minnesota:

Convened partners to advocate for policies that promote and support the wellbeing of families.
Identified and participated in statewide working groups, councils, or committees that aim to improve support for parents and caregivers.
Built a better understanding of the landscape around issues that impact the wellbeing of parents and caregivers (and therefore families), including work flexibility, living wages, and paid parental leave.

Statewide working groups that were identified and staff participated on/led, include:

Newborn Hearing Screening Advisory Committee
Newborn Screening Advisory Commitee
MCH Advisory Task Force
Family Support Organization Collaborative Steering Committee
Care Coordination Community of Practice Steering Committee
Follow Along Program Community Engagement Team
Minnesota Integrated Care for Early Childhood Initiative Community Advisory Committee
Pediatric Mental Health Access Program Steering Committee

These groups include families and caregivers in addition to professionals. Additionally, staff implemented the Family Support Organization Collaborative, which is described further in the CSHCN narrative.

Connecting Families to Family-to-Family Support

Family-to-family support is a vital part of a comprehensive system of care. There are many different opportunities for

parents to connect to family support – such as through the education, child welfare, mental health, and other family-serving systems.

In FFY2024, several family home visiting programs began incorporating group activities for the families served in their programs in an effort to build social support and make additional connections to the community that will continue after their family home visiting program ends.

During FFY2024, CSHCN programs and resources provided families with information on how to connect with organizations that offer family-to-family support, helping them access guidance, shared experiences, and community-based resources.

During this period, MDH maintained an agreement with a partner organization to provide parent-to-parent support for nearly 250 children newly identified as deaf, hard of hearing or deafblind (DHH/DB). Through this agreement, trained parent guides contact families of newly identified infants and children and provide direct hearing loss-specific information on communication, educational and medical options in a nonjudgmental manner. This agreement also includes support services to families of children who have been identified as having congenital cytomegalovirus (cCMV) with hearing loss or other signs or symptoms.

Provide Training for and Support the Implementation of Best Practices Amongst Public Health Professionals and Family Home Visitors

The main activity aimed at building capacity of public health professionals is providing training and supporting the implementation of best practices. By building capacity, we mean that we not only provide trainings to LPH agencies but also provide the needed technical assistance and other support to help ensure they are implementing the best practices – using a continuous quality improvement approach. We focused on the following topic areas: trauma-informed care, Reflective Practice, intimate partner violence, depression, opioid drug use, and adverse childhood experiences (ACEs). This strategy empowers public health professionals and improves the overall systems of care.

During FFY2024, MDH family home visiting offered 36 opportunities, including both trainings and communities of practice (CoPs), to strengthen capacity of staff to support families and communities. Training opportunities covered a wide range of topics, including ASQ and ASQ-SE developmental screening tools, parent-child interactions, motivational interviewing, commercial tobacco cessation, goal setting, and cannabis and other substance use. The model-specific CoPs provided ongoing support and collaboration for grantees, offering a space to share knowledge, problem solve, and exchange best practices. Regular reminders of these opportunities were published in the Family Home Visiting Tuesday Topics weekly newsletter that goes out to a listserv for family home visitors and other interested stakeholders in Minnesota.

[1] National Survey of Children's Health 2022-2023.

[2] US Census American Community Survey (ACS) Microdata Sample, 2023

[3] MN Report Card, Class of 2024, 4-year Graduation Rate

[4] MN's Out-of-Home Care and Permanency Report 2022

[5] Wilder Foundation, 2023

Community health drivers

CROSS-CUTTING/SYSTEMS BUILDING PLAN 2026

Description: Address the key drivers and underlying conditions that influence the health of Minnesota's families and communities.

Background

Addressing the key drivers and underlying conditions that influence the health of Minnesota's families is important because these factors, such as income, education level, early childhood education/care, affordable housing, and access to healthy food, all greatly impact population health outcomes. It is important that Minnesota creates a healthier population through improvement of these social and environmental conditions for all residents.

Social and economic conditions are one of the biggest contributors to health differences. According to the Trust for America's Health (TFAH), research shows that a person's health, including their ability to make healthy choices, is impacted by where they live, their income, their educational attainment, and other factors. Though individual behaviors play a role in health, many of the choices people make depend on the opportunities available to them.

> *"Trying to maintain and stabilize housing has been one of the biggest challenges my growing family has face[d]. It has a huge effect on the family dynamic and mental health and wellbeing of everyone…wages in the work field contributes to this problem. Thriving doesn't even seem like a realistic expectation at this point. Only to maintain. Identity, gender and race all play a huge factor in these circumstances." – Minnesota Story Collective*

Measuring success

Objective

By 2030, decrease the proportion of Minnesota counties that have a high Area Deprivation Index (ADI) by 10%.

State Performance Measure

Area Deprivation Index (ADI)

Percent of Minnesotan communities that have a high ADI.

Health is the summation of genetic makeup and environmental factors. Physical, chemical, and social factors in the environment all play a role in influencing health outcomes. The Area Deprivation Index (ADI) is a validated, rigorous, widely used measure of the social exposome. Exposome is a concept used to describe all the exposures an individual has had in a lifetime and how those exposures impact biology and health. Some factors that are examined to measure social exposome include income, education, employment, and housing quality. Research links living in a disadvantaged neighborhood, as measured by high ADI, to poorer health.

> *"Living in a high ADI area has been linked to a number of health disparities, including higher rates of cardiovascular disease, increased utilization of health services, premature aging and earlier death. Living in a high ADI neighborhood has also been linked to poorer brain health, including higher rates of dementia diagnoses and Alzheimer's Disease changes within the brain." -Neighborhood Atlas*

By addressing social vulnerabilities, the ADI can help improve overall community resilience and health outcomes.

Strategies and activities

Through the 2025 statewide Title V needs assessment and action planning, the strategies and activities below have been highlighted to focus on for the 2025-2030 Title V grant cycle of work specific to community health drivers in the cross-cutting/systems building (CHD) population domain.

CHD Strategies

1. Amplify resources, services, and supports that are responsive to community needs and support the health and wellbeing for all.
2. Strengthen the capacity of public health professionals and community leaders to effectively address community health drivers, such as housing and early childhood systems of care, using a public health lens.
3. Vitalize Title V activities to address community health factors to improve maternal and child health outcomes and access to care across the life course.
4. Ensure data produced and reported through Title V highlight maternal and child health outcomes, explore root causes, discuss their impact, and provide recommendations for improving health across MCH populations.

CHD Activities

STATE TITLE V

Supported

- **Collect and Analyze Data to Better Understand Experiences of Families of CSHCN Through the National Survey of Children's Health (NSCH) Oversampling**

While national data on CSHCN can help identify differences and gaps in access to services and supports for certain subgroups of CSHCN, it is difficult to report on important differences due to data limitations at the state level. The NSCH is a primary data source for CSHCN; however, Minnesota is unable to conduct sub-analyses at the state level due to small sample sizes. However, Minnesota has contracted with the Census Bureau to increase the sample size of children in the state whose parents/caregivers complete the NSCH. Our hope with this oversampling is that we will better be able to conduct subgroup analyses on measures impacting CSHCN in FFY2026 and beyond. Additionally, Minnesota plans to conduct analyses on the health and wellbeing of CSHCN using the five-year estimates of the NSCH (2016 – 2020) that were recently posted in the Data Resource Center. We will compile and publish a report on these findings and will share this across MDH, other state agencies, and community-based organizations. In this report, we will work to visualize the data in ways that are friendly to the public whenever possible using dashboards of summary and de-identified data available for viewing.

- **Coordinate between Title V and FHV initiatives to Serve More Families through FHV**

A major activity aimed at helping promote a comprehensive system that supports families is family home visiting (FHV). FHV helps ensure pregnant women receive adequate prenatal care, learn about healthy development in utero, in infancy, and beyond, and promotes responsive relationships. Then, as children and families develop, FHV helps ensure families with young children receive individualized social, emotional, health-related, and parenting supports, and relate connect to community resources that help stabilize and empower families.

A goal of this five-year block grant cycle is to better coordinate between the MDH Title V and FHV initiatives to ensure we are reaching more families with home visiting services. This goal directly aligns with the goals of Minnesota's MIECHV program grant. We have already begun to strengthen this partnership through the work we have done to combine and coordinate our Title V and MIECHV needs assessments and through the involvement of

FHV leadership and staff in our strategy development work. Moving forward into FFY2026, we plan to continue work around the following activities:

- Understanding home visiting services provided via Title V funding. Based on their annual work plans and reporting, we know that LPH agencies use Title V funding to support a portion of home visiting services. However, we would like to develop a more formal understanding of the number of families served and types of visits provided and will partner with the FHV Section to explore this further. MDH-FHV staff will conduct subrecipient monitoring activities including fiscal monitoring, site visits, and regularly scheduled opportunities for communication and technical assistance. Title V and FHV staff will work internally to improve relationships and better understand Local Public Health's implementation of FHV by braiding a variety of funding sources (MIECHV, TANF, Title V, state funding). Our goal is to provide improved guidance and recommendations to Local Public Health agencies for the optimal use of these funding streams.
- Improving coordination of services for medically underserved communities. We intend to participate in interagency and cross-divisional conversations to provide consultation to and collaboration with early childhood system stakeholders.
- Assessing whether we are reaching medically underserved families who would benefit the most from home visiting services. Through our interagency and cross-divisional work, we will build the partnerships needed to better ensure we are reaching the most families possible. This means ensuring that FHV is available in all regions of the state, and that programs are enrolling appropriate numbers of families. MDH-FHV and Title V staff will also implement enhancements to the grant management process that seeks input from counties, tribes, and non-profits. Providing data reports to monitor fidelity, progress towards meeting MIECHV and Title V benchmarks, and identifying areas for technical assistance and CQI will continue to be a strong focus.
- **Develop and Implement Data-informed Strategies to Prevent Pregnancy-Related Deaths**

In 2024, the MCH section within the Child and Family Health Division at MDH responded to a NOFO and successfully received funding from the CDC National Center for Chronic Disease Prevention and Health Promotion for “Enhancing Review and Surveillance to Eliminate Maternal Mortality”. This funding supports Minnesota’s Maternal Mortality Review Committee (MMRC) within MDH to identify and characterize pregnancy-related deaths for prevention by identifying pregnancy-associated deaths; conducting vital records quality assurance; abstracting clinical/non-clinical data into a standard data system (Maternal Mortality Review Information Application, ‘MMRIA’); conducting informant interviews to inform individual case review; conducting multidisciplinary case reviews by committees; and entering committee decisions into MMRIA.

MDH’s goal will meet criteria to accomplish short term and intermediate goals for this funding request beginning in FFY2026:

- Increased timeliness, accuracy, and standardization of information available about pregnancy-related deaths, including MMRC identified opportunities for prevention.
- Increased engagement and cooperation between MMRCs, partners, and communities to communicate information from data on pregnancy-related deaths.
- Increased availability of MMRC recommendations among communities, clinicians, public health practitioners, and decision makers.
- Increased adoption of clinical and non-clinical policies and programs that reflect the highest standards of care.
- Increased implementation of recommendations that reach or consider the needs of populations affected by pregnancy-related mortality.

- **Develop an Internal CFH Division Mental Health Workplan**

In FFY2023, an internal workgroup was formed with an aim to build capacity for staff engaging in the mental health work we do as a Division with Minnesota's communities and families, through the development of a Division Mental Health Workplan. The purpose of the workplan is to provide a framework for staff engaging in mental health work when applying to funding opportunities, engaging with communities, and developing partnerships, including other MDH Divisions and state agencies. The workgroup developed an initial plan for the division in FFY2024.

In FFY2026 MDH will continue to review the plan and reconcile it with available state and federal funding, including legislative proposals. MDH will continue to identify opportunities to align efforts within and across divisions.

- **Increase Access to Family Planning Services**

MDH will continue to oversee the Sexual and Reproductive Health Services (SRHS) grants program which provides low-income, high-risk people pre-pregnancy family planning services and fact-based sexual health information. During this time, staff will support a total of 35 grantees funded through 2027, including those funded through the additional $6.353 million SRHS funding expansion from the Minnesota 2023 legislative session. Additionally, MDH will continue to strengthen their connection and work to streamline referrals with the Minnesota Family Planning Program (MFPP) administered by Minnesota Department of Human Services. This health care program covers family planning services, diagnosis and treatment of sexually transmitted infections and transportation services to and from health care providers for these services.

- **Promote Policy, System, and Practice Changes to Support Children of Incarcerated Parents**

An estimated 16% of youth in Minnesota have an incarcerated or previously incarcerated parent, making parental incarceration the second most frequently reported ACE for this population (MSS, 2022). Youth with an incarcerated parent have increased risk of poor mental health and illness, substance use, and poor academic outcomes. During FFY2026, Minnesota will continue to grow the Model Jail Practices Learning Community, through a federal Department of Justice grant and the state legislature, to promote policy, system, and practice changes that support children of incarcerated parents. The initiative will connect with at least fifteen counties in Minnesota through a range of activities including:

- Bi-monthly training for jails on model practices
- Quarterly learning community meetings to facilitate quality improvements and share relevant resources.
- MDH will also continue to identify policy issues related to the systems that could work in tandem with jails to better support justice involved children and families, such as child-welfare, schools, and family home visiting. This will include training for these systems and opportunities to build connections with partnering jails.
- Coordinate training in evidence parenting programming for jail and community partners.
- Additionally, Minnesota will continue to work on expanding these efforts to other county jails and continue to support Family Home Visiting (FHV) and other community program investments in justice involved families.

- **Provide Training on Postpartum Depression Screening for Health Care Providers**

Postpartum depression screening for any accompanying caregiver is a recommended component in all Child and Teen Checkups (C&TC) well-child visits in children up to 13 months of age. The MDH C&TC Program C&TC will continue to provide training to medical providers who perform C&TC visits on best practices in conducting postpartum depression screening. The training is also available for Head Start staff, local public health C&TC staff, and university-based post baccalaureate advanced practice nurse (nurse practitioner) training programs.

Connected

Build Support for Expanding Community-Based Program Models Statewide

The Mental wellbeing and Resilience Learning Community (MWRLC) has highlighted many examples of community-based mental wellbeing strategies in Minnesota each month since 2017. Though several programs have garnered significant community interest, local leaders have identified a need for additional training and financial support to make these available and sustainable. With increased awareness of the models among key leaders, we can better identify opportunities to incorporate these into existing grants or programs.

In FFY2026, MDH will do the following:

Continue to host the MWRLC highlighting a range of wellbeing strategies across communities in Minnesota.

Identify opportunities to actively support and connect those interested in advancing or scaling one of the identified strategies.

Continue to elevate initiatives that promote connection to nature. Including, opportunities to connect certified forest therapy guides, and will work with the learning community to support and promote the community resources that flow from this new community capacity, as well as promote the opportunity for other communities to build similar strategies.

Continue to look for funding to support the highlighted initiatives.

Convene stakeholders to identify steps to build infrastructure and support for community led care. For example, defining the minimum expectations for referring community members to higher levels of care when needed, and strategies to sustain this type of community programming.

Champion Minnesota's Integrated Care for Early Childhood Initiative (MN-ICECI)

Minnesota's Title V program will continue to work closely with the MN-ICECI, which is funded by an Early Childhood Comprehensive Systems: Health Integration Prenatal-to-Three Program grant from HRSA. During FFY2026 the MN-ICECI work will center around building a Family Ambassador Corps and exploring options for project sustainability beyond the federal grant period.

The MN-ICECI prioritizes early identification of social, emotional, and developmental needs in young children to connect them with essential resources. To achieve this, families must play a central role in driving system changes. Meaningful engagement of family and community leaders is essential for the success of MN-ICECI. Thus, MN-ICECI focuses on building agency of parents, families, and community members to advocate for their children and communities. Empowering parents as leaders' benefits families, improves outcomes, and enhances system effectiveness by ensuring comprehensive and family-centric decisions.

The Family Ambassador Corps is a cross-cutting strategy of the MN-ICECI. Family Ambassadors are individuals with experience in navigating the early childhood system; they build upon their knowledge and skills to take on meaningful leadership roles within programs, agencies, and communities. They serve as a "parent voice" to help shape the direction of services for themselves and other families.

This Corps serves two main purposes:

. Improving Awareness and Connection to Resources: Ambassadors leverage peer-to-peer outreach, educational initiatives, and ongoing support networks to empower parents, caregivers, and families of young children. By serving as trusted community liaisons, Ambassadors bridge gaps and facilitate access to vital resources and services.

2. Driving Systems Transformation: Drawing on their experience, Ambassadors play a pivotal role in advocating for systemic change within early childhood health systems. By centering parent voices in compelling storytelling efforts, Ambassadors serve as catalysts for shifting mindsets, advancing priorities, and promoting best practices

across the health care landscape.

CHStrong Data Collection

In September 2023, MDH was awarded a grant to conduct population-based surveillance of outcomes, needs, and wellbeing of children and adolescents with congenital heart defects (CHDs), CHSTRONG KIDS. The grant enables MDH to survey a population-based sample of parents or caregivers of children with CHDs to learn about the social and educational outcomes, healthcare utilization, barriers, and quality of life of children with a CHD, as well as the needs and experiences of the caregivers. Much of 2024 was spent recruiting families to participate in this survey and ensuring representation from Minnesota communities. In FFY26, the MN CHSTRONG KIDS team will begin to analyze the responses from Minnesota, Massachusetts, and Georgia.

Dignity in Pregnancy and Childbirth Act

The Dignity in Pregnancy and Childbirth Act addresses differences in maternal health care and includes a requirement for hospitals with obstetric care and birth centers to develop or access a continuing education curriculum and must make available a continuing education training.

Additionally, the Dignity and Pregnancy Act calls on the state to increase the availability of, and access to, doula and midwifery services by removing barriers to communities disproportionately affected by maternal and infant morbidity and mortality. To help improve pregnancy and postpartum outcomes, MDH hired a Maternal Care Access Coordinator to develop a strategic plan and to develop and implement policies, activities, and programs, with community input, aimed at expanding access to prenatal care, doula, and midwifery services by working with internal and external partners and stakeholders. The work of the Maternal Care Access Coordinator will continue to inform cross-sector collaborations with internal and external stakeholders working to advance policies and systems changes to remove barriers to access for doula and midwife services such as trainings, certification, and reimbursement.

Expand and improve the Minnesota Maternal Mortality Review Project (MMRP)

The goal of the MMMRP is to improve the health outcomes of pregnant women through maternal mortality and morbidity reviews. The MMMRP houses the Maternal Mortality Review Committee (MMRC), which reviews maternal death cases and develops recommendations to prevent future deaths.

The MMMRP activities for FFY2026 include the following:

Analyze multi-year data and provide demographics, geographic burden, distribution of death, and cause of death, to inform change of practice or policies.

Review all pregnancy- associated maternal deaths within 18 months of date of death, and document findings and decisions in the Maternal Mortality Review Information Application (MMRIA) to assist with ongoing analysis.

Expand community members and/or those with personal experience on the MMRC.

Disseminate committee findings, analysis, and recommendations to internal and external stakeholders annually.

Develop and disseminate a report on 5 years of maternal mortality reviews including recommendations to (internal and external) stakeholders.

Develop targeted reports on leading causes of death in Minnesota for specific stakeholder groups including providers and policy makers.

Track the implementation of MMRC recommendations at multiple levels.

Collaborate with partners to strategically develop statewide actionable interventions to reduce contributing factors identified by the case reviews.

Promote recommendations from our community action team (perinatal subcommittee) to identify strategies and resources needed for the community to implement recommendations and mitigate barriers to improved pregnancy outcomes.

Train, and cross-train, internal staff on data management and system processes to improve timely access to case information, abstraction, and data entry.

Invest in community driven interventions to address maternal mortality and build upon communities working in culturally tailored approaches in maternal health.

Improve case identification and completion of record collection in partnership with Department of Human Services, other divisions within MDH, the Minnesota Hospital Association, State Medical Examiners, and Law Enforcement entities.

Develop feasible processes and systems to collect and analyze maternal morbidity data to identify leading causes of morbidity in the state.

Tailor quality improvement interventions, in conjunction with the MNPQC, to target and address maternal mortality and morbidity.

Implement an informant interview protocol through a contract with external partners – which reflects a recommendation from the CDC for MMRC partners to use informant interviews for comprehensive case reviews. (Qualitative data gathered from the interviews are used to supplement medical records and other records abstracted for MMRC to review).

Expand the Hear her campaign.

Additionally, maternal morbidity reviews are set to occur in FFY2026.

In FFY2026, staff will work with MNPQC members, community partners, and clinic systems to develop protocols and processes for a maternal morbidity review team. Maternal morbidities are considered “near miss” incidents related to pregnancy or childbirth that did not result in death. The protocols and processes will assist implementing case reviews to expand identification of opportunities to improve care as well as requesting records from newly acquired data sources for case narratives.

Expand Understanding of Key Research and Current Strategies to Support Social connectedness and Other Factors that Influence Mental Wellbeing

During FFY2026, MDH staff will continue to develop and promote content on social connectedness and other selected strategies to promote mental wellbeing, highlighting research, data sources, key talking points, and examples of community strategies to address the issue. These resources will be shared broadly and use examples of strategies highlighted in the MN Thrives database and the Mental Wellbeing and Resilience Learning Community. We will partner with internal and external stakeholders to share these resources and to identify policy and environmental changes that promote social connectedness.

MDH will leverage national resources, including those from the Surgeon General 5 for 5 Connection Challenge to promote social connectedness through the May Mental Health month toolkit, online, and at public events where MDH hosts a table.

Title V staff will continue to co-chair the Suicide Prevention Taskforce’s Committee on Mental Health and Wellbeing. This committee will help oversee the raising awareness of recommendations and resources across the state to promote mental health and wellbeing across the life span in Minnesota’s communities, including attention to social connectedness

Improve Data Available on Minnesotans with Disabilities

Title V CSHCN Staff are co-leading the development of the MDH Disability Data Dashboard. The Disability Data Dashboard Project is a MDH multi-department collaboration that aims to create a publicly accessible data dashboard that communicates disability related demographics, outcomes, and trends for Minnesotans with disabilities. The data dashboard, in alignment with the Minnesota Olmstead Plan, will inform the work of MDH by better measuring and reporting on health outcomes of persons with disabilities and set benchmarks to improve the health and wellness of people with disabilities. Further, the dashboard will serve as a high-quality source of information for academic, health systems, community-based organizations (CBOs) and self-advocates to leverage data in advocacy work, targeted public health interventions, programming, and grant writing materials.

In 2026, Title V staff will continue with other Divisions in MDH to lead an ongoing data workgroup to address gaps in data available related to persons with disabilities, including CSHCN. Specifically, the workgroup aims to:

Identify current data sources and existing baseline data.

Collaborate to improve data partnerships focused on persons with disabilities with other state agencies such as the Minnesota Department of Employment and Economic Development, Minnesota Department of Human Services, and Minnesota Department of Education.

Develop a workgroup focused on the creation of a disability data dashboard.

Identify Barriers to Family Navigation through the NBS Propel Data Collection

In July 2023, MDH was awarded the State Newborn Screening System Priorities Program (NBS Propel) grant from HRSA. As part of this grant, MDH will be conducting community engagement with families of children who were diagnosed with cCMV through newborn screening (NBS) to learn about their experience with the NBS system. Engagement will also take place with providers and other partners to identify systems-level facilitators and barriers to family navigation of the NBS system. A generalized engagement and systemic experience assessment tools will be developed for use when implementing any NBS condition.

Increase Access to Safe and Affordable Housing for Clients who are Pregnant or Parenting Infants

Family home visitors are a resource for routinely screening for clients and families who are experiencing homelessness. Family home visitors at the state and community levels will continue to provide referral and support services to community resources to help find stable housing for families who were pregnant or parenting infants and/or young children.

Participate in the Sickle Cell Data Collection Program

MDH staff will continue to participate in the 2023-2028 Sickle Cell Data Collection (SCDC) program grant funded through the Centers for Disease Control and Prevention (CDC). The purpose of the SCDC is to support the infrastructure for a surveillance system that collects data to inform healthcare practice and policies related to sickle cell disease (SCD), gain a better understanding of the healthcare and health outcomes of all individuals with SCD, regardless of age, insurance, disease severity, or location of health care, and to disseminate data that help inform policy and healthcare standards that improve and extend the lives of people with SCD.

Partner to Implement the Minnesota Partnership to Prevent Infant Mortality Grants

The Healthy Beginnings, Healthy Families program was codified into the Minnesota state legislature in 2023. The goals of this funding are to convene, coordinate, and implement data-driven strategies, and community relevant activities to improve infant health by reducing preterm birth, sleep-related infant deaths, and congenital malformations, and address community health factors. Minnesota and grantees acknowledge that community health factors play a large role in infant health outcomes. Through the infant health grants offered by this program, MDH will continue to support community-led safe sleep education and support, with an aim to reduce infant mortality by

decreasing the incidence of sleep-related tragedies among infants through use of community-specific and community-based best practices that address community health drivers.

MDH will promote safe sleep messaging statewide and collaborate with our community partners and the Minnesota Partnership to Prevent Infant Mortality grantees to expand community-based infant mortality prevention and locally specific resources for populations at greatest risk of experiencing an infant death.

Partner to Implement Requirement for Birthing Facilities to Provide Training to Staff

MDH staff will work to provide ongoing implementation support to birthing facilities required, through the Dignity in Pregnancy and Childbirth Act, to provide staff with annual training beginning in January 2023. With our partners at the University of Minnesota, MDH looks forward to supporting health systems, birthing hospitals, and clinics to ensure that training is provided. The first two modules launched in December 2022 and April 2023.

MDH staff will support ongoing implementation by hosting accessible, no cost training modules, designed in partnership with the University of Minnesota. MDH will continue promoting this resource widely on our website as well as through partner networks to ensure it is widely known and utilized. Additionally, MDH will continue to review all submissions for alternative curriculum submitted by organizations to verify if they meet the requirements of the Dignity in Pregnancy and Childbirth Act.

Partner with Key Stakeholders to Develop Shared Objectives and Maintain the Minnesota Community Resilience Learning Cohort

An overarching goal for mental health promotion efforts in Minnesota is to advance a public health approach to mental health, especially a policy approach. For communities to invest in population level mental health promotion, they must embrace a broader definition of mental health that includes everyone, that recognizes that we all have mental health. Understanding the range of individual, family and community factors that can promote mental wellbeing, especially the impact of policies on our collective mental wellbeing can also support investment in a public health approach to mental health. Finally, communities often need to know what resources they already have, before finalizing priority action steps. Title V staff aim to support this through engagement in the following activities in FFY2026:

Partner with a local community youth organization to work in community with youth and families to identify local policy changes that will impact youth mental health.

Evaluate and communicate about the community process implemented for the RBYMH grant and explore opportunities to scale this model to other communities.

Continue to engage state and community leaders to discuss community level protective factors and policies that promote mental health.

Continue to partner with Leverage existing partnerships between the U of M Extension (UMN)), additional MDH sections and programs (Statewide Health Improvement Partnership (SHIP), Injury and Violence Prevention (IVPS), Suicide Prevention, and Public Health Practice), and Local Public Health to design and test tools that could help communities process or prioritize them to decide what actions are needed to promote mental wellbeing health promotion strategies.

Partner with other MDH community data initiatives to align efforts where feasible, especially those working on quantitative assessment processes (e.g., community health improvement planning). Partners, with support from Title V staff, will assess current systems and community-based strategies for mental health promotion and primary prevention and identify interest and opportunity for new strategies to be utilized.

Partner with the UMN Extension and Center of Excellence in Public Health to finalize the literature review for the

societal level of the expand the mental health socio-ecological model and develop a summary to help in efforts to help guide community leaders prioritize or elevate the strategies identified through the literature review and conduct community planning around mental health and wellbeing.

Partner with Minnesota Perinatal Collaborative (MNPQC) to Provide Technical Assistance using AIM Data

MNPQC maintains the data infrastructure for hospitals to submit AIM metrics to align with the SUD bundle. MNPQC uses the quality improvement platform, SimpleQI. This tool allows each hospital team access to input health system measures, baseline/monthly data reports, and run charts. MNPQC uses the Institute for Healthcare Improvement Model for Improvement called the Plan, Do, Study, Act (PDSA) cycle. The PDSA process supports teams to timely assess applied interventions within their health systems. Teams are provided data and reporting tools, and data benchmarking and analysis. The intent is hospitals would submit AIM data metrics via SimpleQI that then allows MNPQC to export data to submit into the AIM data portal. However, through ongoing technical assistance via AIM, the MNPQC is navigating the best plan forward to streamline data entry across platforms to minimize burden on hospitals to enter data across multiple data platforms. To further streamline data collection across shared partners, MNPQC has been in discussion with the Minnesota Hospital Association to consider incorporating the process and structural measures from this project into MHA's established data collection process. With this infrastructure for data collection, future initiatives on perinatal outcomes related to SUD will be more feasible and sustainable.

MNPQC will continue to provide technical assistance with participating teams through monthly resource sharing and email connections to sustain progress.

Provide Training and Support the Implementation of Best Practices Amongst Public Health Professionals and Family Home Visitors

The main activity aimed at building capacity of public health professionals is providing training and supporting the implementation of best practices. By building capacity, we mean that we not only plan to provide trainings to LPH agencies but also will provide the needed technical assistance and other support to help ensure they are implementing the best practices using a continuous quality improvement approach. We will focus on the following topic areas: trauma-informed care, Reflective Practice, intimate partner violence, depression, opioid drug use, and ACEs.

MDH FHV will continue to host and sponsor MECSH Foundation Training four times per year, Refresher Training two times per year, and Stop-Gap Training as needed for new MECSH home visitors that have a need to begin enrolling families into the program before they can attend the next available in-person Foundation Training. Additionally, virtual training on the PICCOLO parent-child interaction tool was offered to family home visitors across Minnesota beginning in 2025.

LOCAL TITLE V

Supported

Expanding Workforce Capacity to Meet a Variety of Needs

Local public health in Minnesota is increasing staff capacity to meet a variety of needs from community members through various pathways, including:

Employing community liaisons to aid in connecting individuals and families to resources within home communities or navigating referrals to services outside of their home community when needed.

Hiring or contracting for staff and services that provide for translation of program materials, as well as community engagement and recruitment messaging. Some local public health agencies also contract out with translation

and interpretation services for conducting home visiting with families.

Recruiting staff to focus on navigation of services that address community health drivers such as transportation, scheduling appointments, dental services, special healthcare services, housing, and more.

Recruiting staff from the communities served by the local public health agency to increase representation of communities in provision of services.

Accessing professional development and trainings that offer a variety of knowledge and skills to responsively address the various needs of community members based on individual and family preferences and needs.

Local public health agencies will continue this work in FFY2026.

Connected

Data Infrastructure and Alignment

Local public health continues to rapidly expand in the area of data infrastructure and alignment. With the recognition that data is vital to success, local pubic health agencies will continue to work to:

Make sure their data collected and gathered is accurate, can be disaggregated, and can be refreshed or looked at with regularity.

Try to align performance measures to be able to look across an area at impacts and who is being served, particularly looking for gaps or overlaps in services, including: Once we have who isn't being served, who is not staying enrolled for full services, and what barriers are being repeatedly identified in data to change practice.

Get feedback from families via surveys about their programs and services, like home visiting, and they can improve to better to meet families' needs.

Optimal systems and policies

CROSS-CUTTING/SYSTEMS BUILDING PLAN 2026

Description: Support transformation of systems and policies that drive priorities for improving health outcomes and optimally serving MCH populations in Minnesota.

Background

Optimal systems and policies are essential for creating a society where everyone has the opportunity to thrive, regardless of their background, location, or socioeconomic status. Everyone deserves access to necessary resources and opportunities. Systems that function optimally recognize that individuals and communities have different needs and therefore may require different levels of support to achieve similar outcomes. By addressing systemic differences—such as those rooted in demographic differences – optimal policies help address areas like education, healthcare, employment, and housing. Ultimately, optimal systems strengthen society as a whole by promoting social cohesion and shared prosperity.

> *"One of the challenges we recently encountered was a lack of accessible healthcare services in our neighborhood. Many families, including ours, struggled to find affordable and convenient healthcare options. To address this issue, we collaborated with local healthcare professionals and community organizations to organize a health fair. The fair provided free medical check-ups, health education, and resources for families in need. Overcoming the obstacle of limited healthcare access gave us a renewed sense of resilience and unity." - Minnesota Story Collective*

Optimal systems and policies support and center community-led solutions. Community-led solutions are powerful approaches to addressing local challenges because they center the voices, knowledge, and experiences of the people most directly affected. Additionally, community-led efforts often uncover innovative ideas and build local capacity, leading to more resilient and adaptable systems. By shifting agency to those on the ground, community-led solutions create more meaningful and lasting change.

Measuring success

Objective

By 2030, Minnesota aims to have 50 resources provided to Title V grantees and state staff through the Minnesota Title V Resources and Support Hub.

State Performance Measure

Title V Resources and Support Hub

Number of resources provided to Title V grantees and state staff through the *Minnesota Title V Resources and Support Hub* to support with system thinking, data driven decisions making, and community engagement.

During the 2025 Needs Assessment Minnesota received tangible feedback from Title V grantees and state staff on the types of support they are looking for from the state Title V team. Themes from this feedback included communication and connection opportunities with other Title V grantees, learning and training opportunities, and resource mapping and sharing.

Supporting grantees is essential to maximizing impact and sustainability. Beyond financial assistance, grantees benefit from guidance, capacity-building resources, and consistent communication that help them navigate challenges and grow their effectiveness. When grantees are actively engaged with and are supported, it fosters stronger relationships built on transparency. This not only enhances program outcomes but also empowers grantees to innovate, scale their work, and serve their communities more effectively.

Minnesota plans to create a communication hub for Title V grantees to serve as a space for grantees to connect to one another and state Title V staff for sharing resources (including mapping of resources) and asking questions. Minnesota's goal for FFY2026 is the communication hub is created and there are 15 resources provided that align with what has been requested the most from Title V grantees.

Strategies and activities

Through the 2025 statewide Title V needs assessment and action planning, the strategies and activities below have been highlighted to focus on for the 2025-2030 Title V grant cycle of work specific to optimal systems and policies in the cross-cutting/systems building (OSP) population domain.

OSP Strategies

1. Amplify community responsive resources, services, and supports to address systems and policies to support the health and wellbeing of MCH populations.
2. Develop and mobilize strong interagency, multisector, and community partnerships to respond to uneven trends in maternal and infant deaths through targeted interventions.
3. Build workforce and partner capacity to promote systems and policies that optimally serve all MCH populations in Minnesota.
4. Engage partners and interest holders to promote family engagement and partnership across all sectors.

OSP Activities

STATE TITLE V

Supported

Community and Family Engagement Peer-Sharing Through Annual Reporting

Beginning FFY2024, the Minnesota Title V program requires all grantees to include information about their community and family engagement activities in both their annual work plans for the upcoming year and annual reporting for the previous year. This information is then de-identified and shared out to all grantees as examples of ways to conduct community and family engagement. Grantees may reach out to the Minnesota Title V team for contact information of a specific community and family engagement effort, at the permission of the grantee.

Improve Data-Sharing between MDH and Partners

Minnesota has strict data privacy laws, which sometimes impede sharing infant health and mortality data among divisions within a state agency, with other state agencies, and with the public. Of particular concern is not being able to share infant mortality data when there are fewer than twenty infant deaths in a population even when such data are needed for policy and programmatic purposes. In FFY2026 MDH plans to:

Collaborate with the Minnesota DHS – Minnesota's Medicaid Agency – to exchange pregnancy related vital records and/or other state programs to explore opportunities to improve pregnancy outcomes.
Work with the Minnesota WIC program to use vital records data and WIC data to evaluate pregnancy outcomes and services.

Continue efforts with the SDY Case Registry to share SUID data as part of the community engagement component of our CDC SUID grant with all birthing hospitals around the state, community partners and stakeholders, including during our CDC SUID prevention project kickoff meeting, in our safe sleep action plan to be created and disseminated in FFY2025, and to help improve training and infant safe sleep practices in communities.

Seize opportunities to share or present data on infant health and mortality, including on social media, at conferences, meetings, and summits.

Participate on the Governor's Children's Cabinet

Governor Walz is committed to a vision that everyone in our state has an opportunity to thrive. The governor instituted a plan to build One Minnesota, where state agencies collaborate to create a state that works for everyone. Under One Minnesota, the Children's Cabinet was charged with implementing the One Minnesota priorities related to children and families (Refer to Overview of the State for more information). Children's Cabinet activities contribute to the existing goals of ending preventable maternal and infant deaths in Minnesota.

Title V staff will remain engaged in the following activities related to One Minnesota and the Children's Cabinet:

Participate on external work groups to listen to community concerns and member identified needs to inform strategies; and as subject matter experts providing technical assistance and education on best practices to reduce preventable infant and maternal deaths and improve pregnancy outcomes.

Work with local community leaders, schools, institutes of higher education, and community-based agencies to increase workforce among birth workers and increase employment opportunity in the health sector.

Work with family home visitors, community partner organizations, health systems, and policy makers to support fourth trimester care to include assessing and addressing postpartum visits and increasing the utilization of Medicaid's expanded postpartum coverage up to 12 months.

Implement a comprehensive cross-sector plan to prioritize initiatives to ensure a healthy beginning for all children.

Continue to participate in the Governor's Children's Cabinet Mental Health Action Team to share a public health perspective and cultivate promotion and prevention opportunities, including support for potential legislative proposals.

Participate on the Minnesota Interagency Council on Homelessness (MICH) and the Crossroads to Justice Strategic Plan Implementation

The MICH is comprised of 14 state agencies, the Met Council, and the Governor's Office, and is charged with leading MN's efforts to achieve housing stability for people experiencing homelessness in MN. MDH is one of the 14 agencies participating on the MICH, including representation by an Assistant Commissioner of MDH. MICH developed Heading Home Together, an action plan to prevent and end homelessness, identifying what state agencies can do and is reflective of the input of people who have experienced homelessness, practitioners who work in the field, and Federal policy requirements and guidance. The focus of the Council is to prevent and end homelessness among youth and young adults unaccompanied by parents or guardians, as well as prevent and end homelessness among families with children. Title V staff will continue to participate in the MICH activities in FFY2026.

Partner to Implement the Preschool Development Grant

Minnesota's Preschool Development Birth through Five grant is a partnership of the Minnesota Departments of Education, Health, Human Services, and Children, Youth, and Families, along with the Children's Cabinet to align education and care systems across the state. The grant from the U.S. Department of Health and Human Services supports pregnant families and families with children age 5 and younger. Minnesota was awarded a Preschool Development Grant Birth-Five Renewal Grant for 2024-2027. The Minnesota Title V team works closely with the Preschool Development Grant team, especially the Preschool Development Grant Coordinator housed in MDH's

Child and Family Health Division.

Grant activities are determined through an in-depth needs assessment and strategic planning process – which last took place in 2023-2024. CFH staff will continue to support the following activities in FFY2026:

Implementation of the Help Me Connect Online Navigation System
Implementation of the MN StoryCollective storytelling project that works with community partners to collect stories.
Implementation Community Solutions for Healthy Child Development Grants to fund community solutions to improve the wellbeing of children from prenatal to grade three and their families.
Implementation of Community Resource Hubs/Centers – community based coordinated points of entry that provide community responsive, relationship-based service navigation and other supportive services for expecting and parenting families and youth.

Promote the Charting the LifeCourse (CtLC) Framework Across the State

Minnesota partners with the National CoP for Supporting Families on implementing facets of the CtLC framework into our work with people with disabilities and their families, caregivers, and support persons. CFH staff will continue participating on a leadership team comprised of representatives from the Minnesota departments of human services, education, and employment and economic development to help lead this Community of Practice. This team has created a network of MN partners engaged in supporting families across the lifespan using the CtLC framework.

The network, MN-Connect, will provide a platform for this growing community of innovators and early adopters to network with and support one another for continued learning and ongoing application. Technical assistance will be provided by assigned staff from the National CoP for Supporting Families as this initiative continues to develop.

The vision has been defined: To help all MN children and youth (Birth – age 22) with disabilities plan for and achieve their best life. Goals are to:

Increase the number of families and professionals formally trained in CtLC.

Improve access to CtLC resources for families and professionals.

Promote increased utilization of CtLC in a variety of child and youth support setting.

Three work groups are working to define and develop strategies and measures to grow this work in FFY2026 and beyond.

Strengthen Access to Developmental and Social-Emotional Screening and Follow-up through the Follow Along Program (FAP)

As we move into FFY2026, Minnesota will continue to strengthen access to developmental and social-emotional screening and follow-up through the FAP. The FAP is administered by MDH in partnership with LPH agencies and provides regular caregiver-completed screening opportunities for families with young children, along with follow-up support and developmental activities.

During FFY2026, MDH will continue to administer the FAP through grant agreements with LPH agencies and will ensure adherence to established program standards. We will work to strengthen coordination between the FAP, primary care providers, early intervention programs, childcare, and social services, helping ensure families receive timely, connected supports when developmental concerns are identified. MDH will continue working to expand the availability of the FAP statewide as not all counties currently offer the program. Additionally, CFH staff will continue working across state agencies and settings to support early identification and intervention for young children and their families.

To improve the FAP's reach and relevance for all Minnesota families, MDH is in the process of evaluating and

enhancing the program model, with phased implementation beginning in FFY2026. Enhancements are based on ongoing input from families, providers, and community partners and will include:

Further development of a cohesive program brand and updated outreach materials that are clear and family centered.

Begin development of a modernized data system to support more efficient and secure collection, analysis, and use of screening and follow-up data. The system will be designed with interoperability in mind, to enhance alignment with related early childhood systems and support data-informed program improvements over time.

Continuation of a Community Connector partnership to assist families in navigating early childhood systems – including learning about and enrolling in the FAP. Community Connectors offer direct support to families.

The Community Connector initiative includes grants to eight community-based organizations across the state to pilot and implement this model. The primary goals are to:

Increase awareness of the FAP among families with young children.

Support participation by providing navigation assistance and strengthening connections with available services.

Ensure materials and services are aligned with families' communication needs and local contexts.

Encourage ongoing engagement by helping families understand and act on screening results and recommendations.

As part of a broader interagency collaboration with Minnesota's statewide screening programs, this work underscores a shared commitment to addressing the social-emotional needs of young children and their families, ultimately advancing efforts to promote positive health outcomes within maternal and child health (MCH) populations.

The activities planned for FFY2026 reflect Minnesota's commitment to increasing access to developmental screening and follow-up services, improving coordination across systems, and supporting families in ways that are responsive to their preferences, needs, and communication styles.

Support Implementation of the Help Me Connect Online Navigator and Referral System

Minnesota's Help Me Connect Online Navigator and Referral System launched in May 2021 as an online navigator to connect expectant families, families with young children birth to 8 years of age, and professionals serving these families to services in their local communities that support healthy child development and family well-being. Families and professionals can search a database of over 14,000 available programs and services closest to the family's home address under topics such as healthy development and screening resources, early learning and childcare programs, pregnancy support services, disability resources, basic needs, and more. The online resource is also available is Spanish, Somali and Hmong. Since its launch, the site has welcomed over 390,000 unique visitors from all MN counties and neighboring states, approximately 21,000 visitors per month, with top key word searches for autism, housing, transportation, and diapers.

Help Me Connect was adopted into MN State Statute 145.988 during the 2023 legislative session and now receives annual funding of $920,000 to ongoing maintenance, database management and numerous enhancement activities. The Help Me Connect program moved to a new state agency – the Department of Children, Youth and Families – in January 2025 with a variety of programs from the Departments of Human Services, Education, and Public Safety that focus on early childhood and family support services. Interagency collaboration between the Department of Health and the Help Me Connect program will continue long-term to maintain connections and assure information on the Help Me Connect platform is maintained and updated consistently.

Connected

Address Violent Maternal Deaths through Surveillance and Evidence-Based Intervention

Minnesota partnering with MDH's Injury and Violence Prevention Section (IVPS) on a maternal violent death project funded by the Office on Women's Health (OWH). This five-year grant (2021-2026) is designed to reduce deaths among pregnant and postpartum women due to violence with specific interventions around suicide, homicide, and domestic violence. This project aims to 1) enhance surveillance of violent maternal deaths, and 2) expand the evidence-based Confidentiality, Universal Education and Empowerment Support (CUES) intervention. The project team worked closely with the MMRC, MNPQC, and local violence-prevention organizations toward achieving these goals.

The project team will continue working closely with the MMRC, MNPQC, and other local organizations toward achieving these goals, and will engage in the following activities in FFY2026:

Continue Violent Death Reviews using an updated review protocol.
Implement an internal maternal violent death database and quality improvement of reporting forms.
Continue partnership with the MNPQC and intervention partners to develop and disseminate resources on maternal violence in MN.
Focus reporting for violent maternal deaths to be shared with MMRC members and partners.
Develop a dissemination and information sharing plan for data connected to this grant.
Reimburse MMRC members for participation in this the small sub-working group.
Form meaningful connections with medical examiners, including relationship-building through visits to county medical examiners' offices.
Develop an implementation tracker of recommendations related to maternal violence prevention created during the MVDR workgroup members.

Advocate for Policies that Promote and Support the Wellbeing of Parents/Caregivers

Minnesota will convene partners to advocate for policies that promote and support the well-being of families, including the following activities during FFY2026:

Identify and participate in statewide working groups, councils, or committees that aim to improve support for parents and caregivers.
Build a better understanding of the landscape around issues that impact the well-being of parents and caregivers (and therefore families), including student loan forgiveness, work flexibility, living wages, and paid parental leave.
Create and distribute infographics/reports on advocacy topics so they can be used by our partners when advocating for change.
Additionally, during the 2023 legislative session, a bill providing a paid family and medical leave (PFML) program for the state was passed. The program provides MN workers up to 12 weeks off per year with partial pay to care for a newborn or sick family member, as well as up to 12 weeks per year to recover from personal serious illness. PFML will coincide with the new earned sick and safe time program, also signed into law during the 2023 legislative session, allowing employees to earn one hour of sick and safe time for every 30 hours worked, up to a maximum of 48 hours a year. The PFML Act will go into effect January 1, 2026, and the Minnesota Team will provide support toward implementation planning and communications efforts.

Build Partnership and Capacity through MDH's Disability Health Collaborative

The departmental Disability Health Equity Collaborative (DHEC) will continue to meet quarterly into FFY2026. There continues to be a commitment to the work of the group, and membership continues to grow. MDH is currently working to create an internal strategic plan that establishes a unified vision, mission, and strategic directions for collaborative efforts. This process will align perspectives across divisions, engage community partners meaningfully, and clarify MDH's distinct public health role in advancing health for people with disabilities. In FFY2026, MDH will plan to

operationalize this strategic plan.

Collaborate to Implement the Community Solutions for Healthy Child Development Grant Program

The CSF grant program will continue through SFY2027. In FFY2026, grantees will be implementing their programs and receive ongoing technical assistance from CSF grant staff and the CSF advisory council. This will include evaluation support to assess the impact of the grant efforts. CFH and CSF will also continue to seek opportunities to collaborate. CFH staff will aim to provide technical assistance for content expertise to grantees while the CSF staff and grantees will share learnings from implementing their programs in community.

Establish a Fetal and Infant Mortality Review (FIMR)

In 2001, the infant mortality statute that required the Commissioner of Health to conduct a FIMR in MN was eliminated. Without the legislation in place, MDH lacks statutory authority to establish a FIMR process and committee. Without a FIMR, it will be difficult to access relevant information from important sources such as medical records, birth and death records, and coroner's reports to understand fully the circumstances that may have contributed to infant deaths. Since 2014, staff have put forward legislative proposals to reinstate the FIMR without success. In 2021, the proposal advanced as part of the Governor's biennial budget, but the proposal stalled because of concerns about data privacy. During the 2023 legislative session, MDH submitted a proposal to reinstate the FIMR, and it was included in the Governor's revised budget proposals for the 2024-2025 biennium. Unfortunately, the proposal was not successful, but MDH will continue to look for opportunities to advance other infant data initiatives, and provide support to cities, counties, tribes, or other jurisdictions seeking to implement a FIMR or strategies to further reduce infant mortality and improve birth outcomes.

EHDI video project

The Early Hearing Detection and Intervention (EHDI) program will continue to partner with families and community in FFY2026 to develop and promote resources available for families:

A video describing early intervention and its importance for children who are deaf and hard of hearing is now available and the MDH EHDI program will continue promoting this video to partners and families.

The EHDI program continues to work on developing additional videos for parents and caregivers that aim to explore EHDI topics in an easy-to-understand manner. Work is currently underway on a video explaining the EHDI 1-3-6 goals (screening by 1 month, diagnosis by 3 months, and early intervention by 6 months).

Identify Barriers to Family Navigation through the NBS Propel Data Collection

In July 2023, MDH was awarded the State Newborn Screening System Priorities Program (NBS Propel) grant from HRSA. As part of this grant, MDH will continue conducting community engagement with families of children who were diagnosed with congenital cytomegalovirus (CMV) through newborn screening (NBS) to learn about their experience with the NBS system. In FFY2025, MDH engaged with providers and families to begin identifying systems-level facilitators and challenges to family navigation of the NBS system. The continued engagement in FFY2026 will build off these findings and be used to develop a generalized engagement and systemic experience assessment tools for use when implementing any NBS condition.

Identify Opportunities to Develop and Implement Formal Marketing Campaigns on Mental Wellbeing, Trauma, and Resilience

Professional anti-stigma campaigns have been effective at raising awareness about mental illness, as well as how to start conversations about mental health to encourage help seeking behaviors. To build toward a comprehensive marketing and communications plan, MDH staff will continue to work with partners to amplify mental wellbeing messages in FFY2026 by:

Promoting the trauma-informed toolkit to communicate about available resources with different audiences (e.g. parents, jails, early childhood providers, etc.).

Promoting the implementation of a campaign and training around healthy relationships with technology especially

for children and adolescents, including promoting resources developed by Live More Screen Less.
Support communications about the benefits of nature for mental well-being in partnership with the Minnesota Department of Natural Resources, in support of the Children's Outdoor Bill of Rights.
Identify opportunities to promote Child and Teen Check-ups (C&TC) well visits, the state's version of the Early and Periodic Screening, Diagnostic and Treatment service, as well as incorporating other well-being resources and natural supports in clinical settings.
Partner with C&TC to promote county level outreach to juvenile justice systems and support organizations to educate on the importance of preventive care screenings for youth in community based juvenile justice settings and promote the importance of prompt reinstatement of Medicaid and C&TC services when youth are discharged from secure settings.
Partner with C&TC to incorporate information on the 2022 American Academy of Pediatrics (AAP) Bright Futures recommendation to include suicide risk assessment questions into depression screening protocol in clinics into our Best Practices training.
Continue engagement in the Minnesota State Fair Mental Health Awareness event.

Identify Public Health-Focused Recommendations for the State Mental Health Advisory Council Report

In FFY2026, MDH staff will continue participating on the State Mental Health Advisory Council, Family Systems and Prevention Workgroup, and School Mental Health workgroup. The State Mental Health Advisory Council does not submit a report to the Governor during odd years. The workgroups will continue to identify opportunities to advance previous recommendations included: expanding wraparound through the system of care initiative, expanding family peer support opportunities, growing family supports in schools, and building community-initiated care to support young people and families. MDH will continue to support a public health perspective in the work of the State Advisory Council on Mental Health and include related recommendations to the Governor in the 2026 State Mental Health Advisory Council Report.

Implement Minnesota's Early Hearing Detection and Intervention (EHDI) Program Parent Guides

Minnesota's EHDI Program oversees and administers state grant funding to a community organization to implement a statewide parent support program for families of children who are deaf or hard of hearing. The program utilizes trained parents of children who are deaf or hard of hearing as parent guides. The guides are located throughout Minnesota.There is also a congenital cytomegalovirus (cCMV) parent guide. Parent guides contact each family of a child newly identified as deaf or hard of hearing through the state's EHDI program to provide ongoing parent support, information and referral, education, and networking opportunities.

Implement Minnesota Partnership to Prevent Infant Mortality (MPPIM)

The Healthy Beginnings, Healthy Families program was codified into the Minnesota state legislature in 2023. The MPPIM is a statewide multisectoral effort that seeks to leverage existing partnerships and award competitive grants to community-based organizations, tribes, and local public health to improve infant health outcomes in MN. The MPPIM serves as the implementation platform for the state's Infant Mortality Reduction Initiative, and activities include community engagement, exchange of best practices, data management, and advocacy.

Through the infant health grants offered by this program, in FFY2026, MDH will continue to support community-led safe sleep education and support, with an aim to reduce infant mortality by decreasing the incidence of sleep-related tragedies among infants through use of specific, community-based best practices. Additionally, MDH will promote consistent safe sleep messaging statewide and collaborate with our community partners and the Minnesota Partnership to Prevent Infant Mortality grantees to expand community-based infant mortality prevention and specific resources for populations at risk of experiencing an infant death.

Implement the CDC Infant Mortality Prevention Grant – Minnesota Sudden Unexpected Infant Death (SUID)/Sudden Death in the Young (SDY) Registry and Prevention Initiative

In September 2023, MDH was awarded a five-year multi-component CDC grant to improve case ascertainment, data completeness, and timeliness. The grant also seeks to reduce the incidence of sudden unexpected sleep related tragedies. As a part of this grant, MDH has proposed to create Minnesota's first Safe Sleep Collaborative under which an Internal Safe Sleep Planning Team and a Community Safe Sleep Leadership Team will be houses. The Community Safe Sleep Leadership Team will include 15 members from community partner agencies, programs, and initiatives working to improve outcomes. The Community Safe Sleep Leadership Team will steer the work of the grant with a focus on building capacity within communities to improve infant health outcomes.

Participate in the Sickle Cell Data Collection Program

MDH staff will continue to participate in the 2023-2028 Sickle Cell Data Collection (SCDC) program grant funded through the Centers for Disease Control and Prevention (CDC). The purpose of the SCDC is to support the infrastructure for a surveillance system that collects data to inform healthcare practice and policies related to sickle cell disease (SCD), gain a better understanding of the healthcare and health outcomes of all individuals with SCD, regardless of age, insurance, disease severity, or location of health care, and to disseminate data that help inform policy and healthcare standards that improve and extend the lives of people with SCD. Minnesota will continue to work to develop data sharing agreements with clinical partners and our state Medicaid partner, the Minnesota Department of Human Services (DHS).

Participating on Newborn Screening Committees

Newborn Hearing Screening Advisory Committee

The Newborn Hearing Screening Advisory Committee, also known as the Early Hearing Detection & Intervention (EHDI) Advisory Committee, provides guidance in developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment as well as early intervention services for children who are deaf or hard-of-hearing. Members include parents of children who are deaf and hard of hearing, advocates with expertise in issues affecting people who are deaf and hard of hearing, health care providers, hospital representatives, and other medical and education experts.

Newborn Screening Advisory Committee

The Newborn Screening Advisory Committee, also called the Advisory Committee on Heritable and Congenital Disorders, was established in 2003. This committee provides advice and recommendations concerning tests and treatments for heritable and congenital conditions found in newborns, including making informed recommendations to add new disorders to the newborn screening panel.

CFH staff will continue providing support to and serving on these committees in FFY2026.

Prioritize the Interconnection between Health, Homelessness, and Housing to Drive Policy and Systems Change

Homelessness and health are interconnected, and MDH recognizes that homelessness and housing instability significantly impact community and MCH population health. Additionally, housing continues to be a top search through Minnesota's Help Me Connect Resource Hub. While not funded through Title V, MDH created a homeless-specific senior-level position. The Senior Advisor on Health, Homelessness, and Housing was hired in Spring 2022, and to the best knowledge of MDH and the CDC, the Senior Advisor on Health, Homelessness, and Housing is the first position of its kind at a state health department. This position will continue to work with state and local partners on public health and homelessness, including as a lead in the MICH work around the Justice Strategic Plan. Title V staff will continue work closely with this staff member with a focus on the interconnections between homelessness, housing, and MCH population health.

In FFY2026, Title V staff will work with the MDH Senior Advisor on Health, Homelessness, and Housing to explore opportunities to develop information and resources for Title V grantees and the general public to increase awareness and understanding of the interconnections between homelessness, housing, and MCH population health.

This includes developing facts sheets and webinars on addressing housing and homelessness in MCH populations using Title V resources.

Promote Partners to Engage Families and Communities in Program Implementation and Feedback

Minnesota's Family Home Visiting program requires all grantees to include activities on their annual workplans that assures they regularly receive community input and participant/family voice. This input is then used to continually inform and improve their individual programs, as well as the Minnesota Family Home Visiting program as a whole. These requirements will continue in FFY2026.

Strengthen Cross-Sector Partnerships to Address MCH priorities

In FFY2026, MDH staff will engage in the following activities aimed at strengthening cross-sector partnerships to address MCH priorities:

Work with key partners, including the MDH SHIP, MN Public Health Law Network, MDH Healthy MN Partnership, Local Public Health Association, and others, to assess the state landscape for mental well-being related policy initiatives, as well as stakeholders, related research, and reports that support proposed policies.
Utilize the MN Mental Well-Being and Resilience Learning Community to identify examples of relevant policies – inviting presenters to provide relevant policy examples that support their work and proposals with the learning community and partners.
Promote and contribute to the development of tools that help identify important and relevant policies. For example, we will continue to partner with the University of MN Extension and School of Public Health to use the Social Ecological Model which was developed through this partnership.
Contribute to the Trust for Public Land and Child and Nature Network – Green Schoolyard Advisory Committee, in partnership with the MN SHIP, Department of Natural Resources, and MN Department of Education, to inform strategies that support local policy action.

Strengthen and expand the Minnesota Perinatal Quality Collaborative (MNPQC)

Minnesota became an AIM state in Spring of 2022 and the MNPQC, co-led by MDH, is eager to take the next step in statewide quality improvement efforts for maternal health outcomes. The MNPQC is primarily responsible for coordinating AIM implementation and is undergoing exploratory opportunities to develop the data platform to increase efficiency and reduce burden with hospital partners. This grant program will provide five-year funding support to the MNPQC to lead the establishment of an AIM data infrastructure, including data collection portals, reporting, engagement of hospitals/providers, and expand AIM bundles being implemented in Minnesota. MNPQC is especially eager to engage with the AIM community to learn, build and grow this work. Objectives supporting this in FFY2026 are to:

Identify and implement AIM bundles and support data collection and sharing.
Provide AIM technical assistance, training, and sharing QI project success to promote participation.
Identify the next AIM bundle, incorporating the Innovations for Maternal Health Outcomes in Minnesota (I-MOM) project work, including the MCH Task Force Perinatal Sub-Committee, the Perinatal Health Strategic Plan, and community recommendations.
Work to address, as a primary improvement activity, critical cross-sector collaboration, like the urgent need to seamlessly address maternal opioid misuse alongside pregnancy, postpartum and pediatric care.

The state PQC grant program will continue to:

implement continuous quality improvement tools and strategies to improve practices and meet goals.
Advance evidence-based and evidence-informed clinics and other health service practices and processes through quality care review, chart audits, and continuous quality improvement initiatives.
Review current data, trends, and research on best practices to inform and prioritize quality improvement

initiatives.

Support quality improvement initiatives to address substance use disorders in pregnant women and infants with neonatal abstinence syndrome or other effects of substance use.

Provide a forum to discuss state-specific system and policy issues to guide quality improvement efforts that improve population-level perinatal outcomes.

Reach providers and institutions in a multidisciplinary, collaborative, and coordinated effort across system organizations to reinforce a continuum of care model; and

Support health care facilities in monitoring interventions through rapid data collection and applying system changes to provide improved care in perinatal health.

Support Rural Perinatal Health through the Minnesota Perinatal Quality Collaborative (MNPQC)

Minnesota has an active landscape prioritizing improved perinatal outcomes across our communities, particularly for rural residents and those with limited/no access to transportation. In July 2023, Healthy Beginnings, Healthy Families Act passed the MN legislation to ensure the health and well-being of young children and their families. This 18-million-dollar investment in over 4 years includes advancing perinatal health and wellbeing through advancing community and partner strategies. One key investment in partnership as a leading solution have been demonstrated in supporting programs and/or organizations such as a state perinatal quality collaborative. Minnesota legislation identified the need of a nonprofit organization to support efforts that improve maternal and infant health outcomes. MN Perinatal Organization (MPO) is the nonprofit organization that leads the MNPQC. This MNPQC grant is to create or sustain a multidisciplinary network of representatives of health care systems, health care providers, academic institutions, local and state agencies, and community partners that will collaboratively improve pregnancy and infant outcomes through evidence-based, population-level quality improvement initiatives. The grant program started early fall 2023 with a program timeline through June 2026. MNPQC launched the Linking Identification & Navigation for Perinatal Mental Health & Substance Use Care (LINK) initiative active in October 2024 - October 2026. This initiative builds on the success and insights from the initial substance use disorder program and integrates two patient safety bundles designed for maternal health: Care for Pregnant and Postpartum women with Substance Use Disorder and Perinatal Mental Health Conditions. As MNPQC will transition the LINK Initiative into a maintenance phase, the focus for the coming year will shift from initial implementation to sustainability, shared learning, and embedding practices into routine care. An end of 2025 opportunity will be a community of learning including aspects from the AIM bundle on obstetrical hemorrhage.

Support the Transforming Maternal Health Model (TMaH) Implementation

In January 2025, Minnesota was selected through an application process as one of fifteen states to participate in the TMaH Model through 2035, through the Centers for Medicate & Medicaid Services. The Minnesota state Medicaid program and Minnesota Department of Health are partnering to lead implementation of the TmaH model to address maternal health care. States will be required to address the following elements:

Access, Infrastructure, and Workforce

Quality Improvement and Safety

Whole-Person Care Delivery

Minnesota’ s Maternal Care Access Coordinator and Maternal Health Innovations Coordinator are the Minnesota Department of Health representatives serving on the TMaH team. More details will become available as the project is moved further into the pre-implementation period, and toward implementation.

Strengthen State Capacity to Improve Maternal Health Outcomes

In FFY2023, MDH was awarded a new HRSA grant from the State Maternal Innovation and Data Capacity Program. The purpose of the award is to support state capacity to improve maternal health through quality services, a skilled workforce, enhanced data quality and capacity, and innovative programming that aims to reduce maternal mortality

and severe maternal morbidity. MDH created the “Innovations for Maternal Health Outcomes in MN (I-MOM)” program. The purpose of the I-MOM program is focused on alignment and strengthening of the implementation of innovative, data-driven, community-informed and supported perinatal health programs to improve perinatal health outcomes for Minnesota communities.

I-MOM activities include innovative programing, increased data capacity, implementation of AIM statewide quality improvement care initiatives, and support for building a skilled perinatal health workforce to reduce perinatal morbidity and mortality, and goals include:

build a shared perinatal health vision.
strengthen data infrastructure.
improve the collection, reporting, and analysis of AIM data.

As a part of the I-MOM project, MDH established a Perinatal Sub-Committee under the existing Maternal and Child Health Advisory Task Force which supports development of Minnesota’s first Perinatal Health Strategic Plan. The I-MOM Project Planner will lead project management and implementation of the I-MOM project in FFY2026 until the end of the grant period, including collaboration with Title V staff and the Perinatal Sub-Committee.

LOCAL TITLE V

Supported

Collaborate with Community Partners and Families to Develop and Deliver Programs and Services

Local Public Health agencies in Minnesota recognize the importance of building and sustaining strong relationships with community partners and families to develop and deliver programs and services that are appropriate for and responsive to individual and family needs. Example of how local public health agencies are and will continue to do this in FFY2026 include:

Translation of program and recruitment materials through a community review process with families as intended audiences, and professionals that can speak to their use.
Collaborating with community partners to deliver programs and services rather than creating new in-house programs or services because of the established trust from communities.
Creating strong partnerships with other local public health agencies to build staff capacity and deliver individual and family responsive services.
Hiring a Community Health Strategist within local public health agencies to focus on outreach and engagement with communities.
Directly engaging community and family members in development, improvement, and delivery of programs and services through, for example community action boards and community advisory boards.

Public Input

To advance maternal and child health (MCH) outcomes and assure Minnesota's children and families achieve their full health potential, we must include those people who are most impacted by poor MCH outcomes in our efforts – their stories and experience are critical to advancing MCH priorities in Minnesota.

The Child and Family Health (CFH) Division includes community members from MCH populations across Minnesota on groups that we convene, such as the Maternal and Child Health Advisory Committee, the Early Hearing Detection and Intervention and Newborn Screening Advisory Committees, and other workgroups/councils. Additionally, community and family engagement is sought at varying levels across the programs and projects that are planned and implemented on behalf of or in partnership with the CFH Division.

Participating on and Convening Workgroups

CFH Division staff participate on a variety of committees, workgroups, and task forces as subject matter experts or representatives of MDH. In their participation on these groups, staff provide updates on programs and initiatives of the state. They also obtain feedback on community-level needs, opportunities for collaboration, and areas of improvement in the state's work. This feedback is documented, analyzed, and used to inform Title V action planning and programming.

In addition to participating on groups, MDH convenes several committees and workgroups related to various MCH issues. These groups include both professional and community members, including families, MCH consumers, public health and health care professionals, representatives from health plans, other state agency representatives, and others. These groups are often the first audience sought when input from the community is needed on Title V plans and programming. For instance, the CSHCN Family Support "Think Tank" has been a source of a great deal of input on Family Support initiatives within the CSHCN Section. *For more information see the 2024 CSHCN Report and 2026 CSHCN Plan.*

Maternal and Child Health Advisory Committee

The Maternal and Child Health Advisory Committee – formerly the Maternal and Child Health Advisory Task Force – a statutorily required group of external experts and family representatives, provides a significant source of input into the Title V needs assessment and planning process. The committee reviews the block grant priorities and action plan on an annual basis and provides feedback on the strategies developed to address the priority needs. It also directly reports to the Commissioner of Health on important strategies and recommendations related to MCH populations that should be addressed by MDH.

Minnesota StoryCollective

Minnesota (MN) StoryCollective is a cross-agency community engagement project funded through the Preschool Development Grant and managed by the Minnesota Department of Education. Its goal is to provide qualitative data of community stories using the MN StoryCollective tool, developed with the University of Kansas. MN StoryCollective was launched in Summer 2023 in partnership with 13 community grantees to facilitate story collection in their communities using the MN StoryCollective Tool. Patterns of the stories are developed in partnership with communities through sensemaking sessions. Following sensemaking sessions, there is an Action Lab. Action Labs are an opportunity to collectively identify action steps to address the patterns and themes uncovered by the experiences shared through MN StoryCollective. Stories are shared with state leaders, calling attention to the most pressing needs of Minnesota's communities and issues that need to be addressed. The stories shape and inform how Minnesota improves programs and services for individuals, families, and groups, such as school programming, childcare resources, and others which impact the health and wellbeing of Minnesota's communities. Over 2,000

stories have been shared to date, through the MN StoryCollective.

Five-Year Needs Assessment and Action Plan Development

Minnesota's Title V team prioritized the engagement of those people who are most impacted by MCH health disparities throughout the planning and implementation processes of the 2025 Title V Needs Assessment and Action Planning. This engagement includes participation on the 2025 Needs Assessment Steering Committee of community members, including families, MCH consumers, public health and health care professionals, representatives from health plans, and other state agency representatives, as well as a statewide survey to solicit input from Title V grantees and partners on Minnesota's 2025 priorities, strategies, and activities. Steering committee members who elected to, were provided a stipend for their time and work as a part of the steering committee.

Local-Level Opportunities for Input

Local public health (LPH) agencies obtain public input in determining their priorities for the use of Title V funds in their communities. Every five years Minnesota community health boards are required to participate in an assessment and planning process, to determine LPH priorities and focus local resources on the greatest community and organizational needs. Public input is sought for this assessment and planning process. In addition, public hearings are held to review and approve annual budgets and work plans for community health boards. Other activities used by LPH agencies for obtaining public input include advisory/workgroup reviews, community surveys, focus groups, key informant interviews, participation in and convening of committees, and community meetings.

LPH staff share their community needs and plans through an annual reporting process that allows MDH to measure and support shifts in local needs and programmatic priorities. In addition, LPH representatives participated in the five-year needs assessment and strategic planning process to inform MDH of issues within their communities. All most recent community needs assessments and plans from LPH were included in the documents that were reviewed as a part of the 2025 Title V Needs Assessment to support development of the 2025-2030 Title V state priorities.

Additionally, while ongoing, open communication channels are available for reciprocal feedback between the state Title V team and LPH, in 2024, the state Title V team developed a series of connection and feedback opportunities for one-on-one communication and feedback opportunities between the state Title V team and the 52 individual community health boards across the state. This *Title V Connections Tour* took place between March and June of 2024, where state Title V staff met either virtually or in-person with each community health board to gain feedback around how the state Title V team can support at the local level, as well as spent some time hearing about successes and challenges related to Title V implementation at the CHB and community level. Additionally, these connections provided opportunities for CHBs to provide feedback on the 2025 Title V Needs Assessment processes and evolving findings.

As a part of ongoing connections and communication loops with LPH, the Minnesota Title V Team now meets one-on-one with the 52 CHBs (53 as of January 1, 2026) annually for short check points to answer questions and provide any important updates regarding Title V. Additionally, based on the feedback from the 2024 Title V Connections Tour, the Minnesota Title V team will be developing a Minnesota Title V SharePoint site for the purposes of sharing resources and providing connection opportunities across Title V interest holders, including LPH and their partners. One component of this SharePoint site will provide an additional avenue for LPH to provide comments and questions related to the Minnesota's Title V work.

Technical Assistance

At the time of submission, Minnesota has not identified any specific technical assistance needs. If any needs are identified in the future, staff will reach out to the Maternal and Child Health Bureau.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - IAA_DHS Title V-Medicaid_2024.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - NA Leadership Structure.pdf

Supporting Document #02 - Landscape Analysis_Documents.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - orgchart.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Minnesota

	FY 26 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 9,456,167	
A. Preventive and Primary Care for Children	$ 3,892,961	(41.1%)
B. Children with Special Health Care Needs	$ 2,870,059	(30.3%)
C. Title V Administrative Costs	$ 710,735	(7.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 7,473,755	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 7,092,125	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 1,627,944	
5. OTHER FUNDS (Item 18e of SF-424)	$ 2,680,042	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 3,934	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 11,404,045	
A. Your State's FY 1989 Maintenance of Effort Amount $ 6,184,197		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 20,860,212	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 20,860,212	

OTHER FEDERAL FUNDS	FY 26 Application Budgeted
No Other Federal Programs were provided by the State on Form 2 Line 9.	

	FY 24 Annual Report Budgeted		FY 24 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 9,255,161 (FY 24 Federal Award: $ 9,456,167)		$ 9,456,167	
A. Preventive and Primary Care for Children	$ 3,456,638	(37.3%)	$ 3,892,961	(41.1%)
B. Children with Special Health Care Needs	$ 2,928,835	(31.6%)	$ 2,870,059	(30.3%)
C. Title V Administrative Costs	$ 590,798	(6.4%)	$ 710,735	(7.6%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 6,976,271		$ 7,473,755	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 6,941,371		$ 7,092,125	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 3,143,734		$ 3,604,037	
5. OTHER FUNDS (Item 18e of SF-424)	$ 31,994,105		$ 32,705,824	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 41,744		$ 3,934	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 42,120,954		$ 43,405,920	
A. Your State's FY 1989 Maintenance of Effort Amount $ 6,184,197				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 51,376,115		$ 52,862,087	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 138,318,969		$ 125,778,782	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 189,695,084		$ 178,640,869	

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 846,646	$ 799,122
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 692,524	$ 600,226
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 175,000	$ 175,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 1,000,000	$ 506,621
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects Tracking Systems	$ 375,000	$ 380,299
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	$ 320,000	$ 0
US Department of Education > Office of Special Education Programs > Grants to States for Education of Children with Disabilities (Part B of IDEA)	$ 60,000	$ 60,954
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	$ 9,713,000	$ 8,524,648
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 445,000	$ 525,378
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	$ 255,600	$ 322,619
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 38,781	$ 30,360
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) American Rescue Plan (ARP)	$ 2,857,557	$ 0

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 169,311	$ 169,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 8,826,241	$ 10,865
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000	$ 222,453
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 100,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Commodity Supplemental Food Program (CSFP)	$ 1,036,781	$ 922,997
US Department of Agriculture (USDA) > Food and Nutrition Services > Food Distribution Program	$ 69,957,980	$ 68,398,057
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 2,825,143	$ 2,825,143
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 33,221,644	$ 38,112,843
US Department of Education > Other > Preschool Development Grant	$ 883,482	$ 0
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Child and Teen Checkup	$ 487,597	$ 362,872
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > APHL NewSteps	$ 146,575	$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > ELC SetNet	$ 56,773	$ 13,529
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Expansion	$ 300,000	$ 141,129

OTHER FEDERAL FUNDS	FY 24 Annual Report Budgeted	FY 24 Annual Report Expended
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Congenital Heart Defects	$ 400,000	$ 352,523
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sickle Cell Data Colletion	$ 64,127	$ 31,918
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Reimagine Black Youth Mental Health	$ 400,000	$ 420,777
US Department of Agriculture (USDA) > Food and Nutrition Services > Technology for a Better WIC Experience ARPA	$ 350,000	$ 114,023
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Shopping Experience Improvement	$ 528,805	$ 309,287
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Infrastructure - 2022	$ 659,003	$ 138,643
US Department of Agriculture (USDA) > Other > WIC Midwest States Online Ordering Project (SWOOP)	$ 891,399	$ 613,954
Department of Justice > Other > Incarcerated Parents with Minor Children (DOJ)		$ 220,055
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Maternal Mortality Review Commitees		$ 373,487

Form Notes for Form 2:

None

Field Level Notes for Form 2:

None

Data Alerts:

- The value in Line 1A, Preventive And Primary Care Expended, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please correct or add a field level note indicating the reason for the discrepancy.
- The value in Line 1C, Title V Administrative Costs, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
- The value in Line 4, Local MCH Funds, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.
- The value in Line 6, Program Income, Annual Report Expended is greater or less than 10% of the Annual Report Budgeted. Please add a field level note indicating the reason for the discrepancy.

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Minnesota

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 1,533,731	$ 1,533,731
2. Infants < 1 year	$ 170,415	$ 170,415
3. Children 1 through 21 Years	$ 3,892,961	$ 3,892,961
4. CSHCN	$ 2,870,059	$ 2,870,059
5. All Others	$ 278,266	$ 278,266
Federal Total of Individuals Served	$ 8,745,432	$ 8,745,432

IB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Pregnant Women	$ 3,533,057	$ 3,533,057
2. Infants < 1 year	$ 2,527,502	$ 2,527,502
3. Children 1 through 21 Years	$ 2,393,403	$ 2,393,403
4. CSHCN	$ 3,236,598	$ 3,236,598
5. All Others	$ 563,484	$ 563,484
Non-Federal Total of Individuals Served	$ 12,254,044	$ 12,254,044
Federal State MCH Block Grant Partnership Total	$ 20,999,476	$ 20,999,476

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Minnesota

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 1,435,989	$ 1,435,989
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 1,411	$ 1,411
B. Preventive and Primary Care Services for Children	$ 1,289,450	$ 1,289,450
C. Services for CSHCN	$ 145,128	$ 145,128
2. Enabling Services	$ 3,494,922	$ 3,494,922
3. Public Health Services and Systems	$ 4,525,256	$ 4,525,256
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 1,347,761
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 88,228
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 1,435,989
Federal Total	$ 9,456,167	$ 9,456,167

IIB. Non-Federal MCH Block Grant	FY 26 Application Budgeted	FY 24 Annual Report Expended
1. Direct Services	$ 1,731,790	$ 1,731,790
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 3,370	$ 3,370
B. Preventive and Primary Care Services for Children	$ 1,381,912	$ 1,381,912
C. Services for CSHCN	$ 346,508	$ 346,508
2. Enabling Services	$ 4,214,841	$ 4,214,841
3. Public Health Services and Systems	$ 5,457,414	$ 5,457,414
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 0
Physician/Office Services		$ 1,625,388
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 106,402
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 1,731,790
Non-Federal Total	$ 11,404,045	$ 11,404,045

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Minnesota

Total Births by Occurrence: 61,727 **Data Source Year: 2023**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	60,838 (98.6%)	5,648	501	374 (74.7%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Guanidinoacetate Methyltransferase (GAMT) Deficiency	Hearing Loss
Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease
Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Mucopolysaccharidosis Type II (MPS II)
Primary Congenital Hypothyroidism	Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)
Severe Combined Immunodeficiences	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I
Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy			

2. Other Newborn Screening Tests

None

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Minnesota Department of Health Long Term Follow-up Program provides follow-up for infants and children, and their families, with a newborn screening condition. Long Term Follow-up includes several functions: ensure all children with a Newborn Screening Condition receive coordinated, ongoing, comprehensive care within a medical home, and are supported through connection to local, state, and national resources, and to other families or peers; assure connection to best practices by communicating with specialists and families, and monitoring program impact; and identify resource and service gaps and opportunities for systems and policy improvement to optimize health outcomes. Obtained information includes diagnostic, intervention, and services accessed data. Infants are currently typically monitored through approximately 1-2 years of age.

Form Notes for Form 4:

For Critical Congenital Heart Disease (CCHD), the reported numbers reflect only those infants with a positive screen result (i.e., a failed screen). However, a substantial number of children receive a physician override, either due to a prenatal diagnosis of CCHD or because clinical symptoms observed after birth prompt the physician to bypass screening and proceed directly to an echocardiogram. The largest discrepancy between the number of positive results and the overall number of identified cases is likely attributable to these physician overrides. Additionally, we consistently observe a slightly higher number of children who initially pass the screening but are later diagnosed with CCHD compared to those correctly identified through screening.

*For 2023, the date of the early intervention referral has likely not yet been reported. Finalization of the hearing screening data for the year is still in progress.

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Total Number Referred For Treatment**
	Fiscal Year:	**2024**
	Column Name:	**Core RUSP Conditions**

Field Note:
(C) Number Confirmed Cases
Total: 501
BS: 159
EHDI: 227
CCHD: 115

(D) Number Referred for Treatment
Total: 374 (75%*)

BS: 157 (99%)
EHDI: 102 (45%*)
CCHD: 115 (100%)

*For 2023, the date of the early intervention referral has likely not yet been reported. Finalization of the hearing screening data for the year is still in progress.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Minnesota

Annual Report Year 2024

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	3,486	56.0	0.0	15.4	0.9	27.7
2. Infants < 1 Year of Age	4,085	62.6	0.0	26.6	1.5	9.3
3. Children 1 through 21 Years of Age	15,350	45.5	0.0	37.5	10.2	6.8
3a. Children with Special Health Care Needs 0 through 21 years of age^	3,034	53.5	0.0	39.1	1.4	6.0
4. Others	3,753	47.4	0.0	31.3	18.2	3.1
Total	26,674					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	61,715	Yes	61,715	100.0	61,715	3,486
2. Infants < 1 Year of Age	60,886	Yes	60,886	100.0	60,886	4,085
3. Children 1 through 21 Years of Age	1,530,229	Yes	1,530,229	43.9	671,771	15,350
3a. Children with Special Health Care Needs 0 through 21 years of age^	415,999	Yes	415,999	100.0	415,999	3,034
4. Others	4,144,049	Yes	4,144,049	2.2	91,169	3,753

^Represents a subset of all infants and children.

Form Notes for Form 5:

Data on individuals served comes from annual reporting to Minnesota Department of Health (MDH) by Community Health Boards (CHBs). MDH asks each CHB if they used Title V MCH Block Grant federal funds and/or Title V match funds in the area of Improved Pregnancy Outcome (pregnant women), Infant Health, Children, Adolescents, CYSHN, and Family Planning (other). A count of the unduplicated number of prenatal clients served by primary medical coverage is used to get this estimate. Includes individuals who appear to be eligible and likely to apply for public programs. Medical coverage is taken at the first visit of the year.

Minnesota CHBs serve pregnant women, infants, etc. in these counts through family home visiting, follow-along program, developmental/social-emotional screening and follow-up, school based health centers, and much more. We are working towards a more meaningful but not burdensome way to better collect information from our partners so we can better tell the story of whom Title V serve.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2024**
	Field Note: Data comes from annual reporting to Minnesota Department of Health (MDH) by Community Health Boards (CHBs). MDH asks each CHB if they used Title V MCH Block Grant federal funds and/or Title V match funds in the area of Improved Pregnancy Outcome. A count of the unduplicated number of prenatal clients served by primary medical coverage is used to get this estimate.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2024**
	Field Note: Data comes from annual reporting to Minnesota Department of Health (MDH) by Community Health Boards (CHBs). MDH asks each CHB if they used Title V MCH Block Grant federal funds and/or Title V match funds in the area of Infant Health. A count of the unduplicated number of infants served by primary medical coverage is used to get this estimate.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note: Data comes from annual reporting to Minnesota Department of Health (MDH) by Community Health Boards (CHBs). MDH asks each CHB if they used Title V MCH Block Grant federal funds and/or Title V match funds in the area of Child and Adolescent Health and Children with Special Health Care Needs. A count of the unduplicated number of children and adolescents served plus unduplicated number of children and youth with special health care needs by primary medical coverage is used to get this estimate. CHBs report these number of children and adolescents and children and youth with special health care as mutually exclusive categories.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2024**
	Field Note: Data comes from annual reporting to Minnesota Department of Health (MDH) by Community Health Boards (CHBs). MDH asks each CHB if they used Title V MCH Block Grant federal funds and/or Title V match funds in the area of Children with Special Health Care Needs. A count of the unduplicated number of children and youth with special health care needs served by primary medical coverage is used to get this estimate.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2024**
	Field Note: Data comes from annual reporting to Minnesota Department of Health (MDH) by Community Health Boards (CHBs). MDH asks each CHB if they used Title V MCH Block Grant federal funds and/or Title V match funds in the area of Family Planning. A count of the unduplicated number of individuals receiving family planning services by primary medical coverage is used to get this estimate.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2024**
	Field Note: Justification: Through Minnesota's Dignity in Pregnancy and Childbirth Act (Minnesota Statute 144.1461), which was passed during the 2021 legislative session, Title V reaches all pregnant women. This legislation requires all providers working with birthing persons to take implicit bias training, using evidence-based curriculum developed specifically for Minnesota by the Center for Anti-Racism Research for Health Equity at UMN.	
2.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2024**
	Field Note: Justification: Through WIC, FHV, and Newborn screening Title V reaches all infants under 1.	
3.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	Field Note: Source: CMS-416 - children 1 to 20 enrolled in Minnesota Health Care Programs (MHCP). Justification: Title V program reaches all children in MHCP through child & teen check-up (C&TC) program. Minnesota's C&TC program provides health consultation and technical assistance to C&TC providers, C&TC Coordinators and the Department of Human Services. This includes clinical recommendations about best practices in well child care and training about the required screening components for providers, local public health, Head Start programs and others who provide screening for children.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2024**
	Field Note: Justification: Through newborn screening long-term follow-up, the Follow Along Program, birth defects monitoring and surveillance, the C&TC program, the Care Coordination Community of Practice, the Pediatric Mental Health Access Program, the Health Care Homes program, and the Health Care Transition Learning Collaborative, all systems-level initiatives, the Title V program aims to reach the entire population of children and youth with special health needs (CYSHN) in the state.	
5.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2024**
	Field Note: Numerator Source: Unduplicated count of Family Planning Special Projects Outreach Activities Justification: Title V reached individuals through family planning outreach - individuals received factual information on reproductive and sexual health, including pregnancy prevention and all contraceptive methods.	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Minnesota

Annual Report Year 2024

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	61,737	40,170	7,382	6,491	742	4,650	83	1,730	489
Title V Served	3,486	990	335	719	83	166	7	80	1,106
Eligible for Title XIX	25,251	6,524	3,067	4,150	573	1,195	96	576	9,070
2. Total Infants in State	62,211	39,627	8,675	5,083	274	4,068	0	3,522	962
Title V Served	4,085	1,295	622	857	59	321	11	216	704
Eligible for Title XIX	27,770	3,029	954	2,194	421	260	17	415	20,480

Form Notes for Form 6:

Title XIX data = FFY 2024 Minnesota Health Care Programs data
Title V Served = FFY 2024 REDCap Community Health Board report (Deliveries - Section I & Infants-Section IV)
Total Deliveries = CY 2023 Birth Record
Total Infants = ACS 1-Year Estimates Public Use Microdata Sample 2023

Field Level Notes for Form 6:

None

Form 7
Title V Program Workforce

State: Minnesota

Form 7 Entry Page

A. Title V Program Workforce FTEs	
Title V Funded Positions	
1. Total Number of FTEs	125.50
1a. Total Number of FTEs (State Level)	20
1b. Total Number of FTEs (Local Level)	105.50
2. Total Number of MCH Epidemiology FTEs (subset of A. 1)	1.30
3. Total Number of FTEs eliminated in the past 12 months	5.60
4. Total Number of Current Vacant FTEs	4.20
4a. Total Number of Vacant MCH Epidemiology FTEs	0
5. Total Number of FTEs onboarded in the past 12 months	26.10

B. Training Needs (Optional)
No training needs were reported by the state.

Form Notes for Form 7:

FFY2025 state Title V workforce and FFY 2024 Title V workforce. Only those on TItle V dollars are counted here.

Field Level Notes for Form 7:

Form 7 Field Level Notes Table

1.	**Field Name:**	**Total Number of FTEs eliminated in the past 12 months**
	Field Note: All at local level	
2.	**Field Name:**	**Total Number of Current Vacant FTEs**
	Field Note: All at local level	

Form 8
State MCH and CSHCN Directors Contact Information

State: Minnesota

1. Title V Maternal and Child Health (MCH) Director	
Name	Savannah Riddle
Title	MCH Section Manager
Address 1	625 Robert St. N.
Address 2	P.O. Box 64975
City/State/Zip	St Paul / MN / 55164
Telephone	(651) 201-6746
Extension	
Email	savannah.riddle@state.mn.us

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Nicole Brown
Title	CYSHN Section Manager
Address 1	625 Robert St. N.
Address 2	P.O. Box 64975
City/State/Zip	St Paul / MN / 55164
Telephone	(651) 201-3737
Extension	
Email	nicole.brown@state.mn.us

3. State Family Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

4. State Youth Leader (Optional)	
Name	
Title	
Address 1	
Address 2	
City/State/Zip	
Telephone	
Extension	
Email	

5. SSDI Project Director	
Name	Molly Meyer
Title	Senior Research Scientist
Address 1	625 Robert St. N.
Address 2	P.O. Box 64975
City/State/Zip	St Paul / MN / 55164
Telephone	(651) 201-4236
Extension	
Email	molly.meyer@state.mn.us

6. State MCH Toll-Free Telephone Line	
State MCH Toll-Free “Hotline” Telephone Number	(800) 728-5420

Form Notes for Form 8:

None

Form 9
List of Priority Needs – Needs Assessment Year

State: Minnesota

Application Year 2026

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Comprehensive perinatal systems of care	New
2.	Healthy infants, families, and communities	New
3.	Child mental health and wellbeing	New
4.	Adolescent mental health and wellbeing	New
5.	Coordinated support and access for CSHCN	New
6.	Community health drivers	New
7.	Optimal systems and policies	New

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 1

Field Note:
Improve the wellbeing of families with pregnant people and infants through supports and services that are community-based and responsive to individual needs and experiences.

Field Name:

Priority Need 3

Field Note:
Increase the number of children who are screened for and connected with mental, behavior, and wellbeing resources and services that are responsive to individual needs and experiences.

Form 10
National Outcome Measures (NOMs)

State: Minnesota

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations - SMM

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	112.9	4.3	689	61,036
2021	110.3	4.3	679	61,571
2020	95.1	4.0	577	60,686
2019	87.5	3.7	555	63,442
2018	84.1	3.6	545	64,799
2017	71.1	3.3	470	66,114
2016	61.6	3.0	412	66,889
2015	65.3	3.6	331	50,686
2014	63.7	3.1	429	67,345
2013	59.8	3.1	375	62,674
2012	56.4	3.1	342	60,667
2011	55.0	3.0	347	63,038
2010	55.0	3.0	343	62,322
2009	60.2	3.1	382	63,405
2008	52.8	2.8	347	65,694

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SMM - Notes:

None

Data Alerts: None

NOM - Maternal mortality rate per 100,000 live births - MM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2023	14.1	2.1	45	319,625
2018_2022	12.3	1.9	40	325,254
2017_2021	12.4	1.9	41	329,834
2016_2020	10.4	1.8	35	335,158
2015_2019	8.8	1.6	30	341,549
2014_2018	10.4	1.7	36	345,426

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM MM - Notes:

None

Data Alerts: None

NOM - Teen birth rate, ages 15 through 19, per 1,000 females - TB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	7.8	0.2	1,465	188,638
2022	8.2	0.2	1,496	182,998
2021	8.5	0.2	1,561	183,825
2020	9.1	0.2	1,611	177,686
2019	10.1	0.2	1,791	176,831
2018	10.2	0.2	1,794	175,152
2017	12.1	0.3	2,113	174,958
2016	12.6	0.3	2,200	174,361
2015	13.7	0.3	2,386	173,884
2014	15.5	0.3	2,709	174,309
2013	16.8	0.3	2,950	175,143
2012	18.6	0.3	3,295	177,400
2011	19.3	0.3	3,464	179,638
2010	22.5	0.4	4,035	179,598
2009	24.1	0.4	4,384	181,719

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM TB - Notes:

None

Data Alerts: None

NOM - Percent of low birth weight deliveries (<2,500 grams) - LBW

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	7.2 %	0.1 %	4,439	61,623
2022	7.2 %	0.1 %	4,618	63,916
2021	7.2 %	0.1 %	4,665	64,357
2020	6.7 %	0.1 %	4,229	63,333
2019	6.9 %	0.1 %	4,537	65,933
2018	6.9 %	0.1 %	4,617	67,277
2017	6.7 %	0.1 %	4,626	68,535
2016	6.6 %	0.1 %	4,570	69,676
2015	6.4 %	0.1 %	4,494	69,781
2014	6.6 %	0.1 %	4,595	69,858
2013	6.4 %	0.1 %	4,398	69,090
2012	6.6 %	0.1 %	4,550	68,726
2011	6.4 %	0.1 %	4,384	68,353
2010	6.4 %	0.1 %	4,415	68,571
2009	6.5 %	0.1 %	4,604	70,606

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM LBW - Notes:

None

Data Alerts: None

NOM - Percent of preterm births (<37 weeks gestation) - PTB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	9.4 %	0.1 %	5,823	61,663
2022	9.6 %	0.1 %	6,117	63,958
2021	9.6 %	0.1 %	6,195	64,368
2020	9.1 %	0.1 %	5,773	63,396
2019	9.3 %	0.1 %	6,107	65,982
2018	8.9 %	0.1 %	6,004	67,303
2017	8.9 %	0.1 %	6,111	68,549
2016	8.8 %	0.1 %	6,121	69,716
2015	8.5 %	0.1 %	5,906	69,787
2014	8.7 %	0.1 %	6,054	69,863
2013	8.3 %	0.1 %	5,729	69,058
2012	8.6 %	0.1 %	5,922	68,661
2011	8.5 %	0.1 %	5,803	68,273
2010	8.8 %	0.1 %	6,047	68,447
2009	8.7 %	0.1 %	6,117	70,274

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM PTB - Notes:

None

Data Alerts: None

NOM - Stillbirth rate per 1,000 live births plus fetal deaths - SB

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.5	0.3	351	64,366
2021	5.4	0.3	349	64,774
2020	5.4	0.3	343	63,786
2019	5.4	0.3	359	66,386
2018	5.8	0.3	394	67,738
2017	5.6	0.3	386	68,981
2016	5.4	0.3	378	70,127
2015	5.7	0.3	402	70,236
2014	5.3	0.3	375	70,279
2013	5.0	0.3	350	69,509
2012	5.1	0.3	351	69,123
2011	5.6	0.3	383	68,792
2010	5.1	0.3	350	68,960
2009	4.8	0.3	341	70,987

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM SB - Notes:

None

Data Alerts: None

NOM - Perinatal mortality rate per 1,000 live births plus fetal deaths - PNM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	5.1	0.3	325	64,183
2021	5.1	0.3	331	64,594
2020	4.9	0.3	314	63,612
2019	5.0	0.3	332	66,207
2018	5.4	0.3	368	67,528
2017	5.2	0.3	359	68,769
2016	5.4	0.3	379	69,940
2015	5.9	0.3	413	70,040
2014	5.6	0.3	393	70,104
2013	5.9	0.3	409	69,350
2012	6.0	0.3	413	68,976
2011	5.3	0.3	367	68,608
2010	5.3	0.3	364	68,805
2009	4.7	0.3	332	70,829

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM PNM - Notes:

None

Data Alerts: None

NOM - Infant mortality rate per 1,000 live births - IM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	4.5	0.3	288	64,015
2021	4.8	0.3	311	64,425
2020	4.1	0.3	262	63,443
2019	4.5	0.3	299	66,027
2018	5.1	0.3	341	67,344
2017	4.8	0.3	329	68,595
2016	5.1	0.3	358	69,749
2015	5.2	0.3	361	69,834
2014	5.0	0.3	350	69,904
2013	5.1	0.3	352	69,159
2012	5.0	0.3	345	68,772
2011	4.8	0.3	325	68,409
2010	4.5	0.3	312	68,610
2009	4.6	0.3	324	70,646

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM - Notes:

None

Data Alerts: None

NOM - Neonatal mortality rate per 1,000 live births - IM-Neonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	2.9	0.2	184	64,015
2021	3.2	0.2	209	64,425
2020	2.9	0.2	185	63,443
2019	3.0	0.2	201	66,027
2018	3.4	0.2	231	67,344
2017	3.3	0.2	226	68,595
2016	3.5	0.2	241	69,749
2015	3.8	0.2	262	69,834
2014	3.3	0.2	231	69,904
2013	3.7	0.2	253	69,159
2012	3.6	0.2	249	68,772
2011	3.1	0.2	211	68,409
2010	3.1	0.2	212	68,610
2009	2.7	0.2	191	70,646

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Neonatal - Notes:

None

Data Alerts: None

NOM - Post neonatal mortality rate per 1,000 live births - IM-Postneonatal

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	1.6	0.2	104	64,015
2021	1.6	0.2	102	64,425
2020	1.2	0.1	77	63,443
2019	1.5	0.2	98	66,027
2018	1.6	0.2	110	67,344
2017	1.5	0.2	103	68,595
2016	1.7	0.2	117	69,749
2015	1.4	0.1	99	69,834
2014	1.7	0.2	119	69,904
2013	1.4	0.1	99	69,159
2012	1.4	0.1	96	68,772
2011	1.7	0.2	114	68,409
2010	1.5	0.2	100	68,610
2009	1.9	0.2	133	70,646

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Postneonatal - Notes:

None

Data Alerts: None

NOM - Preterm-related mortality rate per 100,000 live births - IM-Preterm Related

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	146.8	15.2	94	64,015
2021	128.8	14.2	83	64,425
2020	137.1	14.7	87	63,443
2019	127.2	13.9	84	66,027
2018	161.9	15.5	109	67,344
2017	148.7	14.7	102	68,595
2016	177.8	16.0	124	69,749
2015	191.9	16.6	134	69,834
2014	140.2	14.2	98	69,904
2013	159.1	15.2	110	69,159
2012	177.4	16.1	122	68,772
2011	125.7	13.6	86	68,409
2010	156.0	15.1	107	68,610
2009	138.7	14.0	98	70,646

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-Preterm Related - Notes:

None

Data Alerts: None

NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births - IM-SUID

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	53.1	9.1	34	64,015
2021	63.6	9.9	41	64,425
2020	44.1	8.3	28	63,443
2019	54.5	9.1	36	66,027
2018	54.9	9.0	37	67,344
2017	42.3	7.9	29	68,595
2016	67.4	9.8	47	69,749
2015	63.0	9.5	44	69,834
2014	67.2	9.8	47	69,904
2013	62.2	9.5	43	69,159
2012	72.7	10.3	50	68,772
2011	65.8	9.8	45	68,409
2010	51.0	8.6	35	68,610
2009	76.4	10.4	54	70,646

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IM-SUID - Notes:

None

Data Alerts: None

NOM - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations - NAS

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	6.3	0.3	385	61,318
2021	5.0	0.3	307	61,827
2020	5.5	0.3	336	60,922
2019	4.9	0.3	307	62,681
2018	4.5	0.3	292	65,003
2017	5.5	0.3	369	66,607
2016	5.2	0.3	346	66,452
2015	5.7	0.3	291	50,841
2014	4.5	0.3	308	67,855
2013	3.5	0.2	232	65,837
2012	2.5	0.2	161	64,765
2011	2.3	0.2	150	65,326
2010	2.1	0.2	133	64,560
2009	1.4	0.2	86	63,592
2008	1.0	0.1	65	65,374

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM NAS - Notes:

None

Data Alerts: None

NOM - Percent of children meeting the criteria developed for school readiness - SR

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	68.0 %	3.0 %	130,287	191,679

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SR - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year - TDC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	10.6 %	0.9 %	128,786	1,210,369
2021_2022	9.9 %	1.1 %	121,055	1,224,921
2020_2021	8.6 %	1.0 %	105,540	1,229,078
2019_2020	10.0 %	1.3 %	122,298	1,228,569
2018_2019	9.8 %	1.4 %	121,036	1,234,055
2017_2018	9.2 %	1.4 %	111,360	1,216,800
2016_2017	9.1 %	1.3 %	108,463	1,197,810

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM TDC - Notes:

None

Data Alerts: None

NOM - Child Mortality rate, ages 1 through 9, per 100,000 - CM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	15.9	1.6	100	627,976
2022	17.4	1.7	109	626,360
2021	15.6	1.6	100	641,159
2020	16.3	1.6	105	643,036
2019	15.8	1.6	102	646,839
2018	14.8	1.5	96	647,159
2017	15.0	1.5	97	646,153
2016	15.9	1.6	102	642,026
2015	16.1	1.6	103	640,481
2014	14.4	1.5	92	640,746
2013	14.3	1.5	92	642,291
2012	14.7	1.5	94	641,576
2011	14.2	1.5	91	639,749
2010	18.1	1.7	116	642,031
2009	15.8	1.6	101	638,145

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM CM - Notes:

None

Data Alerts: None

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 - AM

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	32.5	2.1	246	757,142
2022	33.1	2.1	247	746,796
2021	35.7	2.2	270	757,349
2020	31.2	2.1	228	731,651
2019	27.4	1.9	200	730,878
2018	26.4	1.9	192	728,461
2017	28.7	2.0	208	724,143
2016	25.0	1.9	179	716,938
2015	26.3	1.9	188	715,068
2014	27.8	2.0	199	714,850
2013	23.3	1.8	166	713,901
2012	26.4	1.9	189	715,660
2011	27.1	1.9	195	720,273
2010	31.4	2.1	226	720,171
2009	26.6	1.9	193	725,693

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM - Notes:

None

Data Alerts: None

NOM - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000 - AM-Motor Vehicle

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021-2023	8.6	0.9	98	1,133,694
2020_2022	8.9	0.9	99	1,111,214
2019_2021	8.4	0.9	92	1,098,004
2018_2020	7.8	0.9	84	1,080,927
2017_2019	7.3	0.8	79	1,075,856
2016_2018	7.7	0.9	82	1,070,628
2015_2017	7.7	0.9	82	1,068,791
2014_2016	7.0	0.8	75	1,068,411
2013_2015	7.3	0.8	78	1,071,117
2012_2014	8.0	0.9	86	1,077,958
2011_2013	9.4	0.9	102	1,088,554
2010_2012	10.5	1.0	115	1,097,774
2009_2011	10.9	1.0	121	1,107,933
2008_2010	10.4	1.0	116	1,118,464
2007_2009	11.5	1.0	130	1,131,143

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Motor Vehicle - Notes:

None

Data Alerts: None

NOM - Adolescent suicide rate, ages 10 through 19 per 100,000 - AM-Suicide

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	7.1	0.6	160	2,261,287
2020_2022	6.6	0.5	148	2,235,796
2019_2021	6.9	0.6	154	2,219,878
2018_2020	7.2	0.6	158	2,190,990
2017_2019	8.0	0.6	174	2,183,482
2016_2018	7.6	0.6	164	2,169,542
2015_2017	7.5	0.6	161	2,156,149
2014_2016	7.5	0.6	162	2,146,856
2013_2015	7.4	0.6	158	2,143,819
2012_2014	7.4	0.6	159	2,144,411
2011_2013	6.3	0.5	136	2,149,834
2010_2012	6.4	0.5	137	2,156,104
2009_2011	5.9	0.5	128	2,166,137

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Suicide - Notes:

None

Data Alerts: None

NOM - Adolescent firearm mortality rate, ages 10 through 19 per 100,000 - AM-Firearm

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2023	4.6	0.5	103	2,261,287
2020_2022	5.2	0.5	116	2,235,796
2019_2021	5.2	0.5	115	2,219,878
2018_2020	5.4	0.5	118	2,190,990
2017_2019	5.7	0.5	124	2,183,482
2016_2018	5.5	0.5	120	2,169,542
2015_2017	5.5	0.5	118	2,156,149
2014_2016	5.0	0.5	107	2,146,856
2013_2015	4.7	0.5	101	2,143,819
2012_2014	4.1	0.4	88	2,144,411
2011_2013	3.9	0.4	83	2,149,834
2010_2012	4.0	0.4	87	2,156,104
2009_2011	4.0	0.4	87	2,166,137
2008_2010	3.8	0.4	83	2,178,358
2007_2009	3.8	0.4	83	2,196,142

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM AM-Firearm - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9 - IH-Child

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	107.4	3.9	742	691,115
2021	114.1	4.0	803	704,056
2020	82.9	3.4	588	709,426
2019	93.8	3.6	670	714,468
2018	95.3	3.7	682	715,725
2017	112.1	4.0	802	715,504
2016	107.7	3.9	767	711,963
2015	132.4	5.0	706	533,047
2014	123.2	4.2	875	710,145
2013	127.9	4.2	909	710,969
2012	154.1	4.7	1,093	709,111
2011	152.7	4.6	1,081	708,061
2010	164.5	4.8	1,170	711,040
2009	147.2	4.6	1,042	708,080
2008	168.7	4.9	1,185	702,510

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Child - Notes:

None

Data Alerts: None

NOM - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19 - IH-Adolescent

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022	237.0	5.6	1,770	746,796
2021	266.1	5.9	2,015	757,349
2020	263.9	6.0	1,931	731,651
2019	255.0	5.9	1,864	730,878
2018	273.2	6.1	1,990	728,461
2017	289.9	6.3	2,099	724,143
2016	296.5	6.4	2,126	716,938
2015	283.6	7.3	1,521	536,301
2014	273.6	6.2	1,956	714,850
2013	269.1	6.1	1,921	713,901
2012	282.7	6.3	2,023	715,660
2011	293.1	6.4	2,111	720,273
2010	293.3	6.4	2,112	720,171
2009	286.5	6.3	2,079	725,693
2008	331.6	6.7	2,429	732,494

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM IH-Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of women, ages 18 through 44, in excellent or very good health - WHS

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	53.2 %	1.4 %	530,053	996,589
2022	58.4 %	1.3 %	577,871	989,250
2021	60.9 %	1.2 %	598,833	982,786
2020	66.4 %	1.1 %	645,146	971,607
2019	60.2 %	1.1 %	582,567	967,813
2018	61.0 %	1.1 %	588,244	964,979
2017	59.0 %	1.2 %	565,093	958,351
2017	59.0 %	1.2 %	565,093	958,351
2016	62.4 %	1.1 %	596,426	955,767
2015	64.0 %	1.2 %	607,213	948,759
2014	61.6 %	1.2 %	582,956	945,895
2013	63.4 %	1.6 %	594,955	938,802
2012	62.1 %	1.4 %	580,426	933,925

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM WHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, in excellent or very good health - CHS

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	92.2 %	0.8 %	1,187,277	1,287,939
2021_2022	92.2 %	1.0 %	1,191,963	1,292,735
2020_2021	91.7 %	1.1 %	1,185,946	1,293,575
2019_2020	92.5 %	1.1 %	1,196,262	1,293,827
2018_2019	93.4 %	1.1 %	1,203,308	1,288,626
2017_2018	94.1 %	1.0 %	1,206,881	1,282,966
2016_2017	93.4 %	0.9 %	1,193,047	1,277,126

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM CHS - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 2 through 4, and adolescents, ages 6 through 17, who are obese (BMI at or above the 95th percentile) - OBS

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	11.6 %	0.2 %	3,133	27,074
2018	12.5 %	0.2 %	5,408	43,399
2016	12.2 %	0.2 %	5,765	47,219
2014	12.3 %	0.2 %	5,880	47,773
2012	12.2 %	0.1 %	6,363	51,943
2010	12.7 %	0.1 %	7,297	57,529
2008	12.9 %	0.2 %	6,695	51,715

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	11.8 %	1.1 %	100,805	854,543
2021_2022	13.1 %	1.5 %	110,623	845,493
2020_2021	14.7 %	1.6 %	121,907	827,287
2019_2020	11.3 %	1.6 %	92,967	822,863
2018_2019	9.7 %	1.4 %	80,719	830,844
2017_2018	11.2 %	1.7 %	93,445	830,700
2016_2017	12.2 %	1.6 %	97,502	801,085

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM OBS - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum depressive symptoms - PPD

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	10.2 %	1.9 %	5,731	55,997
2022	12.5 %	2.0 %	7,224	57,819
2021	11.3 %	1.8 %	6,838	60,312
2020	13.8 %	2.0 %	8,099	58,728
2019	10.9 %	1.3 %	6,632	60,829
2018	10.6 %	1.1 %	6,673	62,989
2013	9.6 %	0.9 %	6,229	64,670
2012	9.3 %	1.0 %	5,962	64,261

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPD - Notes:

None

Data Alerts: None

NOM - Percent of women who experience postpartum anxiety symptoms - PPA

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2023	24.5 %	2.6 %	13,717	56,033

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM PPA - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 through 11, who have a behavioral or conduct disRecordOrder - BCD

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	8.6 %	1.3 %	37,172	433,447
2021_2022	9.4 %	1.6 %	40,616	433,479
2020_2021	8.0 %	1.5 %	34,736	436,106
2019_2020	8.5 %	2.0 %	36,904	435,826
2018_2019	10.3 %	2.3 %	44,851	434,762
2017_2018	10.2 %	2.1 %	44,646	436,048
2016_2017	10.3 %	1.9 %	44,755	434,464

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM BCD - Notes:

None

Data Alerts: None

NOM - Percent of adolescents, ages 12 through 17, who have depression or anxiety - ADA

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	24.4 %	1.9 %	110,212	450,784
2021_2022	20.0 %	2.1 %	89,037	444,890
2020_2021	15.5 %	1.8 %	67,759	436,824
2019_2020	18.3 %	2.2 %	79,866	435,332
2018_2019	17.8 %	2.3 %	76,928	431,951
2017_2018	12.9 %	2.0 %	55,135	428,086
2016_2017	14.4 %	1.8 %	61,230	425,169

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ADA - Notes:

None

Data Alerts: None

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system - SOC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	14.2 %	1.7 %	48,095	338,351
2021_2022	17.6 %	2.6 %	53,018	300,587
2020_2021	19.1 %	2.8 %	50,725	266,073
2019_2020	13.3 %	2.2 %	36,082	271,345
2018_2019	12.2 %	2.2 %	33,769	276,512
2017_2018	14.8 %	2.6 %	40,592	274,200
2016_2017	17.5 %	2.7 %	49,285	281,675

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM SOC - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 6 months through 5, who are flourishing - FL-YC

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	81.0 %	2.0 %	293,423	362,353
2021_2022	85.2 %	2.1 %	321,804	377,645
2020_2021	87.7 %	2.1 %	337,723	385,081
2019_2020	89.2 %	2.1 %	353,574	396,184
2018_2019	89.9 %	2.3 %	363,213	404,092

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-YC - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-CA

Data Source: National Survey of Children's Health (NSCH)-CSHCN

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	32.3 %	2.5 %	90,862	281,025
2021_2022	34.4 %	3.3 %	87,688	255,078
2020_2021	38.3 %	3.5 %	86,174	224,969
2019_2020	38.8 %	3.6 %	92,278	237,980
2018_2019	43.8 %	4.0 %	106,815	243,698

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-CA - Notes:

None

Data Alerts: None

NOM - Percent of children with and without special health care needs, ages 6 through 17, who are flourishing - FL-Child Adolescent

Data Source: National Survey of Children's Health (NSCH)-All Children

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	58.9 %	1.7 %	523,614	888,288
2021_2022	62.5 %	2.0 %	550,904	881,378
2020_2021	63.7 %	2.0 %	550,158	864,129
2019_2020	67.0 %	2.1 %	581,207	867,500
2018_2019	73.2 %	2.1 %	636,408	869,677

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM FL-Child Adolescent - Notes:

None

Data Alerts: None

NOM - Percent of children, ages 0 through 17, who have experienced 2 or more Adverse Childhood Experiences - ACE

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2022_2023	14.1 %	1.0 %	180,043	1,276,074
2021_2022	13.9 %	1.2 %	178,026	1,284,637
2020_2021	14.2 %	1.3 %	181,913	1,279,563
2019_2020	14.5 %	1.4 %	184,811	1,271,595
2018_2019	16.3 %	1.6 %	208,285	1,276,959
2017_2018	17.1 %	1.8 %	216,880	1,265,210
2016_2017	17.0 %	1.6 %	211,712	1,246,144

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM ACE - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Minnesota

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	92.2	92.9
Numerator	55,698	52,972
Denominator	60,382	57,013
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	93.8	94.7	95.7	96.6	97.5

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2023	**2024**
Annual Objective		
Annual Indicator	86.0	74.1
Numerator	47,301	38,709
Denominator	55,022	52,239
Data Source	PRAMS	PRAMS
Data Source Year	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	76.3	78.5	80.8	83.0	85.2

Field Level Notes for Form 10 NPMs:

None

NPM - A) Percent of infants placed to sleep on their backs - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	87.5	88	88.5	89	89.3
Annual Indicator	86.0	86.4	90.3	90.3	68.1
Numerator	52,364	50,486	53,992	53,992	36,022
Denominator	60,905	58,449	59,811	59,811	52,859
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	69.5	70.8	72.2	73.5	74.9

Field Level Notes for Form 10 NPMs:

None

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	41.5	42.5	43.5	44.5	45.5
Annual Indicator	39.6	43.5	39.7	39.7	26.4
Numerator	23,128	24,690	22,771	22,771	13,993
Denominator	58,448	56,809	57,410	57,410	53,020
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	28.0	29.6	31.1	32.7	34.3

Field Level Notes for Form 10 NPMs:

None

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	54.5	56	57	58.5	60
Annual Indicator	59.2	63.8	69.4	69.4	78.4
Numerator	34,627	36,646	39,928	39,928	42,792
Denominator	58,484	57,453	57,494	57,494	54,562
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2021	2021	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	80.0	81.5	83.1	94.6	86.2

Field Level Notes for Form 10 NPMs:

None

NPM - D) Percent of infants room-sharing with an adult during sleep - SS

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2024
Annual Objective	
Annual Indicator	75.4
Numerator	41,673
Denominator	55,274
Data Source	PRAMS
Data Source Year	2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	76.9	78.4	79.9	81.4	82.9

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	59.2	60.1	61.6	62.8	63.6
Annual Indicator	57.5	48.7	48.7	46.8	47.5
Numerator	102,904	88,434	77,155	74,250	75,127
Denominator	178,996	181,694	158,549	158,739	158,050
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	48.5	49.4	50.4	51.3	52.3

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	72	77.3	79.6	81.8	82.3
Annual Indicator	79.3	75.5	70.7	67.6	69.6
Numerator	304,000	306,842	303,301	294,767	309,080
Denominator	383,452	406,593	429,104	435,815	444,075
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2019	2019_2020	2020_2021	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	71.4	73.2	75.0	76.8	78.6

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2023	**2024**
Annual Objective		
Annual Indicator	48.3	44.0
Numerator	118,835	148,856
Denominator	246,192	338,157
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	45.3	46.6	48.0	49.3	50.6

Field Level Notes for Form 10 NPMs:

None

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH - Child Health - All Children

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - All Children		
	2023	**2024**
Annual Objective		
Annual Indicator	52.0	51.2
Numerator	675,201	662,037
Denominator	1,299,339	1,292,206
Data Source	NSCH-All Children	NSCH-All Children
Data Source Year	2021_2022	2022_2023

Annual Objectives					
	2026	**2027**	**2028**	**2029**	**2030**
Annual Objective	52.7	54.3	55.8	57.4	58.9

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2021-2025 Needs Assessment Cycle)

State: Minnesota

2021-2025: NPM - A) Percent of infants who are ever breastfed - BF

Federally Available Data		
Data Source: National Vital Statistics System (NVSS)		
	2023	**2024**
Annual Objective	94	94.5
Annual Indicator	90.7	89.6
Numerator	55,751	53,126
Denominator	61,487	59,265
Data Source	NVSS	NVSS
Data Source Year	2022	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - B) Percent of infants breastfed exclusively through 6 months - BF

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2023	**2024**
Annual Objective	40.2	41.3
Annual Indicator	38.2	38.3
Numerator	65,138	66,064
Denominator	170,646	172,580
Data Source	NSCH	NSCH
Data Source Year	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	75	76.1	77.8	79.2	81
Annual Indicator	73.6	71.9	68.2	69.3	74.5
Numerator	704,572	691,348	661,628	674,973	728,498
Denominator	957,132	961,095	969,970	974,404	977,708
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2019	2020	2021	2022	2023

Field Level Notes for Form 10 NPMs:

None

2021-2025: NPM - Percent of children, ages 0 through 17, who are continuously and adequately insured - AI - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective	60.5	61.3	62.5	63.7	64.9
Annual Indicator	59.7	62.4	67.3	66.5	64.4
Numerator	771,820	805,126	865,943	861,769	829,428
Denominator	1,293,684	1,289,616	1,287,332	1,295,564	1,287,773
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018_2019	2019_2020	2020_2021	2021_2022	2022_2023

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Minnesota

SPM 1 - Number of resources provided to Title V grantees and state staff through the Minnesota Title V Resources and Support Hub.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	15.0	30.0	45.0	50.0	55.0

Field Level Notes for Form 10 SPMs:

None

SPM 2 - Percent of Minnesotan communities that have a high Area Deprivation Index (ADI)

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	29.0	29.0	28.0	27.0	26.0

Field Level Notes for Form 10 SPMs:

None

Form 10
State Performance Measures (SPMs) (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 1 - Percent of Minnesotans that did not get routine medical care that they needed because of cost

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		7.3	6.7	6.2	5.6
Annual Indicator	7.8	5.4	5.4	7	7
Numerator					
Denominator					
Data Source	Minnesota Health Access Survey	Minnesota Health Access Survey	Minnesota Health Access Survey	Minnesota Health Access Survey	Minnesota Health Access Survey
Data Source Year	2019	2021	2021	2023	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
Minnesota Health Access Survey done every 2 years.

2021-2025: SPM 3 - Proportion of Minnesota adolescents who report staying in a shelter, somewhere not intended as a place to live, or someone else's home because you had no other place to stay in the past 12 months

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		4.4	4.2	4.1	2.5
Annual Indicator	4.4	4.4	2.9	2.9	2.9
Numerator	5,577	5,577	2,966	2,966	2,966
Denominator	125,375	125,375	100,836	100,836	100,836
Data Source	MSS	Minnesota Student Survey	Minnesota Student Survey	Minnesota Student Survey	Minnesota Student Survey
Data Source Year	2019	2019	2022	2022	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: MSS is administered every three years.	
2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: MSS completed every 3 years	

2021-2025: SPM 4 - Percent of Minnesota adolescents who report having positive mental well-being - fulfilling relationships, contributing to community, and being resilient

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		37	37.8	39.6	39.7
Annual Indicator		36.7	22.7	22.7	22.7
Numerator			22,890	22,890	22,890
Denominator			100,836	100,836	100,836
Data Source		Minnesota Student Survey	Minnesota Student Survey	Minnesota Student Survey	Minnesota Student Survey
Data Source Year		2019	2022	2022	2022
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: MSS only occurs every 3 years	
2.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: Minnesota Student Survey completed every 3 years	

2021-2025: SPM 5 - Percent of children, ages 0-17, living with parents who are coping very well with the demands of parenthood

Measure Status:				Active	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		65.9	66.5	67.2	67.8
Annual Indicator	63.3	59.4	56.2	56.7	54.2
Numerator			718,858	726,270	689,794
Denominator			1,279,740	1,281,856	1,273,190
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 SPMs:

None

2021-2025: SPM 6 - Percent of Division staff who have completed the Tribal State Relations Training

Measure Status:			**Active**
State Provided Data			
	2022	**2023**	**2024**
Annual Objective			55
Annual Indicator			66.7
Numerator			104
Denominator			156
Data Source			CFH Managers
Data Source Year			As of May
Provisional or Final ?			Final

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Minnesota

ESM PPV.1 - Percentage of families who could benefit from family home visiting services that are currently served.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	12.0	14.0	16.0	18.0	20.0

Field Level Notes for Form 10 ESMs:

None

ESM SS.1 - Proportion of mothers who were told by a healthcare provider to place their baby on his or her back to sleep

Measure Status:	Inactive - This measure is no longer collected on MN PRAMS.			
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			95.1	95.8
Annual Indicator	94.3	93.7	100	100
Numerator	55,097	55,862	55,248	55,248
Denominator	58,451	59,592	55,248	55,248
Data Source	MN PRAMS	MN PRAMS	MN PRAMS	MN PRAMS
Data Source Year	2020	2021	2022	2022
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**

Field Note:
Questions was no longer asked on 2023 MN PRAMS.

ESM SS.2 - Proportion of organizations that distribute cribs and/or provide safe sleep education within communities across Minnesota.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	10.0	12.0	14.0	16.0	18.0

Field Level Notes for Form 10 ESMs:

None

ESM DS.1 - Percent of developmental/social-emotional screens that were completed electronically through the Follow Along Program (FAP) in the past year.

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		15	15	16	18
Annual Indicator		2.6	6.2	4.5	5.1
Numerator		480	997	687	940
Denominator		18,533	16,089	15,231	18,318
Data Source		Follow Along Program Data	Follow Along Program Data	Follow Along Program Data	Follow Along Program Data
Data Source Year		2021	2022	2023	2024
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM DS.2 - Percent of developmental/social-emotional screens that were completed through the Follow Along Program (FAP) in the past year.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	41.0	42.0	43.0	44.0	45.0

Field Level Notes for Form 10 ESMs:

None

ESM AWV.1 - Percentage of Child and Teen Checkups (C&TC) where depression screenings are occurring for adolescents enrolled in Minnesota Health Care Programs (MHCP)

Measure Status:	Inactive - Replaced				
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		65.9	67.2	68.5	69.8
Annual Indicator	64.6	65	66.7	66.6	68.4
Numerator	70,259	58,080	80,787	81,361	89,296
Denominator	108,842	89,322	121,119	122,133	130,582
Data Source	MHCP Data	MHCP Data	MHCP	MHCP	MHCP
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

None

ESM AWV.2 - Percent of adolescent students who report that they would have done “nothing” and/or “I’m not sure” to take care of your health problems/needs if their school did not have a School Based Health Clinic (SBHC).

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	45.0	45.0	45.0	45.0	45.0

Field Level Notes for Form 10 ESMs:

None

ESM MH.1 - Percent of care coordinators reporting increased knowledge in serving CSHCN and their families after participating in Community of Practice (CoP) webinars.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives					
	2026	2027	2028	2029	2030
Annual Objective	70.0	72.0	74.0	76.0	78.0

Field Level Notes for Form 10 ESMs:

None

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM BF.1 - Percent of births delivered at MDH Breastfeeding-Friendly Maternity Centers

Measure Status:				**Active**	
State Provided Data					
	2020	**2021**	**2022**	**2023**	**2024**
Annual Objective		28.3	29	29.4	30.1
Annual Indicator		17.4	26.9	13.2	10.4
Numerator		11,341	17,743	8,292	6,226
Denominator		65,138	66,010	62,636	59,694
Data Source		Vital Records and MDH's Accreditation Database	Vital Records and MDH's Accreditation Database	Vital Records and MDH's Accreditation Database	Vital Records and MDH's Accreditation Database
Data Source Year		2020	2021	2022	2023
Provisional or Final ?		Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: 2,908 births at facilities that have 1-2 stars.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: For 2021 births, there were 66,010, of which 17,743 were in facilities with at least one star from MDH: 1 had one, 1 had 2, one had all 5, 14 were BFHI, which automatically makes them 5 star. 26.9% of births.	

2021-2025: ESM WWV.2 - Number of hospitals that are actively participating in Minnesota Perinatal Quality Collaborative (MNPQC) initiative focused on the Alliance for Maternal Innovation (AIM) bundle on substance use disorders (SUDs).

Measure Status:			**Active**	
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			10	16
Annual Indicator			9	16
Numerator				
Denominator				
Data Source			MNPQC	MNPQC
Data Source Year			FY2023	FY2024
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

None

2021-2025: ESM AI.2 - Care coordinators reporting increased knowledge in serving CYSHN and their families after participating in Community of Practice webinars

Measure Status:			Active	
State Provided Data				
	2021	**2022**	**2023**	**2024**
Annual Objective			76	77.5
Annual Indicator		43.5	94.3	54.6
Numerator		80	100	77
Denominator		184	106	141
Data Source		Webinar Evaluation	Webinar Evaluation	Webinar Evaluation
Data Source Year		FY2022	FY2023	FY2024
Provisional or Final ?		Final	Final	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**State Provided Data**
	Field Note: *Provisional – will update with recalculated data (to include 3rd webinar and agree responses)	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Minnesota

SPM 1 - Number of resources provided to Title V grantees and state staff through the Minnesota Title V Resources and Support Hub.
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of resources provided to Title V grantees and state staff through the Minnesota Title V Resources and Support Hub to support with system thinking, data driven decisions making, and community engagement</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of resources provided to Title V grantees and state staff through the Minnesota Title V Resources and Support Hub</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Minnesota Title V Resources and Support Hub

Data Limitations: As the Minnesota Title V Resources and Support Hub is built and utilized, we will work to adapt this measure to better track quality and experiences of grantees interaction with the resources and supports they are receiving.</td></tr>
<tr><td>Significance:</td><td>During the 2025 Needs Assessment Minnesota received tangible feedback from Title V grantees and state staff on the types of support they are looking for from the state Title V team. Themes from this feedback included communication and connection opportunities with other Title V grantees, learning and training opportunities, and resource mapping and sharing.

Supporting grantees is essential to maximizing impact and sustainability. Beyond financial assistance, grantees benefit from guidance, capacity-building resources, and consistent communication that help them navigate challenges and grow their effectiveness. When grantees are actively engaged with and are supported, it fosters stronger relationships built on transparency. This not only enhances program outcomes but also empowers grantees to innovate, scale their work, and serve their communities more effectively.

Minnesota plans to create a communication hub for Title V grantees to serve as a space for grantees to connect to one another and state Title V staff for sharing resources (including mapping of resources) and asking questions. Minnesota’s goal for FFY2026 is the communication hub is created and there are 15 resources provided that align with what has been requested the most from Title V grantees.</td></tr>
</table>

SPM 2 - Percent of Minnesotan communities that have a high Area Deprivation Index (ADI)
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Decrease the percent of Minnesotan communities that have a high Area Deprivation Index (ADI)</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Minnesotans that have a high (> 7 state) Area Deprivation Index (ADI)</td></tr>
<tr><td>Denominator:</td><td>Total Number of Minnesotans census tracks</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Area Deprivation Index (ADI) Interactive Map file. Accessed through Neighborhood Atlas UW Madison - https://www.neighborhoodatlas.medicine.wisc.edu/

Data Limitations: The ADI relies on American Community Survey (ACS) data. Results are subject to the limitations of ACS data. ADI values should only be measured by census block group, as linking ADI values to other geographic units is not a validated approach. Data is analyzed by Minnesota using data created by UW Madison.</td></tr>
<tr><td>Significance:</td><td>Health is the summation of genetic makeup and environmental factors. Physical, chemical, and social factors in the environment all play a role in influencing health. The Area Deprivation Index (ADI) is a validated, rigorous, widely used measure of the social exposome. Exposome is concept used to describe all the exposures an individual has had in a lifetime and how those exposures impact biology and health. Some factors that are examined to measure social exposome include income, education, employment, and housing quality. Research links living in a disadvantaged neighborhood, as measured by high ADI, to poorer health.

“Living in a high ADI area has been linked to a number of health disparities, including higher rates of cardiovascular disease, increased utilization of health services, premature aging and earlier death. Living in a high ADI neighborhood has also been linked to poorer brain health, including higher rates of dementia diagnoses and Alzheimer's Disease changes within the brain.” - Neighborhood Atlas

ADI is measured by community (census track) and can be tracked comparing state or national level rankings. For Minnesota’s analysis we are using the state level ranking.</td></tr>
</table>

Form 10
State Performance Measure (SPM) Detail Sheets (2021-2025 Needs Assessment Cycle)

2021-2025: SPM 1 - Percent of Minnesotans that did not get routine medical care that they needed because of cost

Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Increase the number of Minnesotans that get the medical care they need
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Minnesotans that did not get routine medical care that they needed because of cost **Denominator:** Total Number of Minnesotans
Data Sources and Data Issues:	Data Source: The Minnesota Health Access (MNHA) survey. MNHA is a biennial telephone and mail survey that collects information on the health of Minnesotans and how they access health insurance and health care services. The survey measures how many people in Minnesota have health insurance and how easy it is for them to get health care. Question on survey asks “During the past 12 months, was there any time that (you/TARGET) did not get routine medical care that (you/TARGET) needed because of cost” Data Limitations: The Minnesota Health Access Survey is a self-report survey, and is therefore subject to possible bias associated with self-report surveys, such as social desirability bias or recall bias.
Significance:	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, timeliness of entry into services and many more factors. 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. Disparities in access to health care are felt acutely among families of children and youth with special health needs (CYSHN). In Minnesota, 8.5% of CYSHN did not receive needed health care compared to just 1% of children and youth without special health needs. The cost of health care adversely affects families of CYSHN, with 15% of these families struggling to pay for a child’s medical bills, compared to 10% of families without CYSHN. The difference may seem small, but taken into consideration with the increased likelihood of parents of CYSHN to have to cut back their work hours or stop working altogether to provide care for their child, the disparities in access to and cost of health care can have a significant impact on families and their household income.

2021-2025: SPM 3 - Proportion of Minnesota adolescents who report staying in a shelter, somewhere not intended as a place to live, or someone else's home because you had no other place to stay in the past 12 months
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Decrease the proportion of adolescents who report staying in a shelter, somewhere not intended as a place to live, or someone else's home because you had no other place to stay in the past 12 months</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Minnesota adolescents who report having stayed in report staying in a shelter, somewhere not intended as a place to live, or someone else's home because you had no other place to stay in the past 12 months</td></tr>
<tr><td>Denominator:</td><td>Number of Minnesota adolescents who completed the Minnesota Student Survey</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Minnesota Student Survey (MSS). Limited to 8th, 9th, and 11th grade responses. MSS is an anonymous survey conducted every three years to students in selected grades in regular public schools, charter schools and tribal schools; it doesn’t include all students in Minnesota.

Numerator includes all students who responded yes including yes, I was with my parents or an adult family member or yes, I was on my own without any adult family members.</td></tr>
<tr><td>Significance:</td><td>Nearly half of the state’s homeless population (46%) is comprised of homeless children and youth aged 24 and younger with 32% being children aged 17 or younger (with their parents). Homeless children and youth disproportionally affected by homelessness relative to their make up as a proportion of the state’s overall population. Research shows that kids are more likely to do well in school if they aren’t worrying about where they will sleep. Data from the Youth Risk Behavior Surveillance System (YRBSS) show, youth experiencing homelessness have a higher risk of being in a gang, using heroin, feeling depressed, attempting suicide, or experiencing trauma and violence than their housed counterparts.

There is no one reason for why youth experience homelessness - information from the National Coalition for the Homeless shows some young people lack housing because they ran away from an abusive household, relationship, or foster home or were kicked out of their homes after they come out as LGBTQ. Some are homeless because despite employment, they cannot afford rent and end up living on the street. During the COVID-19 pandemic, the importance of having a safe home is even more critical, as other locations like schools, libraries, community centers, and places of worship have been closed or access severely limited.</td></tr>
</table>

2021-2025: SPM 4 - Percent of Minnesota adolescents who report having positive mental well-being - fulfilling relationships, contributing to community, and being resilient
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of adolescents who have positive mental well-being</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of Minnesota adolescents who report 8 or more mental well-being components</td></tr>
<tr><td>Denominator:</td><td>Number of Minnesota adolescents who completed the Minnesota Student Survey</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Minnesota Student Survey (MSS). Limited to 8th, 9th, and 11th grade responses. MSS is an anonymous survey conducted every three years to students in selected grades in regular public schools, charter schools and tribal schools; it doesn’t include all students in Minnesota.

Positive mental well-being is measured by summing 10 mental well-being components:
• Family Relationships (based off of 2 questions about feeling that one or more adults in their family cares about them),
• Community Relationships (based off of 3 questions about feeling that teachers, other adults at school, and/or adults in their community cares about them),
• Student-Teacher Relationship (based off of 5 questions about how students feel about adults and teachers in the school),
• Peer Relationships (based of off 2 questions about feeling that their friends care about them and/or develop trusting relationships with peers),
• Positive Identity (based off of 6 questions about positive identity (e.g. feel good about myself, future, feel in control of life and future, etc.)),
• Education Engagement (based off of 6 questions about educational engagement (e.g. caring about doing well in school, paying attention, being prepared for class, etc.)),
• Social Integration (based on student’s participating in out-of-school activities at least 3 times a week),
• Social Competency (based off of 6 questions about social competency (e.g. say no to things that are dangerous or unhealthy, express feeling in proper ways, make good choices, etc.)),
• Empowerment (based off of 3 questions about empowerment (e.g. feel valued and appreciate by others, included in family tasks and decisions, etc.)),
• Personal Growth (based off of 4 questions about personal growth (e.g. outside of the school day learning skills like teamwork or leadership, doing thing that gives joy and energy, etc.)).</td></tr>
<tr><td>Significance:</td><td>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. 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,</td></tr>
</table>

	injury, delinquency, and crime. With so many factors that make-up mental well-being it is difficult to succinctly answer questions about population mental well-being with existing data. There are multiple composite measures of mental well-being proposed in the research and many commonly agreed upon components of mental well-being. Ten components of mental well-being are captured in the Minnesota Student Survey: positive identity, social competency, personal growth, empowerment, social integration, educational engagement, and positive family, community, teacher and peer relationships. Positive mental well-being is measured by combining multiple components of well-being to create an overall well-being score.

2021-2025: SPM 5 - Percent of children, ages 0-17, living with parents who are coping very well with the demands of parenthood
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>By 2025, increase the percentage of children, ages 0-17, living with parents who are coping very well with the demands of parenthood by 5%.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Children whose parents reported they are coping very well with demands of parenthood</td></tr>
<tr><td>Denominator:</td><td>Children age 0-17 years</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td></td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: National Survey of Children’s Health. Based on the question, “How well do you think you are handling the day-to-day demands of raising children?”

Results for this measure are weighted to reflect the population of children, ages 0-17, not the population of parents.</td></tr>
<tr><td>Significance:</td><td>When parents and caregivers receive adequate support, they are more likely to be able to cope with the day-to-day demands of parenthood and can then build a safe and healthy home environment for their family.</td></tr>
</table>

2021-2025: SPM 6 - Percent of Division staff who have completed the Tribal State Relations Training
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>At least ninety percent of CFH Division staff complete the Tribal State Relations training, to develop contextual understanding of and increase culturally responsive engagement with American Indian communities across the state</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of CFH staff that have completed the Tribal State Relations Training</td></tr>
<tr><td>Denominator:</td><td>Number of CFH staff in Division</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Title V MCH Block Grant Coordinator Tracking Sheet

Data Limitations: With staff turnover there will be issues with consistency of both the denominator and numerator, so we plan to calculate based on counts as of April 1 of each FFY. There is also limited space in the trainings so there is a need to encourage staff to sign up early when trainings are announced.</td></tr>
<tr><td>Significance:</td><td>Structural and systemic racism plays an integral role in perpetuating poor health outcomes among American Indian women, children, and families, who experience the greatest health disparities in Minnesota. These disparities are caused by historical and ongoing trauma, racism, and colonial practices and policies that create barriers to opportunity and thriving. For example, into the 20th century Anishinaabe and Dakota peoples were continuing to experience displacement, broken treaties, and exploitation of their land by the United States and Minnesota State governments, often through violence and coercion, including genocide. These practices over the last several centuries created and continue to maintain the disparities seen in American Indian MCH populations in Minnesota today – and Tribal leaders across the state have told us they are concerned that the structures and policies within MDH do not address the cultural context of providing services in American Indian communities.
To address this concern, Title V staff will promote and support efforts for at least 75% of Division staff to complete the Tribal State Relations Training. During the 2021 legislative session, Minnesota enacted Minnesota Statute 10.65 Government-to-Government Relationship with Tribal Governments. One of the requirements under M.S. 10.65 is that state employees whose work has tribal implications attend Tribal-State Relations Training (TSRT), a course designed to educate state agency staff about American Indian tribal governments, histories, cultures, and traditions and to empower state employees to work effectively with American Indians and Tribal Governments. Participants learn that each Tribal Nation in our state is unique and that it is important to become knowledgeable about the history, culture, and governance of the Tribe as well as the role of agency’s Tribal liaison(s) to authentically and effectively partner with tribes</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Minnesota

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Minnesota

ESM PPV.1 - Percentage of families who could benefit from family home visiting services that are currently served. NPM – A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth B) Percent of women who attended a postpartum checkup and received recommended care components - PPV

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of families that participate in MDH-funded family home visiting.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of families who participated in MDH-funded family home visiting by year.</td></tr>
<tr><td>Denominator:</td><td>Number of families who would benefit from family home visiting (i.e., U.S. Census estimates of families with young children (under 6 year) living below 185% of the Federal Poverty Level).</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Sources:
• IHVE (Information for Home Visiting Evaluation) data system (MDH’s home visiting database).
• U.S. Census ACS

Limitations: Percentages are estimates vs. actual families eligible. Data in IHVE includes only families who have consented to share data with MDH.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>Family home visiting is a voluntary, home-based service ideally delivered prenatally through the early years of a child's life. It provides social, emotional, health-related and parenting support and information to families and links them to appropriate resources.

Family home visiting programs can decrease access barriers and increase the likelihood that new mothers will receive postpartum care. Trained home visitors can screen for maternal conditions, help postpartum participants make and attend medical appointments, and provide access to community services. Programs that meet the federal guidelines and include postpartum care as a performance measure are likely to increase the rate of postpartum visit attendance.</td></tr>
<tr><td>Significance:</td><td>This ESM measures the reach of family home visiting programs to those that would most benefit from its utilization. Measuring utilization is important because it provides concrete evidence of progress and impact. Without measurement, it's difficult to understand what kind of programs and reach efforts are most effective, where gaps exist, or how efforts are contributing to grantee success. For our purposes we will be tracking at the county level and aligning it with FHV models utilized in the county.</td></tr>
</table>

ESM SS.1 - Proportion of mothers who were told by a healthcare provider to place their baby on his or her back to sleep

NPM – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep - SS

<table>
<tr><td>Measure Status:</td><td>Inactive - This measure is no longer collected on MN PRAMS.</td></tr>
<tr><td>Goal:</td><td>Increase the number of providers who speak with mothers about safe sleep</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of mothers who reported they were told by a healthcare provider to place their baby on his or her back to sleep</td></tr>
<tr><td>Denominator:</td><td>Number of MN PRAMS survey respondents who answered the question about their provider telling them to place baby to sleep on their back to sleep.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Pregnancy Risk Assessment Monitoring Survey (PRAMS)

Data Limitations: Data on the PRAMS survey is self-reported and therefore subject to potential bias such as recall bias, social desirability bias, etc. PRAMS data is collected annually and there can be a lag of one year or more before data is available to states for analysis. Data is weighted.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The evidence informed strategy that the ESM measures is pregnant or parenting people’s receipt of safe sleep information, education, or counselling by a provider on the best and safest position and environments/spaces for babies to sleep in to prevent sleep-related tragedies or injuries from occurring. Evidence on this strategy is accessed through Minnesota PRAMS, which gathers information from mothers on whether they have been told by a provider to put their baby to sleep on their back, in a crib, bassinet, or pack and play in a crib placed in their room, and what objects should and should not go in the bed with their baby. The strategy influences the NPM because parents are more likely to implement the practices recommended by their health care providers when the recommended behavior is modeled in health care settings by providers themselves.</td></tr>
<tr><td>Significance:</td><td>The aspect of the strategy that the ESM aims to measure is the extent to which health care settings/providers are modeling safe sleep best practices via safe sleep counselling and education in their settings. The American Academy of Pediatrics (AAP) recommends that health care providers, including physicians, non-physician clinicians model safe sleep practices starting at the beginning of pregnancy. Providing education or counselling to pregnant or parents/caregivers on infant safe sleep practices grounded in the AAP’s safe sleep guidelines is an important component of safe sleep modeling. Safe sleep modeling occurs when health care settings develop, implement, maintain, and enforce a safe sleep policy that aims to prevent sleep-related injuries and deaths, and staff in turn serves as role models for safe sleep by intentionally delivering information, messages and cues to parents that promote keeping infants safe during sleep. Because parents/caregivers tend to imitate the behaviors and practices they observe in health care settings, it is critical that all health care settings/providers take important steps to provide and require safe sleep training for staff so that they are equipped to counsel parents/caregivers on infant sleep safety using the appropriate delivery technique such as the teach back method. Measuring the proposed strategy can help to provide clues into whether progress is being made towards ensuring that all providers who care for pregnant and postpartum people and their infants are delivering evidence-based safe sleep messages to families.</td></tr>
</table>

ESM SS.2 - Proportion of organizations that distribute cribs and/or provide safe sleep education within communities across Minnesota.
NPM – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding D) Percent of infants room-sharing with an adult during sleep - SS

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of organizations that distribute cribs and/or provide safe sleep education within communities across Minnesota</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of organizations that distribute cribs and/or provide safe sleep education</td></tr>
<tr><td>Denominator:</td><td>Number of organizations currently funded Infant Health and Mortality Prevention Grants and Innovations in Infant Health Grants</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: REDCap (Infant Health and Mortality Prevention Grants) Innovations in Infant Health Grants (Reports to MDH)

Limitations of Data: We are not collecting information from some organization. We don’t know the fully extent of the work being done around distributing cribs and/or providing safe sleep education.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The evidence-based/informed strategy that the ESM measures the work of multiple grant programs in Minnesota that are doing Community-Based Crib Distribution and Safe Sleep Education which is identified as evidence-based (moderate evidence) in the evidence toolkits provided by the MCH Evidence Center.

Literature suggests that to prevent sleep-related deaths during infancy, the American Academy of Pediatrics recommends that infants sleep alone on their backs, in their own safety-approved firm, non-inclined crib, portable crib, bassinet, or play yard, without loose bedding or stray objects during sleep to prevent sleep-related tragedies such as accidental suffocation and strangulation in bed from happening. Distributing cribs and/or providing education about infant sleep safety within communities are important strategies that can help to not only improve access to cribs among families who cannot afford them but can also help to improve parental knowledge about infant sleep safety and increase the likelihood that safer sleep practices are adopted by caregivers to keep babies safe while they sleep or nap.</td></tr>
<tr><td>Significance:</td><td>This ESM measures how many of our grantees are doing this evidence-based Community-Based Crib Distribution and Safe Sleep Education work in Minnesota communities.

Sleep-related infant deaths (i.e., Sudden Unexpected Infant Deaths (SUIDs)) account for the largest share of infant deaths after the first month of life in Minnesota. They are also the fourth leading cause of infant mortality in Minnesota, and a significant contributor of infant mortality in the United States. On average, nine in ten of these deaths in the Minnesota are linked to unsafe sleep environments such as having soft bedding/toys or someone else in the infant's sleep space.</td></tr>
</table>

ESM DS.1 - Percent of developmental/social-emotional screens that were completed electronically through the Follow Along Program (FAP) in the past year.
NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

<table>
<tr><td>Measure Status:</td><td>Inactive - Replaced</td></tr>
<tr><td>Goal:</td><td>Expand access to developmental and social-emotional screening for families with children ages birth to five years through the implementation of an electronic screening system.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of screens in the follow along program that competed a developmental/social-emotional screen electronically</td></tr>
<tr><td>Denominator:</td><td>Number of completed screens in the follow along program</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: The Brookes Publishing ASQ Enterprise and Family Access screening system will provide data reports. Three staff in the MDH Children and Youth with Special Health Needs Section are assigned Account Administrator access to the system and may run eighteen unique reports at any time, such as screening usage, screening scores, and the number of follow up actions. Data reports will be run annually at a minimum.

Limitations of Data: Only 79 of 87 counties have a follow along program. All counties serve children birth – 36 months, however at least a dozen counties additionally serve children between 36 – 72 months of age. Counties may voluntarily choose to use the electronic screening system; it is not required. Consistent data collection activities will be jointly developed by MDH and local public health agencies during the first year of use. Electronic screens can be completed by the family or if duel enrolled completed by a home visitor. All children with data in the Follow Along Program is included in this measure.</td></tr>
<tr><td>Significance:</td><td>Providing electronic access to developmental and social-emotional screening to families has been a priority among state and local early childhood partners for the past several years in efforts to identify strategies to assure all children are receiving recommended screening guidelines. A wide array of early childhood providers are currently providing periodic or one-time screening to families with young children – there are currently seven state-administered programs across state agencies that use the ASQ®-3 and ASQ®:SE-2 instruments. In most situations, there is no communication between screening providers to share screening information that may help avoid duplication, but more importantly, to identify which children have not been screened. The Follow Along Program (FAP) is an early childhood developmental and social-emotional screening system delivered through LPH agencies for families with children birth to 3 years of age. The program offers families periodic guidance on early childhood developmental and social emotional milestones, access to age-appropriate ASQ®-3 and ASQ®:SE-2 intervals, timely referral to assessment/evaluation and community services, and follow up to assure connections have been made. Providing electronic access to age-appropriate screening tools will provide more convenient and timely support to families, while also freeing up more time for program administrators to provide more support and connections for families. With a long-term goal of better communication between screening providers and service providers.</td></tr>
</table>

ESM DS.2 - Percent of developmental/social-emotional screens that were completed through the Follow Along Program (FAP) in the past year.
NPM – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year - DS

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Expand access to developmental and social-emotional screening for families with children birth to five years of age through the implementation of an electronic screening system</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of developmental/social-emotional screens completed and returned in the Follow Along Program</td></tr>
<tr><td>Denominator:</td><td>Number of developmental/social-emotional screen sent in the Follow Along Program.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: The Brookes Publishing ASQ Enterprise and Family Access screening system will provide data reports. Three staff in the MDH Children and Youth with Special Health Needs Section are assigned Account Administrator access to the system and may run eighteen unique reports at any time, such as screening usage, screening scores, and the number of follow up actions. Data reports will be run annually at a minimum.

Limitations of Data: Only 79 of 87 counties have a follow along program. All counties serve children birth – 36 months, however at least a dozen counties serve children between 36 – 72 months of age. Counties may voluntarily choose to use the electronic screening system; it is not required. Consistent data collection activities will be jointly developed by MDH and local public health agencies during the first year of use. Electronic screens can be completed by the family or if duel enrolled completed by a home visitor. All children with data in the Follow Along Program is included in this measure.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>This ESM measures reach and responsiveness of the Follow Along Program (FAP) - an early childhood developmental and social-emotional screening system delivered through LPH agencies for families with children birth to 3 years of age. The program offers families periodic guidance on early childhood developmental and social emotional milestones, access to age-appropriate ASQ®-3 and ASQ®:SE-2 intervals, timely referral to assessment/evaluation and community services, and follow up to assure connections have been made.

Providing electronic access to age-appropriate screening tools will provide more convenient and timely support to families, while also freeing up more time for program administrators to provide more support and connections for families. With a long-term goal of better communication between screening providers and service providers.

Literature supports that expanded access to universal screening through public health programs, like the Follow Along Program, promote and facilitate screening for every child at standardized intervals to help ensure families get timely support and care.

This program directly provides families another venue to receive a developmental screening using a parent-completed screening tool (the NPM) and provides anther avenue for children</td></tr>
</table>

	to be referred and receive the services they need to thrive.
Significance:	Providing electronic access to developmental and social-emotional screening to families has been a priority among state and local early childhood partners for the past several years in efforts to identify strategies to assure all children are receiving recommended screening guidelines. A wide array of early childhood providers are currently providing periodic or one-time screening to families with young children – there are currently seven state-administered programs across state agencies that use the ASQ®-3 and ASQ®:SE-2 instruments. This measure is tracking the reach and responsiveness of the Follow Along Program to show progress on providing the needed screening to improve both early identification of developmental needs and connection to follow-up services or community-based supports when appropriate.

ESM AWV.1 - Percentage of Child and Teen Checkups (C&TC) where depression screenings are occurring for adolescents enrolled in Minnesota Health Care Programs (MHCP)
NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

<table>
<tr><td>Measure Status:</td><td>Inactive - Replaced</td></tr>
<tr><td>Goal:</td><td>Increase the number of adolescents that get access to depression screenings to help reduces adolescent suicide and suicide ideation</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of adolescents (10-20 years old), in MHCP, that received a Mental Health Screening in the calendar year</td></tr>
<tr><td>Denominator:</td><td>Number of adolescents (10-20 years old), in MHCP, that had at least one C&CT visit the calendar year</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Minnesota Health Care Program (MHCP) claims and encounter data. MHCP include Medical Assistance (Minnesota’s Medicaid Program) and MinnesotaCare.

Limitations: Claims data is only as good as what is submitted on the bill. Services that providers know in advance will be denied may be inconsistently submitted as bills and therefore, inconsistently recorded in the files. Covered services for which claims are not submitted are not included in the data. Some components of treatments may not be included in bills (and therefore in the claims data) if reimbursement rates are very low, even if the treatment is provided.</td></tr>
<tr><td>Significance:</td><td>Minnesota has seen higher rates of suicide among youth than the national average for a long time. It is the second leading cause of death among people ages 10-24 and it is important to acknowledge that suicide is not experienced equally across age groups, genders, or geography in Minnesota. Although helping young people prevent depression, suicide, and other mental health challenges is a community-wide effort, primary care providers are well situated to discuss risks, provide screening, and offer interventions. Offering screening and follow-up at preventive visits helps ensure that young people receive mental health services and support from family and peers.

MHCP financed 43.3% of all births (28,550 infants) in 2019 and covers a similar proportion of Minnesota’s adolescents. MDH’s C&TC program, in collaboration with MHCP, provides training to providers around screening tools and best practices. Targeting the high-risk (i.e. medically or categorically needy) adolescents is important. These young people have access to less resources for support and are at higher risk of depression, suicide, and other mental health challenges.</td></tr>
</table>

ESM AWV.2 - Percent of adolescent students who report that they would have done "nothing" and/or "I'm not sure" to take care of your health problems/needs if their school did not have a School Based Health Clinic (SBHC). NPM – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year - AWV

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase access to School Based Health Clinics and learn more about how students access care</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of students that report "nothing" and/or "I'm not sure"</td></tr>
<tr><td>Denominator:</td><td>Number of students that responded to the question "If your school did not have a School Based Health Clinic, what would you have done to take care of your health problems/needs today?"</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: Being built in near future using REDCap for grantees to collect a sample of patient responses (voluntary and deidentified).

If your school did not have a School Based Health Clinic, what would you have done to take care of your health problems/needs today?
• Gone to another doctor or nurse
• Got to the hospital or emergency room (ER)
• Call my parents or gone home
• Nothing
• I'm not sure
• Other

Limitations of Data: The has been historical issues to getting SBHC to voluntary report some data. There is a plan to add this question to the new grant agreement as a requirement for funding.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The evidence-based/informed strategy is measuring the impact of SBHC and their serving adolescents that might not have gotten care if they didn't have access to SBHC. Literature, including the work done with the MCH Evidence Center, suggests that there is emerging evidence supporting the partnerships between primary care clinics and local SBHCs. This strategy is known to increase the ability for adolescents to obtain healthcare services when needed and reduce some of the available differences in community factors that influence health by offering the same services to all students in the school with the SBHC.</td></tr>
<tr><td>Significance:</td><td>Minnesota children and adolescents benefit from having their health needs addressed in a timely, affordable and competent manner where they spend most of their time- at school. School-Based Health Centers (SBHCs) provide students with high quality medical, mental, and behavioral health services from health care providers trained in child, adolescent and young adult care and development. Research demonstrates that young people are more likely to seek out and use health services that are easy to get to, in a familiar location, are youth-friendly, and linguistically appropriate.</td></tr>
</table>

ESM MH.1 - Percent of care coordinators reporting increased knowledge in serving CSHCN and their families after participating in Community of Practice (CoP) webinars.
NPM – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - MH

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of care coordinators who report increased knowledge in topic area after participating in webinars sponsored by Minnesota’s Pediatric Care Coordination Community of Practice.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of care coordinators who completed post survey and reported they strongly agree they have increased knowledge of webinar topic.</td></tr>
<tr><td>Denominator:</td><td>Number of care coordinators who completed post survey.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: The percentage of care coordinators reporting increased knowledge is collected via a survey that is distributed to participants of activities sponsored by the Minnesota Pediatric Care Coordination Community of Practice. The survey is distributed to all participants in CoP webinars during the webinar and then is sent out again to all registrants after the completion of the webinar. Findings from each webinar are tallied and combined into the final reported amount.

In the survey, participants are asked the following question: “To what extent do you agree with the following statement? The information presented increased my knowledge of the topic.” The survey question utilizes a Likert scale for response options, including:
• Strongly agree
• Agree
• Disagree
• Strongly disagree

MDH will collect and analyze the post-webinar survey data on a regular basis.
Limitations of Data: The data only includes those who completed the post-survey they were sent after participating in the webinar. The CoP has approximately a 30% return rate on post surveys for their webinars. There may be a bias in the population who completes the survey versus those who do not – particularly as it relates to acquiescence bias. This bias results in participants being more likely to report positive results. Because of this, we have chosen to only measure those reporting they “strongly agree” that they have increased knowledge rather than including both those who “agree” and “strongly agree.”
Another limitation is that the data is only gathered via post survey and is based on participant report. A potentially more valid way of gathering this information would be conducting a pre- and post-survey, where participants could note the change they experienced from before the webinar to after – though this could cause survey fatigue in participants.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The evidence-based/informed strategy that the ESM measures is reported increased knowledge of care coordinators serving CYSHN and their families after participating in Community of Practice events. Literature suggests that Communities of Practice (CoPs) aid</td></tr>
</table>

	professional development, build capacity, leverage and spread best practices and standards among health professionals. CDC's Public Health Professionals Gateway is one resource to ensure success and evaluation - https://www.cdc.gov/publichealthgateway/phcommunities/communities-of-practice-cops.html. Care Coordinators are key players in helping families navigate systems and access needed care, including assisting and ensuring that families are continuously and adequately insured in order to access needed services and supports.
Significance:	The strategies related to this measure include, "Strengthen local capacity to deliver support where families feel most comfortable" And "Collaborate across systems to remove and reduce barriers to simplify family navigation and improve access to resources and supports." One of Minnesota's approaches toward building community capacity and fostering collaboration is sponsoring a Pediatric Care Coordination Community of Practice (CoP) where care coordinators can learn about best practices in coordination and network/connect with one another. After participating in CoP activities, participants typically report that they're more knowledgeable of the system of care and are more competent/confident in helping families navigate the system. Those who are more confident in their ability to navigate and access care may be more likely help families receive comprehensive coordinated care coordination.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2021-2025 Needs Assessment Cycle)

2021-2025: ESM BF.1 - Percent of births delivered at MDH Breastfeeding-Friendly Maternity Centers
2021-2025: NPM – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months - BF

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of births that occur at Breastfeeding-Friendly Maternity Centers</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of live births that occurred at currently accredited MDH Breastfeeding-Friendly Maternity Centers</td></tr>
<tr><td>Denominator:</td><td>Number of live births in calendar year</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: MN Vital Records and MDH’s Accreditation Database, tracked in Redcap. Accreditation process monitored by WIC breastfeeding unit staff and OSHII staff. Achievement of individual Steps is applied for and progress documented by hospital staff, with completed Steps reviewed and verified by MDH staff and partners from the Minnesota Breastfeeding Coalition.

Limitations of Data: The expiration of accreditation is tied to completion of the 10th Step and other Steps may have been completed longer than 3/5 years prior. MN Vital Records are limited to births that occur to Minnesota Residents in Minnesota.</td></tr>
<tr><td>Significance:</td><td>Most births in Minnesota occur in hospital settings. Maternity hospital practices and policies can undermine maternal and infant health by creating barriers to supporting a mother's decision to breastfeed. When hospitals implement the Baby-Friendly Ten Steps, they have the tools to give mothers the information, confidence, and skills necessary to successfully initiate and continue to breastfeed their babies. Women who get the support they need in the hospital are much more likely to continue once they return home.

MDH’s Breastfeeding-Friendly Maternity Center Five-Star program tracks progress by hospitals in implementing evidence-based processes, provides technical assistance to hospitals applying for Stars, and provides intermediate recognition of work on the Ten Steps, without the costs associated with Baby-Friendly designation, which are a barrier to hospitals achieving BFHI designation. MDH’s program is intended to encourage hospitals to move toward BFHI designation. Hospitals can achieve designation are accredited for 3 years, or, in conjunction with Baby-Friendly USA designation, for 5 years. Each two Steps implemented earns one Star, for a possible total of Five Stars/Ten Steps achieved.</td></tr>
</table>

2021-2025: ESM WWV.2 - Number of hospitals that are actively participating in Minnesota Perinatal Quality Collaborative (MNPQC) initiative focused on the Alliance for Maternal Innovation (AIM) bundle on substance use disorders (SUDs).
2021-2025: NPM – Percent of women, ages 18 through 44, with a preventive medical visit in the past year - WWV

Measure Status:	Active
Goal:	To increase the number of hospitals and health systems that are actively participating in MNPQC projects or AIM SUD bundle.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of hospitals participating in the MNPQC AIM SUD bundle **Denominator:** Number of hospitals
Data Sources and Data Issues:	Data Source: MCH QI Specialist will maintain a spreadsheet of hospitals that that are actively participating in MNPQC initiative focused on the Alliance for Maternal Innovation (AIM) bundle on substance use disorders (SUDs). Important Definitions: Actively Participating – hospital team recruited that submitted a commitment letter to participate in MNPQC AIM SUD initiative. Hospitals - providing care to pregnant and postpartum individuals of reproductive age. Limitations of Data: Hospital participation may range due to size of facility, available capacity and/or members of their team.
Evidence-based/informed strategy:	This ESM measures the implementation of the metrics from the Alliance for Maternal Innovation (AIM) a national data-driven maternal safety and quality improvement initiative. The AIM program leads the development of AIM bundles with metrics aligned with national, state and hospital outcomes that seek to improve systems and quality care to improve maternal health. AIM bundles are available at: https://safehealthcareforeverywoman.org/aim/patient-safety-bundles/#core. Minnesota prioritizing to secure enrollment in the AIM program will advance quality improvement initiatives dedicated to improving maternal health outcomes. The AIM bundle led by the MNPQC will focus to increase the identification and treatment of substance use disorders (SUDs) in the perinatal period for birthing people and infants exposed to substances in Minnesota.
Significance:	Members of the Minnesota Perinatal Quality Collaborative (MNPQC) recognize the importance of the issues addressed by the Alliance for Maternal Innovation (AIM) that aligns directly with MNPQC core initiatives and highly advised by the CDC to become an AIM state. The issues are relevant to discussions on quality improvement in Minnesota as supported by the Minnesota Maternal Mortality Review Committee and our Steering Committee. The materials facilitate the development of specific quality improvement initiatives. Further, formal involvement in the AIM Program aligns Minnesota's efforts with other states' activities. The MNPQC has designed a workgroup centered on perinatal opioid led by key health care professionals in our health systems across the state. Members of the workgroup have multiple representatives that have addiction medicine physician specialists, maternal and fetal medicine providers, neonatologists, pediatricians, family medicine, behavioral health

	specialists, social workers and public health professionals. The MNPQC workgroup membership vetted available best practices, literature, data on burden, and feasibility to identify this QI project, Mother/Infant Opioid and Substance use Treatment and Recovery Effort (MOSTaRE). The MOSTaRE Initiative will emphasize family-centered care that maintains the dyad and will address treatment and prevention of substance exposure during and after pregnancy for both birthing people and their infants. The MNPQC steering committee had identified the initiative focused on opioid use disorder as a priority within the MNPQC strategic plan with intentions to model the AIM opioid / substance use disorder bundle. V2 2020_09 Additionally, this past year Minnesota legislation had the removal of mandatory reporting requirements for prenatal substance use while the pregnant person is seeking prenatal care, postpartum care or other health care services.

2021-2025: ESM AI.2 - Care coordinators reporting increased knowledge in serving CYSHN and their families after participating in Community of Practice webinars
2021-2025: NPM – Percent of children, ages 0 through 17, who are continuously and adequately insured - AI

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of care coordinators who report increased knowledge in topic area after participating in webinars sponsored by Minnesota’s Pediatric Care Coordination Community of Practice</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of care coordinators who completed post survey and reported they strongly agree they have increased knowledge of webinar topic</td></tr>
<tr><td>Denominator:</td><td>Number of care coordinators who completed post survey</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data Source: The percentage of care coordinators reporting increased knowledge is collected via a survey that is distributed to participants of activities sponsored by the Minnesota Pediatric Care Coordination Community of Practice. The survey is distributed to all participants in CoP webinars during the webinar and then is sent out again to all registrants after the completion of the webinar. Findings from each webinar are tallied and combined into the final reported amount.

In the survey, participants are asked the following question: “To what extent do you agree with the following statement? The information presented increased my knowledge of the topic.” The survey question utilizes a Likert scale for response options, including:
• Strongly agree
• Agree
• Disagree
• Strongly disagree

The CoP facilitation grantee will provide MDH the data for the post-survey on a regular basis, and MDH will be responsible for analyzing the data to report on the ESM.

Limitations of Data: The data only includes those who completed the post-survey they were sent after participating in the webinar. The CoP has approximately a 30% return rate on post surveys for their webinars. There may be a bias in the population who completes the survey versus those who do not – particularly as it relates to acquiescence bias. This bias results in participants being more likely to report positive results. Because of this, we have chosen to only measure those reporting they “strongly agree” that they have increased knowledge rather than including both those who “agree” and “strongly agree.”
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</table>

	Community of Practice events. Literature suggests that Communities of Practice (CoPs) aid professional development, build capacity, leverage and spread best practices and standards among health professionals. CDC's Public Health Professionals Gateway is one resource to ensure success and evaluation - https://www.cdc.gov/publichealthgateway/phcommunities/communities-of-practice-cops.html. Care Coordinators are key players in helping families navigate systems and access needed care, including assisting and ensuring that families are continuously and adequately insured in order to access needed services and supports.
Significance:	The strategy related to this measure is, "Building the Capacity of Communities by Cultivating Knowledge and Improving Collaboration." One of Minnesota's approaches toward building community capacity is sponsoring a Pediatric Care Coordination Community of Practice (CoP) where care coordinators can learn about best practices in coordination and network/connect with one another. After participating in CoP activities, participants typically report that they're more knowledgeable of the system of care and are more competent/confident in helping families navigate the system. Those who are more confident in their ability to navigate and access care may be more likely help families gain access to adequate and consistent insurance.

Form 11
Other State Data

State: Minnesota

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12

Part 1 – MCH Data Access and Linkages

State: Minnesota

Annual Report Year 2024

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	More often than monthly	0		
2) Vital Records Death	Yes	Yes	More often than monthly	0	Yes	
3) Medicaid	Yes	Yes	Semi-Annually	6	Yes	
4) WIC	Yes	Yes	More often than monthly	0	Yes	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	0	Yes	
7) Hospital Discharge	Yes	Yes	Semi-Annually	16	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	12	Yes	

Other Data Source(s) (Optional)

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) Minnesota Student Survey (MSS)	Yes	Yes	Less Often than Annually	6	No	
10) Early Childhood Longitudinal Data System	Yes	Yes	Semi-Annually	12	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None

Form 12
Part 2 – Products and Publications (Optional)

State: Minnesota

Annual Report Year 2024

Products and Publications information has not been provided by the State.