m1 DEPARTMENT
OF HEALTH

Minnesota's 2020 Title V Maternal and Child Health Block Grant Needs Assessment

DESCRIPTION OF METHODS AND FINDINGS

Minnesota's 2020 Title V Maternal and Child Health Block Grant Needs Assessment: Methods and Findings

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Student Interns and Fellows

Special thanks to all the amazing student interns that were essential to our Needs Assessment, Strategic Plan, and Evaluation process: Lauren Schwerzler, Jernelle John, Doaa Elgaali, Elizabeth Corey, Abigail Fink, Maura Shramko, Lydia Pfluger, Ann Turcotte, Alyssa Scott, and Kaitlyn Traub.

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We would also like to thank all the support of our community partners, Local Public Health partners, and the Minnesota Department of Health staff, especially those within the Division of Child and Family Health. Without your support this work could not be completed. We would also like to give a special thanks to the Maternal and Child Health Advisory Task Force, our Needs Assessment Leadership Team, and the Strategic Planning Steering Committee.

Executive Summary

The Minnesota Department of Health (MDH) works to *protect, maintain, and improve the health of all Minnesotans*. Funding from the Title V Maternal and Child Health (MCH) Block Grant helps to improve the health and well-being of women, children, youth, and families including children and youth with special health needs (CYSHN).

Within MDH, the Child and Family Health (CFH) Division leads Title V MCH Block Grant activities. The CFH Division provides collaborative public health leadership that supports and strengthens systems to ensure healthy families and communities. The Maternal and Child Health and Children and Youth with Special Health Needs Sections within the CFH Division lead Title V efforts – collaborating with the Family Home Visiting, and Women, Infants, and Children (WIC) Sections in the CFH Division, as well as with other MDH programs. Most of Minnesota's Title V efforts are focused at the population and systems levels.

> Minnesota acknowledges that systemic racism and structural (social, economic, political, and environmental) inequities can result in poor health outcomes across generations. They have a greater influence on health outcomes than individual choices or a person's ability to access health care, and not all communities are impacted in the same way.
>
> **All people living in Minnesota benefit when we reduce health disparities.**

While we are proud of our success in keeping most Minnesotans healthy, we also acknowledge that "the opportunity to be healthy is not equally available everywhere or for everyone in Minnesota."[1] In order to be able to reach our goal of an equitable and just system for our MCH populations, we strive to integrate the Triple Aim of Health Equity (Figure 1) into all our CFH Division and Title V MCH Block Grant work. This means we continually work to expand our understanding of what creates health, to strengthen the capacity of communities to create their own healthy future, and to implement a "health in all policies" approach with health equity as the goal.

Figure 1. Triple Aim of Health Equity

In addition to recognizing the importance of advancing health equity, the CFH Division incorporates the following principles into our efforts to improve systems for Minnesota's women, children, and families:

- *Trauma-Informed:* Recognizing the widespread impact of trauma on MCH populations, while also considering community resiliency and assets.

- *Interconnectedness:* Understanding that many of the issues that MCH populations face are linked together.
- *Life-Course:* Emphasizing that many early life experiences have a lasting impact on health and development.
- *Continuous Quality Improvement:* Encouraging all team members to continually ask, "How are we doing?" and "How can we do better?" So we are continually improving effectiveness of practices, policies, and programs.
- *Evidence-Based and Informed Practices:* Using the best evidence possible to identify the best options for practices or programs.
- *Data-Driven:* Using the best scientific data and methods available to make decisions, which can include using community knowledge or experience if there is a lack of data.
- *Community-Driven:* Recognizing that many solutions lie within communities.

Needs Assessment, Priority Needs, and Action Planning

Every five years, MDH conducts a comprehensive, community-focused needs assessment to gather information on the health and well-being of women, mothers, children and youth, including children and youth with special health needs (CYSHN), and their families. This assessment helps to provide direction on Title V MCH Block Grant activities for the next five years by identifying state MCH priority needs. Ongoing needs assessment activities are also completed to keep apprised of emerging issues within MCH populations. Priorities are set and/or modified based on the needs of populations, federal requirements, Community Health Board priorities, and the capacity of MDH and local public health (LPH) agencies.

Over the past two years, MDH has worked in authentic partnership with families, communities, stakeholders, and public health professionals across the state to better understand the needs of women, children, and families living in Minnesota. Through this work, Minnesota identified eleven priorities for the FY2021 – FY2025 Title V MCH Block Grant cycle.

- **Care during Pregnancy and Delivery:** Increasing accessible, quality health care during pregnancy and delivery.
- **Infant Mortality:** Reducing the number of infants that die before their first birthday.
- **Comprehensive Early Childhood Systems:** Ensuring Minnesota has inclusive systems that link young children and their families to all the support and services they need.
- **Adolescent Suicide:** Reducing the number of youth who take their own life.
- **Access to Services and Supports for Children and Youth with Special Health Needs:** Ensuring all children and families have what they need to thrive.
- **Housing:** Increasing safe, affordable, stable housing for all people living in Minnesota.
- **Accessible and Affordable Health Care:** Ensuring comprehensive, quality health care services, including Family Planning are available and affordable for all.
- **Mental Well-Being:** Ensuring all people living in Minnesota have the opportunity to realize their abilities, deal with day-to-day stress, have meaningful relationships, and contribute to their family and community. This includes building resilience in those who experience childhood trauma and adversity.
- **American Indian Family Health:** Reducing disparities and supporting the well-being of American Indian families.
- **Parent and Caregiver Support:** Supporting parents and caregivers socially and emotionally with family-focused activities, policies, and education.

- **Boys and Young Men:** Protecting and promoting physical, mental, and emotional health among people who identify as male.

The summaries below highlight the gaps that we identified during our needs assessment process. Following the completion of our statewide needs assessment, Minnesota entered into a strategic planning process to develop strategies to address the identified priorities with the community. These strategies are outlined briefly below. During the developing of the strategies, we considered the many assets and strengths of Minnesota communities around these topic areas. We are working towards changing the way we represent our work to a strengths based approach when sharing information about the priorities that are essential for Minnesota women, children, and families to thrive.

Figure 2. Minnesota by the Numbers

MINNESOTA BY THE NUMBERS

31% children aged 0-18 were persons of color or American Indians (2018)

11 Federally-Recognized Tribes

6.3% uninsured (2017) including **50,000** children

14.8 per **100,000** adolescent suicide rate

5.6 Million state population (2018)

55% population in Twin Cities Metro Area

17.7% children aged 0-17 have special health needs

67,348 annual births (2018)

43.9% births covered by Minnesota Health Care Programs (2018)

77.4% women who received prenatal care during first trimester (2018)

Care during Pregnancy and Delivery

Women's health and well-being is significantly impacted by the care they receive during pregnancy and delivery. Early and regular prenatal care (care received during pregnancy) can help to reduce the risk of pregnancy complications that adversely impact the mother and/or the baby. However, only 77.4 percent of women in Minnesota received prenatal care within their first trimester of pregnancy. [2] This is also a health equity issue, as American Indian and African American/Black mothers are less likely to have received adequate prenatal care as compared with non-Hispanic White women. **Error! Bookmark not defined.** Even if women have access to adequate prenatal care, many mothers, especially those living in rural areas, are at higher risk of complications during delivery due to shortages of obstetric care in community hospitals.

Minnesota strategies to improve care during pregnancy and delivery include:

- Expanding family-focused, community-based policy and funding;

- Integrating services and optimizing cross-sector collaboration; and
- Strengthening and expanding culturally-responsive, trauma-informed care.

Infant Mortality

Minnesota's infant mortality rate has declined by 29 percent since 1990, from a high of 7.2 deaths per 1,000 live births to its present level of 4.5 in 2017.[3] While infant mortality rates for all racial groups in Minnesota have declined over time, disparities have remained constant for over 20 years. The infant mortality rate is over 2 times greater for infants born to African American/Black mothers and American Indian mothers than non-Hispanic White mothers in Minnesota.**Error! Bookmark not defined.**

Minnesota strategies to reduce infant mortality include:

- Applying culturally-specific, community-based best practices;
- Improving data collection and evaluation; and
- Facilitating policy and systems changes to reduce infant mortality.

Comprehensive Early Childhood Systems

Every family should have an equal opportunity to interact with a high-quality early childhood system, which includes screening and interventions that promote the social, emotional, cognitive and physical development of their children. Though Minnesota has seen an increase in the percent of children receiving developmental screening using a parent-completed tool from 2016 (50.1%) to 2018 (65.4%), families are still facing significant challenges in navigating the early childhood system.[4] The array of early childhood programs is complex and fragmented, due in part to differences in the way programs are funded and variation in their eligibility and other requirements.

Minnesota strategies to promote a comprehensive early childhood system include:

- Coordinating and implementing access to comprehensive, family-centered services for young children and their families through the development of an online navigation and referral system and supportive community partnerships; and
- Maximizing and increasing funding to support statewide programs that serve families who are pregnant and parenting young children.

Adolescent Suicide

In Minnesota, suicide is the second leading cause of death for young people ages 10-24.[5] In 2018, 120 Minnesotans between the ages of 10 and 24 died of suicide, representing roughly 16 percent of all suicides in the state in that year. Data from the 2019 Minnesota Student Survey shows that 18 percent of female students and 9 percent of male students in ninth grade reported seriously considering attempting suicide in the last year. Moreover, 3 percent of male and 5 percent of female ninth grade students reported actually attempting suicide in the last year. 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.

Minnesota strategies help address adolescent suicide include:

- Empowering youth, young adults, families, and communities to meaningfully engage in creating solutions to increase protection from suicide risk; and
- Expanding and improving *postvention* supports by partnering with the MDH Suicide Prevention Unit in their work on training and responding to communities who have had a death by suicide.

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

Approximately 17.7 percent of Minnesota children 0-17 years old have special health needs, which includes a range of chronic physical, developmental, behavioral, and emotional conditions.**Error! Bookmark not defined.** Though CYSHN use a variety of services and supports, families often have to forgo care due to long waiting lists, problems getting appointments, troubles with eligibility criteria, complex systems to navigate, child care issues, language and cultural barriers, transportation issues, and lack of financing.

Minnesota strategies to improve access to services and supports for CYSHN and their families include:

- Enhancing centralized resources to improve knowledge of services and supports so families can gain access to services through a "no-wrong door" approach;
- Building the capacity of communities by cultivating knowledge and improving collaboration; and
- Constructing a competent and well-compensated workforce.

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, timeliness of entry into services, and many more factors. Between 2015 and 2017, the uninsured rate in Minnesota increased from 4.3 percent to 6.3 percent, leaving approximately 349,000 Minnesotans uninsured. [6] Poor access to health care services can result in unmet health needs, lack of preventive services, hospitalization, and increased financial burden.

Minnesota strategies to improve access to affordable and adequate health care include:

- Reducing the discrimination and marginalization experienced by women, children, and families in our health care system;
- Increasing access to community-based and remote services, such as telemedicine; and
- Utilizing trusted health advocates (such as Community Health Workers) and other person-centered practices to improve the quality of health care services provided.

Parent and Caregiver Support

Parents and caregivers 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 undue stress. 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. [7] This can occur for many reasons, including: employers do not provide needed living wages or paid leave, a lack of parenting support and education resources available for families from diverse backgrounds, and societal-level stigma against asking for help or support.

Minnesota strategies to help improve support for parents and caregivers in the state include:

- Redesigning policies and programs at the state level so that the system is set up in a manner where families are better able to receive needed support;
- Building the capacity of public health professionals to help improve the well-being and resilience of families; and
- Developing innovative ways that parents and caregivers can connect with each other.

American Indian Family Health

The history of American Indians is one of great strength and resilience. Unfortunately, today American Indian women, children, and families experience worse outcomes than other populations in Minnesota. These disparities are caused by historical trauma, racism, and continued colonial practices and policies that create barriers to opportunity and ability to thrive. American Indian children are more likely than other children to live in poverty, grow up in single mother families, be placed in out-of-home care, and are less likely to graduate from high school. American Indian women in Minnesota are 7.8 times more likely to die during pregnancy or within one-year after pregnancy than non-Hispanic White women.

Minnesota strategies to improve outcomes related to American Indian family health include:

- Increasing access to culturally-specific health services;
- Mandating cultural proficiency, as defined by the community; and
- Shifting power and polices to address structural racism.

Housing

Housing is connected to every aspect of people's lives and is a critical factor in financial security, academic success, and being healthy. With housing prices 26 percent more expensive than neighboring states and a nearly 9 percent increase from 2017 to 2018, Minnesota is in the midst of a housing crisis. These prices have led to approximately 26 percent of households in Minnesota to be considered "housing cost-burdened," meaning their housing costs were more than 30 percent of their monthly gross income. Minnesota has the greatest disparities in home ownership rates between White and non-White residents in the nation.

Minnesota strategies to improve access to safe and affordable housing include:

- Working across state agencies to push for legislation that decreases housing costs;
- Promoting person-centered approaches and services; and
- Engaging in cross-agency work to explore creative/innovative housing options for families.

Mental Well-Being

Mental well-being is about having fulfilling relationships, utilizing strengths, contributing to community, and being resilient, which is the ability to bounce back after setbacks. Poor mental well-being, with or without the presence of mental illness, is a risk factor for: chronic disease (e.g. cardiovascular disease and arthritis), increased health care utilization, missed days of work, suicide ideation and attempts, death, smoking, drug and alcohol abuse, physical inactivity, injury, delinquency, and crime. Over 460,000 Minnesotans (8.8%) ages five and older experienced 14 or more mentally unhealthy days in the last month, including significantly higher rates among those who are uninsured, on public assistance, Black, at 100% of the Federal Poverty Level, and who have a high school education.

Minnesota strategies to promote mental well-being include:

- Helping geographic and culturally-specific communities to build capacity and resilience;
- Implementing a public health campaign on mental well-being across the life span; and
- Advocating for legislative policies that promote mental well-being.

Boys and Young Men

Engaging boys and young men in public health efforts is incredibly important. Men play an important role in the health outcomes of their families as partners and fathers within family units. Children and families do better when fathers are involved in their kid's lives. Children who grow up in families with an involved father have better performance in school, stronger behavioral skills, and have higher self-esteem.[8] 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.[9] Boys and young men are more likely to experience violence and be involved with the juvenile justice system with males representing 67 percent of all arrests of juveniles in Minnesota in 2016.[10]

Minnesota strategies to promote the health and well-being of boys and young men include:

- Building capacity to address health of boys and young men;
- Advancing a culture of trauma-informed male inclusion; and
- Providing tools and programs for young men on healthy relationships.

Five-year Needs Assessment Summary

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

"[Needs assessments] provide and disseminate scientifically-credible information to the public, programs, and stakeholders, and policymakers that can be used to identify existing and emerging needs and to advocate for and ensure that, when possible, effective and accountable programs, services and policies are available to meet those needs". [11]

Minnesota's Title V Needs Assessment is an ongoing, data-driven, collaborative process that includes families, service providers, and community-based organizations; local public health agency staff; policymakers and service funders; staff from the Minnesota Department of Health and other state agencies.

Federal Requirements

As one of the largest federal block grant programs, the Title V MCH Block Grant program is a key source of support for promoting and improving the health and well-being of the nation's mothers, children, including children with special needs, and their families. Title V MCH Block Grant legislation requires states to submit an Annual Report and to complete a statewide, comprehensive needs assessment every five years.

The Title V MCH Block Grant addresses key MCH priority areas within population domains. These domains are: 1) Women/Maternal Health; 2) Perinatal/Infant Health; 3) Child Health; 4) Children and Youth with Special Health Needs; 5) Adolescent Health; and 5) Cross-Cutting and Systems Building Issues.

Needs Assessment Leadership Structure

Minnesota established a clear leadership structure in conducting our needs assessment process. The process was guided by a Needs Assessment Leadership Team, which consisted of LPH leaders from urban and rural communities, the University of Minnesota's School of Public Health and other MCH academia, students, the MCH Advisory Task Force, and an internal needs assessment team composed of staff from the Child and Family Health Division. The responsibilities of the Needs Assessment Leadership Team were to:

- Provide feedback and guidance related to data and process matters throughout the needs assessment process;
- Complete criteria-based ranking during prioritization; and
- Review Minnesota's 2021-2025 Title V priorities.

Maternal and Child Health Advisory Task Force

The Maternal and Child Health Advisory Task Force was created by the Minnesota Legislature in 1982 (MN Stat 145.881) to advise (by reviewing and reporting to) the Commissioner of Health on the health care needs of mothers and children throughout Minnesota, priorities for funding the essential MCH services in statute, and more. The Task Force consists of 15 legislatively authorized members with equal representation in three statutory-defined categories: 1) professionals with expertise in maternal and child services, 2) representatives of community health boards, and 3) consumers representatives interested in the health of mothers and children, appointed by the Commissioner of Health to four-year terms. Eight of the terms align with the governor's term (ending in early January) and seven terms end one year later. Applications are made through the Secretary of State's Office of Open Appointments. A complete list of members is located on the Members of the MCH Advisory Task Force webpage.

Internal Needs Assessment Leadership Team

To ensure communication and vested interest from MDH staff, an internal Needs Assessment Leadership Team was formed. They were instrumental in ensuring the needs assessment had support, guidance, and expertise throughout the process.

Table 1. Internal Needs Assessment Team

Role	Name
Division Director*	Joan Brandt
Assistant Division Director*	Kathy Wick
Title V MCH Director*	Karen Fogg
Title V CYSHN Director*	Nicole Brown
Title V MCH Coordinator*	Judy Edwards
Title V CYSHN Coordinator*	Sarah Dunne
Title V Needs Assessment Coordinator*	Blair Harrison
Title V Data Coordinator*	Molly Meyer
State Maternal & Child Health Epidemiologist	Mira Sheff
WIC Section Representative	Kate Franken
FHV Section Representative	Dawn Reckinger
Maternal/Women-Perinatal/Infant Domain Representative	Katie Linde
Child/Adolescent Domain Representative	Maureen Alms
CYSHN Domain Representative	Sarah Mapellentz

*Member of the Title V Leadership Team

Needs Assessment Framework

Minnesota operated from a trauma-informed, intersectional framework aimed to advance health equity and acknowledge the strengths of our state's communities. The needs assessment and its activities are rooted in the social ecological model (SEM), a systems model in which multiple levels of influence (individual, interpersonal, organizational, community, and policy) impact the health of communities. The following principles provide guidance on the implementation of the needs assessment:

- **Health Equity:** Integrate health equity throughout process using the MDH Triple Aim of Health Equity
- **Trauma-Informed:** To adhere to best practices and trauma-informed approaches when conducting stakeholder engagement and needs assessment activities
- **Quality Improvement:** Use a continuous quality improvement approach to increase assets and protective factors and to address challenges as opportunities to advance population outcomes
- **Community Engagement:** Actively engage with community stakeholders utilizing the principles within the MDH Community Engagement Plan
- **Transparency:** Communicate with needs assessment participants, the MCH community, and stakeholders so that information used in needs assessment is shared, and that decision-making processes are clear and understandable (also to support accountability)
- **Accountability:** Be answerable for the consequences of decisions that impact families, communities, and stakeholders
- **Data-driven Decisions:** Use quantitative and qualitative data to inform decision making
- **Evidence-Based and Informed Practices:** Apply evidence-based and informed practices to methodology and planning efforts related to the needs assessment
- **Adaptability:** Demonstrate willingness, flexibility and agility throughout the needs assessment process
- **Collaboration with Systems Partners/Customers:** Focus on both internal and external partners as key collaborators to achieve desired outcomes
- **MCH Target Population:** Focus on target MCH populations, which includes families, women, mothers and fathers, infants, children, adolescents, young adults, and children and youth with special health needs

Appendix A includes further information on the guiding principles, including activities for operationalization.

Trauma-Informed & Intersectional Frameworks

While the needs assessment was grounded in many guiding principles, two were particularly relevant frameworks in advancing health and racial equity through this work: trauma-informed and intersectionality. Needs assessments unearth critical needs and problems facing populations, and health inequities emerging from intersecting social categories and systems of power and privilege often underlie these needs. While public health work aims to promote health, at times our methods do not acknowledge deep-rooted intersectional oppression or its resulting harm. Also, as public health professionals we carry lived experiences of particular social locations and operate within institutions that can be complicit in systems of oppression that cause harm and trauma. It is critical to recognize the pervasiveness of intersectional oppression as well as trauma emerging from such oppression[12]; and that the harm can be caused or exacerbated through our methods and practices.

These frameworks emerge out of rich systems-focused spaces that emphasize transformative change. Trauma-informed approaches recognize the pervasive consequences of oppression and traumatic stress for individuals, communities, and systems.[13] Relevant to public health and needs assessment work, trauma-informed approaches include promoting emotional and physical safety, embodying trustworthiness and transparency, collaboration in evaluation efforts, empowerment to share power and promote agency, choice, and intersectionality.[14] Emerging from Black feminist scholarship and activism, intersectionality highlights how our experiences are shaped by the intersections of our social locations, and resulting privilege and oppression (e.g., racism, sexism, able-ism, classism, and more).[15] Drawing on intersectionality, public health professionals should consider how to highlight voices and lived experiences from varying social locations to understand health inequities. When we look at things in isolation, we risk employing a trickle-down approach to social justice and public health issues, which ultimately, solves nothing.

The Title V Needs Assessment Team was committed to doing the work in such a way that it did not cause trauma or re-traumatize any community members, stakeholders, or team members. The Title V Needs Assessment Team strived to be trauma-informed, while recognizing that our process of learning how to be trauma-informed is ongoing.

Needs Assessment Methods

Minnesota used a mixed methods approach, informed by best practices and evidence-based research, to assess the needs and assets of communities, families, and individuals living in Minnesota.

The needs assessment process was informed by Donna Petersen and Greg Alexander's book, "Needs Assessment in Public Health." Discrete stages of the needs assessment were identified, with evaluation of the process ongoing throughout (see *Appendix B* for detailed timelines).

Figure 3. 2020 Needs Assessment Process
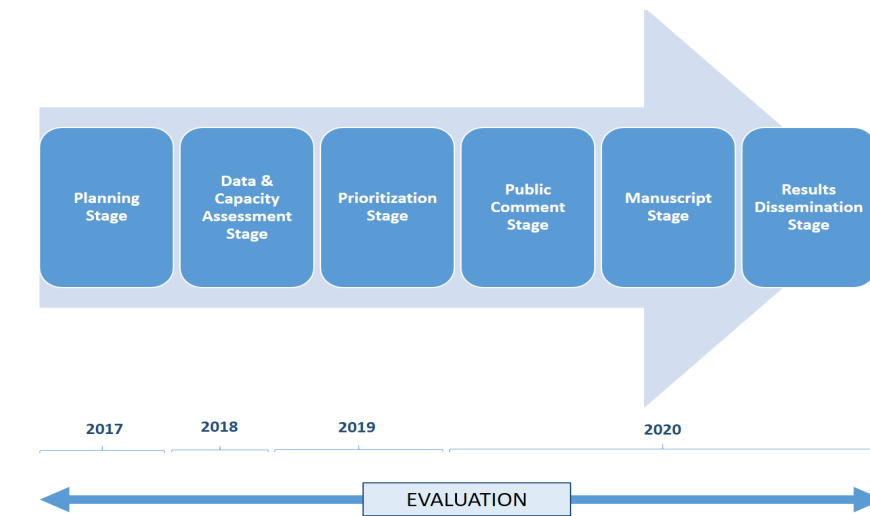
Stakeholder Involvement and Relationship Building

Throughout the needs assessment process, stakeholders were engaged to provide input, co-create activities and processes, and select priorities. The Title V Needs Assessment Team was intentional in planning for stakeholder engagement throughout the process. Community organizations, family work

groups, family-led organizations, and other external stakeholders (e.g. MCH Advisory Task Force, CYSHN Parent Workgroup, the Early Hearing Detection and Intervention, and Newborn Screening Advisory Councils) were involved in the development, review, and approval of the needs assessment plan in early 2018, and the Title V Needs Assessment Team continued to work in partnership with these stakeholders at all stages of the needs assessment process.

We know that in order to advance outcomes and equity in outcomes for Minnesota's children and families, we must include people who are most likely to be impacted by the disparities in our efforts. Title V Needs Assessment Team worked closely with the MDH Center for Health Equity and the Refugee Health Program to receive technical assistance and guidance on obtaining input from community members.

Planning for Stakeholder Engagement

The Needs Assessment Leadership Team determined that due to the complexity of maternal and child health systems, and the depth of engagement needed, a formal stakeholder mapping exercise would be useful in determining exactly who to engage and in what capacity. In May 2018 the Title V Leadership Team and the MDH Community Engagement Director met to complete a stakeholder mapping exercise (see figure 4.).

Figure 4. Stakeholder Mapping
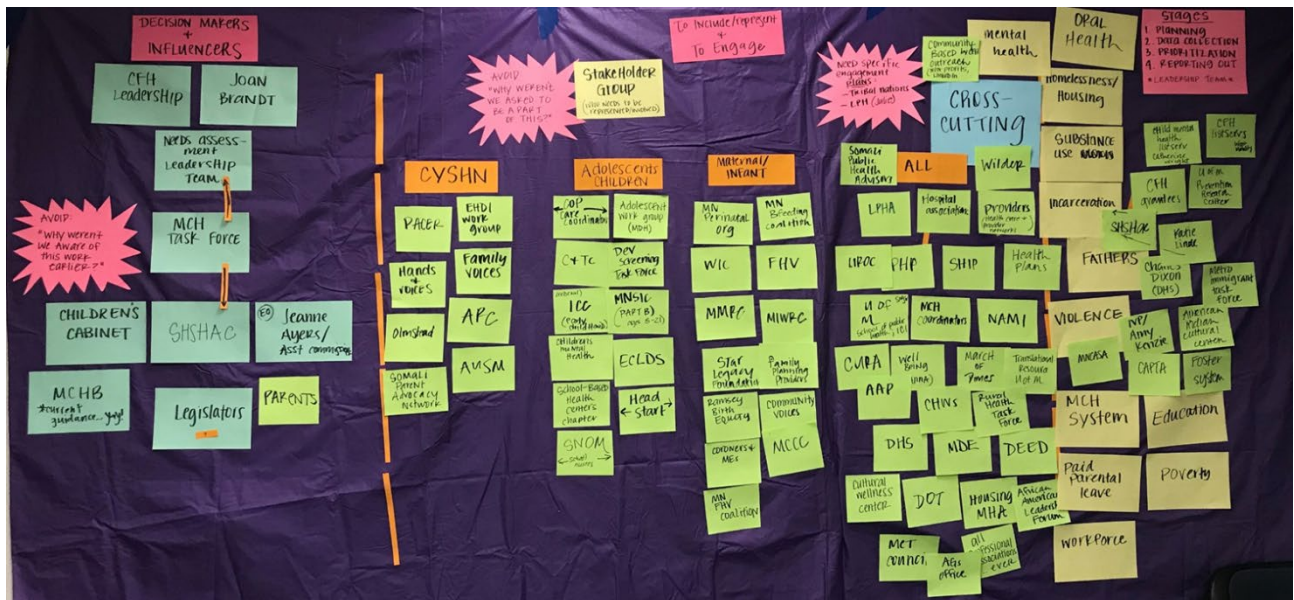
This exercise also involved brainstorming why we engage and who we should engage. There was a lot of intentional forethought in populations that need to be engaged, represented, and be leaders in the work, with a focus on populations that haven't had a seat at the table before in our statewide needs assessment and strategic planning work. Additional results from this stakeholder mapping exercise can be found in _Appendix C_.

Stakeholder Engagement

During the needs assessment process, MDH aimed to not only solicit feedback from the community but to involve the community in the decision-making process, including prioritization of our final priority needs.

During the data collection stage, the Title V Needs Assessment Team engaged 248 people in focus groups, community forums, and key informant interviews. Additionally, there were countless informal interviews with fire department staff, WIC clinic staff, LPH, and other states needs assessment teams. A total of 2,736 people completed a Discovery Survey, and almost 40 percent of all respondents self-identified as a community member. To maintain engagement with stakeholders, all survey respondents were able to opt in to receive communications about the ongoing process – 784 people chose to provide contact information. Emails were sent to this list when additional engagement activities were occurring, and many continued to participate.

A total of 108 people participated in the development of 40 data stories and 40 data placemats. Community forums were held at different community locations in the metro area, as well as all-remote options to be inclusive of people living in Greater Minnesota.

Finally, after the priorities were identified, over 240 MDH staff, family stakeholders, LPH, and health professionals participated in 11 teams that developed Minnesota's 2021-2025 Child and Family Health (CFH) Strategic Plan, which is the basis of our Title V MCH Block Grant Action Plan.

Planning Stage

The Child and Family Health (CFH) Division has a leadership role to form cross-sector partnerships to enable and equip organizations to create lasting solutions on a broad-based scale. Enhanced communication and coordination across the CFH Division is needed for our work to have an extended reach and greater impact. In 2017, Minnesota embarked on a quality improvement project aimed at creating an inclusive, comprehensive, ongoing needs assessment process related to Minnesota's public health system and services and pregnant people, mothers, infants, children, adolescents, CYSHN, and families. During this quality improvement project, CFH staff worked to develop draft guiding principles for the needs assessment process, worked to crosswalk the various assessment processes currently conducted within the CFH Division, and also mapped out an initial process for conducting our needs assessment. This group and their preliminary work was merged into the Title V Internal Needs Assessment Team.

Following the work of the initial quality improvement project, additional activities during the planning stage included:

1. Establishing an organizational structure for the needs assessment:
   a. Hiring a Needs Assessment Coordinator to work with the Title V Data Coordinator in managing the day-to-day activities of the needs assessment.
   b. Establishing a leadership structure for the project (described above in "Needs Assessment Leadership Structure").
2. Developing a Community Engagement Plan, with the assistance of the MDH Center for Health Equity, that outlined how community members (including families, tribes, and others) would be represented during the needs assessment process.
3. Developing tentative communications plans for how data and information would be shared with stakeholders throughout the process.

Data and Capacity Assessment Stage

In 2018, the Title V Needs Assessment Team began the data and capacity assessment stage. In addition to providing an assessment on the overall needs of MCH populations and the capacity of systems partners to meet those needs, the end goal of this stage was to identify a list of potential priorities that would be considered and narrowed down during the prioritization phase.

The Title V Needs Assessment Team examined the strengths, needs, and capacity of Minnesota's MCH populations and MCH workforce using qualitative and quantitative Minnesota-specific data and information. While engaging in data activities, the team again utilized the guidance outlined in Petersen and Alexander's book, *Needs Assessment in Public Health*. As such, data used in the assessment was:

- **Simple:** Well-defined, valid, reliable, understandable to stakeholders
- **Stable:** Provided stable estimates
- **Available:** Timely and readily available
- **Logical, Relevant, Important:** Reflected conditions and service patterns thought to correlate with changes in health status outcomes of interest
- **Has Broad Representation:** Reflected potential health status concerns of a majority of the target population as well as high-risk groups
- **Political Feasibility:** Considered political will, though remember the potential impact of the problem on community health is the most important

Activities that occurred during the data and capacity stage are highlighted in the sections below.

Analyzing Information and Data from County, State, and Federal Sources

The Title V Needs Assessment Team started with compiling data and information already collected about the health and well-being of people living in Minnesota. The team gathered and reviewed available reports, other needs assessments (including community health assessments from local public health agencies), existing literature, national benchmarks and goals, and other relevant factors that influence the MCH environment in Minnesota (e.g., agency capacity, political will, etc.). The team wanted to build upon the large amount of rich quantitative and qualitative county, state, and federal data sources (secondary data sources) that already exist. These resources were essential to the needs assessment process to further the state's understanding of unmet needs, strengths, disparities, and opportunities related to MCH populations.

Additional data sources used in our assessment included:

- Title V Information System
- Minnesota Vital Records
- Minnesota Student Survey
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- National Survey of Children's Health (NSCH)

For a complete list of public data sources used during the needs assessment, see *Appendix D*.

Engaging Stakeholders and Digging Deeper into Needs of MCH Populations

In addition to exploring secondary data, the Title V Needs Assessment Team conducted primary efforts with stakeholders to dig deeper into the needs of MCH populations and those working with them. In order to ensure a wide variety of stakeholders were represented in the needs assessment process, the

Title V Needs Assessment Team conducted a stakeholder engagement mapping exercise. This exercise is detailed above in the Stakeholder Involvement and Relationship Building section, as well as in Appendix C.

In addition, throughout the data and capacity assessment stage (as well as all other stages of the process) the Title V Leadership Team and MCH Advisory Task Force were updated and provided regular guidance into the needs assessment process and the needs of MCH populations.

Listening Sessions

The team held listening sessions with MDH staff to gather information and gain a preliminary understanding of perceived needs of MCH populations. Existing partnerships as well as potential data sources were also identified through these listening session, which included 45 staff members from four Divisions within MDH. In addition, interviews with 20 subject matter experts at MDH were conducted to further supplement the information gathered at the listening sessions.

Discovery Survey

Minnesota used a Discovery Survey to collect the thoughts of interested stakeholders and community members on the greatest unmet needs of women, children, and families in their communities, along with what they need to thrive and live their best lives. The Discovery Survey had two main purposes:

- To hear Community voice
- To use as a tool to evaluate inclusivity

The Discovery Survey was open for six weeks during the summer of 2018. It was web-based, with the exception of a pilot in a county WIC clinic where paper copies were distributed in English, Somali, and Spanish.

2,716 surveys were completed and included in our analysis.

To measure the inclusivity of the survey, respondents were able to self-select multiple demographic characteristics. These questions were entirely optional and allowed individuals to select as many characteristics as they identified with and felt comfortable sharing. About 9 percent of respondents choose to not provide any demographic information.

Over half of the responses were from outside of the seven-county Twin Cities Metropolitan Area, ensuring a representative set of responses geographically (see figure 5). Survey results were also representative by race/ethnicity, but not representative by gender (7 percent of respondents self-reported being male, 85 percent reported female, and 8 percent did not respond). Most respondents were between the ages of 25 and 64, with very few adolescents.

Figure 5. Geographic Distribution of Discovery Survey Responses
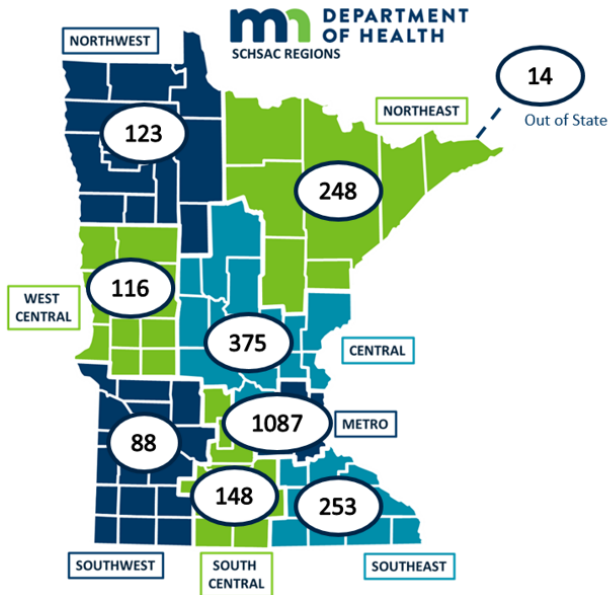
Minnesota Region	Minnesota Population	Survey Responses
Metro	55%	44%
Central	14%	15%
Northeast	6%	10%
Northwest	3%	5%
South Central	5%	6%
Southeast	9%	10%
Southwest	4%	4%
West Central	4%	5%

*264 respondents didn't provide resident county information

The full Discovery Survey results and methods were shared during two live webinars in late 2018. The webinar recording, slides, and transcript are available on the Minnesota Department of Health's Needs Assessment website. Discovery Survey responses informed the selection of the 40 candidate priorities and development of the data stories.

Analysis of Discovery Survey

The qualitative Discovery Survey responses were analyzed using a thematic content analysis via an inductive approach. This means that multiple staff studied the responses repeatedly, looking for patterns in the data. They then developed themes or categories based on the patterns. When staff were studying the responses, it was important for them to remain conscious of their own experiences, values, and biases. According to authors Ulin, Tolley, and Robinson:

> *"Qualitative researchers do not claim to be detached and neural scientists, unencumbered by their own experiences and values. They do believe, however, that by being conscious of their subjectivity, they can better understand and limit its effects on their research activities (from data collection to analysis), thereby allowing participants to express their experiences, values, and expectations without constraint."* [16]

Taking this into consideration, the Title V Needs Assessment Team used the following strategies to reduce limitations due to bias:

- Drawing conclusions carefully, ensuring that the data supports them
- Describing results in the context of the project and the characteristics of the participants the provided input
- Working to be transparent in methodology

More information on the data analysis process for the Discovery Survey is in *Appendix E*.

Limitations of Discovery Survey

One of the strengths of the Discovery Survey was that it was open to anyone who wanted to provide input. Another strength came from leaving the questions open-ended, which helped to keep from leading individuals to specific answers or limiting the input they wanted to provide. These strengths also contribute interpretive limitations, including voluntary response bias and response bias (i.e., conditions and biases that can influence survey responses).

Voluntary response bias occurs when persons can self-select into or respond to the survey, rather than participating by being randomly selected/sampled. Voluntary response bias can lead to having a non-representative sample and/or a sample of strongly-opinionated people. In the instance of Minnesota's Discovery Survey, the respondents mirrored the state's population in proportions by region and race/ethnicity. However, the respondents were not representative by age and gender.

Another limitation is response bias, which occurs when the wording of the question may be loaded in a way that may favor one response over another. For example, based on the key informant interviews conducted as a part of the needs assessment, parental incarceration was a key priority area impacting Minnesota's families. However, the topic was hardly mentioned in Discovery Survey responses. This was likely the case because of the wording of the questions on the Discovery Survey.

Key Informant and Expert Interviews

A number of expert and key informant interviews were also conducted during this stage. The expert interviews helped ensure the needs assessment team used the most effective, up-to-date practices in conducting the assessment, engagement, and analyses. Conducted with nine different experts external to MDH, the interviews covered topics such as: decision-making science, incarceration and corrections, trauma-informed participation in health research, knowledge translation, father involvement, safety and violence, evaluation and research, American Indian research and evaluation, and adolescent and youth engagement.

The goal of the key informant interviews was to learn more about experiences of community members related to the candidate priorities (for more information on how candidate priorities were selected see Narrowing Down to Candidate Priorities section). The key informant interviews were conducted by a team of staff members from the CFH Division. Geographic diversity and racial equity were top considerations when selecting key informants. Those interviewed represented a wide variety of roles, ranging from public health professionals, to health care workers, to business owners, to parents/caregivers, and professors. A list of key informant interviews by stakeholder organization is in *Appendix F*. Because the interviews often focused around difficult topics, including personal stories of suffering and loss, ongoing peer support meetings were scheduled for staff members conducting the interviews.

CYSHN Focus Groups

Nearly 300 Discovery Survey respondents identified as being parents or caregivers of CYSHN. While these responses helped develop some understanding of the needs of families of CYSHN, the CYSHN Program at MDH sought to dig deeper into the findings of the Discovery Survey to understand specific experiences of families. Therefore, following the Discovery Survey, MDH contracted with Wilder Research to conduct focus groups with families of CYSHN. A total of 44 parents/caregivers attended at least one of the focus groups. Six of the focus groups further explored the top themes identified in the Discovery Survey by parents/caregivers, including:

- Health care accessibility

- Health care affordability
- Flexible employment
- Child care
- Well-being
- Parent support and education

In addition to topic area-specific focus groups, Wilder Research and MDH intended to conduct focus groups with parents and caregivers who belong to the Hmong, Somali, American Indian, and Spanish-speaking communities in Minnesota. However, due to difficulty in recruitment, only the American Indian group was convened.

The findings of the CYSHN Focus Groups can be found on the Wilder Research website.

Narrowing Down to Candidate Priorities

After the collection and review of quantitative data and qualitative data, the Title V Needs Assessment Team compiled an extensive, inclusive list of all MCH needs reported – this comprehensive list included 147 different MCH needs. This was too many needs to be able to have a successful prioritization process, so the team conducted a pre-prioritization process at the end of the data and capacity assessment stage to reduce the large list of possible priorities to a working list of candidate priorities. Methods were developed, reviewed, agreed upon, and documented prior to the actual prioritization activity to ensure legitimacy of results. The methods for this 'pre-prioritization' activity are included in *Appendix G*. During this preliminary process, the team narrowed down the list of priorities to 40 candidate priorities. The candidate priorities are listed by domain in the Needs Assessment Findings section, which follows the Prioritization Stage discussion.

Data stories and data placements were then created for the set of 40 candidate priorities. The data stories and placemats included a summary of available quantitative and qualitative information on the priorities. The data stories and placemats were developed to communicate clear, concise, and accessible information to encourage broad participation from diverse stakeholders and community members in the ranking of candidate priorities. Best practices from the literature regarding displaying and communicating data were integrated into the format and writing of the data stories and placemats.

Minnesota's data stories are available online on the MDH Title V Needs Assessment website. Examples of data placemats, brief visualizations of the data stories, are included in *Appendix H*.

Prioritization Stage

Minnesota used a criteria-based ranking approach and community voting process through three rounds of prioritization (see Figure 6). The first round of prioritization included conducting criteria-based rankings of the cross-cutting priorities. This was followed by a round of forums where community members were able to vote for their top choices on needs. The third round then included more criteria-based rankings of domain-specific priorities, and then the criteria-based rankings were combined with community votes to determine the final 11 priorities. More information on the community voting process and criteria-based ranking approach is provided below.

Figure 6. Prioritization Activities
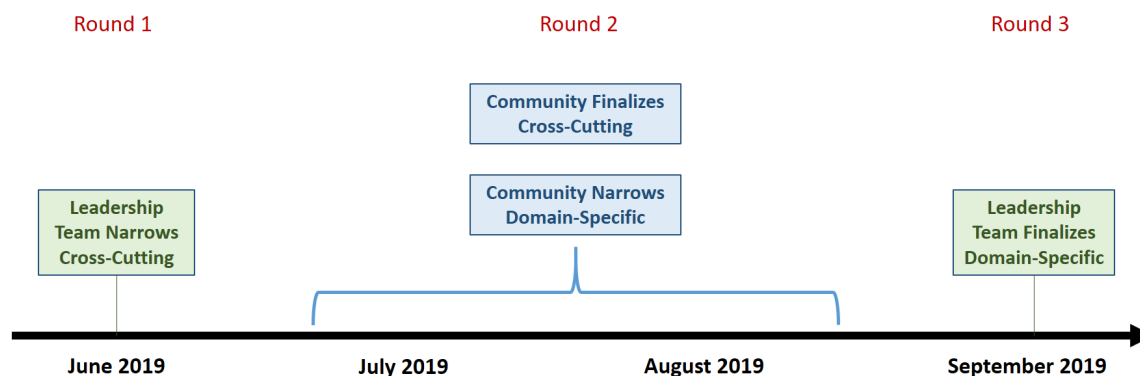
Community Voting Process

Minnesota aimed to have an inclusive priority setting process, involving as many community members as possible through holding community in-person voting events (community forums) as well as remote options for those unable to attend in person. In addition, community input was given higher preference (i.e., weighted) in the determination of final priorities. In-person and virtual forums were held during the summer of 2019. At these events, stakeholders viewed data stories/placemats for the 40 total candidate priorities and voted for their top priorities for each of the Title V population domains (i.e., women/maternal health, perinatal/infant health, child health, adolescent health, children and youth with special health needs, and cross-cutting areas). The stakeholder scores were used to prepopulate a stakeholder input score for the criteria-based prioritization.

Criteria-Based Ranking Approach

The MCH Advisory Task Force and Needs Assessment Leadership Team scored each candidate priority area from 1 (low priority) to 5 (high priority) based on the provided data stories. Reviewers were also encouraged to do their own research and consider information beyond what is provided by the Title V Needs Assessment Team.

Criteria-Based ranking prioritization criteria included:

- **Magnitude:** Number of people who are impacted
- **Trend:** Pattern or change of a series of data points to move in a certain direction over time
- **Health and racial equity:** Differences among different groups of people that are avoidable, unfair, and unjust
- **Impact/severity:** Impact on utilization of resources (financial cost), morbidities, comorbidities, and mortality
- **Perceived preventability:** Able to be prevented, avoided, or stopped in its tracks
- **Effective Interventions**: Effective intervention or evidence-based/informed strategy is available
- **Agency capacity:** Ability for CFH, in partnership with stakeholders, to dedicate resources to address strategies to improve priority
- **Political will:** Collective support from state administration, politicians, and the public
- **Stakeholder Input:** Contributions from community members, stakeholders, internal staff, and other partners throughout needs assessment process

See *Appendix I* for the spreadsheet used during these rounds of prioritization. This method was employed during round 1 and round 3. In round 1, the Needs Assessment Leadership Team evaluated the list of cross-cutting priorities for final selection by the community. In round 3, they selected the final domain-specific priorities.

Needs Assessment Findings

The Minnesota Department of Health's Title V Needs Assessment Team acknowledges that systemic racism and structural (social, economic, political and environmental) inequities can result in poor health outcomes across generations. They have a greater influence on health outcomes than individual choices or a person's ability to access health care, and not all communities are impacted in the same way.

All people living in Minnesota benefit when we reduce health disparities.

The following section details the findings of Minnesota's comprehensive needs assessment, by MCH population domain.

Cross-Cutting/Life Course

Through Minnesota's needs assessment, the majority of needs identified for MCH populations in the state belong in the cross-cutting domain. Historically, less of Minnesota's Title V MCH Block Grant efforts addressed the cross-cutting needs of the MCH population. It is essential to focus our work in these areas. Understanding the intersectionality of these needs grounds our work. In order for us to improve outcomes for Minnesota's MCH populations, cross-cutting/systems changes need to occur. The following issues rose to the top through Minnesota's needs assessment:

- *Housing*: Housing is connected to every aspect of people's lives, critical to financial security, academic success, and health. Minnesota is in the midst of a housing crisis with many unable to own a home, being housing "cost-burdened," or homeless.
- *Accessible and Affordable Health Care*: Comprehensive, quality health care services are important for promoting and maintaining health throughout the lifespan. For many in Minnesota, access to health care is impacted by household finances, insurance coverage, geographic availability, timeliness of entry into services, and other factors.
- *Mental Well-Being*: Mental well-being is about having fulfilling relationships, using strengths, contributing to community, and being resilient, which is the ability to bounce back after setbacks. Over 460,000 Minnesotans (8.8%) ages 5 and older experienced 14 or more mentally unhealthy days or more in the last month, including significantly higher rates among the uninsured, those on public assistance, people who are Black, those at 100% federal poverty level, and those with a high school education.
- *Parent Support and Education*: Parents and caregivers 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 undue stress. Many parents in Minnesota report that they do not feel they are getting the support they need when they feel stressed.
- *American Indian Family Health*: American Indian women, children, and families experience worse outcomes than other populations in Minnesota. These disparities are caused by historical trauma, racism, and continued colonial practices and policies that are barriers to opportunity and thriving.
- *Child Care:* The cost of child care in Minnesota is a significant barrier for families. Minnesota ranks as the fifth least affordable state in the country for center-based infant care, with an average cost of $15,340 per year, which is higher than in-state tuition for a University of

Minnesota freshman. In addition to affordability, simply finding child care can be challenging, with shortages impacting much of the state.

- *Financial Security*: In 2017, 560,996 people living in Minnesota, including 169,040 children under 18, had family incomes below the official poverty threshold ($24,600 for a family of four). People living in poverty in Minnesota are more likely to experience poor health, be food insecure, have chronic stress, live in unsafe neighborhoods, and experience unstable housing. Those in "near poverty" (up to twice the poverty line) are often one crisis away from falling into poverty.

- *Education*: Achieving optimal health and well-being is strongly correlated with having access to high quality, well-funded schools. Minnesota's complex school funding system creates inequities between schools and school districts, affecting students attending these schools. Education inequities seen in Minnesota include differences in graduation rates, achievement levels, early childhood programs, dual credit (high school and college) course offerings, discipline rates, college enrollment, college persistence, college completion, and the diversity of teachers.

- *Transportation*: Public transport provides critical transportation for transit-dependent people who do not own their own car or do not drive. This population tends to consist of young people without their driver's license, disabled persons, low-income workers, and a significant proportion of seniors. In 2010, half of transit riders in Greater Minnesota reported not having either a car or a driver's license.

- *Food Access*: Minnesota ranks 7th worst in the nation for the share of residents with access to healthy foods. Nearly 1 in 10 households in Minnesota experience food insecurity. When families experience food insecurity, they might experience stress about running out of food before they can buy more, eat less healthy meals, and sometimes cut back on the size of meals or skip them entirely.

- *Access to Behavioral Health Services*: According to the National Survey of Children's Health, 31 percent of children in Minnesota with a mental or behavioral health condition that needed treatment did not receive services. Access to behavioral health to promote mental well-being and the prevention, early identification, intervention, and treatment of mental health and substance use issues is a large need in Minnesota.

- *Culture of Safety*: Violence is a public health issue, and it is preventable. Lacking a culture of safety negatively impacts the health outcomes of marginalized groups of people through discriminatory practices, violence, and trauma. Black girls are more likely to be suspended or expelled, perceived as being "disruptive" or "loud," punished for dress code violations, and reprimanded for "defiant" behavior than their classmates. This is an example of structural violence. Additionally, in Minneapolis, 30 people have been killed by police officers from 2000-2018. Nineteen of the victims were Black, five were White.

- *Paid Parental Leave*: 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. Access to paid parental leave is linked to fewer infant deaths, increased breastfeeding duration, and improved birth and developmental outcomes. The United States is one of the only developed countries worldwide that does not offer nationwide paid parental leave. Several states have family-leave laws that support paid parental leave, but Minnesota is not one of them.

- *Navigating Services and Supports*: In Minnesota, 82 percent of eligible children were not enrolled in Child Care Assistance and 50 percent of eligible uninsured Minnesotans were not enrolled in MinnesotaCare or Medical Assistance. Coordinated and efficient systems of care for

women, children, and families are needed to achieve the best possible health outcomes and to thrive, but do not exist or are out of reach for many.

- *Culturally Responsive Care*: Culture plays a huge role in how women and families define health and how they interact with the health care system. Over 11 percent of people living in Minnesota speak a language other than English at home, and in 2016 there were more than 100,000 people in the state who spoke English less than "very well." Language impacts health literacy. Our health care systems are not easily navigable for people with limited health literacy (e.g., complex forms, needing to identify providers and services).
- *Fathers*: Approximately 324,000 Minnesotan children, or 1 in every 4, are currently living in homes without a father. Children who grow up in families with an involved father have better performance in school, stronger behavioral skills, and have higher self-esteem.
- *Safe Neighborhoods*: Neighborhoods in Minnesota tend to be segregated based on race, ethnicity, or socioeconomic status, which results in disparities in property values, school funding, grocery stores, and home ownership. Features of neighborhoods have been linked to life expectancy and early death, overall health status, experience of violence, mental health, disability, birth outcomes, chronic diseases, health behaviors, injuries, and other important health indicators.

Women/Maternal Health

Beyond the social determinants of health and needs impacting all populations, there are specific unmet needs women experience. Minnesota's 2016-2020 women/maternal health priority of promoting routine well-woman visits to support the mental and physical health needs of women and increase the proportion of pregnancies that are intended, saw improvements. There was a 10 percent increase in routine well-women visits from 68.7 percent in 2014 to 75.8 percent in 2018. Despite the improvements, women, especially women of color, still face challenges receiving comprehensive preconception, prenatal, postnatal, and interconception visits. The following needs affecting women and maternal health were identified through Minnesota's needs assessment:

- *Care during Pregnancy and Delivery*: Nearly one-fourth of women in Minnesota did not receive prenatal care within their first trimester of pregnancy, with American Indian and African American/Black mothers less likely to have received care. Even if women have access to prenatal care, many are at higher risk of complications during delivery due to shortages in obstetrics care in community hospitals.
- *Family Planning*: Approximately 20 percent of women with a recent live birth reported their pregnancy was unplanned. When a pregnancy is unintended, unwanted, or poorly timed, the mother and baby are at higher risk for problems during and after the pregnancy.
- *Maternal Morbidity and Mortality*: Each year in Minnesota, approximately 20-35 women die and 3,000 experience morbidities during pregnancy, labor/delivery, or postpartum. Many of these morbidities and mortalities could have been prevented by early diagnosis and treatment.
- *Postpartum Support and Care*: Approximately 1 in 10 women in Minnesota self-report experiencing postpartum depression. Providing postpartum support and care is crucial to ensuring the health of mothers and their babies.

Perinatal/Infant Health

Minnesota's infant mortality rate has been consistently lower than the United States rate overall; yet, little to no progress has been made in reducing infant mortality in the past decade. There has been

progress in Minnesota's 2016-2020 priority needs related to perinatal and infant health. The proportion of infants ever breastfed increased from 84 percent in 2012 to 90.4 percent in 2016. Safe Sleep practices of placing the infant to sleep on their back and on a separate surface have remained rather steady. There was a 5 point increase in those who reported placing infant to sleep without soft objects or loose bedding (from 48.0% to 53.5%). However, the persistent racial disparities in health outcomes in Minnesota infants continues. The main areas of need for infants in Minnesota from the assessment included:

- *Infant Mortality*: While infant mortality rates for all racial groups in Minnesota has declined over time (by 29% since 1990), the disparities have remained constant for over 20 years.
- *Breastfeeding*: Though Minnesota data shows that the rate of breastfeeding initiation has increased overall since 2012, there are significant differences in initiation based on education, age, race, and income of mothers.
- *Neonatal Abstinence Syndrome*: The rate of NAS in Minnesota has increased drastically in the past decade. In addition to being at risk of premature birth and low birth weight, babies born with NAS can experience withdrawal symptoms, such as breathing problems, diarrhea, seizures, and fever.
- *Stillbirths*: Roughly 1 out of every 185 pregnancies in Minnesota ended in a stillbirth – a tragic and traumatic event for families.

Child Health

The overall health status of children in Minnesota has remained steady from 2016 to 2018, with approximately 91 percent of children in excellent or very good health. State-level data using the National Survey of Children's Health (NSCH) have shown an increase in the percent of children receiving developmental screening using a parent-completed tool within the same time frame. This points toward some effectiveness in Minnesota's strategies to improve developmental screening rates in the last 2016-2020 Title V cycle. However, even with this increase, families are facing significant challenges in navigating the early childhood system. The following issues were identified for children through Minnesota's needs assessment:

- *Comprehensive Early Childhood Systems*: Minnesota faces significant challenges in implementing a coordinated, equitable, and efficient system of care for children and their families. Though statewide data on actual service gaps and barriers is limited, anecdotal evidence from families consistently indicates that services are unavailable, unknown, or hard to access.
- *Childhood Trauma*: Approximately 37 percent of children in Minnesota have experienced one or more adverse childhood experiences (NSCH), and many more have experienced other forms of childhood adversity, which can lead to lifelong physical and mental health problems.
- *Foster Care*: Around 16,600 children and young adults experienced out-of-home care in 2017, with younger children, those from rural counties, and African American and American Indian children disproportionally represented in the foster care system.
- *Child and Adolescent Well-Visits*: Though well-visits are effective in allowing for early identification of potential health or developmental concerns, some populations across the state are less likely to receive well-child care, including those who live in rural areas, live in poverty, and are uninsured.
- *Oral Health*: Though oral health is interconnected with physical health, many children in Minnesota are without access to dental health care.

Adolescent Health

Current efforts to improve the well-being of adolescents in the state have led to reductions in the teen pregnancy rate and higher engagement with youth in programmatic decision-making. However, while Minnesota's efforts to strengthen the health system to better meet the needs of adolescents have been effective in some areas, we are still struggling on other measures of well-being. For instance, the number of adolescents who had a preventive visit has been hovering steady around 76 percent. Furthermore, the mental well-being of young adults (especially young men) has been brought forward by community members as an emerging public health issue. The main areas of need for adolescents from the assessment included:

- *Adolescent Suicide*: Suicide is the second leading cause of death for young people ages 10-24, with American Indian and Alaska Native youth experiencing suicide rates nearly 3 times that of youth of other races.
- *Boys and Young Men*: Boys and young men in Minnesota have been underserved and are struggling with higher rates of substance use, suicide, mental health struggles, violence, and victimization compared to girls and young women.
- *Bullying*: Bullying is increasingly recognized as a significant social problem facing our youth with nearly one out of five Minnesota students reported being bullied or harassed weekly.
- *Physical Activity*: Fewer children and youth are meeting physical exercise guidelines, which may be impacted by access to safe, adequate, and affordable recreational activities.
- *Teen Pregnancy and Childbirth*: In 2017, 2,113 babies in Minnesota were born to mothers under age 20. Teen childbirth is a strong risk factor for poor outcomes for both infants and their mothers.

Children and Youth with Special Health Needs

Approximately 17.7 percent of Minnesota children 0-17 years old have special health needs, which includes a range of chronic physical, developmental, behavioral, and emotional conditions. CYSHN and their families often need a wide variety of medical, psychosocial, educational, and support services. Minnesota's 2016-2020 priority needs related to CYSHN aimed to help promote a comprehensive, coordinated, and integrated system of services/supports and ensure adequate health insurance coverage. However, NSCH state-level data shows downward trends related to key measures of a well-functioning system, including medical home, care coordination, transition, and adequate insurance. Though block grant efforts worked to improve systems for CYSHN and their families through promotion of medical home, transition, and insurance best practices, families still report difficulty navigating the state's complex system and gaining access to needed services. The main areas of need from the assessment included:

- *Access to Services and Supports*: Families often have to forgo care due to long waiting lists, problems getting appointments, troubles with eligibility criteria, complex systems to navigate, child care issues, language and cultural barriers, transportation issues, and lack of financing.
- *Coordinated Care*: Systems and services are difficult and confusing to navigate because there is a lack of effective care coordination occurring in the state. When care is not coordinated, children and families can receive fragmented or duplicative services – or may not end up receiving needed services at all.

- ***Autism Spectrum Disorders***: There are significant gaps in ability to receive a timely evaluation and diagnosis for conditions such as Autism Spectrum Disorder, causing families to have to wait to receive vital early intervention services.
- ***Deaf/Deafblind/Hard of Hearing***: Without early identification and early opportunities to learn language, some children will fall behind their hearing peers in communication, cognition, reading, and social-emotional development.
- ***Transition***: Significant gaps exist in accessing the needed supports to transition from pediatric to adult health care, especially for youth with more complex medical needs.

Needs assessment findings were the drivers of the finalization of priority needs. As explained in Needs Assessment Methods section, stakeholders used community voting and criteria-based ranking to evaluate these candidate priorities that arose from the needs assessment process to determine Minnesota's 2020 Priority Needs. At the end of prioritization the state action plan was developed in partnership with stakeholders during a highly collaborative, inclusive process. More information about this process can be found in the Community-Focused Strategic Planning section.

Minnesota's 2020 Priority Needs

Eleven Title V 2021-2025 priority areas were identified during Minnesota's prioritization process. Many of Minnesota's priority needs are related to priority needs in the previous five-year reporting cycle, but overall, we heard loud and clear the need to focus our efforts towards health equity and the social determinants of health. Half of the priority needs identified are cross-cutting and will require continued collaboration with stakeholders to develop and implement effective strategies.

The final eleven priorities are:

- **Access to Services and Supports for Children and Youth with Special Health Needs:** Ensuring all children and families have what they need to thrive.
- **Accessible and Affordable Health Care:** Ensuring comprehensive, quality health care services, including Family Planning, are available and affordable for all.
- **Adolescent Suicide**: Reducing the number of youth who take their own life.
- **American Indian Family Health:** Reducing disparities and supporting the well-being of American Indian families.
- **Care during Pregnancy and Delivery:** Increasing accessible, quality health care during pregnancy and delivery.
- **Comprehensive Early Childhood Systems:** Ensuring Minnesota has inclusive systems that link young children and their families to all the support and services they need.
- **Housing:** Increasing safe, affordable, stable housing for all people living in Minnesota.
- **Infant Mortality:** Reducing the number of infants that die before their first birthday.
- **Mental Well-Being:** Ensuring all people living in Minnesota have the opportunity to realize their abilities, deal with day-to-day stress, have meaningful relationships, and contribute to their family and community. This includes building resilience in those who experience childhood trauma and adversity.
- **Parent and Caregiver Support:** Supporting parents and caregivers socially and emotionally with family-focused activities, policies, and education.
- **Boys and Young Men:** Protecting and promoting physical, mental, and emotional health among people who identify as male.

It is important to acknowledge the intersectionality of the priority needs. These needs do not exist in isolation, which is important to remember as we approach solutions. In addition to the topics themselves being intersectional, there are also intersecting processes and systems through which power and oppression are produced, reproduced, and actively resisted. Figure 7 shows how the candidate priorities relate to one another through these intersecting processes.

Figure 7. Causal-Loop Diagram of 2020 Title V MCH Block Grant Priority Needs
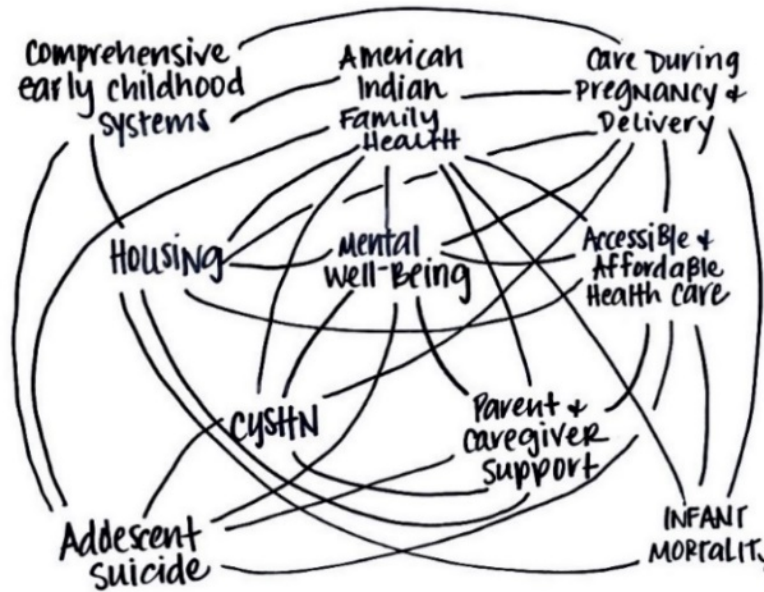
Performance Measure Framework

Minnesota utilized an inclusive priority-setting process to determine our strategies and performance measures to track our progress on these strategies. Minnesota's state selected priorities along with the corresponding performance measures are displayed in the two tables below. We plan on continuing to work with stakeholders to improve and add to our performance measure framework including creating a measures for Boys and Young Men. We touched briefly on current proposed strategies for addressing Minnesota's new priorities in the Executive Summary. To learn more about our proposed strategies and how our selected national and state performance measures help drive improvement, see the individual priority needs documents coming in spring 2021.

Table 2. Maternal and Child Health Domains Performance Measure Framework

Domain	State Priority Need	National Performance Measure	Evidence-Based or – Informed Strategy Measure
Women's/ Maternal Health	**Care during Pregnancy and Delivery** - Increasing accessible, quality health care during pregnancy and delivery.	Percent of women, ages 18 through 44, with a preventive medical visit in the past year (NPM 1)	Percent of Minnesota Perinatal Quality Collaborative (MNPQC) members who completed implicit bias training in the last year
Perinatal/ Infant Health	**Infant Mortality** - Reducing the number of infants that die before their first birthday.	A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding (NPM 5) AND A) Percent of infants who ever breastfed and B) Percent of infants breastfed exclusively through 6 months (NPM 4)	Percent of births delivered at Minnesota hospitals with national Safe Sleep Hospital Certification Percent of births delivered at MDH Breastfeeding-Friendly Maternity Centers
Child Health	**Comprehensive Early Childhood Systems** - Ensuring Minnesota has inclusive systems that link young children and their families to all the support and services they need.	Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year (NPM 6)	Percent of children enrolled in the follow along program that completed at least one developmental/social-emotional screens electronically in the year
Adolescent Health	**Adolescent Suicide** - Reducing the number of youth who take their own life.	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year (NPM 10)	Average depression screening rate (percentage of well-visits where depression screenings are occurring) in clinics participating in the state's CoIIN project
Children with Special Health Care Needs	**Access to Services and Supports for Children and Youth with Special Health Needs** - Ensuring all kids and families have what they need to thrive.	Percent of children ages 0 through 17 who are adequately insured (NPM 15)	Percent of families receiving family-to-family support who report increased confidence in navigating care for their child

Table 3. Cross-Cutting Domain Performance Measure Framework

State Priority Need	State Performance Measure
Accessible and Affordable Health Care - Ensuring comprehensive, quality health care services, including Family Planning are available and affordable for all.	Percent of Minnesotans who did not get routine medical care they needed because of cost
American Indian Family Health - Reducing disparities and supporting the well-being of American Indian families.	Proportion of Minnesota tribes that participate in a planning process with MDH to ensure MDH is providing culturally relevant services
Housing - Increasing safe, affordable, stable housing for all people living in Minnesota.	Number of stakeholders engaged in housing and homelessness planning
Mental Well-Being - Ensuring all people living in Minnesota have the opportunity to realize their abilities, deal with day-to-day stress, have meaningful relationships, and contribute to their family and community.	Percent of Minnesota adolescents who report having positive mental well-being through fulfilling relationships, contributing to community, and being resilient
Parent and Caregiver Support - Supporting parents and caregivers socially and emotionally with family-focused activities, policies, and education.	Percent of children, ages 0-17, living with parents who are coping very well with the demands of parenthood

Emerging Issues

Since the completion of Minnesota's needs assessment, additional issues have come to the forefront that significantly impact the health and well-being of the state's MCH populations. These issues, including the COVID-19 pandemic and the ongoing fight for racial justice, are described in further detail below.

COVID-19 Pandemic

Beginning in early 2020, MDH responded through its Emergency Preparedness Incident Command Structure to the growing number of COVID-19 cases within Minnesota. Beginning in March and with no foreseeable end, staff from across the department were reassigned to assist with the response in a variety of roles. Much of the work of the Child and Family Health division was put on hold, as over 75 percent of the staff were assigned to support the response. It is anticipated that with the peaks and valleys of the pandemic, the impact on our workforce will continue through the end of 2020 and beyond. Given the anticipated effect of the pandemic on both state and local budgets, we expect that we will need to plan for budget reductions. The impact of the pandemic will likely be felt for years to come and will have a lasting impact on the well-being of our workforce and community. As the pandemic has continued, several issues have emerged that will clearly impact the work of our Division as we move into the future:

- The pandemic has exacerbated the disparities that exist within Minnesota. Health outcomes for those with COVID-19 have been poorest for those communities most impacted by housing instability, food insecurity, and health care access.

- Well-child and well-women visits and immunization rates have declined as families delay routine health care out of fear of contracting COVID-19 if they visit their health care provider.
- CYSHN may be at increased risk for complications from COVID-19. In addition, school and other closings affect the availability of important therapies and supports for CYSHN.
- Pregnant women might have a greater risk for severe illness when they contract COVID-19.

Anti-Racism and Racial Justice Movement

The murder of George Floyd at the hands of Minneapolis police, and the resulting demonstrations and riots, amplified attention to inherent racism in our systems and policies. Dr. Martin Luther King, Jr. asserted, "A riot is the language of the unheard." As a public health institution, MDH acknowledges that systemic failure has endured far too long and we have an urgent obligation to take concrete steps toward equity. To achieve positive change and an end to racism, we must collaborate with the Black, Indigenous, and Communities of Color boldly, swiftly, and thoughtfully. We must work to disrupt and dismantle racism in all its manifestations and structures in our policies, systems, programs, and practices that are designed to improve but instead maintain health inequities and injustices in our Black, Indigenous, and Communities of Color. MDH aims to support future initiatives for collaboration and conversation on issues regarding race and justice and to proactively engage more in advocacy work in the communities most impacted by inequities.

The historical trauma for Black, Indigenous, and People of Color, along with the disproportionate impact of the COVID-19 pandemic and the murder of George Floyd on these same communities, calls for organizational response to and understanding of the impact of trauma on these communities. Additionally, it is imperative to develop ways to support community healing and well-being, as well as recognize the resilience inherent in these communities.

Community-Focused Strategic Planning

The CFH Division at MDH acknowledges that in order to advance MCH outcomes and equity, we need to work together in authentic, collaborative, and innovative ways. This is the only way that we will be able to "move the needle" in reducing the disparities in our communities. Therefore, we have taken a different approach toward our current needs assessment, prioritization, and strategy development/strategic planning process. The foundation of this new approach rests in the belief that solutions lie within the community and as such, the focus is on engaging with the community to ensure that we are planning and implementing programs and initiatives that will have the greatest impact and benefit.

Following the completion of our statewide needs assessment, Minnesota entered into a strategic planning process. The intent of the strategic planning process was to authentically engage with the community in the development of a set of strategies to address the priority needs which were identified during the needs assessment. These strategies would be used to guide the work of the CFH Division for the next five years and are incorporated into the state's Title V MCH Block Grant action plan.

Minnesota received assistance from the National MCH Workforce Development Center in developing a community-focused strategic planning process. The first stage of this process was establishing a Strategic Planning Steering Committee to help develop, drive, and champion the strategy development process. The Steering Committee was composed of CFH Division staff, representatives from LPH agencies and the University of Minnesota, and family leaders. Members and their roles are detailed below in Table 4.

Table 4. Strategic Planning Steering Committee Membership

Member Name	Role/Perspective
Joan Brandt	Co-Lead, Project Sponsor, CFH Division Director
Sarah Dunne	Co-Lead, Title V MCH Block Grant – CYSHN Section Staff
Judy Edwards	Title V MCH Block Grant – MCH Section Staff
Molly Meyer	Title V MCH Block Grant – Data/Epidemiology Staff
Karen Fogg	Title V MCH Block Grant – MCH Section Manager
Gina Adasiewicz	LPH – Dakota County
Amanda Larson	LPH – Sherburne County
Sarah Reese	LPH – Polk-Norman-Mahnomen Community Health Board
Kate Franken	CFH Women, Infants, and Children (WIC) Section
Dawn Reckinger	CFH Family Home Visiting Section
Tricia Brisbine	Family Advisor
Zobeida Bonilla	University Partner – University of Minnesota, School of Public Health
Jamie Slaughter-Acey	University Partner – University of Minnesota, School of Public Health
Lisa Gemlo	CFH CYSHN
Mo Alms	CFH MCH
Barbara Frohnert	CFH CYSHN

The Strategic Planning Steering Committee developed a vision and values for the Strategic Plan. The values describe how the state aspires to work in partnership with the community. Though they were developed specifically for the strategic planning process, the vision and values also serve as a framework

for CFH Division and Title V work going forward. Figure 8 below details the vision and values for the Strategic Plan.

Figure 8. CFH Strategic Plan Vision and Values

Vision
Improve outcomes & equity for Minnesota's children, women, families, & communities through authentic partnerships & shared decision-making.

Transparent
We will concisely explain & visualize the process we will use to identify strategies & how we intend to measure our progress so team members can understand where we are & our next steps.

Inclusive
We encourage the involvement of individuals from different sectors & experiences, & acknowledge the inherent worth & dignity of all.

Collaborative
We acknowledge that we need to work together in relationship with each other, because relationships are at the heart of collaboration. This includes genuine connection that values the diversity & unique contributions.

Adaptable
We will demonstrate willingness and flexibility to consider different ideas, & remain agile throughout the process. This includes trying new things & learning from failure as we work as a team.

Data-Driven
We will use the best scientific data & methods available alongside other information, including community knowledge/experience, to make decisions.

Honoring of Community and Cultural Wisdom
We will listen to & respect the knowledge that our partners have gained living & working with their communities.

The Steering Committee served as the central leadership group for the strategic planning, and then a set of Strategy Teams was established. A Strategy Team was established for each of the priority needs identified through the needs assessment. The purpose of the Strategy Teams was two-fold:

- Identify and develop strategies to address the priority need.
- Review and evaluate progress on implementing strategies.

The process took a collective approach toward leadership, meaning there was not a hierarchical structure. Rather, the process was community-driven with strategic guidance coming from the Steering Committee.
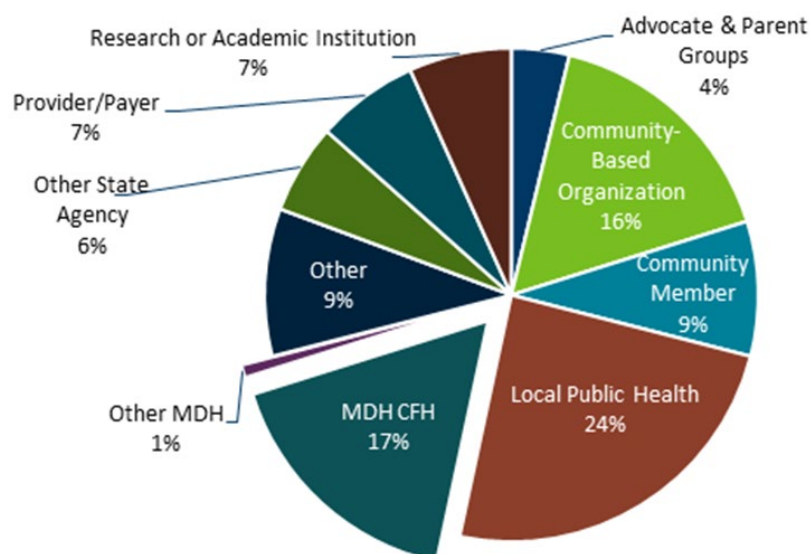
Developing Strategies

Strategy Teams were assembled for each of the priority needs identified in the statewide needs assessment. Each Strategy Team included 20-30 members. Composition of groups was dependent on the priority need the team addressed; however, in general, teams were composed of the following representatives:

- MDH Staff
- Other State Agency Staff
- LPH Staff
- University/Academic Staff
- Community-Based Organization Staff
- Providers and Payers
- Advocates
- Youth and Family Representatives
- Interested Community Members
- Data/Research Scientist/Epidemiologist Staff

Strategy Team members were recruited using emails, social media posts, newsletters, and direct contacts. Participants completed a survey to express their interest in participating in the strategic planning and to select their top choices for Strategy Teams. Over the course of a month-long recruitment period during the fall of 2019, over 240 people expressed interest in participating, and all were assigned to be a member of a Strategy Team. Families and/or Community Members were included on all Strategy Teams. Figure 9 provides an overview of the membership of the Strategy Teams, based on the role identified by the members. Because MDH is invested in ensuring community members could participate in our strategic planning process, stipends were made available with Title V funding.
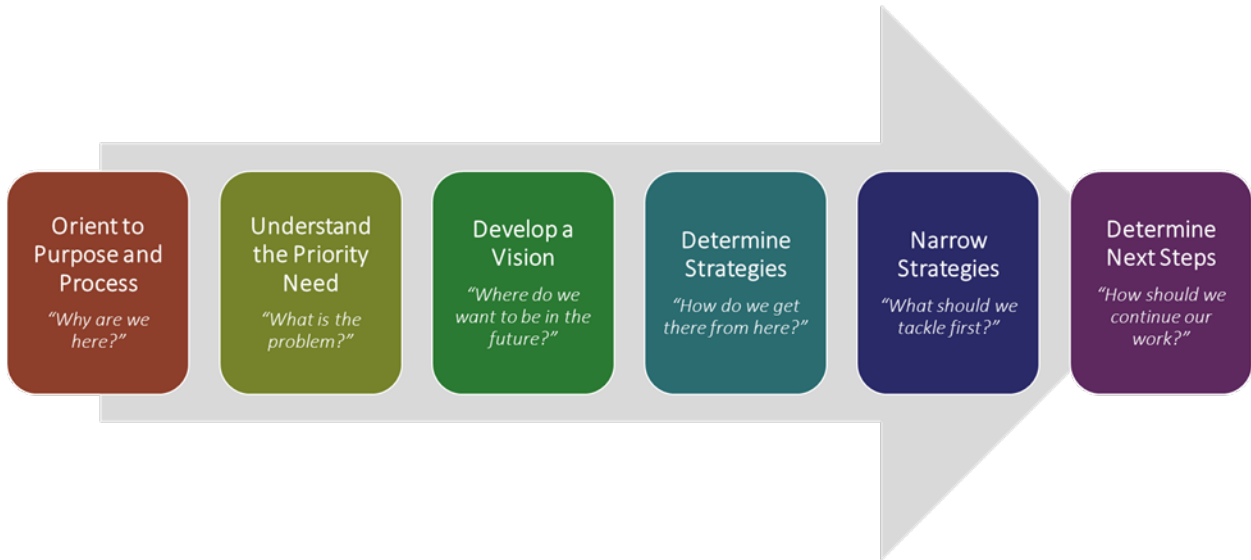
Figure 9. Strategy Team Membership, by Role

The Strategy Teams were led through a similar process to determine strategies to address their priority need. Figure 6 provides a visual of the process. More information on the methods of recruiting Strategy

Teams and the strategy development process can be found in the Supporting Documents at the end of this application.

Figure 10. Strategy Development Process Steps

Orient to Purpose and Process
"Why are we here?"

Understand the Priority Need
"What is the problem?"

Develop a Vision
"Where do we want to be in the future?"

Determine Strategies
"How do we get there from here?"

Narrow Strategies
"What should we tackle first?"

Determine Next Steps
"How should we continue our work?"

Moving forward, MDH intends to continue to engage with the Strategy Teams to discuss ongoing needs and challenges related to the priority areas, provide updates on our progress in implementing the strategies, help problem solve on barriers that are encountered, and celebrate achievements.

Evaluation of Needs Assessment Process

In 2019-2020, Dr. Maura Shramko, postdoctoral fellow in the Division of General Pediatrics and Adolescent Health at the University of Minnesota, designed and conducted a process evaluation of the Title V Needs Assessment carried out by MDH. Specifically, this evaluation aimed to describe the process of the needs assessment through the lens of recommended practices for intersectional and trauma-informed public health research.

Evaluation questions included:

- What are best or recommended practices for understanding community needs using a trauma-informed intersectional lens?
- In what ways did the needs assessment successfully apply a trauma-informed intersectional lens?
- In what ways could the needs assessment better address trauma-informed intersectional lens?
- How might future steps in the assessment process and dissemination of findings infuse an intersectional and trauma-informed lens?

The methods utilized to conduct this evaluation included a literature review, document review, and key informant interviews.

Five key takeaways, as displayed in figure 11, were identified from the literature, including: positionality matters[1]; reconsidering methods and approaches; integrating reflexivity[2]; acknowledging harm caused by systems; and taking action towards healing and justice.

Figure 11. Visual of Five Key Takeaways

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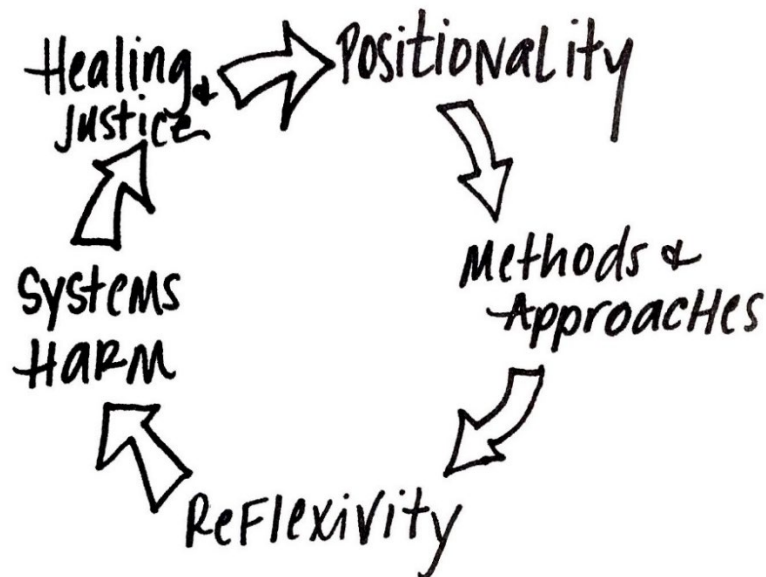
[1] Positionality is the social and political context of our identities and lived experiences. Our positionality contributes to (and potentially biases) our understanding of the world and how we do our work.

[2] Reflexivity is the act of continually reflecting on the research process (by the researcher and their team).

For more information on the summary of literature that informed our trauma-informed, intersectional evaluation process see Intersectionality and Trauma-Informed Applications for Maternal and Child Health Research and Evaluation: An Initial Summary of the Literature.

Document review and key informant interviews were used to describe the process, and identify successes, challenges, and recommendations through the trauma-informed and intersectionality lenses. For example, stakeholders identified successes such as high level of public health stakeholder engagement, the vision and commitment of the needs assessment process to applying a trauma-informed and intersectionality lens, and the framing of American Indian health and naming it as its own priority area. Challenges described included structural and/or silo-ed dynamics at MDH and the state more broadly, missed opportunities for engagement (e.g., immigrant and refugee communities, incarcerated parents, and men), and the lack of funding for process and community engagement. A final report with recommendations is being drafted, and findings will be shared to inform the next cycle's needs assessment in early 2021.

Reflections on the Process

Conducting a statewide needs assessment presents a number of challenges and raises certain tensions. Minnesota would like to highlight several reflections that were learned throughout this work:

Undeniable Intersectionality

The topics addressed in the cross-cutting data stories do not exist in isolation, which is important to remember as we do needs assessments and approach solutions. During the data story reviews every work group asked, "But why aren't we also talking about X, Y and Z in this data story?" While many of the topics do make appearances in related data stories, we could not possibly have defined and described all of the overlap in the cross-cutting priorities; but that does not mean it is not present. The diagram below starts to demonstrate how connected each topic is, and we encourage you to keep this in mind as you complete your review.

> "There is no such thing as a single-issue struggle because we do not live single issue lives." – Audre Lorde

In addition to the topics themselves being intersectional, there are also intersecting processes and systems through which power and oppression are produced, reproduced, and actively resisted.

Figure 12. Cross-Cutting/Life-Course Candidate Priorities
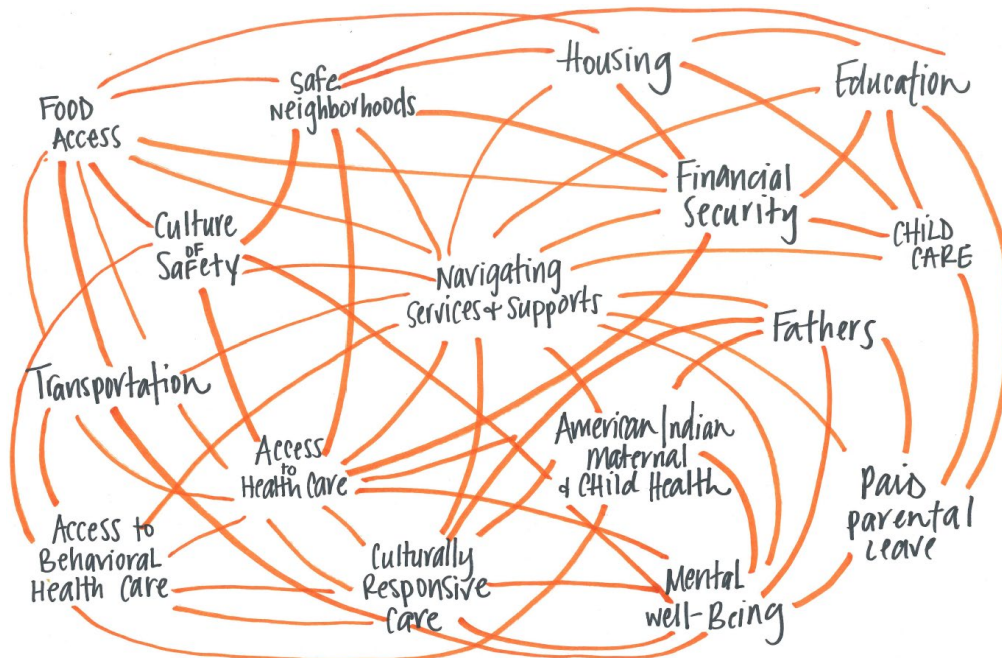
Non-linear Approach

One of the most resounding conclusions developed out of Minnesota's needs assessment is that rigid, linear frameworks and models are not appropriate for our cultural communities, namely our Tribal Nation/American Indian communities. While we began with a framework in mind, we pivoted and

adapted as taught and requested by our partners. This created a much richer process, more robust findings, stronger community partnership, and invaluable information.

Through this process we learned to be prepared for surprises and adapt our approach if needed. It is okay to have a well thought-out plan change if the stakeholders you want involved are not engaged or connecting to the process.

Trauma and Resilience are part of Change and Hope

The stories we have heard and are sharing about the health of women, children, and families have no shortage of trauma. While needs assessments innately highlight gaps and disparities, it is important to know that there are successes, innovations, and traction in many areas throughout the state. People in Minnesota are working hard to heal their communities and make change.

Minnesota's Black, Indigenous, and Communities of Color have endured generations of trauma and continue to experience oppression and trauma today. However, with trauma comes resiliency. Community assets like the preservation of language and culture, strong and close-knit cultural communities, and adaptability and determination in the face of adversity are resiliency factors. Efforts to advance health equity must take into account trauma, while supporting the resilience that exists within communities to create culturally-grounded, community-driven solutions.

Need for Asset-Focus Assessments

There is a lot of strength, resilience, and success in our communities and populations. There is a need to shift our work to focus on identifying resources and successful programs in our communities so we can support and embolden this work.

Thinking about Individuals Can Overshadow the Role of the System

Most of what we know today about health comes from data collected on individuals: individual rates of disease or injury, and individual behaviors like substance use and exercise. When we emphasize personal choice as *the* key strategy for improving health, we attribute health problems to the individual alone, rather than seeing each person as someone interacting with and being affected by their physical environment, social relationships, history, policies, and systems.

The Minnesota Department of Health's Title V Needs Assessment Team acknowledges that systemic racism and structural (social, economic, political and environmental) inequities can result in poor health outcomes across generations. They have a greater influence on health than individual choices or a person's ability to access health care, and not all communities are impacted in the same way.

This tension persists because so much of what we know about health comes from our analyses of individuals. We must move from a focus on individual-level analysis to gain an understanding of communities while also addressing the policies and systems that create or hinder health.

There is Deep Diversity within Diversity

Each individual, population, and community is unique, and each has value. However, quantitative research methods require creating categories for analysis, and grouping people, populations, and communities in such a way that can hide some real and important differences.

Although much of the data here are presented by race/ethnicity to reflect the diversity of the state's populations, the differences within each population group can be as great as the differences between different population groups. The category of Asian or Asian Pacific Islander, for example, encompasses over 40 different countries with very different languages and cultures. While public health has made progress in differentiating, for example, African-born people from U.S. born African Americans, and identifying significant Asian groups like the Hmong, in general the data do not permit the analysis of all possible differences within every population. Data throughout the data stories should be understood as providing insight into the health of different populations, but do not show the whole story.

Race and Class Impact Health in Distinct Ways

Racism is a major player in what creates health and disparities in Minnesota and the data stories created through the needs assessment process provided information by race/ethnicity to call out the differences and to facilitate conversations about how structural, institutional, interpersonal, and internalized racism impact health. In some places, data is also presented by income. While income is sometimes used to signify social class, income and class are not exactly the same. Social class or "socio-economic status" (SES) includes additional factors like occupation and education.

Race, income, and social class are interrelated, and the effect of racism relegates American Indian, African American/Black, Hispanic/Latino, and other populations of color to a lower socio-economic status.[1] It can be tempting to assume that talking about poverty alone is sufficient in considering the effects of race/ethnicity on health, but it would ignore the separate, significant effect of racism on health.

In some parts of Minnesota, the populations of American Indians and persons of African, Hispanic/Latino, or Asian descent are quite small (2 percent or less). In these regions, it is essential to consider the role of social class in shaping health inequities through generations of White families.

We Need Better Data (…and are working on it!)

Only limited statewide data are available for some populations, such as the LGBTQ (lesbian, gay, bisexual, transgender, and queer/questioning) community, specific ethnic and cultural groups (e.g. Somali and Hmong populations), and people with disabilities (e.g. children and youth with special health needs). This creates a challenge in making population-level comparisons and providing a complete picture of the health and health inequities experienced by these populations. There are also issues with how to do reliable statistical analysis with small populations. Too often populations with small numbers are suppressed or collapsed into non-meaningful categories that further erase their experiences.

> *"We are a small population of people because of genocide. No other reason. If you eliminate us in the data, we don't exist. We don't exist for the allocation of resources." - Abigail Echo-Hawk, Pawnee, Director of the Urban Indian Health Institute*

A lot of great work is going into re-thinking and improving both the collection of data and reporting small populations. We pledge to continue this work, continue to learn, improve the way we represent

data, and empower audiences to interpret information themselves instead of suppressing information, while ensuring that privacy and confidentiality is upheld.

Data Stories Can Only Say a Little, About a Lot of Things

Data stories, which informed our prioritization, provided snapshots of many data points to draw an overall picture of maternal and child health and the conditions that create it. Many topics here have been studied and written about in great detail by others. We encouraged those participating in our prioritization events to dive deeper into topics that interest them by using the citation list in each story to learn more. These data stories communicated information for a discrete task, they do not show the whole picture of what is happening in the community.

Need for Community-Based Research Partners

Making a personal connection requires effort and does not occur immediately. Asking people interested in staying updated on the needs assessment provided a list of potential stakeholders to reach out for strategic planning. We continually asked teams to strategize about how to keep stakeholders engaged.

It is also important to reimburse community members for their time. When working with families or other community members, we need to remember that many participate in our work on their own time. Many community partners are volunteering unpaid time and effort and may be required to take time off from work to participate. Because of this, we worked to make stipends available for all community members participating in the strategic planning who needed them.

Limitations of our Needs Assessment

We must be aware of our biases. Doing things differently is hard work and requires consistent reflection. We also need to be able to reflect on when we are experiencing secondary trauma or being triggered so we can take care of ourselves.

Positionality Statement

The authors of this paper acknowledge that their backgrounds, lived experience, and professional locations affect the lens through which they do their work, and as such wish to be transparent about their position in the work.

Blair Harrison grew up in Mankato, Minnesota and has her undergraduate degree in Community Health Education from Portland State University. She received her Master of Public Health degree from Yale University and since graduating has worked extensively at the intersection of evaluation and trauma; in 2019 she completed her certificate in Trauma-Effective Leadership from the University of Minnesota. Blair is currently the Senior Advisor on Health, Homelessness and Housing at the Minnesota Department of Health. While completing this work she was a Senior Research Scientist in the Division of Child and Family Health.

Molly Meyer grew up in Loveland, Colorado and Eau Claire, Wisconsin. She has her undergraduate degree in Genetics, Cell, and Developmental Biology from University of Minnesota and her Masters of Public Health in Maternal and Child Health Epidemiology from the University of Illinois at Chicago. She has spent her career working to improve utilization of data for informed decision-making, using the frameworks of health equity, intersectionality, and data feminism. Molly is a Senior Research Scientist at Minnesota Department of Health.

Sarah Dunne grew up in Council Bluffs, Iowa. She received her Bachelors and Masters degrees in Social Work from the University of Nebraska at Omaha. She also has a Masters of Public Health in Maternal and Child Health Epidemiology from the University of Minnesota. As a skilled systems thinker and problem solver, Sarah has spent her career working to break down barriers to care for families and children through family-centered approaches. She currently serves as a Supervisor in the Children and Youth with Special Health Needs Section at the Minnesota Department of Health.

Appendices

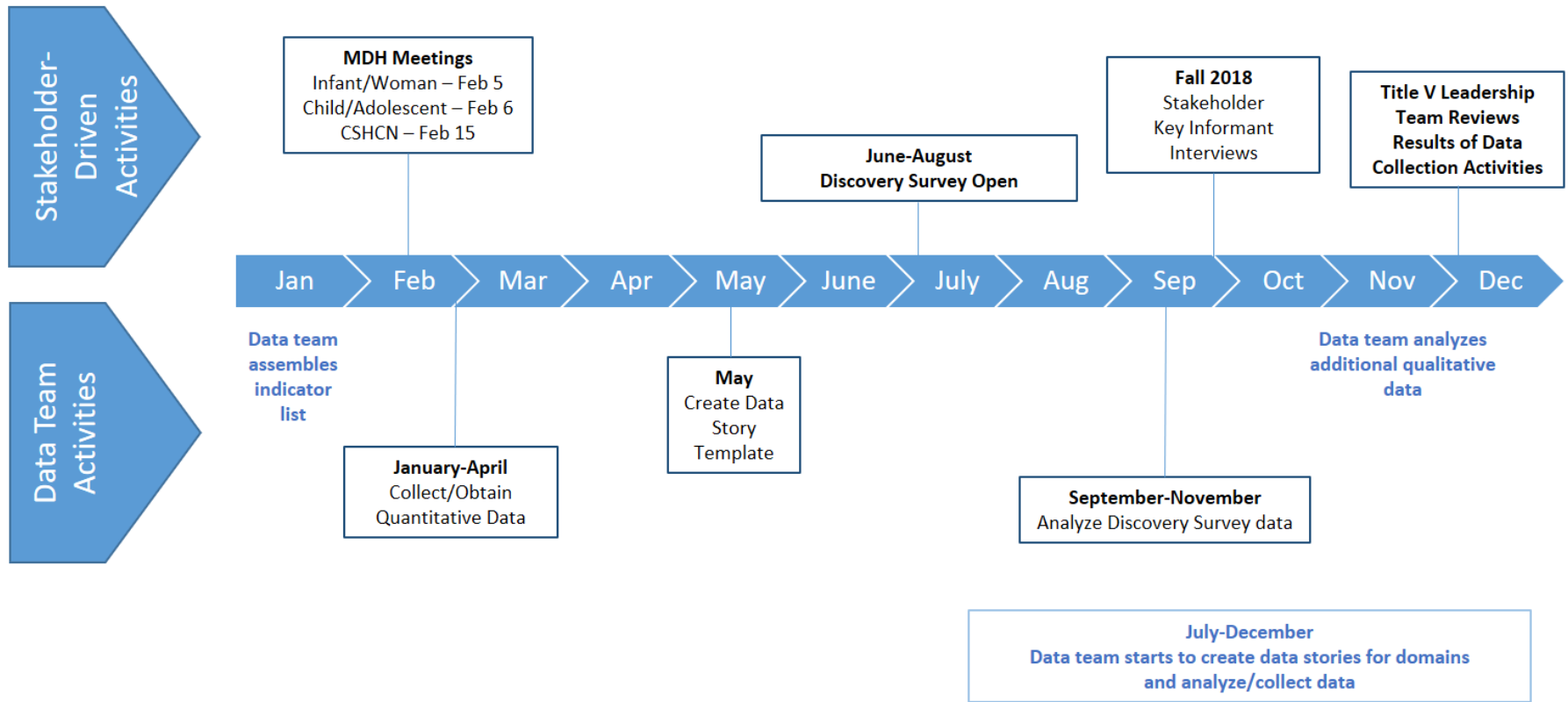## Appendix A: Guiding Principles for CFH Ongoing Needs Assessment Process

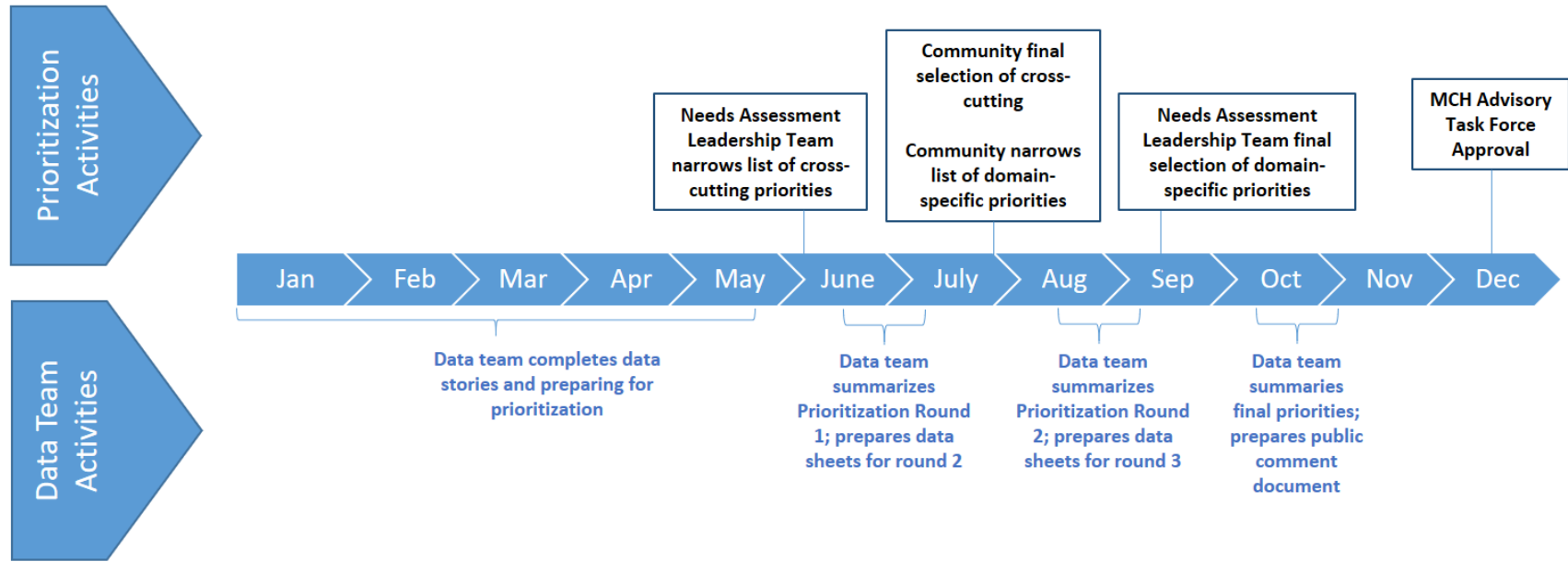| Key Principle	Activities to Operationalize
MCH Target Population: Focus on target MCH populations, which includes families, women, mothers and fathers, infants, children, adolescents, young adults, and children and youth with special health needs.	All populations have commonly understood/agreed upon definitions within the division All populations are included when collecting data All populations are included in fact sheets/snapshots presented to community/stakeholders
Health Equity: Integrate health equity throughout process using the MDH Triple Aim of Health Equity.	Implement Health Equity as the goal Expand our understanding of what creates health Strengthen the capacity of communities to create their own future Reference/utilize data on health and health disparities, MDH reports, and policy briefs Collaborate with partners/communities to ensure health equity is discussed and community suggestions are honored
Quality Improvement: Use a continuous quality improvement approach to increase assets and protective factors and to address challenges as opportunities to advance population outcomes.	Together with both internal and external partners, identify assets, protective factors, challenges, and opportunities specific to MN's MCH population Utilize continuous quality improvement expertise within the CFH Division Utilize quality improvement processes and tools appropriately throughout the needs assessment
Community Engagement: Actively engage with community stakeholders utilizing the principles within the MDH Community Engagement Plan.	Utilize MDH Community Engagement Plan with focus on intentional efforts to learn from MN's MCH population, with special effort to include those from racially, ethnically, culturally, and geographically diverse backgrounds. Actively seek, consider, and rely upon MCH community and stakeholder expertise to inform efforts and results.
Transparency: Communicate with needs assessment participants, the MCH community, and stakeholders so that information used in needs assessment is shared, and that decision-making processes are clear and understandable (also to support accountability)	Document sources of data and methods used in needs assessment Document meeting proceedings and decision-making processes Communicate with all participants and stakeholders on a regular basis throughout the needs assessment process
Accountability: Be answerable for the consequences of decisions that impact families, communities, and stakeholders.	Evaluate effectiveness of processes and programs Follow-up and/or act on feedback received Consistently report to the MCH Advisory Task Force
Data-driven Decisions: Use quantitative and qualitative data to inform decision making.	Identify and collect valid, relevant, and updated data to describe the MCH population and its needs Use the best available data and understand its limitations Utilization of prioritization process Balance data with stories, including lived experiences

Key Principle	Activities to Operationalize
	Internal partners have the ability to access aggregate public data
Evidence-Based and Informed Practices: Apply evidence-based and informed practices to methodology and planning efforts related to the needs assessment.	Create MCH/CYSHN Topic Inventory Crosswalk Qualitative and quantitative method design and implementation Apply a systematic framework to the prioritization process
Adaptability: Demonstrate willingness, flexibility and agility throughout the needs assessment process.	Remain open to change and compromise in an effort to enhance the process Consider and integrate new guidance throughout process
Collaboration with Systems Partners/Customers: Focus on both internal and external partners as key collaborators to achieve desired outcomes.	Identify internal and external partners. Develop nontraditional partners Seek input, guidance, and collaboration from identified partners, including local public health, in addition to other key stakeholders. Construct mutual goals and objectives to best utilize the synergy of all partners. Coordinate and track strategies and deliverables from all sectors. Building long-term relationships

Appendix B: Timeline with Activities

2018: The Data Stage

Stakeholder-Driven Activities

MDH Meetings
Infant/Woman – Feb 5
Child/Adolescent – Feb 6
CSHCN – Feb 15

June-August
Discovery Survey Open

Fall 2018
Stakeholder
Key Informant
Interviews

**Title V Leadership
Team Reviews
Results of Data
Collection Activities**

| Jan | Feb | Mar | Apr | May | June | July | Aug | Sep | Oct | Nov | Dec |

Data Team Activities

**Data team
assembles
indicator
list**

January-April
Collect/Obtain
Quantitative Data

May
Create Data
Story
Template

**Data team analyzes
additional qualitative
data**

September-November
Analyze Discovery Survey data

July-December
**Data team starts to create data stories for domains
and analyze/collect data**

2019: The Prioritization Stage

Prioritization Activities

Needs Assessment Leadership Team narrows list of cross-cutting priorities

Community final selection of cross-cutting

Community narrows list of domain-specific priorities

Needs Assessment Leadership Team final selection of domain-specific priorities

MCH Advisory Task Force Approval

Jan > Feb > Mar > Apr > May > June > July > Aug > Sep > Oct > Nov > Dec

Data Team Activities

Data team completes data stories and preparing for prioritization

Data team summarizes Prioritization Round 1; prepares data sheets for round 2

Data team summarizes Prioritization Round 2; prepares data sheets for round 3

Data team summaries final priorities; prepares public comment document

Appendix C: Stakeholder Mapping Exercise

In planning for the data activities of the Title V Needs Assessment, our Title V Team, CFH sections, CYSHN parent work group, and community members generated a list of potential stakeholders to engage in our process. Here is the results of the brainstorming session for who we should engage and why we engage.

Why do we engage stakeholders?

- Redistributing power
- Not just checking a box in a work plan – hearing from the source
- Caregiver Empowerment Framework – cognitive empowerment (have the information), decision-making empowerment (can make a decision), behavioral empowerment (can act or not act), hope (reason that you want to be empowered at all) – false hope it not good, the hope needs realism/action associated with it
- Assess readiness to change
- Connecting people in the community (independent of MDH) / convene (expectation that MDH has the broadest view)
- Holds us accountable – the work needs to have an impact and if it doesn't, we need to know that / if we've done things wrong we need to know that
- Opportunity to amplify work that is already being done – connecting them to other people or ways that we can support that work
- Identify system barriers (what are we responsible for that are in the way of stakeholders)
- Collective decision-making creates creative solutions & greater buy-in (champions in the community

- Community engagement grounds us in the work – the 'why' / helps with burnout (retention strategy for MDH / personal enrichment in your work)
- Identifying opportunities for shared leadership
- Being the state that people look to for innovation and best/emerging practices "good isn't good enough"
- Advance health equity
- Encourages dissent
- Responsive to current needs of stakeholders- be in the know / help mobilize

Populations that need to be engaged, represented and leaders in the work:

- Fathers
- Rural
- Tribal Nations
- Limited English/non-English speaking
- Racial & ethnic diversity
- LGBTQ
- Foreign-born/refugee
- Incarceration
- Poverty/material hardship
- Mental health
- Substance Use
- Teen parent
- Single parent
- Children and adolescents
- Housing
- Those who are deaf/hard of hearing
- Those who identify as being disabled

Appendix D: Child and Family Health Public Data Resource List

MATERNAL & CHILD HEALTH PUBLIC DATA RESOURCES (LINKS)

These links will connect you to Minnesota specific data resources related to maternal and child health (MCH) including children and youth with special health needs (CYSHN).

CFH Created Data Resources

WIC (health.state.mn.us/divs/fh/wic/localagency/reports/index.html)

Birth Outcomes | Breastfeeding | Health Risks | Food Benefits | Participation & Demographics | Weight Status, Growth, Anemia

Minnesota Created Data Resources

Public Health Data Access Portal (data.web.health.state.mn.us/web/mndata/)

Birth Defects | Birth Outcomes: Infant Mortality, Prematurity, Low Birth Weight, Sex Ratio | Poverty & Income | Lead | Maps

Early Childhood Longitudinal Data System (eclds.mn.gov)

By District/School/State | Linked education, health, & humans services data | Early Care & Education | Economic & Food Assistance | Attendance | Proficiency | Deaf/Hard of Hearing | Birth Outcomes | Maps – Parent Aware Rated Programs, early Head Start, Head Start, and Family Home Visiting

County Health Tables (health.state.mn.us/data/mchs/genstats/countytables/index.html)

By County/CHB | Births, Fertility/Birth Rates, Death Rates | Prematurity & Low Birth Weight | Infant Mortality | Prenatal Care | Cesarean Births | Fertility and Family Planning | Teen Birth & Pregnancy Rates | Socio-Demographic Factors | Educational Status of Mother | Race & Ethnicity of Mother

SUMN.ORG - Substance Use in Minnesota (sumn.org)

By County/Regions/State | Alcohol | Tobacco and Nicotine | Drugs | Shared Risk & Protective Factors | Mental Health | Gambling | Treatment

Minnesota US Census Data by Place (mn.gov/admin/demography/data-by-place/)

By County | Recent, historic, and future Population Estimates | Poverty | Social Characteristics | Fertility Data | Economic Characteristics | Employment Status | Health Insurance Coverage | Disability Characteristics | Country of Birth for Foreign-Born populations | language spoken at Home

Minnesota Compass (mncompass.org)

Children & Youth | Disparities | Early Childhood | Education | Housing | Risk & Reach

Minnesota Health Access Survey (pqc.health.state.mn.us/mnha/PublicQuery.action)

Interactive Data Tool | Biennial telephone survey | Health insurance and health care access

SLEDS (sleds.mn.gov)

By District/School/State | Linked student data from pre-kindergarten through completion of postsecondary education and into the workforce | High School Academics | Enrollment | Completing College | Entering the Workforce

Child and Teen Checkups (www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_018157)

Annual reporting to CMS (CMS-416) on the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)/Child and Teen Checkups Program (C&TC) includes breakdowns by County & Tribes | Race & Ethnicity | Foster Care

Minnesota Injury Data Access System (MIDAS) (health.state.mn.us/communities/injury/midas/index.html)

Drug overdose and substance use | Injury | Violence | Motor vehicle crash outcomes

MN Report Card (rc.education.state.mn.us)

By District/School/State | District and school information | Test Results | Demographic Information

Child Welfare Data Dashboard (mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/child-protection-foster-care-adoption/child-welfare-data-dashboard)

By County/State | Monitor the status of children served by Minnesota's child welfare system | Response Time | Maltreatment Reporting | Permanency | Placement Stability | Foster Care Reentry |Aging Out of Foster Care | Relative Care | Physical Health at Entry | Caseworker Visits

Minnesota Department of Health Data and Statistics (health.state.mn.us/data/index.html)

Complete list of Data/Statistics links within Minnesota Department of Health by Diseases and Conditions | Life Stages and Populations | Health Behaviors/Risk Factors | Health Care Systems | Vital Statistics

Nationally Created Minnesota Data Resources

Child & Family Data Archive (childandfamilydataarchive.org)

The new Child and Family Data Archive (C&F Data Archive) is the place to discover, access, and analyze data on young children, their families and communities, and the programs that serve them. The C&F Data Archive hosts over 300 datasets. Data users have access to downloadable data on children and families, with the ability to analyze selected datasets online. Users can also search and compare variables and peruse data-related publications.

Child development | Child care | Child health | Early education | Family engagement | Head Start | Home visiting | Parent child relationship | Parenting skills | School readiness | more

Title V MCH Block Grant - MN (mchb.tvisdata.hrsa.gov/State/Detail/MN)

Funding by Source | Funding by Individuals Served | Funding by Service Level | Individuals Served/Insurance Coverage | State Priorities | National Performance Measures | National Outcome Measures

National Survey of Children's Health (childhealthdata.org/browse/survey)

Child and Adolescent Health Measurement Initiative reports out over 300 indicators and survey items for child and family health and well-being and multiple Title V Maternal and Child Health Performance and Outcome measures. By survey year and geographic level.

Neighborhood Atlas (www.neighborhoodatlas.medicine.wisc.edu/mapping)

Area Deprivation Index (ADI) measures socioeconomic status disadvantage by census block/neighborhoods, ranking areas from least disadvantaged to most disadvantage. It includes factors for the theoretical domains of income, education, employment, and housing quality. The measure was created by Health Resources & Services Administration (HRSA) and adapted by a research team at the University of Wisconsin-Madison.

County Health Rankings (countyhealthrankings.org/app/minnesota/2018/rankings/outcomes/overall)

The annual County Health Rankings measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, the quality of air and water, income inequality, and teen births in nearly every county in America. The annual Rankings provide a revealing snapshot of how health is influenced by where we live, learn, work and play. They provide a starting point for change in communities.

Child Opportunity Index (diversitydatakids.org)

The Child Opportunity Index is a measure of relative opportunity across a metropolitan area calculated based on indicators of Educational Opportunity, Health and Environmental Opportunity, and Social and Economic Opportunity. Index is only measured for large metro areas.

Child Trends Interactive Map (childtrends.org/publications/mapping-the-link-between-life-expectancy-and-educational-opportunity)

Child Trends interactive map allows users to explore the link between life expectancy and high school educational opportunity for teenagers in neighborhoods across the United States including Minneapolis/Saint Paul and Duluth.

Kids Count Data Center (datacenter.kidscount.org/data#MN)

KIDS COUNT is a project of the Annie E. Casey Foundation and a premier source of data on children and families. Each year, the Foundation produces a comprehensive report — the KIDS COUNT Data Book — that assesses child well-being in the United States. The indicators featured in the Data Book are also available in the Data Center.

U.S. Census Data (data.census.gov/mdat)

Details Census data where analyst can control variables, age categories, etc.

Appendix E: Qualitative Analysis

We utilized a thematic content analysis via an inductive approach in analyzing the discovery survey responses. Initial tagging was completed by four Title V Needs Assessment Team members using a simultaneous coding method (i.e. one response often had multiple tags). Interrater reliability was achieved through several stages of review of tagging by other research team members to ensure consistency between team members. Similar or overlapping tags were grouped together and then sent to the Title V leadership Team for review and feedback. The list of priorities and associated tags was then discussed in an in-person, intensive review by the primary Title V researchers and an additional non-needs assessment epidemiologist and research scientist. The Title V data coordinator then reviewed each survey response (additional interrater reliability) and the lead qualitative researcher did one additional pass-through as well (a process called 'constant comparison' – the reading and re-reading of data to search for new themes and better understand the data). After tags and priorities were finalized from a qualitative perspective, we uploaded the data to SAS and completed a full quantitative analysis to ensure completeness of the tags/priorities and that counts were accurate.

Interpretive Limitations of Qualitative Coding: It should be noted that coding is not an exact science; it is a largely interpretive act and requires cognitive flexibility and creativity. A researcher's level of personal involvement and passion for a topic area can affect how data is interpreted, coded, and grouped. Qualitative coding reflects the constructs, language, culture and theories that structure the study and the project to begin with. To limit bias as much as possible, we utilized simultaneous coding, constant comparison, and multi-person coding.

Qualitative Analysis Methods

Step 1: Four Title V Needs Assessment Team members took subsets of the discovery survey responses and independently read, reviewed, and took notes about themes for questions #1 and #2 in the margins of the response set. To jot notes is a process called 'open coding' and to record first impressions is a process called 'initial coding'. Researchers coded the responses, or used a word or short phrase to summarize the response or a portion of the response. After reviewing their individual response subsets, the researchers met to discuss the themes that they noted. All themes were combined to develop an initial theme set.

Step 2: The lead qualitative researcher then reviewed every response for question #2 in excel and tagged the response with more specific themes (tags) within the broader theme set categories using a technique called 'simultaneous coding' (meaning one response often had multiple tags assigned). Only question #2 was reviewed at this stage because it was the question about unmet needs; question #1 was reviewed in Step 1 to ensure we did not miss a potential theme that might show up in Step 2 but be worded differently.

Step 3: The lead qualitative researcher combined all tags and removed duplicates. Similar tags were combined when the meaning was the same, just being captured with different words; for example: "support for single moms" and "supporting single moms" were combined to be "support for single moms". This significantly reduced the number of tags, as the original list was 600+.

Step 4: Two Title V Needs Assessment Team members each took half of the responses and tagged the responses using the tag list generated by the lead qualitative researcher. They were also encouraged to add or change tags if they felt a response did not fit under the developed tag structure (interrater reliability). A recommendation for future work would be to have gone one step further to conduct participant validation – wherein survey respondents were asked if they'd like to read through a subset of

survey responses to either validate or refute the Title V Needs Assessment Team's interpretation of the responses. Interpretations were conservative, meaning if the researcher could not easily discern the intent of the response it was tagged as being unusable and not included in the analysis.

Step 5: Tagging by the three team members was reconciled.

Step 6: Again, similar or overlapping tags were grouped together (informed often through input from subject matter experts) by the Title V Needs Assessment Team into priorities. An example of this would be the tags "affordable childcare", "safe childcare" and "flexible childcare" were grouped together into the priority "childcare".

Step 7: This list of priorities and associated tags was sent to the Title V leadership Team for review and feedback.

Step 8: The list of priorities and associated tags was then discussed in an in-person, intensive review by the primary Title V researchers and an additional non-needs assessment epidemiologist and research scientist.

Step 9: The violence tags/priorities were reviewed in person with Amy Kenzie and her team at the Minnesota Department of Health for input.

Step 10: The food tags were reviewed by two WIC epidemiologists, and then in an in-person meeting was held with Susan Bishop and Liana Schreiber of SHIP at the Minnesota Department of Health.

Step 11: The Title V data coordinator then reviewed each survey response (additional interrater reliability); and the lead qualitative researcher did one additional pass-through as well (a process called 'constant comparison' – the reading and re-reading of data to search for new themes and better understand the data).

Step 12: After tags and priorities were finalized from a qualitative perspective, we uploaded the data to SAS and completed a full quantitative analysis to ensure completeness of the tags/priorities and that counts were accurate.

Figure 12. An example of the team's iterative work with the tags and the constant comparison process in action

Appendix F: Key Informant Interviews Corresponding to Priorities, Spring 2019

Stakeholder Organization	Stakeholder Position at Organization	Title V Priority
Meeker County Public Health	Public Health Nurse	Well Child
Children's Cabinet of the Governor's Office	Executive Director	Early Childhood Systems
Joi Unlimited Coaching and Consulting	Founder, CEO	Mental Well-Being
PACER Center	Coordinator	Coordinated Care
University of Minnesota School of Public Health	Assistant Professor	Mental Well-Being
Star Legacy Foundation	Executive Director	Still Births
Minnesota Hospital Association	Quality and Process Improvement Specialist	NAS
Neighborhood Health Source	Executive Director	Health Care
Minnesota Department of Health	Retiree, Former Staff	Family Planning
McGregor School District	Education Director	Education
Meeker Memorial Hospital	Lactation Coordinator (IBCLC)	Breastfeeding
Hands and Voices	Director of Outreach	Deaf
March of Dimes	Director of Maternal Child Health & Governmental Affairs	Infant Mortality
UMN Extension	Health & Nutrition Educator	Food Access
Department of Human Services	HTHP grant coordinator and policy specialist on extended foster care	Foster Care
Alia Innovations	Founder & CEO	Childhood Trauma
Esther Home	Director of Community Development	Maternity Care
The Father Project	Coordinator	Fathers
Minnesota Department of Education	Interim Director	Bullying
Minnesota Department of Health	Suicide Prevention Program Coordinator	Suicide
	Founder and Executive Leadership	Oral Health
University of Minnesota	Professor/Faculty	Culture of Safety

Stakeholder Organization	Stakeholder Position at Organization	Title V Priority
MDH IVP	Program Staff	Culture of Safety
Recovree	Founder and CEO	Access to Behavioral Health Services
CYSHN Parent	CYSHN Parent	CYSHN

Appendix G: Pre-Prioritization Methods

Pre-prioritization was needed to reduce the large list of 'ever-mentioned' items to a working list of candidate priorities. Methods were developed, reviewed, agreed upon, and documented prior to the actual prioritization activity to ensure legitimacy of results.

Methods

1. A master list of possible needs was created. These possible needs were identified from many different inputs including: current priorities, maternal and child health research scientists brainstorming session, internal MDH feedback from February 2018 meetings and CFH meetings, feedback from subject matter expert meetings in spring 2018, Community Health Assessment (CHA) findings, discovery survey themes, and MCH Task Force mentions, and Title V MCH Block Grant framework (i.e. National Performance Measures, etc.).

Internal MDH meetings
Existing priorities/NPM
Subject Matter Expert meetings
Key informant interviews
Discovery Survey

Identify unique needs
(n=XXX individual needs)

Remove never-mentioned
(n=XXX individual needs)

Merge similar needs
(n=XXX individual needs)
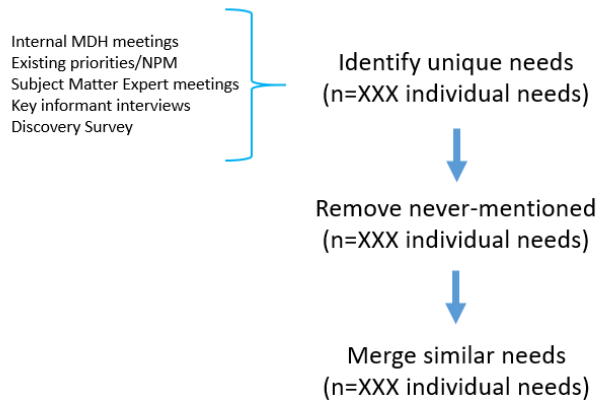
A total of 147 possible priorities were identified.

2. If a possible priority was not mentioned during a listening sessions, key informant interviews, or on the Discovery Survey, it was removed from the list of priorities being considered.
3. Many of the needs identified individually on the master list were highly similar, and the Title V Needs Assessment Team performed coding and editing using an iterative consensus-seeking approach to merge like needs.

After completing these initial steps 76 "ever mentioned" priorities moved on to scoring.

4. We created a scoring rubric to apply to the "ever mentioned" possible priorities. Each possible priority was scored to rank how often the priority was raised. See scoring rubric below with scoring guidance.

Discovery Survey Top 10 mention in racial minorities that's different than overall top ten (Score = 1, else = 0)	Mentioned in Discovery Survey 4 = Over 200 3 = 40-199 2 = Mentioned more than 10 times 1 = Mentioned at least 1	Internal Meetings 2 = Mentioned Frequently 1= Mentioned	Current Title V Priorities (Score = 0.5, else 0)	Total Score

5. We preselected a range how many candidate priorities would be selected for each domain:
   a. Cross-Cutting (10-15)*
   b. MCH Domains (4-6 per domain)
   ▪ *Due to the large response
6. Before scoring it was decided by the Title V Leadership Team, in consultation with the Director of the Center for Health Equity, to remove 'Health Equity' as a stand-alone priority. It was agreed upon that embedding health equity into each need/priority is more effective than having health equity be a stand-alone topic. The Title V Needs Assessment and proceeding Strategy Development process operates from a trauma-informed, advancing health equity framework and **Health Equity** a focus within each and every priority.
7. After scoring 'ever mentioned' priorities we assessed the scores by domain. The Title V Needs Assessment Team found clear cut off in scores within each domain following the preselected range of candidate priorities. These priorities were considered our candidate priorities for creating data stories, data placemats, and doing criteria-based prioritization.

We arrived at a list of 40 candidate priorities using this methodology.

Appendix H: Data Placemat Examples

HOUSING

Safe, affordable, stable housing for all people living in Minnesota

"[Women, children and families need] safe, affordable housing. There are many other important things needed to live life to the fullest. But without a safe place to sleep, its hard to do anything else."
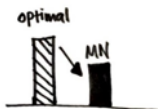
Minnesota is facing a housing crisis.

A household is considered housing cost-burdened when 30 percent or more of monthly gross income goes to paying for housing:

26 percent of households (1 in 4) in Minnesota are housing cost-burdened

In the rental market, a healthy vacancy rate is 5%, but in Minnesota it is as low 2%

SORRY! NO VACANCIES

optimal

MN

Homelessness in Minnesota has increased 10 percent since 2015

African Americans make up 39 percent of homeless adults, but only 5 percent of adults statewide

American Indians make up 8 percent of homeless adults, compared to 1 percent statewide
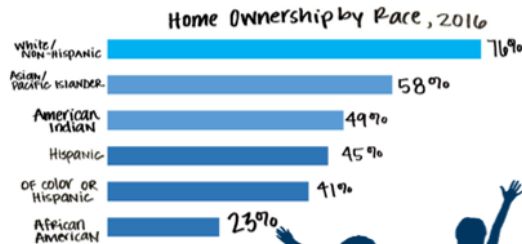
Why It's Important

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 being healthy. Every person living in Minnesota should have a safe, affordable place to live in a thriving community. But not all do. Homelessness and health are interconnected: with poor health being both a cause and result of homelessness. **Nearly half** of the state's homeless population (46%) is comprised of homeless children and youth age 24 and younger with 32 percent being children age 17 or younger (with their parents).

Since 2000, white and Asian households in Minneapolis have seen an increase in household income, while black households experienced a **40 percent decrease** in income during the same time period.

Minnesota is home to the greatest disparity in home ownership rates between white and non-white residents in the nation.

Home Ownership by Race, 2016

White/Non-Hispanic	76%
Asian/Pacific Islander	58%
American Indian	49%
Hispanic	45%
Of color or Hispanic	41%
African American	23%

White people are 3.3x more likely to own a home than black people in Minnesota

m DEPARTMENT OF HEALTH

CARE DURING PREGNANCY + DELIVERY

## Accessible, quality health care during pregnancy and delivery

"[Women, children, and families need] streamlined, comprehensive, support services and resources... a comprehensive model that would address the root causes of poverty and break the cycle for future generations. Another big unmet need within my immediate community of the North Shore, is access to birthing facilities. Everyone north of Duluth along Highway 61 from Two Harbors to Grand Portage, have no local birthing facilities. Your only options are to drive to Duluth, or have a homebirth. Having such limited options for access to care, is a huge disparity and burden on our community."

Babies of mothers who do not get prenatal care are **3x** more likely to have a low birth weight and **5x** more likely to die than those born to mothers who do get care.

Approximately **1 in 30** or **2,289** infants were born to a woman who received late (care that started in 3rd trimester) or no prenatal care.

Only **77.1%** of women received prenatal care within their first trimester of pregnancy.

Barriers to Prenatal Care among women who didn't get it as early as they wanted, 2012-2017
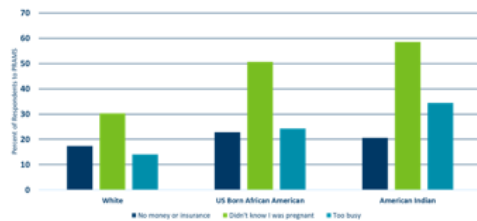

44% of mothers living in Greater Minnesota experienced at least one barrier to prenatal care.

mn DEPARTMENT OF HEALTH

Why It's Important

Having a healthy pregnancy and access to quality birth facilities are the best ways to promote a healthy birth and thriving newborn. Getting early and regular prenatal care is vital. Prenatal care is more than doctor's visits and ultrasounds; it is an opportunity to improve the overall well-being and health of the mom which directly affects the health of her baby. Prenatal visits give parents a chance to ask questions, discuss concerns, treat any complications timely, and ensure that mom and baby are safe during pregnancy and delivery. Receiving quality prenatal care can have positive effects long after birth for both the mother and baby. When it is time for the mother to give birth, having access to safe, high quality birth facilities is critical.

Mothers living in rural areas are at

higher risk

of pregnancy complications including preterm birth, out of hospital birth, and giving birth in a hospital without obstetric services.
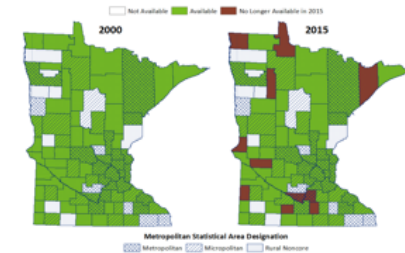
Between 2000 and 2015, the number of community hospitals offering birth services in Minnesota in rural counties fell **37%** compared to only **4%** in metro counties.

Appendix I: Criteria-Based Prioritization Spreadsheet

Criteria	Criteria Explanation	Scoring Guidance	Accessible and Affordable Health Care	American Indian Maternal and Child Health	Child Care	Culturally Responsive Care	Culture of Safety	Education	Applied Weight
Magnitude	The number of people who are impacted.	1 = low 2 = moderate is some populations 3 = moderate 4 = high in some populations 5 = high							1
Trend	A pattern of gradual change or general tendency of a series of data points to move in a certain direction over time.	1 = clear improvement 2 = some improvement 3 = no improvement 4 = some worsening 5 = clear worsening							1
Health and racial equity	Attainment of the highest level of health for all people. Inequities are differences (i.e. disparities) among different groups of people that are avoidable, unfair, and unjust.	1 = no disparities 3 = moderate disparities 5 = persistent/high disparities							2
Impact/severity	The impact/effects of the utilization of resources (financial cost), morbidities, comorbidities, and mortality.	1 = generally minor 3 = frequently moderate 5 = frequently severe							1
Perceived preventability	Able to be prevented, avoided, or stopped in its tracks.	1 = not currently preventable 3 = partially preventable 5 = preventable							1
Effective interventions	Effective intervention or evidence-based/informed strategy is available (efforts will make a measurable impact in 2, 5, and 10 years).	1 = no known effective interventions 3 = at least 1 known effective intervention 5 = many known effective interventions							1
Agency capacity	The ability for Child and Family Health, in partnership with stakeholders, to dedicate resources to address strategies to improve priority.	1 = No dedicated or available resources 3 = No current dedicated resources but possible available resources 5 = Dedicated and available resources							1
Political will	The collective support from state administration, politicians, and the public.	1 = Support from none 3 = Support from at least one 5 = Support from all							1
Stakeholder input*	Contributions from community members, stakeholders, internal staff, and other partners throughout Needs Assessment process.	1 = Low frequency of mentions 3 = Medium frequency of mentions 5 = High frequency of mentions							2
		Total	0	0	0	0	0	0	

* Stakeholder input score will be combined with results from community forum.

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