2021-22 Report to the Commissioner

MATERNAL AND CHILD HEALTH ADVISORY TASK FORCE

APRIL 2023

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Maternal and Child Health Advisory Task Force Overview

The Maternal and Child Health (MCH) Advisory Task Force was created by MN Statute 145.8811 in 1982 and re-established in 2012. The MCH Advisory Task Force charge is to advise the Commissioner of Health on the health care services/needs of maternal and child health populations in Minnesota, on the use of funds for maternal and child health and children with special health needs administered through MDH, and the priorities and goals for maternal and child health activities. The Task force is also charged with establishing, in consultation with the Commissioner, statewide outcomes that will improve the health status of mothers and children.

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

General principles supported by the task force:

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

Membership

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

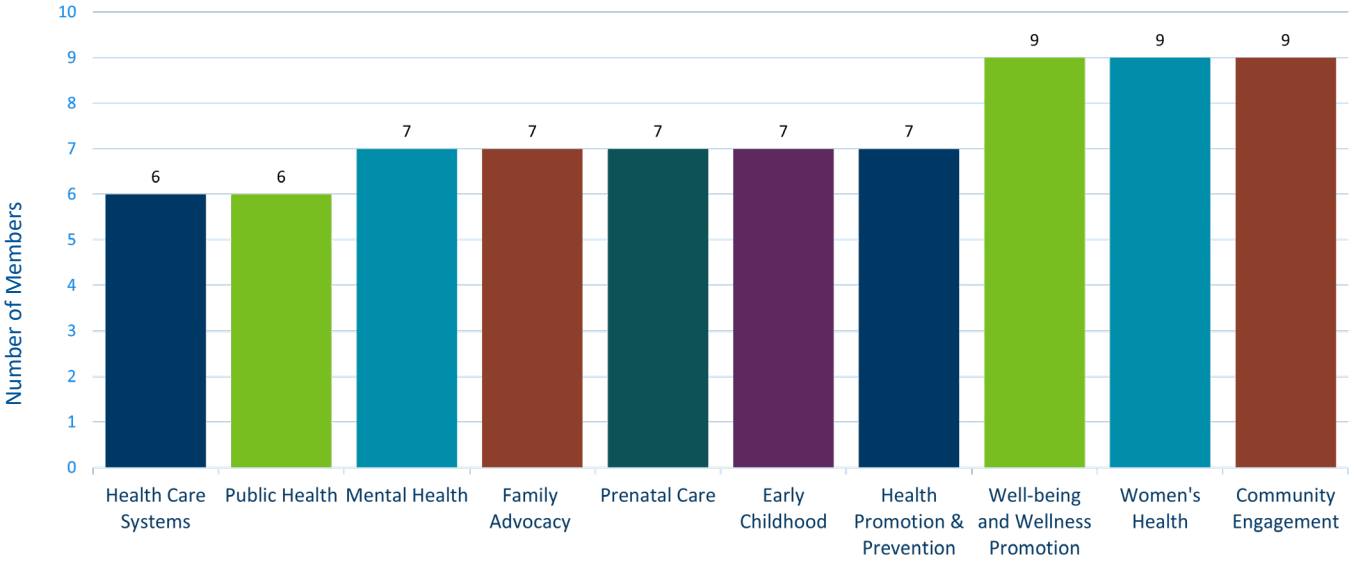
Four task force members resigned in December and early 2022 March 2022, the executive committee reviewed applications and made recommendations to fill four Open Seats in the consumer and professional representative categories. One of the appointed Consumer Representatives, Eugene

Nichols, had been an ex-officio member since 2018. Newly appointed representatives are Najoica Elmore (Consumer), Sameerah Bilal-Roby (Professional) and Stephanie de Sam Lazaro (Professional).

At the height of the COVID pandemic, one of the priorities adopted by the task force was to expand our membership to ensure expertise to address the emerging issues, health disparities, health care services and needs and communities we serve were represented in our membership. In 2021 and 2022, our Membership Committee held meetings to identify gaps in community representation and in areas of expertise that may be needed that were not reflected in our membership. In addition to filling those gaps through our recommendations to fill statutory Open Seats, the Executive Committee also made recommendations to appoint two new ex-officio members: Ellen Jirik and Lindsey Wimmer.

Figure 1 below is an illustration of the membership's areas of maternal and child health expertise, including ex-officio members. Please note this graph does not depict all areas of expertise members possess only the top 10. Other areas of expertise not shown are nutrition, pediatric oral health, health care administration, trauma informed care, infant mortality, Medicaid managed care, health equity, and reproductive health.

Figure 1. 10 Most Represented Areas of Membership MCH Expertise



Member Name	Member Category	Organization
Stephanie Graves (**Term end date: 1/1/2024**) *MCH Area(s) of Expertise*: Stephanie was reappointed to the MCH Advisory Task Force in 2020 and has expert knowledge in early childhood and school readiness, targeted home visiting, infant mortality prevention, safety net services, and community engagement.	Community Health Board Representative	Minneapolis Health Department

Member Name	Member Category	Organization
Meredith Martinez (**Term end date: 1/1/2027**) *MCH Area(s) of Expertise*: Meredith is the Family Health Area Manager for Hennepin County Public Health. She provides strategic direction and oversees the operations of maternal and child health programs at Hennepin County, including Child and Teen Checkups, Family Home Visiting, WIC and the Follow Along program. She also has knowledge of mental health, women's health, and early childhood systems.	Community Health Board Representative	Hennepin County Public Health
Debra Purfeerst (**Term end date: 1/1/2023**)* *MCH Area(s) of Expertise*: Deb was appointed to the MCH Advisory Task Force in 2012. She has 35 years of experience in rural public health, and currently serves as Rice County CHS Administrator and Public Health Director. Deb provides expertise in local public health and governance, targeted family home visiting, women's health, reproductive health, health promotion and Child and Teen Checkups.	Community Health Board Representative	Rice County Public Health
Tamiko Ralston (**Term end date: 1/1/2024**) *MCH Area(s) of Expertise*: Tamiko is a Community Health Board Representative and was appointed to fill an Open Seat vacancy in 2018. She was reappointed to a second term, effective January 2020. Tamiko is a Public Health Nurse with experience in case management, screening, early intervention and referral, community outreach and engagement, birth equity, and mental health and wellness promotion. Tamiko coordinates the Birth Equity Council for Ramsey County.	Community Health Board Representative	Saint Paul-Ramsey County Public Health
Chera Sevcik (**Term end date: 1/1/2023**) *MCH Area(s) of Expertise*: Chera is the Community Health Administrator for Faribault & Martin County CHB overseeing the family home visiting Women Infant and Children supplemental nutrition program, environmental health, elderly care coordination, Child and Teen Check-ups, health promotion, Statewide Health Improvement Program, disease prevention and control, and public health emergency preparedness. Chera was appointed to the task force as a Community Health Board Representative in 2019 and is currently serving her first four-year term.	Community Health Board Representative	Human Services of Faribault & Martin Counties
Bryn Basri (**Term end date: 1/1/2025)** *MCH Area(s) of Expertise:* Bryn has served on the MCH Advisory Task Force since 2017. She has experience with children with special needs, healthcare administration, research, and maternal and infant health. Bryn has worked as a doula and childbirth educator, and she has managed a family and specialty clinic.	Consumer Representative	
Tricia Brisbine (**Term end date: 1/1/2023**)* *MCH Area(s) of Expertise*: Tricia has served on the MCH Advisory Task Force since 2014. She is the parent of a child with special healthcare needs. She has a great deal of experience navigating health systems, financial and insurance resources, and support systems within the community, in the state and nationwide. She	Consumer Representative	

Member Name	Member Category	Organization
also has knowledge of mental health, disabilities, and family advocacy.		
Najoica (Joi) Elmore (**Term end date: 1/1/2027**) *MCH Area(s) of Expertise:* Joi has a background in the mental health field and finds joy in helping others navigate life. She has a particular interest in working with pregnant and parenting women and has lead trainings on topics addressing health disparities and inequities amongst BIPOC women.	Consumer Representative	Wayside Recovery Center
Janet Morales (Term end date: 12/6/2021) *MCH Area(s) of Expertise* Janet has personal experience with stillbirth, perinatal loss and pregnancy after loss support groups, breastfeeding, milk donation, and parenting a child with special health needs. Janet was appointed as a consumer representative in 2019.	Consumer Representative	
Eugene Nichols (**Term end date: 1/1/2027**) *MCH Areas(s) of Expertise:* Eugene has served on the task force as an ex-officio member since 2018. Currently serving his first term appointment as a Consumer Representative. His past experiences include serving on the Ramsey County's Healthy Families America Advisory Committee advocating for mothers with children between ages 0-5, Ramsey County Community Health Advisory Council, and as Board Chair for Open Cities Health Center, a federally qualified health center whose goal is keeping the whole family healthy by ensuring access to health care. Eugene has served on several of the task force subcommittees and temporary workgroups.	Consumer Representative	
Jayne Whiteford (**Term end date: 1/1/2024**) *MCH Area(s) of Expertise:* Jayne has been a Consumer Representative since 2018. She has experience with Minnesota Health Care Programs, developmental disabilities, and mental illness services, in addition to personal experience with high-risk pregnancy, NICU, and early intervention services. Jayne also has experience in research, community interventions, social work, translating program policies into practice, and rural and urban health.	Consumer Representative	
Paige Anderson Bowen, Chair (**Term end date: 1/1/2025**) *MCH Area(s) of Expertise*: An MCH Advisory Task Force member since 2017, Paige brings knowledge in community-based health care delivery, maternal and child health consulting, program design, global health, MCH program management, monitoring and evaluation, family planning/reproductive health, women's health, health equity, social determinants of health, and health care access. As Chair, Paige presides over executive committee.	Professional Representative	
Dr. Diane Banigo (Term end date: 1/1/2023) *MCH Area(s) of Expertise*: Dr. Banigo brings experience and expertise in women's health, prenatal care, community-based health care and reproductive health. She was appointed in	Professional Representative	D.I.V.A. Moms/Minnesota Community

Member Name	Member Category	Organization
November 2019 to fill an Open Seat vacancy for a Professional Representative.		Care/East Side Family Clinic
Sameerah Bilal-Roby (**Term end date: 1/1/2027**) *MCH Area(s) of Expertise:* Sameerah is the Director of the Wilder African American Babies Coalition and Projects and the Program Manager for the Integrated Care High Risk Initiative (ICHRP). She devotes her time sharing her knowledge through adult training and development. Her knowledge includes well-being wellness promotion, family advocacy, trauma-informed care, early childhood, infant mortality and community engagement.	Professional Representative	Amherst H. Wilder Foundation
Stephanie de Sam Lazaro (**Term end date: 1/1/2027**) *MCH Area(s) of Expertise:* Stephanie is an occupational therapist who has spent the majority of her clinical practice working with children and families, primarily in early intervention and home-based services. She was appointed to fill an Open Seat previously held by Elizabeth Taylor-Schiro, which expired December 31, 2022. Stephanie	Professional Representative	St. Catherine University
Andrea MacArthur (**Term end date 4/1/2022**) *MCH Area(s) of Expertise:* Andrea has expertise in community-based health care delivery, program design, MCH program management, monitoring and evaluation, family planning/reproductive health, health equity, social determinants of health, and health care access.	Professional Representative	Innova Engagement
Dr. Michelle O'Brien, Chair, 2019-21; Past- Chair, 2022 (**Term end date 1/1/2023**)* *MCH Area(s) of Expertise*: Dr. O'Brien was appointed in 2012 and has expertise in the medical care of women and children. Her background includes prenatal care, breastfeeding support/promotion, substance use disorders (including opiate use disorder) in pregnant and parenting women, trauma informed care, and resilience/mindfulness/mental wellbeing. Michelle is an MCH Advisory Task Force executive committee member.	Professional Representative	
Elizabeth Taylor-Schiro (**Term end date: 6/21/2022**) *MCH Area(s) of Expertise:* Elizabeth has academic experiences in the fields of human development, evaluation studies, and public health; and personal experiences with adverse education and health outcomes for mothers and children. She is passionate in creating partnerships with parents and families in attempt to guide their child and family toward optimal health and educational outcomes.	Professional Representative	

***NOTE: The three members identified above whose terms expired January 1, 2023, have agreed to remain on the task force in an Ex-officio membership capacity.**

Activities

The work of the MCH Advisory Task Force is governed by a set of Operating Procedures approved by the membership. Throughout 2021, the Task Force held its quarterly meetings in a virtual format. Beginning in February 2022, the Task Force began meeting bi-monthly. The Executive Committee submitted recommendations for appointments to the Commissioner of Health to fill Open Seats in all three membership categories: Consumer, Professional and Community Health Board representative due to resignation, relocation and MDH employment.

Other task force activities completed in 2021-2022 included:

- Quarterly updates on status of COVID vaccinations in Minnesota
- Solicited nominations and selected the 2021 and 2022 Betty Hubbard MCH Leadership Award recipients for outstanding contributions to maternal and child health in Minnesota at the statewide and community levels.
- Hosted a virtual Betty Hubbard MCH Leadership Award Ceremony to present the award and recognize, along with family and friends, the 2020 and 2021 award recipients at its December 10, 2021 meeting.
- Reviewed and provided feedback to Title V MCH Five-Year State Action Plan, focusing on strategies and activities to be implemented in federal fiscal year 2021.
- Hosted the 2022 Betty Hubbard MCH Leadership Award Ceremony to recognize the 2022 recipients.

Figure 2 below illustrates the Task Force's ongoing tasks, monitoring, and bi-annual 2022-23 Work Plan.

Figure 2. Ongoing Tasks

Presentations by MCH Experts

To stay abreast of current issues affecting MCH services and health care and populations experiencing health inequities and disparities, subject matter experts were also invited to task force meetings to present on trends or emerging issues negatively impacting health outcomes for Minnesota mothers, children, and families.

Presentation	Presenter(s)	Task Force Meeting
Health Equity Legislation for MCH Populations	**Rep. Ruth Richardson**, MN Legislature, District 52	June 11, 2021
MN School Based Center Alliance	**Julie Neitzel Carr**, MDH Adolescent Health Coordinator & Shawna Hedlund, President, MN School Based Center Alliance	June 11, 2021
Impact of Incarceration on Minnesota Families	Tierre Webster, Executive Director, Damascus Way	June 11, 2021
COVID-19 Health and Academic Recovery Initiatives	**Stephanie Graff**, MDE Assistant Commissioner **Angela Mansfield**, MDE Program Manager/Effectiveness Specialist, **Craig Wethington**, MDE Interim Director, School Safety & Assistance Center	September 10, 2021
Children's Mental Health	**Tom Steinmetz**, CEO, Washburn Center for Children	September 10, 2021
MN Thrives Initiative	**Anna Lynn**, MDH Mental Health Promotion Coordinator	September 10, 2021
Mental Health & Suicide Prevention Cohort	**Kelly Felton**, MDH Suicide Prevention Coordinator	September 10, 2021
COVID-19 Workforce Development Initiative	**Denise Herrmann,** MDH State School Health Nurse Consultant	September 10, 2021
COVID-19 Immunization During Pregnancy	**Anna Fedorowicz**, MDH Adolescent & Adult Immunization Coordinator	April 8, 2022
MDH Health Equity Update	**Dr. Halkeno Tura**, Director, MDH Center for Health Equity	June 10, 2022
Overview of Alongside Network	**Jen Aspengren**, Founder & CEO, Alongside Network	June 10, 2022
MDH Health Equity Presentation	**Dr. Brooke Cunningham**, MDH Assistant Commissioner, Health Equity Bureau	October 14, 2022
Minnesota Health Plans Discussion	**Chelsea Georgesen**, Director of Government Programs and Health Equity Co-chair, MN Council of Health Plans **Vanessa Bembridge**, Quality Management Team, Hennepin **Patty Graham**, Quality Improvement, HealthPartners	October 14, 2022
MCH Maternal Health Innovation Grant	**Karen Fogg,** Manager, MDH Maternal and Child Health Section	December 9, 2022

Recommendations to the Commissioner of Health

Members of the MCH Advisory Task Force (Task Force) agreed that racism is a public health issue and should be an overarching objective for all recommendation topics. Task Force is submitting the following priority areas where-focus and efforts by the Commissioner are needed 1) to improve the health of all Minnesotans; and 2) to ensure that communities and people are thriving, and everyone has what they need to attain optimal mental well-being and health.

The Task Force's recommendations follow each priority summary and indicate action to be taken according to the following three classifications:

1. **MDH ACTION**
   Recommendations relating to the governance of the department of Health as well as the policies and programs it oversees. Strategies and activities developed and implemented independently by MDH staff and the Commissioner.
2. **LEGISLATIVE ACTION**
   Policy recommendation requiring legislative action or approval of the state legislature and subsequent approval by the Governor. The Commissioner works directly with the Governor to implement the recommendation.
3. **COLLABORATION**
   Recommendation to work with individuals, community groups, MDH, and other state and county organizations to develop a policy, program, or legislative recommendation. May require legislative action prior to implementation.
4. **RACISM AS A PUBLIC HEALTH ISSUE**
   Recommendations are identified in specific topics where health inequities and disparities are results of historical and systemic polices and laws and social determinants of health that prevent optimal health outcomes for all Minnesota residents.

Recommendations Table

As noted above, the topics listed in this recommendation table are the priority needs identified in the comprehensive statewide 2020 Title V MCH Needs Assessment. Each recommendation topic in the table below has a hyperlink to access the narrative for each topic. You will be able to return to the table by clicking the link at the end of each narrative.

Recommendations	MDH Action	Legislative Action	Collaboration	Racism as a Public Health Issue
Racism as a Public Health Issue				
Support legislation to make racism a Public Health issue, such as House Resolution No. 1 declaring racism as a public health crisis.	**X**	**X**	**X**	
Hold systems accountable for disparities in birth outcomes/address racism as a priority in birth outcomes	**X**	**X**	**X**	

Recommendations	MDH Action	Legislative Action	Collaboration	Racism as a Public Health Issue
Access to Services and Supports for CYSHN				
Address, recognize and collaborate to address the impact of the overall workforce shortage in all areas of support for CYSHCN, including school, home care, medical and mental health care, and social services.	X	X	X	
Support more equitable access to care regardless of race, culture or where a family lives, rural, urban, or small town.	X	X	X	
Recognize and respond to the adverse impact the COVID-19 pandemic had on persons with disabilities/special health needs and their families.	X	X	X	
Recognize disability as a health equity issue.	X	X	X	
Collaborate with DHS to increase Medical Assistance reimbursement rates.	X	X	X	
Address pay differential between nursing for homecare and hospitals (Nursing shortage)	X	X	X	
Mental health providers shortages. Broaden and expand the definition of mental health providers in Minnesota	X	X	X	
Support policies and legislation that promote the importance of paid parental and caregiver leave	X	X	X	
Support policies related to inclusive childcare including funding of family, friend, and neighbor child care providers	X	X	X	
Accessible and Affordable Health Care				X
Reduce barriers to participation in Minnesota Health Care Programs, such as not instituting a work requirement.		X	X	
Advance proposals to change MN laws regarding 12-month continuous eligibility for those aged 0 to 19		X		
Take demonstrable steps to improve enrollment and renewal processes		X	X	

Recommendations	MDH Action	Legislative Action	Collaboration	Racism as a Public Health Issue
Continued support of ACA Exchange Products		X	X	
Continue to support health care (MNSure) navigators		X		
Increase access to chemical and mental health services statewide, particularly acute care for children		X	X	
Support increase of funding for fluoride varnish, sealant application, and other dental services. Consider the use of emergent workforce personnel to deliver the service.		X	X	
Continue telehealth flexibilities put in place during PHE.		X		
Adolescent Suicide				
Advocate for funding for comprehensive suicide prevention programming that targets youth 10-24 years of age, particularly those at highest risk (American Indian and Black males, American Indian females and youth living in rural areas).		X	X	
American Indian Family Health				X
Actively pursue and include American Indian community members/experts in roles within divisions, programs and projects to ensure the American Indian population is represented and involved in program/project/funding planning and implementation (Indigenous evaluator for PDG grant as a part of MDE is one example of this) – work with MN hub	X		X	
Require historical and intergenerational trauma and American Indian history training for all MDH employees and council/workgroup/task force members	X			
Ensure that a specific amount of funding is dedicated to American Indian populations across all grants and programs	X			
Invest in and partner with community organizations focused on addressing disparities in American Indian children, mothers, and family systems to allow community member engagement in MDH activities	X		X	
Support legislation to make racism a public health issue		X		

Recommendations	MDH Action	Legislative Action	Collaboration	Racism as a Public Health Issue
Ban/Restriction on Flavored Nicotine Products, including Menthol				X
Advocate for the governor's support for total restriction/ban on all flavored nicotine products including menthol (HF0904)	X	X		
Support the continued funding of the state's Quit Line for cessation and prevention support (HF3153)	X	X		
Boys and Young Men				
Continue collaboration with the City of St. Paul, County Commissioners, District Community Council, Ramsey County Public Health, and community leaders and advocates seeking alternative solutions to incarceration	X		X	
Advocate for sentencing guidelines reform with the Governor.		X		
Care during Pregnancy and Delivery				X
Remove barriers to receiving prenatal care by increasing access to reliable transportation, affordable and culturally appropriate healthcare, and use of doulas and midwives.	X	X		
Support holding systems accountable for disparities in birth outcomes/ need to address racism as a priority in birth outcomes	X	X	X	
Review risks related to lack of rural hospital OB services and necessary supports to hospital staff in rural areas, to ensure safe, adequate, culturally appropriate prenatal/OB services.				
Promote healthy pregnancy by working to increase access to quality prenatal care (*midwife and doula services*), providing education on the importance of early and regular prenatal care and increasing the availability of safe, high quality (*culturally appropriate*) birthing facilities.	X		X	

Recommendations	MDH Action	Legislative Action	Collaboration	Racism as a Public Health Issue
Compensation for Consumer Representative				
Support compensation for MCH Advisory Task Force consumer representative members	X	X		
Comprehensive Early Childhood Systems				X
Partner in implementation of Minnesota's Preschool Development Grant with community organizations, including tribal nations and urban American Indian specific communities, and provide additional support to community hubs	X		X	
Provide additional ongoing support for community organizations and state agency programs to utilize Help Me Connect platform			X	
Dedicate funds to complete a systemic needs assessment to identify service gaps and barriers	X			
Support state legislation to make racism a public health issue	X	X	X	
Support ongoing funding for preventative services, including, early childhood education, and preschool scholarships for low-income families, including access to quality childcare, particularly for low-income families.				
Housing				X
Provide financial and staff support to the MDH Calling All Sectors Project whose goal is to ensure that no child is born into homelessness	X			
Work across state agencies and departments to push for housing legislation that decreases housing costs and increases availability of affordable housing			X	
Support state legislation to make racism a public health issue and utilize resources to assess how racism is at the foundation of housing issues		X		
Infant Mortality				X
Support legislation to reinstate the Fetal Infant Mortality Review process.		X		

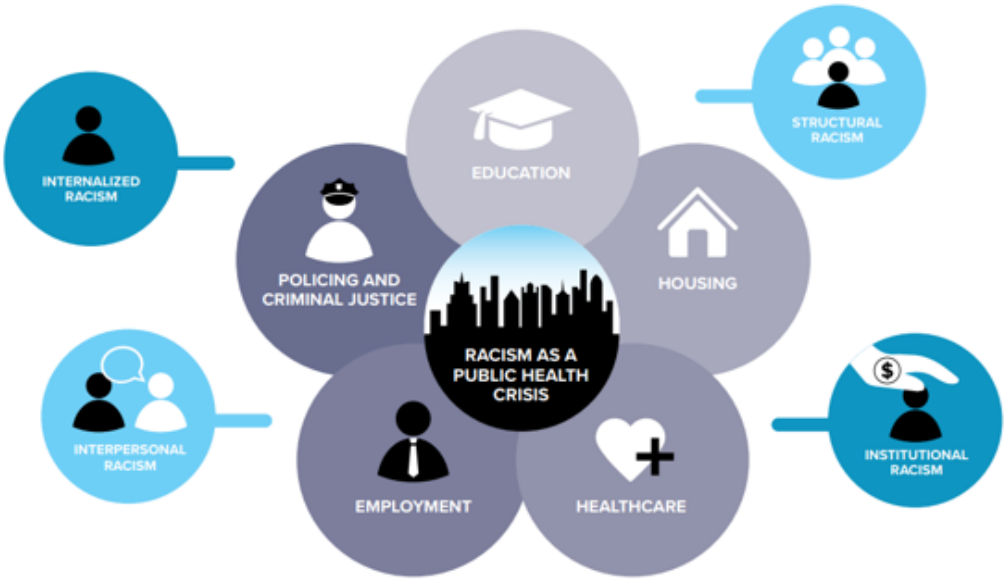
Recommendations	MDH Action	Legislative Action	Collaboration	Racism as a Public Health Issue
Advocate for universal free well-woman visits for women of reproductive age which address both mental and physical health risk factors related to infant mortality.		X		
Advocate for legislation funding to establish a FIMR process for infant deaths that includes stillbirths	X		X	
Immediate Post-partum LARC				
Create additional reimbursement for placement and availability of immediate post-partum LARC in hospitals.	X		X	
Identify and remove barriers for the placement of immediate post-partum LARCs in hospitals and birth centers				
Raise the awareness of and educate women about access and availability of LARC placement immediately after childbirth	X		X	
Parent and Caregiver Support				X
Support policies and legislation that promote the importance of paid parental and caregiver leave.	X	X		
Support funding of family, friend, and neighbor child care providers	X	X		
Support inclusive child care	X	X	X	
Trauma Informed Care				
Support funding for provider education related to trauma informed care		X	X	

Racism as a Public Health Issue

Between March and July 2020, 84 cities and towns as well as 42 counties declared racism a public health crisis. Several federal bills, including the anti-racism and Public Health Act of 2020 has been proposed. By declaring racism a public health crisis, governments acknowledge they have a responsibility to put an end to the system of racism, which includes addressing the social determinants of health as described in Figure 1 below.

In the past, most governments attributed racial health disparities only to specific instances of racism, such as redlining or residential segregation. But the COVID-19 pandemic and recent police violence have laid bare a system of racism that drives inequality in all aspects of American life, including education, employment, healthcare, housing, and law enforcement.[1]

FIGURE 3: RACISM AS A SYSTEM



Source: Racism is a Public Health Crisis. Here's how to respond. Ruqaiijah Yearby, Crystal N. Lewis, Keon L. Gilbert, Kira Banks. September 2020

Noted in Minnesota's House Select Committee on Racial Justice Report to the Legislature dated December 22, 2020, "Racism is sapping the strength of the whole society by wasting human resources. When the brilliance in some of our communities is ignored and we're not investing in the full education of our kids—because we don't think there is genius in the barrios or in the ghettos or on the reservations—that's sapping the strength of our whole society." In short, the definition of racism is not centered on a narrow interpretation of "who's racist and who's not." Rather the definition is more comprehensively focused on the systemic impact of racism, which has a harmful impact on our entire state and nation. We are all adversely impacted by the system of racism, and we all play a role in addressing the adverse impacts.

In all priority needs topics below you will see disparities that exist as a result of systemic racism. Without addressing the root causes of the systemic racism, including social determinants of health, we cannot effectively reduce disparities.

Back to recommendations table

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

An estimated 225,436 children and youth in Minnesota (approximately 17.4% of children 0-17 years old) have special health needs, which includes a range of chronic physical, developmental, behavioral, and emotional conditions.[i] These children and youth use a variety of services and supports, including (but not limited to) dental services, specialized therapies and child care, mental health counseling, respite care, specialized medical care and equipment, special education services, other community-based services, and more.

Unfortunately, it is not always easy or possible to access these crucial services. According to the 2019-2020 National Survey of Children's Health, 88.4% of children and youth with special health needs and disabilities (CYSHN/D) did not receive care in a well-functioning system.[1] This was especially the case for non-Hispanic Black and Hispanic CYSHN/D, who were less likely than all CYSHN/D to have received care in a comprehensive medical home, received services necessary to transition to adult health care, and received care in a well-functioning system.

CYSHN/D and their families are more likely to report having forgone needed services compared to those without special health needs. Unfortunately, the more complex the needs of the child, the less likely they are to receive needed services. Those living in poverty, in rural areas, or who identify as non-white often face the greatest barriers to care.

Families often must forgo care due to challenges in accessing care, such as long waitlists or problems getting appointments, troubles with eligibility criteria, complex systems to navigate, a lack of support services for parents and other family members, child care issues, language and cultural barriers, and transportation issues.

The MCH Advisory Task Force has four recommendations for the Commissioner of Health as it relates to increasing access to services and supports for CYSHN/D:

- Address workforce shortages that impact access to care
- Support more equitable access to care
- Recognize and respond to the adverse impact the COVID-19 Pandemic has had on CYSHN/D and their families
- Recognize disability as a health equity issue

Address workforce shortages that impact access to care

Many families of CYSHN/D face challenges accessing care because of a shortage of qualified professionals, especially as it relates to receiving home health services such as home care nursing and personal care assistance. The direct care workforce is experiencing major shortages for many reasons including low pay, poor benefits, and lack of insurance coverage that leads to unsustainable careers. The MCH Advisory Task Force recommends that the Commissioner of Health work with those from other

[1] A well-functioning system is one in which 1) children receive screening and are identified for needed intervention early, 2) families are partners in making decisions related to the child's care, 3) children have access to comprehensive primary care (medical home), 4) children have easy access to services, 5) children and families have adequate insurance and financing for supports, and 6) youth are adequately prepared to transition to adult health care.

state agencies to address these workforce shortages that are impacting access to quality care for CYSHN/D and their families.

ICI Report on direct care workforce (https://ici.umn.edu/program-areas/community-living-and-employment/direct-support-workforce)

Direct Support Professionals (DSPs) are the paid staff who support individuals with IDD to live their lives and enjoy the same opportunities and experiences as people without disabilities. DSPs support people in whatever ways they need to enhance inclusion and independence. Their work promotes informed decision-making, understanding risk, and exercising rights and choices. Providing direct support is highly complex and requires significant skills, including sound judgment, independent problem-solving, decision-making, behavioral assessment, crisis prevention and intervention, and communication. Many DSPs are isolated, without co-workers, supervisors, or clinical professionals on-site to provide assistance or guidance. DSPs are interdisciplinary professionals whose duties resemble many tasks typically completed by teachers, nurses, allied health professionals, social workers, counselors, and others. Highly effective DSPs are skilled at developing strong relationships with those they support and their families, and are flexible enough to change, depending on each person's needs and abilities.

DSPs work in family and individual homes, intermediate care facilities, small community residential group homes, community job sites, vocational and day training programs, and other locations. Two-thirds work full time, and half rely on means-tested public assistance. With an average age of 42, they are predominantly women (89%), but are racially and ethnically diverse. White (non-Hispanic) workers make up 47% of the workforce, while 30% are African American, and 16% are Hispanic/Latino. Nearly a quarter were born outside the United States, compared with 16% across the total U.S. workforce. About 45 percent have completed some college coursework or have a college degree. Most employers use the occupational title of Direct Support Professional, yet many DSPs may have different titles including direct support specialist, personal care assistant, habilitation specialist, job coach, residential counselor, family care provider, personal assistant, and others.

Data on the workforce crisis

In 2013, there were about 880,000 full-time equivalent (FTE) DSP positions dedicated to providing assistance to 1.4 million people. Given that approximately 30% of the DSP workforce is part-time and estimating that 2.5 part-time workers are needed to fill one full-time equivalency, there were an estimated 1.3 million DSPs supporting individuals with IDD. In order to sustain services at the current levels, given current turnover rates, 574,200 new DSPs need to be hired into the workforce every year. To provide services to the approximately 200,000 people with IDD on waiting lists, an additional 167,001 new DSPs would need to be hired. Given the high growth and demand in need, the persistent turnover rates, and a strong U.S. economy, the number of new DSPs that will need to enter the workforce is expected to grow each year between now and 2030.

Wages for DSPs pose a significant problem. At $11.76 per hour, the average DSP who works full-time is paid less than the federal poverty level for a family of four. Many organizations provide health insurance to employees, but most cannot afford the premiums. Most organizations offer paid time off to full-time DSPs, but part-time workers often have no paid benefits. Almost half of DSPs receive publicly funded benefits, such as medical, food or housing assistance. Most DSPs work a second (or third) job to earn enough money to pay their bills. Unacceptably low wages and limited benefits often correlate with low value, respect, and status. DSP wages are so low and their accountability so high, that far too often good people leave a highly-skilled profession they love.

High turnover has been well-documented in the DSP workforce for nearly three decades. The annual turnover rate in the DSP workforce is an estimated 46%, with about 38% leaving in the first six months and approximately 21% leaving within 6-12 months. Costs associated with replacing DSPs range between $2,413 and $5,200.

The health, safety, and well-being of people with IDD are at risk daily because of the workforce problems. "A revolving door of strangers coming in and out of a person's life, often required to support in the most intimate personal care routines, means that far too often they may not trust or develop a meaningful professional relationship with the DSP. Signs and symptoms of illness are missed, opportunities for community participation are lost, and people with an IDD have few choices other than congregate models, such as group homes or sheltered work settings, because community staffing is unstable."

(*https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/long-term-services-and-supports/workforce/*)

People with disabilities and older Minnesotans struggle to recruit and retain direct support professionals (DSPs). For example, in 2020, more than 50 Minnesotans reported they moved into nursing homes because they couldn't find a caregiver to provide in-home services.

DSPs are workers who provide critical support services to people with disabilities and older adults. Although their support is essential to the health and well-being of many Minnesotans, numerous positions remain unfilled. The Department of Employment and Economic Development's (DEED) Minnesota Job Vacancy Surveys for fourth quarter 2019 and second quarter 2020 reported that personal care aide positions had the highest number of vacancies of any occupation statewide. Vacancies continued to increase during the pandemic. Personal care aides have been in the top five of the Occupations in Demand list for many years. The DHS Legislative Report: DWRS Labor Market Reporting 2019 (PDF) finds a relatively high degree of instability in the DSP labor market because of staff turnover.

Because of these workforce shortages, families are often faced with having to coordinate and/or provide their child's care. According to the 2019-2020 National Survey of Children's Health, approximately 17.9% of families of CYSHN/D reported having to leave their job, take a leave of absence, or cut down the hours they work during the past 12 months because of their child's health. This is compared to 2.3% of families who don't have children with special health needs/disabilities.

Support more equitable access to care

In Minnesota, many services for CYSHN/D are administered at the local level and differ between counties. This can make it difficult for families to know what services are available, if they are eligible for them, and how to access them.

> *"Waiver programs are administered differently from county to county and the amount of money distributed differs by county. So, when we are providing support, it is very hard to say, 'This is what is available to you in your county,' because it is variable across counties." – Key Informant Interview, Carolyn Allshouse, Family Voices of Minnesota*

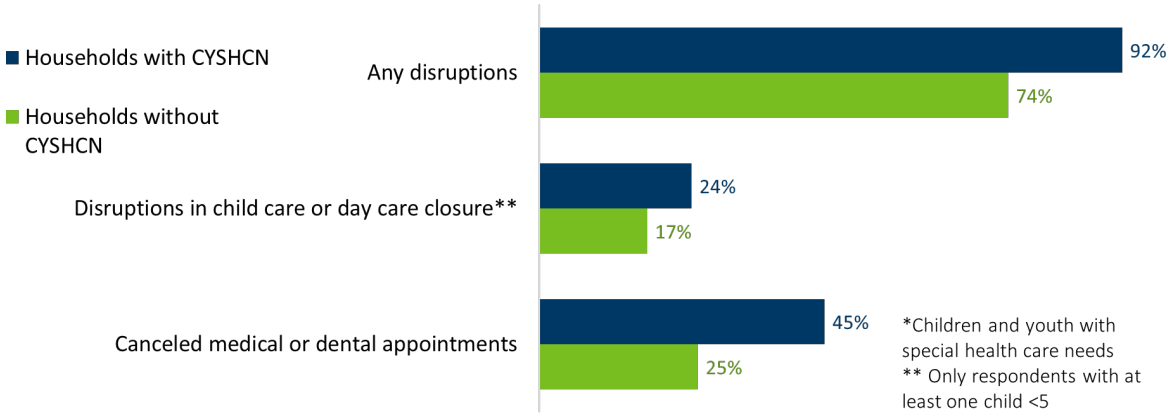
Recognize and respond to the adverse impact the COVID-19 Pandemic has had on CYSHN/D and their families

The MCH Advisory Task Force also recommends that the Commissioner of Health works to recognize and respond to the adverse impact the COVID-19 pandemic has had on CYSHN/D and their families. In

typically good times, families of CYSHN/D experience increased levels of isolation and a lack of social/emotional support. These issues have only been magnified during COVID-19 pandemic. During the response to the pandemic, safety measures were instituted to protect the health of the public. These well-intended measures protected many from the loss of life, but had significant adverse impact on families of CYSHN/D.

According to a report of the American Academy of Pediatrics, households of CYSHN/D were more likely to report they experienced disruptions in day-to-day life compared to other households. Figure 4 below shows how households with CYSHN/D experienced higher rates of disruptions in child care/day care, had more canceled medical appointments, and were impacted by the inability to receive free or reduced cost meals at school.

Figure 4. Households with CYSHCN* Reported Greater Disruptions to Family Life



The same survey found that parents of CYSHN/D who reported providing services to their child were more likely to report feeling overwhelmed compared with those who did not provide these services. This stress has been magnified when typical support systems were restricted because of the pandemic.[2]

CYSHN/D are experiencing a lot of difficulties with regression and behaviors because of disruptions to their care. Dr. Matthew Siegel, the Director of the Developmental Disorders Program at Maine Behavioral Healthcare said, “The impact of the pandemic has been massive on this population. It has been a silent crisis that has not gotten a great deal of attention in media and government.” Siegel said specialists who work in the field of developmental disorders are seeing regression in education and behavior during the pandemic that families and professionals had worked for months and years to improve.[3,4] These and other challenges have only become more acute and deeper. The workforce crisis has become even more grave, leaving individuals and their families more stretched than ever before.

[2] American Academy of Pediatrics (2021). The impact of the pandemic on households with CYSHCN. Retrieved from https://www.aap.org/en/patient-care/family-snapshot-during-the-covid-19-pandemic/the-impact-of-the-pandemic-on-households-with-cyshcn/.
[3] Lawlor, J. (2021). Families of people with IDD rebuild frayed ties as pandemic eases. Disability Scoop. Retrieved from https://www.disabilityscoop.com/2021/05/25/families-idd-rebuild-frayed-ties-pandemic-eases/29353/.
[4] Alcorn, T. (2021). To keep their son alive, they sleep in shifts. And hope a nurse shows up. *New York Times*. Retrieved from https://www.nytimes.com/2021/06/04/health/nursing-shortage-disabled-children.html.

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

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

Recognize disability as a health equity issue

With advancements in medicine, more and more children with disabilities and special health needs are living into adulthood. An estimated one in for adults in the United State (61 million adults) reported having a disability.[5] Data from 2019 shows that persons with disabilities report having less access to health care, having higher levels of anxiety and depression, and engaging more in high-risk behaviors such as smoking.[6]

The MCH Advisory Task Force recommends that the Commissioner of Health formally recognize disability as a health equity issue. This includes allocating resources to build data systems that better collect, analyze, and disseminate data and information to better understand disparities within the disability population. This also means recognizing the intersectionality of disability and race and how it impacts individuals. There are strong connections between racism and ableism that lead to barriers to care and ultimately poorer outcomes. It is important to understand how racism and ableism are linked and how that impacts Black, Indigenous, and People of Color (BIPOC) with disabilities/special health needs.

> *"Racism and ableism are often thought of as parallel systems of oppression that work separately to perpetuate social hierarchy. Not only does this way of looking at the world ignore the experiences of people of color with disabilities, but it also fails to examine how race is pathologized in order to create racism. Meaning that society treats people of color in specific ways to create barriers, and these poor conditions create disability. The concept of disability has been used to justify discrimination against other groups by attributing disability to them." – Isabella Kres-Nash*[3]

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Accessible and Affordable Health Care

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

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[5] Okoro, C. A., Hollis, N. D., Cyrus, A. C., Griffin-Blake, S. Prevalence of Disabilities and Health Care Access by Disability Status and Type Among Adults — United States, 2016. *MMWR Morb Mortal Wkly Rep* 2018; 67:882–887. DOI: http://dx.doi.org/10.15585/mmwr.mm6732a3

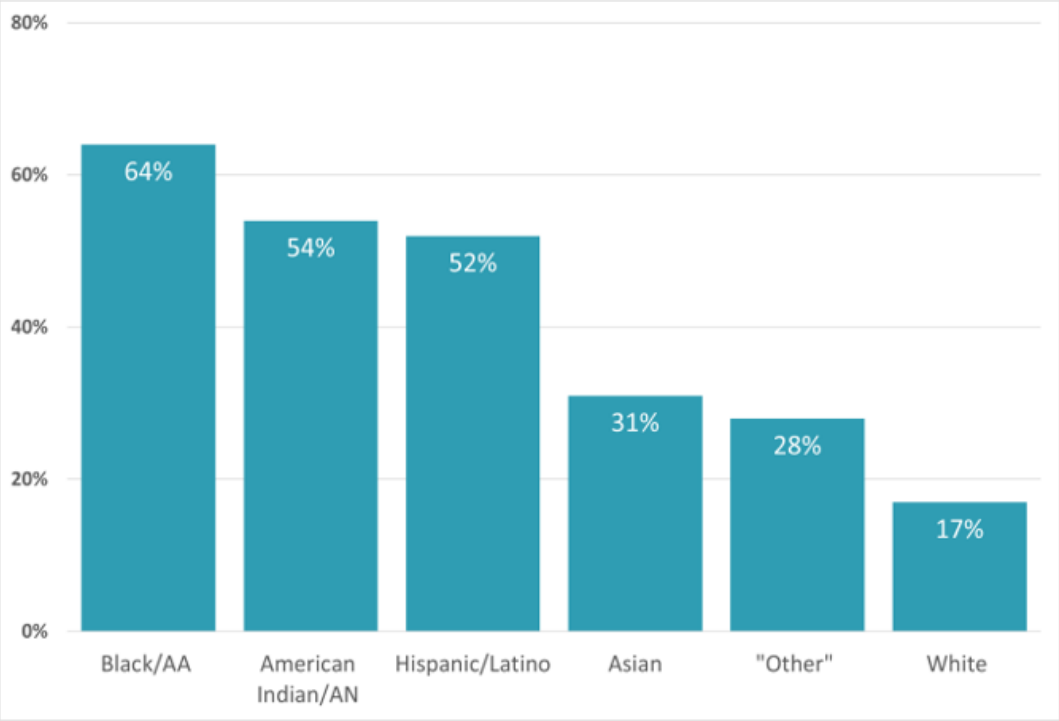
[6] Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, Division of Human Development and Disability. Disability and Health Data System (DHDS) Data [online].

Access to Health Care Programs

During the Covid-19 Federal Public Health Emergency (PHE), Minnesota implemented continuous enrollment for Medicaid eligibility. This meant that enrollees did not need to renew their coverage and did not lose their coverage during the PHE. Once the PHE ends, the state must restart Medicaid eligibility renewals. There is concern that this process will have an adverse impact on how many people maintain their health insurance coverage.

Medicaid provides health insurance for a large percentage of Minnesotan children, especially in BIPOC communities (shown in Figure 5 below):

Figure 5. Percent of Minnesota Children with Source of Insurance Coverage, by Race, 2017-2018



Source: SHADAC analysis of the 2017-2018 American Community Survey (ACS) Public Use Microdata Sample (PUMS) files. Note: Data years 2017 and 2018 were combined to increase the same size and improve the reliability of estimates among Minnesotans by race and ethnicity.

As described in the recent DHS report *Building Racial Equity into the Walls of Minnesota Medicaid A focus on U.S.-born Black Minnesotans (February 2022)*, access to Medicaid is a primary barrier faced by Black Minnesotans. The report specifically calls out improvements in the enrollment and renewal process as areas of opportunity to increase health care access for BIPOC communities. DHS outlines three action items to improve this process:

- Advancing proposals to change Minnesota laws regarding 12-month continuous eligibility for those aged 0-19.
- Taking demonstrable steps to improve enrollment and renewal processes.
- Continuing to support navigators.

Making renewal notices more accessible to enrollees, e.g., available electronically in addition to mailed paper documentation. The MCH Task Force supports these efforts and recommends implementing these activities prior to the end of the Public Health Emergency to reduce the impact of the restart of the renewal process.

Access to Health Care Services

The DHS report also found that: "The Medicaid and CHIP Payment and Access Commission (MACPAC) analysis of national household survey data has shown that "adults with Medicaid are more likely to report delayed medical care because of concerns about out-of-pocket costs, difficulty obtaining appointments, or because they do not have transportation" (MACPAC, 2021). Access to specific care like mental health providers can be especially inequitable. A 2014 JAMA study found that only 43% of psychiatrists accept Medicaid (Bishop et al., 2014). Barriers to care have been demonstrated among Minnesotans on Medicaid with a 2017 analysis of survey data showing that 55% reported some access barriers (Allen et al., 2017)."

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

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

To increase access to services, the MCH Task Force supports efforts to continue telehealth options and flexibilities that were in place for the COVID-19 pandemic. Telehealth reduces travel time for members who live farther away from their providers or need to see their providers frequently, such as those with complex medical conditions and children and youth with special health care needs.

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Adolescent Suicide

Among adolescents and young adults (ages 15-24), Minnesota has a higher suicide rate (15.5 per 100,000) than the national rate (14.5 per 100,000).[2] The suicide rate for Minnesota youth has been higher than the United States average for a long time. In Minnesota, suicide is the second leading cause of death for young people ages 10-24. In 2019, 111 Minnesotans between the ages of 10 and 24 died of suicide, representing roughly 15 percent of all suicides in the state in that year.

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

Data from the 2019 Minnesota Student Survey shows that of 8th, 9th, and 11th graders, 16 percent of female students, 8 percent of male students, and 42 percent of non-gender binary/transgender students reported either seriously considering attempting or attempting suicide in the last year – that's over 15,000 students.

There are large race/ethnicity disparities in suicide, with American Indian adolescents experiencing the highest rate of suicide. In Minnesota, American Indian and Alaska Native youth experience suicide rates that are nearly 3 times that of youth of other races. Minnesota is also starting to see an increase in suicides among Black youth, which is similar to what is being found nationally. American Indian youth in Minnesota have the highest rate of suicide (28 per 100,000) followed by White (8.8 per 100,000), Black (7.6 per 100,000), and Asian (6.7 per 100,000) youth.[7] Young people living in rural Minnesota also have significantly higher suicide rates when compared to their urban peers.

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American Indian Family Health

American Indians have, for generations, been intentionally and systematically violated in every way. The trauma experienced has been reinforced by government policies, racism and oppression, and economic systems that purposefully denied access to safety, health care, food, education, employment and dignity.[8] "Repeated and ongoing violation, exploitation, and deprivation have a deep, lasting traumatic impact, not just at the individual level but on whole populations, tribes and nations. This is what is known as collective trauma, historic trauma, and intergenerational trauma."[9]

American Indian women, children, and families experience the greatest health disparities in Minnesota. These disparities are caused by historical trauma, racism, and continued colonial practices and policies that create barriers to opportunity and thriving. Oppressive systems have denied American Indians access to adequate health care, employment, and food and nutrition. This has led to greater child poverty rates, a larger number of children growing up in single-parent households, greater rates of placement in out-of-home care, and lower high school graduation rates. In 2019, the American Indian child poverty rate was 37.1 percent compared to 11.2 percent of all Minnesota children living in poverty.[2] 51.4 percent of American Indian children are growing up in single mother families.[3] Only roughly 50 percent of American Indian youth graduate from high school.4 Compared to White children, American Indian children in Minnesota are 18.5 times more likely to be placed in out-of-home care.[5]

The health issues faced by Minnesota's American Indians are not unique but are often experienced in greater proportion than in white communities and communities of color. Only 55 percent of American Indian people rely on Indian Health Service or tribally operated clinics/hospitals for care; many access health care outside of the tribal system.

However, American Indian communities rely on a number of strengths when seeking to improve health outcomes:

- Extended family and kinship ties

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

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

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

- A shared sense of collective community responsibility
- Retention and reclamation of traditional language and cultural practices
- The ability to "walk in two worlds" between native and mainstream cultures
- Indigenous generational knowledge and wisdom
- When planning interventions with neighboring American Indian communities, it is extremely important to consult with local cultural advisors for questions about, for example, varying disease symptoms or culturally appropriate treatment options.

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Ban/Restriction on all Nicotine Flavors including Menthol

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

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

T-21 for the State of Minnesota will reduce access to tobacco products and decrease smoking initiation among young Minnesotans, thereby preventing challenging tobacco addictions, secondary and tertiary health issues from developing. Menthol and flavors are still attractive for young people and must be addressed, as tobacco companies continue to entice young people to use tobacco products by marketing novel delivery methods for flavored nicotine and menthol. Price reduction by issuing redeemable coupons via social media continues to be a threat to efforts toward reducing youth smoking. The following organizations also support reducing youth initiation to tobacco: American Cancer Society Action Network, American Heart Association, American Lunch Association, ClearWay Minnesota℠, Minnesota Academy of Family Physicians, and Service Employees International Union (SEIU) Minnesota State Council. Supporting the T-21 bill for the State of Minnesota would reduce access to tobacco products and decrease smoking initiation among Minnesota youth, preventing challenging tobacco addictions from forming and secondary and tertiary health issues.[10]

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

Currently, the momentum has increased to restrict the sale of all flavors including menthol products. HF0904 (11 authors) will be prioritized during the next legislative session. The public health community should support the ban on all nicotine products and nicotine delivery systems. This includes traditional nicotine and synthetic nicotine.

Cessation: Supporting efforts to increase funding for cessation services should be an immediate action item. HF 3153 and its companion Senate file are being championed during this legislative session which ends May 2022.

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

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Boys and Young Men

Engaging boys and young men in public health efforts is incredibly important. Despite work being done by public health agencies, community-based organizations, and others to engage this population in education, services, and programs, it remains critically important to attend to the needs of boys and young men. Historical trauma, systemic racism, socially influenced gender roles, and stigma around men seeking mental health care has led to widespread systems-level failures that have left boys and young men underserved and struggling with higher rates of substance use, suicide, mental health struggles, and victimization compared to girls and young women.[11]

In Minnesota, male youth aged 10 to 24 are significantly more likely to die by suicide than female youth (17.4 per 1,000 vs 4.1 per 1,000, respectively). Data from vital records shows that in Minnesota, the male rate of suicide increased by 20 percent from 2016 to 2018 while the female rate dropped 38 percent. Boys and young men are also more likely to experience violence and be involved with the juvenile justice system. Males represented 67 percent of all arrests of juveniles in Minnesota in 2018.[6] According to data from the Minnesota Department of Education's Report Card, in 2019, only 81 percent of males attending public school graduated on time (i.e., within 4 years) compared to 86.5 percent of female students. Doing nothing to address this important social dilemma will place future generations of African American young men at risk. The pervasive school to prison pipeline only serves private enterprise and ignores the healthy maturation of an entire segment of Minnesota society. Social justice reform, including sentencing reform guidelines post incarceration (removal of fines once the debt to society has been paid via prison time), must be addressed. Disparities in all conditions of the Social Determinants of Health combined with structural racism must be addressed with urgency.

Disparities in the experience of violence and associated negative health outcomes can be traced to historical trauma and systemic racism, which over time has resulted in the health disparities seen today. Preventing or diminishing the impacts of mental illness, experience of violence, and disparities in incarceration as boys and young men age into adulthood requires extensive efforts to address the health of boys and young men during early childhood and adolescence.[12]

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

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

Care During Pregnancy and Delivery

Having a healthy pregnancy and access to culturally appropriate and quality pregnancy care are ways to promote a healthy birth and have a thriving newborn. Research supports improved pregnancy outcomes for birthing people using doula and midwife services, especially for Black and Indigenous birthing people. Getting early and regular prenatal care starting in the first trimester is important for both the pregnant person and baby. Prenatal care is the health care pregnant people receive during their pregnancy. Prenatal care is more than clinic visits and tests; it is an opportunity to improve the overall well-being and health of the pregnant person which directly affects the health of their baby and ability to care for their baby.

Early prenatal care starting in the first trimester and regular clinic visits throughout the pregnancy along with testing for potential complications has been the standard of medical care per professional guidelines. A contributing factor to low birth weight and preterm birth as well as maternal morbidity and mortality is systematic racism. Babies of pregnant people who are exposed to systemic barriers that prohibit them from getting care are born with low birthweight at rates three times greater and die at rates five times greater than babies born to pregnant people who are not exposed to these systemic barriers and do receive prenatal care. [1] Recently research has supported training health providers on implicit bias and racism. Improving pregnancy outcomes includes system and community support of social detriments of health, culturally appropriate care, and other community and family support for birthing people.

In 2019 in Minnesota, 82.4 percent of pregnant people received prenatal care within their first trimester of pregnancy. At this time, we do not have this data broken down by race, ethnicity and rural vs. urban. Approximately 1 in 30 or 2,138 infants were born to a parent who received late (started in the third trimester) or no prenatal care at all. Systemic racism creates barriers to accessing quality care throughout pregnancy and delivery. This also results in unfair and unjust treatment of women and pregnant people of color and their families in the healthcare system. As a result of structural racism, disparities are seen in the adequacy of prenatal care utilization across race/ethnicity and contribute to the disparities in health outcomes. Less than half of births to American Indian mothers receive the recommended adequate/intensive prenatal care utilization recommended by obstetric professional organizations. More work needs to be done with the communities experiencing the greatest health disparities in pregnancy outcomes. Such as how to promote access to doula and midwife services. Train health providers working with birthing people on how to communicate and treat without biases.

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

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Compensation for Consumer Representatives

To encourage active participation and attendance at Task Force meetings from its consumer representatives, the Task Force recommends that MDH propose legislation requesting the five community representatives—not attending in a professional capacity and not paid to attend by an employer—receive compensation for their attendance. The compensation would acknowledge the value and expertise of community members. Some state committees provide stipends to consumer

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representatives for their time or reimburse for childcare or transportation. The Task Force would like their consumer members to receive the same consideration and be compensated for their time attending task force meetings.

Comprehensive Early Childhood Systems

Human brains grow faster between the ages of 0-3 than any other point in life, forming more than one million new neural connections every second.[13] "When babies have nurturing relationships, early learning experiences and good nutrition, those neural connections are stimulated and strengthened, laying a strong foundation for the rest of their lives. When babies do not get what their growing brains need to thrive, they do not develop as they should. This leads to life-long developmental, educational, social, and health challenges."[14] The quality of babies' early nurturing and learning experiences has a lasting impact on their life-long learning and success. When we invest in infants, toddlers, and their families, we ensure a strong future for us all.

Minnesota families need easier access to health care, mental health services, early care and education, and local services and resources that are culturally honoring and support health, development, and safety. In Minnesota, public health and human services operate under local control with services delivered at the county-and Tribal-level in Minnesota's 87 counties and 11 Tribal nations. Education, Part C, and Part B services operate in over 300 independent school districts. Eleven tribal nations offer culturally relevant services but are often unknown or ignored as potential referral resources by outside providers. Anecdotes from statewide providers consistently indicate that services are unavailable, unknown, or hard to access, but there is no statewide data that defines actual service gaps and barriers.

Many projects and grants over the last ten years have started working to improve comprehensive early childhood systems across government agencies. Formal recommendations from local partners to the state in 2016, along with the results of a 2018 audit by the Office of the Legislative Auditor, confirmed the need for a centralized system for resource navigation, referral and follow-through, and documentation of gaps and barriers in the system. During the recent Preschool Development Birth to Five Grant Needs Assessment and strategic planning process, parents and providers shared their perspectives on the current assets and barriers that affect families who are experiencing racial, geographic, and economic inequities.

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

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Housing

Where we live matters. Housing is connected to every aspect of people's lives and is a critical factor in financial security, academic success, and health. Research shows that kids are do better in school if they are not worrying about where they will sleep, and adults are better able to get and keep jobs, achieve

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

financial security, and have good health and well-being when they have a secure home.[1] Every person living in Minnesota should have a safe, affordable place to live in a thriving community. But not all do.

Minnesota is facing a housing crisis. Even before the COVID-19 pandemic, home prices in Minnesota have been steadily increasing and have been consistently more expensive than neighboring states. Between 2017 and 2018 alone, home prices in Minnesota increased 8.9 percent, and were 26 percent more expensive than homes in neighboring states. In the rental market, a healthy vacancy rate is 5 percent, but in Minnesota the statewide rate ranges from 2.2 percent to 4 percent in the Twin Cities metro.[1] As the cost of owning a home increase in Minnesota, there are less affordable rental homes and apartments. Minnesota has seen dramatic rent increases over the past few years with rents rising hundreds of dollars a month, sometimes doubling, leaving renters unable to afford their homes. This often leads to displacement, with people needing to double up with family and friends, seek temporary shelter, live in their cars, or live on the streets until they can find a new apartment. Homelessness can cause interruptions in employment, education issues for kids, and poorer health outcomes.

- Even when families have a home, they may not be safe. Homes that are not free from physical hazards contribute to infectious and chronic diseases, injuries, and poor childhood development. [2, 3] Poor quality housing conditions like water leaks, bad ventilation, dirty carpet, and pest infestation can lead to increases in mold, allergens and mites which are associated with poor health, especially asthma exacerbation. Approximately 40 percent of diagnosed asthma among kids is believed to be attributable to exposures where they live.

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

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Infant Mortality

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

Minnesota's infant mortality rate has declined 42.5% since 1990, from 7.3 deaths per 1,000 live births to 4.2 in 2020. Despite Minnesota's improved infant mortality rate and ranking, the state's overall rate disguises substantial variation by race/ethnicity – the burden of infant mortality is not shared equally across population groups.

For infants born between 2016-2020, Minnesota's infant mortality rate was more than two times greater for infants born to African American/Black and American Indian mothers than infants born to non-Hispanic White mothers. Stress from racism and discrimination causes harmful changes in the body that can increase the rate of infant mortality.[15] Infant mortality rates among African Americans/Blacks in

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

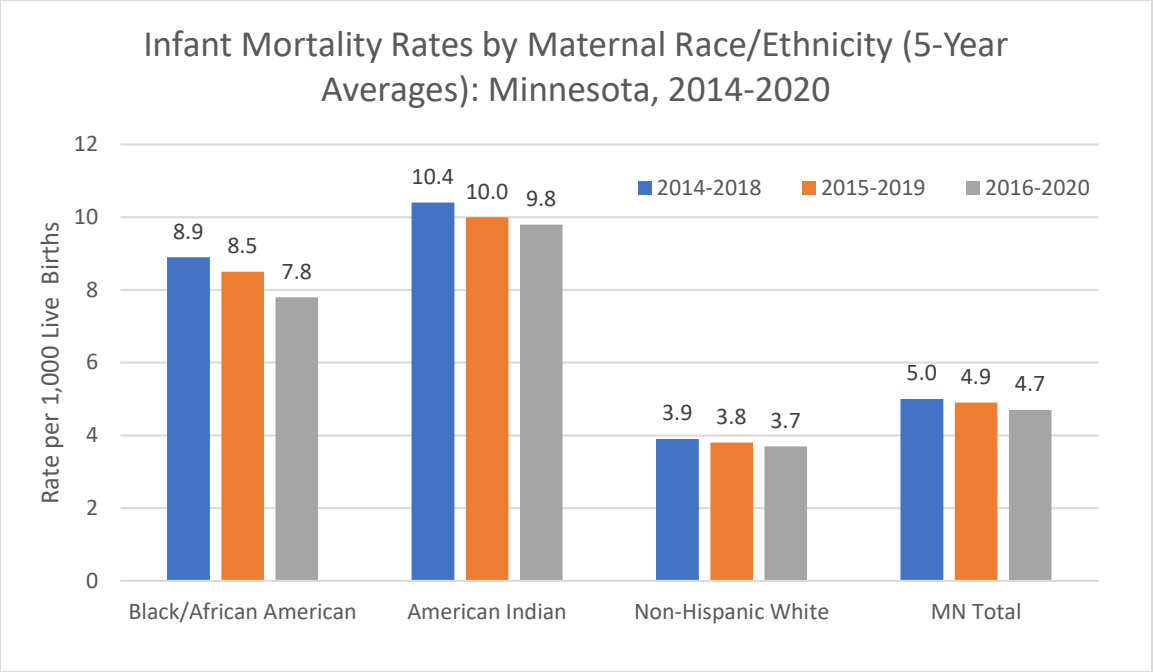
Minnesota vary greatly depending on the mother's birth country. From 2016-2020 infants born to U.S.-born African Americans/Black mothers had an infant mortality rate that is almost two times (10.1 per 1,000) that of infants born to foreign-born black mothers (6.2 per 1,000) and nearly triple the rate of infants born to non-Hispanic white mothers (3.7 per 1,000).

The infant mortality rate is over two times greater for infants born to African American/black mothers (9.0/10,000), American Indian mothers (10.5/10,000) and Other/Unknown mothers (13.3/10,000) than non-Hispanic white, Asian/Pacific Islander or white mothers in Minnesota. Preterm birth and low birthweight are leading causes of neonatal infant mortality (the first month of life), while sudden infant death syndrome is the leading cause of post neonatal mortality. Stress related to racism and discrimination leads to changes in the body that can increase the rate of neonatal infant mortality. The development of gestational hypertensive disorders or gestational diabetes also increases the risk of preterm birth and neonatal mortality. Both of these conditions are more common among women of color and among women who enter pregnancy at a high pre-pregnancy weight or who have pre-existing hypertension or type 2 diabetes. Social determinants of health, such as poverty and housing instability, contribute to post-neonatal mortality.[16]

FIMR is a continuous quality improvement methodology and community-based, action-oriented process developed by the American College of Obstetricians and Gynecologists and the Maternal and Child Health Bureau designed to reduce disparities and fetal and infant death. A visual representation of the FIMR process can be found in Appendix I.

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

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



Although Minnesota has experienced a steady decline in infant mortality since 2014-2018, infant mortality rates per 1,000 live births vary widely by mother's race/ethnicity. For example, from 2016-2020, the rate was 7.8 among infants born to Black/African American mothers, 9.8 among infants born to American Indian mothers, and 3.7 among infants born to White mothers. Furthermore, in 2020 there were 326 fetal deaths and 264 infant deaths in Minnesota.

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

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Immediate Post-partum LARCs

The ACOG has confirmed that it is safe to insert LARCs immediately postpartum after the delivery of the placenta, for either vaginal or cesarean birth or after an abortion, or within 48 hours of giving birth. LARCs have been approved by the Food and Drug Administration and is also supported as safe and effective by CDC, American Academy of Family Physicians and Associate of Certified Nurse Midwifes.

Their use is effective in reducing unintended pregnancy; currently Minnesota's unintended pregnancy rates are estimated to be about 36%. LARCs have very low failure rates, and a reduced likelihood of noncompliant use. Generally, there are very few contraindications, such as age or previous pregnancies, for their use. Although there has been an increase in the use of LARCs for Minnesota Health Care Program recipients, usage remains low.

Task Force recommends additional reimbursement for placement of immediate post-partum LARC be created and made available to Minnesota women in hospital settings. According to CDC, LARCs possess a number of advantages: they are cost effective, have efficacy and continuation rates, require minimal

maintenance, and are highest in patients' satisfaction. States have flexibility in how they reimburse for LARC, and by promoting access to contractive methods of choice—and the support necessary to use chosen methods effectively—states can support not only the health of women and their children, but also reduce unintended pregnancies.

Payment challenges related to LARC utilization exist in both fee-for-service and managed care environments, as well as in inpatient and outpatient settings (primary, specialty, or other ambulatory care. In inpatient settings, single prospective payment for labor and delivery services may not sufficiently address additional costs to provide LARC immediately after delivery to the hospital or provider for placement or insertion services. Recognizing the benefits to immediate post-partum LARC, CMS is available to provide technical assistance to states Medicaid officials who are interested in reviewing options for modifying LARC policies to implement payment strategies to optimize LARC utilization

Some strategies of payment approaches other states Medicaid agencies have use to optimize access and use of LARC fall into five broad categories:

1. Provide timely, patient centered comprehensive coverage for the provision of contractive services for women of child-bearing age.
2. Raising payment rates to providers for LARC or other contractive devices in order to ensure that providers offer the full range of contraceptive methods
3. Reimbursing for immediate postpartum insertion of LARC by unbundling payment for LARC from other labor and deliver services.
4. Removing logistical barriers for supply management of LARC devices (e.g., addressing supply chain, acquisition, stocking cost and disposal cost issues).
5. Removing administrative barriers for provision of LARC (e.g., allowing for billing office visits and LARC procedures on the same day; removing preauthorization requirements.)

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

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Parent and Caregiver Support

A parent or caregiver is a figure in a child's life that provides care, safety, and security for a child – they can be biological, adopted, foster parents, grandparents, or other primary caregivers. Parental support and education positively impact parents and families. Supporting parents can benefit the parent-child relationship, help families meet their physical, emotional, and financial needs, and improve health outcomes for children and parents.

A major factor in a parent or caregiver's ability to provide a safe and healthy home for their children is having resources and supports available to them. It is particularly important for parents to get support when they feel overwhelmed or stressed. According to the Zero to Three National Parent Survey, almost half (48%) of parents of young children do not feel they are getting the support they need when they feel stressed – with moms and birthing parents being more likely to say they have inadequate support than dads (57% vs. 39%).[1]

Supporting caregivers can have numerous positive downstream effects on the health of children by reducing family separation.[17] Parents need a network of supportive relationships, strategies for coping with stress, resources, knowledge, and an understanding of child development. Unfortunately, a lack of these critical supports can cause otherwise well-intentioned parents to engage in abuse or neglect. Parents and caregivers who have resources and support are more likely to provide safe and healthy homes for their children and families and reduce the need for out of home placement following confirmed instances of abuse of neglect.[18]

The parent-child relationship and the environment of the family, which includes all primary caregivers, are foundational to a child's well-being and healthy development. The impact of parents is critical during the first years of life when a child's experiences are almost entirely created and shaped by caregivers and their family environment.

The MCH Advisory Task Force has three recommendations for the Commissioner of Health as it relates to supporting parents and caregivers:

- Support policies and legislation that promote the importance paid parental and caregiver leave
- Support funding of family, friend, and neighbor childcare providers
- Support inclusive childcare

Support policies and legislation that promote the importance paid parental and caregiver leave

In the first months and year of life babies discover the world through experiences with parents. Neuroscience and behavioral research confirm that the foundation for future relationships, health, and the capacity to learn and thrive throughout life begins before birth and is influenced strongly prenatally and during the first three years of life.[19] This critical time in a child's life is a unique opportunity for parents to address healthy development, bonding and attachment, breastfeeding and ensure infants get proper nutrition and immunizations. Forming secure parent-child relationships requires care, consistency, and above all, time. Paid parental leave is critical, as parental involvement during the early years of a child's life strengthens bonds, helps with forming secure relationships, and decreases chronic stress among families with newborns.

Support funding of family, friend, and neighbor childcare providers

"Seventy-four percent of households with children under the age of 13 in Minnesota use childcare. Of that number, 46% rely on unlicensed family, friends, and neighbors for care, with grandmothers constituting the majority of these caregivers."[20] There are limited formal supports for these types of providers, although they could attend training if they choose. Child Care Assistance allows payment for family, friends, and neighbor providers if they meet certain requirements, including training and background studies. However, the percentage of children receiving Child Care Assistance that use these types of providers has dropped significantly in recent years. In 2010, about 22% of children receiving

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[17] McDonell, J. R., Ben-Arieh, A., & Melton, G. B. (2015). Strong Communities for Children: Results of a multi-year community-based initiative to protect children from harm. *Child Abuse & Neglect* 41: 79-96.
[18] McDonell, J. R., Ben-Arieh, A., & Melton, G. B. (2015). Strong Communities for Children: Results of a multi-year community-based initiative to protect children from harm. *Child Abuse & Neglect* 41: 79-96.
[19] Ruhm, C. J. (2000). Parental leave and child health. *Journal of Health Economics*, 19, 931–960.
[20] Evaluation of the Minnesota Family, Friend and Neighbor Grant Program DHS-5269-ENG 1-10 Report to the 2010 Minnesota Legislature, 2010.
[5] Foster, C. C. et al. (2021). Children with special health care needs and forgone family employment. *Pediatrics*, 148(3): e2020035378. doi:10.1542/peds.2020-035378

Child Care Assistance used a family, friend, or neighbor. In 2018, about 2% used a family, friend, or neighbor.

Support inclusive childcare

Along with the overall childcare shortage in Minnesota, childcare opportunities for children with disabilities and special healthcare needs have even more challenges. Between 14.5% and 40.9% of parents of children with disabilities and special healthcare needs leave the workforce due to insufficient access to childcare opportunities for their children[5]. Lack of inclusive childcare also limits the early childhood development and social development of children with disabilities and special healthcare needs as they miss out on opportunities to engage with same as peers.

The state of Minnesota needs to foster partnerships between state agencies and childcare providers to develop inclusive childcare placements and explore opportunities for PCAs, homecare nurses, and behavioral support specialists to be shared across home and childcare environments. Additionally, grants for inclusive childcare could support parents remaining in the workforce.

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Trauma-Informed Care

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

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

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

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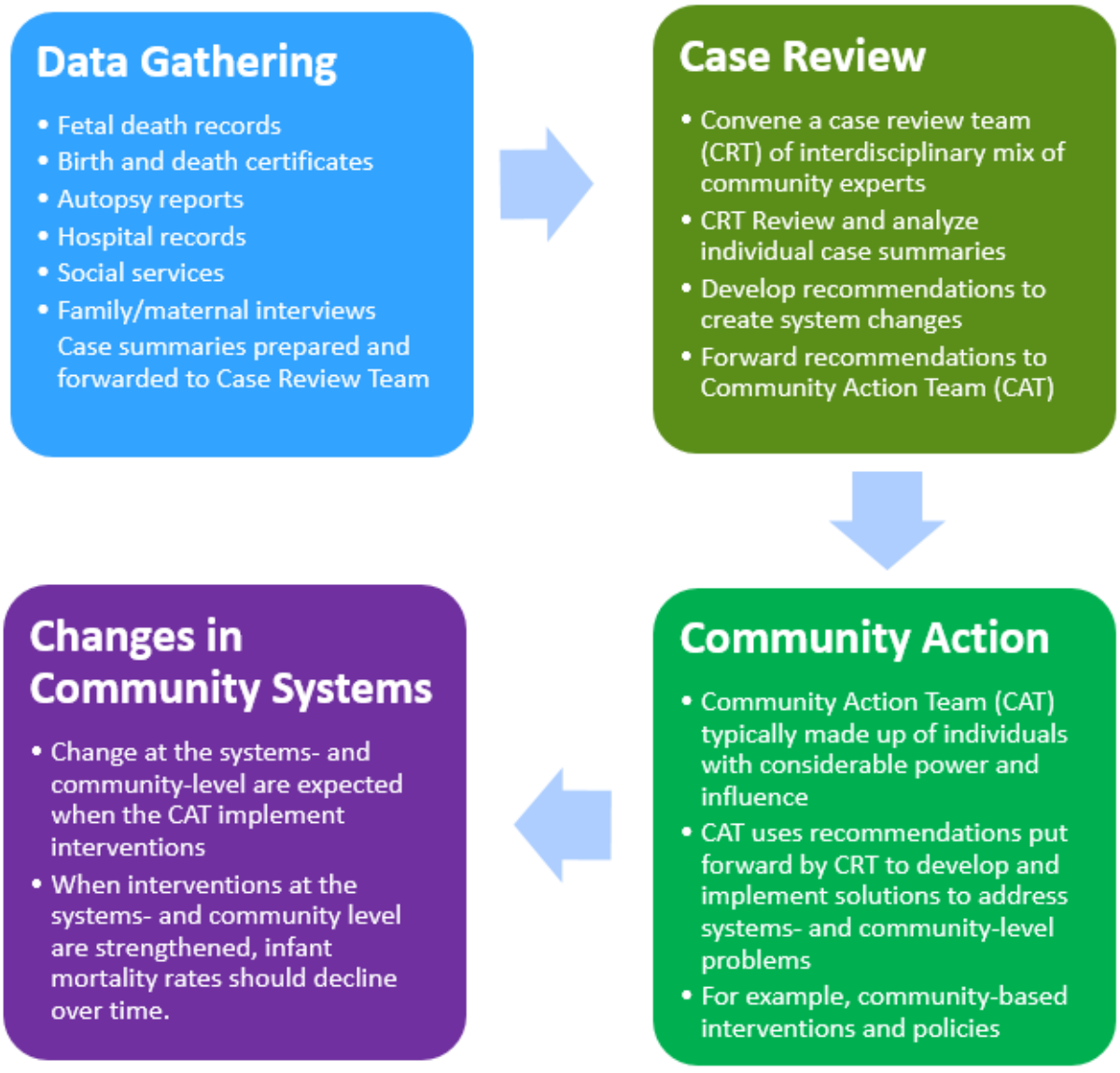
Reference: Center for Health Care Strategies, Inc. Key Ingredients for Trauma-Informed Care https://www.chcs.org/resource/key-ingredients-trauma-informed-care/.

APPDENDIX I

Fetal Infant Mortality Review Process



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

APPDENDIX II

House Resolution No. 1

A House resolution declaring racism a public health crisis.

Whereas, race is a social construct with no biological basis; and

Whereas, racism is embedded in the foundation of America, beginning with chattel slavery in 1619; and

Whereas, much of the Black experience in America has been endured under slavery and Jim Crow, which created preferential opportunities for white people while subjecting people of color to hardships and disadvantages in every area of life; and

Whereas, public health disparities have persisted for over 400 years and there are long-standing, unaddressed disparities as well as systemic racism and other socioeconomic inequities; and

Whereas, the American Public Health Association defines racism as a social system with multiple dimensions: individual racism is internalized or interpersonal, and systemic racism is institutional or structural. Systemic racism is a system of structuring opportunity and assigning value based on the social interpretation of how one looks that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources; and

Whereas, racism is complex and it is imperative to employ an intersectional lens and approach that considers the unique ways that racism intersects with disabilities, immigration, gender, documentation status, and LGBTQ+ communities; and

Whereas, racism causes persistent racial discrimination in housing, education, employment, and criminal justice; and

Whereas, the American Medical Association, the American Academy of Pediatrics, the American College of Obstetrics and Gynecologists, and the American Public Health Association recognize that racism is a social determinant of health that has a profound impact across the lifespan of an individual and that failure to address racism is an urgent public health issue that will exacerbate and perpetuate existing health inequities; and

Whereas, more than 100 studies have linked racism to worse health outcomes; and

Whereas, in Minnesota the highest excess death rates exist for Black and Indigenous communities, at every age demographic; and

Whereas, Minnesota must address persistent disparities in health outcomes and the social, economic, educational, and environmental inequities that contribute to them; and

Whereas, while there is no epidemiologic definition of crisis, the health impact of racism clearly rises to the definition proposed by Sandro Galea: "The problem must affect large numbers of people, it must threaten health over the long-term, and must require the adoption of large-scale solutions"; and

Whereas, racism is a public health crisis affecting our entire state and a comprehensive and intersectional approach is necessary to address the crisis, *Now*, *Therefore*,

Be It Resolved by the House of Representatives of the State of Minnesota that it declares racism a public health crisis; and

Be It Further Resolved, based upon this affirmation, the Minnesota House of Representatives will actively participate in the dismantling of racism by:

Collaborating with the state's law and justice agencies and the community to work to ensure public confidence that public safety is administered equitably;

Studying, evaluating, and conducting an assessment of the existing policies and practices of the Minnesota House of Representatives through an intersectional lens of racial equity, setting measurable goals to advance equity through these policies and practices;

Conducting an assessment related to all human resources, vendor selection, including reviewing internal processes and practices related to hiring, promotions, and leadership appointments;

Enhancing data-driven education efforts on understanding, addressing, and dismantling racism, and how racism affects public health, family stability, early childhood education, economic development, public safety, housing, and the delivery of human services;

Supporting local, regional, and federal initiatives that advance efforts to dismantle systemic racism, partnering with local organizations with a demonstrated track record of confronting racism, and meaningfully engaging with communities of color;

Convening a House Select Committee on Minnesota's response to addressing racism as a public health crisis to ensure House legislative efforts are analyzed through an intersectional race equity lens; and

Hereby encouraging the Governor and the Senate to also adopt resolutions affirming that racism is a public health crisis resulting in disparities in family stability, health and mental wellness, education, employment, economic development, public safety, criminal justice, and housing.

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[1] Racism is a Public Health Crisis, How to Respond. 20.09_Racism-is-a-Public-Health-Crisis.pdf (house.gov)