Maternal and Child Health Services
Title V Block Grant

State Narrative for MINNESOTA

Application for 2007
Annual Report for 2005

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

The signed Assurances and Certifications are available upon request from:

Minnesota Deptment of Health
Maternal and Child Health Section
ATTN: Barb Kizzee
PO Box 64882
St. Paul, MN 55164-0882

Phone number (651) 201-3749

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

In Minnesota, the opportunity for public input into the MCH planning process is ongoing, utilizing a variety of methods at both the state and local levels. State law distributes two-thirds of the federal MCH Block Grant by formula to local public health agencies (called Community Health Boards (CHB)) and limits the use of these funds for programs that address MCH and CYSHCN issues.

CHBs are required to establish local public health priorities and determine the how they will address identified local public health priorities. CHBs reported in 2005, that they primarily used community surveys, focus groups, key informant interviews and community forums to garner public input. Other opportunities for input occur at public hearings when annual budgets are reviewed and approved.

The Maternal and Child Health Advisory Task Force provides a particularly significant source of input. This statutorily required advisory group, comprised of 15 members equally representing professionals, representatives from local public health, and consumer representatives, is charged with reviewing and reporting on the health care needs of Minnesota's mothers and children and recommending priorities for funding and activities. The Task Force played a key role in the 2005 MCH Needs Assessment. The MCH Block Grant application and report is sent to Task Force members for comment. The application is available on the Minnesota Department of Health website for review by the general public.

II. Needs Assessment

In application year 2007, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

III. State Overview

A. Overview

Minnesota is seen as a state where the people enjoy a high quality of life and experience generally better measures of health compared to most other states. Minnesota consistently ranks as one of the most desirable and healthy states in which to live and work. When parents are asked about the overall health status of their child, 90.4% report that it is excellent or very good (compared to 84.1% nationally .) Seventy-eight percent of Minnesota's children have mothers in the work force compared to 69 percent nationally--which may be related to the fact Minnesota has the highest percent (25.6%) of children ages 6 to 11 who stayed home alone. Minnesotans are engaged in their communities; the voter turnout in Minnesota for the 2004 elections was the highest in the nation.

Minnesota is however experiencing the same pressing economic challenges being felt across the country. The 2003 legislative session opened facing a $4.5 billion shortfall, which was resolved primarily with program cuts -- many of which settled heavily on maternal and child populations. Minnesota's publicly funded health insurance programs such as Medical Assistance and MinnesotaCare, its TANF program, local public health funding, and state's social services programs either had reductions in budget or changes in eligibility criteria - most set to begin July 1, 2003. The most recent 2005 legislative session opened facing an additional $466 million budget deficit. The legislature is in an extended session working to make painful choices and decisions. ***/2007/ The 2006 Legislative session however, saw a slight improvement in the economic picture with an available small surplus. It is expected that Minnesota will also enter the 2007 Legislative session with a small surplus. //2007//***

Demographics Minnesota is a medium-sized state, encompassing slightly more than 84,000 square miles. Minnesota's per capita income in 2003 was $34,039, the eighth highest in the country. The 2003 unemployment rate was 5% compared to the national rate of 6%. While it remains a major agricultural producer, Minnesota's economy is also driven by service sector industries such as healthcare, manufacturing, financing, insurance, real estate, and wholesale and retail trade. The workforce sustaining this economy comes from a population (2000 Census) count of 4,919,479 people, making Minnesota the 21st most populous state in the nation. Fifty-four percent of the states residents live in the seven-county, Minneapolis-St. Paul metropolitan area. Minnesota has seven metropolitan statistical areas (MSAs) where seventy percent of the population lives. 65 percent of the statewide population increase of 544,380 that occurred between 1990 and 2000 took place in this seven-county Twin Cities area. American Indians comprise a significant proportion of the population and cultural heritage of Minnesota. According to the 2000 US Census, 58,192 American Indian or Alaska Natives lived in the state, of these, 32,029 were children. In 2000, approximately half of the American Indian population lived on seven Chippewa and four Dakota reservations, while the remainder lived in major population centers and communities spread across the state.

Minnesota's population is aging. Overall, Minnesota's age distribution is similar to the national average, but there were some marked differences in age group trends between Minnesota and the U.S. between 1990 and 2000. The median age of Minnesota is 35.4 and the United States median age is 35.3. Minnesota's median age is expected to rise to 41.3 by 2025. The elderly population grew much slower in Minnesota than nationally. The under 10 population also grew less in Minnesota than in the nation. The under-5 population showed a 7 percent gain in the U.S., while falling 2 percent in Minnesota. The 5-to-9 group went up 14 percent nationally but only rose 3 percent in Minnesota. In contrast, Minnesota had stronger than average growth in almost every age group from 15 to 64. The biggest difference was among 15 to 19 year-olds. This population went up 26 percent in Minnesota, much higher than the 14 percent gain nationally .

Demographically, Minnesota had a relatively homogenous racial and ethnic population for most of the twentieth century. This is changing, and although the absolute numbers of populations of

color are small, the rate of change is not. In 2000, Populations of Color represented 10.6 percent of the total population in Minnesota as compared to 5.6 percent in 1990. By 2025 it is estimated that non-White population will represent 17 percent of the State's population . Between 2005 and 2015, the nonwhite population is projected to grow 35 percent, compared to 7 percent for the white population. The Hispanic Origin population is expected to increase 47 percent.

Minnesota's immigrant populations continue to increase. In the late 1970's Minnesota began to see a new wave of international immigration. Following the end of the war in Vietnam, large numbers of refugees from Southeast Asia began to arrive in Minnesota. After the fall of the Soviet Union in 1991, an increased number of refugees came from Eastern Europe. The hostilities in Bosnia-Herzegovina brought more refugees from what was Yugoslavia. Famine and civil war bring large numbers of refugees from Africa. Minnesota's non-profit organizations are welcoming and provide needed services and support to these newcomers, and Minnesota has become a prime destination for refugees. During this same period of time, immigrants came to Minnesota to work in high tech industries. Large numbers of people came from India, China, and Pakistan. These well-educated and well-trained immigrants were hired in the 1990's by the booming technological companies throughout the state.

In the most recent data (federal fiscal year 2002) from the Office of Immigration Statistics, 13,522 immigrants came to Minnesota from 160 different countries and every continent except Antarctica. Minnesota's major immigrant populations include: Latinos, Hmong, Somalis, Vietnamese, Russians, Laotians, Cambodians and Ethiopians. Many immigrants come here from other states. The effects on Minnesota have been far reaching with visible changes in small towns and cities, schools and businesses. These eight national origin, ethnic or language groups noted above each represent more than 1,000 children in Minnesota's schools in the 2003-2004 school year. As an example, in the town of Pelican Rapids, with a population of 1,900, there are now 24 languages spoken .

These significant demographic changes such as the aging of its population, concentration of various populations in its metropolitan areas, and rising dependency ratios (elderly and children as a ratio to the working-age population) will impact not only the need for and the type of healthcare, but will also affect housing, education, business, commerce, employers and social services.

Economics - Poverty In Minnesota there are 718,474 families with related children under 18 years, with 1,186,982 children. Eight percent of children live in poor families, compared to the national percent of 17%. Twenty-four percent of children live in low-income families, compared to 38 % nationally. Fifty-six percent of these children have at least one parent who is employed full-time annually. Only 9% of children in low-income families do not have an employed parent . The number of children eligible for the free/reduced price school lunch has been increasing, from 24.7% in 1992-1993, to 26.4% in 1996-1997, to 28.5 % in 2001-2002. WIC enrollment has been increasing steadily over the past several years. April enrollments for the past 3 years have grown from 111,717 in 2003, to 116,308 in 2004, to 123,643 in 2005.

Health Disparities While Minnesota enjoys a high level of health status indicators overall, there are significant and highly concerning disparities in health status measures for populations of color and American Indians -- particularly in outcomes related to women and infants. Because the health status of mothers and infants is highly affected by the social conditions in which they live, it is also important to make note, at least generally, of some of these key indicators, which all show disparities to the disadvantage of populations of color and American Indians. Table 1 provides an overview of some of these social condition indicators. (See attached Table 1).

In 2003 the self-identified racial composition of women who gave birth was mostly white (84%). The remaining 16% of the women who gave birth self-identified as African American (7.6%), Asian (5.5%), and American Indian (2.0%). The birth rate per 1000 teens 15-19 years old for 2001 -- 2003 varied by race as follows: African-American 122.1; American Indian 112.4; Asian

67.9; Hispanic 129.8; and White 29.4 . According to 1997-2001 Minnesota birth certificate data, rates of inadequate/no prenatal care are three to four times higher among populations of color in Minnesota (African Americans (12.4%), American Indian (17.4%), Asian (9.8%), and Hispanic (11.2%) compared to such rates for white pregnant women (3.2%) .

Between the time periods 1989-1993 and 1997-2001, the percent of premature births decreased in all racial/ethnic groups except for White, which increased slightly. However disparities still exist so that approximately 1 of 10 African American, American Indian and Asian babies are born premature compared to 1 in 14 White and Hispanic babies . The change in low birth weight (under 2500 grams) from 1989-1993 to 1997-2001 have been less than one percent for all racial and ethnic groups except African Americans, where the LBW decreased from 11.5 to 9.1 percent. This is still the highest disparity in comparison to low birth weights for American Indians at 5.8 percent, Asians at 6.4 percent, Hispanics at 4.8 percent, and Whites at 4.0 percent.
Mortality rates for infants and mothers differ greatly by race and ethnicity. Based on 1996-2000 data neonatal mortality rates (deaths that occur before the 28th day of life) are particularly disparate between African Americans (8.5/1,000), American Indians (6.2/1,000) and whites (3.4/1,000). In other words, African American neonates are 2.5 times more likely and American Indian neonates are 1.8 times more likely to die than their white counterparts . In Minnesota, American Indian (5.7/1,000) and African American infants (4.2/1,000) suffer much higher rates of postneonatal mortality (deaths that occur from 28 to 365 days of life) compared to White infants (1.7/1,000) .

Maternal mortality rates are based on women who die while pregnant or within one year of termination of pregnancy, irrespective of cause. Based on 1990-1999 data, African American women died of pregnancy-associated issues at a rate 2.4 times higher than the white rate. The American Indian women's pregnancy-associated death rate was 2.8 times the white rate .

Insurance - Access Minnesota continues to maintain one of the lowest rates of uninsured populations in the nation. Some recent information however is showing some potentially negative changes in those rates. Based on the 2004 Minnesota Health Access Survey, there is a general increase in uninsured Minnesotan's (from 5.4% in 2001 to 6.7% in 2004). This increase was driven by a decrease in employer-based health insurance coverage, a shift in Minnesota's income distribution, and a change in Minnesota's Hispanic/Latino population. In 2004, Minnesotans were more likely to be uninsured or covered by public health insurance programs and less likely to be covered by group or employer-based health insurance coverage than they were in 2001. Rates of uninsured continue to show disparities based on race, with the change being most pronounced for Hispanic/Latino Minnesotans.

Results from the Minnesota Health Access Survey of 2004 show some significant changes between 2001 and 2004 of insured rates for women and children. Between 2001 and 2004 uninsured rates increased for all children (birth-17) from 6.4% to 7.7%. In the Black population (birth-17) uninsured rates decreased from 16.9% to 12.4 %, but this is still double the White rate of 6.4%. The overall non-White uninsured rate for 2004 is 16.0% with Hispanic being highest at 31.6 % (up from 19.7% in 2001).

Within the birth to 5 year old group, the uninsured rate rose from 5.7% in 2001 to 9.2% in 2004. The non-White rate remained relatively stable, while the White rate increased from 4.2% to 8.0%. This Birth to 5 year old uninsured rate is higher than the overall uninsured rates for the 6-12 age group (7.0%) and the 13-17 age group (7.1%). It is too early to tell whether these rates may have been influenced by policy changes from the 2003 legislative session, which went into effect on 7/1/2003. The Children's Defense Fund of Minnesota estimated these policy changes would negatively impact the insurance status for 20,000 children.

This study also indicated that rates of uninsurance for women in the childbearing years (15-44) increased from 11.5% to 12.8% overall. Table 2 describes these changes for women. (See attached Table 2).

State funded health programs in Minnesota provided health insurance coverage for roughly 654,000 state residents at some point during state fiscal year 2004 through it's three publicly funded basic health care programs -- Medical Assistance (Minnesota's Medicaid program), General Assistance Medical Care (GAMC), and MinnesotaCare. The Minnesota Department of Human Services (DHS) administers MinnesotaCare and oversees MA and GAMC, administered by counties. About 70 percent of DHS's budget is devoted to these three programs. About half of enrollees in all programs combined are children under 21. ***/2007/ During the 2006 Legislative session, a pay-for-performance system for publicly funded health care programs was approved. Minnesota will be the first state in the nation to participate in a pay-for-performance protocol known as Bridges to Excellence for diabetes management in state health plans. //2007//***

Medical Assistance (MA) Medical Assistance is the state's Medicaid program and provides acute, chronic and long-term care services to low-income seniors, children and families, and people with disabilities. Families, children and pregnant women account for 69 percent of Minnesota's MA enrollees, but account for only 22 percent of its expenditures. The majority of expenditures, more than 78 percent, are for people who are elderly or have a disability. Program expenditures for state fiscal year 2004 totaled $4.99 billion, of which the federal share was $2.63 billion. MA provided coverage for a monthly average of $464,000 in FY 2004. The average monthly enrollment of children was 321,291.

The state currently operates its Medicaid program with one Section 1915(a) waiver, one Section 1915(b) freedom of choice waiver, six Section 1915(c) home and community?based waivers, and Section 1115 waivers. The Section 1115 waiver is the state's MinnesotaCare Health Care Reform Waiver. The TEFRA waiver allows some children with disabilities who live with their families to be eligible for Medical Assistance without counting parent's income. Also the Home and Community Based Waiver programs allow some children with disabilities who live with their families to be eligible for Medical Assistance without counting the parent's income. Medical Assistance for Employed Persons with Disabilities allows working children with disabilities who are at least 16 to quality for Medical Assistance under a higher income limit.

The central Medicaid 1115 waiver is the state's PMAP waiver. The Prepaid Medical Assistance Program (PMAP) began in 1982 when Minnesota was selected by the federal Health Care Financing Administration (HCFA) as one of five original states to implement managed care for non long-term care services for designated Medicaid populations on a prepaid, capitated basis. Populations covered by the now statewide PMAP program include families with children, elderly, children in foster care placement, and on a voluntary basis, children eligible for MA through subsidized adoptions, and children who are seriously emotionally disturbed and who are eligible for MA-covered targeted case management. There is federal financial participation for coverage of pregnant women and children in the MinnesotaCare program (described later in this section). As of December 2004, 83 of Minnesota's 87 counties were participating in the PMAP+ program. A 1997 state law authorized all counties to choose the type of Medicaid managed care model to be implemented in their county: either PMAP or County-Based Purchasing. County-based purchasing would allow counties (instead of the state) to purchase and/or provide comprehensive Medicaid services on a risk basis contingent upon federal 1115 waiver approval.

Minnesota has received approval for an 1115 waiver demonstration project for family planning that is being planned for implementation on July 1, 2006. ***/2007/ Waiver implementation was delayed one year due to systems issues. When fully implemented the waiver is expected to serve 50,000 individuals between the ages of 15 and 50. //2007//*** This will provide eligibility for family planning services, including treatment for STIs identified in a family planning visit, to women and men at or below 200% FPG and provide automatic extension of family planning coverage for one year to anyone who loses MA or MinnesotaCare coverage.

MinnesotaCare is a state subsidized managed care program funded by a tax on hospitals and

health care providers, federal Medicaid matching funds, and enrollee premiums and co-payments. Medical payments for MinnesotaCare totaled $487 million in FY 2004, with average medical payments per enrollee of $273 a month. The average monthly MinnesotaCare enrollment in 2004 was 148,000. Families with children are eligible for the program on a sliding-fee scale if their family is income and asset eligible. There is no asset limit for pregnant women or children. Federal financial participation is claimed for pregnant women and for children and benefits for these two populations are the same as those provided for under the Medical Assistance (Medicaid) program. Federal financial participation is also claimed for parents and relative caretakers enrolled in MinnesotaCare.
Erosion or crowd-out barriers consist of essentially three eligibility provisions. First, children, families and pregnant women must be permanent residents; families without children must not only be permanent residents, but also must have resided in the state for six months prior to enrollment. Second, individuals cannot have had other health coverage for four months prior to enrollment except for children in families with income at or less than 150 percent of FPG or for individuals making a transition to MinnesotaCare from MA or GAMC. The third eligibility provision denies, with certain exceptions, eligibility for individuals who have had access to employer subsidized insurance (50 percent or more of premium cost) through a current employer in the 18 month period prior to enrollment in the MinnesotaCare program. In response to the state's budget deficit, a more limited benefit set was established for adults without children. As a budget reduction strategy, effective 10/1/03 benefits limitations were added to hospitalization, physicians, drugs, outpatient services and lab/diagnostic services. A $10,000 limit on hospital care with a 10 percent co-pay requirement was added. In addition, premiums were increased for all populations using the program.

General Assistance Medical Care (GAMC) GAMC is a state funded program that covers acute care services for residents not categorically eligible for MA but who meet income and asset standards comparable to the medically needy standards of the MA program. The program provides coverage for most, but not all, of the same health services offered by the MA program. Individuals who may be eligible include adults with no dependent children, adults residing in group resident housing, adults awaiting a determination of disability, and adults participating in the state's General Assistance program. In 2004, GAMC provided medical care for a monthly average of 34,900 low-income Minnesotans - primarily low-income adults, ages 21-64, who have no dependent children. Expenditures in FY 2004 were $245.6 million, with average medical payment for a GAMC enrollee of $587 a month. As part of the state's response to the budget deficits of the last few years, effective 10/1/03 eligibility for GAMC was lowered from 175 % of federal poverty level (FPL) to 75 % of FPL. A new "catastrophic" health program for individuals between 75 % of FPL and 175 % of FPL was established but, to cover hospitalization costs only and includes a $1,000 deductible.

In response to the severe budget shortfalls, changes were made in the 2003 and 2004 Legislative sessions to these public health care programs that have had a significant impact on mothers, children and children with special health care needs. Beginning July 1, 2003, parental fees for children on the TEFRA waiver program were increased -- in some cases by more than 1,000%; waiver slots for MR/RC, TBI, CADI were reduced or capped; and services to adults were modified, requiring co-pays for drugs, doctor visits and non-emergency emergency room visits while dental care was limited to $500 per year. Beginning July 1, 2004, Medical Assistance income eligibility for pregnant women went from 275 % of FPL to 200 % of FPL, and MA income eligibility for children ages 2 through 18 was lowered from 170 % FPL to 150 % FPL. ***/2007/ Income eligibility (FPL) changes for Medicaid eligibility were never fully implmented //2007//*** Infants born to mothers on MA now qualify for one year of automatic eligibility rather than two years. In October 2004, it became necessary for children enrolled in MinnesotaCare and Minnesota's Section 1115 waiver programs to reapply for coverage every six months, rather than the previous 12 months. The Department of Human Services estimates that in FY 2007 this change will reduce the average monthly enrollment in MinnesotaCare by 6,000 children.

As families come off of MA, the data does not indicate that they are enrolling in MinnesotaCare as

an alternative. Overall, MinnesotaCare is seeing a steady decline in enrollment numbers since July 2003, when most legislative cuts were implemented. There was a 6% decrease in enrollment numbers for children under 21 from August 2003 (70,447) to August 2004 (66,019).

Effective 7/1/2003 changes were made to General Assistance Medical Care (GAMC) and Emergency GAMC was eliminated, leaving 2,200 of Minnesota's poorest young adults with no health insurance or source of regular care. In the second half of 2003, coinciding with these cuts to GAMC, Hennepin County (largest populated county) experienced a 39% increase in uninsured patients requiring inpatient services and an 8% increase in those requiring outpatient services. After July 1, 2003, Hennepin County's Assured Access Program (not insurance, but enables enrollees who are uninsured and ineligible for public programs to receive discounted services from participating community clinics) saw an increase in enrollment for children of 55%.

Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs) are areas that are federally designated as lacking adequate health care services. Populations in 54 out of 87 counties are in federally designated Health Professional Shortage Areas (HPSAs) for primary care. 73 counties include either a HPSA or an MUA designation or both. Additionally, populations in 41 counties are in dental HPSAs and populations in 70 counties are in mental health HPSAs. While some of these designations are in urban areas with high percentages of poverty and minority populations, the majority are located in frontier and rural counties in the state. These areas tend to lack employment opportunities and experience a higher rate of uninsurance than other areas in the state. See the HPSAs maps on the following websites. The first one is rural at http://www.health.state.mn.us/divs/chs/DDHPSADec04.jpg and the urban map is at http://www.health.state.mn.us/divs/chs/MetroDentDec04.jpg. Also the Medically Underserved Areas can be seen at http://www.health.state.mn.us/divs/chs/MUASept04.jpg for rural areas and
http://www.health.state.mn.us/divs/chs/MetroMUAFeb05.jpg for urban area.

HPSAs and MUAs help meet the health care needs of medically underserved rural and urban populations of Minnesota by supporting the health care safety net services. Clinics located in these areas and providing health care services to underserved population can meet eligibility criteria for a number of federal and state assistance programs, including grants and reimbursement incentive programs.

/2007/ STATE LEVEL INITIATIVES
Minnesota Mental Health Action Group (MMHAG) MMHAG is a public-private effort to improve mental heath services in Minnesota. Launched by the Minnesota Department of Human Services, all of Minnesota's major health plans and facilitated by the Citizen's League -- MMHAG has begun developing strategies to implement the changes required to bring about a more coordinated system that meets the needs both of adults and those of children. MMHAG created a blueprint for addressing these issues that called for 1) early identification of mental health problems and early, effective intervention; 2) increasing access to services and inpatient psychiatric hospital beds; and development of quality standards monitoring processes, and introduction of evidence based practices into children's mental health care. Based on recommendations from MMHAG, the 2006 Legislature adopted some key components of the Governor's Mental Health Imitative. These included more than $10 million in new funding to address the shortage of psychiatrists, improve front-line services for children and adults; track service availability; and to begin to evaluate outcomes. These changes help set the stage for other elements of the initiative to be proposed in the next legislative session.

BUILD Initiative in Minnesota Minnesota's BUILD Initiative has developed a statewide five-year plan, Minnesota's Road Map for School Readiness, to help ensure that the programs needed by children and families are available, affordable, and of high quality. Infrastructure, as well as programs, is vital. Elements of the BUILD early childhood infrastructure are early learning standards, assessment, professional development, a

quality rating system, governance, adequate resources and financing, and evaluation. Priorities for 2006 include 1) mobilize support for school readiness; 2) enhance quality choices for parents; 3)secure funding; and 4) strengthen accountability. //2007//

TITLE V PROGRAM ROLE

The role of the Title V program in the state's health care delivery environment is to assess the health needs of mothers, children, and their families and to use that information to effectively advocate on their behalf in the development of policies concerning organizational and operational issues of health systems, and to advocate for programs and funding streams which have the potential to improve their health. The state's Title V program does have a significant assurance role. The Title V program areas of MCH and CSHN administer, coordinate and support many activities addressing maternal and child health, including the Title V Block Grant. The maternal and child health responsibilities of the Division include statewide planning and coordination of services through the acquisition and analysis of population-based data, the provision of technical support and training; coordination of various public and private efforts; and support for targeted preventive health services in communities with significant populations of high risk and low income families.

Program goals described in a later section are accomplished through partnerships with both state and local level agencies. The Department has interagency agreements with the Department of Human Services related to Title V/Title XIX activities, and also partners with local Community Health Boards, the Minnesota Department's of Education, Economic Security, Corrections, and Public Safety. Along with many other institutions of higher education, Minnesota is fortunate to have an excellent School of Public Health at the University Of Minnesota's Twin Cities campus. The close working relationship with this school, particularly with the MCH and nursing programs provides resources for both members of this partnership and future MCH practitioners.

CURRENT DEPARTMENTAL PRIORITIES/INITIATIVES

As the Minnesota Department of Health positions itself for the next years of this decade, legislative and gubernatorial direction as well as community- and population-based health issues will shape its priorities. The current governor, Tim Pawlenty, has identified health prevention as a priority, with a specific emphasis on obesity. The MDH administration, through it's Health Steering Team (HST), made up of the Executive Office staff and Division Directors, has undertaken strategic planning activities which led to the development of work groups to review these priorities: 1. Vision for MDH; 2. Organizational Structure; 3. Regulatory Roles, Responsibilities and Process; 4. Defining a Coordinated Process for Pursuing Funding for MDH Priorities; 5. Interagency Initiatives; 6. Providing Optimal Support to Local Agencies Responsible for Public Health; and 7. Data Collection.

/2007/ Through the strategic planning process, the Department of Health identified four priority focus areas: Emergency Preparedness; Health Disparities; Preparing for an Aging Population and Health Care System Reform. Committees have been charged with 1) taking a department-wide perspective on the priority; 2) identifying key measures and outcomes the department should accomplish or work toward; 3) identifying how each division contributes to the outcomes and 4) coordinating and monitoring the department's effectiveness in each priority area. The work on these new priorities has just started but they will help frame the work of the Department over the next several years. //2007//

Throughout 1998 the Department undertook a comprehensive effort to revise the state's public health goals and objectives and published Strategies for Public Health. This document is a compendium of ideas, experience and research offered to help local public health and other community agencies achieve the objectives of Healthy Minnesotans, 2004. Work is now underway to update this document for a Healthy Minnesotan's 2010. Title V staff will be responsible for the update the the Goals and Strategies impacting maternal and child health populations.

Initially established in the Community Health Services (CHS) Act of 1976, Minnesota has a strong

public health infrastructure system of locally operated public health agencies and a good relationship between the state and local entities. As part of this original CHS Act, the Minnesota Legislature created the State CHS Advisory Committee (SCHSAC) that provides recommendations to the Commissioner of Health. This statute was revised in 1987 to create the Local Public Health Act, and again in 2003 when significant administrative changes were made.

These revisions included changes in funding for local public health wherein eight funding sources were combined in order to achieve administrative efficiencies, better target local priorities, and move towards results-based accountability. These grants are: the Community Health Services Subsidy, Maternal and Child Health, WIC state dollars, the Infant Mortality Grant, the Family Home Visiting Grant, the Youth Risk Behavior Grant, the MN ENABL grant, and the Eliminating Health Disparities Grant to Tribal governments. The combined funds are distributed through two formulas -- one to city and county-based community health boards and one to Tribal governments.

Additionally, these administrative changes necessitated planning to create accountability measures -- through development of statewide outcomes associated with a list of essential activities, as well as a revised reporting system. Title V staff have been very actively involved in the planning and development of these changes. Through this work six broad areas of public health responsibility were defined: assure an adequate local public health infrastructure; promote healthy communities and healthy behaviors; prevent the spread of infectious disease; protect against environmental health hazards; prepare for and respond to disasters and assist communities in recovery; and assure access and quality in health services. Title V related work is found in all six responsibilities. ***/2007/ Statewide outcomes identified for each of the six essential public health responsibilities support the work of the Title V programs and strengthen the partnership around maternal and child health issues with local public health agencies. There are 35 statewide outcomes and except for the outcome to "reduce the rate of hospital admissions for falls in persons aged 65 and older" all outcomes would improve overall maternal and child health within the state. //2007//***

More information on this significant planning and infrastructure building activity can be found at http://www.health.state.mn.us/phsystem.html#essential A schematic representation on Minnesota's local public health improvement process is available http://www.health.state.mn.us/cfh/na

Decision-making Processes

There are a number of institutionalized forums that allow the Commissioner of Health, and the Community and Family Health Division Director to remain up-to-date on the social, political and economic dynamics affecting health care issues. All of the groups described below provide for a statewide perspective of various stakeholders on different policy issues, which affords the Title V Directors a number of different vehicles for defining problems and policy and for feedback on recently enacted policy.

1. The Health Steering Team (HST) HST consists of the health department's Executive Office staff and the Division Directors. It meets monthly to provide input into departmental policies, determine priorities, and to identify and resolve issues.

2. The Maternal and Child Health Advisory Task Force (MCHATF) is a statutorily created standing advisory committee that assists the Commissioner of Health on selected policy issues. It is a 15-member group equally represented by consumers, maternal and child health professionals, and community health agency members with ex-officio representation from the Minnesota Department of Human Services; the Minnesota Department of Education; and the University of Minnesota MCH Program. Its purpose is to advise the Commissioner, the Division Director and the Title V program on the health status and health care needs of mothers and children. In 2005 the MCHATF created two priority work groups to focus on: 1) monitoring the impact of the 2003-2004 Legislative Session policy and budget changes, and 2) maintaining and

improving early childhood programming. ***/2007/ Significant time this past year has been spent on developing recommendations for the Commissioner of Health in the areas of child and adolescent health, perinatal health, and children with special health care needs. This work builds on the MCH needs assessment completed in 2005. Each recommendation defines specific strategies or action steps that could be taken to address one or more of the state priorities identified in the needs assessment process. As of June 30, 2006 recommendations have been approved for child and adolescent health and prenatal health. Recommendations for children with special health care needs will be developed during the summer of 2006 and the full report and recommendations will be forwarded to the Commissioner of Health in the fall of 2006. This work will be used in refining the work of the Title V programs over the next year. //2007//***

3. The State Community Health Services Advisory Committee (SCHSAC) is a standing advisory committee comprised of county commissioners and local community health administrators. It meets at least four times a year and its purpose is to advise the Commissioner of Health on all matters relating to the development, maintenance, funding and evaluation of the local public health system. Each year the SCHSAC forms 3-5 work groups comprised of local public health experts to address topics of pressing interest to local public health agencies. It also sponsors an annual statewide conference for state and local public health professionals.

4. The Rural Health Advisory Committee consists of legislators, rural providers, and consumers. Its purpose is to advise the Commissioner and other state agencies on rural health issues and rural health planning. It too carries out its responsibilities through work groups. Their current focus is on mental health issues in rural communities. ***/2007/ Focus areas currently are the aging population, E-Health and telemedicine. //2007//***

5. Title V/Title XIX: The senior program managers for the Title V and the Title XIX programs meet quarterly to discuss maternal and child health issues and proposed changes in their respective programs and concerns due to changes in federal and/or state policy. The Title XIX agency is also the designated Title XXI agency.

6. The Management team of the Division of Community and Family Health meets on a monthly basis to resolve immediate operational issues and to discuss and define long-range issues.

B. Agency Capacity

The mission of the Community and Family Health (CFH) Division is to provide collaborative public health leadership that supports and strengthens systems to ensure that families and communities are healthy. This is done by partnering to: ensure a coordinated state and local public health infrastructure; improve the health of mothers, children and families; promote access to quality health care for vulnerable, underserved and rural populations; and provide financial support, technical assistance, accurate information and coordination to strengthen community-based systems.

The vision for the public health system in Minnesota is of a strong and dynamic partnership of governments, fully equipped to address the changing needs of the public's health. Minnesota Statutes Section 144.05 gives authority to the Commissioner of Health to develop and maintain an organized statewide system of programs and services to protect, maintain and improve the health of Minnesotans. This includes authority to collect data, prevent disease and disability, establish and enforce health standards, train health professionals, coordinate local, state and federal programs, assess and evaluate the effectiveness and efficiency of health service systems and public health programs in the state, and advise the governor and legislature on matters relating to the public's health.

The language within Minnesota Statutes Chapter 145 lays out the state requirements for the

distribution of the Maternal and Child Health block grant, with two thirds to go out to local Community Health Agencies through a formula; establishes the MCH Advisory Task Force; and articulates program requirements for use of state funds for WIC, family planning, abstinence education, fetal alcohol syndrome, and home visiting. ***/2007/ and the Woman's Right to Know and Positive Alternatives Programs. //2007//*** The Minnesota statute articulates that a third of the block grant money retained by the Commissioner of Health may be used to: 1) meet federal maternal and child block grant requirements of a statewide needs assessment every five years and prepare the annual federal block grant application and report; 2) collect and disseminate statewide data on the health status of mothers and children within one year of the end of the year; (3) provide technical assistance to community health boards in meeting statewide outcomes; (4) evaluate the impact of maternal and child health activities on the health status of mothers and children; (5) provide services to children under age 16 receiving benefits under Title XVI of the Social Security Act; and (6) perform other maternal and child health activities as listed in federal code for the MCH block grant and as deemed necessary by the commissioner.

The delivery of primary and preventive public health services by local government in Minnesota occurs within a framework governed by "Community Health Boards (CHB)." The Boards themselves are comprised of elected officials, either county commissioners or city council members. The Boards provide policy formulation and oversight of the local public health administrative agencies which are responsible for conduct of public health core functions. There are 53 CHBs in the state including 27 single-county boards, 61 counties cooperating in 21 multi-county boards, four cities, and one city-county board. This infrastructure provides for a community-based decision-making process based on a needs assessment with state leadership and support. The process recognizes differences among communities and provides a flexible range of responses. Core funding is provided through the Local Public Health Act ($31 million including $6.1 million of Title V funds). Total CHB expenditures for 2005 was $282 million of which a third was from local taxes.

CROSS-CUTTING TITLE V PROGRAM CAPACITY

The MCH Advisory Task Force: The Maternal and Child Health (MCH) Advisory Task Force was created by the Minnesota Legislature in 1982 to advise the Commissioner of Health on the health status and health care services needs of Minnesota's mothers and children, and the distribution and use of federal and state funds for MCH services. Fifteen members are appointed by the Commissioner with five each representing MCH Professionals, MCH consumers, and Community Health Boards. Terms are four years, half coterminous with the governor's term and half one year later. Work groups of the Task Force are often convened with a specific charge to bring back to the full Task Force recommendations made following more in-depth research and discussion. Current work groups include monitoring theimpact of the 2003-2004 legislative session policy and budget changes on mothers and children, and improving early childhood programming. ***/2007/ The new work plan for the next year revolves around developing strategies or action steps to address the state priorities identified in the needs assessment process. //2007//***

MCH Epidemiology: A newly formed data/epi team was created in response to recommendations made during the 2003 CAST 5 data capacity process. The purpose of the team is to provide a broad base of technical expertise and support for data-related activities (e.g., needs assessment, research, program evaluation) to CFH staff with emphasis on building the capacity of staff to work with data through one-on-one coaching, consultation, and division-wide trainings. The team consists of 3 PhD level staff: the SSDI research scientist, another research scientist, and an epidemiologist. This team brings increased methodological and analytic capacity and will leverage efforts to advance SSDI project objectives. The Data/Epi team has been actively partnering with programs on data activities, working on committees, organizing training opportunities, and developing structures for increased collaboration and data sharing within and across programs. Among the new structures formed is a Data Users Group, which is intended to foster communication and collaboration among researchers, analysts, policy planners, and others responsible for data utilization in and outside of the MDH. ***/2007/ In 2005, Title V and Title XIX entered into an Interagency Agreement whereby Title V agreed to cover the salaries of 1.5***

FTE epidemiologists at the Department of Human Services to be able to use Medicaid data to work on jointly identified issues. The first project identified was determining cost effectiveness of a medical home model for children and youth with special health care needs covered by Medicaid/MinnesotaCare. //2007//

MCH Special Projects Grant: The Maternal and Child Health Special Projects (MCHSP) grant program was created in 1985 to distribute two-thirds of Minnesota's share of the federal MCH Title V Block Grant and an appropriation of state general funding to Minnesota's Community Health Boards. MCHSP funds provide core funding for support of local public health infrastructure focused on the improved health of mothers, children, and their families. The program also targets funds to serve high-risk and low-income individuals in statewide priority service areas: improved pregnancy outcomes, family planning, children with handicapping conditions/chronic illness, and child and adolescent health. The 2003 Legislature consolidated MCH dollars, along with seven other categorical programs, into the resulting Local Public Health Grant (LPHG) that provides funding for Community Health Boards and Tribal Governments. Accountability for MCH block grant dollars remains separate within this LPHG structure. Local match for the MCH funds was raised from 25 percent to 50 percent.

Tribal Governments: While the Department of Health and the CFH have been working with tribal governments for some time, the process became more formalized in 2003 with the establishment and the hiring of a Tribal Liaison. Located within the Office of Minority and Multi-Cultural Health (OMMH), the position is uniquely situated to establish stronger ties with Tribal Governments and Tribal Health Directors. Legislative action in 2003 acknowledged the role Tribal Governments play in the health status of their communities by including them in the Local Public Health Grant. In response to the significant disparities in infant mortality, childhood obesity, teen suicides and teen pregnancies, tribes were directed to use the new money in this grant for maternal and child issues. Staff work closely with the Tribal Health Liaison to provide technical assistance and support to the Tribal health staff and programs for all three MCH population groups.

Mental Health Program: The mental health area supports ongoing implementation of the statewide suicide prevention plan activities including grant administration, K-12 and American Indian suicide prevention work groups, and technical assistance and information dissemination to local public health, schools, and other community-based entities. Additionally, this staff supports the mental health promotion activities incorporated throughout Title V program areas, e.g. maternal mental health, infant mental health, child social emotional development, screening and early identification, and healthy youth development. This staff represents the department on mental health committees and work groups and also provides support and expertise for interagency mental health policy and planning activities out of the executive office around mental health systems and issues. ***/2007/ The 2005 Legislative Session saw the elimination of the Suicide Prevention Grants ($902,000) and the staff position related to this area. The same year, Minnesota became one of the states awarded the HRSA State Agency Partnership for Promoting Child and Adolescent Mental Health grants. This grant along with some Preventive Block Grant and Title V funds allows Title V to maintain staff focused on critical mental health activities. //2007//***

Dental Health Program: The dental health program provides oral health promotion training, technical consultation and assistance to professionals, and educational materials to CHBs, schools and the general public. Program staff partners with the Department of Human Services in areas of dental policy and access issues. With funding from HRSA, Minnesota Children's Oral Healthcare Access Project grant promoted the oral health of pregnant women and young children, to improve the early oral health status of infants and children served by Minnesota WIC program, and improve the awareness and anticipatory guidance skills of WIC parents related to the oral health needs of their children.

/2007/ The Positive Alternatives Grant Program: This program funds private, non-profit organizations to support, encourage, and assist women in carrying their pregnancies to

term and carrying for their babies after birth. This legislation makes available $2.5 million annually for alternatives-to-abortion programs. Currently 37 organizations have been awarded funding to provide a variety of services to pregnant women including dula and case management services; client advocate services; parenting programs; transitional housing; medical and educational support and necessary items such as cribs, car seats and formula. //2007//

In addition to specific program areas listed below, Title V staff and programs work to leverage capacity by partnering with related programs situated in other Divisions within MDH. These include lead screening and abatement, Birth Defects Information System, immunizations, STI and HIV programs, breast and cervical cancer control, asthma, several health promotion program areas, the methamphetamine program, and children's environmental health.

POPULATION CAPACITY: PREGNANT WOMEN, MOTHERS AND INFANTS
Perinatal - The perinatal focus of work involves program staff with health providers to develop quality preconception, family planning, prenatal, perinatal, and genetics services that increase the potential for healthy pregnancies and newborns. Staff assess needs, develop standards, and provide technical support services, training, and public education. This component assures counseling and education for patients and family members with known or suspected genetic diseases; assures genetic consultation, education and diagnostic support to physicians and other health professionals; and partners with the Public Health Laboratories program for detection of metabolic diseases through newborn screening. The infant mortality staff provides education, information and assistance to community and Tribal public health, works closely with Twin Cities Healthy Start, and with the OMMH in their Eliminating Health Disparities Initiative (EHDI) in the area of infant mortality reduction. Infant mortality staff are active with the Prematurity Campaign of the March of Dimes and with the Minnesota Perinatal Organization and work with the Minnesota SIDS Center. In response to the increase of infant deaths due to bedsharing, Infant Sleep Safety Education folders and a brochure entitled "Safety Tips for Bedsharing with Your Baby" were made available. This brochure is distributed to birthing hospitals throughout the state. Another compiled education folder brings together all the infant sleep safety messages including information on bedsharing, and are being distributed to local public health, tribal health, and community-based organization. ***/2007/ The 2005 Legislative session passed language that required the Department of Health to develop and distribute information on postpartum depression and Shaken Baby Syndrome prevention. Working with community partners, MDH identified materials that are to be used by hospitals and healthcare providers to educate women and their families regarding postpartum depression. Guidance was developed for health care providers regarding educating parents during well-child checks for children birth to 3 years of age regarding Shaken Baby Syndrome prevention. //2007//***

Substance Abuse - These activities focus on the childbearing and prenatal population and include dissemination of a Women and Substance Use in the Childbearing Years Prevention Primer, a compendium of resources and a guide for client and community prevention educators and planners. Work is underway on the CDC FAS Prevention grant with the purpose to increase Minnesota's capacity to integrate targeted and population based alcohol and contraception screening and behavior change interventions for women of childbearing age in select community settings; to reduce binge and prenatal drinking in women 18-44; to increase contraception use in women 18-44; to increase collection and use of data on women's drinking and contraceptive use; and to prevent and reduce FAS in targeted prenatal and preconceptional populations at risk for binge and prenatal drinking. MDH oversees a state funded FAS prevention grant to a local advocacy organization for work on public education, screening and evaluation activities, and intervention programs. Prenatal smoking prevention and cessation activities include work with the Indigenous People's Task Force, and work with a new state partnership sponsored and facilitated through the AMCHP, ACOG, PPA, and CDC technical assistance project.

Reproductive Health - The Family Planning Special Projects grants provide funding and technical

assistance and support to the 41 community-based clinics and organizations that provide assessment, education and contraceptive methods services, and supports a family planning and STI hotline. Staff work with policy issues at the legislature and with implementation activities of the new state 1115 family planning waiver demonstration project. Abstinence grant activities include: community organization activities, use of a curriculum consistent with established principles for education, a media campaign, and state directed training and technical assistance for community-based projects.

Home visiting - Staff provide support to local public and Tribal health staff for home visiting activities they undertake through the Local Public Health Grant. The state supports NCAST training for home visiting nurses and has increased a focus on maternal and infant mental health training and assessment. Staff provide training to utilize the home safety checklist for injury prevention.

Women's Health - Women's Health Grant activities were focused on increasing the number of low-income women of color receiving primary and preventive health care services by identifying service gaps and eliminating barriers to care. Although this federal grant has now ended, the relationships developed through this grant continue to provide opportunities for collaboration. The Women's Health Team, convened by Title V staff, provides opportunity for women's health programs from across the Department to work together so that systems of care serving women are improved. Working closely with the Community Center of Excellence at Northpoint Clinic, and with the U of M Academic Center of Excellence in women's health, a joint women's health website has been developed at www.healthymnwomen.org.

Infant Health - Staff partner with the MDH Newborn Screening Advisory Committee and with the MDH laboratory on systems development, data and tracking linkages, and providing education, outreach, technical assistance, and materials development. Newborn screening follow-up staff facilitate enhanced care coordination and services for infants found by newborn bloodspot screening. The MDH supports hospitals to provide newborn hearing screening and tracks results through integration with the state's Newborn Bloodspot Screening database, and is developing integration with vital statistics via a web-based system. Staff provide: technical assistance to hospitals; early intervention and follow-up; provider training; public information; and enhancement of a statewide family-to-family support network. Program activities are coordinated with Part C along with other MDH staff, faculty for the University of Minnesota Department of Otolaryngology, and members of the Universal Newborn Hhearing Screening Advisory Committee. Staff work with the Departments of Human Services and Education to provide state leadership in early hearing detection and intervention, including tracking and reporting of outcomes. Sixteen regional teams continue to build capacity in their regions to better serve deaf-hard of hearing children and their families.

POPULATION CAPACITY: CHILDREN AND ADOLESCENTS

Child and Adolescent Health Screening - This area of work supports accessible quality health and developmental screening and health promotion for all children. Goals of the program are adoption of healthy behaviors and assurance of early identification, treatment and remediation for those with health problems. Services include development of child health screening and health promotion guidelines, provision of training and technical consultation, and public education efforts. Specific programs supported include Child and Teen Checkups (Minnesota's EPSDT program) consultation, Nursing Child Assessment Satellite Training (NCAST) program, the scoliosis screening program, and maternal/infant mental health.

Birth Defects Information System (BDIS) Although the lead for this activity is in the Division of Environmental Health, Title V staff contribute significant expertise and time on the planning and the ongoing implementation of Minnesota's Birth Defects Information System.

School Health / Child Care - Specific attention is given to promotion of the health and safety of children in child care settings, school health (including hearing and vision screening), adolescent

health, and children's mental health issues. Staff work closely with the Title V-CYSHCN as well as staff from related state agencies such as Departments of Education and Human Services. A report has been produced on a comprehensive system for the safe administration of medications in Minnesota schools, anchored by the development of statewide standards and guidelines and local district policies and procedures. This is available at http://www.health.state.mn.us/divs/fh/mch/schoolhealth.medadmin/. ***/2007/ These guidelines are being implemented in schools throughout the state through trainings and technical assistance. //2007//***

Adolescent Health - Adolescent preventive health services are addressed through outreach and implementation of "Being, Belonging, Becoming: MN Adolescent Health Action Plan", which includes a focus on strengthening adolescent health care services and systems. Outreach includes technical assistance on use of a youth development framework for addressing adolescent health issues, information about best practices and health care guidelines, implementation of recommendations for action, and use of available resources to support effective strategies. Staff provides technical assistance to EHDI grantees, local public health and other community-based entities, and works closely with the Department of Education, other adolescent program areas within MDH, and the University of Minnesota Konopka Institute for Best Practice in Adolescent Health, Division of General Pediatrics and Adolescent Health, building skill and capacity of adolescent-focused work and programs across the state.

Early Childhood - The MCH Bureau's State Early Childhood Comprehensive Systems Planning Grant is underway to develop a state plan for an integrated comprehensive early childhood screening system. The interagency partnerships between Title V, the Departments of Human Services and Education, and Minnesota Head Start have increased efforts to decrease duplication of preventive care and foster coordination between childhood programs that require preventive visits. Work through these relationships has provided joint regional screening workshops and the development of the Minnesota Child Health and Development Screening Quality Indicators: A Comprehensive Framework to Build and Evaluate Community Based Screening Systems.

POPULATION CAPACITY: CHILDREN WITH SPECIAL HEALTH NEEDS
Diagnostic Clinics are a component of the MCSHN program and provide quality medical and rehabilitation assessments for children with suspected or diagnosed special health needs, are staffed by a multi-disciplinary team or specialist with pediatric expertise, complement local health care, and are located in communities where such services are not available. Several of these clinics are contracted with institutioal providers, including the International Diabetes Center and Gillette Specialty Health Care. ***/2007/ One clinic is the Development and Behavior Clinic (DBC). The Children's Mental Health Services Division of the Department of Human Services has agreed to assist the Title V - CYSHCN program in analyzing the role of the DBCs as part of the overall children's mental health system. //2007//***.

Community Systems and Development Team - This team has staff located in District Offices of the state, provides a wide variety of activities at the local, regional, and state levels with public and private agencies and families, including information and referral, child find and outreach, education and training, advocacy, technical consultation, newborn metabolic screening follow-up, and program/policy development. ***/2007/ The capacity of the team was significantly increased by the addition of another district staff consultant. //2007//***

Interagency Systems Development - In addition to the Part C interagency activities, staff participates in the state mandated Minnesota System of Interagency Coordination to support the development and implementation of a coordinated, multidisciplinary, interagency intervention services system for children ages birth through 21 with disabilities. This model, based on Part C, requires the development of an Individual Interagency Intervention Plan for all qualifying children, youth and young adults. Significant interagency planning and negotiating has been required between the Departments of Health, Human Services, Education, and Economic Security to

support this multi-agency activity. ***/2007/ The concepts inherent in collaborative learning sessions that were learned from the medical home collaborative experience will be applied in order to remove barriers to implementation. //2007//***

Follow-Along Program - Staff provide technical assistance and training to local public health agencies to support the Follow-Along Program in order to provide periodic monitoring and assessment of infants and toddlers at risk for health and developmental problems and to ensure early identification, assistance and services. The software program for this activity, which uses the Ages and Stages Questionnaire as the screening tool, includes a social emotional component - the ASQ-SE. Special trainings have been targeted on this tool to the Somali population and to the Department of Human Services and local social services agencies on the use of the ASQ-SE to meet the requirements for mental health screening of children in the child welfare system. ***/2007/ The ASQ and ASQ-SE continues to be adopted by local agencies. It is the screening tool of choice for the Children's Mental Health Services' ABCD-II grant initiative and has been added to the Child and Teen Checkup (EPSDT) program's trainings. //2007//***

Research and Policy Analysis - The Research/Analysis and Policy work supports the development and enhancement of capacity to collect and analyze data for research and policy issues around children with special health needs and their families. It has engaged in a number of interagency collaborative activities to assess, direct and influence policy decisions that positively impact children with special health needs. ***/2007/ Factsheets on each of the 44 conditions followed by the birth defects information system were developed. Leadership will also be provided at the Part C ICC level for what will be a significant expansion of Part C enrollment. //2007//***

Medical Home - Minnesota has adopted the medical home learning model promoted by the National Initiative for Children's Health Care Quality in its national medical home collaborative to advance the medical home concept -- particularly for children with special health needs. Eleven teams are in place throughout the state, each consisting of a pediatrician, a care coordinator, and two parents. Staff working closely with the state chapter of the AAP, has generated responsiveness to some some productive media education and outreach, and will continue this work through the newly awarded New Freedom initiative grant. ***/2007/ Minnesota participated in the second National Medical Home Learning Collaborative conducted by NICHQ. It was also one of the original 12 grantees under the President's New Freedom Initiative and will continue medical home activities as part of that initiative. //2007//***

Outreach / education / follow-up - Staff work with Birth Defects Information System (BDIS) staff to provide follow-up to families of all children confirmed as having neural tube defects, cleft-lip/palate or chromosomal anomalies. Staff provide health information related to the infant's condition, and refer the family to additional programs and services and is gearing up to provide these same services for the 44 conditions that BDIS will be tracking.

Staff provides frequent trainings to families and providers about various public program services and how to access them through their "Taking the Maze Out of Funding" sessions. These trainings provide updated information to numerous sectors and providers throughout the state regarding program and policy changes. The Information and Assistance line provides information about and assistance in finding and accessing services and supports for children with special health needs and their families. Additionally, the web-based Central Directory of Early Childhood Services provides information about services and programs in both the web and hard copy format.

Broad dissemination occur of condition-specific Guidelines of Care for Children with Special Health Care Needs which include Asthma, Cerebral Palsy, Cleft Lip and Palate, Feeding Young Children with Cleft Lip and Palate, Congenital Heart Disease, Cystic Fibrosis, Diabetes, Down Syndrome, Deaf and Hard of Hearing, Fetal Alcohol Syndrome and Fetal Alcohol Effect, Hemophilia, Juvenile Rheumatoid Arthritis, Muscular Dystrophy, Neurofibromatosis, PKU, Seizure

Disorder, Sickle Cell Disease, and Spina Bifida.

SPECIAL SUPPLEMENTAL NUTRITION PROGRAM (SNP) /WOMEN, INFANT AND CHILDREN (WIC)
Also within the CFH Division, Title V staff work with SNP and WIC staff on many shared goals for healthy pregnant women and improved pregnancy outcomes, and healthy infants and young children. Clearly aligned with Title V program activities, Special Supplemental Nutrition Programs has a total of 30.8 FTEs funded by the U.S. Department of Agriculture. This section is comprised of the Special Supplemental Nutrition Porgram for Women, Infants and Children (WIC) and the Commodity Supplemental Food Program (CFSP). These two programs are designed to improve the health and nutritional status of the eligible populations through the provision of healthy foods, nutrition education and health care referrals. This section distributes federal funds from the United States Department of Agriculture to local Community Health Boards, Community Action Programs, and Tribal governments to administer the WIC program; and to local food banks to administer the CFSP program. Participation rates have been rising steadily and currently, over 123,000 persons per month are served. ***/2007/ Over 129,600 persons were served in May of 2006. //2007//***

An attachment is included in this section.

C. Organizational Structure

State Department of Health The Minnesota Department of Health (MDH) is one of the major administrative agencies of state government. The Commissioner of Health is appointed by the governor with confirmation by the state senate, and serves at the pleasure of the governor. State law imposes upon the Commissioner the broad responsibility for the development and maintenance of an organized system of programs and services for protecting, maintaining, and improving the health of the citizens of Minnesota.

The Executive Office is organized into three Bureaus: Policy Quality and Compliance Bureau, Health Protection Bureau, and Community and Family Health Promotion Bureau. Within the Bureau of Community and Family Health Promotion is the Division of Community and Family Health, (CFH), which is responsible for the administration of programs carried out by allotments under Title V.

The CFH Division is organized into the Director's Office and six sections: Office of Public Health Practice, Office of Rural Health and Primary Care, WIC/ Supplemental Nutrition Program Section, Maternal and Child Health Section, Minnesota Children with Special Health Needs Section, and Integrated Support for Cross Divisional Activities Section. The last three sections house the staff and resources where the primary Title V activities take place, although Title V staff work across the whole CFH Division -- as well as across the department. This new Division structure was created in August of 2004, when the Division of Family Health was combined with the Community Health Division. The former Director of the Division of Family Health at that time took on a new role of the Title V Coordinator, under which she reports directly to the Director of the Community and Family Health Division.

The CFH Director's Office houses 17 staff, 6 of which are at least partially funded by the federal Title V funds: 4 grant and administrative staff, an IT staff, and the Title V Coordinator.

The mission of the MCH Section is to provide statewide leadership and public health information essential for promoting, improving or maintaining the health and well-being of women, children and families throughout Minnesota. The structure to support this work consists of 3 work units: Newborn and Child Health Unit, Family and Women's Health Unit, and the Support Unit. This Section has 7.4 FTEs funded by federal Title V funds; 10.8 FTEs funded by targeted state funds; approximately 14.05 FTEs funded by various federal grant programs; and other positions funded through a mix of sources for a current total of 32.3 FTEs.

The Minnesota Children with Special Health Needs (MCSHN) Section is the Title V CYSHCN program. As such, it seeks to improve the quality of life for children with special health needs and their families through the promotion of the optimal health, well being, respect and dignity of children and youth with special health needs and their families. MCSHN provides statewide support to achieve: early identification, diagnosis and treatment, family centered services and systems of care, access to health care and related services, community outreach and networking, and collection and dissemination of information and data. MCSHN is structured into the Research and Policy Unit, and the Community and Systems Development Unit, which has 6 staff housed in District Offices across Minnesota. MCSHN has 18.35 FTEs funded by the federal Title V funds, 3.55 FTEs funded through interagency agreements with the Department of Education, 1 FTEs funded by federal grants, and approximately 1.5 state funded FTEs for a total of 24.05 FTEs.

The Integrated Support for Cross Divisional Activities Section is responsible for supporting and strengthening cross-divisional activities which include: broad internal and external communication; how the Division uses data to monitor and evaluate programs and the health status of mothers and children, including children with special health care needs; and work on emerging issues that require Division --wide input and monitoring as well as a special focus on adolescent and school health. This Section has 6.80 FTEs funded by federal Title V funds; 0.4 funded by Preventive Block Grant; 1.5 FTE funded by SSDI; 0.5 FTE funded by CDC funds; and other partial FTEs funded by a mix of state and federal funds, for a total of 9.8 FTEs.

As required, organizational charts are available on file in the Community and Family Health Office.

Local Public Health More detail regarding the structure, function, and Title V relationships with local public health are described in Section B, Agency Capacity. In 2004, the State Community Health Services Advisory Committee appointed a work group to identify essential local public health activities that should be available in all parts of the state. This Essential Local Public Health Activities Framework is intended to: define a set of local public health activities that Minnesotans can count on no matter where in the state they live; recommend a statewide plan for implementation; provide a consistent framework for describing local public health to state and local policy makers and the public; and provide a basis for ongoing measurement, accountability and quality improvement related to the implementation or assurance of essential local activities. The website address http://www.health.state.mn.us/cfh/na provides a schematic of Minnesota's Local Public Health Improvement Process. Title V staff have been and remain actively involved in the ongoing planning for these significant revisions to Minnesota's public health system involving the creation of a set of Essential Local Public Health Activities, Statewide Outcomes, and an Outcome Reporting System. This has provided a good opportunity to insure that MCH related program areas were incorporated into this framework of essential services, statewide outcomes, and development of the reporting system. Title V staff continue a high level of involvement in the ongoing planning, and the training and guidance to local public health as these significant system changes are implemented. More information on this activity is available at http://www.health.state.mn.us/phsystem.html#essential.

D. Other MCH Capacity

See previous Section C Organizational Structure for the location and numbers of Title V staff.

SENIOR MANAGEMENT BIOGRAPHICAL SKETCHES

The state MCH Director, the Director of the Community and Family Health Division, has served in that capacity since August of 2004. Prior to that time she was the Director of the Community Health Division for 4 years, and has held a number of positions throughout the Health Department

including Tobacco Endowment Director, Manager of Environmental Health Services and Manager of Acute Disease Prevention Services. She has worked at the Department for over 20 years, prior to which she worked in local public health agencies in two different Minnesota counties. She has a Masters in Public Health Nursing from the University of Minnesota, and served a term as president of the Minnesota Public Health Association. ***/2007/ The Director of the Community and Family Health Division resigned in June 2006 to take another job. The current interim Division Director has worked for the Department of Health for the last 33 years. For the past ten years, she has served as Assistant Division Director first with the Division of Family Health and then with the Division of Community and Family Health. Her educational background is in nursing and she spent her first 20 years with the department in the area of children with special health care needs. The Department intends to do a national search for candidates for this position. It is expected that the position will be filled in the prior to the end of 2006. //2007//***

The state CYSHCN Director, the MCSHN Section Manager, has a Master's degree in hospital and health care administration and has 21 years of experience in health planning, five in hospital corporation activities, 9 in maternal and child health and 7 in CSHCN.

The MCH Section Manager The Section Manager has worked in public health for 25 years in MCH. Much of her experience has focused on providing services to high risk parents including pregnant and parenting teens. After 20 years of providing MCH services at the local level she accepted a position at the Minnesota Department of Health working in the Reproductive Health Unit. Work in this unit included provision of technical assistance for a MCH programs including MN ENABL (Education Now and Babies Later), TANF home visiting, family planning, infant mortality reduction and women's health. In February 2004 she accepted the position of Maternal Child Health Section Manager at the Minnesota Department of Health.

The Title V Coordinator was previously the state MCH Director for 5 years, and has over 20 years of MCH experience -- both at the state and local level. She is an occupational therapist by training and has a MPH in the MCH area from the University of Minnesota.

Parent roles The CYSHCN program has, since FY 2000, had a Family Consultant Advisory Group. Consisting of up to eight parents, this group has brought to policy discussions the voice of parents and their children. Parents demonstrated significant leadership and advocacy skills in service system or policy development at the state or local level prior to his/her selection, and most had been through previous advocacy and or leadership programs. Many parents were either graduates of Parents in Policymaking (a program of the Governor's Council on Developmental Disabilities) or the Minnesota Early Learning Design {MELD} Special Parent trainings. The Family Voices representative in Minnesota has provided administrative oversight to the Advisory Group.

The Advisory Group has been meeting to review the six core outcomes of the Bureau's ten-year action plan and is framing specific actions for the state's work plan, and has also focused on health disparities documented through analysis of the Minnesota Student Survey. Discussions have also been underway regarding important transition issues of responsibilities of local public health agencies brought about by the 2003 legislative changes in the funding of local public health due to significant budget deficits.

Several staff are also parents with one or more children who have a special health care need. The roles these parents perform and the positions they occupy in the program include supervisory, policy and program planning, and technical consultation for statewide programs.

E. State Agency Coordination

Collaboration and coordination is a fundamental value and strategy for the work of Title V. It is essential to the accomplishment of our goals. Many of the earlier sections of this report as well as the Performance Measure narratives describe multiple partnerships between Title V, other MDH program areas, other state agencies, community-based entities, and local public health. These relationships are both long-standing, and also include some exciting new opportunities. Some of these are formal with MOUs and MOAs in place, and many are less formal.

INTRA-AGENCY COORDINATION
Office of Rural Health and Primary Care Minnesota's Title V and Primary Care Office (PCO) programs support each other's mission and the goals and objectives of their respective SSDI and Cooperative Agreement (CA) grants. The mission of the PCO is to improve access to preventive and primary care services for underserved Minnesotans. The Title V program works, in part, to further efforts of organizations that deliver health services to mothers and children and to provide leadership for statewide maternal and child health issues. Both programs promote the development of community-based, family-centered, comprehensive, coordinated, and culturally competent systems of services as a priority. The MCH Mental Health Coordinator is working closely with the Rural Health Advisory Committee on their priority for the year -- mental health issues in rural Minnesota. Focus areas include resources and provider capacity, and system issues rural Minnesota in the area of mental health. ***/2007/ Current focus areas include the ageing population, E-health and telemedicine. The Office of Rural Health and Primary Care was also assigned the responsibility for the Dental Access Grants. These funds support innovative clinical training for dental professionals and programs, which increase access to dental care for underserved populations. Approximately $1.5 million is available each year to support partnerships between dental training programs and safety net providers, including local public health agencies. //2007//***

The Office of Minority and Multi-Cultural Health (OMMH) relies on Title V staff for specific program area expertise for the Eliminating Health Disparities grantees, and Title V staff likewise rely on OMMH staff for access, guidance and assistance in their work with ethnic/cultural activities and groups. These partnerships have produced several joint trainings, conferences and other projects. Title V continues its leadership and commitment to support work with American Indians in Minnesota. The Title V Coordinator and other key Title V staff work closely with the MDH Tribal Health Liaison on planning for and attending quarterly Tribal Health Directors meetings, supporting internal department?wide meetings on American Indian health; traveling together on site visits to reservations; and providing information, resources and support for the American Indian Health Grants made directly to Tribes in Minnesota.

Tobacco Prevention and Control Program (TP&C) and Title V MCH Section staff continue to work together to address tobacco prevention among children and families in Minnesota, with a growing focus on smoking cessation for pregnant women. Staff from both sections partner in the Robert Wood Johnson/ ACOG/Planned Parenthood project.

Center for Health Statistics (CHS) staff work on numerous projects with Title V staff, including data analysis, data and systems planning, training and presentations, and consultation. While the Title V Coordinator is the Principal Investigator for PRAMS in Minnesota, the day-to-day administration takes place in CHS, and the PRAMS steering committee includes staff from both Divisions. Joint activities are underway include matching birth certificate information, newborn screening information, and the upcoming Birth Defects Information System (BDIS).

The Division of Environmental Health houses several program areas on which Title V has been and continues to be priority partners, including the BDIS, lead programs, and work on children's environmental health. The state Public Health Laboratory and Title V staff work in tandem on the newborn bloodspot and hearing screening programs in planning, administration, education and training, monitoring, evaluation and follow-up. Routine newborn screening meetings are held with management staff from both Divisions.

Ongoing relationships exist between Title V staff and several other program areas in MDH that generally enhance the work of both partners and frequently produce special short-term projects or activities. These areas include the immunization program, injury prevention, nutrition (outside of WIC), sexual violence prevention, STI / HIV prevention, and as described elsewhere, and the women's health team, ***/2007/ as well as the mental health team and adolescent health team //2007//*** convened and supported by Title V but drawing it's members from across the department.

INTER-AGENCY COORDINATION
Department of Human Services (DHS): The Title V programs and the Department of Human Services (the state's designated Title XIX and Title XXI agency) have a long history of collaboration framed by a formal interagency agreement. See Title V-Title XIX Interagency Memorandum of Understanding . Current collaborative efforts include the Family Service Collaboratives and the Children's Mental Health Collaboratives. DHS is represented on the MCH Advisory Task Force in an Ex-Officio status and Title V participates on the Medicaid Advisory Task Force. Numerous other activities are noted throughout this application. Formal contracts exist which provide DHS funding for staff in Title V programs relative to EPSDT, home visiting and services to deaf, hard of hearing, and deaf-blind individuals. Management and Executive Office staff of MDH and DHS meet on a quarterly basis to discuss issues of mutual interest and concern. Minnesota has several early childhood programs administered by DHS and representatives of these programs were involved in the MECCS grant (Minnesota's State Early Childhood Comprehensive Statewide Systems grant). Title V staff are important partners with DHS involved in the ABCD II grant, aimed at strengthening services and systems that support the healthy mental development of young children.

Department of Education The Title V program and the Department of Education (DOE) collaborate on many projects and programs: Family Service and Children's Mental Health Collaboratives, Part C, Early Childhood Screening, pregnancy prevention and abstinence education programs, Fitness Fever, Minnesota Healthy Beginnings, service coordination (for ages 3-21), third party billing, a children's advocate group, and a grant advisory board regarding children with special health care needs and child care. There is active collaboration between DOE and MDH on the Minnesota Student Survey, including Title V staff. In State Fiscal Year 2004, the CYSHCN program expanded its Interagency Agreement with MDE to include Part B as well as Part C (of IDEA) responsibilities.

The DOE is the lead agency in Minnesota for the Early Childhood Intervention Program (Part C); a joint initiative of three state agencies: (Health; Human Services; and Education) and local IEICs (Interagency Early Intervention Committees). Through an interagency agreement, the Department of Health receives funding for specific activities and staff within the CYSHCN program. As part of the Part C activities, staff actively participate on the mandated State Agency Committee (SAC) and the Governor appointed Interagency Coordinating Council (ICC). The Department of Health's Part C team provides outreach, information, training, and technical assistance on health related early childhood topics and issues to families; state, regional, and local health, education, and human service agencies; public and private providers and IEICs (Interagency Early Intervention Committees). The team has primary lead for public awareness/child find; ongoing technical support of the Follow Along Program (tracking system for identifying children at-risk); a statewide information and assistance line (central directory requirement); establishing and maintaining an interagency data system; and providing training and technical assistance on managed care issues, health benefits coordination, and outreach to health care providers on Minnesota's early childhood intervention system.

Department of Corrections: The Department of Corrections participates with MDH, DHS, and Minnesota Department of Education on children's mental health issues in the state. This relationship has been long standing and children's mental health issues provide avenues and linkages to address children's mental health issues in juvenile correction centers. Title V staff also collaborate with the Minnesota Department of Corrections on adolescent health issues

through the Interagency Adolescent Female Subcommittee (IAFS). This is a subcommittee of the Department of Correction's Advisory Task Force for Female Offenders in Corrections. The MCH Adolescent Health Coordinator is a member of the IAFS and provides the adolescent health perspective to its work, assuring gender-specific programming for girls in corrections.

Children's Mental Health Collaboratives: The primary focus for children's mental health in Minnesota is the development of a community-based, unified system of services for the child and family. The Comprehensive Children's Mental Health (CCMH) Act requires that counties provide a specified array of mental health services to children. The CCMH Act establishes guidelines for development of Children's Mental Health Collaboratives including integration of funds in order to use existing resources more efficiently minimize cost shifting and provide incentives for early identification and intervention. This focus on early identification and intervention gives increased importance to public health agency efforts and expands opportunities for coordination with other services. Local partnerships with social services, corrections, and education agencies create integrated systems that improve services to children with mental health problems and provide services for their families.

Family Service Collaboratives: Family services collaboratives were initiated in 1993 by the Minnesota legislature which mandated public health's involvement, recognizing the vital role public health plays in assessing and addressing the health of all mothers and children in communities and the state. Included in this initiative were collaboration grants to foster cooperation and help communities come together to improve results for Minnesota's children and families. By providing incentives for better coordination of services, Minnesota hoped to increase the number and percentage of babies and children who are healthy, children who come to school ready to learn, families able to provide a healthy and stable environment for their children and children who excel in basic academic skills. Recognizing that no single funding source alone is responsible for changing outcomes, a set of statewide core outcomes was distilled from the collaboratives' efforts. Promoted across systems in 1998, this list has been included in the work of the Family Support Minnesota formerly the STATES Initiative, the KIDS Data Project, and Minnesota Healthy Beginnings, among others. Many of these outcomes and their indicators align with the federal/state MCH performance measures; and many others offer future directions for development of measurement tools, in particular, those with the promotional perspectives of family support.

Coordinated System for Children with Disabilities Aged Three to 21 -- involving multiple state agencies: State law mandates a coordinated interagency system for children from three to 21 with disabilities, as defined by IDEA. CYSHCN staff have been actively involved with an 18 member State Interagency Committee made up of seven state agencies and other participants for oversight of this planning, as well as numerous workgroups creating the guidance for this system at both the state and community level.

University of Minnesota: Collaboration between the Title V programs and the University of Minnesota School of Public Health continues on various research, evaluation and training projects. The MCH program within the School of Public Health holds an Ex-Officio position on the Department's Maternal and Child Health Advisory Task Force. The Department's Title V program collaborates with the school's MCH program community education activities including presenting at its annual summer Institute. A number of MPH students have their internships in the Division of Community and Family Health, and several Title V program staff are graduates of the program. Faculty from the University have provided training and technical assistance to Title V staff through informal communications as well as some sessions--particularly as part of the building capacity activities underway over the past two years. The MCH Adolescent Health Program collaborates extensively with the University of Minnesota Konopka Institute for Best Practices in Adolescent Health, Division of General Pediatrics and Adolescent Health. This partnership focuses on building the capacity and skill of adolescent-focused programs across the state. MCH Reproductive Health staff collaborate with the National Teen Pregnancy Prevention staff at the University of Minnesota on numerous projects including the implementation of the state teen

pregnancy prevention and parenting plan. The CYSHCN program serves as mentors for each of the students in the University of Minnesota School of Nursing program emphasizing CYSHCN. In addition, CYSHCN program, the School of Public Health and the Center for Urban and Regional Advancement (CURA) of the Humphrey Institute (University) worked together to evaluate MCSHN Developmental Behavior Clinics. The University of Minnesota receiving status as an Academic Center of Excellence in Women's Health has brought opportunities for enhanced relationship and shared activities. This dual partnership has also extended to include the Community Center of Excellence at an urban Minneapolis clinic. MCH epidemiology staff from the University were helpful in planning, recruiting, and hiring for a new MCH Epidemiologist position at MDH.

F. Health Systems Capacity Indicators

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	24.9	25.9	28.4	33.6	
Numerator	896	858	973	1073	
Denominator	359623	331177	342137	319809	
Is the Data Provisional or Final?				Final	

Notes - 2005
The 2005 data are not yet available.

Narrative:
Information for this measure shows the rate of hospitalizations for asthma for children less than five years of age at a high in 2000, followed by a drop in 2001, then a continual inrease from 2001 to 2004. The denominator for children of this age has decreased, while hospitalizations have gone up. Further analysis of the data indicates that the asthma hospitaliation rates in this age group in Minneapolis and St. Paul have actually been decreasing over this same period. This is also the same period during which the Controlling Asthma in American Cities program has been running, targeting childen in these two communities. Additional data mining may help us discern what population is driving this increase and whether there are "pockets" of higher rates based on geographic location, insurance status, ethnicity, or socio-economic measures. From there some targeted strategies can be identified.

In 2002, the Department of Health along with various stakeholders completed a "Strategic Plan for Addressing Asthma in Minnesota." Supported by a grant from the CDC (amounting to $700,000 per year for five years) the Minnesota Department of Health was able in October of 2002 to begin to implement, with a wide range of partners, a comprehensive set of strategies identified in the strategic plan. Strategies include gathering better data about the prevalence of asthma; creating greater pubic awareness of asthma; providing asthma education to health professionals; and developing public policies to reduce exposure to environmental triggers of asthma. The goal of the plan is to reduce hospitalizations and emergency room visits due to asthma and to improve the lives of those who live with asthma. The work of the Asthma program while not child specific has a significant impact on children with asthma and the Title V programs will continue to work collaborative with the Asthma program.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	72.2	77.4	85.7	87.3	
Numerator		37954	47494	46819	
Denominator		49049	55420	53617	
Is the Data Provisional or Final?				Final	

Notes - 2005
The 2005 data are not yet available.

Notes - 2003
The large increase in the indicator is due, in part, to an increase in the number of children enrolled in Medicaid as well as a slightly different and more accurate way to analyze these data.

The new analysis includes infants in the denominator who were "age zero at ANY point during the year." In the past, some infants were missed because age was defined at the end of each month. Using this method, infants were lost if they had their 1st birthday in January of the year because they were age 1 as of the last day of that month, which overrode the fact that they were age zero for a few days in the year.

The numerator is higher for a similar reason. In the past, screenings during the year were counted only for those months in which the child was age zero at the end of the month. The new analysis counts screenings for kids who were age zero at any point in the year; even if they had moved into the age 1 category when the screening was rendered.

Narrative:
Title V staff from both MCH and CYSHCN programs work closely with staff from the Medicaid program (administered by the Department of Human Services) to support continual improvements in this measure. These partnerships have been successful in assuring that more Medicaid infants are being screened. MCH has an interagency contract to provide all the training for providers who implement Minnesota's EPSDT program, which is titled Child and Teen Check-up (C&TC). Trainings specific to administering C&TC are provided to health care providers, and include on-site follow-up consultations and clinic flow assessment. Information goes out routinely to local public health staff regarding their C&TC rates and gaps, so they can adjust their outreach strategies.

Regarding Medicaid eligibility and access in general, trainings are also provided to PHNs, school nurses, and county C&TC coordinators about the MA application process and forms, how to enhance outreach to public and private C&TC providers, and how to advise health professionals and families about medical care funding sources. CYSHCN staff provide regular trainings regarding program and resource availability and eligibility, including information regarding Medicaid and C&TC.

The Family Home Visiting program strongly encourages and supports appropriate childhood screenings with their families. From a broader perspective, there are two existing collaborative activities currently underway focusing on early childhood screening: the Minnesoeta Early Childhood Conmprehensive Screening (MECCS) grant, and BUILD, a multi-sector planning and advocacy group. Both are assessing needs and capacities, discussing, and making recommendations for policy and systems changes to improve child find, screening, assessment and intervention. Additionally, over this past year, as a new infrastructure was being developed for accountability and reporting from local public health as part of the Local Public Health Grant, two new outcome measures were created that are relevant to this HSCI: Increase the percentage of children ages 0-3 who are screened for developmental and social-emotional issues every 4-6 months; and increase the participation rate of Medicaid and MinnesotaCare enrolled

children aged 0 to 21 in the Child and Teen Check-Up Program.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	0	0	0	0	0
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final

Notes - 2005
No changes in MN SCHIP anticipated for 2005.

Notes - 2004
SCHIP eligibility in infants 0-2 is between 275% and 280% FPG.

Because of Minnesota Care eligibility to 275%, the numbers of children impacted by SCHIP eligibility is very small.

Notes - 2003
SCHIP eligibility in infants 0-2 is between 275% and 280% FPG.

Because of Minnesota Care eligibility to 275%, the numbers of children impacted by SCHIP eligibility is very small.

Narrative:
Because SCHIP eligibility in Minnesota only covers infants from 0 to 2 years, whose family incomes is between 275% and 280% FPG, there are very few children in Minnesota's SCHIP program, making this measure non-applicable. MinnesotaCare, Minnesota's state subsidized insurance program was in place prior to enactment of SCHIP and it's eligibility goes to 275% FPG.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	76.5	77.1	77.5	77.9	
Numerator	51453	52313	54180	54844	
Denominator	67259	67857	69880	70426	
Is the Data Provisional or Final?				Final	

Notes - 2005
The 2005 data are not yet available.

Narrative:
While the number of women giving birth has increased over the past several years, the Kotelchuck Index has kept pace and even improved slightly. When one digs deeper into the

numbers however, there continue to be disparities in prenatal care for women of other than White. Insurance rates for Hispanic women of child-bearing age, along with the growing number of undocumented immigrants, continues to present challenges for assuring adequate prenatal care. Title V staff work with our Office of Minority and Multi-Cultural Heatlh and local public health and community clinics, as well as with Twin Cities Healthy Start, to increase these rates. We are just now preparing our first PRAMS data book that includes information describing pregnancy experiences. We over-sampled American Indian and African American mothers during our first 3 years of the program and have found some interesting informaiton in our intiital analyses of that limited data. Due to budget issues, we have had to discontinue oversampling but are now working to find or create resources to reinstitute that.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	86.6	88.1	88.1	87.6	88.4
Numerator	310156	355851	355484	397000	403000
Denominator	358000	404000	403484	453000	456000
Is the Data Provisional or Final?				Final	Final

Notes - 2005
Denominator: 422,000 ever enrolled during FFY 2005 + 34,000 uninsured all year and potentially eligible for MA or MinnesotaCare (based on the 2004 survey) = 456,000

Narrative:
This indicator has remained relatively stable. New state efforts targeting preventive services for children will offer additional support to our efforts in this area. Please refer to narrative under HSCI #02 for more details on htese state initiatives.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	41.4	41.2	45.9	46.7	48.5
Numerator	26454	27107	32063	33479	35728
Denominator	63831	65746	69788	71681	73680
Is the Data Provisional or Final?				Final	Final

Narrative:
While this indicator has shown improvement over the last five years, it continues to be worrisome that a significant number of Medicaid enrolled children are not receiving appropriate preventive dental visits. Minnesota's Medicaid program provides a comprehensive dental benefit set for children. However, challenges continue in locating a provider, especially in rural Minnesota, that will either accept or take new Medicaid patients. Significant legislative attention has created a number of new initiatives designed to improve access to services. In addition the Medicaid program in partnership with the MDH Dental Health program has been working to develop a new dental delivery system. Minnesota was selected as one of thirteen state teams by the Center for Health Care Strategies to participate in developing innovative solutions to improving access to and the quality of oral health services. The MCH Bureau, State Oral Health Collaborative Systems grant allows us to enhance our efforts to improve the number of children who receive appropriate dental preventive care.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Indicator	0.0	0.0	0.0	0.0	
Numerator	0	0	0	0	
Denominator	7190	8726	9593	8471	
Is the Data Provisional or Final?				Final	

Notes - 2005
The 2005 data are not yet available.

Notes - 2004
Minnesota Medicaid covers rehabilitative services.

Notes - 2003
Minnesota Medicaid covers rehabilitative services.

Narrative:
Virtually all children and youth on SSI in Minnesota are eligible for Medicaid, which provides a comprehensive package of services, thereby negating the role of Title V CYSHCN program in providing rehabilitative services. Therefore, this number is zero. However, the CYSHCN program, while not providing direct services, does contact all families of children in Minnesota who applied for SSI to assure families receiving SSI know about eligility for Medical Assistance and if the child was not eligible for SSI what other options may be available to them. This is also an opportunity to answer general questions and assist families as needed.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2004	matching data files	7.7	6.1	6.6

Narrative:
LBW rates have increased comparatively for both Medicaid and non-Medicaid births. Once again, there are disparities in these populations based on race/ethnicity - and also for younger mothers. Because there are higher rates of women of color and teen moms in Medicaid, this higher rate for Medicaid mothers would be expected. Further data analysis should be done to determine if there are any additional unique indicators of risk within the data to which we have access. Please refer to HSI #01A-B, and HSI #02 A-B for additional details on increases in LBW in general.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2003	matching data files	5.3	4.3	4.6

Narrative:
Rates for infant death have decreased since 2003 for both the Medicaid population (down from 7.4 to 5.3) and for the non-Medicaid population (down from 5.3 to 4.3), with the Medicaid decrease being the larger of the two. Care must be exercised however, in interpreting these changes as the number of infant deaths is very small. Title V staff continue to work with the Office of Minority and Multicultural Health on reducing the disparities in infant mortality between Whites, American Indian, and populations of color by providing technical assistance and support to Eliminating Health Disparities grantees, and through the Save 10 public awareness campaign. Title V staff work closely with Twin Citiies Healthy Start, and also participate in the "Child Death Review Team with Department of Human Services staff to identify system issues which might influence outcomes.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2004	matching data files	75.3	91.6	86.4

Narrative:
Women on Medicaid continue to start prenatal care later than non-Medicaid women. However, the rate for 1st trimester prenatal care went up slightly for Medicaid women from 74.7 to 75.3 percent and for non-Medicaid women it decreased marginally from 91.8 to 91.6 percent. There is still a large gap between these two populations. As we develop a better data base from our PRAMS program, we can look at analyzing differing pregnancy experiences for MA and non-MA women, including start of prenatal care and reasons for delays.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity***	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2004	matching data files	69	79.7	76.2

Notes - 2007
Discrepency between the value entered for HSCI 05D "ALL" and the value provided for HSCI 04 is due to different data sources (matched vs. unmatched datasets).

Narrative:
Kotelchuck Index rates decreased more for Medicaid women (72.2 down to 69) than for non-Medicaid women (80 down to 79.7), further widening the gap between these two populations. Our new data analysis staff person, a joint position shared between DHS(Medicaid) and MDH (TItle V) should be able to help us delve more deeply into Medicaid and PRAMS data to look for any helpful information as to this decrease in particular and this issue in general. MCH is also in the process of hiring a new staff person in a position with a stronger focus on pre-conception and planned pregnancies. This will provide greater resources and greater focus on prenatal issues.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2005	275
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2005	280

Narrative:
Because Minnesota Care eligibility goes up to 275%, and SCHIP eligibility in Minnesota covers infants from 0 to 2 years between 275% and 280% FPG, there are very few children in Minnesota's SCHIP program, making this measure non-applicable. There were no changes in eligibility this past year.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 2) (Age range 2 to 18) (Age range 19 to 20)	2005	 275 150 100

INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 2) (Age range to) (Age range to)	2005	280

Narrative:
Because Minnesota Care eligibility goes up to 275%, and SCHIP eligibility in Minnesota covers infants from 0 to 2 years between 275% and 280% FPG, there are very few children in Minnesota's SCHIP program, making this measure non-applicable. There were no changes in eligibility this past year.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2005	275
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2005	275

Narrative:
Because SCHIP eligibility in Minnesota only covers infants from 0 to 2 years, whose families income is between 275% and 280% FPG, there are very few children and no pregnant women in Minnesota's SCHIP program, making this measure non-applicable. There were no changes in eligibility this past year. Minnesota's subsidized insurance program, MinnesotaCare, was in place prior to enactment of SCHIP and eligibility goes up to 275% FPG

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	No
Annual linkage of birth	1	No

certificates and WIC eligibility files		
Annual linkage of birth certificates and newborn screening files	3	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2007
Discussions are planned with WIC for the current year to explore the potential for establishing this linkage as part of the SSDI Program.

BDIS is in its formative stage. Our MCH epidemiologist is very actively involved in this activity area and data will be directly available to the MCH Program in the coming years.

Narrative:
With the establishment of a focused MCH data/epi team of 3 staff, our capacity in this area continues to improve. Through the SSDI grant activities, relationships with WIC are becoming more productive and linkages with and access to WIC data are under discussion. The MCHB Data Integeration continues to provide MCH leadership for data linkages between newborn bloodspot and hearing screening, vital records, and is working also with immunizations and lead screening. The data/epi staff are actively involved in work on BDIS, FAS, Follow Along Program, PRAMS, oral health data, and the beginning development of planning activities considering enhanced interoperability of child health information systems - both within MDH and longer term with external partners. Shared data positions between Title V and Medicaid has significantly improved Title V access to Medicaid data, and further enhanced the partnership between these two agencies around Title V issue and program areas.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	**Does your state participate in the YRBS survey? (Select 1 - 3)**	**Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)**
Youth Risk Behavior Survey (YRBS)	1	No
MN Student Survey	3	Yes

Notes - 2007

Narrative:
The Minnesota Student Survey is administered every 3 years to 6th, 9th, and 12 th graders. In response to the question regarding cigarette smoking in the 2004 survey, data indicates a continued downward trend across all 3 age groups. After increasing in the early 1990's, the

smoking rates amont 12th graders dropped from 42.1% in 1998 to 22.6% in 2004. The 6th and 9th grade reported smoking rates have declined for 6th graders from 7.0% in 1998 to 2.6% in 2004 and among 9th graders from 29.9% in 1998 to 14.7% in 2004. These are the lowest smoking rates ever reported in the history of the Minnesota Student Survey, althought more than a quarter of the 12th graders (26.6%) still reported smoking cigarettes in the past month. The student survey will again be administered in the spring of 2007.

MDH continues to administer grants to community organizations to develop and implement strategies for achieving tobacco-free environments, implementing comprehensive school-based tobacco prevention programs,and reducing youth access to toacco in Minnesota communities. The grant funds target youth ages 12 - 17 years who are at risk of initiating tobacco use.

IV. Priorities, Performance and Program Activities

A. Background and Overview

/2007/ The 2005 needs assessment identified ten new state priorities. The MCH Advisory Task Force over the last year has worked to identify specific strategies to effectively move Minnesota forward in attaining our annual performance objectives. These recommendations covering all three of the MCH populations will be submitted to the Commissioner of Health this fall for consideration. Both Title V programs have begun the important work of incorporating the priorities into their daily work as noted in the discussion of National and State Performance Measures, their Activity Tables and in other areas of this application.

Minnesota's priorities are broad-based and encompass significant maternal and child health, including children with special health care needs, issues. The ability to impact these priorities will require close partnerships be maintained with local public health, other state agencies, such as the Department of Human Services (the designated Medicaid and Mental Health Authority) and the Department of Education (lead agency for Part C), with advocacy organizations such as PACER and the Minnesota Organization for Adolescent Pregnancy Prevention and Parenting, with professional organizations such as the Minnesota Dental Association, AAP Minnesota Chapter, and ACOG, as well as other areas in the Department of Health such as the Office of Minority and Multicultural Health. As detailed in other areas of the application these relationships have been established and there is a long history of working together for common goals.

The following measures either met or exceeded the target, based on the most recent data available:

* ***NPM 1 -- newborn blood spot screening***
* ***NPM 17 -- VLBW births at high-risk facilities***
* ***OM 3 -- neonatal mortality rate***

Improvement was made on the following performance measures, although the target was not met:

* ***NPM 7 -- immunization rates***
* ***NPM 9 -- third graders with a dental sealant on at least one molar***
* ***NPM 10 -- motor vehicle accidents of children 14 years or younger***
* ***NPM 12 -- newborn hearing screening***
* ***OM 4 -- post-neonatal mortality rates***

Measures were maintained, but the target was not met on these following measures:

* ***NPM 16 -- youth suicide***
* ***NPM 18 -- infants born to mothers receiving care in first trimester***
* ***OM 1 -- infant mortality rate***
* ***OM 6 -- child death rates***

Measures that worsened and will require further focused effort or data analysis:

* ***NPM 8 -- teen pregnancy prevention***
* ***NPM 13 -- children without health insurance***
* ***OM 2 -- black to whit ratio of infant mortality***
* ***OM 5 -- perinatal mortality rates***

The remaining measures are either based on SLAITS for children with special health needs or are new measures and as such have no new comparison data. //2007//

The state performance measures reported on in this section A are the closing out of those measures from the last 5 year reporting cycle. New state priorities and performance measures

have been developed out of the 2005 Needs Assessment process and information on those is provided in section B below. The (grid) below provides a comparison of Minnesota's state performance measures for the last 5 year cycle and the next 5 year cycle.

The following performance measures either met or exceeded the target, based on the most recent data available:

- NPM1 -- newborn blood spot screening
- NPM8 -- teen pregnancy rates
- SPM1 -- enrollment of birth to three year olds in the Follow-Along screening program
- SPM4 -- child abuse and neglect rates
- SPM6 -- alcohol, tobacco and drug use during pregnancy
- SPM9 -- out of home placement for CSHN
- SPM10 -- CSHN with an Individualized Interagency Intervention Plan
- OM1 -- infant mortality rate
- OM2 -- black to white ratio of infant mortality
- OM3 -- neonatal mortality rate

Improvement was made on the following performance measures, although the target was not met:

- NPM7 -- immunization rates
- NPM9 -- third graders with a dental sealant on at least one molar
- NPM10 -- motor vehicle accidents of children 14 years or younger
- NPM12 -- newborn hearing screening
- NPM15 -- VLBW
- NPM18 --infants born to mothers receiving prenatal care in first trimester
- SPM2 -- insured children receiving standard comprehensive health visits
- SPM3 -- injury incidence for all MCH populations
- OM4 -- postneonatal mortality rates
- OM5 -- perinatal mortality rates
- OM6 -- child death rates

Measures were maintained, but the target was not met on these following measures:

- NPM13 -- children without health insurance
- SPM5 -- rates of unintended pregnancies

Measures that worsened and will require further focused effort:

- NPM11 -- breastfeeding at hospital discharge
- NPM16 -- youth suicide
- NPM14 -- Medicaid-eligible children that received a service
- NPM17 -- VLBW births at high-risk facilities

These following measures are based on the SLAITS for children with special health needs, so have no new data available:

- NPM2 -- families partnering in decision making at all levels
- NPM3 -- medical home
- NPM4 -- adequate public and/or private insurance
- NPM5 -- services being organized for easy use
- NPM6 - youth receiving services necessary for transition

B. State Priorities

This section describes the relationships between the new state priorities from the recently completed 2005 needs assessment and several measures: the national performance and outcome measures, Health System Capacity Indicators, Health Status Indicators, Minnesota's state priorities from the previous 5 year cycle, and some of the statewide outcomes for

Minnesota's developing Local Public Health Grant (LPHG) activities. These LPHG statewide outcome measures are newly developed and work is currently underway to establish the reporting system through which these measures will be reported by local public health agencies to MDH. These priorities are in no particular order.

Priority 1 -- Improve early identification of and intervention for CYSHCN -- birth to three years. Early identification, screening and referral systems identify children's strengths as well as their needs. These systems can maximize healthy child development and minimize adverse health, social and emotional incidents. Universal screening of all children, birth to age three--regardless of perceived risk factors--promotes thorough identification of those with special health care needs and subsequent provision of intervention services to children who are eligible under Part C of Individuals with Disabilities Education Act (IDEA). This priority is related to NPM 1 - newborn screening, NPM3 - medical home, NPM5 -- services being organized for easy use, NPM12 -- newborn hearing screening, HSCI #2 & 3 children on Medicaid and MinnesotaCare who received at least one initial or periodic screening, and the new statewide outcome for essential local public health activity #19 -- Increase the percentage of children ages birth-3 who are screened for developmental and social emotional issues every 4-6 months. This state priority is essentially the same as the priority from the last 5 year cycle to assure early identification and intervention for young children.

Priority 2 -- Assure that children and adolescents receive comprehensive health care, including well child care, immunizations, and dental health care. Well-child care reduces long-term costs by encompassing a variety of health promoting/disease preventing services and by providing opportunities to detect and treat health conditions early. Within the Medicaid population, as in the entire population of children and adolescents in Minnesota, incidence of chronic disease is growing - particularly childhood obesity, diabetes, asthma, mental health disorders, and injuries. Prevention and health education services, and early detection and treatment may assist in reversing this trend. This state priority is related to NPM 1 -- newborn screening, NPM 4 -- adequate insurance, NPM 7 -- immunizations, NPM 9 -- 3rd graders with protective sealant on molar, NPM 12 -- newborn hearing screening, NPM 13 -- children without insurance, NPM 14 -- BMI index at or above 85th percentile, HSCI#1 -- asthma hospitalizations, HSCI#2 -- MA enrollees receiving at least one initial or periodic screen, HSCI#6 -- FPL eligibility for MA, HSCI #7B -- EPSDT children receiving dental service, and the new statewide outcome for essential local public health activity #24 increase the percentage of 2 year olds that have been age appropriately immunized.

Priority 3 -- Prevent teen pregnancy and sexually transmitted infections. Teen pregnancy has been steadily decreasing in recent years but has reached a plateau in Minnesota, while STIs have continued to increase among females and among adolescents and young adults, with significant disparities among some racial/ethnic groups. If undetected and untreated, these STIs can lead to other severe health issues and possibly infertility. This priority is related to NPM8 -- teen birth rate, HSI#05a Chlamydia rate for females 15 to 19, and the new statewide outcome for essential local public health activity #13 decrease the rate of births/pregnancies to adolescents ages 15-17.

Priority 4 -- Prevent child abuse and neglect. Child maltreatment is among the most prevalent and far-reaching forms of violence in Minnesota. All four maltreatment types (neglect, physical abuse, sexual abuse, mental/emotional injury) are represented here. Further, child and adolescent maltreatment often precedes adult violence and substance misuse/addiction as the abused child grows older. This is a repeated state priority from the last 5 year cycle and is related to the new statewide outcome for essential local public health activity #21 - reduce the rate of maltreatment and sexual abuse of children ages birth to 17 years olds.

Priority 5 -- Promote planned pregnancies and child spacing. Pregnancies which are intended and/or planned will likely result in improved health outcomes, lower occurrence of perinatal/postpartum depression, fewer abortions, decreased child maltreatment and other

negative outcomes for pregnant women, infants and children. Access to family planning is critical to achieve this goal. This priority is a repeat from the last 5 year cycle and is related to NPM8 - teen birth rates, NPM 18 - early prenatal care, HSI#1 -- low birth weight births, and is related to the new statewide outcome for essential local public health activity #13 decrease the rate of births/pregnancies to adolescents ages 15-17.

Priority 6 -- Assure early and adequate prenatal care. Minnesota records approximately 70,000 births annually with an estimated 1.1 million women of childbearing age. The percent of women who met the Kotelchuck Index has been increasing slowly and for 2003 is at 77.5 percent. Women with late or no prenatal care are unlikely to receive the services that promote early identification of problems and the healthiest birth outcome possible. There are continuing racial/cultural and economic disparities in rates of adequate prenatal care. This priority is related to several other measures of prenatal care -- NPM18, HSCI#4, HSCI#5; to 5 of the 6 outcome measures related to infant mortality, as well as HSCI#05b re: infant mortality for MA and non-MA; to birth weights -- NPM 15, HSCI#5, HSI#1, HSI#2; and is related to the new statewide outcome for essential local public health activity #32 early and adequate prenatal care.

Priority 7 -- Promote mental health for children and adolescents, including suicide prevention. Mental disorders were the sixth leading cause of emergency room visits among 5-19 year olds in Minnesota and the leading cause of hospitalization for 5-14 year olds in 2001. From 1998-2002 suicide was the third and second leading cause of death for 10-14 year olds and 15-19 year olds, respectively. Disparities exist within some racial and cultural populations. This priority is related to NPM 16 -- suicide deaths among youth ages 15-19, and to several of the new statewide outcome for essential local public health activities: #14 -- reduce the rates of suicide; #15 -- reduce the rate of hospital-treated self-inflicted injuries; #16 -- increase the screening for mental health needs for children, adolescents, and children with special health needs; #18 -- increase the percentage of children birth to 3 who are screened for mental health and social emotional issues every 4 to 6 months.

Priority 8 -- Eliminate racial and ethnic health disparities impacting mothers and infants. There are substantial health disparities for pregnant women, mothers and infants in Minnesota. Many of these disparities are masked by the excellent health outcomes and very high proportion of our white population. Health disparities exist in birth weight outcomes, infant mortality, neonatal and perinatal mortality, maternal mortality, insurance status, adequacy of prenatal care, and numerous social and economic conditions that affect health. This priority is related to OM #2 -- ratio of black to white infant mortality, HSI#08 -- deaths of infants and children by racial subgroup, and to the new statewide outcome for essential local public health activity #1 increase the number of community health boards that assess disparities and social conditions that underlie health and address them in their action plans.

Priority 9 -- Improve access to care of children and youth with special health needs (including medical home, specialty care and services, oral health and that services are organized for easy use). CYSHCN often have multiple disabilities and service needs cutting across several areas. Thus it is critical to have access to a variety of specialized services, as well as oral health care. Of those children in Minnesota who needed specialty services in 2001, nearly 23,000 (14%) had one or more unmet needs, placing MN last in the Upper Midwest in meeting specialized service needs for CYSHCN. This priority is related to NPM 3 -- medical home, NPM 4 -- adequate insurance, NPM 5 -- families reporting community-based service systems are organized so they can use them easily, NPM 6 -- services to support transition, NPM 9 -- 3rd graders with sealant on molar, NPM 13 -- children without health insurance, HSI#9 -- state health program enrollment, HSCI#1 -- asthma hospitalizations, HSCI#2 -- MA enrollees receiving at least one initial or periodic screen, HSCI#6 -- FPL eligibility for MA, HSCI#7 -- EPSDT children receiving dental service, and new statewide outcomes for essential local public health activities #33 -- families partnering in decision-making, #34 - families reporting organized services systems, and #35 -- increase clients enrolled in health insurance programs.

Priority 10 -- Improve access to comprehensive mental health screening, evaluation, and treatment of CYSHCN. Anxiety, depression (including suicidal thoughts) and other mental disorders often occur among CYSHCN. In addition, CYSHCN are highly vulnerable to maltreatment, including neglect and physical, sexual, and mental abuse. Early identification of and intervention for mental health issues are critical in this population. Having health insurance can influence access to mental health services thereby creating a relationship between this priority and all the insurance measures: NPM 4 -- CYSHCN with adequate insurance, NPM 13 -- children without insurance, HSCI#6 -- FPL eligibility for MA, and HSI#9 -- state program enrollment. This priority also relates to NPM 16 -- youth suicide deaths, HSI#3 -- deaths due to injury, HSI#4 -- nonfatal injury, and to the new statewide outcomes for essential local public health activities #14 suicide rates, #15 hospital treated self-inflicted injuries, #16 increase the screening for mental health needs for adolescents, children with special health needs and pregnant and postpartum women, and #35 -- increase the number of clients who are enrolled in health insurance programs.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	98.5	99.7	100.0	100.0	
Numerator	65618	67839	81	74	
Denominator	66617	68034	81	74	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	100	100	100	100	100

Notes - 2005
2005 data not yet available.

Notes - 2003
The sharp reduction in the numerator and denominator is due to a change in the way this indicator is reported. Instead of the number of newborns screened the denominator now represents the number of newborns confirmed for at least one condition. The numerator represents the number of confirmed cases that received appropriate follow-up.

a. Last Year's Accomplishments
The percentage of newborns screened has remained stable at an estimated 99% since 1996. Timely follow-up of infants screened to definitive diagnosis, as reported since 2003, is 100%. The newborn screening fee remained $61.00 per infant. Pursuant to the revised 2003 state statute, the Minnesota Department of Health Newborn Screening Advisory Committee was formalized and met in April, 2004. All newborns must be screened for phenylketonuria (PKU), congenital hypothyroidism, congenital adrenal hyperplasia, galactosemia, and hemoglobinopathies. The Newborn Metabolic Screening Program tests samples taken from newborns, notifies primary physician of positive test results, tracks the results of confirmatory testing and diagnosis and links families with appropriate resources. This program is operated as a partnership of Community and Family Health Division and the Public Health Laboratory Division.

Major activities which began in 2004 include 1) adding biotinidase deficiency to the newborn screening mandated panel. Related activities encompassed obtaining approval, developing

laboratory methods and expertise, creating educational materials, providing outreach to the community, involving the pediatric metabolic specialists to build capacity, develop clinical response plans and treatment protocols for this added test. 2) Finalizing a contract with Mayo Medical Laboratories for transfer of the MS/MS component of the screening panel (amino acid, organic acid, fatty acid oxidation disorders) from MDH to Mayo in addition to a second tier test for congenital adrenal hyperplasia was a major initiative. New procedures and methods of communication were implemented. 3) UPS specimen pick up was implemented statewide. 4) Education, technical assistance and outreach to approximately 80 hospitals accounting for 90% of the births in Minnesota was accomplished through consultative site visits by genetic counselors and follow up staff.

The newborn screening fee increase and support through the MCHB/HRSA cooperative agreement provided for program and data coordination, an increase in administrative support, IT, and follow up program staff resulting in improved notification and tracking for abnormal newborn screens, development of provider and consumer education materials and increased collaboration between the blood spot and hearing programs within the Minnesota Department of Health.

A pediatric nurse practitioner and newborn screening follow up staff facilitated enhanced care coordination and services for infants found by newborn bloodspot and hearing screening and their families. Resources available for families included pediatric specialists, genetic counseling, high-risk public health follow up programs, early education, WIC, and financial programs such as Medical Assistance, Minnesota Care and others.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide newborn testing as recommended by the State Newborn Screening Advisory Committee.	X			
2. Expand follow-up activities to identified infants & their families for all NBS tests.	X	X	X	X
3. Refine lab procedures for reducing false positive/negative test results.	X	X	X	
4. Expand educational materials & activities to include all disorders identified by NBS bloodspot and early hearing detection and intervention.	X	X		
5. Refine integrating data collection, infant follow-up & tracking, and program outreach with hearing screening program.	X	X	X	X
6. Link identified infants & their families to community resources & a medical home	X	X		X
7. Support primary care providers, comprehensive centers and systems that care for infants and children with rare disorders.	X			X
8. Continue active participation on the Newborn Screening Advisory Committee.				X
9. Implement linking blood spot and hearing data with birth/death certificates			X	X
10. Develop and implement an evaluation plan for program initiatives.				X

b. Current Activities

1) Screening for biotinidase deficiency began for all infants in Minnesota; ongoing evaluation of the process and implementation continues for this disorder. 2) Now that the Mayo Medical Laboratory contract is in place to screen amino acid, organic acid, and fatty acid oxidation disorders cases are reviewed weekly between Mayo, University of Minnesota Pediatric Metabolic

Clinic staff and Minnesota Department of Health newborn screening lab and follow up staff in order to assure optimal diagnosis, treatment and referral for infants and their families. 3) The realization of a long time goal for data linkage between birth/death records and newborn screening has been made possible in large part because of efforts related to one of the priorities in the MCHB/HRSA cooperative agreement. Policies and procedures to locate and follow up on infants who "missed" having a newborn screen are being developed. 4) Infants with endocrine, hemoglobinopathies, metabolic and hearing disorders found on newborn screening and their families are offered care coordination and referral to a variety of financial, support, educational, community resources. Methods to integrate coordination activities into the newborn screening system more fully and to evaluate the impact of these activities are being developed. 5) Staff are participating with the University of Minnesota pediatric endocrine department in the development of a new multidisciplinary clinic to serve children who have congenital adrenal hyperplasia and their families. 6) Minnesota is developing a new newborn screening brochure.

The Minnesota MCH Bureau State Genetics Implementation Grant, supports enhancing, expanding and integrating current activities around both newborn blood spot and hearing screening programs. The state also has a newborn screening data and program integration grant from HRSA/MCHB.

c. Plan for the Coming Year

An initiative is underway to add Cystic Fibrosis and hearing screening to the Minnesota newborn screening blood spot panel. Building capacity to accomplish this will be a focus of activity including exploring lab fee increase to support screening and follow-up efforts. Other areas of emphasis will be: 1) improving repeat tracking, improving documentation in the data base, and linking birth certificates with newborn screening. 2) strengthening the education component with the medical home provider when presumptive positives are identified; 3) expanding outreach, education and technical assistance activities related to newborn screening especially hospital neonatal intensive care units and prenatal providers 4) exploring an expansion of the Mayo partnership in areas of screening, clinical protocols and research applications; 5) improving hemoglobinopathy communications and support; 6) developing screening brochures in multiple languages; 7) revising the "bloodspot card" to meet program needs; 8) Consider the role of the newborn screening program in trait counseling for hemoglobinopathies and cystic fibrosis.

Support from the data and program integration grant, will enhance efforts to improve systems and data linkages among programs. Efforts will continue to strengthen relationships with statewide population-based programs such as MCSHN, Universal Hearing Screening Program, high risk Follow Up Programs, and early education. The Newborn Screening Advisory Committee, which includes Title V staff, will maintain a key role in identifying future program directions and priorities.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			59.1	59.1	63
Annual Indicator		59.1	59.1	59.1	59.1
Numerator			97156	90893	
Denominator			164329	153795	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**

Annual Performance Objective	63	63	63	63	63

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2004. The survey will be administered again in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2004.

Notes - 2003
Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2003. The survey will be administered again in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2003.

a. Last Year's Accomplishments
There were four areas of either direct parental involvement or support for parental involvement during the report year. The first area includes the formation of medical home teams, which were first formed in early 2004. Each team is comprised of a pediatrician, care coordinator and two parents. Medical home teams met twice during the report year and once during the current year using the collaborative learning model advanced by NICHQ (see NPM#3 for more detail). Consultation for, and education of, parent members of the medical home teams continued through the end of 2004 and into 2005 through collaborative learning sessions held in January and September of 2005; as well as through support for an extranet designed for medical home teams. PACER Center and its Family and Health Advocacy Center is also contracted with for consultation and education for parent members of medical home teams.

The state Family Voices representative was a member of a small group of individuals that had been acting as the overall steering committee for medical home activities. This group formed the nucleus of a similar group for the New Freedom Initiative (NFI) grant awarded by the Bureau in late April of 2005.

The second area entails activities dedicated to the MnSIC/III-P process (see NPM#5). The state CYSHCN director is a member of the policy-making body governing this process and has continued to advocate for the inclusion of parents (which would require legislative action) on this body. The third area includes the Family Voices presence in the state. The coordinator of Family Voices became a member of the statewide Maternal and Child Health Advisory Task Force at the beginning of the report year. This task force is a standing task force appointed by the Minnesota Commissioner of Health to advise the commissioner on al maternal and child health issues including issues affecting CYSHCN.

A fourth area is inclusion of parents and advocacy groups in a number of activities. For example, parents and advocacy groups were actively involved in the MCH Block Grant 5-year needs assessment process that took place in early 2005 and which is described elsewhere in this application. A series of forums on the III-P concept, product and process (see NPM#5) were held over late 2004 and early 2005 to identify issues, barriers, problems and resolutions. Three forums were held with special education teachers, county social service personnel and local public health representatives. One forum was held for parent advocacy groups and one forum for all groups. The CYSHCN director played a leadership role in conducting these forums and is providing continued support for a strategy of involving more parents in this process through

sustained outreach to local IEICs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Update MAZE training materials to reflect legislative, policy and procedural changes to programs.				X
2. Continue to partner with PACER Center, Inc., in reaching parents as a MAZE audience	X		X	X
3. Continue work with parent consultants to the CYSHCN program				X
4. Support medical home teams and their parent-members through Title V resources		X		
5. Apply lessons learned about family involvement from medical home collaborative activities to the Development and Behavior Clinics	X			X
6. Provide financial recognition of parent time on medical home and other activities pursuant to the New Freedom Initiative grant		X		
7. Revise (as necessary) fact sheets for parents on genetic conditions of infants identified through the state's birth defects information system			X	X
8. Advocate parent membership on the State Interagency Committee (SIC) of the Minnesota System of Interagency Coordination (MnSIC)			X	X
9. Support outreach activities of the MnSIC process to parents on Interagency Coordinating Committee				X
10. Continue leadership in the Part C program and support of parents on both the ICC and the IEICs		X		X

b. Current Activities

MAZE training materials were updated after the 2005 Legislature adjourned. Presentation targeted to parents on eligibility and coverage of state programs, including Medicaid, MinnesotaCare, Home and Community-Based waivers continue to be given. The Family Voices coordinator resigned her position at PACER Center in January of 2006 to join the CYSHCN program as coordinator of the New Freedom Initiative (NFI) grant. She continues to be a co-coordinator of Family Voices in Minnesota. Her successor at PACER Center is the other Family Voices co-coordinator, has joined the steering committee for the NFI grant and has recently been appointed to the MCH Advisory Task Force. Parent partners of local medical home teams are active members of their respective teams and help develop and implement the team's ongoing improvement plan. Parents are able to partner in decision-making at the clinic level and are able to design and evaluate services that meet the needs of families and children through this model.

The NFI grant helped to provide resources for a Parent Leadership Summit for families of CYSHCN held in April of 2006. It was facilitated by PACER Center. The summit was organized by a planning committee of parents and its purpose was to help families become more effective system leaders in their participation on mandated and non-mandated boards, task forces and advisory committees in the health, education and social services systems. Presentations included: a keynote address by Polly Arango on family leadership, how to effectively tell your family's story, how to facilitate meetings and how to develop your leadership style. The day included a discussion on what families identify as systems issues within the health, human services, and education systems.

Financial support and partnership is provided to the Family-to-Family Health Information Center

and Family Voices of Minnesota located at PACER Center. This contract provides the resources for PACER representatives to serve on the NFI grant leadership team, provide support and coordination to medical home parent partners including compensation for time, assistance in the planning and implementation of the Family Leadership Summit, facilitation of a Parent Council to provide ongoing feedback to MCSHN programs and staff, and provide for active family involvement on work groups for the NFI grant.

Two medical home learning sessions were conducted. Parents are included as presenters sharing their expertise and experience. Presentations have included the following topics: The role of parents on Medical Home Teams; Family-Centered Care; Using Care Plans Effectively; and The Importance of Parent Networking.

c. Plan for the Coming Year

Three basic concepts define the approach that the CYSHCN program takes in its overall strategic and operational program decisions. First, its mission statement focuses on "Provid(ing) leadership through partnerships with families and other key stakeholders to improve access and quality of all systems impacting CYSHCN and their families." Second, the program continues to explore means to integrate the six MCH Bureau performance measures impacting CYSHCN as a whole in order to improve systems. And third is the concept of explaining family-centered care and implementing that concept in program activities.

The emphasis on quality has led to an extremely close working relationship with both the state AAP chapter and PACER Center (a nationally known family advocacy organization). The CYSHCN program will work with the state chapter on the AAP program -- Partners for Quality -- and the chapter's embryonic Minnesota Child Health Leadership Consortium and will ensure parental involvement in both.

The New Freedom Initiative grant will provide the resources to continue collaborative learning sessions and parent involvement on the medical home teams. One of the work activities in the grant is to host an annual family summit and a one-time youth summit. MAZE trainings will continue.

Staff will continue to work with parent advocacy groups for co-sponsorship of MAZE trainings targeted for parents. The program will continue to support inclusion of parents on the governing body of the MnSIC III-P activity (see NPM#5) and it will continue to support outreach to parent members of local IEICs as a strategy to build parent knowledge and information about the III-P concept, product and process. The CYSCHN program will continue collaboration in the operation of the Part C program of IDEA with the Departments of Education and Human Services through an interagency agreement. This agreement supports the maintenance of the Part C program in Minnesota including CYSHCN membership on the Interagency Coordinating Committee (ICC) and technical consultation by Title V MCSHN staff to the 96 local Interagency Early intervention Committees (IEICs) throughout the state.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			48.7	48.7	53.6
Annual Indicator		48.7	48.7	48.7	48.7
Numerator			80059	74898	

Denominator			164392	153795	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	53.6	53.6	54	54	54

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2004. The survey will be administered again in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2004.

Notes - 2003
Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2003. The survey will be administered again in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2003.

a. Last Year's Accomplishments
The state began active implementation of its MCH Bureau Medical Home Grant in 2004 when it adopted the medical home collaborative learning model promoted by the National Initiative for Children's Healthcare Quality (NICHQ). Eleven teams were formed from clinical practices throughout the state with each team comprised of a pediatrician, a care coordinator, and two parents. Two Learning Sessions were held in 2004. In federal fiscal year 2005, five additional teams were recruited for participation.

Two Learning Sessions were held in 2005. The January session focused on the concept of medical home, issues of spread, parent role, cultural and linguistic competence, community outreach and the Medical Home Index tool. The September 2005 session focused on the Chronic Care Model, care coordination, data collection, specialist-primary care practitioner interaction and transition.

Significant gains in Medical Home Index scores were realized after the first year of participation. Major efforts at integrating mental health and transition topics into the learning session curricula were also made. The state's Director of Children's Mental Health Services is an active participant in the learning sessions.

In early 2005, staff participated in the second national medical home collaborative. The national collaborative presented opportunities to work more closely with state Medicaid officials to discuss financing and reimbursement issues. Minnesota formed four teams: a state-level team and three practice teams. One team practices in a tertiary care institution in Minneapolis, the second team practices in a large regional city (St. Cloud), and the third team is from a medium-sized town (New Ulm) in rural Minnesota. These teams also attended the second learning session in Washington, D.C. later that fall.

The Minnesota Medical Association (MMA) released a report of its Health Care Reform Task Force in January of 2005. The report, entitled Physicians' Plan for a Healthy Minnesota: The MMA's Proposal for Health Care Reform, makes a series of recommendations to increase the effectiveness of care. One of these recommendations is to "support a medical home for every adult and child in Minnesota…" and goes on to suggest that the MMA work to educate patients and payers about the concept. There are increasing opportunities for promotion of medical home

because of this statement. MDH was awarded a President's New Freedom Initiative grant by the MCH Bureau in April of 2005. This funding permits efforts to integrate activities toward achieving the six core outcomes and the state priorities within the context of the medical home quality improvement learning collaborative.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop strategies for spread and sustainability				X
2. Link information material about medical home to families of infants identified in newborn screening programs			X	X
3. Link information material about medical home to families of infants identified through the Birth Defects Information system.			X	X
4. Continue to partner with the state chapter of the AAP.				X
5. Explore reimbursement strategies for medical home with state Medicaid officials.				X
6. Continue efforts at integration of mental health services with medical home activities.	X		X	X
7. Promote concept of medical home through education of local public health personnel.				X
8. Pursue curricula development about medical home with appropriate university programs.				X
9. Update written material about medical home used by CYSHCN program.				X
10. Work with state medical association, as it promotes medical home.				X

b. Current Activities

President's New Freedom Initiative grant helped to fund learning sessions held in January and April of 2006. The January session focused on the Model for Improvement, parent partnerships, the Chronic Care Model, emotional and behavioral health of CYSHCN, financial resources for CYSHCN and mentoring of new teams by veteran teams. The April 2006 session focused on the Model for Improvement, parent partnerships, care plans and care coordination, data collection and remarks by Dr. C. Homer of NICHQ.

There are now a total of 18 practice teams working on creating medical homes for their CYSHCN. Several articles about the Minnesota experience have been written and included in the state AAP chapter's newsletters and several presentations made to internal and external audiences about the state's medical home activities. Senior state Medicaid officials have been briefed on the concept and activities pursuant to the Bureau's grants. Medical Home practices have been highlighted in their respective local communities through various media such as newspaper articles and radio shows. CYSCHN staff continue to support medical home activities in their communities -- often facilitating team meetings or parent groups.

Many CYSHCN living in west-central and northwestern Minnesota receive care in North Dakota or from Minnesota-based clinics owned by MeritCare or Altru, which are North Dakota based health systems. Consequently, there has been active outreach to the North Dakota Title V-CYSHCN program and its leaders have attended the last two learning sessions. In early 2006 an interagency agreement was signed between the Minnesota Department of Health and the Minnesota Department of Human Services (DHS) permitting the use of MDH funds to support a research position at DHS in order to analyze Medicaid claims and encounter data of interest to the Title V programs. The first area of work pursuant to this agreement will be to design a methodology to analyze data to document whether cost savings accrue to the Medicaid system

through the use of care coordination. This documentation will be used to help justify reimbursement of medical home type activities.

With the encouragement of the CYSHCN program, the New Ulm medical home team indicated its interest in participating in the AAP's "Developmental Surveillance and Screening Policy and Implementation Project" or D-PIP. It was one of 15 sites nationwide to be selected to participate in this national pilot study.

c. Plan for the Coming Year

The MCSHN program will continue medical home activities through funding from the President's New Freedom Initiative grant. Current work will continue with an emphasis on recruiting new practice teams into the learning collaborative, supporting current teams, evaluating the impact of having a medical home on children, their families and payers. This will include learning sessions, continued support in building the infrastructure of the state AAP chapter and continued partnership with the state chapter in quality improvement initiatives such as the recently created Pediatric Quality Consortium. It also will entail collaborating with DHS to continue the analyses of Medicaid data to document savings from care coordination.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			68.8	68.8	70
Annual Indicator		68.8	68.8	68.8	68.8
Numerator			113101	105795	
Denominator			164392	153795	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	70	70	70	70	70

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004

Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2004. The survey will be administered again in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2004.

Notes - 2003

Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2003. The survey will be administered again in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2003.

a. Last Year's Accomplishments

Insurance coverage was one of the top ten priorities identified by the CYSHCN population work group in the Title V needs assessment process conducted in the winter and spring of 2005, as well as one of the top 15 priorities of all three population groups (CYSHCN, Women and Infants, and Children and Adolescents) participating in that process; although it was not one of the final 10 priorities adopted by the state Title V program in mid-2005. Minnesota has always been a leader in insurance coverage of its children. State-specific studies indicate 93-95 percent of children in this state have health insurance and that the majority of those without coverage are eligible for either Medicaid or MinnesotaCare.

The issue of the adequacy of insurance for all children (not to mention CYSHCN) has never been as rigorously addressed as the question of whether children have any type of health insurance. The only study speaking to the adequacy of insurance is the National Survey of Children with Special Health Care Needs conducted in 2001. That study indicated that 68.8 percent of Minnesota's children with special health care needs had adequate insurance at the time of the survey.

One area of continuing activity in the area of insurance by the CYSHCN program is that staff is instrumental in educating families and community professionals about eligibility and coverage criteria of publicly funded, health insurance programs. This activity, called MAZE trainings ("Who Pays: Taking the Maze out of Funding"), provided 40 different training sessions to 685 individuals through these trainings during the report year.
Staff also work closely with the Children's Mental Health Services program of the Minnesota Department of Human Services by supporting training sessions on the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood™ (DC:0-3™). This is a classification system based on the recognition that young children suffer from mental health and developmental disorders and that a system for diagnostic classification sensitive to the developmental issues of young children was needed as well as one that can also be used as a basis for third-party reimbursement. DC:0-3™ codes can be converted to DSM-IV codes for reimbursement. Logistical support for two statewide training sessions on this system was supported by the Title V-CYSHCN during the report year.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Analyze changes in publicly-funded, state health insurance and waiver programs				X
2. Update MAZE materials to reflect legislative policy or procedural changes to programs.				X
3. Promote and conduct MAZE trainings in communities throughout the state and integrate MAZE trainings as a resource into medical home activity		X		X
4. Continue support of Children's Mental Health Services initiatives and DC:0-3 Trainings	X		X	X
5. Maintain and enhance staff knowledge base about insurance issues and implications				X
6. Promote inclusion of CYSHCN-related insurance questions on appropriate surveys conducted by MDH (or other) programs				X
7. Explore the feasibility of developing a framework or structure to address issues of "adequate" insurance, HSAs and HRAs				X
8. Address the impact of availability of health insurance for small business employees and its impact on families of CYSHCN				X
9. Continue to work with DHS on reimbursement for care coordination				X

10. Continue to explore Section 1915 waiver for reimbursement of children's hospice and palliative care				X

b. Current Activities

In the current federal fiscal year four activities have been directed, in part, to the issue of adequacy of insurance. The first is the ongoing MAZE trainings described in the report section above. The second activity is the collaboration with the Children's Mental Health Services of the Minnesota Department of Human Services (DHS) and the Part C program at DHS to sponsor DC: 0-3™ trainings throughout the state. The Part C program will pay the cost of 4-5 training sessions during the current year and the Title V-CYSHCN program will pay for training materials required of participants and will provide staff support for the logistics of the trainings.

The third area involves discussions between the CYSHCN program and hospice personnel of a children's hospital to examine the feasibility of Title V funding a short-term pilot study in order to support documentation for a proposed Section 1915 waiver to reimburse hospice/palliative care for children. The fourth area is an interagency agreement that was signed between the MDH and the DHS, permitting the use of Title V funds to support a research position at DHS in order to analyze Medicaid claims and encounter data of interest to the Title V program. The first area of work pursuant to this agreement will be to design a methodology to analyze data to document whether cost savings accrue to the Medicaid system through the use of care coordination. This documentation will be used to help justify reimbursement of medical home type activities.

This activity will be complemented through technical assistance from the Catalyst Center, which is a national center dedicated to improving health care insurance and financing for CYSHCN. It is part of the Health and Disability Working Group in the School of Public Health at Boston University and is the MCH Bureau cooperative agreement grantee for the Bureau's initiative in health insurance and financing. Minnesota is one of the states selected by the Center for in-depth consultation on a specific financing/insurance topic.

c. Plan for the Coming Year

The study cited in the report year narrative above also documents an increasing percentage of adults employed in businesses of 100 employees or less. This has significant importance for both the percentage of children covered by private insurance and the adequacy of that insurance, especially with the increased emphasis on Health Savings Accounts and Health Reimbursement Accounts. Although employer-based insurance decreased from 69.7 percent to 63.4 percent between 2001 and 2004, it remains the predominant source of insurance coverage for Minnesotans. At the same time, however, there was a statistically significant increase between 2001 and 2004 in both the number of Minnesotans employed in a business size of 51-100 employees and in the number of uninsured Minnesotans employed in a business size of 51-100. These observations raise concerns about availability and affordability in addition to the unanswered question of adequacy and suggest several potentially troubling issues for CYSHCN and their families. For example, how does the observation that increasing numbers of Minnesotans are being employed in small businesses affect families of CYSHCN? Will parents of CYSHCN who are employed by small businesses experience greater pressure to disenroll? Will their employer decide against health insurance for all employees because of high utilization of dependents of certain employees? What is the affordable cost? The CYSHCN program needs to strategically address the issues inherent in these questions as well as the significance of the data on children birth through five years of age that was cited in the report year narrative.

Discussions surrounding the potential to develop a 1915 waiver for children's hospice and palliative care will continue. Efforts to secure reimbursement for care coordination and similar medical home-type activities will continue through the interagency effort between DHS and MDH. The collaboration between the CSHCN program and the Children's Mental health Services program at DHS will continue and the CSHCN program intends to fund several DC:0-3™ training

sessions. Ongoing training of direct service providers in key grant programs such as WIC, Family Home Visiting, Family Planning, and Positive Alternatives will continue to assure low-income families are assessed for appropriate insurance coverage and referred if necessary to appropriate public programs.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective			73.5	73.5	78.5
Annual Indicator		73.5	73.5	73.5	73.5
Numerator			120828	113039	
Denominator			164392	153795	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	78.5	78.5	79	79	79

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
The indicator reported in 2002 have pre-populated the data for 2004 for this performance measure. Data from the National Survey of Children with Special Health Care Needs (SLAITS) administered 2000-02. Survey will be readministered in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2004.

Notes - 2003
The indicator reported in 2002 have pre-populated the data for 2003 for this performance measure. Data from the National Survey of Children with Special Health Care Needs (SLAITS) administered 2000-02. Survey will be readministered in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2003.

a. Last Year's Accomplishments
In 1998 Minnesota enacted legislation known as the Interagency Services for Children with Disabilities Act. This system, now formally referred to as the Minnesota System of Interagency Coordination (MnSIC) by its state and local partners, has as its purpose the "…development and implementation of a coordinated, multidisciplinary, interagency intervention service system for children ages birth through 21 with disabilities."
This legislation affects all agencies and educational organizations working with these individuals and their families and includes the state Departments of Health, Human Services, Education, Corrections, Commerce, Employment and Economic Development, and Human Rights. It also affects local community interagency committees serving children and youth with disabilities and their families.

A state appointed committee -- the State Interagency Committee (SIC) -- has been appointed to oversee and make key policy decisions about the development and implementation of this

initiative at the state level. The CYSHCN director is a member of this policy-making body. The governing boards of the 96 plus local Interagency Early Intervention Committees (IEICs) are designated with the responsibility of designing and implementing their birth through 21 interagency system. The governing boards are members of local school boards and county boards. However, other local interagency groups such as the Family Services Collaboratives, Children's Mental Health Collaboratives, and Community Transition Interagency Committees have responsibility to work in cooperation and coordination with this process. This coordinated birth through 21 interagency system is modeled after the Part C program of IDEA.

The CYSHCN program has an interagency agreement with the Department of Education, which is the lead state agency for implementation of IDEA. This agreement delegates the child find responsibility pursuant to IDEA to the MDH. The Infant Follow Along Program is one way this responsibility is implemented. Staff work closely with the Children's Mental Health Services (CMHS) Division of the Minnesota Department of Human Services (DHS). One activity supported by a DHS Commonwealth Fund grant (ABCD-II), included provider training in the Diagnostic Classification 0-3TM (DC:0-3TM) system, to facilitate young children with diagnosable conditions accessing mental health services under the state's Medicaid system. The CYSHCN program co-sponsored two statewide training sessions in this methodology.

Trainings called "Who Pays/Taking the Maze out of Funding" is provided to parents, professionals and advocates. The percentage of parents in the audience increased from 11 percent to 19 percent.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to partner with other state agencies to fully implement the III-P process.				X
2. Create an updated, searchable, web-based central directory for Part C		X		X
3. Continue state support and technical assistance for the Infant Follow Along Program			X	X
4. Inform and educate providers, community professionals and parents about the ASQ-SE mental health screening component of the Ages and Stages Questionnaire			X	X
5. Continue active participation and leadership in statewide ICC, IEIC and Part C activities				X
6. Support Children's Mental Health Services of the Department of Human Services in implementation of DC: 0-3			X	X
7. Provide community outreach and training for Part C, III-P, ASQ-SE and Medical Home			X	X
8. Provide staff development to enhance their expertise for technical consultation in above mentioned programs				X
9. Continue presence and leadership for the State Interagency Committee (SIC) and its Interagency Management Team (IMT) and various committees				X
10. Integrate the state early childhood comprehensive screening systems activities to enhance effectiveness of existing screening and medical home activities			X	X

b. Current Activities

Five areas of focus that the State Interagency Committee (SIC) adopted include communication, evaluation, transition, coordination of services and mental health. The CYSHCN Director is the

"champion" for the communication area. This includes collecting input on challenges and opportunities, outreach to administrative stakeholders (special education), provision of information to families on the coordinated interagency system, increased awareness of MnSIC products and guidance materials, increased awareness and skills at the local level on systems development, provision of technical assistance to local agencies on the coordinated system and support of local entities to provide ongoing training to local providers. Staff continues to work closely with the Children's Mental Health Services (CMHS) Division at DHS. The director of CMHS is the Principle Investigator of a grant from the Commonwealth Fund (ABCD-II) directed to supporting children's mental health development through an integrated set of activities (e.g. co-locating mental health services in a primary care setting). One corollary activity includes provider training in the Diagnostic Classification 0-3™ (DC:0-3™) system, which can be cross walked with the DSM-IV classification system thereby permitting young children with diagnosable conditions to access mental health services under the state's Medicaid system. The Title V CSHCN program continues to collaborate with the Children's Mental Health Services Division through co-sponsorship of two seminars (Introduction of Infant Mental Health and Diagnosis of Infants and Toddlers: DC:03TM) in five rural locations around Minnesota during May and June 2006. Approximately 200 mental health professionals throughout the state will receive this training by the end of June.

The State Interagency committee (SIC)'s primary strategy for communication continues to rely upon the infrastructure of the 96 local Interagency Early Intervention Committees (IEICs), employing as many communication vehicles as possible with parent members of the IEICs. It is felt that direct communication with parents will increase the number of parents familiar with the process and increase the number who will choose to participate in it. MCSHN District staff continue to provide opportunities for parents to be empowered to participate on a variety of interagency groups to further the agenda of MnSIC at the local level through integrating activities with the New Freedom Initiative Integrated Community Systems of Care grant. For example, activities include encouraging the adoption of the Medical Home model of service delivery, advocating with community "health" coalitions and projects and establishing relationships with other regional staff (e.g. DHS, Children's Mental Health) to influence local system development. MCSHN staff continues to provide "Who Pays" trainings across the state

c. Plan for the Coming Year

The primary strategy for communication over the next few years to ensure community-based service systems are organized for ease of use by families rests with utilizing the infrastructure of the 96 local Interagency Early Intervention Committees (IEICs). The legislation that enacted MnSIC stipulated it was the right of the parent of an eligible child to use this system of coordinated care. The CYSHCN program will take what it has learned from the medical home collaborative process including the Breakthrough Series and the Model for Improvement and apply it to MnSIC. It is hoped that this will build grass roots support for that process.

Part C activities will continue and changes pursuant to the recent re-authorization of IDEA will be implemented. The CYSHCN program will continue to collaborate with Children's Mental Health Services through co-sponsorship of the DC:0-3™ training sessions and will continue implementation of the second and third years of its New Freedom Initiative Integrated Community Systems of Care for CYSHCN grant. "Who Pays" training materials will be updated and trainings provided free of charge to multi-disciplinary audiences, especially parents will continue.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective			5.8	5.8	6.4
Annual Indicator		5.8	5.8	5.8	5.8
Numerator			9535	8920	
Denominator			164392	153795	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	6.4	6.4	6.4	6.4	6.4

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

Notes - 2004
Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2004. The survey will be administered again in 2005. Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2004.

Notes - 2003
Data from the 2000-02 National Survey of Children with Special Health Care Needs (SLAITS) was applied to 2003. The survey will be administered again in 2005.

Denominator is based on a prevalence estimate of 12.4% of the child population in MN having a special health care need. Child population based on US Census estimate for 2003.

a. Last Year's Accomplishments
The III-P and MnSIC product, process and concept have been described in detail in NPM #5. The III-P product and process was implemented in the following phases: children up to age 9 became eligible for this process in 2001, children up to age 14 became eligible in 2002 and children up to age 21 became eligible in 2003. Significant barriers at the local level surfaced during 2004 and 2005, but steps are being taken to address those obstacles. Barriers include student and family ignorance of the III-P process and its usefulness in transition planning as well as local provider (special ed, county social services) reluctance to adopt the III-P concept because it is seen as a voluntary, unfunded mandate. The concept underlying medical home collaborative learning sessions was suggested by the CYSHCN program as a tool to encourage local communities to increase use of this process. This suggestion was adopted in the fall of 2005 at the state level and will be implemented in the coming year.

The medical home initiative conducted collaborative learning sessions in April and September of 2005. The September session included a presentation on transition by one of the co-directors of the Healthy and Ready to Work National Center. The CYSHCN program held a very successful interactive videoconference on adolescent brain development in June of 2005 presented by Dr. David Walsh, a nationally known speaker. Two hundred and forty-three participants at nine different sites throughout the state attended this conference.

Two CYSHCN staff, one from a metro district and one from a rural district, continued participation on the State Transition Interagency Committee, providing the group with expertise on funding resources. Resource materials such as fact sheets and handouts on the health aspect of transition planning were developed for parents and providers. Staff identified disparity in transition planning services between the metro area schools and the small rural schools. Outreach to local Community Transition Interagency Committees (CTIC) was designated as a priority to be addressed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue involvement in MnSIC and III-P activities				X
2. Assure transition is incorporated in medical home learning sessions				X
3. Include transition expertise on the steering committee of the New Freedom Initiative grant				X
4. Continue to promote transition as a major topic to be addressed by the state chapter of the AAP			X	X
5. Continue involvement with the Minnesota State Council on Disability				X
6. Use the Minnesota Student Survey to identify transition issues			X	X
7. Assure youth membership and involvement in groups formed to implement New Freedom Initiative grant		X		X
8. Promote transition issues as curricula components at university graduate programs on CYSHCN				X
9. Transition services for adolescents seen in DBC clinics	X			
10.				

b. Current Activities

MnSIC activities included transition as one of its five major work plan activities. The specific work activities were relatively modest and included an environmental scan of state agency activities about transition and an inventory of available support to transition students.

The CYSHCN program continues to promote transition as a topic to be addressed by the private and public sectors through multiple activities. Participation on the State Transition Interagency Committee (STIC) continues with current activities such as the Youth Summit and publication of a booklet on transition. Staff participate in regional school nurse meetings and present information on transition planning, IEP and 504 plans and YSHCN related topics such as transitioning to adult health care and healthy behaviors. Staff provide transition information at regional local public health MCH coordinator's meetings. They also participate as members of local interagency transition committees, Community Action Network committees, asthma and other coalitions within their respective districts. New handouts were developed, several have been incorporated into the MAZE manual as well as posted on the CYSHCN program website. A power point presentation is currently being revised. Transition information is provided on an individual basis by district consultants at Development & Behavior Clinics.

c. Plan for the Coming Year

The CYSHCN director is a member of the MnSIC governing committee and will follow its activities on transition issues. The CYSHCN staff serving as coordinator of the New Freedom Initiative grant will also follow the MnSIC transition activity and the steering committee for this grant has added a pediatrician from the Department of Pediatrics at the University of Minnesota who specializes in transition to its group. Several activities pursuant to the New Freedom Initiative grant will touch directly or indirectly on transition issues. These include organizing a parent and youth summits that will identify transition issues of concern for the CYSHCN program/NFI grant to follow up on. The state chapter of the AAP has created a Pediatric Council (Minnesota Child Health leadership Consortium) as part of the NFI grant will begin to address transition issues in the coming year. All of these activities will either engage youth and transition challenges or include transition challenges as system issues (e.g., insurance, care coordination, reimbursement).

The CYSHCN program will identify a statewide transition workgroup whose membership will include parents and youth with both urban and rural representation. In addition, efforts to address mental health needs of subgroups of CYSHCN such as minority populations, adolescent survivors of cancers and chronic illnesses diagnosed in childhood will be addressed. Current participation in state interagency committees will continue and efforts to provide technical assistance to local interagency committees will be expanded. District consultants will continue to provide local service providers and parents with education, awareness and training on transition issues such as self-advocacy, finding adult health care, independent living and obtaining secondary education and/or employment through presentations and individual consultation. A "Transition Packet" will be developed for dissemination. District consultant efforts to increase awareness of the gaps and barriers to transition planning and services in the rural area will continue. Additional efforts to provide technical assistance to YSHCN in schools with high rates of poverty and high drop out rates will be a focus.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	90	90	90	90	90
Annual Indicator	76.3	76.6	83.9	85.2	
Numerator	50295	49053	55373	56015	
Denominator	65918	64037	65999	65745	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	90	90	90	90	90

Notes - 2005
The 2005 data is not yet available.

Notes - 2004
The percentage of children age 19 to 35 months old who have completed recommended immunizations is estimated from the National Immunization Survey. The denominator is estimated from the birth records, resident 2 year olds. The numerator is calculated as the percentage of children, age 19 to 35 months old, who have completed immunizations, multiplied by the denominator.

Notes - 2003
The percentage of children age 19 to 35 months old who have completed recommended immunizations is estimated from the National Immunization Survey. The denominator is estimated from the birth records, resident 2 year olds. The numerator is calculated as the percentage of children, age 19 to 35 months old, who have completed immunizations, multiplied by the denominator.

a. Last Year's Accomplishments
Although Minnesota's statewide immunization rate always comes out in the top 15 states within the CDC studies, there are pockets of under-immunized children in some high risk populations. In Minnesota, Title V is not the lead entity on immunization activities, rather the immunization program is housed in the Division of Infectious Disease Epidemiology. Title V staff collaborate with the immunization program by supporting and providing outreach and information, and providing immunization training sessions to providers through Child and Teen Checkups (EPSDT)

trainings.

Minnesota's immunization registry, the Minnesota Immunization Information Connection (MIIC) is a statewide network of 7 regional immunization registries and services involving health care providers, public health agencies, health plans, and schools working together to prevent disease and improve immunization levels. In Minnesota, all parents of newborns are notified of their enrollment in the registry through Minnesota's birth record process and an immunization information packet given to them in the hospital. They are given an 800 number to call if they have questions or want to opt out.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Target information on immunizations to high-risk populations			X	X
2. Provide immunization training sessions to public and private providers through C&TC/EPSDT training			X	X
3. Assure immunization review part of WIC clinic services			X	X
4. Support local community immunization registries			X	X
5. Support MIIC strategic plan with emphasis on recommendations for integrating information with other child health data systems.				X
6. Support local immunization clinics	X			
7. Support inoperability of data across various data sets. (Medicaid, WIC, Birth Certificates, Immunization Registry, BDIS, etc.)			X	X
8.				
9.				
10.				

b. Current Activities

Title V continues to provide information about immunizations, immunization requirements, access and availability, and other immunization related information to child care, home visiting and C&TC nurses, and other local public health MCH staff. Information is also downloadable from the MDH web site. In October 2005, a Strategic Plan for 2010 was created for MIIC and included goals and objectives regarding provider participation, intervention, integration/data exchange, and data quality. One objective specifically addressed the need to partner in the planning to develop an interoperable child health information system with newborn hearing and vision screening and other child health data systems. The MCHB Data integration grant included immunization staff at the Public Health Informatics Institute "Connections" site visit meeting in Michigan regarding Newborn Screening Integration with other child health information systems. This meeting helped solidify the partnership between immunization and Title V and provided useful information from the other states on experiences, strategies, best practices, and lessons learned in working towards development of an integrated child health information system.

c. Plan for the Coming Year

Continue activities stated above with a focus on those activities to support the development of an integrated/interoperable child health information system with immunization as a key partner.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	15.9	14	13.5	13.5	13
Annual Indicator	13.9	14.2	13.4	13.6	
Numerator	1529	1572	1467	1478	
Denominator	110039	110604	109237	108688	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	13	12.5	12.5	12.5	12.5

Notes - 2005
The 2005 data is not yet available.

Notes - 2003
Source of data is MN birth records.

a. Last Year's Accomplishments
Approximately $5 million in federal MCH Block Grant, Title X and state funds were provided through grants to local public health agencies, tribal governments and non-profit organizations for family planning services (outreach, public information, counseling and method services) with approximately one-third supporting family planning services for teens.

A Family Planning and STI hotline is also supported by state funds and is staffed by individuals trained in information and referral as well as family planning and STD counseling. Almost 5,000 calls were handled by the hotline in 2004. Information on the hotline number is mailed to Medicaid/Minnesota/Care recipients each year.

Grant activities continued under the MN ENABL program include: 1) community organization activities implemented collaboratively by community groups and interested persons to reinforce the MN ENABL message; 2) use of a curriculum consistent with established principles; 3) a media campaign promoting the abstinence message; 4) state directed training and technical assistance for community-based projects. MN ENABL is funded by the state general fund dollars and 510 federal abstinence dollars. The MDH was designated by the Governor as the administrator of the Section 510 Abstinence Education program in the State.

Staff partnered with Department of Human Services to design and carry out an implementation plan for the 1115 Medicaid Waiver. The MCH Staff convened a Teen Pregnancy Prevention Brown Bag discussion group made up of community partners. This forum has provided the opportunity to communicate about issues impacting teen pregnancy prevention efforts. Consultation and technical assistance to Eliminating Health Disparities Grantees who have focused on reducing teen pregnancy in high-risk populations is also provided.

One effort to support school based clinics was investing 8 hours per month in one of the clinics seeing patients primarily for reproductive health issues.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support PRAMS data collection & analysis				X
2. Provide access to FPSP services	X	X	X	
3. Partner with DHS to successfully implement 1115 Waiver for family planning services			X	X
4. Increase public understanding of social, economic, & public			X	X

health burdens of unintended pregnancy, especially to teens				
5. Develop public understanding & support for policies & programs that reduce unintended pregnancies			X	X
6. Continue abstinence programs that supports adolescents in their decision to postpone sexual involvement	X	X	X	X
7. Promote youth activities that support resiliency & healthy behaviors	X		X	X
8. Support hotline for family planning & STI services	X			X
9. Support school-based clinics & advocate for comprehensive reproductive education	X		X	X
10. Update and implement with other stakeholders the state Teen Pregnancy Prevention Plan			X	X

b. Current Activities
Contracts for MN ENABL grantees were renewed until December, 2007. Currently 22 grantees throughout the state are funded.

The new grant cycle for Family Planning Special Projects (FPSP) grants began January 2004. Site visits to most of the 41 FPSP grantees were completed in 2004. FPSP grantees and MDH staff have met with DHS staff about implications for clinics with implementation of the 1115 Medicaid Waiver. MDH has provided key linkages between the provider community and DHS. Continued work in this area will be critical to successful Waiver implementation, scheduled for July 1, 2006.

Teen Pregnancy Brown Bag sessions will continue with community members. Technical assistance support has continued to the Eliminating Health Disparities grantees and has included reviewing teen pregnancy prevention curriculum and media campaigns targeted to high risk populations.

The Adolescent Health Coordinator has continued providing 8 hours per month of clinical service in one of the school based clinics.

c. Plan for the Coming Year
Continued coordination, collaboration and advocacy will be necessary to preserve and continue work regarding prevention of unintended pregnancy. MN has a strong history of building on existing partnerships and shared resources to reduce teen pregnancy.

The Teen Pregnancy Brown Bag sessions will continue to facilitate communication and collaboration between MDH staff and community partners.

Reproductive Health staff will work with DHS to implement the 1115 Waiver and continue to act as a liaison between DHS and providers, and collaborate with DHS to bring needed information and training to providers. MN ENABL grantees and FPSP grantees in partnership with MDH will provide critical direct services to MN adolescents in an effort to reduce teen pregnancy and teen birth rates.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005

Annual Performance Objective	14	15	16	17	18
Annual Indicator	9.3	10.0	10.4	12.0	
Numerator	10653	12322	12861	14794	
Denominator	114050	123636	124201	122956	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	14	14.5	15	15.5	16

Notes - 2005
The 2005 data are not yet available.

Notes - 2003
As reported, this indicator represents the percent of Medicaid-eligible children (ages 6-12) who received protective sealants. Data on protective sealants among third grade children in the general population are not available.

a. Last Year's Accomplishments
The percent of children ages 8-12 eligible for Minnesota Fee-For-Service, Managed Care/Medical Assistance and MinnesotaCare programs that had sealants on one or more molar teeth has remained steady in the 10-12% range. Data on protective sealants among third grade children in the general population are not currently available.

The Oral Health Program provided oral health training, technical consultation, and educational materials to Community Health Boards, schools and the general public and worked with the Department of Human Services in areas of dental policy and access issues.

The C&TC staff provided training sessions to C&TC providers that included discussions of dental sealants and dental assessments.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Promote the appropriate use of dental sealants to dental professionals & the public.			X	X
2. Develop strategies that make it easier for children to receive sealants.			X	X
3. Promote & encourage school-based/school-linked sealant programs & appropriate follow-up.			X	X
4. Partner with the DHS to increase utilization of dental services for public program participants.			X	X
5. Incorporate preventive dental practices in the C&TC trainings.			X	X
6. Integrate oral health anticipatory guidance into WIC clinic settings.	X		X	
7. Develop an Oral Health Data book of available and suitable MN specific oral health data.			X	X
8. Participate in the coalition to support and implement the campaign of Oral Health America “Smiles Across Minnesota.”			X	X
9.				
10.				

b. Current Activities
The Dental Health Program staff provides current, scientifically sound oral health information to individuals and groups as appropriate. Staff work with advocates including the Minnesota Dental

Association, the Minnesota Dental Hygienists Association, the Minnesota Board of Dentistry and the Minnesota Department of Human Services on the multifaceted problems of dental access.

Currently under contract but not completed is a project from HRSA funding to develop a web-based oral health screening training curriculum to enhance the oral health of MN's children who are eligible for Minnesota EPSDT program called Child and Teen Checkups Program. This learning curriculum will be directed toward primary health care (non-dental) medical providers. It is anticipated that this attention to children's preventive oral health needs will ultimately improve the number of children who receive appropriate dental sealants.

The C&TC staff continues to provide Child and Teen Checkups training sessions that include discussion of dental sealants, dental screening and anticipatory guidance.

c. Plan for the Coming Year
Continuation of current activities with a particular focus on development of a Maternal and Child Oral Health Data Book. This Data Book will identify suitable and useful MN specific oral health data including dental sealants and other preventive oral health services that will improve knowledge and understanding of MN oral health issues and facilitate sound programmatic guidance.

In addition, MN has been identified by Oral Health America (an independent national non-profit organization founded in 1955 and dedicated to improving oral health for all Americans -- www.oralhealthamerica.org) as one of five states nationwide to receive a major campaign to raise awareness of oral health's importance to total health. Dental sealant services, oral health coalition support and media and public education are the primary components of this "Smiles Across Minnesota" campaign.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	2.8	2.6	2.5	2.5	2.4
Annual Indicator	2.6	4.2	3.5	3.4	
Numerator	27	46	36	35	
Denominator	1039285	1085097	1024333	1030130	
Is the Data Provisional or Final?				Final	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	3.2	3	3	2.8	2.8

Notes - 2005
The 2005 data are not yet available.

Notes - 2003
Source of data is death certificates.

a. Last Year's Accomplishments
The motor vehicle crash child death rate (birth to age 14) per 100,000 in 2004 was 3.4 compared to 3.51 in 2003. Two Title V supported activities contribute to reducing risk of injury in a motor vehicle-related crash: 1) statewide distribution of car seats and booster seats to those in need;

and 2) intensive training of public health staff and local volunteers in the science of car seat and booster seat installation. Both activities were accomplished in partnership and collaboration with Minnesota SafeKids and the Department of Public Safety. Title V funding supports local injury prevention activities and, in 2004 more than 5,000 Minnesota children benefited from program support.

The Child and Teen Checkups (C&TC) program continued to provide training sessions to C&TC providers in 2004 that included anticipatory guidance on safety issues including car seats and seat belt use.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Distribute car seats and booster seats to families; teach proper installation and use.	X	X		
2. Train car seat and booster seat checkers.			X	X
3. Support the GDL and “Click it or ticket campaigns of OTS, Department of Public Safety.				X
4. Support, through data analysis, the shift in MN to standard enforcement of seat belts (Every body, every seat, every time).				X
5. Continue emphasis in Positive Alternatives, Family Home Visiting and C&TC on using the home safety checklist with families being served.			X	X
6. Support enforcement of speed limits, prevention of distracted and drowsy driving, and reduction of impaired driving, which places children at risk eaths.			X	X
7. Promote seat belt use for children.		X	X	
8.				
9.				
10.				

b. Current Activities

Distribute additional car seats / booster seats to those who need them; ensure that adult women, teens and children are properly restrained in a motor vehicle; and improve dissemination of information on Minnesota's seat belt law.

The C&TC program will provide Child and Teen Checkups training sessions that include anticipatory guidance on safety issues including car seats and seat belt use.

We expect to see a reduction in crash death rates if health professionals advocate for motor vehicle safety instruction as a viable aspect of their daily responsibilities. Correct restraint needs to be modeled by parents and care givers, queried and taught by health professionals, and car / booster seats need to be provided to those who otherwise would not be able to afford them.

The Minnesota Legislature could strengthen enforcement of laws related to seat restraints, alcohol use by vehicle operators (our DUI limit of 0.08 was implemented August 1, 2005), speed violations, and nocturnal teenage driving. Action in any of these categories will improve the health outcomes of Minnesota's children. Improvements in Minnesota's EMS and trauma care systems will reduce the risk of death post-crash. Authorizing legislation to formalize and implement a comprehensive trauma system in Minnesota was enacted August 1, 2005. Minnesotans are driving more, however, thus increasing exposure to and risk of motor vehicle crash injury and/or death.

c. Plan for the Coming Year
Continue current activities described in b. Particular challenges include protecting Minnesota's newest residents --immigrants from Somalia, Sudan and Southeast Asia. Statewide, of the 35 children in this age group who died in a motor vehicle crash, 19 either did not use safety equipment or the use of safety equipment was unknown. As in 2003, six children died in an alcohol-related crash. An intervention implemented (by the Minnesota Legislature) during the current year and that will be continuing next year includes a training requirement in the proper installation and use of child safety seats for all licensed child care providers. New funding for child car restraints and appropriate parental safety training became available July 1, 2006 and will allow local non-profit organizations to identify and support low-income families in the use of appropriate child restraints.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					44.3
Numerator					
Denominator					
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	45	46.3	47.5	49	50

Notes - 2005
Data from CDC's 2004 Breastfeeding National Immunizations Survey, which is based on a sample of 340 women. 2004 data applied to 2005 because 2005 data are not yet available.

a. Last Year's Accomplishments
The percentage of women who breastfed their infants at hospital discharge was reported as 79.4 +/- 5.3%. in 2004, essentially unchanged (2003: 79.5 +/- 5.1%). Rates are from the CDC National Immunization Survey. Breastfeeding initiation rates for some special population groups, including refugee and low-income populations, are lower. The Hmong and Somali populations have lost breastfeeding traditions, upon immigration to the United States, the Hmong often ceasing to breastfeed and the Somali often breastfeeding with supplementation and shorter duration than before immigration. Native Americans also breastfeed at lower rates than the general population. Rates vary considerably between Minnesota communities. Progress continues but numerous barriers to breastfeeding remain in the general population. Low income, immigrant and some other special populations face additional barriers.

Increasing the duration of breastfeeding continues to be a challenge for all population groups. Research demonstrates a dose-response to breastmilk, with greater benefits for exclusive breastfeeding and longer durations of breastfeeding. In 2004 breastfeeding duration to 6 months was reported as 44.3+ 6.4 % (44.7% +/- 6.1%, 2003, CDC immunization survey) for the general population. The HP2010 goal is 50%. The American Academy of Pediatrics and other groups recommend breastfeeding to a year or more for all infants.

Breastfeeding is encouraged and supported through the MDH Family Home Visiting (FHV) program, and local public health activities. Distribution of breastfeeding materials is also done through FHV e-mail lists and on the FHV website. The Minnesota WIC program implemented multiple activities to promote and support breastfeeding, with many of the populations targeted by

MCH. WIC invited a variety of community partners to breastfeeding workshops and meetings held throughout the state to increase communications and to build skills in breastfeeding counseling.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assure that MCH Public Health Strategies on breastfeeding promotion continue to be available			X	X
2. Support breastfeeding promotion and support as a component of the Family Home Visiting services.	X			X
3. Continue to provide breastfeeding education & support through WIC, ie training and technical assistance to local WIC programs, and local programs provide breastfeeding support services to WIC participants.	X		X	X
4. Provide technical assistance and training to local programs to help them identify opportunities and implement strategies to promote and support breastfeeding.			X	X
5. Continue WIC Peer Breastfeeding Support Grants and TA to grantees	X			X
6. Convene cross-program meetings to identify ways to integrate breastfeeding promotion & support into a wide array of MCH programs.				X
7. Propose policies that support breastfeeding.			X	X
8.				
9.				
10.				

b. Current Activities

The to be hired women's health coordinator would work closely with the State WIC Breastfeeding Coordinator to assure that current information is provided throughout the state and that educational opportunities are provided for public health nurses regarding breastfeeding.

To address lower rates of breastfeeding in the Hmong population, two activities were undertaken. In October 2005, MCH staff contracted with a Hmong elder and cultural expert to participate in a community resource fair for newly arrived Hmong families in St. Paul. She staffed an exhibit table with resources in the Hmong language and posters of Hmong families promoting breastfeeding. She demonstrated breast pumps and appropriate breastfeeding "cover up" clothing. She had contact with 47 Hmong people including women, and couples in addition to others who simply observed the display. In November 2005, staff provided consultation to a private family practice clinic in Minneapolis that serves primarily Hmong patients. Assistance was provided in helping them produce a DVD promoting the health benefits of breastfeeding for the Hmong community that will be widely distributed in 2006 to other agencies serving Hmong childbearing families.

A Family Planning Special Projects grantee is continues to promote LAM (lactation amenorrhea method) to populations that don't accept other methods of family planning. Informal sharing of information and opportunities to promote and support breastfeeding is shared within Title V and WIC. Local public health staff, supported by MCH Block Grant funds, advocate breastfeeding and include breastfeeding promotion strategies in contacts with families.

WIC provides leadership for multiple activities to promote and support breastfeeding. WIC continues to offer workshops on breastfeeding counseling, in locations throughout the state. Workshops are attended by WIC staff and their community partners, including local MCH staff. Workshops will be held June 23, 2006 in St Paul, and October 5, 2006 in Moorhead.

Breastfeeding information for parents and professionals is available on the MDH website. WIC is updating their breastfeeding promotion and support guidance document, and will incorporate strategies to increase breastfeeding duration. The WIC breastfeeding coordinator is working with a group planning a statewide breastfeeding coalition.

A peer breastfeeding support program funded by USDA-WIC has been implemented in nine Minnesota counties, and includes peers that speak English, Spanish, Somali, Hmong, and ASL. The 2005 Legislature appropriated $2.5 million a year for a grant program to support women in maintaining their pregnancies and supporting their infants after birth. This program will also be in a position to encouragement and support of women who choose to breastfeed.

c. Plan for the Coming Year
Continue to develop linkages to promote and support breastfeeding, including meeting with MCH staff to discuss breastfeeding promotion and support, and practices within communities that can hinder breastfeeding. Continue to place special interest in our newest cultural/ethnic populations. Investigate partnering for breastfeeding training. Continue to provide current and relevant breastfeeding information to local public health staff, and work on the consistency of breastfeeding messages between programs and between staff within programs and communities.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	65	85	95	98	98
Annual Indicator	75.0	59.3	77.0	96.5	
Numerator	50566	38106	53904	68123	
Denominator	67422	64213	70006	70579	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	98	98	99	99	99

Notes - 2005
The 2005 data is not yet available.

Notes - 2004
Rate is based on 85% of the 111 hospitals in MN that report directly on the occurrence of a newborn hearing screening. The remaining 15% of hospitals conduct the hearing screening but do not report.

Denominator is the number of births in the State.

Notes - 2003
Rate is based on 85% of the 111 hospitals in MN that report directly on the occurrence of a newborn hearing screening. The remaining 15% of hospitals conduct the hearing screening but do not report.

Denominator is the number of births in the State.

a. Last Year's Accomplishments
The measure reflects the number of hospitals participating in standardized hearing screening and reporting to MDH, rather than the direct ascertainment of infants screened. By the end of the

year 2004, all of the 111 birthing hospitals and 6 NICU/Special Care Nurseries reported implementation of universal newborn hearing screening (UNHS). For babies born in 2004 (70,579, provisional births), 55,520 (78.7%) hearing results (screened, not screened) were reported on 66,152 blood spot forms submitted. In the reported data, 53,587 babies were screened, 1,053 babies did not pass the screen (refer rate of 2%), 1,933 were not screened, with 120 refused.

The Centers for Disease Control and Prevention (CDC) Early Hearing Detection and Intervention (EHDI) 5- year Cooperative Agreement ended 6/30/05. A new 3-years (7/1/05 to 6/30/08) award was received to continue building the EHDI tracking and surveillance system. The HRSA MCHB UNHS 5-year grant ended 3/31/05 but was renewed for 3 years (4/1/05 -- 3/31/08) to improve lost-to-follow-up and access to early intervention -- although at decreased funding.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance on implementing newborn hearing screening to hospitals & communities			X	X
2. Provide education & training of providers, including audiologists			X	X
3. Provide information to parents of the importance of screening & if identified with a hearing loss, additional follow-up			X	X
4. Refine & expand the data tracking & follow-up system			X	X
5. Integrate data collection, follow-up & tracking with newborn metabolic screening			X	X
6. Work with a variety of stakeholders on assuring follow-up, referral & intervention for infants		X	X	X
7. Continue federally funded grant activities in this area		X	X	X
8. Support hospital quality assurance activities		X	X	X
9.				
10.				

b. Current Activities

Title V staff continues to partner with the Departments of Human Services and Education to provide state leadership in the promotion and technical support of early hearing detection and intervention. Due to the budget limitations, only one workshop was conducted for the 16 Regional EHDI teams.

The MDH tracks newborn hearing screening results through integration with the state's Newborn Blood Spot Screening program and linking with vital statistics.

Title V has continued to collaborate with local Part C Coordinators, Follow Along Program nurses. The 16 Regional EHDI teams continue to build regional capacity to better serve deaf/hard of hearing children and their families. In addition, Title V staff continue to: provides ongoing technical support to screeners and trainings to public health nurses, physicians and other early interventionists; collaborate with contracted Lifetrack Resources Family Support Connection, and develop a statewide family-to-family support network.

One contracted audiologist provides out reach consultation to screening hospitals for program refinement and quality improvement. The CDC cooperative agreement is focused on development of a data tracking and follow-up system as well as education and training of providers. One major education activity was the Multi-Disciplinary EHDI Conference on April 3 and 4, 2006 funded by a CDC public health conference grant (9/1/05 -- 8/31/06). The audience

(about 150) included primary care physicians, advanced nurse practitioners, nurses (hospital, clinic, and public health), audiologists, early interventionists, community and family support agencies, EHDI coordinators from border states, and parents. It was a very successful conference that will move Minnesota's EHDI Program forward--beyond screening and onto intervening--by creating an awareness of research, presentation of best practices, communicating the need for improvement, and encouraging application and action.

Reimbursement remains an issue for long-term sustainability of a statewide screening, reporting, tracking and follow-up system.

Based on data presented by EHDI/Title V staff, the Statutory Newborn Screening (NBS) Advisory Committee submitted (10/05) a recommendation to the MDH Commissioner for adding newborn hearing screening to the state's mandated NBS panel.

c. Plan for the Coming Year

Focus will be on both short- and long-term follow-up to serve children with a hearing loss and their families; on hospitals and audiologists reporting data to the state; quality improvement of the screening programs; and, further enhancement of the data integration with other child health data systems, such as the vital records, immunization, CYSHCN program and WIC to assure that children are not lost to follow-up in the EHDI process. All collaborative and limited contractual activities will continue with a focus on provider and parent education to assure minimal loss to follow-up. Activities will focus on developing sustainable EHDI quality assurance programs for hospitals and communities.

Staff will work with border states to reach agreements in data/resource sharing for border babies, mid-wives, and regional public health agencies to assure home births and hard-to-reach populations to get needed screening, diagnosis and early intervention. Staff will continue multi-agency policy discussions with Department of Human Services, Deaf and Hard of Hearing Division, Dept. of Education-Low Incidents Division, Department of Employment and Economic Development.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	3	2.8	2.6	2.4	2.2
Annual Indicator	6.4	6.5	6.5	7.9	
Numerator	84039	81784	81170	98354	
Denominator	1313116	1258216	1248770	1240280	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	7.5	7	6.5	6.3	6

Notes - 2005
The 2005 data are not yet available.

Notes - 2004
Source of 2004 data is the Health Access Survey.

Notes - 2003
Source of 2003 data is the BRFSS.

a. Last Year's Accomplishments
While Minnesota has consistently had one of the lowest rates of uninsurance in the country, the rate of insurance coverage decreased (68.4% to 62.9%) in Minnesota between 2001 and 2004. This decrease in insurance coverage occurred after years of increasing or stable insurance rates. A decrease in employer-based health insurance coverage, changes in employment, a shift in Minnesota's income distribution, and a change in the composition of Minnesota's Hispanic/Latino population are felt to have contributed to this lower rate of insurance coverage. Minnesota's rates of uninsured continue to show disparities based on race, with the change being most pronounced for Hispanic/Latino Minnesotans. Except for Blacks (16.4% in 2001 compared to 12.8% in 2004), the rates of uninsurance for all races increased during this time span.

In 2004 Minnesotans were more likely to be uninsured or covered by public health insurance than they were in 2001. Public program enrollment in Minnesota increased from 21.2% of the population in 2001 to 25.1% in 2004. Uninsurance rates increased to 7.4% in 2004 from a low of 5.7% in 2001.

The number of uninsured children in Minnesota increased by 11,000 from 2001 to 2004, leaving an estimated 68,000 children without health care coverage. Uninsurance rates increased particularly significantly for children under the age of 5 (3.9% to 6.8%) and young adults ages 18 to 24 (13.7% to 18.9%). Changes made to eligibility criteria for Minnesota's public programs made in 2003, increase costs of private health insurance, cuts in public program outreach activities and an increase in the number of Hispanic/Latino children are felt to contribute to the higher number of uninsured children.

Title V staff, through a variety of venues worked on increasing enrollment in insurance, including public programs, and to influence policy around eligibility and benefits. Maze trainings (Taking the Maze out of Funding) educate families, especially families with CYSHCN and providers on public program eligibility. Staff in the Family Home Visiting Program, and WIC Program also emphasized the importance of grantees assessing children's health insurance or public program status and referring appropriately. The work of the statutorily directed Maternal and Child Health Advisory Task Force continued to monitor the outcomes of policy changes made in 2003. The legislative passage of the Local Public Health Act, requiring the identification of performance outcome measures for local public health has offered the opportunity to highlight the importance of insurance or public program coverage for children. One of the outcomes identified for the next four years is "Increase the number of clients who are enrolled in health insurance programs (including public programs)." Data of local public health efforts will begin to be collected beginning in January 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide MAZE trainings for parents and professionals		X		X
2. Partner with DHS to assure that all children eligible for public programs are enrolled		X	X	X
3. Work within existing systems to assist families in identifying insurance options				X
4. Continue to participate on the BUILD Coalition				X
5. Update and distribute the Part C Central Directory and the Parent Information Packets		X		X
6. Maintain insurance coverage component of the Family Home Visiting program			X	X
7. Develop communication plan for using information related to				X

health insurance to educate and inform providers, families, planners and policymakers.				
8. Participate on Department priority area of Health Care Reform activities.				X
9.				
10.				

b. Current Activities

Information provided under the Maze trainings was updated and workshops held around the state. A new grant program working with pregnant women has included the requirement that insurance status be assessed and women referred and supported through appropriate insurance or public program application. The Health Economics Section has refined earlier data analysis from the 2004 state survey providing more detailed information on the insurance status of Minnesota's children. Work on the data elements needed around clients enrolled in health insurance programs for the Local Public Health Act reporting is currently being discussed. Beginning July 1, 2006, individuals eligible for Minnesota's 1115 Waiver for family planning services will be screened for broader Medicaid eligibility. It is anticipated that a significant proportion of individuals accessing 1115 Waiver services will be under the age of 21. Another activity that Title V staff will participate in is the identification of effective strategies for local public health to implement to achieve their goal of increasing the number of clients who are enrolled in health insurance programs.

c. Plan for the Coming Year

The Title V programs will continue to support the activities listed above. One of the identified concerns to be considered by the Title V/Title XIX Group for the upcoming year is the impact of no health care coverage on children. The MCH Task Force will continue its work on monitoring the impact of eligibility changes to public programs on children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					30.7
Numerator					14701
Denominator					47885
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	29	27.5	25	23.5	22

Notes - 2005

Performance indicator for 2004 was applied to 2005 because data for the 2005 are not yet available. Source of data is PedNSS.

a. Last Year's Accomplishments

Data for this new measure indicates generally rising rates of BMI at or above the 85th percentile for the young children in WIC over the past 4 years. The overall rate has increased from 28.7% in 2001 to 30.7% in 2004. In 2004, the white (27.3%) and Black (28.3%) children are below the overall rate (30.7%), but the Hispanic (36.9%), American Indian (50.2%) and Asian/Pacific Islander (34.7%) are above the overall rate. The Minnesota WIC program has recognized this growing health issue and the disparities across this measure. The Minnesota WIC Nutrition Education Plan is focused on childhood obesity prevention, with the following objectives: 1) staff

training; 2) participant education; 3) staff modeling of healthy behaviors; and 4) collaborating with community partners who share the goal. The WIC food list was revised to highlight and encourage breastfeeding and use of lower fat foods.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Weigh and measure (twice/year) children ages 2-5 participating in WIC, plot data on growth grids and calculate BMI.	X			
2. Identify children at-risk-of-overweight or overweight, using BMI.	X			
3. Provide referrals to primary health care provider and other health and social services as needed.	X			
4. Counsel caregivers and provide nutrition education (e.g. related to feeding practices, diet and physical activity).	X	X		
5. Tailor the WIC Food package to best meet child's dietary needs.	X	X		
6. Transmit anthropometric data to CDC for PedNSS reports.				X
7. Share anthropometric data summaries with local and state stakeholders to guide policy decisions.				X
8. Participate on development of Obesity State Plan development			X	X
9. Incorporate appropriate referral mechanisms to WIC from other child programs such as home visiting, Follow-Along Program, Positive Alternatives grantees, etc.			X	X
10.				

b. Current Activities

State WIC staff work to support the implementation by local WIC staff of the state WIC Nutrition Education Plan. In compliance with this plan and WIC requirements, local WIC staff weigh and plot BMI to identify children who are overweight or at risk for becoming overweight and provide counseling and referrals for the parents/caregivers. Title V responsibility includes incorporating referral to WIC of those young children found in need of nutritional services identified through Title V programs, coordinating services to jointly served families, and in collaboration with WIC identifying public health strategies to address the issue of obesity in Minnesota. Both WIC and Title V were asked to join other MDH programs in staffing the development of a Minnesota Obesity Prevention Plan funded by CDC.

c. Plan for the Coming Year

Continue clinical activities (assessment, referral, education and tailored food package); continue data management and reporting; and continue and build on activities described in FY 05-06 WIC Nutrition Education Plan and reflected in the WIC FY 07 State Plan. Continue collaborative activities between Title V and WIC and continue to participate on development of a state obesity prevention plan.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					

Annual Indicator					14.9
Numerator					
Denominator					
Is the Data Provisional or Final?					Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	13	12	11	10	10

Notes - 2005
The performance indicator for 2003 was applied to 2005 because data for 2005 are not yet available. Source of data is the PRAMS survey.

a. Last Year's Accomplishments
Minnesota began creating systematic changes to deal with smoking cessation in childbearing-age women when in 2004 when MDH was invited to participate in a national Action Learning Lab (ALL) process on the issue of smoking in pregnancy. Minnesota and 9 other states received technical assistance from a national collaborative of organizations including the Association of Maternal & Child Health Programs (AMCHP), the American College of Obstetricians & Gynecologists (ACOG), Planned Parenthood Federation of America (PPFA), and the Centers for Disease Control's (CDC) Division of Reproductive Health.

A State Team comprised of Title V staff, along with staff representing MDH's Tobacco Office, Planned Parenthood of MN/SD, and MN ACOG Chapter attended technical training sessions in Washington, DC in March and July of 2004 and in July 2005. Their mission in coming together was to develop Action Plans for Smoking Prevention and Cessation for Women of Childbearing Age, including Pregnant Women. Between invitational meetings, the State Team received ongoing technical assistance and refined MN's Action Plan through audio conferences conducted by the national agency staffs. MN's State Team leader in this effort is the Infant Mortality Reduction program staff.

In January 2005, through a successful CDC tobacco quitline enhancement grant application, the Tobacco Section recruited a public health nurse as a tobacco cessation specialist to organize a project to increase use of MN's tobacco counseling quit lines by pregnant smokers. This specialist became the 5th member of the State Team.

An inventory of smoking cessation patient education information specific to pregnant smokers was built. Representative prenatal primary care and public health clinics were chosen to pilot a Helping Pregnant Smokers Quit initiative, and a system to make priority referral by fax from prenatal clinics to the appropriate cessation counseling quitline was developed, tested and implemented. The state's public telephone counseling program, called QUITPLANSM, agreed to pay the costs for counseling any uninsured pregnant smokers who wished to enroll. In the first six months of the project, enrollment by pregnant smokers increased tenfold, from 5 callers to 49 pregnant callers.

In addition, all new WIC staff received training and materials on integrating the 5 A's brief counseling and referral to state quit lines into their WIC program activities. Several local public health agencies have requested and received training and materials on 5 A's brief counseling and cessation resources for their home visiting nurses. These trainings have emphasized the risks of postpartum relapse and include strategies for helping women become non-smokers vs. temporary cessation for pregnancy duration.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Access MN vital record, PRAMS and WIC databases for baseline incidence of smoking in pregnancy and ethnic/racial disparities			X	
2. Implement with partners the Smoking Cessation for Women State Plan.		X		X
3. Repeat and extend motivational interviewing (MI) training for smoking cessation			X	X
4. Consult with metro Neighborhood Health Care Network community health centers to develop staff skills, then offer cessation services onsite			X	X
5. Work with others within the Department (OMMH) and external partners, (ACOG and midwives) to identify strategies on effectively reaching high-risk populations.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Displays of resources for helping pregnant smokers, and other women of childbearing age quit and maintain quit status were exhibited at the Community Health Conference in September 2005, the Minnesota Perinatal Organization annual conference in October 2005, and March of Dimes' 4th Annual Prematurity Summit in November 2005. Title V staff participate in planning the Prematurity Summit to assure that the impact of prenatal tobacco use on prematurity, low birth weight, and other poor pregnancy and infant outcomes is referenced in the presentations. The 2005 Summit devoted an entire session to innovative strategies to address smoking in pregnancy as well.

In December 2005, the physician State Team member presented the new ACOG Committee Opinion, Smoking Cessation During Pregnancy (October 2005) at the chapter's annual winter conference, and updated members on progress of the priority fax referral of pregnant smokers from clinics to state quit lines.

An article published in Minnesota Medicine in December 2005, written by Title V staff in partnership with Indigenous People's Task Force researchers highlighted the disparity in smoking rates experienced by American Indian women giving birth in MN compared to all other groups. The article, aimed at MN's physician providers, served to put the issue in historical and cultural context and was a call to action for providers to help their American Indian patients respond to the problems tobacco is creating for themselves, their children and their families.

In April, 2006, the State Team delivered a day-long training to 154 participants from public health, clinics, and community organizations entitled, Motivating Pregnant Smokers to Quit: Training, Tools & Techniques. The training was broadcast simultaneously to 10 sites by videoconference. Public health nurse consultants worked on-site in each city, in order to facilitate demonstration of the techniques and allow for interview practice by participants. The agenda emphasized current best practice advice on smoking cessation through a presentation by the ACOG member of the State Team on "The Hidden Dangers of Smoking in Pregnancy", information on what happens when a smoker gets referred to QUITPLANSM Helpline, the ACOG Smoking Cessation During Pregnancy curriculum for take-home reference, a video segment demonstration of application of the 5-A's in a clinic setting, and research findings that Health Canada has distilled into a situational analysis called "Expecting to Quit". The training culminated in a 3-hour interactive introduction to Motivational Interviewing to Promote Behavior Change lead by an expert from the Mayo Clinic's Nicotine Dependence Center. Demand for this training exceeded capacity at nearly every site; repeat trainings on a regional basis and an archive of presentation slides on the MDH

website are planned.

c. Plan for the Coming Year

1.) Utilize MN vital records, PRAMS and WIC atabases to estimate baseline incidence of smoking in pregnancy. One system change that affects MN's ability to monitor this National Performance Measure was the discontinuation of the requirement that providers and health plans submit the Minnesota Pregnancy Risk Assessment form (MPAF) to the Title XIX program as of July, 2005. Completion of that form to document screening all Medicaid-eligible pregnant women for medical and psychosocial risk factors, including use of tobacco, alcohol and other drugs had been required statewide since 1998. Previous MCH Block Grant Annual Reports indicate 73% of the 22,000 deliveries covered by Medical Assistance in 2001 were screened prenatally using the MPAF. In the absence of that monitoring system, Title V staff will work for early access to the remaining perinatal databases in state vital records, PRAMS and WIC programs to obtain a baseline incidence of smoking in during pregnancy for Minnesota women.

2.) Invite voluntary local public health agency participation in the MDH Helping Pregnant Smokers Initiative. Preliminary results from the Initiative's demonstration sites suggest that the women most apt to need help quitting smoking in pregnancy overlap much with the population currently receiving WIC and MCH services from local public health agencies. In FFY 2007, Minnesota expects to utilize staff and other resources to support local public health staff and others in skill-building for best practice cessation management, including referral to no-cost telephone counseling services.

3.) Repeat and extend motivational interviewing (MI) training for smoking cessation. The overwhelming interest, "standing room only" turnout for the Department's first training in Motivating Pregnant Smokers to Quit (see current year activities above), and positive evaluation/feedback strongly indicate the need to offer more MI training. Plans are to repeat the motivational interviewing introductory training in different regions of the state, as requested, and work to include primary care clinic nursing staff in the skill building as well. Further, using a combination of methods such as conference calls and web conferencing, satellite broadcast and face-to-face interactive programming, Mayo Cessation counselors, Title V staff and State Team members plan to periodically cover more MI techniques, as well as offer consultation to health care providers as they start to apply MI techniques in their public health practice.

4.) Consult with metro Neighborhood Health Network (23 independent, community clinics serving minorities, and uninsured persons in the Twin Cities), project to develop staff skills, then offer cessation services onsite. This activity, planned in partnership with members of the State Team, aims to mentor clinicians currently providing prenatal care to increase tobacco dependence treatment as part of that primary care.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	8.6	8.5	8.4	8.2	8
Annual Indicator	10.3	8.9	10.1	10.0	
Numerator	37	34	38	38	
Denominator	357513	383051	376843	378976	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	9.8	9.8	9.6	9.6	9.4

Notes - 2005

The 2005 data are not yet available.

Notes - 2003
Source of data is death certificates.

a. Last Year's Accomplishments
The suicide death rate (per 100,000) among youth aged 15-19 years decreased from 10.6 in 1996 to 7.7 in 2000 and increased to 10.3 in 2003. There were 36 suicide deaths in 2002, 38 suicide deaths in 2003 and 37 in 2004.
Work has continued to implement our statewide suicide prevention plan. Over 200 adults in ten communities were trained to present adult and youth gatekeeper suicide prevention education. They, in turn, educated over 1,900 youth and 420 adults in the risk and protective factors and warning signs for suicide.

Outreach to diverse communities has also been an important focus. Over 4000 Hmong teenagers read the Hmoob Teen Magazine, which presents articles on topics related to suicide prevention. A teen board plans and researches the articles. Another example is the Ninijanisag (Our Children) Program, which helps American Indian youth increase their protective factors of cultural connectedness, connection to elders and other community leaders. Somali television broadcast suicide prevention information to approximately 20,000 viewers. Eighteen sessions provided suicide prevention education for youth, while ten workshops educated service providers about Somali-specific suicide prevention education. Several events raised awareness of youth suicide prevention. "Shades of Blue: Suicide Prevention among Youth from Diverse Communities" was held in May 2005. Over 150 professionals attended the conference to learn about best practices. The Honor the Youth Spiritual Run originated in Minneapolis on August 18, 2005 and continued over four days through Mille Lacs, Leech Lake, Bemidji, ending in Red Lake. The purpose of the Run was to raise awareness of suicide prevention, violence and substance use in the Native American communities utilizing traditional practices and ceremonies. Over thirty community organizations participated in the Run, and community gatherings ranged from 50-100 people in each of the five communities. Media coverage occurred throughout the state.

A new resource for youth also began. The Native Youth Crisis Hotline is housed within Women of Nations, an organization that serves Native American families experiencing violence. The Hotline began on August 18, 2005 and is staffed 24 hours per day, 7 days a week. The purpose of the hotline is to offer confidential crisis counseling and referrals for Minnesota American Indian youth. Over 10,000 hotline cards have been distributed.
The state funding for suicide prevention was eliminated, and the Minnesota Department of Health found funding to carry the program for an additional six months, while working with grantees to transition their programs. The Minnesota Mental Health Action Group (MMHAG) finalized recommendations to improve early identification and intervention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implementation of state suicide prevention plan			X	X
2. Technical assistance to public health & other community agencies				X
3. Participate actively on the Children's Subcommittee of the State Advisory Council on Mental Health				X
4. Continue to support youth activities that support resiliency & healthy behaviors			X	X
5. Continue to analyze student survey data to identify populations at higher risk				X
6. Collaborate with external partners such as Suicide Awareness				X

Voices of Education and Yellow Ribbon Minnesota.				
7. Continue to staff American Indian Suicide Prevention Workgroup				X
8. Continue to evaluate hospital discharge and ER care.			X	
9.				
10.				

b. Current Activities

In November, MDH collaborated with two community organizations to host a suicide prevention conference. The conference brought together 80 public health, mental health and youth-serving professionals to learn about current research and best practices, as well as to provide input on the update of the Minnesota State Suicide Prevention Plan. MDH continues to provide technical assistance to communities regarding their suicide prevention initiatives. Additionally, MDH is developing a fact sheet with recommendations for suicide prevention in the elementary school setting to promote earlier identification and intervention. MDH secured a HRSA grant for State Agency Partnerships to promote child and adolescent mental health, which supports suicide prevention activities. MDH also applied for a federal SAMHSA grant to develop new youth suicide prevention initiatives.

The Governor's Mental Health Initiative was partially funded allowing forward movement in revamping Minnesota's current mental health service system. This initiative came out of a private-public effort to improve mental health services in Minnesota called MMHAG.

Title V staff began to convene a mental health workgroup to provide coordination and communication about mental health activities across the department. Title V is represented on both the Children's Mental Health Subcommittee of the State Advisory Council on Mental Health. The focus of involvement is the Early Intervention and Prevention Workgroup, which has worked primarily on promoting a socioemotional component to early childhood screening, in particular, educating parents from diverse backgrounds about the importance of and process for screening. Additionally, Title V staff participate on the Mental Health in Special Education Leadership Committee, which has developed three modules of training for teachers around early intervention and classroom strategies. Staff are also collaborating with the Department of Education and the Department of Human Services to plan a cross-disciplinary conference on children's mental health.

c. Plan for the Coming Year

Will continue current activities as well as gather additional input on the state suicide prevention plan through regional meetings and online information.

MDH is seeking funding for two major initiatives: a resource facilitation pilot project for youth suicide attempters and a youth summit for American Indian communities. To support the needs of youth suicide attempters and their families, a resource facilitation project would focus on three pilot sites. Resource facilitation is a form of targeted case management that has been successfully used with patients with traumatic brain injuries. The families of youth suicide attempters would be offered support and assistance in accessing resources and in transitioning back to work, school and their communities. This service does not replace any mental health, medical or rehabilitation follow-up that may be needed. It is intended to provide on-going support for families.

The Youth Summit is the centerpiece of a comprehensive approach to suicide prevention in American Indian communities. Stakeholders from four tribes and three urban Indian organizations consulted on the proposed project emphasized the need for youth involvement in suicide prevention. They also stressed the need to build upon previous wisdom and expertise in the

American Indian community.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective	90	96	79	80	82
Annual Indicator	96.0	77.5	76.8	84.6	
Numerator	752	642	584	654	
Denominator	783	828	760	773	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	86	87	88	89	90

Notes - 2005
The 2005 data are not yet available.

Notes - 2004
The 2004 data are not yet available.

Notes - 2003
Birth record data and hospital information are used for this measure.

a. Last Year's Accomplishments
In 2004, there were 773 births of infants weighing 1,500 grams or less, of which, 654 or 84.6 percent were born in facilities appropriate for high risk very low birth weight deliveries. This represents an improvement from 2003 when only 82.8 percent were born in such facilities (See section b).

The Minnesota Perinatal Organization (MPO) and the Minnesota March of Dimes are examples of two organizations whose purposes focus on healthy pregnancy outcomes. The Title V staff are involved with both groups in program planning for health professionals. The MPO targets all health professions involved in perinatal care by providing educational conferences to improve the health care of pregnant women and newborn infants. The March of Dimes focuses on both consumer and professional education. Title V and other health department staff work closely with March of Dimes on professional and consumer education on folic acid, preconception care, disparities in infant mortality and other birth outcomes, birth defects, and is collaborating with March of Dimes on their new prematurity education and research campaign.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor the status of perinatal centers in Minnesota				X
2. Collaborate with external partners such as the March of Dimes and the MN Perinatal Organization				X
3. Promote guidelines for Perinatal Care			X	X
4. Monitor the number & place of birth for high-risk deliveries				X
5. Actively participate in maternal case management collaborative meetings to improve maternity and infant care for				X

diverse and low-income families.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
There is continuing health system resistance to designation and expected utilization of regional high risk care centers. Minnesota's data on this performance measure worsened significantly, when an urban hospital with many annual births to high risk women converted from a Level III high-risk perinatal center to Level II in January, 2002. The same managed care entity, had two level III hospitals within 10 miles of each other and opted to reduce one of them to a level II. Title V staff will continue to monitor this data for changes.

Title V staff will monitor births of very low birth weight infants according to "Guidelines for Perinatal Care" 5th edition, 2002, published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG).

c. Plan for the Coming Year
Continue activities currently stated. Title V staff will continue to explore opportunities to educate providers about the importance of high-risk deliveries occurring at appropriate facility levels.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective	87.1	87.9	88.8	89.7	90.5
Annual Indicator	84.6	85.5	86.5	86.4	
Numerator	54090	55987	57935	58410	
Denominator	63916	65490	66963	67633	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	88	88	89	90	90

Notes - 2005
The 2005 data are not yet available.

Notes - 2003
Source of data is birth records.

a. Last Year's Accomplishments
In 2004, 86.4 percent of infants were born to women receiving care beginning in the first trimester, representing a marginal decrease from 86.5 percent in 2003. In 2003, Minnesota ranked 13th among the states and the District of Columbia in the percent of women receiving prenatal care in the first trimester and had a rate higher than the US average which was 84.1 percent. Minnesota's rank for non-Hispanic Black women starting prenatal care in the first trimester improved from 7th worst to 13th worst at 72.3 percent but was lower than the US at 75.9 percent. The rate for Hispanic women improved to 71.0 percent, and the rank improved from 13th worst to 24th worse but was lower than the US average at 77.5 percent. (Rankings among the

states on first trimester prenatal care for 2004 are not yet available from the National Center for Health Statistics.)

During the 2003 Minnesota legislative session changes were made to Minnesota statutes as they relate to the Local Public Health grant, including MCH activities. One of the most significant features is the new focus on accountability that required the development of statewide outcomes, focused on improving health, and to be associated with a set of essential local activities. During 2004, Title V staff, local public health and individuals interested in maternal and child health developed these outcomes. One of the approved statewide outcomes is "Increase the number of pregnant women receiving early and adequate prenatal care." The Commissioner of Health is charged with monitoring and evaluating whether each Community Health Boards (CHBs) has made sufficient progress toward the selected outcomes. Concurrently, the MCH Advisory Task Force continues to monitor the impact of state budget cuts on funding for maternal and child health services at the local level and small working sub groups from the Advisory Task Force are in the process of developing recommendations to the Commissioner of Health regarding improving Minnesota women's rate of early prenatal care.

Title V staff continued to work with public health agencies, representatives of managed care, and local providers to create a comprehensive, population-based model of prenatal care. Within this model, early identification of pregnancy, pregnancy intent, and early initiation of prenatal care is emphasized. A mapping project is underway to pinpoint those areas with higher rates of late prenatal care. Examples of initiatives to improve the numbers of women who initiate early prenatal care include the Twin Cities Healthy Start Program, the Nurse Family Partnerships in St. Louis and Clay counties, and the Maternity Case Management Excellence project in Minneapolis and St. Paul. Local CHBs, with Title V support, promoted the initiation of prenatal care in the first trimester. Some provided free pregnancy testing with referrals for appropriate services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Update and implement Perinatal Plan		X	X	X
2. Support activities that focus on primary health care, family planning, & medical homes for women	X	X	X	
3. Continue involvement on the Healthy Start grant		X	X	X
4. Partner with racial & ethnic communities to identify & implement strategies for improving early prenatal care		X	X	X
5. Continue partnerships related to community health worker program		X		X
6. Improve statewide universal and system capacity to provide perinatal mental health care.				X
7. Continue TA to OMMH and their grantees on reducing infant mortality				X
8.				
9.				
10.				

b. Current Activities

In greater Minnesota, as reported by CHBs, state district nursing consultants, and state and local WIC staff, some providers and clinics are routinely instructing some of their patients to wait until their second trimester before coming in for prenatal care. Changing these dynamics may be challenging. Early and adequate prenatal care for all of Minnesota's pregnant women is one of the ten priority areas identified in the five year MCH state needs assessment.

CHBs continue various activities to promote the initiation of prenatal care in the first trimester. Outreach activities are fundamental to increase the number of women who will begin early prenatal care. CHBs initiate and maintain collaborative relationships with other community organizations frequented by women of childbearing age. By reinforcing the importance of early pregnancy identification and referral as well as healthy life styles to community-based organizations and the women they serve, the opportunity for impacting attitudes and behavior is increased. CHBs promote such messages through collaborations with area health clinics, hospitals, extension services, social services, schools, Head Start programs, and early child and family education programs. A collaboration of 15 counties in greater Minnesota is applying for training to become a Nurse Family
Partnership site further enhancing Minnesota's local public health home visiting skills during pregnancy.
Title V staff continue to partner with state colleges and universities on their education program for community health workers (CHW). It is anticipated that CHW's will extend the reach of the health system, including public health nurses and clinics, to serve more people, particularly populations of color, immigrants, and American Indians. Currently, Title V staff are exploring reimbursement issues for the work CHWs perform as a means of sustaining the CHW project. This will be a long-term effort with results to be determined in the future.

A 2005 initiative, the Positive Alternatives Grant Program, will make funds available in July of 2006 to organizations that encourage and support women in carrying their pregnancies to term by providing a variety of designated services. Among these is a focus on promoting healthy pregnancy outcomes that requires all grantees to provide information on, referral to and assistance with accessing medical care. This includes encouraging and facilitating early access to prenatal care through early pregnancy testing, assistance in enrolling in state-funded medical insurance, and prompt access to medical care. By identifying barriers to early prenatal care, many of these organizations have proposed programs that focus on decreasing the number of their clients affected by these barriers.

c. Plan for the Coming Year
This performance measure is addressed in Title V's Perinatal Plan (See attached .pdf file.) and was identified as a priority in the MCH needs assessment. Title V staff will address the overarching issues leading to delays in prenatal care: pregnancy intendedness, family planning, preconception care, primary health care, and establishing a medical home, and will work collaboratively with communities to promote culturally appropriate education and awareness regarding the importance of early prenatal care, and to address disparities in accessing early prenatal services.

D. State Performance Measures

State Performance Measure 1: *Proportion of counties that universally offer the Follow-Along Program, or an equivalent approved tracking program, to all children birth to age three.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					52.9
Numerator					46
Denominator					87
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**

Annual Performance Objective	53	55	57	58.5	60

a. Last Year's Accomplishments

The CYSHCN program has an interagency agreement with the Minnesota Department of Education for the child outreach activities pursuant to relevant provisions in Part C of the Individuals with Disabilities in Education Act (IDEA). These responsibilities are carried out through the Infant Follow Along Program (FAP). The FAP provides periodic screening and monitoring of those infants and toddlers at risk for health and developmental problems. It improves chances of identifying developmental problems at an early age, facilitates early intervention services for the child and links families and children to needed services. The FAP is supported programmatically and is funded through Title V and Part C of IDEA at the state level and a combination of Title V and local funds at the local level. The Ages and Stages Questionnaire (ASQ) is the screening tool utilized by the FAP. The social emotional component of the ASQ (the ASQ-SE) has been added to screening activities at local agency discretion over the last three years. Ongoing training is provided to local agencies (primarily local public health agencies) on administration of and implementation of the FAP.

As of December of 2003, less than one-half of one percent (0.43 percent) of Minnesota infants birth to one were identified as eligible for early intervention services compared to 0.91percent nationwide; and only 1.43 percent of infants and toddlers birth to age three were identified as eligible compared to 2.23 percent nationally. Based (in part) on this data, the federal Office of Special Education Programs (OSEP) determined, in a 2005 program audit of IDEA in Minnesota, that the state is not implementing eligibility criteria consistent with Part C provisions or the state's approved Part C application for federal IDEA funds. The MCSHCN program will work with the Department of Education on changes necessary to meet federal requirements.

In 2005 the MDH Environmental Health Division ended a two-year, CDC-funded birth defects pilot study that focused on newborn infants with confirmed neural tube defects, cleft-lip/palate or chromosomal anomalies and began implementation of a more comprehensive birth defects information system that includes 44 identified conditions. In the pilot study, the CYSHCN program contacted identified families to provide health information and referrals to programs and services. This has subsequently expanded and continues that referral responsibility in the more comprehensive system. Infants born in the seven-county, Minneapolis-St. Paul Metropolitan Area with one of any of the 44 conditions are referred for follow-up. Families are then contacted to ensure appropriate referrals to services are made and families are also referred to either the Follow Along Program or Part C Early Intervention Services. Fact sheets for use by families and providers on each of the 44 conditions were completed in the summer of 2005.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide technical support to local public health agencies participating in the program.				X
2. Convene advisory group to guide implementation of program enhancements				X
3. Integrate social emotional component into all screening programs			X	X
4. Continue hosting regional FAP Coordinators Meetings				X
5. Analyze program data & disseminate written report			X	X
6. Provide statewide training on reimbursement & funding sources & effective screening, assessment & intervention			X	X
7. Train professionals including FAP coordinators and Human Services professionals on ASQ-SE				X

8. Collaborate and coordinate FAP activities with other state agency initiatives involving social-emotional screening of young children				X
9. Continue developmental and social-emotional screening of children 0-3 as an outcome measure for the Local Public Health Grant Activity.			X	X
10. Support Community Health Board use of federal Title V funds for this activity	X			

b. Current Activities

Local agencies continue to expand the FAP by including the social-emotional component of the Ages and Stages Questionnaire in screening activities. An analysis of financial support of the locally implemented, state supported Follow-Along Programs indicated use of Medicaid administrative dollars as well as funds from Part C of IDEA, Title V and local tax levies. Children enrolled in the FAP as of December 31, 2005 totaled 19,401 or 9.6 percent of the birth to three population. Slightly more than one-half of the local agencies offer the FAP to families regardless of risk factors. In addition, local public health departments provided direct services to over 4,000 infants and toddlers with or at risk for special health care needs including nearly 600 infants and toddlers with known disabilities.

The CYSHCN program continues to provide technical assistance to local public health agencies through training sessions and software enhancements for the Follow Along Program. Intensive training around the issue of social-emotional development using the ASQ-SE as the screening tool continues to be provided to health, education and human services professionals. The Birth Defects Information System (BDIS) program plans to expand its program statewide during 2006-2007. The CYSHCN program will play a role in that expansion and continue to provide referral assistance to families.

Work with interagency partners continues to increase the percentage of young children who receive early intervention services. A particular focus has been participating in evaluating various screening tools for use by local agencies that can be used to identify children who may have a developmental delay. Improving early identification and intervention for children birth to three is the priority this performance measure addresses. However, this single performance measure provides a limited picture of the multiple efforts directed toward this priority. A stakeholders group reviewing Minnesota's criteria for eligibility for Early Intervention services has been meeting since May of 2006. The group will make recommendations to the Department of Education (the lead agency for Part C in Minnesota) for changes to the Minnesota Rule governing eligibility in response to the OSEP audit by August. Recommendations will include guidance relevant to "conditions with a high probability of resulting in developmental delay". The current work with BDIS is particularly relevant to this discussion with over 300 referrals as a result of BDIS efforts. An evaluation of child find (the outreach function pursuant to Part C) materials is a work activity for state fiscal year 2007.

c. Plan for the Coming Year

A new and related priority - improve early identification and intervention for children birth to three - was identified in the most recent Title V needs assessment. Three specific areas of activity will contribute to early identification: The Follow-Along Program, the Birth Defects Information System and child find capacity building at the local level for early intervention services through Part C of IDEA. Current activities will continue and expand. The BDIS will expand from surveilling births in the seven-county, Minneapolis-St. Paul Metropolitan area to all births in the state. The change to Minnesota Rules for Part C eligibility criteria will be re-written and brought to public hearings beginning in December 2006. Technical assistance and training will be provided to Follow-Along Programs. It is anticipated that child find materials will be modified to the extent that the results of the evaluation indicates.

State Performance Measure 2: *Percent of children enrolled in Medicaid who receive Early Periodic Screening, Diagnosis, and Treatment (EPSDT), also known as Child & Teen Checkup (CTC) in MN.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					62.3
Numerator					156113
Denominator					250456
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	64	65	66	67	68

a. Last Year's Accomplishments
In Minnesota the Title XIX EPSDT program is called C&TC (Child and Teen Check-Ups). The percent of C&TC eligible children and adolescents who received at least one preventive health visit was 62.3% in 2005; the same percent as in 2004. In general, the data indicate many lost opportunities for the provision of preventive care to these population groups.

Under contract with the Department of Human Services (DHS), Title V staff offered an extensive schedule of C&TC training sessions to health care providers. Participants included public health nurses, school nurses, private providers, and C&TC Outreach Coordinators. On-site follow-up consultations and clinic flow assessments were provided by a MDH certified pediatric nurse practitioner for newly trained nurses and refresher training was offered to more experienced nurses.

The interagency partnership between Title V, DHS, the Department of Education, the University of Minnesota Irving B Harris Center for Infants and Toddler Development, and the Minnesota Head Start -- State Collaboration Office led to the release of statewide recommended pediatric developmental and social-emotional screening tools (www.health.state.mn.us/divs/fh/mch/devscrn).

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue as an outcome measure for the Local Public Health Grant activity			X	X
2. Continue as a joint activity with the DHS as it relates to the Medicaid enrolled children				X
3. Continue WIC & CYSHCN clinic activities to support appropriate use of preventive visits.		X		X
4. Provide technical assistance and training to a variety of key providers			X	X
5. Maintain and enhance partnerships with other organizations that are working to assure child care.			X	X
6. Continue to distribute the Adolescent Health Action Plan: Being, Belonging, Becoming			X	X

7. Continue Medicaid participation on MECCS Interagency Leadership Team			X	X
8. Support local public health outreach activities to Medicaid eligible children	X		X	X
9.				
10.				

b. Current Activities
Title V continues to collaborate with DHS on the Child and Teen Checkups Program (Minnesota's EPSDT program). Through formal and informal relationships with DHS, Title V provides technical support to public and private C&TC providers, and to Outreach Coordinators in their efforts to inform clients and providers regarding C&TC. Also, Title V provides statewide training for Medical Assistance providers to increase quality comprehensive preventive health visits. Child and Teen Checkups training sessions continue to be updated regularly and are offered for public and private providers focusing on standards and screening components such as anticipatory guidance.

Vision screening recommendations for children birth to 3 years were revised. Both a vision and developmental screening web based training module was designed and implemented for C&TC providers as well as other early childhood vision screeners in public programs. (www.health.state.mn.us/divs/fh/mch/webcourse/index.html).
Title V continued collaboration with professional organizations, educational programs/institutions, state and local agencies, health plans and related childhood health programs to promote quality preventive care for Minnesota children, including education and training on strategies to address obesity (e.g., BMI and nutrition). Title V collaborates with the Department of Human Services (DHS) in the planning, development and evaluation of the components and standards for the C&TC.

c. Plan for the Coming Year
Continue activities currently stated above.

State Performance Measure 3: *Percent of sexually active ninth grade students who used a condom at last intercourse.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator				69	
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	70	71	72	73	74

Notes - 2005
Most recent data are from 2004.

Notes - 2004
Source of data is the MN Student Survey, which is administered every 3 years.

Percent of sexually active 12th grade students who used a condom at last intercourse was 61%. Response rates for 9th and 12th graders were 72% and 55%, respectively.

a. Last Year's Accomplishments

Minnesota uses state funding ($3.7 million) to support Family Planning Special Projects grants (FPSP) which includes financial support for all method services including condoms. Presently there are forty-one FPSP grantees representing all regions of the state. Thirty four percent (11,748) of the clients receiving counseling services through FPSP were aged 14 -- 19; 37% (9,168) of the clients receiving family planning methods were aged 14 -- 19. One thousand seven hundred and five (1,705) male clients received family planning methods through FPSP. In addition to FPSP, the Department of Health has a Title X grant that is given in whole to a clinic serving high-risk youth. Local public health agencies continue to use federal Title V dollars to provide family planning method services, reproductive counseling services, and health education about reproductive health in group settings.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to support Minnesota Student Survey data collection and analysis				X
2. Support access to family planning services for sexually active youth	X	X	X	
3. Increase public understanding of social, economic and public health burdens of unintended pregnancy			X	X
4. Continue abstinence programs that support adolescent in their decision to postpone sexual involvement	X		X	X
5. Support school based clinics & advocate for comprehensive reproductive education	X		X	X
6. Update and implement with stakeholders the MN Teen Pregnancy Prevention Plan			X	X
7.				
8.				
9.				
10.				

b. Current Activities

FPSP, Title X, and the MCH Block Grant continue to support reproductive health services including method services and outreach. Minnesota continues to support an abstinence education program that supports adolescents in their decision to postpone sexual involvement. Current program activities in reproductive health are focused on planning for reduced state family planning funds. Planning is underway regarding the need for significant FPSP program changes resulting from legislation which significantly reduced FPSP grant support. As a result of the decreased funding a statewide FPSP program is not feasible. Federal approval for Minnesota's 1115 Family Planning waiver application was received in 2004 and waiver implementation was announced effective July 1, 2006. Under the waiver program, adolescents (15 and above) are eligible for family planning services.

c. Plan for the Coming Year

Continue current activities as stated. As the 1115 family planning waiver is implemented, keeping family planning service providers informed of progress and providing technical assistance will be a major focus of program activity. In order to maximize the effectiveness of the 1115 waiver, continuation of Title V, and state-funded family planning activities will be needed. A continuing challenge in 2007 will be to address the impact in reductions of family planning special projects grant funding.

State Performance Measure 4: *Incidence of determined cases of child maltreatment by persons responsible for a child's care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator				6.0	6.2
Numerator				7784	7983
Denominator				1286894	1286894
Is the Data Provisional or Final?				Final	Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	6.1	6	5.9	5.8	5.7

a. Last Year's Accomplishments

Determined child maltreatment by a person responsible for a child's care decreased from 6.6 incidents per 1,000 children (0-17) in 2003 to 6.0 incidents per 1,000 children (0-17) in 2004. In Minnesota, counties may use Alternative Response, to report of child abuse, whereby they offer a voluntary strengths-based response to families needs and provide supportive servicesNo determination of maltreatment is made as part of the family assessment.

Child maltreatment has been identified as an important public health issue in the Minnesota Public Health Goals and as a priority issue for the 2005 Block Grant Needs Assessment reporting requirement. Staff provided significant expertise in the development and revision of these documents.

Staff have provided technical assistance and consultation for local Community Health Board (CHB) and Tribal Government Family Home Visiting (FHV) Program staff.

In January 2005, staff arranged Newborn Assessment trainings in three locations at the request of local CHB MCH Coordinators in the southwest counties. Over 90 participants attended. In February, March and April 2005, staff participated in planning a series of three video trainings on Methamphetamines and the risks of exposure to pregnant women and children. A facilitated discussion followed each training session regarding the Methamphetamine problem to local communities. The February Methamphetamine training had over 900 registered participants at 30 sites around the state. Staff participated in planning the 2005 Child Abuse Prevention Conference. Trainings were provided for local public health and tribal agency staff on a new curriculum developed by NCAST titled "Promoting Maternal Mental Health During Pregnancy". The trainings and addressed the impact that maternal mental health has on the health and well being of children, including intervention strategies to promote positive parenting and prevention of child maltreatment.

Staff consult and participate on the Department of Human Services' (DHS) Child Mortality Review Panel. DHS added staff and began a revision/expansion of the review process. Trainings were implemented to improve child death reviews at the local level throughout the state. This will enable the state panel to review clusters of similar deaths through a more efficient process and make recommendations for systems changes to protect children based on greater numbers of cases.

Staff coordinated Nursing Child Assessment Satellite Training Sessions (NCAST) and supported use of the Parent Child Interaction (PCI) tools by county and tribal public health nurses.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Identify and participate in opportunities to collect surveillance, best practices and policy development to reduce maltreatment.				X
2. Continue involvement on infant/Child Death & Child Maltreatment Review Panels				X
3. Develop/update & distribute infant death investigation guidelines			X	X
4. Provide information to local health & other partners regarding available crisis services		X		X
5. Disseminate strategies for prevention of child maltreatment i.e., home visiting			X	X
6. Continue to provide NCAST training				X
7. Continue as outcome measure for Local Public Health Grant activity				X
8.				
9.				
10.				

b. Current Activities

Technical assistance and consultation is provided for local public health and tribal government home visiting program staff. In November 2005, staff collaborated with the Infant Mortality Program Consultant, Midwest Children's Resource Center (MCRC) of Children's Hospitals and Clinics and Minnesota Hospital Association (MHA) to develop and distribute Shaken Baby Syndrome (SBS) prevention education materials to Minnesota's birthing hospitals and health care providers of children ages birth to 3 years olds.

In April 2006, staff participated in planning the 2006 Child Abuse Prevention Conference and in March 2006 co-sponsored an interactive videoconference training on Promoting April as Child Abuse Prevention Month. In May 2006, trainings will again be provided for local public health and tribal agency staff on the NCAST curriculum titled "Promoting Maternal Mental Health During Pregnancy".

The MDH website includes areas of focus such as: training resources, home visiting strategies and best practices, home safety resources, shaken baby syndrome prevention materials, infant sleep safety educational materials, and home visiting guidelines.

Staff continues to participate on the Child Mortality Review Panel.

Infant Mortality Partnership with Minnesota Sudden Infant Death Center is a key component of Minnesota's efforts to reduce infant mortality. Title V funding partially supports the Center. The Center serves the entire state providing grief support to families and child care providers. The Center also provides education statewide on risk reduction interventions.

Increasing numbers of Minnesota's infant deaths have occurred as unintentional injuries such as overlay, asphyxia, and entrapment related to unsafe infant sleep conditions. Title V staff collaborate with the Center to provide Infant Sleep Safety Education folders. These are being distributed to local public health, tribal health, and community-based organizations. A new Minnesota-specific public education campaign on safe infant sleep was launched in March, 2006. Work is also underway with state and local breastfeeding coalitions including La Leche League chapters to make safe infant sleep messages compatible with breastfeeding promotion

messages.

c. Plan for the Coming Year
Continue activities currently stated. Prevention of child abuse and neglect was again identified in the MCH Needs Assessment process as one of the top ten priorities for Minnesota for the next five-year cycle of the MCH Block Grant. Performance measures and activities related to these next priorities are currently being determined. Current partnerships and activities are likely to continue.

State Performance Measure 5: *Percent of pregnancies that are intended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			66.0		
Numerator			43136		
Denominator			65329		
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	70	71	72	73	74

Notes - 2005
Data for 2005 are not yet available.

Notes - 2004
Data for 2004 are not yet available.

Notes - 2003
Source of data is PRAMS.

a. Last Year's Accomplishments
Baseline data was collected in 1999 as part of the state's Behavioral Risk Factor Surveillance System (BRFSS). Unintended pregnancy was estimated at 43%. Analysis of the 2002 - 2003 PRAMS data indicates the unintended pregnancy rate to be 33%. BRFSS will be collecting new information on unintended pregnancy during 2005.

Title V, Title X, and state funds are expended for family planning services, including method services. In 2003, local CHBs used $756,000 to deliver method services to 3,180 individuals. In 2005, Title X funds of $180,000 were used to deliver method services to 1680 high-risk adolescents, and $3.7 million in state dollars supported methods services for 24,640 individuals.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyze PRAMS data				X
2. Ensure efficient & effective use of state funds for family planning services.	X	X	X	
3. Partner with Department of Human Services to successfully implement 1115 Family Planning Waiver			X	X

4. Increase public understanding & support for policies & programs that reduce unintended pregnancies		X	X	X
5. Promote statewide implementation of abstinence based education for 12 to 14 year olds			X	X
6. Consider policy and program recommendations for prenatal, interconception care and child spacing.			X	X
7. Implement youth activities that increase resiliency & support healthy behaviors			X	
8. Continue to direct resources to a hotline for family planning & STI services	X	X	X	X
9. Support school-based clinics & advocate for comprehensive reproductive health education	X	X	X	X
10.				

b. Current Activities

Title V, Title X and state funds continue to support family planning services. During the 2003 legislature, the legislature reduced state family planning funds by $1.2 million, to $3.7 million, beginning in SFY 2005. Federal approval for Minnesota's 1115 Family Planning waiver application was received in July 2004. Implementation is planned for July 2006. The waiver will allow individuals with incomes up to 200 percent of FPG to obtain coverage of family planning services.

c. Plan for the Coming Year

Continue current activities as stated. As the implementation date for the 1115 family planning waiver nears, keeping family planning service providers informed of progress and providing technical assistance will be a major focus of program activity. In order to maximize the effectiveness of the 1115 waiver, continuation of Title V, Title X and state-funded family planning activities will be needed.

State Performance Measure 6: *Percent of pregnant women screened for depression during routine prenatal care.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator			82.5		
Numerator			54491		
Denominator			66046		
Is the Data Provisional or Final?				Provisional	Provisional
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	83	84	84	85	85

Notes - 2005

2005 data are not yet available.

Notes - 2004

2004 data are not yet available.

Notes - 2003

Source of data is the PRAMS Survey.

a. Last Year's Accomplishments

This is a new state performance measure so the current activities are representing the same as last year's accomplishments.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote maternal depression screening by providers during routine prenatal and postpartum visits as well as during pediatric and well child visits			X	
2. Update/translate (as needed) and disseminate maternal depression education materials to prenatal, hospital, postpartum, and pediatric/well child practitioners		X		
3. Provide technical assistance and educational opportunities for county and tribal health staff on maternal mental health promotion, risk/protective factors, screening and referral, and issues related to working with women with mental illness				X
4. Provide education through appropriate media to health consumers and the public on maternal mental health and the importance to the health and well being of the mother and her family.		X		
5. Provide leadership and collaborate with other state agencies and providers, health plans, and others regarding the need to address appropriate mental health services for prenatal and postpartum depression				X
6. Promote and monitor reimbursement for prenatal and postpartum depression screening by the Department of Human Services and Minnesota Health plans				X
7.				
8.				
9.				
10.				

b. Current Activities

The PRAMS Data Users Group at MDH plans to analyze and review Minnesota's 2004 PRAMS data on postpartum depression. The question "At any time during your most recent pregnancy or after delivery, did a doctor, nurse, or other health care worker talk with you about ‘baby blues' or postpartum depression? Yes/No" was added in 2004.. This data source will be used as a proxy until a data source is developed or identified that provides data on the percent of women screened for depression during the prenatal period specifically. The Data Users Group will review the 2004 data to see if it can inform us on the percent of pregnant or postpartum women in Minnesota for whom their health care provider discussed "baby blues" or postpartum depression during pregnancy or after delivery.

Postpartum Depression Education legislation was passed in 2005 that requires hospitals to provide new parents and other family members, as appropriate, written information about postpartum depression (M.S.145.906). Staff facilitated a work group that represented a broad range of health care providers, consumers, mental health advocates and families to develop educational materials for this purpose and to develop policies and procedures for the implementation of the legislation. These materials are available for downloading on the MDH website at: http://www.health.state.mn.us/divs/fh/mch/fhv/strategies/ppd/index.html. The work group will be reconvened to discuss next steps. The work group identified systems issues that they felt should be addressed to help women experiencing perinatal depression and their families.

Between May, 2005 and May, 2006, staff coordinated nine regional two-day NCAST trainings for

county and tribal health staff on Promoting Maternal Mental Health During Pregnancy. They participated in planning the NAMI-Minnesota conference which was dedicated to Postpartum Depression. More presentations are planned on maternal mental health, postpartum depression, and screening for perinatal depression in a variety of venues: for MDH staff, at local public health agency staff meetings, at regional MCH group meetings, and at statewide conferences, such as the Prevent Child Abuse Minnesota Annual Conference.

Staff provided technical assistance to one Minnesota HMO on the postpartum depression screening tools available. This HMO has instituted a policy where providers can receive reimbursement for completing the Edinburgh Postpartum Depression Screen on its postpartum plan members.

c. Plan for the Coming Year

The 2004 PRAMS data on women who reported that their provider discussed "baby blues" and postpartum depression with them during their pregnancy or after delivery will be reviewed and shared with the PRAMS Data Users Group, the PRAMS Advisory Committee, as well as with other agencies and groups, as appropriate. Data from 2005 will also be analyzed and shared as appropriate, to raise awareness of the need to screen for perinatal depression and to assess whether this data item should be revised or additional questions developed and added to the Minnesota PRAMS questionnaire when CDC next allows revisions to be made, i.e. in 2009. Staff will confer with other agencies, institutions and health plans about the possibility of collaborating with them in the collection and analysis of perinatal depression screening data from other potential data sources. If no other sources can be identified, then discussions will be held about the possibility of adding this data item to other data collection systems for future data collection and analysis.

Title V staff will continue to provide leadership, technical assistance, and training opportunities to its community partners, county and tribal health staff, among others regarding the importance of perinatal depression screening and the need to address systems issues that limit access to timely and appropriate mental health services for perinatal depression.

State Performance Measure 7: *The degree to which Title V programs enhance statewide capacity for a public health approach to mental health promotion and suicide prevention for children and adolescents.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					1
Numerator					1
Denominator	4	4	4	4	4
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	2	2	3	4	4

Notes - 2005

Stage 1 is nearly completed with the remaining activity being to c) draft a mission statement which outlines our vision of and commitment to mental health promotion and suicide prevention in the state.

a. Last Year's Accomplishments

Mental health came up as a priority issue for all three populations in Minnesota's 2005 needs assessment activity. This is a process goal around capacity building to be accomplished in four stages. Attainment of this goal will be evidenced by the development and implementation of a statewide plan to build capacity for the role of public health in mental health promotion and suicide prevention for children and adolescents. Because of the critical relationship of maternal mental health to the mental health and development of infants and children, some activities for maternal mental health are also included.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Determine the extent and current status of all mental health activities across all divisions at MDH				X
2. Represent MDH on State Advisory Council on Mental Health and Children's Mental Health Subcommittees and related mental health workgroups				X
3. Update, with key stakeholders the state Suicide Prevention Plan				X
4. Determine the additional capacity and training needs of PHNs, health educators and other local staff regarding mental health promotion and suicide prevention				X
5. Support development of needed resources and capacity for local public health agencies statewide.				X
6. Continue to provide trainings around children's mental health issues.				X
7. Continue to provide staff support to Executive Office related to MMHAG activities			X	X
8. Partner with DHS (mental health authority) related to mental health screening, intervention, and mental health treatment				X
9.				
10.				

b. Current Activities

Title V staff have been convening regular meetings of a Mental Health Work Group, open to anyone from MDH with interest in or relationship to mental health in their work. The group consists of about 40 members from across the department, including an Assistant Commissioner. The primary objectives of this group are to provide a focus and forum for sharing mental health activities, looking for possibilities for coordination and collaboration, providing information and training around mental health promotion, and providing a focal point for broader planning and resource development. This work group provided the "material" for the development of an informal inventory of current mental health related activities across MDH. Over this past year, several trainings were held across the state around maternal mental health promotion for visiting nurses, with one specifically offered for Tribal workers. Several trainings have also been held around infant mental health, with both general education and skill development and training specific to the DC: 0-3 classification of infant diagnostic coding that supports treatment and reimbursement. The 2003 state legislature passed laws requiring information be provided for physicians to give to mothers about post partum depression. MDH convened a workgroup to consult on materials. This information is available on the web at http://www.health.state.mn.us/divs/fh/mch/fhv/strategies/ppd/index.html. The workgroup is working on next steps, including education for providers and recommendations for pediatric clinics.

MDH received funding from HRSA for State Agency Partnerships for Promoting Child and Adolescent Mental Health. As part of the work on that grant, MDH is developing

recommendations for suicide prevention in an elementary school setting.

MDH also is represented on both the Children's Mental Health Subcommittee and the State Advisory Council on Mental Health. The focus of involvement is the Early Intervention and Prevention workgroup, which has worked primarily on promoting a socioemotional component to early childhood screening, in particular, educating parents from diverse backgrounds about the importance of and process for screening. Additionally, MDH is represented on the Mental Health in Special Education Leadership Committee, which has developed three modules of training for teachers around early intervention and classroom strategies. MDH is also collaborating with the Department of Education and the Department of Human Services to plan a cross-disciplinary conference on children's mental health.

MDH continues to convene the Minnesota Council for Suicide Prevention and the American Indian Suicide Prevention Workgroup. MDH also partnered with Suicide Awareness, Voices of Education and Yellow Ribbon Minnesota to sponsor a conference on suicide prevention and to update the Minnesota Suicide Prevention Plan.

c. Plan for the Coming Year
Continue activities noted above with the mental health work group, supporting or providing trainings as resources are available, and continuation of the State Agency Partnerships for Promoting Child and Adolescent Mental Health grant activities. Complete phase one of the action plan for this measure to draft a mission statement that outlines our vision of and commitment to mental health promotion and suicide prevention throughout the state, including the role of public health in attaining that vision. We will then begin to move into phase 2 during which time we will work with local public health agencies to: (1) determine the additional capacity and training needs of LPH nurses, health educators and other local staff regarding mental health promotion and suicide prevention; and (2) support development of needed resources and capacity for our LPH constituents statewide.

State Performance Measure 8: *The ratio of the low birth weight (<2500 grams) rate for American Indian women and women of color to the low birth rate for white women.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator				13.5	
Numerator				82.4	
Denominator				6.1	
Is the Data Provisional or Final?				Final	
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	1.2	1.2	1.1	1	1

Notes - 2005
The data for 2005 are not yet available.

Notes - 2004
2004 rates of LBW for individual racial and ethnic populations per 1,000 live births are as follows: 106.1 for African-American women, 78.4 for Indian women, 69.0 for Asian women, 64.0 for Hispanic women, and 60.6 for White women.

a. Last Year's Accomplishments
This is a new State Performance Measure and the current activities are representative of last year's accomplishments.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ongoing collaboration with Twin Cities Healthy Start		X	X	X
2. Ongoing partnership with MN State Colleges on Community Health Worker education project		X	X	X
3. Ongoing technical assistance to the Eliminate Health Disparities Initiative, infant mortality grantees			X	X
4. Ongoing collaboration with the Latino Healthy Mothers and Babies group		X	X	
5. Continue to dialogue with Tribal Health Leaders around issues related to poor pregnancy outcomes.			X	X
6. Continue to provide TA to Tribal Governments on Family Home Visiting			X	X
7.				
8.				
9.				
10.				

b. Current Activities
Staff provide consultation and resources to community-based programs funded to address racial/ethnic disparities in birth outcomes including infant mortality and LBW. The federally-funded Twin Cities Healthy Start (TCHS) program provides outreach, case management, and health education to African American (AA) and American Indian (AI) pregnant and parenting families in Minneapolis and St. Paul to reduce their disparity in infant mortality. Staff work with TCHS as part of the Consortium and the Executive Committee. Staff helped develop the Local Health System Action Plan (LHSAP) and brought other partners, such as Title XIX, WIC and health plans, in contact with TCHS as they worked on long and short term goals for sustainability and system changes. TCHS received a state FAS prevention grant which funded their Support Sisters project, they receive infant sleep safety education folders, shaken baby prevention materials, smoking cessation in pregnancy resources, and were included in trainings on promoting maternal mental health hosted by Title V.
A related project from a goal of the LHSAP includes staff participation on the Community Health Worker (CHW) project. Recognizing that disparities in LBW are related to the availability of culturally competent health care services, TCHS and Title V, and others, have collaborated with the MN State Colleges and Universities (MNSCU) to develop, pilot, and implement a CHW education program at community colleges in MN. The program provides an education and career path for students who wish to continue their education in the health care or social service fields.

Staff provide consultation and resources to programs funded by the state's Office of Minority & Multicultural Health's Eliminate Health Disparities Initiative (EHDI) which includes funding for reducing infant mortality disparities between Whites and populations of color. Most of the programs fund doulas who are community members trained and certified as Doulas. The Doulas provide support, education, referrals, and advocacy to women and their families throughout pregnancy, childbirth and infancy.

Staff participate in the Latino Healthy Mothers and Babies work group initiated by Catholic priests in the Twin Cities who observed increased funerals for Latino stillborns and infants (in 2004-2005) than they had been in previous years. Although Latino rates of deaths have been comparable to the white rate, the priest's perceptions were real because the population has grown. Major

problems the work group uncovered were the significant barriers Latinos have to existing health and support services, especially when pregnant. A resource workshop was held in April, 2006, to train Catholic lay health workers and clergy from the metro diocese on what it takes to have a healthy pregnancy including actions to reduce LBW, what Latino-friendly resources are available, and how to provide support to pregnant and parenting Latino families in their communities.

c. Plan for the Coming Year
Continue all activities described above.

State Performance Measure 9: *Percent of Children and Youth with Special Health Care Needs (CYSHCN) with one or more unmet needs for specific health care services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2001**	**2002**	**2003**	**2004**	**2005**
Annual Performance Objective					
Annual Indicator					14.1
Numerator					21685
Denominator					153795
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	14.1	10	10	10	10

a. Last Year's Accomplishments
There is professional consensus that children with a medical home are more likely to have their need for services met across all systems than are children without a medical home. Establishing, spreading and sustaining the concept of medical home in Minnesota is the primary activity used to address this performance measure. Medical Home teams were first established in Minnesota in 2004 through a MCH Bureau Medical Home grant (2002-2005). That grant funded collaborative learning sessions, which were held in January and September of 2005. Curricula included the concept of medical home, issues of spread, parent role, cultural and linguistic competence, community outreach, the Medical Home Index tool, the Chronic Care Model, the Model for Improvement, care coordination, data collection, specialist-primary care practitioner interaction and transition. The Title V CYSHCN program and three local medical home teams also participated in the second national Medical Home Collaborative during 2005.

One of the objectives of the New Freedom Initiative grant (2005-2008) awarded by the MCH Bureau to Minnesota Department of Health in April of 2005 is to help build the infrastructure of the state chapter of the American Academy of Pediatrics through partial support of a full time staff position with the chapter. The goal was to help increase the advocacy capacity of the chapter to address unmet needs of children. This position was filled in September of 2005.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue support of medical home teams.		X		X
2. Continue support of mental health activities and initiatives.		X		X
3. Continue efforts to include addressing the issue of unmet needs as part of President's New Freedom Initiative grant work activities				X
4. Utilize Parent Summit to identify unmet needs.				X

5. Utilize Youth Summit to identify unmet needs				X
6. Continue operation of MCSHN clinics.	X			
7. Sponsor Gillette Specialty Healthcare regional conferences				X
8. Continue collaboration with DHS to analyze Medicaid claims data to support care coordination.				X
9. Continue to promote primary care providers as part of Early Intervention teams				X
10. Work with Children's Hospital to analyze reimbursement for hospice and palliative care				X

b. Current Activities

The CYSHCN program continues to support medical home learning collaboratives and to provide technical assistance and consultation to medical home teams in conjunction with the New Freedom Initiative grant. Learning collaborative objectives include exploration of methods to increase access to mental health care that involve establishing relationships between medical home clinics and mental health providers, using consultation with mental health professionals to assist primary care physicians in management of mental health diagnosis, and coordination of telemedicine to make specialty care (including mental health) more accessible.

The CYSHCN program is partnering with the Children's Mental Health Services Division at the Minnesota Department of Human Services (DHS) to provide statewide trainings on the DC: 0-3™ diagnostic criteria as a method to increase local capacity. This is a taxonomy that allows a more child friendly diagnostic classification system that can be converted to the DSM-IV classification system for purposes of reimbursement thereby decreasing financial barriers to mental health services. There will be trainings at four sites by June 30th on introduction to infant mental health and introduction to the DC:0-3™ system. Over two hundred mental health professionals are expected to attend these sessions.

A statewide family summit was held in May of 2006 to which all parents serving in an advisory capacity to state- and community-level education, health and human services programs, work groups and task forces were invited. It is intended that summits will be held in each year of the three-year grant and staff will attempt to select one to three topics on which to develop issue briefs from each year's summit.

One of the medical home teams was selected as one of fifteen national pilot sites in the AAP's D-PIP project that will test the AAP's new algorithm on developmental surveillance

State leaders including the CYSHCN director, the state AAP chapter and Family Voices agreed to initiate and support a Pediatric Council and as part of the infrastructure capacity building of the chapter. The initial meeting was held in April and those invited concurred with a vision of the council as a Pediatric Quality Health Consortium. Those attending included senior Title V and senior Title XIX state leadership, medical directors from health plans, senior administrative leadership from hospitals, the university's pediatric residency program, the state medical association and individual physicians at the forefront of quality improvement initiatives.

c. Plan for the Coming Year

The activities that are shared with the New Freedom Initiative grant will continue to be the primary strategy to address this performance measure. Currently, 14.1 percent of CYSHCN in Minnesota have one of more unmet needs for specific health care services. Through efforts to enhance and spread the medical home concept with primary care providers throughout the state, the CYSHCN program intends to decrease this number through assuring that primary care providers are knowledgeable regarding the medical home model, providing support and technical assistance to primary care providers in an effort to enhance local capacity, identifying unmet needs at the district level on an ongoing basis and is communicated to the appropriate entities, and continuing

to explore the option of telemedicine in an effort to meet the identified needs.

Regional CYSHCN staff are responsible for coordination of specialty clinics within their districts. These clinics are designed to address unmet needs and include Development and Behavior clinics, Facial-Dental clinics and Habilitation Technology clinics. One objective of these clinics through the work with contracted consultants, enhance local capacity in order to meet these needs. One district is exploring how activities that support and enhance the local medical home clinic could be linked to augment local capacity in order to provide similar services to the current specialty clinic model.

The CYSHCN program maintains and staffs a toll-free phone line giving access to families and providers to information regarding services and resources in their communities. Family calls are typically related to unmet needs of their child and/or family. The program will continue to promote and support DC:0-3™ trainings, to support the local practice participating in the AAP's D-PIP study, and the state Medicaid program in its efforts to increase developmental surveillance as part of the EPSDT well child screenings.

State Performance Measure 10: *Degree to which comprehensive mental health screening, evaluation, and treatment is provided to Children and Youth with Special Health Care Needs (CYSHCN).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2001	2002	2003	2004	2005
Annual Performance Objective					
Annual Indicator					6
Numerator					6
Denominator	20	20	20	20	20
Is the Data Provisional or Final?					Final
	2006	**2007**	**2008**	**2009**	**2010**
Annual Performance Objective	7	8	9	10	11

a. Last Year's Accomplishments
The state Title V programs (especially its CYSHCN program) has worked closely with Children's Mental Health Services (CMHS) of the Minnesota Department of Human Services over the last few years. CMHS is one of five grantees participating in the ABCD-II grant activity of the Commonwealth Fund (ABCD-II is the second cycle of the Commonwealth Fund's Assuring Better Child Health and Development). This grant activity is funded by the Commonwealth Fund and administered by the National Association of State Health Policy (NASHP). Minnesota's objectives include supporting primary care provider efforts to meet the needs of children at risk for delay in social or emotional development that do not meet the criteria for receiving services from the existing children's mental health system.

A four-member team including the ABCD-II Grant Coordinator, the state Medicaid MCH Quality Assurance Manager, the CMHS Director and the CYSHCN Director attended the annual NASHP conference in August 2005. This has led to closer collaboration and coordination of activities between CMHS and Title V in implementation of the SECCS grant, sponsorship of DC:0-3 trainings, integrating mental health curricula into medical home learning sessions and CMHS' proposed evaluation of Development and Behavior Clinics. These clinics provide a one-day, multidisciplinary team and diagnostic assessment of children up to the age of 21. The children who are referred have multiple behavioral, developmental, educational and physical issues. Most referrals from schools, most children are five to nine years of age, most have private insurance, most were already receiving special school services, most were referred by schools in school districts of less than 2000 children and most children had multiple issues.

The Minnesota Department of Education (MDE) is the lead state agency for implementation of Part C in Minnesota. Through an interagency agreement with MDE, theCYSHCN program is responsible for the child find outreach activities pursuant to Part C requirements. One of the ways this is fulfilled is through the Follow Along Program. The ASQ is the screening tool used by the FAP. The ASQ-SE component was added approximately three years ago on a pilot basis. Local agencies have been adding the social-emotional component at their discretion since then. Staff provide training and consultation to local agencies on the FAP and administration of the ASQ-SE.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to integrate mental health issues in medical home collaborative learning session curricula.				X
2. Continue collaboration with Children's Mental Health Services (CMHS) of the Minnesota Department of Human Services.				X
3. Continue financial and logistical support for DC:0-3™ trainings throughout the state.				X
4. Continue supporting CMHS in its implementation of the Commonwealth Fund's ABCD-II grant.				X
5. Continue to enhance facilitation skills of the CYSHCN program's district staff to support regional trainings and workshops.				X
6. Continue to promote universal implementation of the ASQ and ASQ-SE.	X		X	
7. Continue to promote adoption of the III-P product and process.				X
8. Continue to conduct Development and Behavior Clinics.	X			
9. Continue support of the medical home team selected by the AAP as one of 15 national sites to help implement the D-PIP project.		X		
10. Collaborate more closely with Head Start of Minnesota in collection and analysis of ASQ-SE data.				X

b. Current Activities

Continue support of ASQ-SE screenings through support and administration of the Follow Along Program. Over 20,000 children are currently enrolled in this program and continue to hold Development and Behavior Clinics. The CYSHCN program continues to collaborate with the CMHS program through financial and staff support of its DC:0-3Ô trainings. It contracts with the Zero-to-Three organization to conduct these training sessions throughout the state. The CYSHCN program also purchased required training materials on behalf of participants in the training sessions and its regional consultants serve as site facilitators for the trainings.

Child find outreach activities continue through the Follow-Along Program, use of the ASQ screening tool and its social-emotional component, the ASQ-SE. The state Medicaid program contracts with the Title V program for CTC (EPSDT) trainings for local public health agencies and these trainings now include training on the ASQ and ASQ-SE screening tools.

c. Plan for the Coming Year

Continue to support CMHS in its ABCD-II activities through financial support of DC:0-3 trainings, through district staff facilitation of these trainings and integration of mental health curricula into medical home collaborative learning sessions. The DC:0-3 trainings will be held in various cities

outside of the seven-county Minneapolis-St. Paul metropolitan area, including the Fargo-Moorhead and Grand Forks-East Grand Forks areas to encourage attendance by North Dakota professionals.

State level support for the Follow Along Program will continue with emphasis on more local programs adopting the ASQ-SE component of the ASQ screening tool and Development and Behavior Clinics will continue.

E. Health Status Indicators

HSI 01A-B, 02A-B: Low and very low birth-weight births

While the percentage of very low birth weight births has remained fairly constant since 2001, there was a small increase in the percentage of LBW births in recent years. Specifically, between 2003 and 2004, live births weighing less than 2,500 grams increased from 6.3 to 6.6 percent and live singleton births weighing less than 2,500 grams increased from 4.7 to 4.9 percent. Improvements in the medical management of high-risk pregnancies, with induction and early delivery or rapid cesarean delivery, as well as improvements in neonatal care are most likely contributing to these trends. With eight level-3, perinatal centers and a thriving Assisted Reproductive Technology (ART) industry, Minnesota is well positioned to respond effectively to the changing health care needs of pregnant women and neonates.

Another contributing factor to the rise of live LBW births is an increase in multiple births in Minnesota, which reflects trends nationwide. Since the introduction of ART, the ratio of multiple births to singleton births in Minnesota has increased from 1 in 55 births in 1980 to 1 in 29 births in 2003. The CDC estimates that 9 percent of ART singleton infants are born at LBW and 94 percent of ART triplet or higher order multiples are LBW. ART infants account for 18 percent of multiple births nationwide.

HSI 03A-C, 04A-C: Fatal and non-fatal injuries

No clear patterns emerge from data reported on fatal and non-fatal injuries among children 14 years and younger or youth aged 15 through 24 years. There was a slight increase in the death rate due to unintentional injuries among children aged 14 years and younger between 2003 and 2004; however, this increase (from 7.6 per 100,000 in 2003 to 9.2 per 100,000 in 2004) cannot be explained by a corresponding increase in deaths due to motor vehicle crashes and may simply indicate random variation. A slight, downward trend is evident in the rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years. Similarly, the death rate from unintentional injuries due to motor vehicle crashes decreased substantially in this age group between 2003 and 2004, dropping from 25 per 100,000 in 2003 to 20 per 100,000 in 2004. A downward trend is also evident in the rate of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger. Factors that might help to explain these reductions include increased seat belt usage among children and adolescents, and some strengthening of policies related to graduated drivers' licenses in Minnesota.

Over the past two years, MDH has worked to improve its procedures for entering and managing hospital discharge data, which is helping to reduce duplicates and errors in diagnostic and e-codes. With these new procedures in place, the validity of data reported on injuries in the Title V Block Grant is expected to be of increasingly high standard.

HSI 05A-B: Chlamydia

Between 2003 and 2004 in Minnesota, the rate of Chlamydia for adolescent women aged 15

through 19 years decreased 9.5%, from 16.3 to 15.5 per 1,000 women. During the same period for women aged 20 through 44 years, the rate of Chlamydia increased 15%, from 5.2 to 6.1 per 1,000 women. While a decreased infection rate among adolescent females is somewhat encouraging, Chlamydia rates for both 15 through 19 year olds and 20 through 44 year olds remain high compared to previous years. In fact, the overall rate of Chlamydia in Minnesota has doubled since 1996. Doubling of the rate has occurred among both men and women and has nearly tripled among 25-29 year olds and 30-39 year olds. Among 15-19 year olds, rates have increased 1.5 times.

In addition to age groups, increases in Chlamydia have been observed across racial groups and geographical areas. Since 1996, rates have doubled among Hispanics, Whites and Asian/Pacific Islanders. Rates for Blacks and American Indians have increased by 32% and 60%, respectively. Chlamydia rates have also increased by geography with the most marked increases happening in Greater Minnesota and the suburban 7-county metro area.

The observed increase since 1996 is most likely due to a combination of four factors: 1) improved testing technology with increased sensitivity; 2) improved screening practices by clinicians, 3) the addition of an active surveillance component, and 4) an increase of the disease in the population. The effect of the first three factors are likely to have leveled off over time, so recent increases are most likely being driven by an actual increase of the disease in the population.

HSI 06A-B: Population demographics enumerated by age group and race/ethnicity

Population estimates for 2004, enumerated by sub-populations of age group and race/ethnicity, were provided by the U.S. Bureau of Census. According to these projections, the population of infants and children aged 0 to 24 years accounts for 35% of the total population in Minnesota. With respect to race, estimates suggest that 86% of Minnesota's infants and children are White, 7% are Black or African-American, 5% are Asian, and 2% are American Indian or Native Alaskan. An estimated 5% of Minnesota infants and children are Hispanic. Given that these population data are projections only, little can be said about actual trends in state demographics over the past four years. However, it is clear that there is increasing diversity in Minnesota and, with this diversity, increasing challenges for Title V programs to introduce culturally appropriate strategies that target the diverse set of needs of this growing segment of the population.

HSI 07A-B: Live births

Live births to Minnesota residents increased only 0.8% between 2003 and 2004, from 70,053 to 70,709 infants. The crude birth rate decreased from 13.9 to 13.8 per 1,000 persons, a decrease of 0.7%. The fertility rate (births per 1,000 female population age 15-44) increased 0.6% from 64.1 in 2003 to 64.5 in 2004.

Births to mothers under the age of 20 and to those age 35 and over have been of special interest to public health professionals because these births tend to have more complications during pregnancy and childbirth, more infants of low birth weight and with congenital anomalies, and more infant deaths. There were 4,123 births to mothers under 20 years of age in 2004, a drop of 16.8% from the births to this age group in 2003. The number of live births to mothers age 35 and over continues to rise, increasing 1.4% from 2003 to 2004. In 2004, an average of thirty births were to women age 35 and older each day.

Compared with data reported in 2003, the number of births appeared to increase in 2004 for Black, Asian and Pacific Islander, and Hispanic mothers, but decreased for White and American Indian women. These changes, particularly for White mothers, are due in part to a change in the way race information is collected and coded. Beginning with 2004 data, an individual may report more than one race, as well as Hispanic origin, which is still collected as a separate item. It appears that most of the decrease for White mothers is an artifact of the method used to assign a

race code to those who reported their race as 'Other'.

HSI 08A-B: Deaths of infants and children

There were a total of 912 deaths to Minnesotan infants and children in 2004, which represents a slight increase (2.9%) from the 883 deaths reported in 2003. Minnesota's infant mortality rate of 4.7 per 1,000 live births did not change during this timeframe. The number of infant deaths, 332 in 2004 compared to 327 in 2003, is an increase of 1.5 percent. Care must be exercised in interpreting these changes as the number of infant deaths is very small. Thus a change in number or rate, though appearing to be rather large, may not be statistically significant.

Beginning with 2004 data, more than one race may be reported for an individual as well as Hispanic origin, which is still collected as a separate item. No significant changes were noted in the distribution of deaths by race as a result of this change. Improving the collection and standardizing the use of demographic data will help to identify high-risk populations and monitor the effectiveness of health promotion and disease prevention interventions targeting these groups.

HSI 09A-B: Miscellaneous demographic data

According to the U.S. Bureau of Census, there were an estimated 1,394,018 infants and children aged 0 through 19 years in Minnesota in 2004. Approximately, 21% of children were reported to live in households headed by single parents in 2000, with the percentage varying considerably by race. Whereas an estimated 16% of Asian children and 17% of white children lived in single parent homes in 2000, 62% of African-American children and 73% of multi-racial children lived in such households.

While the Minnesota Department of Human Services (DHS) does not provide data on the number of children living in foster homes, specifically, they do report on the number of children living in "out of home placements" and estimate that roughly 57% of these placements are in foster home care. The number of children in out of home placements decreased by 6% between 2003 and 2004, with just 1% of children aged 0 through 19 years reported to be in placements in 2004. American Indians had the highest percentage (7%) of children in out of home placements compared to any other racial or ethnic population in that year. Given that adverse health outcomes disproportionately affect infants and children in foster care and/or single parent homes, increased attention must be directed to these high-risk groups.

According to the National Center for Education Statistics (NCES), the high school dropout rate for Minnesotan youth, grades 9-12 years old, has been declining steadily since 1996, when a 5.5% dropout rate was reported. More recent estimates indicate a 4% dropout rate for the 2000-01 school year. Despite this relatively low rate for Minnesotan youth overall, racial and ethnic disparities are evident and reflect national trends of disproportionately high dropout rates in Hispanic and African-American youth and low rates among White, non-Hispanic, and Asian/Pacific Islander students. Leaving high school before graduation is known to lead to continued poverty and a higher incidence of juvenile arrests. It is therefore not surprising that racial disparities are evident in the rates of juvenile crimes in Minnesota in 2004, with a four times higher arrest rate for African-American youth and a two times higher arrest rate for American Indian youth compared to the rate for youth overall. In 2004, juvenile arrests accounted for 25% of total arrests, with the total number of arrests increasing by approximately 2% from the previous year.

Data on enrollment in various State programs for 2004 and 2005 indicate a 17% decrease in the percentage of children in TANF families and a 28% decrease in enrollment of children in the Food Stamp Program (which includes children in the Minnesota Family Investment Program [MFIP] who receive a food assistance benefit). This compares to a 25% increase in enrollment in the WIC program and relatively stable enrollment in the Medicaid program. Decreases in TANF are

can be explained by the introduction of a back to work program that occurred in Minnesota during the last four months of the 2005 fiscal year. The program resulted in a higher employment rate at the end of the fiscal year and a six-month delay in TANF enrollment. Given this delay, it is likely that participation in TANF program will increase again in the coming years.

HSI 10-12: State Demographic Data

According to the U.S. Census Bureau, Minnesota's population increased 6% between 1990 and 2000, from 4,626,514 persons to 4,919,479 persons. In 2000, it was estimated that 10% of the statewide population was of color, American Indian and/or Hispanic. Dramatic increases occurred in some populations during the recent decade, including a 165% increase in the Hispanic population, a 90% increase in the Asian population, and a 100% increase in the African-American population. Home to the largest Somali population and the second largest Hmong population in the United States, Minnesota is experiencing increasing diversity.

Approximately 70% of Minnesota's population lives in urban areas, primarily in the Twin Cities area of St. Paul and Minneapolis, and 29% live in rural areas (collectively referred to as "Greater Minnesota"). A significant number of American Indians and people of color live in the areas of Greater Minnesota as well as in the Twin Cities metropolitan area. On average, these populations are considerably younger than the Caucasian population with one-third of non-white and American Indian populations under the age of 18 years compared to one-quarter of the white population within this age group.

The demand on health care services in the metropolitan and urban areas where Minnesota's population is concentrated is considerable. The high concentration of poor families living in these areas without a regular source of coordinated health services also translates into over utilization of emergency services and frequent walk-ins to community and public health clinics. Reflecting national trends, there are a greater percentage of children at all levels of poverty (50%, 100% and 200%) than the State's total population, underscoring the tremendous importance -- and considerable challenge -- of the work that is done by Title V programs to protect the health and wellbeing of Minnesota's infants, children and families.

F. Other Program Activities

Toll-free Telephone Numbers - For parents and others, the Minnesota Title V programs assure toll-free telephone access to information about health care providers and practitioners who provide health care services under Titles V and XIX SSA and about other relevant health and health-related providers and practitioners. MDH has worked to accomplish the intent of this requirement by improving the effectiveness of previously established special purpose toll-free arrangements.

1. The Title V CYSHN Program has operated a toll-free Information and Assistance telephone line since March of 1990. The toll-free number is 800 728-5420. This line offers a comprehensive listing of services provided by state and county health and human services departments, hospitals, associations, family support groups and allied public and private entities. The toll-free number is included on all educational and informational publications developed and distributed and is included in all media announcements.

2. Minnesota does not have a dedicated 800 number for questions related to prenatal care or pregnancy. The Department of Human Services (DHS) consumer services call center 800 number handles questions related to obtaining prenatal care services from Medical Assistance or MinnesotaCare. Calls related to prenatal health programs and other maternal and child health matters are referred to Title V. Information regarding obtaining prenatal services and related

questions can also be accessed via the MDH or DHS internet web sites.

3. The MinnesotaCare program provides an automated state toll-free line that operates 24 hours a day, seven days a week. The automated message is available in seven languages including Spanish, Hmong, Somali, Vietnamese, Laotian, Bosnian, and Russian. The number is (651) 297-3862 (metro) and 1-800-657-3672 (greater Minnesota). The toll-free number will provide the caller with general information about the plan, qualifications for acceptance, and application information. All outreach materials distributed by the Department of Human Services include this state toll-free number for clients to call with questions. The line handle about 200,000 calls per year.

4. The Minnesota Family Planning and STD hotline is funded through state appropriations. The hotline is staffed by individuals trained in information and referral as well as family planning and STD counseling. The number is 800-78-FACTS. Approximately 5,000 calls are handled by the hotline annually. All family planning and STD related educational materials distributed by the Minnesota Department of Health include the hotline number. Annually, a pamphlet about family planning, which includes the hotline number, is mailed to all Medicaid recipients.

5. The WIC Program (Women, Infants and Children) 800 number is funded through Minnesota's federal WIC grant and provides 24 hour - 365 days a year phone coverage. Callers to the WIC 800 number are provided with the business telephone number of the local WIC project in their geographic area. The toll-free number is 800-WIC-4030. The service responds to approximately 3,300 calls per year. All WIC outreach materials distributed by the state WIC office and the local projects include the 800 number. There is also a WIC supported specialized line related to breastfeeding (877-214-BABY).

6. The Minnesota Immunization Hotline was established in 1994 and operates between the hours of 8:00 a.m. - 4:30 p.m. Monday through Friday. The toll-free number is 800 657-3970. The Hotline is staffed by a team of nurses and other professionals highly-trained in immunizations. Its primary purpose is to provide a timely source of information and consultation for providers and consumers faced with the increasing complexities of immunizations. ***/2007/ The Minnesota Immunization Hotline ended July 2, 2006. This decision was made in order to best use limited resources. Providers and patients with general immunization questions are referred to CDC INFO Contact Center. //2007//***

G. Technical Assistance

Please see Form 15. Further internal discussions are needed and we would look to the HRSA project officer for suggestions of appropriate individuals in a position to provide requested technical assistance.

V. Budget Narrative

A. Expenditures

Please see Forms 3-5 and appropriate related notes.

B. Budget

The Division of Community and Family Health provides oversight to the Title V Maternal and Child Health programs including the CYSHCN Programs although several programs impacting the health and well being of mothers and children are located in other areas of the Minnesota Department of Health. These programs include: newborn screening programs (except for newborn hearing screening); reducing disparities in infant mortality, lead screening, immunizations, Birth Defects Registry, tobacco and injury prevention efforts. Funds supporting these programs are in addition to those outlined in this application. No federal Title V funds are used directly to support these activities nor are any of these activities currently used for match or maintenance of effort.

Federal sources of funds that are administered by the Division of Community and Family Health include: HRSA funds of $13,755,188; CDC funds of $7,991,924; Department of Education funds of $533,000 and Department of Agriculture funds of $101,057,284 for a total of $123,337,396. As would be expected Department of Agriculture funds supports Minnesota's WIC and Supplemental Commodity Food Program as well as a Breastfeeding Peer Support Grant Program. Department of Education funds support child find activities under the federal IDEA program. CDC funds support a wide range of efforts including FAS prevention, EHDI, mental health promotion and local public health BT grants. HRSA supports our core maternal and child health programs as well as the CYSCHN program activities. BT and rural health funding is also available to critical care hospitals and clinics.

State funds used to support programs within the Division of Community and Family Health come to just over $35 million with the primary portion $21 million going out under the Local Public Health Grant. State funds support abstinence education, family planning services, CYSHCN diagnostic clinics, FAS prevention, newborn hearing screening, Women's Right to Know, Family Home Visiting program, infant mortality, management activities as well as professional loan forgiveness programs, trauma system development and community and rural hospital grant programs.

The source of matching funds for the Title V Block Grant comes from both state and local sources. Since legislation in 1982, two thirds of the Title V block grant goes by formula to Minnesota's Community Health Boards (CHBs) who provide the local public health infrastructure focused on the improved health of mothers, children and their families. The 2003 Legislative session consolidated these Title V dollars, along with seven other categorical programs, into the resulting Local Public Health Grant (LPHG) that provides funding for Community Health Boards and Tribal Governments. At that same time the match requirements for CHBs was raised from 25 percent to 50 percent. Community Health Boards predominately use local tax dollars and some state grant dollars to meet their required match. Additional federal match requirements were met by state funds administered at the state level to support MCH and CYSHCN programs efforts. The largest of these efforts is the state funded Family Planning Special Projects Grants.

Minnesota's maintenance of effort from 1989 is $6,184,197. The budget documents that Minnesota continues to exceed this level of effort.

Significant changes in the budget occurred with the loss of Suicide Prevention Grant funding ($918,487) and the Dental Health Program ($100,000) in the 2005 Legislative session. However, during that same session the Department of Health was appropriated $50,000 in SFY 2006 and $2.5 million in SFY 2007 and thereafter to implement program that support, encourage, and

assist a woman in carrying her pregnancy to term and caring for her baby after birth.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.