HRSA
Health Resources & Services Administration

Title V MCH Block Grant Program

MINNESOTA

State Snapshot

FY 2017 Application / FY 2015 Annual Report

November 2016

Title V Federal-State Partnership - Minnesota

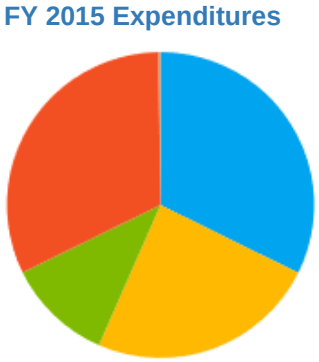
The Title V Maternal and Child Health Block Grant Program is a federal-state partnership with 59 states and jurisdictions to improve maternal and child health throughout the nation. This Title V Snapshot presents high-level data and the executive summary contained in the FY 2017 Application / FY 2015 Annual Report. For more information on MCH data, please visit the Title V Federal-State Partnership website (https://mchb.tvisdata.hrsa.gov)

State Contacts

MCH Director	CSHCN Director	State Family or Youth Leader
Susan Castellano MCH Director susan.castellano@state.mn.us (651) 201-3872	Barb Dalbec CYSHN Director barb.dalbec@state.mn.us (651) 201-3758	No Contact Information Provided

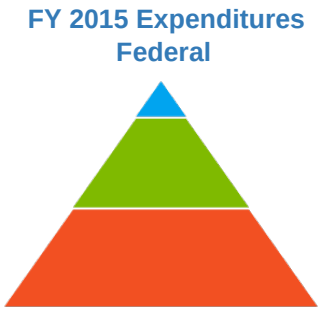
Funding by Source

Source	FY 2015 Expenditures
Federal Allocation	$9,097,317
State MCH Funds	$6,822,988
Local MCH Funds	$3,142,737
Other Funds	$9,019,129
Program Income	$63,517



Funding by Service Level

Service Level	Federal	Non-Federal
Direct Services	$1,444,194	$3,023,920
Enabling Services	$3,654,860	$7,652,710
Public Health Services and Systems	$3,998,263	$8,371,741



Total Reach of Title V in Serving MCH Populations

Populations Served	Individuals Served	FY 2015 Expenditures	%
Pregnant Women	23,055	$6,452,301	23.3%
Infants < 1 Year	69,916	$4,136,978	15.0%
Children 1-22 Years	559,670	$7,218,769	26.1%
CSHCN	280,978	$9,292,905	33.6%
Others *	78,003	$555,222	2.0%
Total	1,011,622	$27,656,175	100%

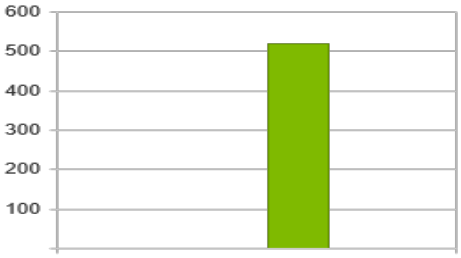
*Others– Women of childbearing age, over age 21, and any others defined by the State who are not otherwise included in any of the other listed classes of individuals.

FY 2015 Expenditures

FY 2015 Individuals Served

Communication Reach

Communication Method	Amount
State Title V Website Hits:	0
State Title V Social Media Hits:	0
State MCH Toll-Free Calls:	520
Other Toll-Free Calls:	0



Selected National Performance Measures

Measure #	Measure Short Name	Population Domain
NPM 1	Well-Woman Visit	Women/Maternal Health
NPM 4	Breastfeeding	Perinatal/Infant Health
NPM 5	Safe Sleep	Perinatal/Infant Health
NPM 6	Developmental Screening	Child Health
NPM 10	Adolescent Well-Visit	Adolescent Health
NPM 11	Medical Home	Children with Special Health Care Needs
NPM 12	Transition	Children with Special Health Care Needs
NPM 15	Adequate Insurance	Cross-Cutting/Life Course

Evidence-Based or –Informed Strategy Measures

NPM #	NPM Short Name	ESM #	ESM Title
NPM 1	Well-Woman Visit	ESM 1.1	Number of engaged users viewing social media messages delivered by the Title V program promoting the well-woman visit and other health-related topics
NPM 4	Breastfeeding	ESM 4.1	Number of Baby Friendly Hospitals
NPM 5	Safe Sleep	ESM 5.1	Number of MN hospitals with national Safe Sleep Hospital Certification
NPM 6	Developmental Screening	ESM 6.1	Number of providers and clinic support staff completing online modules on social-emotional development
NPM 10	Adolescent Well-Visit	ESM 10.1	Develop 2-4 C&TC outreach strategies
NPM 11	Medical Home	ESM 11.1	Percentage of families who requested referral to family-to-family support who were connected to the service.
NPM 12	Transition	ESM 12.1	Number accessing evidence-based materials on health care transition
NPM 15	Adequate Insurance	ESM 15.1	Number of families, providers, and stakeholders training in health insurance financing options

State Performance Measures

SPM #	SPM Title	Population Domain(s)
SPM 1	Percent of pregnant women enrolled in Minnesota Health Care Programs (MHCP) that receive 17-alpha-hydroxyprogesterone caproate (17P)	Perinatal/Infant Health
SPM 2	Percentage of young women of reproductive age at risk of unintended pregnancy that adopt or continue use of Long-Acting Reversible Contraception (LARCs) in Minnesota Health Care Programs (MHCP)	Women/Maternal Health
SPM 3	Percent of adolescents participating in out-of-school activities.	Adolescent Health

Executive Summary

Minnesota (MN) is considered a medium-size state with a relatively homogenous population estimated at 5,489,594. However, the composition of the state's population has been changing. While still less diverse than the U.S. as a whole, Whites currently make up 81.4 percent of the population, a significant decrease from 97.8 percent in 1960.

In 2015, MN was ranked 4th healthiest in the US by the UnitedHealth Foundation, first in the nation for health care by the Commonwealth Fund and first in the nation for overall child well-being. But, these rankings do not tell the whole story. For many populations the opportunity to be healthy is not available leading to significant and persistent disparities in health outcomes. For example, MN's African American and American Indian babies die at twice the rate of white babies and women of color were two to three times more likely and American Indian women seven times more likely to receive inadequate or no prenatal care.

These statistics are alarming and will require significant efforts by all to assure that gaps in health disparities are narrowed and health equity achieved for mothers and children. Success will only be achieved through equal access to health care, excellent schools, economic opportunities, quality environmental surroundings to play and work, affordable housing, good transportation, safe neighborhoods and a childhood without poverty, racism, abuse or violence.

Title V is actively engaged in a number of national and state initiatives that are looking to achieve health equity and improve health for those impacted by disparities.

- Engagement on both the National and Regional Collaborative Improvement and Innovation Network (COIIN) to Reduce Infant Mortality.
- Engagement in the Systems Integration Academy to improve the system that serves children and youth with special health care needs with a focus on care coordination in the health care home and parent engagement in the process.
- Prevention efforts are being focused more upstream on working to strengthen the resilience of young children, their families and the communities in which they live to assure mental well-being.
- The Children's Cabinet, established by Governor Dayton in August 2011, brings together the Commissioners of the Departments of Education, Health and Human Services to focus on working collaboratively to ensure MN children are healthy and prepared to achieve their full potential.
- Improving kindergarten readiness for at-risk young children was the focus of MN's Race to the Top Early Challenge grant. Awarded in late 2011, this $45 million grant was a joint partnership between the MN Departments of Education, Health and Human Services. Efforts targeted providing at-risk children access to high quality early childhood programs, improving the early childhood workforce, developing early learning standards, improving developmental and social-emotional screening, supporting health and safety in child care settings, and measuring our outcomes and progress. These efforts will continue through December 2016 under a no cost extension.

Health disparities and health equity were core themes throughout the needs assessment process. Using a health equity lens, assuring that community voices were included throughout, using a "health in all policies" approach and assuring that populations experiencing the greatest health needs had a voice in the solutions constituted the framework used to guide the process. Title V staff worked hard to reach out and engage consumers and stakeholders to assure active and ongoing involvement in the process. Building on previous state and local public health needs assessments, existing public health reports and active community and stakeholder involvement, the process identified MCH and CYSHCN priority needs in the six domains.

Women/Maternal Health

Priority Needs: Promote routine well-woman visits to support the mental and physical health needs of women. Increase the proportion of pregnancies that are intended.

Routine screening for maternal depression, especially for low-income women, has been a concern as data indicates women of color in MN are much more likely to experience perinatal mood disorders. PRAMS data indicates that African American women reported frequent postpartum depression symptoms after their child was born at double the rate of White women. Medicaid data indicates that while new mothers are good about scheduling and getting their newborn in for well child care, they are not as consistent about their own post-partum visits. Supported by the Department of Human Services and using a quality improvement process, efforts to integrate maternal depression screening into the well child visit has been successful in getting more mothers screened, identified and referred to appropriate treatment. MN also has a Bush Foundation grant to look at issues related to maternal mental health in women of color and American Indian women. The high prevalence of depression and/or anxiety in the perinatal period for women of color and American Indian women and the low rates of treatment are concerning. The project explores innovative solutions within cultural contexts that will be most helpful to high-risk women.

Unintended pregnancy has long been recognized as associated with a number of maternal behaviors that can negatively impact pregnancy and infant outcomes. It is estimated that 34 percent of all pregnancies in MN are unintended. PRAMS 2013 data indicates that 31 percent of White women, 42 percent of African American women and 42 percent of Hispanic women did not plan to become pregnant at the time of their most recent pregnancy. Changes in the availability and access to contraceptives through ACA have provided women more access with less out of pocket expenses for contraceptives. MN's Medicaid program provides presumptive eligibility for family planning services making it easier for women to get services when they need it without waiting for an application to be processed. The MN Legislature last year provided an additional $1 million annually to the $5.5 million already available to support reproductive health outreach activities and more effective services to at-risk women. This allows family planning clinics to offer longer term contraceptives that are recognized as being more effective in reducing the number of unintended pregnancies but are more costly to provide.

Perinatal/Infant Health

Priority Needs: Reduce infant mortality rate and racial and ethnic disparities in infant deaths. Promote and support breastfeeding.

MN consistently ranks among the states with the lowest infant mortality rates. Over the last 20 years, infant mortality rates in MN have declined for all racial and ethnic populations. However, infant mortality rates for African Americans and American Indian infants continue to be more than two times greater than for White infants. The causes of infant mortality vary by population: sleep-related causes are a primary source of infant deaths in the American Indian community, prematurity is the leading cause of death among African-Americans, and birth defects are the primary source of infant deaths in the Asian, Hispanic, and White populations.

To reduce disparities in infant mortality rates and to ensure that all infants survive beyond age one, Title V partnered with a diverse group of public, private and non-profit stakeholders to develop an infant mortality reduction plan. The plan includes strategies that range from reducing sleep-related deaths and preterm births to improving health equity and addressing the social determinants of health that most significantly impact disparities in birth outcomes. This plan along with involvement on the National and Regional COIIN to reduce infant mortality will guide MN efforts over the coming years

Evidence of the positive impact of breastfeeding on the future health of both mother and baby is growing. Low-income women are at higher risk for not breastfeeding, and over the last ten years, WIC, in collaboration with Title V staff, have worked to improve breastfeeding initiation and duration in this population. Significant progress in breastfeeding rates among MN WIC participants was made from 2001 (65 percent) to 2010 (74 percent) particularly among racial and ethnic populations. In these years, breastfeeding initiation increased by over 30 percent in African-American women, over 86 percent in Asian women, and 17 percent for White women. Hispanic women have consistently had the highest rates of breastfeeding among WIC participants and at 84 percent met the Healthy People 2020 goal.

Child Health

Priority Need: Promote developmental screening and appropriate follow-up to support social-emotional and physical needs of children.

MN's child poverty rate rose to 14.9 percent in 2014 with nearly 189,000 kids in the state living in poverty up from 14.1 percent the previous year. Research is demonstrating that children who are raised in families experiencing chronic stress created by long-term poverty are at much greater risk of significant and long-term health issues, including developmental and social and emotional problems. In MN, an African American child is 4.8 times more likely to live below the federal poverty line, an American Indian child 3.9 times more likely, a Hispanic child 3.1 times and an Asian child 2.1 times more likely than White children.

Title V is engaged in a number of strategies to improve access to developmental screening and appropriate follow-up including working with other state agencies and the National Help Me Grow Center to plan for implementation of a comprehensive state wide system of referral and closing the feedback loop, collaborating with the Department of Human Services on reaching out to and training providers who are currently not incorporating EPSDT into their clinic visits and working in partnership with the Departments of Education and Human Services to identify recommended culturally and linguistically appropriate screening tools and to implement on-line screening for parents and providers as well as other resources available to help the child and family.

Children and Youth with Special Health Care Needs (CYSHCN)

Priority Need: Promote a comprehensive, coordinated, and integrated system of services and supports for CYSHCN and their families.

There are an estimated 236,953 children in MN with special health care needs. This represents approximately 18.5 percent of MN's children from birth to age 18. MN's children and youth with special health care needs experience a wide range of disparities when compared to children without a special health care need. They are more likely to be overweight, have a higher percentage of parents who usually/always feel stress due to parenting, have a higher likelihood of someone in the house who smokes tobacco and are more likely to have experienced two or more adverse family experiences.

According to the 2009/2010 National Survey for Children with Special Health Care Needs, a little over 20 percent of MN children are served by systems that meet all age-relevant core outcomes. Only 54 percent of MN families receive care within a medical home and approximately 47 percent of youth are receiving necessary transition services.

Title V ongoing support to the implementation of Health Care Home legislation in MN has been critical in assuring that needs of children and youth with special health care needs are considered as the program is implemented. Currently 55 percent of all primary care clinics in the state are certified as Health Care Homes serving about 3.6 million Minnesotans.

Title V staff have been actively engaged in MN's Olmstead plan. The plan is the result of many people working together, across and within state agencies and with stakeholders to ensure services to individuals with disabilities are in the most integrated setting appropriate to the individual. Work continues in clarifying roles, timelines and outcomes to meet court requirements.

Adolescent Health

Priority Needs: Strengthen the health system to better meet the mental and physical health needs of adolescents. Help communities engage and support young people to be connected to community, school and caring adults.

In 2011-2012, only about 77 percent of MN adolescents had a preventive medical visit in the past year. Thus, opportunities for providers to discuss such things as pregnancy prevention, STI/HIV awareness and testing, alcohol and drug use, tobacco use, unhealthy dietary behaviors, inadequate physical activity and behaviors that result in unintentional or intentional injury are less likely to occur.

Minnesota's teen birthrate dropped by 8 percent in 2014 and has fallen 58 percent since 1990 – reaching 15.5 births per 1,000 females aged 15 to 19. While MN has seen a dramatic decline overall in teen pregnancy rates, significant and persistent disparities exist. In 2014, the Non-Hispanic White teen birth rate was 10.2 per 1,000 females 15-19, Non-Hispanic African American teen birth rate was 34.7; American Indian teen birth rate was 47.2; Asian teen birth rate was 19.61 and the Hispanic teen birth rate was 38.8. Efforts through MN's federal Abstinence and Personal Responsibility Education Program grants focus on implementing evidenced based teen pregnancy prevention programs; access to family planning services through Title XIX, Title X, Title V and state family planning grants, and efforts to reduce secondary teen pregnancies through Maternal Infant Early Childhood Home Visiting and state supported home visiting programs have all contributed to the decline in teen pregnancies.

The Adolescent Health Action Plan is a statewide effort, led by Title V, to bring interested stakeholders and adolescents together to develop MN's revised action plan for adolescent health.

Cross-cutting or Life Course

Priority Need: Ensure adequate health insurance coverage.

Access to health care services is important to support the health of MN's mothers and children. Since the launch of MN's health insurance exchange, MNsure, hundreds of thousands of Minnesotans have been enrolled in quality, affordable health insurance. The 2015 MN Health Access Survey indicates that the percent of Minnesotans who were uninsured dropped from 10.7 percent in 2013 to 6.7 percent in 2014 to 4.3 percent in 2015. Public coverage increased for the second consecutive year, including a large increase in the percent of children covered. While the numbers are heartening, the persistent issue of medical care being delayed or ignored because of cost persist, as well as the adequacy of coverage for children and youth with special health care needs. Continued monitoring of Affordable Care Act impact on MCH populations, particularly children and youth with special health care needs will be important.